INTEGRATING HIV/STD AND PRIMARY HEALTH CARE SERVICES: INTERNATIONAL POLICY DEVELOPMENTS AND NATIONAL RESPONSES WITH SPECIAL REFERENCE TO SOUTH AFRICA

A Thesis

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ABSTRACT

The overall aim of this thesis was to understand how new policies are reflected in national policy, and subsequently implemented. It suggests a fruitful way of analysing how policies fare is through exploring the notion of policy transfer - a complex process, mediated by different groups of actors. The focus for this study was on one particular policy: that of integrating management of HIV and sexually transmitted diseases (STD) with primary health care (PHC) services.

During the 1990s, after clinical trials showing that HIV transmission could be slowed if STDs were controlled at the PHC level, the international community strongly promoted the idea that management of HIV and STDs should be integrated into PHC services. This thesis explores the trajectory of this impetus: from policy development at international level, to the response at national level. It suggests that integration of these services was driven by strong leadership from women's groups and international donors. New technologies, such as syndromic management of STDs, were perceived to be one of the ways in which integration could be introduced at the primary level. However, reviewing such experience that exists, shows that the enthusiasm for integration of HIV/STDs with PHC services was soon tempered as limited political, financial and technical resources hindered effective implementation. The study argues that limited political interest in integration was due partly to the fact that some countries were characterised by a relatively coercive relationship between external funders and national policy makers. This meant that efforts to introduce policy reforms were not strongly supported by governments, through allocation of financial or other resources, and donors were forced to spend according to their own priorities. Thus while there was agreement at national levels to policies, in fact, at sub-national levels implementation was weak.

The thesis then goes on to explore South Africa's experience, which provides a contrast to the experience of many other African countries. Relatively isolated from international discourse until the early to mid 1990s, South Africa developed its own policies on integration, reflecting many of the same concerns and interests of the international community, but generating such concern from within the country, rather than having it imposed from outside. The thesis analyses developments in policy in the country, from agenda setting to policy formulation, and then looks at what happened during implementation in the Northern Province, one of the poorest parts of South Africa, and more akin to its northern neighbours than other areas. It shows that policies were developed in a context of radical and rapid political and economic change and, as a result, national policy makers sometimes failed to take account of impediments to implementation at sub-national levels, or of the constraints to service delivery.

The thesis concludes by expanding on an analytical framework for policy which incorporates the notion of policy transfer, as a necessary adjunct to understanding how policies are formulated and implemented. It suggests that where international agendas are not reflected in national policy discourse, they are less likely to be fully absorbed or implemented. However, even where policies are transferred between national and sub-national levels, problems remain with implementation which need to be addressed.

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AIDS	acquired immune-deficiency syndrome
ANC	African National Congress (South Africa)
ATICC	AIDS Training, Information and Communication Council (South Africa)
BCG	bacillus Calmette-Guerin (vaccination against tuberculosis)
CBO	community based organisation
CEDAW	Convention on the Elimination of Discrimination Against Women
COPE	'client oriented provider efficient'
COSATU	Congress of South African Trades Unions
DALY	disability adjusted life year
DAWN	Development Alternatives for Women
DFID	Department for International Development (UK)
DHS	Demographic and Health Surveys
DHW	Department of Health and Welfare (Northern Province, South Africa)
DHWMT	district health and welfare management team (Northern Province, South Africa)
DISC	District Information Systems Commission (Northern Province, South Africa)
DOH	Department of Health
DOTS	directly observed therapy, short course
DPT	diphtheria, pertussis and tetanus vaccination
EU	European Union
FLEP	Family Life Education Project, Uganda
FP	family planning
GDP	gross domestic product
GEAR	Growth, Employment and Redistribution Policy (South Africa)
GPA	Global Programme on AIDS
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IUD	intra-uterine device
IWHC	International Women's Health Coalition
LSHTM	London School of Hygiene and Tropical Medicine
MCC	Medicines Control Council (South Africa)
MCH	maternal and child health
MCWH	maternal, child and women's health
MOH	Ministry of Health
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGO	non-government organisation
OPD	outpatients' department
PHC	primary health care
PID	pelvic inflammatory disease
PPASA	Planned Parenthood Association of South Africa
RDP	Reconstruction and Development Plan (South Africa)
RHRU	Reproductive Health Research Unit (South Africa)
RPR	rapid plasma reagin
SAIMR	South African Institute for Medical Research
STD	sexually transmitted disease
STI	sexually transmitted infection
SWAp	sector-wide approach
TB	tuberculosis
TLC	Transitional Local Council (Northern Province, South Africa)
TPA	Transvaal Provincial Administration (Northern Province, South Africa)
UK	United Kingdom
UN	United Nations

UNAIDS   United Nations AIDS programme
UNDP   United Nations Development Programme
UNFPA   United Nations Population Fund
UNICEF   United Nations Children's Fund
US   United States
USAID   United States Agency for International Development
WHO   World Health Organisation

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'For 30 years, the population field has sought and protected funds specifically segregated and allocated for family planning services and related research and policy. Other sectors, such as child survival and maternal and child health, similarly segregate funds. Segregating funds in this way has discouraged cross-sectoral collaboration and comprehensive programs around the world. Though the issue receives little public attention, this was and remains one of the more challenging aspects of the Cairo debate.'

(Germain and Kyte 1995: 6).

'Long-haul reforms call for a different kind of policy analysis to help guide decision makers: analysis that makes sense of broader factors and pays explicit attention to what it takes to make policy changes happen, not simply design what they should do.'

(Brinkerhoff 1997: 1).

CHAPTER 1: INTRODUCTION, BACKGROUND AND METHODS

1.1 Background and rationale for research

1.1.1 Relationships between international and national policies

The aim of international health policy is to provide guidance and assistance to national policy makers, in order to improve health care and public health for the greatest number of people. To achieve such a lofty goal, during the past 50 years, myriad international organisations were established to aid the improvement of health care world wide and, after the 1940s, there were large increases in funds flowing to low income countries (Mosley *et al.* 1991). These funds were provided by rich Northern countries concerned to improve public health and their agendas dominated subsequent developments in global health policy institutions. These institutions achieved great reductions in mortality and morbidity but huge challenges remain. In general, the largest improvements took place in countries and populations that were relatively easy to access with services. This has led to growing inequalities between those whose needs were met or not by health care (Gwatkin 2000; Makinen *et al.* 2000). Inequalities now exist both between and within countries and stem from social, political and cultural discrimination as well as inequity in health service delivery. Those left behind include sectors of society which have traditionally been neglected, such as the poorest, women and particular ethnic groups (Brockerhoff & Hewett 2000; Gakidou *et al.* 2000).

During the 1990s, shifts in global relations led to rapid expansion in financial transactions, communication and diffusion of ideas (Deacon 1999). While not a central concern of health policy makers, these phenomena created a new context for international actors and have changed the institutions and structures through which they worked (Walt 1998). Similarly, national health policy makers became increasingly exposed to these discourses, which restricted their options but also facilitated their involvement in setting international agendas. At the same time, large numbers of non-state, for- and not-for-profit organisations began to participate in financing and providing health care at international and national levels. This changing nature of international relations, combined with the failure of efforts to meet the health needs of large sections of society, led to questions over the limitations of the international policy process (Gwatkin 2000). In health, such questions included: why international gold standards fail to be absorbed into national policy; how international organisations can co-operate better when funding national health programmes; why there are such large gaps between policies formulated and implemented; what the contribution of non-governmental actors to international health should be and how it should best be regulated; and how international funds could be allocated more effectively to meet the needs of the poor.

This thesis cannot hope to address all these questions. Instead, some of them will be examined through the lens of one recent international health policy: the integration of HIV and sexually transmitted disease (STD) related services with primary health care (PHC). This policy addressed two important health issues, reducing HIV and STDs and improving women's reproductive health, which were high on the international health policy agenda during the 1990s. HIV/STDs disproportionately affect vulnerable sections of society and have been concentrated to date in sub-Saharan Africa, the poorest region of the world (UNAIDS 1999). The emphasis on women's reproductive health was driven by concerns of international women's groups to redress the imbalance in access to both resources and healthcare between men and women (Germain & Kyte 1995). In addition, the policy was prominent in debates about the future of international health under new global institutions (Lush *et al.* 1999).

By choosing a policy which received substantial international support, this research aimed to document and analyse how international consensus on health policy was reached, including the actors involved, their interests and influence over the process. The study also examined the way the policy was then transferred from international to national level and what happened subsequently with implementation. This stage of the research focussed on countries in sub-Saharan Africa, where the health issue was of high priority and links with international actors providing financial assistance to health sectors were strong. A case study was conducted in South Africa, to provide more detailed analysis of the relationships between international and national actors and agendas. While South Africa was by no means typical of other countries in the region, being richer and historically more isolated from the international community, by contrasting its experience with that elsewhere, lessons were drawn about how an international policy became absorbed into national policy and subsequently implemented.

The main theme of the research was that, in their enthusiasm to get new policies into practice, international actors could become over-zealous in their dealings with national actors. Where national financial, technical and political resources were weakened by years of poverty and mismanagement, governments were more vulnerable to outside interference in their policy agendas and more likely to be coerced into policies they would not necessarily prioritise themselves. By contrast, where national resources were strong, as in South Africa, vulnerability to coercion was reduced and instead, international discourses fed into national agendas more effectively. In the latter situations, because policies were locally owned and supported, implementation was likely to be more effective.

1.1.2 Introducing the policy: integration of HIV/STD and primary health care services

During the 1990s, high and rising prevalence of STDs, including HIV, in low income countries heightened international concern over the absence of a cheap and simple means of preventing or treating these infections. Seventy per cent of global HIV infections in 1998 occurred in sub-Saharan Africa, a total of four million people, nearly half of whom were under the age of 25 (UNAIDS 1998). High levels of other STDs were also found in so-called low risk populations in many low income countries: the World Health Organisation (WHO) estimated that, in 1995, there were 65 million new sexually transmitted infections (STI) in sub-Saharan Africa alone (WHO/GPA 1995), out of a total of 333 million globally. By that time, such infections were also acknowledged to contribute to the spread of HIV (Cohen 1998) and, as a result, recent HIV prevention efforts have focused on managing STDs (Grosskurth *et al.* 1995; Dallabetta & Diomi 1997).

In 1993, the *World Development Report* estimated that 8.9 per cent of global burden of disease for adult women was due to STDs, excluding HIV, and that it was the second biggest cause of ill health in this group, after maternal causes (World Bank 1993). The following year, at the International Conference on Population and Development (ICPD), the international community affirmed a commitment to provide a comprehensive and integrated package of reproductive and sexual health services for women, including management of HIV and STDs (United Nations 1995). Hence, in the five years post-ICPD, in order to reduce the spread of HIV and improve women's reproductive health, particular emphasis was placed on controlling these infections through the mainstream services that women were using.

The rationale for this approach stemmed from both theoretical considerations and empirical findings. At first glance, HIV/STD control and women's reproductive health had much in common: both included health problems arising from sexual intercourse; and both relied on health services which were used mainly by women. Within PHC, maternal and child health and family planning (MCH/FP) services were relatively accessible and well attended in most low income countries so adding STD control to these services should have been financially and logistically rational (Mayhew 1996). It also capitalised on a common interest in encouraging a more informed approach to sexual intercourse and its possible consequences (Dixon-Mueller & Wasserheit 1991). Furthermore, where HIV/STD prevalence was high, FP advice and methods should have been appropriate to the disease environment and associated sexual health risks. Finally, a trial of STD syndromic management in rural Tanzania showed that it was possible to reduce incidence of HIV infection by around 40 per cent (Hayes *et al.* 1995). This trial was specifically designed to be replicable in PHC settings and was highly cost effective (Gilson *et al.* 1997). As a result, policy makers became enthusiastic about implementing STD management programmes at primary care levels, especially in places where HIV/STD

prevalence was high, and 'integration' became the mantra of governments and donors alike (USAID 1995).

However, there were significant but overlooked discrepancies between the health care provided in the Tanzania trial and that found at most PHC clinics in sub-Saharan Africa. First, the former included men, for whom syndromic management is known to be more effective than for women (Dallabetta *et al.* 1998). Second, the package of activities included was broad, including intensive community awareness raising, partner notification efforts, medical supervision and logistics enhancement, in addition to syndromic management of presenting STDs. By contrast, many efforts to control STDs in PHC concentrated on syndromic management while neglecting other important interventions. Furthermore, soon after the emergence of this agenda, the international community also recognised that there were disadvantages, including: reduced effectiveness relative to vertical, problem-specific programmes (Potts 1995; Hawkes 1998); increased costs associated with over treatment using syndromic algorithms (Dallabetta *et al.* 1998); sensitivities among health providers and their clients; and the difficulty of implementing a wide variety of new and clinically complex activities.

Despite these limitations, during the mid-1990s, many health outlets in low income countries moved to integrate service delivery, although patterns of integration varied considerably (Bastos dos Santos 1992; Grosskurth *et al.* 1993; Lande 1993; Finger & Barnet 1994). A 1995 workshop with participants from 18 sub-Saharan countries showed confusion over the definition of integrated services and a surprising lack of knowledge about organisational and other issues (USAID 1995). Three years later, at a follow-up workshop on interim achievements, the debate over definitions continued[1], reflecting the many varied forms that integration could take. First, integration could vary by **type of facility**: in district hospitals, it was possible to have both MCH/FP and HIV/STD treatment and prevention in one site. In contrast, in rural health centres, such comprehensive services were probably not feasible, although some level of HIV/STD information, prevention or referral linkage could be incorporated into existing MCH/FP, often delivered by a single provider. Alternatively, HIV/STD and MCH/FP clinics could be run at the same outlet on different days or at different times, with a range of staff catering to the needs of varied clientele, including women, men and adolescents.

Second, integration could vary according to **administrative level**, incorporating both horizontal and vertical approaches (Pachauri 1994; Potts 1995). For example, while there could be a high level of integration at outlet level, at a policy level, MCH/FP and HIV/STDs usually had separate, vertical

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[1] Personal observations at second workshop on integration of MCH/FP and HIV/STD services in sub-Saharan Africa, December 1998, Nairobi: report not yet available.

management systems. At district level, it may have been more efficient to manage HIV/STD and MCH/FP programmes through decentralised and integrated administrative systems. Higher levels of management, however, found it necessary to maintain separate offices to determine national policy. Such programmes also satisfied the accountability and transparency needs of international funders.

Third, the appropriateness of an integrated HIV/STD service could depend on the **prevalence of disease**: in high prevalence situations, mass treatment may be the most cost-effective and efficient method of prevention; in low prevalence situations, however, targeting high risk groups is more suitable (De Lay 1994; Pachauri 1994; Meda 1995). Because of these wide ranging options, integration, and attitudes towards it, needed to be examined separately at each level of an administration, from service outlets through programme managers to policymakers. Patterns of integration depended on national situations and a single blueprint was unlikely to be appropriate.

In many countries, however, the relevant information to guide these policy decisions was not available (Germain *et al.* 1992; Pachauri 1994; Dehne & Snow 1999). The information needed could be conceptualised in three areas: policy, provider and client. Questions at the policy level included establishing the attitudes of key actors in government, donor and other relevant institutions and the factors that constrain policy options at the centre. Although information on policies regarding the integration of these services was limited, past experience showed that many health policies floundered when they came to execution because of insufficient ownership or consideration given to implementation. At the provider level, information was needed: on the nature, quality and accessibility of services currently provided, to identify those aspects of existing MCH/FP and HIV/STD services which could realistically be integrated; and on provider attitudes to integration and how service delivery personnel might be trained to perform additional tasks. At the client level, it was not always clear how MCH/FP clients might react to an expanded reproductive health service and what its impact might be. Information was thus required on the views of different types of client attending health services.

In sum, there were two principal reasons to integrate HIV/STD management with PHC services: to reduce the spread of HIV; and to improve women's reproductive health. Doubts existed, however, over whether or not it would be possible to achieve these ends through such an intervention. Nevertheless, there were substantial efforts at international level to promote HIV/STD management through MCH/FP services: this thesis addressed the processes of international agenda setting and policy development at national level in response to this international agenda.

1.2   Aims and objectives of the research

The overall goal was to understand better the relationship between international, national and sub-national policy processes. The study therefore aimed to analyse: (i) rationales for and process of setting global policy agendas; (ii) national experiences with formulating and implementing policies in response to a global agenda, with a focus on sub-Saharan Africa; (iii) agenda setting and policy formulation in South Africa; and (iv) gaps between national policy intent and implementation in the Northern Province, South Africa.

In order to achieve these aims, a number of specific objectives were identified with respect to the policy in question:

1.   to define 'integration' as it was used in reproductive health after 1994 and analyse the origins of the concept, potential benefits for service users and limitations to the approach;

2.   to conceptualise links between the international agenda setting process and health policy processes at national level, including similarities between national and international agenda setting, the process of transfer from international to national levels and factors affecting subsequent implementation in services;

3.   to analyse how integration emerged onto the international health agenda, through the activities of different networks of policy makers and their political relationships;

4.   to document and analyse the processes of policy formulation and implementation for integration in sub-Saharan African countries (using secondary data particularly from Ghana, Kenya and Zambia), characterised by extreme resource constraints, heavy donor influence and poor management capacity;

5.   to compare these experiences of agenda setting and policy formulation with those in South Africa, a country with very different political, economic and social circumstances;

6.   to assess the process of implementing policies in the Northern Province, South Africa and to understand how a strong commitment to integrated PHC affected HIV/STD control efforts; and,

7.   to assess how well theoretical models fitted the data on international health policy agendas and national policy formulation and implementation, what the outcome was in terms of service provision and health impact and what lessons could be drawn for analysing other international health policies.

1.3   Frameworks for analysing health policy in low income countries

1.3.1   Policy analysis approach

In order to achieve these goals, analytical techniques which fell under the broad label of policy analysis were used. Policy analysis is an approach which aims to understand how policies develop rather than what their content is (Walt 1994). It draws on theoretical frameworks from a range of disciplines, including political science, sociology, public policy and economics. In so doing, it emphasises above all the role of actors in the policy process and the way different actors relate to each other through their particular interests in and influence over the issue in question. Actors can be individuals or groups based in organisations. They can be state or government, particularly Ministries of Health (MOH) in health policy, but can also include those outside government, such as non-government organisations (NGOs), private organisations, medical provider associations or international agencies. Understanding how these different actors interact to influence policy decisions in particular fields is a central aim of policy analysis.

Actors take their decisions within a broader political, economic or cultural context (Leichter 1979). This context reflects both the national and international setting for policy and increasingly national actors must take international events and influences on policy into account. Context often determines which actors participate in policy decisions and which are more likely to get their interests reflected in policy. Actors also, however, determine context to some extent, since the institutions through which they interact determine the political context and the kind of resources available for policy.

1.3.2   International agenda setting and transfer to national levels

In assessing the role of actors and their context in policy, it is important to consider different stages of a policy process. In this research, two stages were of particular interest: agenda setting; and implementation. Agenda setting refers to the process by which an issue reaches the attention of policy makers. Although this could be assumed to be a rational process of evaluation of new problems and possible solutions to them, key models in the literature suggest otherwise (Hogwood & Gunn 1984; Reich 1995). Instead, agendas are depicted as resulting from the interactions between problem, politics and policy streams which progress relatively independently until particular windows of opportunity for reform arise (Kingdon 1984). Understanding the contribution of actors and their context to the progression of these streams is therefore one way of shedding light on why issues rise onto the agenda at certain points in time and whether they are likely to be acted upon in later stages of policy.

One way in which issues might reach the national agenda is through interactions between international and national actors. Thus issues which are of high priority to international actors, particularly where those actors are powerful, may be more likely also to appear on national agendas. This process has been referred to as policy transfer, in which lessons are drawn from one setting to inform policy development in another (Dolowitz & Marsh 1996). Again, transfer of policy is largely determined by actors, their ideology and the context within which they work: where these factors are considered to be relatively close, it is assumed that policy will be transferred more easily. Where they are less close, more coercive mechanisms may be required to ensure that policies reach national agendas. This is a particular feature of policy making in low income countries where the presence of external actors, such as the World Bank, with the resource power to influence the policy agenda in their own interest can distort other indigenous policy processes.

1.3.3 Implementation of policy in low income countries

Once a policy has been transferred, it needs to be formulated into a concrete statement by the government of what it intends to do about a particular issue. It may or may not then be implemented, the second policy process of interest in this research. To ensure that something actually comes of the commitment it has made to a national agenda, a government needs to allocate financial, technical, managerial and political resources (Grindle & Thomas 1991). The literature on how this takes place is large and focuses particularly on the participation of a wide range of actors in determining the process of implementation, especially those at the bottom of the hierarchy who often get neglected in decision making networks. The literature has been relatively quiet, however, on the influence of international actors on national policy implementation, especially where the policy in question originated in the international sphere.

Most of these policy analysis frameworks were developed for analysing policies in Northern country settings. There are, however, key differences between Northern and Southern settings which will be explored in this research. Policy analysis frameworks were used here to investigate the processes of agenda setting and implementation for policies to integrate HIV/STD services with PHC. Rather than attempting to evaluate the effectiveness of particular interventions, the study assessed how governments reformed their health services in response to the international agenda for integration. The study focused on these issues in sub-Saharan Africa, a region where the policy was potentially of high priority, given epidemiological results on the HIV/STD epidemics, but where governments were slow to respond to the crisis. The research highlighted the process by which governments reacted to the international agenda for integration and the participation of different actors in this process. It then looked at how policies were subsequently implemented. A comparative case study methodology was used in which the principal case study was South Africa, studied through empirical field work in

1998. Experiences here were compared with those elsewhere, as reported in the literature of the same period.

1.4 Choice of case study countries

1.4.1 Focus on sub-Saharan Africa

Table 1.1 Prevalence of HIV/STDs, contraceptive use and ante-natal care attendance in four selected countries

Country	Disease prevalence in pregnant women and contraceptive and ante-natal care use		Reference population and date
Ghana	HIV	2.4	National, 1997
	Chlamydia	3.6	Kumasi, 1987
	Gonorrhoea	-	
	Syphilis	-	
	Contraceptive use	10.0	National, 1993
	Ante-natal care attendance	87.0	National, 1993
Kenya	HIV	10.6	Nairobi, 1994
	Chlamydia	8.8	Nairobi, 1994
	Gonorrhoea	2.4	Nairobi, 1994
	Syphilis	6.8	Nairobi, 1992
	Contraceptive use	27.0	National, 1993
	Ante-natal care attendance	95.0	National, 1993
South Africa	HIV	22.8	National, 1998
	Chlamydia	8.0	Rural KwaZulu/Natal, 1996
	Gonorrhoea	4.0	Rural KwaZulu/Natal, 1996
	Syphilis	8.0	Rural KwaZulu/Natal, 1996
	Contraceptive use	49.0	National, 1998
	Ante-natal care attendance	94.0	National, 1993-98
Zambia	HIV	26.6	Urban, 1994 (rural = 12.7)
	Chlamydia	-	
	Gonorrhoea	-	
	Syphilis	17.5	Lusaka, 1994
	Contraceptive use	11.0	National, 1996
	Ante-natal care attendance	96.0	National, 1996

Sources: Drescher *et al.* 1988; Ghana Statistical Service 1994; Jenniskens & Obwaka 1994; National Council for Population and Development 1994; de Graft-Johnson 1995; Temmerman 1995; Pham Kanter *et al.* 1996; Thomas *et al.* 1996; Central Statistical Office 1997; UNAIDS & WHO 1998a; UNAIDS & WHO 1998b; UNAIDS & WHO 1998c; Department of Health 1999; Medical Research Council 1999.

In sub-Saharan Africa, many of these issues were highly pertinent to concurrent efforts to improve public health. With epidemic levels of both HIV and classic STDs (Table 1.1[2]), high priority was set

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[2] In Table 1.1, data from Ghana, Kenya and Zambia are shown along with those from South Africa, the main case study of this thesis. These three countries were all part of a study of integration which I was involved in (see Section 1.6). While evidence from elsewhere in sub-Saharan Africa will also be referred to in Chapter 4, because this study had been conducted, inevitably more information was available on these countries. They were selected according to the following criteria: to show variation in MCH and FP use and HIV/STD

on identifying ways to mitigate their effects. However, many countries in this region were also poor, indebted and had weak capacity for implementing the kind of radical health reforms needed to address such problems. Health budgets were constrained and public health facilities were facing major dilemmas in sustaining quality of care. In this situation, many accepted that HIV/STD services could no longer be isolated from FP, MCH or PHC in general. The international community therefore stepped in to promote more efficient and effective health services and in many cases financed substantial proportions of national health budgets in these areas.

In sub-Saharan Africa, there were good grounds for believing that many countries in the region had commenced fertility transition (Cleland *et al.* 1994; Table 1.1). Of the countries shown above, for example, Kenya and South Africa experienced significant rises in contraceptive use during the 1980s and 1990s, while, in Ghana and Zambia, contraceptive practice remained low but was expected to rise in the near future. However, the growing acceptance of contraception was taking place against a background of a high burden of STDs and a worrying level of HIV sero-prevalence among pregnant women. Kenya, South Africa and Zambia had all experienced problems with high rates of HIV and STD infection; in Ghana, they were not yet high but appeared to be rising. In all countries, attendance at ante-natal care, at least once in a pregnancy, was widespread.

However, in Africa, as elsewhere in the developing world, MCH/FP services and STD treatment were traditionally provided by separate services, physically, financially and organisationally. They were gender-biased, the first focusing on women (as mothers), the second attracting three men to every one woman and often targeting youth (Mayhew 1996). STD services remained a neglected part of public health and needed significant injections of financial and other resources. While stigma and fear were attached to providing and receiving STD and HIV/AIDS services, MCH/FP services were relatively well resourced and had relatively high credibility in both the private and public sector.

Most countries had long provided integrated MCH and FP services as part of PHC, although they often had separate, vertical management and FP policy was often the responsibility of a parastatal. In addition, all countries had national AIDS control programmes which also covered STDs and were institutionally separate from MCH/FP. Both HIV/STD and PHC programmes tend to be heavily supported by international donors. HIV/STD services existed in most countries, although often confined to dedicated clinics in major urban centres (Germain *et al.* 1992; Cohen & Trussel 1996). There was also considerable variation in public and private sector provision. In Kenya, for example, 68 per cent of FP clients used public services (National Council for Population and Development

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prevalence; that secondary data on both epidemiological patterns and service use were available; and that they were anglophone, so as to facilitate cross-country comparisons through collaborative workshops.

1994) and contraceptive prevalence was quite high. In contrast, in Ghana and Zambia, where contraceptive use was low, 57 per cent and 56 per cent of clients respectively obtained contraceptive supplies from private sources (Central Statistical Office 1993; Ghana Statistical Service 1994). Nevertheless, the public sector in all countries provided some MCH/FP and HIV/STD services, and was often targeting a population which could not afford to use the private sector, particularly those in rural areas.

1.4.2 Focus on South Africa

South Africa was the principal case study in this research. As seen in Table 1.1, in the 1990s, HIV/STD prevalence was very high and FP and ante-natal services were also widely used. These figures suggest that both reproductive health and integration of HIV/STD services should have been priorities in South Africa. Public health services for the poor, black population were largely provided by the government, although they were of far inferior quality to the private sector, which was used mainly by richer, white population groups with private insurance. After the first democratic elections in 1994, the health sector in South Africa underwent significant reforms, emphasising equity and quality in provision of PHC services (Gilson et al. 1999). In addition, as part of constitutional devolution of powers to nine new provinces, implementation of health care became the responsibility of provincial administrations. To capture this aspect, the research focused on services in the Northern Province, which was the poorest of the nine and had services most similar to those in other sub-Saharan African countries.

The choice of South Africa had both advantages and disadvantages for analysing policies to integrate HIV/STD and PHC. The main advantages of South Africa related to its mid-way position between Northern and Southern countries. As a result of apartheid, South Africa had been described as having two systems co-existing (Spence 1999): one was made up of a recently democratic, strong state which is relatively well resourced (compared to elsewhere in sub-Saharan Africa) and an advanced industrial economic base; the other consisted of a rural, poor, ill-educated population with low access to services or employment. In addition, until 1990 it was relatively isolated from international fora because of apartheid-related sanctions; subsequently, because it had little need for significant external budgetary support, links with the international community were substantively different from elsewhere in the region (Schneider & Gilson 1998).

Health policy developments reflected this dual system, by benefiting from relatively strong political, financial and technical resources at national level on the one hand but, on the other, suffering from weak implementation in the face of crumbling infrastructure and long term inequities in service provision. As a result, while national agenda setting and policy formulation processes were similar to

those in Northern countries, implementation processes at provincial and local levels were, particularly in Northern Province, more closely related to those in other sub-Saharan African countries. Given the need to analyse empirical data from the South with frameworks from the North, this particular context provided opportunities for close observation of the extent to which theory fitted reality. In addition, because the health system was much more decentralised in South Africa, it provided the opportunity for a detailed study of implementation at provincial level as well as gaining understanding of national agenda setting processes.

The disadvantages of the South Africa case study were the other side of the same coin: because it had this very particular setting, great care was needed when making generalisations relevant to elsewhere in the region. Indeed, it is possible that the period studied here was so special as to lack relevance to future policy development in South Africa itself. Nonetheless, having recognised this potential hazard, this research attempted to compare the situation and processes in South Africa with those from other countries by drawing on such case studies as existed and other information in the literature.

1.4.3 Justification of case study approach

A case study has been defined as '*an account and an analysis of particular events and decisions*' (Curry 1992: 1 as quoted in Thomas 1998: 307). The main advantage of case studies is that they facilitate (but do not ensure) an in depth understanding of particular issues taking place in particular settings at a **contemporary** time. In this way they differ from both historical studies, which relate to past events, and surveys, which tend to describe rather than explain events (Yin 1994). Thus, they allow the researcher to focus time and effort in one place and to concentrate on achieving comprehensive coverage of all the influences on the issue in that setting. Studies which rely on a series of comparative cases are therefore better characterised as uncontrolled experiments than as a survey with a small sample (Thomas 1998).

Case studies are particularly useful for policy research since they are sufficiently flexible to allow for the simultaneous investigation of various layers of policy activity (Thomas 1998). In this research, these layers included the processes of national agenda setting, implementation and service delivery along with the political and economic context of policy development and the likely epidemiological impact. Furthermore, the relationship between national or peripheral policy processes and international policies could also be investigated. In this way, a further advantage of case studies was realised: their utility in challenging established policy norms. Referred to by Thomas (1998) as 'challenging cases', some case studies can be used by researchers to shed light on policy development in a variety of different contexts and to generate alternatives both to policy content and to the process of implementation. If this is the intention, then it is important that cases are selected to present some

interesting point about the policy in question, rather than sampled to be representative of some broader population of cases.

This, however, highlights the main disadvantage of case studies: that they may not be widely applicable to a more general question since the setting which has been considered may be highly specific compared to elsewhere. For example, the Mwanza trial of syndromic management on which much of the policy development discussed in this thesis was based, took place in one rural, East African setting which subsequently turned out to be a major determinant of its success[3]. Research for this thesis was essentially based on one principal case study, South Africa, which was compared with available literature on others, mainly in sub-Saharan Africa. Thus, while causal relationships may be well understood in the particular context of the case in question, the validity and reliability of extending the findings to other settings may be compromised (Kirk & Miller 1986; Thomas *et al.* 1998).

There are two notable ways in which such disadvantages can be avoided. First, it is important to acknowledge explicitly the limits of applicability of evidence from any single case study. In this study, the focus was on evidence from one region, sub-Saharan Africa, with the intention of providing real insight into a policy development in different settings from the original trial but where the issue was of high priority. While every country clearly has its own social, political and economic background, in many ways, countries in this region shared certain important characteristics, for example: extreme poverty; post-colonial orientation and history; and severe reproductive health problems.

South Africa, by contrast, was richer and had recently experienced a political revolution unlike any other country in the region. As a result, the government's commitment to comprehensive PHC was strong, partly as a reaction to previous disease and population control programmes of the apartheid regime. These two factors combined to produce special opportunities in the area of integrating HIV/STD with primary level services. They also allowed a case study of the process of policy development in South Africa to be a fruitful comparison with experiences elsewhere, given explicit awareness of the effects of the different context. Having said that, the Northern Province of South Africa was one of the poorest provinces and thus provided a relatively good comparison with service delivery constraints elsewhere in Africa. Again, the important issue was that contextual differences between the key case study in this research and other settings were fully accounted for in the analytical frameworks used. Thus, as will be further developed in Chapter 3, policy analysis concepts

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[3] Indeed, later results on mass treatment of STDs in Rakai, Uganda failed to show any impact at all, a finding explained by the different epidemiological and socio-economic context.

focus specifically on the detail of local context and allow the researcher ample opportunity to understand why a particular setting might be different from elsewhere.

The second way in which the disadvantages of the case study approach were minimised was in the particular methods used. Unlike quantitative survey methods, which aim to create typical or average scenarios and tend to reject unusual or outlying findings, the qualitative methods used here emphasise unusual findings as important to explain why a particular pattern of events takes place (Silverman 1998). Thus while statistical generalisation is not possible from case studies, since they are not sampled with this purpose in mind, theoretical generalisation is possible, in terms of the likely outcome of particular policy approaches (Thomas et al. 1998). In addition, in arriving at theoretical conclusions, the methods of policy analysis can be used to provide internal validation through techniques such as triangulation (Woodhouse 1998). Thus, reports from focused interviews can be critically compared with documents and other data collection exercises to check information is consistent. Clear, methodical documentation of all investigations can also help to reduce the imbalance towards subjective judgement which can potentially bias conclusions (Thomas et al. 1998). Details of these methods will be addressed in the next section.

1.5 Methods

At the heart of methodological debates in social science lies the fundamental issue of how to balance positivist or objective descriptions of reality with more humanist or subjective accounts (Miller & Glassner 1998). Qualitative information gathering is essentially an inductive process, i.e. it is grounded in ideas which are generated by the subjects of study and how they construct reality (Patton 1990; Silverman 1993). For the researcher, it involves developing a series of interim hypotheses based on plausible associations to be tested in varied settings using a range of different methods. These hypotheses are flexible, contextualised and usually emerge as a result of themes, concepts or relationships established during the process of research. To make best use of a case study approach, it is important that the material or data collected fully represent the depth of the issue in hand and that they reflect the opinions and perceptions of different actors as well as objective evidence of 'reality'. In order to achieve this, a range of methods can be used, including literature reviews, focused interviews and data analysis or surveys (Thomas 1998). The main point is that results obtained from all these methods should be combined to build a story, based on an original set of ideas with input from a range of sources of information. Methods must be iterative, flexible and complementary; original ideas may be challenged by the research and questions may need to be redefined in the course of the research process.

In this research, evidence collected was of two types: in depth, critical review of literature and case studies on international and national experiences with policy development; and interviews, textual analysis and operations research into policy development in South Africa. The following methods were used: semi-structured and in-depth interviews; policy document or textual analysis; focus groups; structured questionnaires; literature review; and secondary data analysis. The research process was iterative, drawing on both empirical evidence and conceptual frameworks to meet the four aims of the research set out in section 1.2. Evidence was also collected so as to contribute to further improvements in theoretical models of agenda setting, policy transfer and implementation in low income countries. Finally, during the three and a half year research period, I was located at the London School of Hygiene and Tropical Medicine (LSHTM), where I was privileged to have access to a wide range of key international researchers in this filed. I was therefore able to conduct many informal interviews with colleagues at the LSHTM, as well as with external experts passing through. As part of my work I also attended several international conferences[4] at which other academic, donor and national policy makers were available as important key informants.

1.5.1 Literature review and secondary data analysis

The first and second aims, to analyse the rationales for and process of setting the international agenda for integrated reproductive health, and to document national experiences with addressing this agenda, were achieved through in depth, critical reviews of the literature. This included: HIV/STD epidemics, and their social and economic impact; lessons on failed attempts to mitigate their effects and the rising interest in integration as part of reproductive and sexual health; the international politics of reproductive health, and how the agenda for integration was set within this context; and evidence on how policies for integration were transferred to national level and subsequently implemented.

The nature of these areas of the literature required more than a descriptive survey of available published information. For some areas, such as the epidemiology of HIV/AIDS, published information was both easily available and comprehensive. For others, however, such as the international agenda setting process for integration of HIV/STD services with PHC, although there was fairly widespread acknowledgement that a political process took place, little was documented. Hence, any critical review of literature required substantial evaluation and analysis in terms of a set of hypotheses and arguments which could be verified both directly and indirectly. Very few papers were written specifically on these kinds of issues although many touched on such subjects incidentally. Structuring this evidence to create a coherent argument was therefore a painstaking process of

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[4] These included: the General Conference of the International Union for the Scientific Study of Population, Beijing, 1997; the Annual Meeting of the British Society for Population Studies, Cambridge, 1998; the Setting

interpretation, validation and contextualising (Barrientos 1998). Changes over time in the type of information, and the geographical or ideological perspective of authors and their data, were analysed as well as the actual substance of the debate. In addition, policy prescriptions emerging from publications were assessed along with the theoretical assumptions on which they were based. The aim was to place each piece of the jigsaw carefully in its correct relationship with other parts of the picture.

In depth searches were therefore conducted for literature the following areas: prevalence, incidence and patterns of HIV/STDs, contraceptive use and ante-natal care attendance; different interventions to control HIV/STDs and how they were promoted in low income countries; the origins of the concept and agenda to integrate reproductive health care; the relationship between reproductive health concepts and those of PHC; and the politics of PHC, HIV/STDs and reproductive health internationally and in low income countries. *Medline, Popline, Health Star* and the internet were all searched using comprehensive search terms and methods.

As well as published literature, so-called 'grey' literature was accessed from personal contacts and the libraries of international organisations during the course of the research, in order to gain as full a picture as possible of the available information[5]. Grey documents, being unpublished, can be harder to access, less objective and potentially of lower quality, since they reflect to a greater extent the views of the organisation from which they originate. They may make unstated assumptions, have unclear theoretical or methodological background and address an illusive audience. Therefore, assessing bias, censoring or representativeness can be difficult from simply reading the document. Instead, care must be taken to interpret the content of such publications through the lens of the likely ideology, interest and influence of the publishing organisation or author (O'Laughlin 1998). Grey literature used in this research included the three reports produced by collaborators on the study of integration of HIV/STD and PHC services in Ghana, Kenya and Zambia[6].

Secondary data sources on population based indicators and service delivery were also used. These included the Demographic and Health Surveys (DHS), the WHO Global Programme on AIDS (GPA) Sexual Behaviour Surveys, the Population Council Family Planning Situation Analysis Surveys and other one-off epidemiological or operations research studies in the area of interest. Problems with

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the African Agenda II Meeting, Nairobi, 1998; and the Third European Conference on Tropical Health, Liverpool, 1998.

[5] Indeed, the literature review was completed after the field work, during which much of the evidence was collected from various sources around sub-Saharan Africa and internationally. It would have been insufficient to confine this assimilation of evidence in the period prior to field work, as most doctoral students would expect.

[6] Research in South Africa formed a fourth case study in this study. The relationship between this thesis and the study referred to here are fully described in section 1.6 below.

using such sources included both the unknown quality of the data and lack of control over which information was actually available. These international survey efforts aimed to collect comparable data from as wide a range of countries as possible leading to inevitable compromises on local depth or specifics (Cleland & Ferry 1995; Miller *et al.* 1998; Macro International Various). Nevertheless, they contributed to the overall context of policy development for integration of HIV/STD services with PHC by providing evidence on epidemiological, demographic characteristics of populations and the availability of services to meet their needs.

All these different sources of information were used to develop a comprehensive picture of what was known about integrating HIV/STD and PHC services, how these policies developed at international and national levels and how they were implemented in sub-Saharan Africa. This identified two important areas which the thesis hoped to address in detail: how the South Africa case study would be different from experiences elsewhere; and gaps in knowledge which the South African work could attempt to fill. Together, they set the scene for addressing the second two aims of the research.

1.5.2 Field research

These aims, to analyse policy formulation and implementation respectively in South Africa, were achieved through in-country field work using a range of methods. Field work took place during a series of visits to South Africa in February 1998, May to September 1998 and March 1999. Table 1.2 is a research matrix which sets out the ways in which different research methods were used to address the study objectives. The study was iterative in nature, such that information obtained through a particular method on one area of policy or programme was fed back into other relevant spheres.

First, qualitative research was conducted into the process of policy decision making in South Africa, to understand how national policies were made in relation to international agendas. This was accomplished largely through interviews at national and provincial levels and document analysis. Because of the decentralised nature of policy making in South Africa, most field work took place in the Northern Province. At national level, the focus was on understanding the roles of national programmes and their external advisors in setting standards and objectives. Their activities were analysed in the context of the broader health service and political context of the time. The second approach was to conduct new field work at a range of reproductive health service outlets to assess the extent to which policies have been implemented. A sample of 20 facilities was visited and structured interviews and focus group sessions were conducted with both providers and clients. The third dimension of research consisted of analysis of policy, epidemiological, demographic and service availability data from a range of secondary sources using methods which have been described in section 1.5.1. Particular attention was paid to reviewing literature on the political and economic

environment of policy development in South Africa, given the rapid and radical changes taking place at the time of the research.

Table 1.2 Aims of field work in South Africa and methods to achieve them

AIMS METHODS	Analyse existing health policies and programmes for integration (including: organisation; costs; resources; management)	Identify gaps between policy intent and implementation at provincial, regional and district levels
Policy analysis interviews and document review	• interview key informants (government, donor, NGOs etc) • analyse policy statements • analyse budgets and financial flows • examine human resource plans and organograms • track donor pressure and assistance • examine reports of local conferences • assess monitoring/evaluation activities • analyse in-country research activities	• examine programme operational plans • analyse patterns of service delivery • evaluate links and communications between centre/province/district/facilities • analyse levels of autonomy and control of district services (over personnel, transport, budgets, etc) • analyse power relationships between different programme levels • assess financial, training, supervision, monitoring and drugs supply mechanisms • evaluate record systems
Facility-based interviews	• examine involvement of service personnel in overlapping policy networks • analyse control of local facility staff over service delivery • focus on HIV/STD services, not covered by already available data	• assess services and staff available including hours of opening • evaluate staff, transport, supplies costs • examine drug/supplies availability • analyse quality of care data (method mix; technical competence; counselling skills) • assess attitudes of clients to policy
Secondary data analysis	• analyse data on costs of different service packages • collate data on HIV/STD/contraceptive prevalence rates and ante-natal attendance • collate surveillance data, death registration and hospital caseloads	• analyse surveys of health service delivery, quality and efficiency • analyse data from other health service and management information sources, especially on training and quality of care

1.5.3 Semi-structured or focused interviews with policy makers

As with social science research in general, debates over how to conduct interviews have been polarised between two groups: those who aim to elucidate some perfect, objective truth through the untainted environment of the interview (positivists); and those who seek a narrative representation of the world outside and emphasise the interaction between interviewer and respondent (social constructionists) (Miller & Glassner 1998). Positivist approaches tend to lead to survey interviews in which the subject is seen as passive and the conversation is managed carefully to serve the purposes of inquiry (see for example, Converse and Schuman 1974 quoted in Holstein & Gubrium 1998: 118). Social constructionists, by contrast, tend to favour interview techniques which emphasise the emotional views of the respondent and search for mutual understanding, often requiring the interviewer also to present their own views and emotions on the subject (see for example, Douglas 1985 quoted in Holstein & Gubrium 1998: 119).

In reality, of course, '*objectivity exists, not as an absolute or inherently meaningful condition to which humans react but as an accomplished aspect of human lived experience*' (Dawson and Prus 1995: 113 as quoted in Miller & Glassner 1998: 100). This experience is reported by the respondent in ways which are affected by his/her relationship with the interviewer and any social distance between the two will colour the picture presented. Rather than trying to minimise or maximise this effect, it should be explicitly acknowledged and incorporated into the design of any questions and interpretation of any discussion. The interviewer should not try to be invisible or anonymous but is responsible for going beyond building a rapport to understand the reality of the respondent and contextualising their responses (Miller & Glassner 1998). While respondents may present a view of the social world which conforms to common assumptions, they may also challenge it and reasons for any challenge should be explored to develop a fuller picture of the issue under discussion. Nevertheless, the interviewer remains in a defined role with respect to the respondent and the conversation should be guided by that role rather than masquerading as an informal conversation.

This method of explicit interaction between interviewer and respondent has also been called 'active interviewing' (Holstein & Gubrium 1998). '*In the broadest sense, the interviewer attempts to activate the respondent's stock of knowledge and bring it to bear on the discussion at hand in ways that are appropriate to the research agenda*" (Holstein & Gubrium 1998: 123). Analysing such interviews requires attention to the process by which the social picture was developed as well as the substance of the picture. If such interviews are viewed as interactions rather than one-way flows of information, the problem of subjectivity bias is incorporated into the analysis and becomes meaningless. These methodological issues are particularly important where the social distance between the interviewer and respondent is wide, either by class, gender, nationality or race (as in this research), and where such distance has significant implications for the relationship. Even greater effort is required by the interviewer to overcome normal communication inhibitions between social groups and understand the position from which the respondent is likely to be speaking (Miller & Glassner 1998).

Interviews can also be conducted with groups of respondents and are known as focus group interviews. Developed originally as a marketing tool, they have become an increasingly popular social science method (Merton *et al.* 1956). Typically, such groups comprise six to twelve relatively socially homogenous participants and last between one and two hours. The aim is not for the group to reach a consensus but for it to provide information on social realities through the comparison of reports by different individuals responding to each other (Patton 1990). The main advantages of focus groups are that they provide a more rapid means of obtaining information from a larger number of respondents and that they have inherent checks and balances on opinions or pictures which respondents present in that other members of the group can contradict or disagree with particular

positions. The disadvantages of focus groups are that it is more difficult to go into specific issues in depth, because the conversation on each issue takes longer with more people, and that respondents are unlikely to provide sensitive or confidential information in this environment (Patton 1990).

This research used interviews during conversations with health policy makers involved in the development of HIV/STD policy in the context of integrated PHC in national and provincial administrations and external organisations (see Appendix A for a list of people interviewed in South Africa). Most interviews were open-ended discussions of relevant topics, guided by a pre-prepared list of questions specific to the particular respondent, which aimed to investigate their views on the general area of the research. Occasionally, the list of questions included highly specific pieces of information which were required for the research, such as budgets, operational plans etc. Where this was necessary, the interview was divided carefully into a time for collecting such detailed data and a time for discussing the policy in general. In some interviews, important key informants were identified, who were able to provide substantial insight into issues which could be followed up elsewhere in the research. Key informants were visited more than once if issues had arisen on which they could shed further light. To limit the quantity of data for analysis, interviews were recorded in careful notes rather than by tape recorder. These notes were transcribed into computer files as soon as possible after the interview, usually on the same day; personal observations on the nature of the interview, any distinguishing characteristics of the respondent and the relationship between the respondent and interviewer were attached to these transcriptions.

Interviews at district and sub-district level (see section 1.5.5 for further details of the study design) were guided by a pre-determined set of specific questions which were required to fulfil the information needs of the research and to conform with the broader four country study of which it was a part (see section 1.6). However, these questions were largely open-ended and, while they led to a slightly more structured interview, they were also conducted by the same researcher as conducted all national and provincial policy interviews, thus facilitating comparisons, expansion on particular points of interest and triangulation. Notes were taken both on the formal questionnaire and on a separate piece of paper where the conversation diverged from the pre-determined structure. On this separate paper were also notes on the district political and economic context which could aid interpretation of data collected at district and sub-district levels. Focus groups were also conducted in facilities with staff not included in one-to-one interviews.

1.5.4 Document analysis

Analysing the documents which incorporate policy decisions and legislation forms a crucial step in enhancing validity and reliability of interview data. In addition, such texts can shed important light

on how an organisation chooses to represent reality, in terms of their layout, language and content (Atkinson & Coffey 1998). Documents include official policy statements as well as minutes of meetings, workshop reports, expert committee reports and technical guidelines. Crucially, documents should not be interpreted and analysed as though they are objective and isolated statements. Instead, they usually relate strongly to other documents, creating a sequence or hierarchy of published information which can be used to track the development of policy. They are essentially a record of what an organisation opts to present as its decisions and, as such, frequently have no identified author and are presented as authoritative, factual and official accounts of the policy process. This use of authority and rhetoric itself serves the purpose of communicating to an audience of administrative cadres what the policy direction is and, sometimes, what the different roles should be within that process.

Many authors have written on the importance of placing both text and author in their proper context, including the discursive rules by which knowledge is produced, encoded and displayed. Such analytical approaches often follow the lead of Foucault's discourse analysis (as described in Prior 1998) and have also been described as creating a genealogy or classification of text. The basic concept is that it is just as important to assess where a set of facts come from as it is to establish whether or not they are true (Atkinson & Coffey 1998). Document analysis therefore contributes to understanding the overall context of policy discourse, the actors involved, their positions on the policy and relations between them. Many aspects of this discourse can be obtained through studying documents in sequence and including sections such as lists of attendees at meetings and lists of supporting organisations in the analysis.

In this research, policy documents which emerged in either draft or final form at national or provincial level in South Africa were examined and analysed. These ranged from the national health White Paper, to statements on health policy by political parties, to provincial and district health administration operational plans and budgets, and finally to service delivery guidelines. The process of producing policy documents, through meetings, workshops, drafting and agreements was assessed. Comparisons were made between policies from different departments or organisations to establish the extent to which they concurred, overlapped or contradicted each other. Documents were also assessed according to the role, power and affiliation of the institution which produced them. Where appropriate and available, the budgets associated with particular policies were documented and analysed.

1.5.5 Structure of district and sub-district field work

Policy analysis at national and provincial/regional level was complemented by a semi-structured survey of a small number of health care facilities in the Northern Province. The principal aim of this section of work was to follow the implementation of policies through the management system rather than to provide a representative picture of health services throughout the province. To this end, four (out of seven) regions in the Northern Province were selected and, in each region, one future district was purposively selected according to the priorities of provincial staff[7]. For example, where there was a pilot project for a particular new intervention which was relevant to the study, that district was selected. Alternatively, where there was a particular HIV/STD problem in the population, again, that district would be selected. The rationale for this selection system was that the process of policy making at the time of this study was both dynamic and incipient in this particular field. In order to gain access to everything that had been achieved, it was necessary to select areas in which policy makers had also perceived a particular priority for early intervention. In the district administrations, interviews were conducted with the staff responsible for managing both MCH/FP services and HIV/STD control.

In each district, the main district hospital, one health centre and three peripheral health clinics were visited, all within one referral system. At the hospital, an interview was held with the person in charge of HIV/STD services (if any) at the district hospital outpatients department (OPD) and the person in charge of MCH/FP services. Health clinics were selected to represent the constellation of services in each particular district. For example, where there were mobile clinics, these were included, along with representation of the different grades of PHC clinic ranging from small to large staff complements. At these four facilities, the person in charge of the facility (known as the In Charge) was interviewed. All interviews were formal, using a pre-determined, semi-structured questionnaire. Where such staff were present, informal interviews were also held with: the person in charge of a separate outpatients clinic; the pharmacist; and the laboratory technician.

Rather than evaluating quality of care through observations of clinical practice, these interviews focused primarily on the process of implementation. The aim was to establish how policies were implemented and what the impact of national decisions and structures were on district managers and local facilities. To achieve this, the questionnaires covered issues related to provider training, drugs systems (in line with national prescribing rules), record-keeping, monitoring, supervision and

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[7] The process of devolution from regions to districts was on-going at the time of the research (see Chapter 6); facilities were still being managed by regional administrations although they had been allocated to future districts. Therefore facilities were selected to represent the local service areas which would sit under future district administrations. Regional/district manager interviews also took this rapidly changing context into account.

communication with other facilities and offices in the district (see Appendix B for questionnaires). Information on services provided was limited to inquiring about the basic minimum package of STD services which had been recommended by WHO[8]. Quantitative data was analysed separately from the more open-ended information obtained through the process of the interviews. It included data on number and training of staff, number of patients seen, types of drugs and commodities available, and particulars of services and health promotion activities undertaken. Univariate analysis was conducted using a Microsoft Excel spreadsheet; the subsequent information was used to support evidence obtained from interviews with facility staff and their patients.

At each clinic, focus group interviews were also held with PHC staff who had not been interviewed above, in the absence of the clinic In Charge. The purpose of these sessions was to establish attitudes among providers to integration as well as their understanding of issues surrounding HIV/STD management. In addition, interviews were held with up to four clients at each facility to gain an idea of clients' attitudes to integrated services and the extent to which they were aware of issues surrounding HIV/STDs in the community and the services available at the facility.

The principal limitations to these interviews were two fold: first, it was not possible in this study to corroborate reported activities with independent observations of services provided; second, interviews were only conducted in a small number of clinics in one specially chosen area in the province. However, these limitations must be balanced by the advantages of gaining an in depth understanding of the *process* of implementing policies through relatively open conversations with actors who were not threatened by the feeling of being evaluated.

1.6 Collaboration with other researchers

The field work in this thesis was conducted under the auspices of a Wellcome Trust-funded project, 'A comparative study of barriers and opportunities for integration of reproductive health services in four countries in Africa'[9], which took place between 1997-99. In South Africa, one of the four countries, I undertook all field work personally with an assistant provided by the Northern Province Department of Health and Welfare (DHW) to help with questionnaire and focus group administration, client interviews and translation where necessary. However, this project was also undertaken in collaboration with researchers in three other countries, Ghana, Kenya and Zambia, and as part of a

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[8] These included: syndromic management of presenting STDs; promotion of condoms as dual protection; screening of pregnant women for syphilis; routine prophylaxis against ocular gonorrhoea in newborns; services for high risk groups in the area; health promotion and education; and pelvic examinations for new FP clients.
[9] Unlike field work, all other components of the thesis (including literature reviews, analytical and theoretical framework development and analysis of international policy developments) were undertaken separately from the project purely for the purposes of my doctorate.

team at the LSHTM. The two senior members of the project team were both involved in this doctoral research, one as my supervisor and the other on my research committee. Collaborators overseas were identified to gain better insight into the policy processes and contexts in other countries and to facilitate a lengthy research period in each place. In Ghana, Kenya and Zambia, all field work was undertaken by these collaborators with initial and mid-term visits by myself in order to contribute to the research where necessary and to ensure that at least one member of the team had gained insight into all four countries.

Nevertheless, while research of this collaborative nature inevitably involves input from a wide range of people, the bulk of the research conception, design and analysis was my own. Throughout the project all questionnaires (see Appendix B), sampling and field work design were my original work. They were presented for comment at a workshop at which all researchers were present and minor changes were made as a result. Standardised tables for policy documentation and analysis in all four countries were also prepared largely by myself, with some assistance from other members of the London team.

Reports from Ghana, Kenya and Zambia were prepared by the respective collaborators but I prepared the South Africa report (which forms the basis for Chapters 5 and 6 of this thesis) alone. The LSHTM team was responsible for all international comparisons and papers, which were drafted after a workshop at which all researchers presented results and undertook preliminary comparisons. Fifteen publications documented the results of this research: four journal papers; four policy/newsletter papers; one book chapter; one report; and five conference papers (see Appendix C for a list of publications relating to the project which were produced during the period of this doctoral research).

1.7 Research limitations

Many of the limitations of this research were mentioned in the text above. Here a summary of key problems with the approach taken will be made with justifications for how they were avoided as far as possible. From a public health perspective, the first potential limitation to the methods used here was that they revolved around a single case study conducted in one country in sub-Saharan Africa. The approach taken contrasted with that of traditional epidemiological or public health research, which usually attempts to obtain results from as wide a range of representative examples as possible, in order to generalise based on common findings and relationships. Instead, in this research, the emphasis was on explaining the particular events which took place in their contexts rather than developing a model of typical events and, in this effort, careful attention was paid to relationships between different actors, their context and the policy in question. Furthermore, the study was firmly grounded in a

substantial review of the theoretical literature which provided a validity to the questions being asked and interpretation of results which epidemiological studies can rarely claim.

However, in addition to the general problem of limited case studies, the particular case study chosen also had a unique historical background and was experiencing at the time a rapid, radical transformation in every aspect of society, policy and epidemiology. It could therefore be claimed that it was representative of neither other countries in the region nor other time periods within South Africa. However, while generalisations could have been difficult based on the South Africa case study, its presence as a counter-factual to the context and experiences elsewhere in the region was used to generate insight into the way policy decisions were taken for this particular policy.

A second limitation to this research was its silence on health care outside mainstream government health services. The focus of the study was explicitly restricted to public sector policies and programmes, thus neglecting large components of HIV/STD and other reproductive health care which, in many countries, are provided in the private sector. This limitation received comment from various sources, especially given recent heightened interest in private sector contributions to public health and service provision in low income countries. My response was simply that it would not have been possible to cover such a wide range of service providers as well as capturing the many levels of policy development, from international to local, in one piece of work. In addition, the focus on policy development as opposed to quality of care or other areas of service provision also required a greater emphasis on public than private sector efforts.

The final major potential limitation to the work was the use of theoretical frameworks which were largely developed for examining policy processes in Northern settings for analysing policy development in low income countries. As discussed in Chapter 3 and later in the conclusions in Chapter 7, there are many significant differences between Northern and Southern contexts in the way policies develop, whether through relations between actors, systems of governance or political and economic institutions. Most analytical models available in the political science, public policy or sociology literatures do not address these differences and focus exclusively on Northern issues.

In addressing this limitation, this thesis hoped to make a theoretical as well as empirical contribution to the literature. Thus, as well as documenting and analysing the process by which integration reached policy agendas and was implemented, a critique was provided of the relevance of existing theoretical models to understanding this process. Areas where the models fit the information quite well were identified as well as those where the reality was substantially different from what might have been expected from theory alone. In some cases, such as when looking at international to

national policy transfer, existing limited literature failed completely to address key aspects of the process and, here, suggestions for further research and theoretical development were made.

1.8   Structure of thesis

This chapter introduced the topic of the research, including: a statement of the problem; objectives of the research; the analytical framework to be used to achieve these aims; and the methods used to collect new data.

Chapter 2 provides an analytical review of international literature available on: HIV and STD epidemiology; FP, MCH, HIV and STD service provision, utilisation and policy developments; scientific justification for integrating HIV/STD care with PHC; and limitations to this new approach.

Chapter 3 examines literature on policy analysis, especially focusing on the processes of agenda setting, policy transfer between international and national levels and implementation. It develops a new analytical framework using the theoretical literature.

Chapter 4 analyses literature on: international policy developments towards integrating MCH/FP and HIV/STD services; and progress in national settings towards implementing integrated care. It uses the analytical framework of Chapter 3, with a particular focus on Ghana, Kenya and Zambia .

Chapter 5 addresses agenda setting and policy formulation at national level in South Africa, including the political and economic context of policy development and the process of massive transformation of the health sector.

Chapter 6 examines the implementation of integrated services in the Northern Province, South Africa including the financial, technical, managerial and political resources allocated to this policy. Service delivery through districts and facilities is also evaluated and the attitudes of clients and providers to integration is discussed.

Chapter 7 is a synthesis of the conceptual framework with evidence from the international literature review and field work findings from South Africa. Conclusions are drawn from the research to contribute to theoretical debates and developments in reproductive health policy.

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CHAPTER 2: LITERATURE REVIEW ON INTEGRATING HIV/STD SERVICES WITH PRIMARY HEALTH CARE

2.1 Introduction and background

The international agenda for integrating HIV/STD services with PHC emerged extremely rapidly in response to the urgency of the HIV/AIDS pandemic. Many of the policy recommendations which were promoted, however, were based on little evidence. The term 'integration of HIV/STD and PHC' incorporates a wide range of issues, including the rationale for and content of services, the way to provide them, the way to manage them and the likely impact they might have on health status. Although there is a substantial literature on some of these issues, such as the most effective treatments for STDs (Adler *et al.* 1998; Holmes *et al.* 1999) or evaluating the impact of FP services (Mauldin and Ross 1991; Ross *et al.* 1992; Mundingo 1996), conceptualising the most useful interaction between them remains difficult. While two literature reviews of integration have been undertaken (Mayhew 1996; Dehne and Snow 1999), neither was able to provide practical solutions to the many problems. The most important gaps in understanding arise in three areas: (i) how to provide effective STD care for women; (ii) which services to integrate with existing PHC; and (iii) how to manage these services in resource-poor settings.

The aim of this literature review is to examine the background to international policies for integration more closely in order to understand why integration of HIV/STD with PHC has been promoted so strongly and how effectively it has been implemented. By investigating the motivations and intentions behind the major players in setting global agendas, light can be shed on what integrated services have been intended to achieve. By examining the context of low income country settings, further understanding can be reached of the likelihood of such policies ever becoming programme and service reality.

The review starts with a section on the global epidemiology of HIV and other STDs, with particular attention to sub-Saharan Africa and women. The next section examines evidence for effective prevention and management programmes for HIV/STDs, especially as they are relevant to resource-poor settings. It then shifts focus to investigate the concept of integration, what its origins are and what evidence there is for its feasibility and effectiveness, both in PHC and in reproductive health. Issues which arise separately at service and policy/programme level are addressed.

2.2 Statement of the problem: the HIV/AIDS/STD pandemics

2.2.1 Global HIV/AIDS epidemiology and socio-economic impact

Table 2.1 Estimates of adult prevalence of HIV, 1997

Region	Adult prevalence (%)	Adults and children living with HIV/AIDS (number)
Sub-Saharan Africa	8.00	22,500,000
Caribbean	1.96	330,000
North America	0.56	890,000
South and Southeast Asia	0.69	6,700,000
Latin America	0.57	1,400,000
Western Europe	0.25	500,000
North Africa and the Middle East	0.13	210,000
Australasia and Oceania	0.10	12,000
Eastern Europe and Central Asia	0.14	270,000
East Asia and the Pacific	0.07	560,000
TOTAL	1.10	33,400,000

Source: UNAIDS 1998a.

By the end of 1997, the HIV virus had infected a cumulative total of more than 47 million people globally, 33 million of whom were still alive (UNAIDS 1998a; Table 2.1). Of these, 70 per cent were in sub-Saharan Africa and most were under 30 years old; 10 per cent of new infections in 1997 were among children under 15, 90 per cent of whom lived in sub-Saharan Africa, mostly infected from their mothers. The consequences of HIV infection are grave: according to the WHO, HIV/AIDS is the fourth biggest cause of death worldwide and in Africa it is now the leading single cause of death, at 19 per cent of all deaths (WHO 1999). In sub-Saharan Africa, 12 million people had already died from HIV related causes by the end of 1997, a quarter of them children (UNAIDS 1998a).

The disease spread extremely rapidly in some parts of the world, especially sub-Saharan Africa. Rises in mortality occurred at most ages: among infants and children, death rates stagnated or rose in several African countries (Timaeus 1998); projections have shown that globally, infant mortality in 1996 would have been around 52 per 1000 without HIV, compared to 73 per 1000 with it (Foster 1997). Among adults, death rates doubled or tripled between the 1980s and mid 1990s in Uganda, Zambia and Zimbabwe and rose substantially elsewhere (Timaeus 1998). During the late 1990s, death rates among HIV positive adults ranged from five to 11 per cent each year and more than half of all adult deaths in sub-Saharan Africa could be attributed to HIV (Boerma et al. 1998). Combined increases in mortality at all ages led to large falls in life expectancy in the 1990s: for example, in rural Uganda, life expectancy at birth fell from around 60 years in 1990 to 43 years in 1995 (Nunn et al. 1997).

While the impact of HIV on death rates in sub-Saharan Africa was generally high, there were variations by age group, region and sex. For example, the effects of HIV on female mortality were

higher than on male mortality because of the younger age at which women are infected (Foster 1997). Globally, in 1998, while HIV caused 4.8 per cent of disability-adjusted life years (DALY[10]) for men, it caused 5.5 per cent for women (WHO 1999). By region, the effect of HIV on child death rates was more dramatic in Southern Africa than in Eastern and Central Africa, partly because the HIV prevalence was higher and partly because child mortality was lower before the advent of HIV/AIDS in these countries (Nicoll *et al.* 1994). Children acquire HIV mainly from their mothers and around 30 per cent of HIV positive women pass the virus onto their offspring during pregnancy, labour or while breastfeeding (Fowler and Rogers 1996). While in some countries promotion of breastfeeding has become a controversial political issue, the most effective way of preventing childhood HIV remains to prevent infection in women (del Fante *et al.* 1993; Heymann 1995; Nicoll and Newell 1996; Academy for Educational Development 1998).

2.2.2 Social and economic impact of HIV/AIDS

The impact on the societies and economies where the disease is highly prevalent is huge: unlike other causes of death, which strike mainly the elderly and the very young, HIV/AIDS kills the most economically productive people, aged 25-40 years. The result is a host of macro- and micro-level, household and business, individual and community effects which are likely to dramatically slow development in countries which have severe epidemics.

Economic effects are now felt both at a macro level and at the level of individual companies. In hard-hit countries, HIV/AIDS has decreased income per head by reducing the growth of gross domestic product (GDP) by more than population growth (Ainsworth and Over 1994). In 1993, World Bank simulations showed a slowing of the growth of income per head by an average of 0.6 per cent a year in the ten worst affected African countries (World Bank 1993). These reductions in GDP stemmed from high costs of treatment, impact on skilled labour and increased household poverty. Many businesses felt the impact of HIV/AIDS on their labour forces, particularly in labour intensive industries which characterise low income country economies. For example, in Kenya it was estimated that because of absenteeism, training needs and health care, HIV would increase labour costs to business by 17 per cent by the year 2005 (Forsythe and Roberts 1995). In Tanzania, the International Labour Organisation estimated that the labour force would shrink by 20 per cent by 2010 because of HIV/AIDS (International Labour Organisation 1995a).

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[10] The disability adjusted life year (DALY) is defined by the World Bank as: '*a unit used for measuring both the global burden of disease and the effectiveness of health interventions, as indicated by reductions in the disease burden. It is calculated as the present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year*' (World Bank 1993: x).

Effects on health care costs are dramatic, despite the most aggressive and costly therapies against HIV infection not being available in low income countries. During the 1990s, health systems began to feel the impact both in terms of increases in demand for health care for HIV/AIDS treatment and reductions in supply of health care due to deaths among providers (Over 1998). In Kenya, total annual health care treatment costs for people with HIV/AIDS were projected to grow from 1.4 billion to 11.2 billion Kenya Shillings[11] between 1990 and 2010, with huge burdens placed on inpatient hospital facilities (Leighton 1996). In Swaziland, HIV was projected to consume 13 per cent of the total government health budget by 1999 (Loewenson 1996). In Lusaka, Zambia in 1998, three quarters of hospital beds in the main national teaching hospital were occupied by patients with HIV related illness (personal communication, Medical Superintendent, Lusaka General Hospital).

The greatest impact of HIV/AIDS, however, is felt at household level, where productive family members' illness and death leave dependent members stigmatised, orphaned and sometimes destitute (Bor et al. 1993). There are three potential areas of household impact: increased costs of care; decreased revenue from loss of labour; and decreased productive investment (Loewenson 1996; Bloom and Godwin 1997). These can arise during illness, as a result of death or in the long term. Little information is available but there are several studies of health care costs in the literature. For example, lifetime health care costs per person with HIV/AIDS were estimated to be US$200 in Malawi (Forsythe 1992) and US$1,000 in Zimbabwe (Forgy 1993). Treatment and funeral expenses in Tanzania were estimated at US$60 in Tanzania, roughly equivalent to the yearly income of a rural resident (World Bank 1993).

Children are particularly vulnerable to the long term consequences of their parents' deaths. For example, in South Africa, it was estimated that by 2005, there would be over a million AIDS orphans (Abdool Karim et al. 1997a). In Uganda in 1990, it was estimated that 12 per cent of children under 15 years had lost one parent to HIV/AIDS and those who had lost their mothers were particularly vulnerable to long term misfortune (International Labour Organisation 1995b). Orphans may be cared for by other family members or through traditional community structures but all have special needs because of trauma, stigma and future economic disadvantage through reduced access to schooling and parenting (HIV Management Services (Pty) Ltd. 1998).

Women are often more vulnerable but less able to protect themselves against infection than men due to their unequal social status, inequitable access to services and lack of control over either their own or their partners' sexual behaviour (De Cock et al. 1994). The most important direct risk factor for women in sub-Saharan Africa is engagement in commercial sex: for example, by the early 1990s, in

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[11] In December 1998, there were approximately 60 Kenyan Shillings to the US$.

Nairobi and Abidjan, 90 per cent of commercial sex workers were found to be HIV positive (Piot *et al.* 1987; De Cock *et al.* 1990; Estebanez *et al.* 1993). In national surveys of sexual behaviour undertaken in the early 1990s, between one and 25 per cent of men reported contact with a sex worker (Carael *et al.* 1995; Cleland and Ferry 1995). However, many of the women in these interactions intermittently resorted to commercial or other unsafe sex because of limited alternative opportunities. This is a particular problem for younger women and is reflected in the different patterns of infection by age among men and women. For example, according to UNAIDS, a recent community-based study in one area of Kenya showed that 22 per cent of 15-19 year old girls in the general population were already infected with HIV, compared with just four per cent of boys of the same age. In a Zambian study of young city-dwellers in the same age group, HIV infection was reported in 12 per cent of the girls and five per cent of the boys. In the age bracket 20-24 years, a study in Ethiopia found that 35 per cent of young women were infected, three times higher than the 11 per cent rate among the men (UNAIDS 1998b). Other unsafe practices which are specific to women and common in some parts of Africa include the use of vaginal drying agents and female genital mutilation (Brown *et al.* 1993; McNamara 1993).

In addition to direct risk, although many women are monogamous themselves they lack autonomy over their partners' high risk activity, such as not using condoms or high number of sexual partnerships. For example, in Kigali, Rwanda, 25 per cent of women with one stated lifetime sexual partner were HIV positive (Allen *et al.* 1991). With a few notable exceptions, women and men in sub-Saharan Africa report low use of condoms, either because they are reluctant to use them or cannot get them (O'Farrell *et al.* 1992; Kapiga *et al.* 1995; Blanc *et al.* 1996; Lagarde *et al.* 1996). Condoms are strongly associated with non-marital sex and as such are stigmatised in long term relationships. Where women demand condom use of men, they expose themselves to accusations of infidelity, domestic violence or divorce (Gupta and Weiss 1993). These threats are more serious in the context of women's social and economic dependency on men.

2.2.3 Experience with preventing and treating HIV/AIDS

In industrialised countries, the focus of HIV/AIDS control efforts is on expensive and advanced chemotherapy of asymptomatic HIV positive people to prevent or slow the onset of HIV disease. Clinical efforts are combined with high profile, costly advertising campaigns targeting both general and core population groups (Gold *et al.* 1994). In low income countries, secondary AIDS epidemics are now emerging with pressure to care for patients at primary level (Gilks *et al.* 1998) but, during the 1990s, HIV control efforts focused on primary prevention, with treatment of opportunistic infections restricted to those who can attend major urban hospitals.

Prevention efforts included condom promotion, awareness raising for behavioural change and health education, promoted through PHC facilities, the mass media, community events, inter-personal communications and structural interventions. Information about risky behaviour, availability of condoms, local beliefs and practices, health care facilities and traditional and private practitioners can all help to foster a better understanding of the epidemic and how it is spread or prevented (De Cock *et al.* 1994; Adler *et al.* 1998). Increasingly, policies to counsel and test for HIV status are being advocated as a means of reducing high risk sexual behaviour, although ethical and cost issues inhibit rapid implementation of freely available HIV tests (Hudson 1996; Munodawafa & Gwede 1996; Abdool Karim *et al.* 1997b; McKenna *et al.* 1997).

Evaluation of health promotion efforts is difficult: the impact on levels of HIV infection has evidently been minimal and, in most countries in sub-Saharan Africa, little is known about the effects of health promotion on intermediate risk factors (Hunter 1993; Aral and Peterman 1996). What literature there is suggests that it is far easier to spread information than to engender fundamental behavioural change. In order to achieve behavioural changes, a wide range of activities must be undertaken at individual, community, work place and health service levels (Skinner *et al.* 1991; Adler *et al.* 1998). These messages need to be carefully targeted to the population which they are accessing and can be more successful where they involve the targets themselves in planning and conception (Evian *et al.* 1991; Mathews *et al.* 1995; London 1996). Individuals only adapt their behaviour when they feel supported as well as provided with full information. Psychological models of change recognise various stages, including: accurate information; time to reflect on the need to make changes; support in making changes; and assistance with building new skills (Azjen and Fishbein 1980; Becker 1984; Proshaka *et al.* 1992).

None of these models, however, addresses the political difficulties which governments in sub-Saharan Africa have experienced in dealing with the threat of HIV/AIDS to traditional social and cultural values in their societies. While behavioural and attitudinal surveys showed that these values were rather poor reflections of modern reality, especially among young people in urban areas (Carael *et al.* 1995; Cleland and Ferry 1995), nevertheless, they reflected a system of religious and moral codes which did not condone sexual activity outside long-term relationships. The continuity of these values in the face of changing sexual behaviour can only be understood in the context of declining living standards, poor economic development and social opportunity which characterised many modern African societies (Prual *et al.* 1991). Combined with generally low status of women relative to men and limited communication between the sexes, especially about sexual matters (Bassett and Mhloyi 1991; Grundfest Schoepf 1992; Blanc *et al.* 1996), these factors contributed to extremely complex political situations for fostering social debate about sensitive issues.

Governments therefore found it difficult to support explicit health and sex education programmes (Caldwell *et al.* 1992). For example, in Kenya, despite international evidence to the contrary, powerful pressure groups, especially those affiliated to the church, remained convinced that open discussion of sex and HIV/AIDS would increase rather than decrease sexual freedom and that condoms were religiously sanctioned (Kigotho 1997). Governments have always found it particularly difficult to interfere in what is essentially a private activity from which the state has traditionally been excluded (Folbre 1992). Lack of demonstrated impact for any of the preventive interventions also reduced incentives for politicians to get involved in what were assumed to be doomed policies. Greater political mileage was instead gained from persistent blaming of outsiders for spreading disease and immoral values and behaviour (Caldwell *et al.* 1992). As a result, despite calls for an inter-sectoral approach to dealing with HIV/AIDS, in practice HIV/AIDS control was seen as primarily a responsibility of MOHs and affiliated National AIDS Control Programmes. In the context of resource constraints, efforts which could be undertaken in services which already existed were more popular than those which required substantial development investment.

2.2.4 Links between HIV and STDs: the evidence

Linked to these issues, in the mid-1990s, the emphasis of HIV prevention efforts shifted from behaviour change education to controlling other STDs. While STDs are not a new problem themselves, they have received increased attention as evidence has emerged on their role in facilitating HIV infection. Infection with an STD, either ulcerative or non-ulcerative, among both men and women, is now known to be strongly associated with a greatly increased risk of HIV transmission (Wasserheit 1992; Cohen 1998). This was proven through biological studies showing higher quantities of HIV virus in genital secretions in the presence of other STDs and that HIV shedding decreased after STD treatment (Cohen *et al.* 1997; Ghys *et al.* 1997; Mostad *et al.* 1997). The link with HIV was found for a large number of STDs, including gonorrhoea, chlamydia, genital ulcers and trichomoniasis, although much less is known about quantifying this risk or the extent to which asymptomatic STDs also contribute to increased HIV risk (Grosskurth 1999). Early biological findings were supported by the results of trials among sex workers in Africa which demonstrated that, by treating STDs effectively, HIV incidence could also be reduced (Laga *et al.* 1994).

In 1995, the results of a community-based, randomised, controlled trial in Mwanza district, Tanzania demonstrated that the same results could be achieved in a rural setting using an intervention specifically designed for PHC (Grosskurth *et al.* 1995; Hayes *et al.* 1995a). During this trial, HIV incidence in the intervention areas was 38 per cent lower than that in control areas as a result of a range of new activities: syndromic management of presenting STDs (see section 2.3.1); community awareness raising of services; condom promotion; partner tracing; and enhanced supervision of

medical staff. In addition, the intervention was found to be highly cost effective, at US$10 per DALY relative to other primary level services, such as child immunisation, which cost between US$12-17 per DALY (Gilson *et al.* 1997). Although a subsequent trial in Rakai district, Uganda of mass treatment of STDs for HIV prevention failed to have any impact, the explanation is now thought to be related to: the later stage of the HIV epidemic and the lower proportion of HIV infections attributable to STDs; the lower availability of services for treatment of re-infections; and the higher proportion of viral, non-curable STDs, especially herpes (Flemming and Wasserheit 1999). The outcome of these studies was therefore a renewed interest in STDs in low income countries and the extent to which they contribute to the rapid spread of HIV.

2.2.5 STD global epidemiology

Table 2.2 Estimates of new adult cases of curable STDs (millions aged 15-49, 1995)

Disease Region	Total	Syphilis		Gonorrhoea		Chlamydia		Trichomoniasis	
		Men	Women	Men	Women	Men	Women	Men	Women
N America	14	0.07	0.07	0.83	0.92	1.64	2.34	3.78	4.23
W Europe	16	0.10	0.10	0.60	0.63	2.30	3.20	5.30	5.76
Australasia	1	0.01	0.01	0.06	0.07	0.12	0.17	0.29	0.32
L America / Caribbean	36	0.56	0.70	3.45	3.67	5.01	5.12	8.52	9.10
SS Africa	65	1.56	1.97	7.30	8.38	6.96	8.44	15.07	15.35
N Africa and ME	10	0.28	0.33	0.77	0.77	1.67	1.28	2.32	2.22
E Europe and C Asia	18	0.05	0.05	1.17	1.16	2.15	2.92	4.90	5.17
E Asia and Pacific	23	0.26	0.30	1.80	1.47	2.70	2.63	4.83	4.53
S and SE Asia	150	2.66	3.13	14.56	14.55	20.20	20.28	39.56	35.87
TOTAL	333	5.55	6.66	30.54	31.62	42.75	46.38	84.57	82.55

Source: WHO/GPA 1995; Gerbase *et al.* 1998.

In 1995, the WHO estimated that there were 333 million new STD infections in the world (WHO/GPA 1995); of these, 65 million were in sub-Saharan Africa. The 1993 World Development Report suggested that STDs, excluding HIV, accounted for 8.9 per cent of the total burden of disease among women and 1.5 per cent among men (World Bank 1993). STDs can also lead to chronic pain, infertility, PID, abortion, neo-natal infection and death. Women are more likely to suffer from long term adverse consequences of these infections than men, because their reproductive systems are more vulnerable and the diseases are less likely to show symptoms: 70-75 per cent of chlamydia and around half of gonorrhoea infections in women are thought to be asymptomatic (Gerbase *et al.* 1998; Holmes and Ryan 1999).

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There are more than 30 pathogens which cause 'classic' STDs but the main four are: chlamydia, gonorrhoea, syphilis and trichomoniasis (Table 2.2). There are huge variations in incidence of new infections around the world: sub-Saharan Africa, with around 10 per cent of the world's population, suffered 20 per cent of the STD infections (excluding HIV). The most common infection is trichomoniasis, followed by chlamydia, gonorrhoea and syphilis respectively. While all infections other than trichomoniasis are more common among women than men, except for chlamydia, this sex difference is more marked in sub-Saharan Africa than elsewhere.

The major risk factors for STD transmission can be categorised according to an epidemiological model of disease transmission. This model states that the chance of infection is proportional to: the efficiency of pathogen transmission; the mean rate of sexual partner change; and the average duration of infectiousness (Anderson 1999). Factors, such as age at sexual debut, number of partners, contraceptive use, circumcision and interaction with core transmission groups, which act through one of these three direct determinants of infection, can increase or decrease risk (Cleland and Ferry 1995; Caldwell and Caldwell 1996; Garnett et al. 1996; Morris et al. 1996; Moses et al. 1998). In addition, health seeking behaviour and quality of care affect the probability of complications and transmission to another infected individual.

As for HIV infection, risk factors for STD infection vary considerably (Aral and Holmes 1999); although STDs are obviously acquired through personal actions, there are also particular characteristics of individuals and their environments which can determine the extent to which they engage in high risk activities. These characteristics vary by social, cultural, economic and political context but the most important to bear in mind for the purposes of this research are: gender relationships which affect the exposure of women to risk (Grundfest Schoepf 1992; Carael et al. 1995; Plichta and Abraham 1996; Bolan et al. 1999); and the process of modernisation and especially urbanisation, through which young men and women migrate to cities where they are exposed to higher risk (D'Costa et al. 1985; MacDonald 1996). In general, urban residents who are sexually active but not married and are young are most at risk; nevertheless, high infection levels have also been found among so-called low-risk rural populations.

2.3 Components of an effective STD control programme

Health promotion activities for preventing both STDs and HIV infection are similar and have been dealt with above (section 2.2.3). Suffice to say that a comprehensive campaign to prevent infection with HIV or STDs should include activities in the community, at health facilities and through private organisations (Adler et al. 1998). As for HIV, in many low income countries, there has been relatively

little success with implementing effective STD prevention. Once infection has occurred, management of STDs involves four activities: case detection; case management; condom promotion; and contact tracing (Adler *et al.* 1998; Holmes and Ryan 1999). There are two kinds of clinical environment within which these might be taking place: the specialist STD clinic; and the primary provider. In many low income countries, until the 1990s, specialised STD clinics or dermatovenereologists provided most curative STD care, usually isolated from other public health approaches to HIV/STD control (Grosskurth 1999). More recently, PHC facilities were encouraged to provide STD management, including: syndromic management of STDs; assessment of STD behavioural risk; screening for STD infection; HIV/STD health promotion; STD laboratory tests; HIV/STD partner notification; condom promotion; and community awareness raising of HIV/STDs and health care available.

2.3.1 Case management

Case management of STDs can involve a range of approaches, including aetiological, clinical and syndromic diagnosis and management (Adler *et al.* 1998). The aetiological approach is commonly used in industrialised countries and relies on microscope and laboratory cultures to establish which pathogen is causing infection. The clinical approach does not employ laboratory tests but relies on the clinician being able to recognise signs and symptoms of different pathogens, something which is very difficult for STDs and therefore not recommended. Thus, although many hospital-based clinicians in low income countries continue to rely on laboratory support for STD diagnosis prior to treatment for specific infections, for some time, international consensus has promoted an approach which relies on identification of common sets of symptoms and signs or 'syndromes', caused by a range of pathogens (WHO 1991; WHO/GPA 1994; WHO 1995).

'Syndromic management' of STDs refers to the treatment of more than one infection which may have caused a particular syndrome (Dallabetta *et al.* 1998; Holmes and Ryan 1999). The main syndromes which occur are: genital ulcers; vaginal discharge; cervical infection; PID; urethral discharge; and testicular pain. Each of these symptoms is caused by a range of different pathogens which are difficult to identify clinically in the absence of laboratory tests. Thus, where tests are not available, too expensive or take time, and so rely on the patient returning for results, presumptive treatment for a range of common pathogens is now recommended. In addition, co-infection with STDs is common so even in industrialised countries, syndromic management is recommended for patients presenting with PID or urethral discharge and dual therapy is common for those with confirmed gonorrhoea or chlamydia (van Dam *et al.* 1998).

For each syndrome, a standard algorithm allows clinicians to determine appropriate treatment. These vary considerably in sensitivity, specificity and effectiveness[12]. Algorithms for genital ulcers in men and women, and urethral discharge and testicular pain in men have all been found to have high cure rates in resource-poor settings and to be substantial improvements on clinical recognition of signs and symptoms of specific pathogens, in the absence of laboratory diagnostic facilities. Algorithms for PID, vaginal discharge and cervical infections are, however, much less effective, mainly due to the very low sensitivity and specificity of the relationship between symptoms and disease (van Dam *et al.* 1998).

The two most important problems are related to the major cervical infections, gonorrhoea and chlamydia, both of which have severe long term consequences for reproductive health if untreated. First, although the algorithm for vaginal discharge was widely promoted for managing cervical infections, these infections are now known not to give vaginal discharge symptoms (Behets *et al.* 1995; Ryan *et al.* 1998). Instead vaginal discharge is usually caused by such infections as bacterial vaginosis, which can have severe consequences (including possible enhanced HIV transmission risk [Al Harthi *et al.* 1999; Olinger *et al.* 1999]) but is not sexually transmitted, and for which the algorithm works quite well (Behets *et al.* 1995). Second, cervical infections often have no other symptoms or signs even when a full pelvic examination is performed and there is no obvious alternative to the vaginal discharge algorithm for managing cervical infection (Ryan *et al.* 1998). In response, WHO recommended incorporating socio-demographic and behavioural risk factor assessment stages with the algorithm along with pelvic examinations to identify those at risk of sexually transmitted cervical infection (WHO/GPA 1994). Trials showed slightly increased sensitivity and specificity of algorithms when combined with these additional activities (Mayaud *et al.* 1995).

The main disadvantage of syndromic management is therefore that it cannot address the needs of asymptomatic patients and additional strategies are needed to identify cases who do not present at health facilities independently. Syndromic management can also contribute to increased costs since, although most STD diagnostic tests are considerably more expensive than the drugs, considerable over-treatment occurs given each syndrome must be treated for a range of pathogens, some of which may not be present. Another problem is antimicrobial resistance, which over-use of drugs can exacerbate. This is, however, likely to be less harmful than the regular availability of poorly prescribed over-the-counter antibiotics in many low income countries. Finally, the low positive

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[12] Syndromic management was comprehensively reviewed in a supplement of the journal *Sexually Transmitted Infections* in 1998. This section is based on the papers in this supplement.

predictive value of some algorithms gives a strong possibility of women being wrongly labelled as having an STD, which could expose them to considerable stigma or danger of violence.

2.3.2 Case detection: risk assessment; screening; laboratory support

Case management refers to treatment of patients who present with symptoms at health services but, because STD symptoms are both hard to identify and sensitive, not everybody with an infection will present. It is well known that 50-75 per cent of gonorrhoea and chlamydia infections in women are asymptomatic; increasingly, these infections in men are also being found to have no symptoms and one study has found 80 per cent of trichomoniasis infections in men to be asymptomatic (Jackson *et al.* 1997). Case detection therefore refers to a range of activities which are geared towards identifying people who are infected but either have no symptoms or have not presented at the health service (Adler *et al.* 1998). Some STD tests, such as syphilis RPR[13], can be performed in PHC settings and do not require sophisticated equipment or training. Most case detection, however, depends on laboratory support and can therefore be difficult to implement in low income countries. Even where laboratories are available, treatment would depend on the patient returning for results which can rarely be guaranteed. Vaginal and cervical infections can also be detected through clinical examination of non-STD patients, although the accuracy of clinical identification of pathogens is generally poor (Vuylsteke *et al.* 1993).

Screening is one component of case detection and usually refers to a wider coverage of either a whole population or one particular high risk group. For example, in areas of high syphilis prevalence, all pregnant women should be screened using simple and cheap RPR tests to prevent them passing infection on to their new born children. For other pathogens, screening is normally restricted to high risk groups, such as sex workers, since costs and ethical considerations preclude wider application. Tests vary hugely in their ability to detect true cases and in general cheaper and simpler tests have lower positive predictive values (Adler *et al.* 1998).

Contact tracing can also identify new infections by using an index case to gain information on partners who may also be infected. This can be done anonymously, using partner notification forms which contain information on the treatment the index case has received, or it may involve interviewing the index case in detail about their sexual history in order to refer partners for treatment (Asuzu *et al.* 1984; Winfield and Latif 1985; Jenniskens *et al.* 1995). Provider referrals involve more active and expensive efforts in which partners are tracked down in the community. In low income countries, the latter approach is not feasible; care must also be taken where the index case may have been infected by their long-term partner who has acquired infection elsewhere.

2.4 Where to provide these services: integrated or separate clinics?

2.4.1 Advantages of integrating with primary health care relative to specialist clinics

While a substantial amount is now known about what to do to control STDs and thus HIV, debate continues over the best place to deliver these services. In low income countries, the most widely available health care is provided through basic PHC facilities. The origins of this approach lie in the 1978 Alma Ata declaration, which rejected traditional hospital-based health systems and enshrined an international commitment to comprehensive, basic services as part of a broader political and economic development agenda (WHO 1978). As a result, after the 1970s, services were in theory provided, in the first instance, through accessible and affordable health posts, with referral to more limited secondary and tertiary facilities as required (Walt and Vaughan 1982; Rifkin and Walt 1986). These services were to include both curative and preventive care for people of all ages.

Table 2.3 Indicators of coverage of primary health care services around the world

Indicator Region	% women using contraception (1987-94)	% births attended by trained personnel (1990-96)	% children immunised (1990-95)
E Asia and Pacific	74	77	88
L America / Caribbean	60	76	85
M East and N Africa	37	58	86
S Asia	40	33	73
Sub-Saharan Africa	16	38	53
World	58	58	77

Sources: UNDP 1997; World Bank 1997.

Thus, by comparison with dedicated sexual health or dermatovenereology clinics, which served largely urban populations or special groups such as sex workers and their clients, PHC aimed to reach the general population (Table 2.3). It should therefore be an ideal setting in which to provide STD prevention and treatment. Indeed, this realisation prompted the trial in Mwanza to establish whether or not this would be effective for reducing HIV incidence (Hayes et al. 1995b) and one of the most important claims of the trial was that it was replicable in PHC settings (Grosskurth et al. 1995).

There are many potential advantages to integrating HIV/STD services with PHC. It is financially efficient to use an existing health care infrastructure rather than constructing extra facilities specifically for sexual health (World Bank 1993; Pachauri 1994). Furthermore, these facilities are staffed by trained personnel who could provide STD care and prevention with relatively little additional training and supervisory input (Dixon-Mueller and Wasserheit 1991; Lande 1993).

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[13] The RPR (rapid plasma reagin) is the simplest test for syphilis.

Finally, PHC facilities are supported by a range of logistical systems, including drugs and transport, and are the cornerstone of a wider district health system which includes referrals to a district hospital with more comprehensive laboratory and clinical facilities (Smith and Bryant 1988; Newell 1989; Zwarenstein et al. 1993; Wilkinson 1995).

2.4.2 Reality of primary health care: contraceptive and ante-natal care for women

However, early in the 1980s, ideological shifts in the PHC movement and financial and logistical dilemmas undermined the Alma Ata ideals. After then, in practice, instead of comprehensive services, a select set of economically efficient services was provided by specialised nursing staff focused on child health, ante- and post-natal care for mothers or FP (Feachem et al. 1992). As a result, PHC in much of sub-Saharan Africa was used mainly by women for preventive care for themselves and their offspring in addition to basic curative care for children and sometimes adults (Werner et al. 1997). These services were supplemented by intermittent campaigns against selected infectious or tropical diseases, such as polio or smallpox, which were often delivered by completely separate health teams (Greenough 1995; Cairncross et al. 1997; Taylor et al. 1997). Outpatient, curative care for adults, especially men, was largely left to district hospitals or the private sector.

During the 1990s, under the influence of new funders, the PHC agenda expanded to incorporate a wider range of cost effective packages designed to address key diseases or groups of diseases, including AIDS, STDs, tuberculosis (TB), school health and tobacco and alcohol programmes which afflicted different population groups (World Bank 1993; World Bank 1997; WHO 1998). However, despite the fact that these new issues clearly require services for a wider population, the emphasis at health facilities has so far remained on services for women and their children.

Data on service use in the 1990s in sub-Saharan Africa reflected these trends: coverage of ante-natal care was high and, in most countries, over 80 per cent of women attended care at least once, although usually late in pregnancy (Figure 2.1). During ante-natal consultations, women received advice and information about their pregnancy and childbirth including possible complications, tetanus toxoid immunisations and screening for high risk obstetric indications. Coverage of trained personnel at deliveries was less widespread: between 24 and 69 per cent of women were assisted by some kind of trained person at birth (Figure 2.1[14]). Immunisation of children is shown as a comparison for the reproductive health indicators and demonstrates wide variations in coverage of complete vaccination of children[15]. Incomplete vaccination coverage was, of course, much higher. Use of modern

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[14] In Chad and Mali, these figures refer to trained birth attendants; elsewhere they refer to doctors or midwives.
[15] A complete set of immunisations includes: BCG, measles, three doses of DPT and polio, including polio 0.

contraceptives, by contrast, was generally low, ranging from three to 42 per cent and in only three countries did more than a fifth of women use contraceptives.

Figure 2.1 Percentage of women and children receiving primary health care services
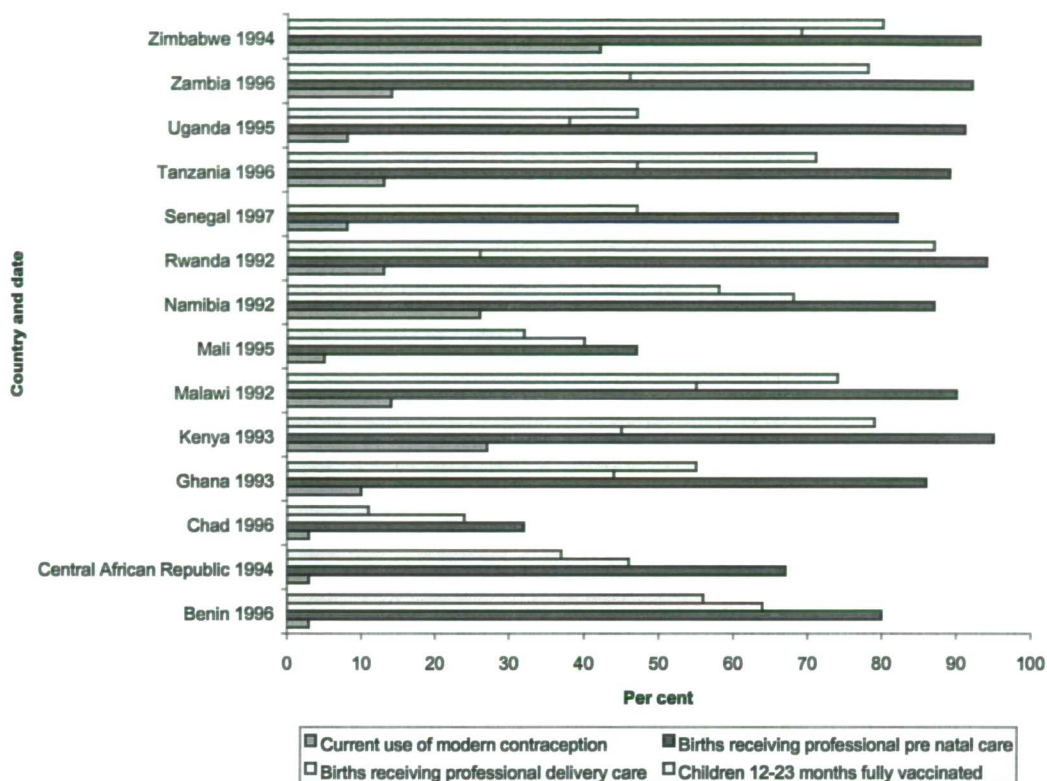
Source: Macro International, Demographic and Health Surveys: various dates.

These data imply that there are potential opportunities for integration of new activities; however, any integrated activity will address women's needs to a greater extent than men's. STD case detection and subsequent management where necessary could, in theory, be undertaken during FP or ante-natal consultations or even when women bring their children for immunisation. Health and condom promotion could also be incorporated into routine health education messages at clinics. In sum, despite this restricted population, there is an intrinsic appeal to the idea of using existing opportunities for STDs control, especially given the potential serious consequences of infection for women.

2.5   Limitations to the integrated approach

2.5.1   Missing the men

Information on men's use of PHC was less readily available than for women and children for three reasons: first, there was much less interest in the health needs of adults and especially men (Feachem *et al.* 1992; Reich 1995); second, the major international population-based data collection efforts did

not question men (Macro International Various); third, information collected at health facilities focused on priority programmes, which largely provided services for women and children (World Bank 1993; UNDP 1997). Nevertheless, the limited evidence suggests that, in general, men use public PHC less than women and therefore present fewer opportunities for routine screening or risk assessment during other health care interactions (Bolan et al. 1999). Data on health seeking behaviour for symptomatic STDs were also limited (Ward et al. 1997) but suggested that, unlike for other health care, men were more likely than women to seek care earlier because symptoms tended to be more acute (Bolan et al. 1999). However, the type of care which men chose could vary considerably between formal and informal sectors or private and public services and they might be better able to afford private medical fees than women (Crabbe et al. 1996; Benjarattanaporn et al. 1997).

Combined with the greater effectiveness of STD management tools for men than for women, these issues create barriers to achieving the public health goal of HIV/STD control through PHC. However, for individual women, the rationale for STD treatment being available in these facilities is still strong since the potential sequelae of these infections are so severe and the dermatovenereology clinics which men often attend can be less sensitive to the needs of women (Bolan et al. 1999; Grosskurth 1999).

2.5.2 Feasibility

Despite clinical and public health limitations, after the early 1990s, considerable effort went into implementing integrated STD management in PHC, especially in sub-Saharan Africa (Hardee and Yount 1995; Askew et al. 1998). Although it is too early to evaluate the impact of these efforts, there is growing evidence on the feasibility of the approach. There are two elements of feasibility which are important to investigate: first, for each intervention, there are questions on what steps are needed for effective implementation; second, for STD control, there are questions on how all the different interventions have been managed as part of a programme. In general, there is more information on the first than the second issue, while the second may be more important for STD control (Mayhew 1996; Dehne and Snow 1999).

The most important evidence comes from a number of Situation Analyses of MCH/FP services by the Population Council (Askew et al. 1998) under the auspices of the United States Agency for International Development (USAID). These studies, conducted in the mid 1990s, suggested that, despite national commitments to integrating STD management activities at facilities, most facilities were not able to provide such services. While the majority claimed to be providing some kind of HIV/STD counselling or information, rather few were able to treat STDs, sometimes because drugs or

equipment were out of stock but also because training was sporadic (Askew *et al.* 1998). Other operations research by the Population Council suggested that clinical interventions were promoted more than preventive activities but that even for these, quality of care was poor (Baakile *et al.* 1996; Twahir *et al.* 1996; Mukaire *et al.* 1997).

In addition to these studies, there were a number of other one-off studies of integrating particular interventions, usually conducted by non-government providers and researchers. In a review of these studies, Dehne and Snow (1999) concluded that, integration of information and health promotion activities was more successful where policy makers and providers made an effort to implement new activities, although the impact on behaviour change was unknown or limited. For clinical interventions, the findings were less positive, largely due to the paucity of data on real improvements in treatment for MCH/FP clients. On the contrary, what evidence there was suggested that successful programmes for expanding access to STD treatment for women (mainly in Latin America) were not integrated. Evidence from NGO facilities in Africa suggested that successes were achieved in clinics which were comprehensive to start with, rather than those where STD services were grafted onto pre-existing FP. Furthermore, both types of intervention appeared to have more impact on the quality of FP than STD services, suggesting that there were many more lessons to be learnt before STD management was feasible.

Finally, there was even less evidence on the costs of integrated services and whether they were more cost effective than separate services. Findings from small scale operations research suggested that costs were reduced with integration since STD management was usually performed by nurses rather than doctors (Ladha *et al.* 1996; Lule *et al.* 1998). However, other studies suggested that interventions which focused on high-risk populations were more efficient than those addressing low-risk populations (Cleland and Lush 1998). Furthermore, it was difficult to assess costs in national programmes since training efforts and drug supply systems for integrated services were mostly not completed (Dehne and Snow 1999).

The over-riding impression from these preliminary evaluations is of poor quality of care combined with frequently missed opportunities for STD management or prevention. Where interventions had been implemented, they were usually specific activities, such as syphilis screening for pregnant women, or risk assessment for new FP clients. There was little evidence of a comprehensive, holistic approach to sexual health for women.

2.5.3 Management of integrated services: vertical and horizontal approaches

Most studies of implementation of integrated services focused directly on the facilities at which services are provided (Dehne and Snow 1999). Many questions remain, however, about the most effective way to manage these services, leading some authors to distinguish between functional and organisational integration (Hardee and Yount 1995). While there is consensus that a high quality STD service is best integrated with other PHC activities, there is less agreement over the best way to organise and manage integration. The purpose of management is to direct the logistical, financial and human resource support that providers need to ensure a high quality service. On the one hand, it may be more efficient to organise structures around one particular disease problem, for which a range of activities are required, leading to vertical programmes. On the other hand, it may be better to establish structures which manage a particular type of activity, which will have to attend to issues relating to a range of different diseases, resulting in horizontal systems (Figure 2.2).

Figure 2.2 Generic Ministry of Health Structural Organogram for Sub-Saharan Africa
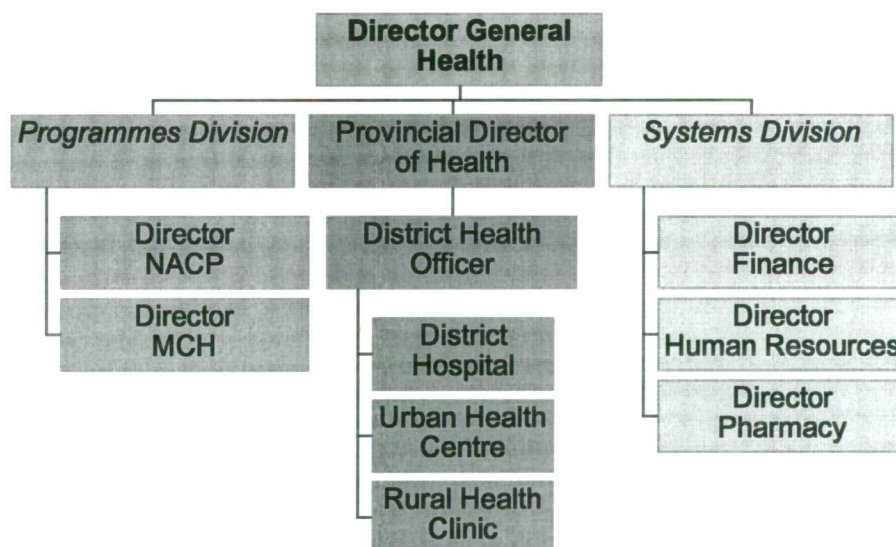
Traditionally in many sub-Saharan African countries, MCH, FP and AIDS control were all directed by institutionally separate vertical programmes based at national Ministries of Health. These programmes were established and funded in the 1970s and 1980s by governments and international donors in order to prioritise activities of particular public health importance within a PHC framework (WHO 1998). Through them, financial and human resources, drugs, guidelines and training could flow relatively efficiently and transparently down to clinics in order that activities which were deemed to be of particular importance were not overlooked (Smith and Bryant 1988; Matomora *et al.* 1991; Bradley 1998). The approach was top-down and promoted adherence to nationally set goals which

were assumed to reflect local priorities. Relatively little flexibility was allowed at district level in determining how resources should be used or adapted to a particular context.

More recently, enormous effort went into strengthening MOH human resource, finance, drugs and other logistics systems (Berman 1995; Janovsky 1996). Administrative and financial reforms focused on improving the efficiency and transparency of these systems, in the hopes that they would manage the bulk of health provision, reducing the need for technical programmes to get involved in administration. Supported by such donors as the World Bank, with greater interest in improving governance and economic development than controlling specific diseases, and greater financial power, these efforts resulted in a shift of policy interest away from programmes and towards systems (World Bank 1993; World Bank 1995).

In addition to vertical and horizontal structures, there are different administrative levels – national, provincial and district – at which different responsibilities are held and thus different priorities may emerge (Figure 2.2). For example, at national level, where directors are responsible for reducing national burden of disease, the priority could be HIV/AIDS control through a programme of specific, targeted activities. By contrast, at district level, where managers are responsible for efficient service provision, the priority might be a constant supply of all relevant drugs to facilities (Smith and Bryant 1988). For HIV/STD control, the issue is further clouded by the breadth of activities required: some, such as treating symptomatic STDs, are better integrated with existing services and may therefore be better managed through horizontal structures. Others, such as services for sex workers or condom distribution, clearly require specific, technical input which is quite different from any other disease and may be better managed by national staff through a dedicated, vertical programme. A key concept in the limited literature on this issue is that, whatever the activity, vertical programmes need to co-ordinate with horizontal systems at every administrative level; in practice, this happens rather little.

There is some evidence in the literature on the poor interaction between vertical programmes and horizontal systems (Cairncross et al. 1997; Bradley 1998). Of particular concern is whether, in the course of managing specific services, vertical programmes actually disrupt, rather than merely usurp, horizontal systems. These issues have recently re-emerged as a result of the renewed interest in district management systems under the health reform agenda. Decentralisation of financial and administrative decision making to district health teams has shifted the axis of responsibility to a lower administrative level, in the hopes that this will increase accountability for local area health status (Janovsky 1996). However, district managers are ill equipped for prioritising and lack information on local or national health problems (Keller 1991; Sandiford et al. 1992). As a result, they may not take decisions in line with national priorities, potentially creating problems for vertical programmes. For

example, district level decisions on staff deployment can hamper programme efforts to distribute new technical training evenly among clinics.

In sum, although the debate about vertical and horizontal management raged for at least 20 years, there is remarkably little evidence to support the superior efficiency of either approach. The interaction between types of structure and levels of administration is crucial in determining the efficiency with which service delivery is managed. Factors which affect interaction include: formal and informal communication between actors; resource flows and amounts; internal hierarchies and politics; external context and influence of donors on decision making; and type of policy being undertaken. It is likely that where policy goals and function are clear, the detail of organisation and structure for implementing them is less important. Where goals and function are muddled and complex, the need for a vertical programme is greater; this vertical programme may, however, disrupt current or future sustainability by undermining the capacity of horizontal systems to manage relevant activities.

2.5.4 Context of high or low prevalence of STDs

In areas where there is a high prevalence of STDs, the public health benefits of integration almost certainly outweigh the costs. However, in low prevalence settings, where HIV is still confined to groups with high risk behaviour and other STDs range in prevalence from two to ten percent, the case for grafting STD activities onto routine MCH/FP is much less convincing than in high risk settings (Hawkes, S., 1999 personal communication).

Given limitations to the effectiveness of STD control tools in PHC settings, there are three obvious dangers in such a policy (Cleland and Lush 1998). First, it involves large expenditures on drugs, training and so on for modest potential returns in public health. Second, over-prescription of antibiotics because of poor diagnostic techniques can contribute to pathogen resistance, as is already seen for gonorrhoea (Piot and Tezzo 1990). Third, women may be discouraged from seeking MCH/FP services if they are confronted by STD diagnostic questions or tests which they find offensive, embarrassing or irrelevant. STD control activities for women are further hampered by difficulties in reaching women's partners. While contact tracing is practically impossible in low income countries, treatment of STDs is ineffective if the patient will be immediately re-infected by her partner. Similarly, promoting condoms to women is missing its target audience and potentially exposing women to violence. Health education for safe sexual behaviour may also not be entirely appropriate or effective if directed at women, given their lower rates of partner change than men and limited control over the sexual activities of their partners (Bolan *et al.* 1999).

In sum, there are important limitations to the integrated approach to STD control which may outweigh public health benefits in areas with low STD prevalence. Having an STD has more serious long term consequences for women than for men which implies that, irrespective of the implications for HIV incidence, curing STDs is of benefit to women. However, prevention of both STDs and HIV is more complicated and the question remains whether targeting women in HIV/STD control campaigns is the best way of preventing HIV/STD infection in women. It may be that treating or preventing STDs in their male partners, or indeed the other partners of those men, through relatively separate, specialist services is a more effective way of mitigating the effects of STDs for everybody. This is even more likely to be the case in places where STD prevalence is low and, given the number of infections which are asymptomatic, the number of cases presenting at MCH/FP clinics will be small.

2.6 Conclusion

In conclusion, there are significant problems with conceptualising, delivering and managing integrated STD prevention and management and HIV control. The preceding analysis of these problems begs the question: why has this approach been so heavily promoted over the last five years? The most important problems appear to arise out of insufficient consideration of local context when designing new interventions. For example, when scaling up from the Mwanza trial to national programmes, policy makers failed to appreciate the importance of the lack of men at PHC facilities. Alternatively, at national level, planners failed to take into account HIV/STD prevalence and thus the number of symptomatic infections at facilities when considering the likely effectiveness of the approach.

The development and application of international gold standards for health care in low income countries has a long and tortured history. One of the problems with the approach is that, despite best intentions, these gold standards are rarely sufficiently adapted to local context. Policies developed in international fora are transferred, sometimes under duress from international funders, with inadequate sensitivity to particular population needs or service background (Dolowitz and Marsh 1996; Common 1998). A new approach to the policy transfer problem looks at why this should be, including the process by which consensus is reached, the organisations and actors involved in developing gold standards and the means by which they are disseminated in national or local settings. In this thesis, Chapter 3 will examine these ideas and apply them to the problem of integrated STD management to shed light on how and why this approach achieved such international prominence. Chapters 4 to 6 will then address the impact of these policies in sub-Saharan Africa.

2.7 Summary

- The international agenda for integrating HIV/STD control with PHC has been strong since 1994. HIV is now one of the most serious health issues facing the world: it is the fourth biggest killer world wide and the leading cause of death in sub-Saharan Africa. The social and economic impact of HIV/AIDS on the macro-economy, in industry and at a household level are huge and there are increased pressure on health services. Infections take place in difficult contexts of poverty and poor gender relations.

- During the 1990s, prevention programmes for HIV/AIDS evidently failed in sub-Saharan Africa, despite their relative success in industrialised countries. Condoms remain unpopular and rates of partner change, especially among young men, are high. Governments experienced political difficulties with addressing sensitive cultural issues in the public arena. The identification of biological and clinical links between infection with HIV and other STDs meant that the focus of HIV control efforts has recently been on managing STDs.

- Controlling STDs involves prevention and management. Recently, traditional laboratory diagnostic techniques gave way to the syndromic approach, under which sets of signs and symptoms are attributed to a group of common pathogens which are all treated using standard algorithms. The main syndromes are genital ulcers, genital discharge and PID; the algorithm for vaginal discharge is particularly ineffective. Syndromic management offers nothing to those who have no symptoms, which can be a high proportion of infections.

- STD management can be undertaken in either PHC facilities or specialised clinics: after 20 years of promotion, coverage of PHC is relatively high. However, there are several limitations to integrating STD services into PHC, most importantly that men do not attend PHC services as much as women. This has major implications for the potential success of HIV/STD control efforts, particularly given the low effectiveness of the STD management tools for women.

- Either vertical programmes or horizontal systems can be used to manage integration at national, provincial and district tiers of administration. Co-operation between these different structures is weak. Questions remain over whether vertical programmes disrupt rather than just usurp horizontal systems, especially at district level. Given these difficulties, there are concerns over whether the effort is worth it. Evidence suggests that in areas of high STD prevalence the public health benefits outweigh the costs. In low STD prevalence areas, however, a more targeted approach is probably more appropriate. Recent international policy statements reflect these concerns.

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CHAPTER 3: FRAMEWORK FOR POLICY ANALYSIS

3.1 Introduction

Chapter 1 set out to understand how the international agenda for integration was established and how it was reflected in national policy. Chapter 2 analysed the scientific rationale for integrating HIV/STD services with PHC. The aim of this chapter is to move towards understanding the process by which this idea was transformed into policy.

Analysis of health policy in low income countries has three key difficulties. The first is that many of the analytical frameworks available in the literature were developed from empirical and theoretical work on the political processes of European and North American established democracies. This creates problems for application in places where institutions of governance are weaker, and where different assumptions about administrative capacity and resource availability must be made. The second difficulty is that international health policy, to a greater extent than other areas of social policy, involves highly complex technological debates over service delivery, balanced by severe resource constraints. Therefore, in order to understand how health policy develops, it is necessary to analyse negotiations between networks of specialists and non-specialists, at international, national and local levels, over both scientific developments and shifts in resources available. Third, in sub-Saharan Africa, despite political institutions being founded on concepts of the nation state, indigenous policy processes are disrupted by powerful outside influences on the setting of agendas and resource allocation. Outside influence comes in two forms: first, indirectly, through developments in the global scientific knowledge base, which national governments participate in and are increasingly expected to respond to; and, second, much more directly, in terms of bilateral and multi-lateral relations with external governments or agencies, who assist with formulation and financing of new policy.

All these issues are of central concern to the analysis of developments in policies to integrate HIV/STD services and PHC. The policy being studied is a relatively new concern, suggesting that both at international and national levels, much of the activity will be in agenda setting and formulating policy, which need further analysis. The process of agenda setting in low income countries is, however, a neglected area of policy research, including how it relates to international agendas and how it affects implementation (Reich 1995a; Birkland 1998). Furthermore, the relationship between international and national policy actors is such that there tends to be greater emphasis on policy design. Implementation is left to national governments although understanding of this process is weak (Common 1998).

In this chapter, there are therefore two broad aims: to review broader literature on the approaches and concepts of policy analysis, with a particular focus on why policies reach a prominent position on the policy agenda; and to examine literature on ways in which international agendas are implemented in national policy. In developing an analytical framework from this literature, the aim is to draw out carefully those aspects of conceptual models which are useful in understanding and explaining developments in this particular policy. Thus while the chapter will focus particularly on literature on **agenda setting, policy transfer** and **implementation**, each of these literatures will also be critiqued in terms of its applicability in low income country settings and for understanding integration of HIV/STD services with PHC. Where examples or models are available from low income country settings or from health policy specifically, they will be used, although most writing has not been in these areas. Where a model which has been developed in Northern settings does not appear to fit Southern settings, questions will be raised about its overall usefulness as a representation of reality.

3.2   Conceptual background to policy analysis

Figure 3.1 Conceptual framework for policy analysis

CONTEXT

ACTORS
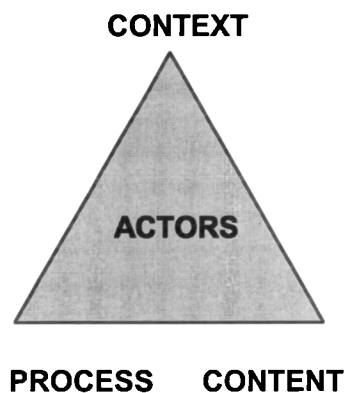
PROCESS   CONTENT

Source: Walt & Gilson 1994.

Until recently, policy research in international health focused on the technology or content of policy, neglecting the processes of policy development and implementation (Walt & Gilson 1994). Because of this neglect of process, policies were often formulated and implemented ineffectively in response to new research, and expected policy outcomes were not achieved (Hogwood & Gunn 1984; Grindle & Thomas 1991). For example, most research on FP focused on services and methods, but very little on institutional or political constraints to delivering services (McIntosh & Finkle 1994; Thomas & Grindle 1994; Lee et al. 1998). Similarly, little is known about the organisational factors affecting the implementation of HIV/STD control programmes (Pachauri 1994). A policy analysis approach to health addresses why and how national policies are formulated and implemented; while technical aspects of delivery have to be understood, they are not sufficient to explain whether policies will be

effective or not. The principal approach is historical and focuses on changes over time in: the context of policy; the process of policy development; the actors who influence policy; and the content or characteristics of policy (Walt and Gilson 1994; Figure 3.1). The content of policies was covered in chapter two; in this chapter, theories on analysing context, actors and processes of policy making are described.

3.2.1 Context

The context of policy refers to the political, economic and cultural environment in which health policy decisions are taken. In health, attention has recently been paid to the influence of political systems and power on the policy process, reflecting interest in the way actors interact to negotiate policy decisions (Grindle 1980; Jordan & Richardson 1987; Finkle & McIntosh 1994; Reich 1995b). While the policy literature ranges from the role of different institutions[16], such as the state or market, to the participation interest groups, the fundamental focus has been on relations between different actors and how their relative power affects decision making (Ham & Hill 1993; Cox 1995; Wrong 1995; Barker 1996; Hill 1997). In particular, since health policy has generally been considered to be a low politics issue, or one which rarely concerns politicians in day-to-day decisions (Walt 1994), understanding organisational politics has become an important area of research, especially for examining gaps between policy intent and implementation (Grindle 1980; March & Olsen 1989; Brinkerhoff 1997). However, there are areas of health policy which can generate intense political turmoil and thus may become high politics issues, on which governments stake considerable political risk (Walt 1994). For example, at the international level, McIntosh and Finkle (1995) showed how FP became intensely politicised at the ICPD, with the Holy See forming alliances with Muslim states to counter Western moves towards sexual and reproductive health and rights (see Chapter 4). Similarly, at national level in South Africa, Schneider (1999) demonstrated how senior politicians became mired in AIDS controversies (see Chapter 5).

The economic context also influences policy development in a number of ways, depending on the political situation. In many low income countries, health services are severely constrained by lack of state resources and the low priority accorded to health within government and international development spending (McPake et al. 1993; Gilson 1995; Potts & Walsh 1999). For example, in 1990, low income countries spent between two and seven per cent of their GNP on health, a total of US$2-40 per capita (World Bank 1993). Despite efforts to foster private sector provision of medical care, general poverty restricts the extent to which individuals are able to use private services,

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[16] The term institution can be used in two ways: first, in its common sense of bureaucratic organisations; and, second, in the sense of rules and norms of behaviour and interaction which frame relations between individuals. Here, it will be used largely to mean the latter; for the former, organisation will be used instead.

particularly for preventive services or those which have added public health benefits beyond the individual concerned (De Cock *et al.* 1994; Kickbusch 1997). Lack of state financing of health care contributes to widening inequities in access to care which parallel inequalities in power and social status.

In addition to these political and economic contextual factors, other exogenous influences can change the trajectory of policies over time. According to one model, these can include structural, situational, cultural and environmental factors, acting at both global and national levels (Leichter 1979). Structural factors refer to the constant, relatively unchanging political and economic influences described above as well as national geography or urbanisation of the population (Waite 1988; Webb 1997). Situational factors refer to temporary shifts in political and economic influences, such as currency fluctuations or elections, which influence policy decisions. Cultural factors include the influences of social norms and values on policy and decision making and, in health, also on the spread of disease in society. For example, Ulin (1992) has shown how women in Africa who wanted to protect themselves from HIV infection were constrained by their socio-cultural context when trying to negotiate condom use with their male partners. Similarly, in Botswana, MacDonald (1996) found that cultural norms around fertility and its limitation contributed to the rapid spread of HIV. Finally, environmental factors refer to influences which derive from situations outside the country of interest, such as the global economy or political relations between states (Lee & Zwi 1996). For example, international health policy is increasingly influenced by global economic, political, cultural and technological developments under the general term globalisation (Walt 1998). Kickbusch (1997) also showed how the role of state institutions in public health changes in the context of these new global economic and political trends. The involvement of international development agencies, with their own specific agendas, in many low income country health sectors further complicates policy development and widens the spectrum of actors and interests involved in decision making (Cliff 1993; Hiscock 1995; Buse & Walt 1997).

3.2.2 Actors

The actors involved in policy making, their interests and influence must be taken into account since they determine which solutions are chosen and how they are put into practice. In health policy, the principal decision making body is usually the MOH. Other important actors to consider include medical provider associations, independent pressure groups, pharmaceutical industry representatives and not-for-profit organisations (Walt 1994). These actors act at international as well as national and local levels, representing a wide range of positions with varying degrees of power and influence over decisions.

Groups of central policy actors form networks to make policy decisions (Marsh 1998). Networks form as relatively loose '*links between actors in a particular policy domain*' (Marsh 1998: 1) and, in addition to state actors, may include academic, media, civil society or private organisations, with different political orientations and interests but similar expertise or specialisation which brings them together. Networks can exist both nationally and internationally as well as in specific policy sectors. In health, for example, Jackson (1998) showed how different technical experts were brought together by WHO to formulate consensus over a new international malaria policy. The structure and formation of networks can be fairly constant, for example medical provider organisations, or they can be ephemeral, for example when coalitions form at particular times to present a coherent position on a particular policy issue (Marsh 1998). Elsewhere in the network literature, policy communities have been described as tighter, longer lasting and more closely interacting groups of actors than networks. Epistemic communities are a particular type which form around specific technical interests. Actors within them have common technical qualifications, language and epistemological approaches and interact to influence policy reform (Haas 1990).

Analytical approaches for studying actors and their roles in policy traditionally varied, first, according to the relative weights given to individual agency or to structures and institutions which influence individual choices (Tornquist 1999). Approaches which dwell more on agency are known as pluralist and address issues around the behaviour of different policy makers, such as politicians, bureaucrats or even individuals or groups in society (Hill 1993). Such approaches assume relatively widespread participation in policy, such that the interests and influence of different sectors of society in policy decisions are seen to be relatively equally represented (Smith 1977). A second conceptual variation is the extent to which actors and structures are located in either state or market spheres. In this research, the focus is on public health policy and the state institutions which determine its development. The market sphere has, however, influenced policy, through the interactions between governments and private or non-profit organisations.

Marxist or elite theory focuses more on structure than agency, suggesting that networks and communities exist within a context and have internal structures of power and influence which usually reflect the prevailing socio-political system (Lukes 1974; Wrong 1995). For example, state actors with economic interests often have more power than other civil society or private actors due to their pre-eminence in the neo-liberal political framework which guides most modern societies (Bebbington & Riddell 1995). However, while '*exogenous factors do affect policy networks, it is how that context is interpreted and negotiated by the members of the network which affects outcomes*' (Marsh 1998: 187). Thus, although the actors who make up networks often reflect prevailing social inequalities, there are cases where less structurally powerful actors can generate policy change through mobilising other forms of influence over decisions, such as the media or pressure groups (Walt 1994). This

suggests that both elite theory and pluralist approaches can be useful in understanding how different actors exert influence over a dynamic policy process.

Distinguishing between different actors, their networks and context, and understanding that they are all important and contribute to policy making, is a crucial step in analysing how decisions are taken. In low income countries, networks which link national actors with those at international level are particularly significant. When examining policies which originated among international epistemic communities, it is important to gain insight into how these communities interact with both national policy elites and international organisations. Some literature showed that the elites of low income countries developed similar aspirations to those in the country or international organisation from which a policy idea originated and thus arrived at similar policy conclusions (Mosley *et al.* 1991). Other literature suggested a more heavy handed, top-down relationship between international and national actors in introducing policy reform (Cliff 1993; Hiscock 1995; Buse & Walt 1997; Mayhew *et al.* In press). This study will explore the relationship between international and national policy elites, as well as links with managers and services providers, to see where their interests overlapped and how far those executing or receiving services had a say in policy development for integrated HIV/STD management.

3.2.3 Process

The literature generally refers to four stages in the policy process: agenda setting; formulation; implementation; and evaluation (Hogwood & Gunn 1984; Walt 1994). Although conceptually separate, and often analysed as though progress takes place rationally from one to the next, these processes rarely progress linearly, instead overlapping considerably in time and effort. They will be described briefly here and examined in more depth in sections 3.3 and 3.4; for this research, the processes of agenda setting and implementation were of greatest interest and receive more attention here.

Agenda setting refers to the process by which an issue emerges as one which requires attention by decision makers. A rational or linear model of agenda setting suggests that policy makers act within specific bureaucratic or political mandates to identify a policy problem within their sphere of influence (see Wolman 1992 for a discussion of the problems with this approach). They then consult widely to identify potential solutions to the problem before making a decision over what would be most appropriate in their particular context and with their resources. The model emphasises scientific and administrative consensus over policy reform and neglects potential political conflict over priorities and resources.

A non-rational framework for understanding agenda setting describes different types of issues receiving varying interest from policy makers over time, according to a much wider range of political, economic and social influences (Kingdon 1984). The most widely used model suggests three interest streams: problem identification (the problem stream); the politics of actors who determine what are important issues for the policy agenda (the politics stream); and a set of alternative solutions to the problem (the policy stream). The first two streams are frequently analysed in rational approaches. However, according to Kingdon (1984), two important areas are often neglected: first, the role of hidden participants or specialists, who are often members of policy networks although not officially elected or appointed to take decisions; second, the way policy alternatives are produced, such as by transfer or diffusion of ideas (see below, section 3.3). Between them, these two create the policy stream as a flow of new ideas with varying support and evidence for feasibility (Weiss 1979; Trostle *et al.* 1999). This policy stream interacts with the problem and politics streams and when, at certain points in time, the three interest streams coincide, windows of opportunity for policy change can arise (Kingdon 1984).

The literature identifies a number of criteria which influence the chances of selecting different policy alternatives, including technical feasibility, popular support and legitimacy for state action (Hall *et al.* 1975; Kingdon 1984). The Kingdon model therefore rejects a linear or rational model of policy progression from problem identification through alternative solutions to a policy decision. Instead, policy entrepreneurs form networks with mainstream political actors (bureaucrats and elected officials) to determine innovative solutions to identified problems, taking advantage of windows of opportunity where the three streams coincide to raise the chance of an issue reaching the decision agenda. The streams themselves do not develop haphazardly but reflect the on-going interactions between actors, networks and their context, as discussed above. Windows of opportunity, by contrast, may arise apparently randomly, for example through elections or other focusing events[17] (Birkland 1998). In international health policy, such focusing events also include the publication of new data, triggering widespread interest in an issue, or the hosting of a large international conference, again drawing political and media attention to what might usually been seen as a technical issue. In low income countries, national focusing events are rarely examined and their role is little understood. In particular, given the influence of external events on policy development, it is possible that international events have greater influence than national events. In this research, events which influenced the setting of the agenda for integration will be analysed.

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[17] A focusing event is defined by Birkland as '*an event that is sudden; relatively uncommon; can be reasonably defined as harmful or revealing the possibility of potentially greater future harms; has harms that are concentrated in a particular geographical area or community of interest; and that is known to policy makers and the public simultaneously.*' (Birkland 1998: 54).

In many low income countries, networks involved in agenda setting are also affected by the strong role of external policy entrepreneurs. Known also as policy intermediaries, or actors who mediate between technical experts and decision makers, their role is much neglected in the literature (Stone 1999). They include both donor representatives and technical advisers, sponsored and recruited by international organisations, and are even further removed from the political process than their equivalents in Northern countries. They frequently reside in different countries from those they are advising and have dual roles with respect to the host government and the organisation which has paid them. Their ambitions and priorities may not always coincide closely with those of the government they ostensibly assist and they may respond to a different schedule of focusing events, occurring at international level, than their national colleagues. Their role in developing policy for integration will be addressed in this research.

Moving on from agenda setting, **policy formulation** refers to the process by which, having emerged onto the agenda, issues are addressed and solutions are sought. In some of the literature, formulating health policies is seen as largely an administrative affair, involving members of the bureaucracy in determining feasible responses to a particular problem (Walt 1994). However, in reality, the initial documentation of policy is rarely such a linear process and instead is infused with the interests and power of different groups involved in decision making (Walt & Hammeijer 1992; McIntosh & Finkle 1995; Schneider 1998). Although not the primary focus of this research, it is important to note that policy formulation can be formal, through producing appropriate documents and holding routine or special meetings. It may also be an informal process, in which individuals communicate with each other outside routine meetings and memos to establish common ground for action. Formulation may involve national level actors in determining a policy solution but it may also include both international experts and local-level representatives, brought in to provide their perceptions of feasibility and ensure support for implementation. Generally, however, health policy formulation in low income countries takes place at national level, involving the central MOH, relevant international donors and sometimes private organisations. In rare circumstances, administrators from provincial, regional or district administrations may also be involved, although often such wide consultation is limited. These issues are addressed further in the literature on the processes of **policy implementation** and **policy evaluation** in section 3.4. First, relationships between international and national agenda setting and formulation processes will be explored.

3.3   Introducing policy transfer to the analytical framework

Having examined some of the basic models and concepts of policy analysis above, this next section introduces literature which deals with one particular issue: how policies developed in one context are used to develop policies in another. This literature draws on comparative studies of how ideas and

technologies spread. The aim is to shed further light on international-national policy linkages in order to identify mechanisms through which international concepts, politics and policies might have affected national policy development. Specifically, a policy transfer analytical framework is examined because this small literature highlights communication and lesson drawing between actors and networks in different settings. In an increasingly globalised world, interactions between states, through either bilateral relations or multi-lateral institutions, influence policy outcomes more than they used to. Understanding how these interactions take place and how they might be refined, with respect to developing effective, affordable, feasible and equitable health policy, could make a potentially important contribution to improving international public health. The policy transfer literature has neglected low income countries, however, and has rarely been used to examine health policy. Thus some care has been taken to disentangle what are useful concepts around relationships between different actors, and how they learn from each other, and what are unhelpful assumptions about participation and rationality in policy decisions.

3.3.1 Defining transfer: process, actors and context

According to Dolowitz and Marsh (1996), policy transfer refers to '*a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place*' (Dolowitz & Marsh 1996: 344). Policy transfer is a relatively new concept in the literature on comparative policy analysis. It grew out of post-Second World War analyses of policy diffusion which recognised that countries in similar political, economic and geographical settings often identified similar policy problems or agendas, and developed and implemented similar solutions (Walker 1969). These processes have also been described as policy convergence (Bennett 1991a) and policy transfer can be seen as a subset of diffusion or convergence that accords particular weight to active learning by policy makers (Rose 1993) relative to contextual determinants of policy development. It is a fundamentally dialectical framework which analyses the constant interaction between actors and their context in setting agendas and determining policy responses to them. Its chief difficulty even in Northern settings is whether national contexts can ever be seen as similar enough to generate the kind of emulation and sharing of ideas by actors suggested by the framework. In international health, this issue is pertinent since national settings are often very different but not usually accounted for in the transfer of international gold standards (see for example, Basch 1993).

The transfer framework also allows analysis of the content of policies and in particular the way technical interventions relate to the ideological background of the actors involved (Bennett 1991a; Dolowitz 1997). In its simplest form, actors are seen as drawing lessons from elsewhere through identifying a policy problem, observing the way others have dealt with a similar problem, assessing

the extent to which the solution fits with their own political or economic ideology and adapting it where necessary. However, this linear view of policy rarely fits reality: actors may include state as well as independent pressure groups, international organisations, private corporations and policy entrepreneurs or experts. Particularly in low income countries, intermediaries, including think tanks, academics and donors, can be crucial participants in facilitating, or inhibiting, transfer (Stone 1999).

There are different degrees of policy transfer: adaptation of lessons from elsewhere may produce significant policy innovation; alternatively, it may lead to a negative outcome and result in no policy change (Dolowitz 1997). Transfer can also take place through many mechanisms (Dolowitz & Marsh 1996). In examining evidence of transfer, policies may be found to have been directly **copied** from elsewhere, and therefore have exactly the same formulation and institutional implementation structure. This level of similarity is rare but there may be evidence of **emulation**, in which standards from elsewhere are adopted but the language and programme of implementation is different. For example, in international health, WHO guidelines and training manuals are widely used to standardise national policy design. Elsewhere, a **synthesis** of policies may take place, with actors selecting appropriate solutions from various sources and combining them into a new strategy. For example, WHO clinical guidelines may be combined with lessons from elsewhere on implementation in health services. Finally, transfer may occur simply through **inspiration**, as when international visits or evidence stimulate new ideas on how to address a problem (Bennett 1991b). For example, MOH officials frequently visit other countries to learn about how reform efforts have been managed and supported elsewhere. Of course, policies may appear to be similar but have been developed largely in isolation and not as a result of any kind of direct transfer of ideas. In this case, policy convergence may have occurred through response to similar policy problems in different settings.

3.3.2 Voluntary or coercive transfer

The distinction between policy convergence and transfer is somewhat false in that actors will always be involved in policy decisions. The key to **transfer** is that it emphasises agency through lesson drawing by decision makers, as opposed to structural determinants of policy similarity. Lesson drawing can be voluntary, i.e. actors search independently for solutions which fit their problems and context. However, the emphasis on agency underplays the role of a coercive environment, either through the direct influence of some external power or through indirect restrictions on policy choices or process which arise in particular contexts (Dolowitz & Marsh 1996; Common 1998). Most policy transfers between international and national levels are likely to lie on a continuum between coercive structural elements and voluntary agency.

The most direct form of coercive policy transfer is when an external power forces a government to adopt a particular policy. This may occur, for example, through legal mechanisms forcing countries to adhere to bilateral trade agreements, or, as happens frequently in low income countries, when international organisations impose strict conditionalities to providing external financial support to governments. The World Bank, for example, can introduce particular financial or service delivery requirements, such as increasing roles for private providers, for governments to adhere to in order to receive its funds (Mosley *et al.* 1991; Owoh 1996). Donors do not always apply such strict funding criteria but may insist that their money can only be used for certain activities which they prioritise. For example, Cliff (1993) and Clapp (1994) described relationships between government and donors in health policy in Mozambique and Guinea respectively, where donors were able to impose their own priorities on areas of health policy such as drugs systems and provision of technical assistance. Relations between governments and trans-national corporations may also result in coercive policy transfer and companies can be powerful in determining investment, trade or environmental regulation by threatening to take their business elsewhere (Heidenheimer *et al.* 1990).

Transfer can also be indirectly coercive as a result of externalities in the policy process and the functional interdependence of modern states. Thus the fact that countries are now linked by many global political and economic institutions means that their apparently free policy choices in response to a particular problem are in reality limited either by international law or by the policies and actions of their neighbours (Walt 1998). Such policy convergence has been noted particularly in the financial sector but is increasingly affecting other areas of policy (Dolowitz & Marsh 1996). Countries can also be pushed towards a particular policy choice when technological advances and competition force actors to consider new or alternative solutions to a problem. Technological advance can arise either in another country or through the development of international consensus, thereby influencing governments throughout the world to update their policies (Bennett 1991a). In health, while participation in international efforts to control infectious diseases is ostensibly voluntary, it can place governments under huge pressure to co-operate in global control campaigns. For example, Greenough (1995) showed how in India in the final stages of smallpox eradication, many human rights abuses took place in the zeal to ensure immunisation of the entire population. Similarly, Cairncross *et al* (1997) analysed some of the ethical problems associated with top-down, single issue approaches to delivery of health care.

3.3.3 Aspects of policy to be transferred

Dolowitz and Marsh (1996) distinguished many aspects of policy to be transferred. For this research, these were subsumed into three broad categories: technology – the content of health interventions;

outcomes or processes – the means by which interventions are delivered and the impact they have on health status; and ideology – the ideas and political economy behind a particular choice of policy.

There is a substantial literature on **technology** transfer in health, much of which refers to adoption of new clinical practice, information technology or drugs (Stocking 1988; Tjam 1994; Rosen & Mays 1998; Wasunna & Wyper 1998). The principal focus of these studies in industrialised countries was on ways medical providers adopted new practice around treatments, drugs and use of information technology, especially as health systems reoriented towards increasing power of managers and administrators relative to clinicians. For example, the recent debate on the promotion of evidence-based medicine and health policy has led to the development of databases, such as the Cochrane library, which document and evaluate evidence for new practice on behalf of clinicians (Parada *et al.* 1997; Jadad & Haynes 1998). This literature suggests that networks or communities of professionals share technological information through academic journals, promotions by pharmaceutical or biotechnology companies, newsletters or bulletins and expert groups (Robert *et al.* 1998).

In low income countries, much literature addressed the development and transfer of appropriate technology or that which meets basic needs for health care and is affordable for the majority of the population. The literature ranged from environmental health interventions (Bell & Franceys 1995) to those addressing the control of infectious disease, such drugs for TB (Basch 1993), or preventing multi-drug resistance in infections with parasites, malaria and TB (Waller 1997). Some authors also documented shifts in thinking about infectious disease control away from traditional, top-down international eradication efforts and towards a more integrated health systems approach (Cairncross *et al.* 1997; Bradley 1998).

Such shifts in thinking about health care delivery systems have led international decision makers to focus more on the **processes** by which health interventions are delivered and increasingly it is recognised that, in order to ensure effective adoption of new technology, more than simple technical detail is needed. For example, the Bristol case in the United Kingdom (UK) demonstrated difficulties which arose when managers interfered in clinical audit and review procedures (Ramsay 1998). In low income countries, information on cost effectiveness, appropriateness, quality, public demand, regulations and ethics are now routinely required to support efforts to change clinical practice (Collins *et al.* 1994). In addition, the structures and institutions to ensure effective policy formulation and implementation, and the policy goals and targets which facilitate the process, can also be transferred (Brinkerhoff 1997).

This introduces an important concept, that information on process or systems can both be transferred itself (i.e. an outcome of transfer) and influence the success of technology transfer (i.e. a determinant of transfer) (MacCormack 1989; Sandiford *et al.* 1992; Basch 1993; De Cock *et al.* 1994). Where systems are neglected, their absence may contribute to gaps between policy intent and implementation (Grindle 1980). In particular, in assuming a rational process of transfer and lesson drawing, senior policy actors often exclude implementers or their representatives from networks of decision making and thus jeopardise their future participation in putting policies into practice (Hogwood & Gunn 1984; Grindle & Thomas 1991; Hill 1993). These concerns have been at the forefront of recent international efforts to improve institutional capacity for policy development through reforming structural, financial and administrative systems (Foltz 1994; Berman 1995; Gilson 1995; Janovsky 1996). They are also pertinent when examining transfer of international policies to national level, such as in this research.

During the course of analysing the transfer and implementation of health reforms in low income countries, some authors also raised fundamental concerns over governance and political and economic systems, as well as the **ideologies** behind them (Foltz 1994; Marc *et al.* 1995; Owoh 1996; Over 1999). These concerns highlighted that even focusing on policy institutions and processes as well as technology does not necessarily result in effective policy transfer. Thus, in health, unless policy makers in low income countries maintain an ideological position by which they prioritise improvements in equity or quality of services, they are unlikely to make the necessary resources available for providing care, and gaps between policy formulation and implementation remain large (Dolowitz & Marsh 1996). For example, Lee *et al.* (1998) found that, during the 1970s and 1980s, countries which took a neo-liberal political and economic stance, and saw themselves as allied to Western ideas, were more likely to have strong population control policies than those oriented more to the Eastern block.

Studies elsewhere in the literature also found that policy actors were more inclined to draw lessons when they knew more about the setting from which the technology was being transferred and felt that the political, economic and ideological systems resonated with their own (for a health example, see Rosen 1997). Indeed, where political structures were perceived as similar in two places, policy transfer was also seen as likely to be feasible and effective. Furthermore, in some cases, aspects of this political and economic ideology were also transferred, thereby facilitating transfer of technology or institutions (Stocking 1992; Dolowitz 1997; Rosen & Mays 1998). As for processes, the transfer of ideology can therefore be seen as both an outcome in itself and a determinant of the transfer of technology. These ideas are important for low income countries, since technology transfer often takes place either in an ideological vacuum or in association with specific recommendations for development of systems, institutions and ideological justification. In Northern countries, such outside

interference in administrative and political processes would be unacceptable; hence perhaps their neglect in the literature. In low income countries, it is a reality and the mechanisms by which such influence is exerted and its effect on subsequent policy success are a crucial area of research.

3.3.4 Mechanisms of policy transfer or convergence

According to Bennett (1991a), there are four non-mutually exclusive ways in which policies converge: '*emulation, where state officials copy action taken elsewhere; elite networking, where convergence results from trans-national policy communities; harmonisation through international regimes; and penetration by external actors and interests*' (Bennett 1991a: 215). For policy transfer, as opposed to convergence, the key distinctions between these processes are the extent to which similar policies in two places or times are the result of conscious actions on the part of policy actors (as opposed to structural similarities) and what the relationships are between the actors in those two places or times. Each of Bennet's mechanisms therefore can incorporate both roles for actors and the influence of context in shaping their decisions.

In low income countries, the more common mechanisms are likely to be elite networking and external penetration, given the nature of the actors involved and the context of their work. To understand the process of health policy development in these settings, international networks, including national representatives, multi-lateral organisations and independent intermediaries, are therefore particularly significant (March & Olsen 1989; Cox 1995; Brinkerhoff 1997). Internationally, throughout the 1980s and 1990s, there was an increased emphasis on market as opposed to state institutions in policy and, as part of this process, international networks expanded to include actors not previously represented at this level (Marsh 1998). For example, during this period, there was an increase in the influence of economic actors, such as the World Bank, and international women's groups in reproductive health policy and a concurrent decline in power for traditional medical actors, such as the WHO (Lee *et al.* 1996).

The role of international organisations and networks in determining low income country policy development increases the difficulty of analysing the policy process because their systems of decision making, implementation, accountability and governance are so different from those of nation states (Common 1998). The theoretical process of transfer, involving national decision makers assessing experience elsewhere and adapting lessons for their own context, is therefore mediated, and potentially disrupted, by intermediate actors with different motivations, ownership of outcomes and political legitimacy (Stone 1999). For example, the financial strength of donors in low income countries can result in a highly coercive relationship with national actors. It can also disrupt interaction between state and non-state actors, either by excessive focus on state policy development

through a central policy elite or by working solely through non-state actors and by-passing normal policy processes (Hulme & Edwards 1997). In using this analytical framework, therefore, this research hopes to gain insight into what happens when international actors penetrate national policy processes substantially and how this picture compares with others in which penetration is not so deep. Given imbalances in financial and technical resources between international and national actors, the line between networking and penetration may be a fine but important one in explaining health policy development in low income countries.

3.4 Implementation of policy

3.4.1 Links between transfer of agendas and implementation of policy

While much of the transfer literature focused on analysing how and why different types of policy are transferred, rather little was written on the success of decisions taken in the process and the constraints which arise to prevent it. Since transfer can be both an outcome and an explanatory variable, it is important to consider constraints to, first, the transfer of ideas and technology from international to national settings, and second, the effectiveness of subsequent implementation in different countries. Nevertheless, in general, the policy transfer literature tended to address issues of agenda setting or policy formulation, neglecting attention to implementation of resulting policy decisions (Wolman 1992). This may be part of a much criticised general trend in policy analysis to regard agenda setting and formulation as the interesting stages of policy development but implementation a merely technical issue (Walt 1994).

As discussed above, however, in low income countries, transfer of agendas and formulation of policy often takes place under coercive conditions at national level. Problems associated with this process contribute to the well known implementation gap, whereby, although national policy makers are exhorted by donors to enact a certain reform, little change takes place down the line. One potential explanation for this is that members of the policy elite involved in national decisions have incentives to introduce reform without considering carefully the practical implications: international donor representatives need to disburse substantial funds quickly; and national governments are keen to receive such funds, irrespective of apparent conditions attached to them. In this situation, although an agenda or a policy may appear to have been transferred, in reality, both international and national actors have unconsciously or consciously colluded to create such an impression, without taking necessary care to develop appropriate mechanisms for implementation.

A second possible explanation is that the exclusion of lower level cadres from national policy decision making leads to lack of ownership of a reform. Implementation is often seen primarily as following

in a linear manner from formulation, instead of as an on-going process linked iteratively to central decisions. This has been associated with top-down administrative procedures and subsequent lack of accountability at local levels for service delivery. Investigation into the process of implementation is therefore crucial for understanding the extent to which a national policy elite is able to sell its decisions to peripheral managers: indeed, it has been suggested that unless a policy is implemented, it cannot be considered to have been transferred (Wolman 1992). The following section will therefore discuss what is known in the literature about optimum conditions for effective implementation, in order to shed light on the relationship between agenda setting and implementation in low income country settings.

3.4.2 Traditional debates in implementing policy

During the 1970s, an era dominated by neo-liberal thinking, implementation was seen as largely an administrative issue in which practical decisions were taken through technical means, for example economic analysis of the relative cost-effectiveness of different policy options (Loevinsohn 1994). Implementation failures were thought to be due to gaps in understanding of technical issues which could be fixed by better training and adherence to authority. At this time, with notable exceptions (for example, Pressman & Wildavsky 1973), implementation was rarely the subject of political analysis (Brinkerhoff 1997). During the 1980s, however, developments in thinking about the process of implementation took place, with an increased emphasis on understanding why lower level administrative cadres failed to undertake the routine management necessary to put a policy into practice. The role of policy analysis in understanding organisations, and how they could improve their capacity for management through better governance, systems and communication, was enhanced during this period (Brinkerhoff 1997). Much of the literature on implementation therefore addresses these issues, although, again, largely based on empirical work in Northern settings.

In one of the early writings on this theme, Hogwood and Gunn (1984) posited that, under ideal conditions, in order to ensure effective implementation, the following ten conditions would need to be met: the external context is suitable; adequate time and resources are available; the right combination of resources is available; the policy is based on a valid theory of cause and effect; this relationship between cause and effect is direct; dependency relationships are minimal; there is understanding of and agreement on objectives; tasks are fully specified; there is perfect communication and co-ordination; and there is perfect compliance with authority. They went on to point out that these ideal onditions are rarely met, particularly where weak institutions are prevalent: *'in plain terms, a policy is usually seen as being put at risk because of one or more of the following three causes: bad execution, bad policy or bad luck.'* (Hogwood & Gunn 1984: 197). Cleaves (1980) suggested a similar set of conditions, including that the policy: was simple and involved marginal change; had a

one-actor target; had a one-goal, clear objective; and was of short duration. Both models approached the question from a **top down** perspective, i.e. one in which implementation was seen as proceeding, more or less efficiently, from some central policy decision down to local management (Ham & Hill 1993). Top down approaches also assumed that the impact of policy objectives could be evaluated over time and that policy reformulation took place in response to lessons from evaluations (Sabatier 1993).

Bottom up theorists, by contrast, suggested that policy development should start with identifying a network of actors involved in service delivery and asking them about their goals, strategies, activities and contacts. *'Rather than treating implementation as the transmission of policy into a series of consequential actions, the policy-action relationship needs to be regarded as a process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends.'* (Barrett and Fudge 1981, as quoted in Hogwood & Gunn 1984: 207). Grindle and Thomas (1991) emphasised characteristics relating to cost-benefits of reform from different perspectives and the level of participation in designing it. They also addressed implementation in terms of the resources available, split into four main categories: political – the support implementation can expect to receive from senior political figures as well as among the general population; financial – the funds both allocated and actually spent on implementation; managerial – the human resources and time allocated to implementing a reform; and technical – the specialised guidance, training and commodities acquired to ensure effective implementation (Grindle & Thomas 1991).

In addition, the context of the policy process affects the formation of networks and the access of different policy actors to resources. As discussed above, the distribution of power within different political systems affects the way decisions are taken and the breadth of participation in resource allocation (Cleaves 1980). Hjern suggested that, in order to ensure representation by the full range of stakeholders, a network should be constructed from actors involved in every aspect of service delivery (Hjern *et al.* as quoted in Sabatier 1993: 277). This network is then used to negotiate an implementation structure, in contrast to its imposition through a top down approach. Evaluation through such a system also proceeds in a more consultative manner, according to objectives agreed among the various actors in the network.

Comparing top down and bottom up approaches suggests that both are valid but in different ways. On the one hand, the fact that *'those seeking to put policy into effect are usually elected while those upon whom action depends are not'* (Hogwood & Gunn 1984: 207), raises questions over the legitimacy of participation of lower level managers in policy decision making. On the other hand, in many contexts, responsibility for decision making and administration is now being shifted to lower

management tiers (Zwi & Mills 1995), suggesting that greater attention needs to be paid to involving these cadres in decision making. Thus, while top down approaches probably mirror reality in low income countries more than bottom up, there are lessons to be learnt from the emphasis on networks, resources and participation in decision making that bottom up theories maintain (Ham & Hill 1993).

In order to involve those responsible for implementation in low income countries, it is important to consider that the decision making process takes place at many different levels of a system, including international, national, provincial and local. Furthermore, actors can be mainly state-based but usually also incorporate a wide range of international, private sector or NGO stakeholders, as well as intermediaries. Actors at central level have greater access to financial and political resources and are involved in administrative decisions around how to put plans into practice. Their administrative decisions, however, need to be co-ordinated with those taking similar decisions at peripheral levels and resources allocated appropriately. To enhance communication and information sharing between these levels, various mechanisms can be used, including (in declining order of strength): budgetary controls; financial incentives; legislative measures; rules; circulars; letters; and voluntary agreements. Information can be used to create a coalition framework (Sabatier 1993), or an interactive model of policy implementation (Grindle & Thomas 1991), in which a policy problem is assessed according to the positions of different actors at different levels and then a decision is taken in line with likely resources and feasible outcomes.

3.4.3 New institutionalism and the future of implementation theory

More recently, these ideas have been taken further under the theories of new institutionalism which originated in 1980s thinking about governance and institutional capacity. Recent policy analysis, however, has sought to merge these ideas with more practical advice for policy makers on analysis and implementation of policy. Thus, according to Brinkerhoff, '*long-haul reforms call for a different kind of policy analysis to help guide decision makers: analysis that makes sense of these broader factors and pays explicit attention to what it takes to make policy changes happen, not simply design what they should do.*' (Brinkerhoff 1997: 1). Effective implementation is therefore increasingly seen as a process rather than a specific output and the focus of policy analysts is on collaborating with practitioners over how to improve this process (see, for example, Crosby 1996; Walt 1998). Again, improving communication between policy makers at all levels of a system is seen as central to this approach.

New institutionalism as a theoretical approach grew from the new institutional economics, which primarily addressed policy issues around the management of public goods, common property

resources and collective action (Ostrom *et al.* 1993). Scholars in this multidisciplinary[18] area have focused on the appropriate allocation of responsibility between state and market for delivery of different types of goods and service. Institutional analysis has also been used to shed light on arrangements which determine whether or not a policy is effectively implemented. The assumption behind the analytical approach is that, too often, policy failure has been blamed on administrative difficulties or poor performance rather than inappropriate establishment of institutions to guide allocation of responsibility. These issues are especially pertinent in low income countries where institutions tend to be weak and implementation is highly top-down.

A framework for analysis to improve on this situation has been suggested by Brinkerhoff (1997); it examines four areas of policy development. The first is the physical and technical context of policy, by which is meant the content of policy, or the nature of the goods or services involved, and the context of implementation, such as the economic, political or cultural situation. The second area is the institutional arrangements involved in policy development. This incorporates analysis of the institutions affecting policy, where institutions are defined as sets of rules governing interaction between policy makers, for example, markets or state hierarchies. The third area looks at patterns of interaction between different stakeholders, which emerge as the result of the interplay between the physical and technical context and the institutional arrangements. Finally the framework addresses the potential outcomes or effectiveness of policy on individual or social welfare (Brinkerhoff 1997).

The advantage of such an approach to the study of policy development is threefold: first, it facilitates the integration of implementation into analysis of the policy process; second, it allows investigation of the impact of institutional arrangements at different stages of the process on the eventual outcome of policy; and third, it adds depth and detail to the health policy analysis framework offered by Walt and Gilson (1994). This is particularly important for this research since we are interested in policies which may have been imposed from outside under coercive conditions. In such conditions, institutional arrangements for implementing policy are less likely to be appropriate for the particular policy in question (Martin 1992). This is because those involved in defining the policy problem and identifying potential solutions (external donors, for example, and the national policy elites they work with) are far removed from those responsible for implementing any reform (technocrats and managers). The distance is not only in terms of operational level; it also incorporates huge differences in legitimacy, constituency, resource mobilisation and organisational design (Crosby 1996). The aim of much current work in implementation is therefore to analyse some of these differences and make

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[18] As cited in Brinkerhoff (1997: 5), disciplines have included: organisational studies (Powell & DiMaggio 1991); public administration (Ferris & Tang 1993); anthropology (Ensminger 1992); political science (Ostrom *et al.* 1993); and economics (Clague 1994).

recommendations to policy makers at international and national levels on how to take them into account at early stages of policy development and absorb their possible effects.

3.5 Analytical framework for the thesis

This chapter has reviewed a huge, multi-disciplinary theoretical literature on various processes of policy development. Before moving to empirical data, this section will consolidate the literature into a coherent conceptual framework to guide analysis of information from the case studies. Through this conceptual frameworks, the research aims to make contributions to the literature on policy development in low income countries, a neglected area of research. Figure 3.2 presents this new conceptual framework in diagrammatic form.

Moving from top to bottom, the figure starts with the agenda setting process at international level, including the three streams of problem identification, policy solutions and political processes. In health, at international level, policies may be formulated as part of a new agenda and often an international elite will be involved in developing gold standards for application in a range of national contexts. This international elite may be drawn from multi-lateral organisations, bilateral donors and appropriate professional groups, each with their own positions of interest and influence. They form a network of actors with different power and resources to influence global policy. The network responds to international focusing events, including the publication of new data on disease or the development of new interventions. The recognition it can expect to receive for its priorities is further affected by international political processes.

Moving down the diagram to national level, the setting of agendas also takes place and, again, the three streams interact through networks of national policy elites. Agendas may be transferred from international levels (as represented by the arrows in the diagram) or indigenously developed. Even in the latter case, each stream may separately be affected by international developments, through the participation of national actors in international policy developments or the involvement of international actors in national policy debates. Again, power relations are key to these networks and agenda setting can be highly elitist with restricted participation by those outside a core group of decision makers. Understanding which international policy discourses get reflected in national policy debates is central to this model. Policies formulated in response to new national agendas also depend on the level of outside influence, and international actors may or may not be involved with national actors in this more administrative process. Such influence may be direct, through for example, the work of technical consultants appointed to guide policy development, or indirect, through the diffusion of international ideas and discourses into national policy debate.

Figure 3.2 Framework for analysing integration of HIV/STD and PHC services

	AGENDA SETTING		
INTERNATIONAL LEVEL	**Problem stream**	**Policy stream**	**Politics stream**

Policy **formulation** among
international actors

AGENDA SETTING

NATIONAL LEVEL	**Problem stream**	**Policy stream**	**Politics stream**

Policy **formulation** among
national actors

PROVINCIAL/DISTRICT LEVEL
Policy **implementation** and feedback by
provincial and district actors
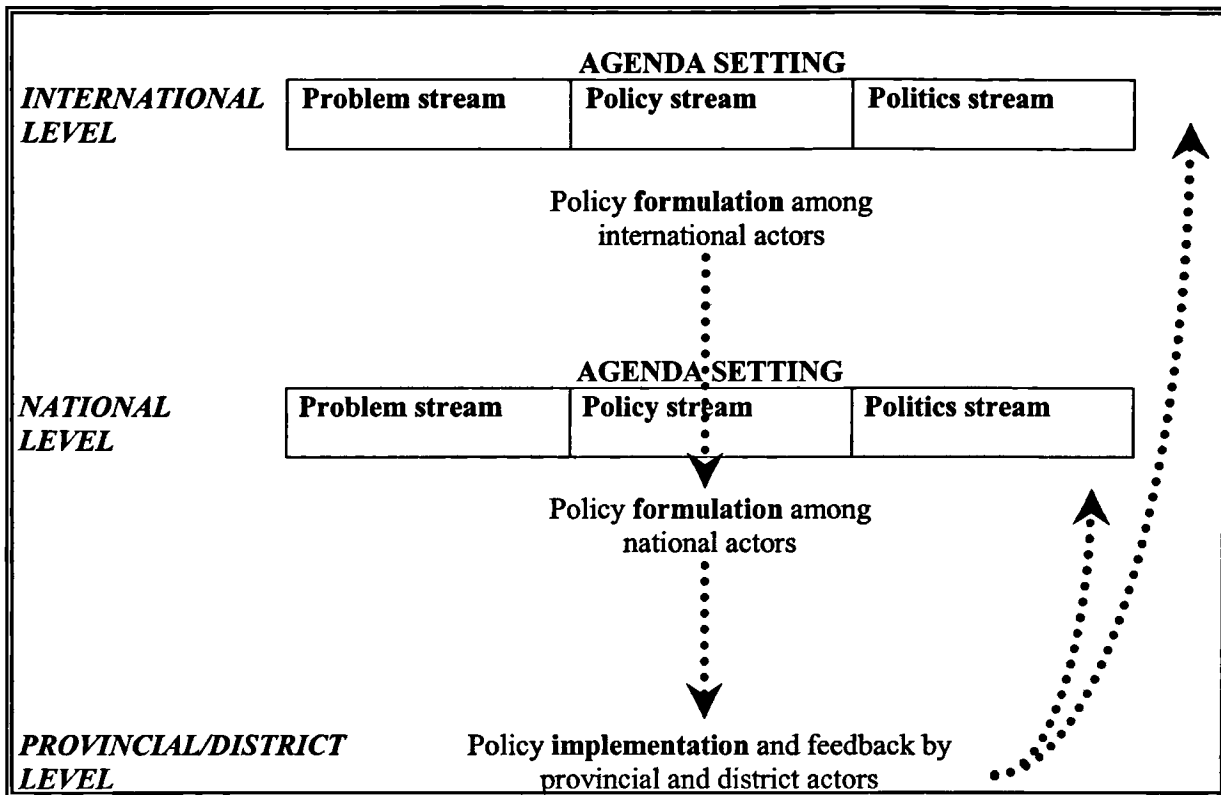
Once policy reforms have been formulated at national level, they are then in theory implemented at provincial and district levels. Implementation involves a different network of national and local actors in decisions over the administrative, technical and financial management of service delivery programmes. The process is rarely as linear and rational as depicted here and usually involves complex interaction and negotiation between actors at different levels and with different responsibilities. The extent to which these actors have been involved in national policy debates also affects their compliance with and willingness to implement new reforms. Where reforms are complex and multi-faceted, it is all the more important to involve lower cadres in initial decision making processes as well as to facilitate feedback mechanisms, as depicted by the arrows on the right side of the diagram.

Assuming a linear approach like this to analysing policy in low income countries is risky: the idea that policies progress rationally from the point at which a problem is identified to the delivery of a solution in health clinics ignores a host of intermediary power, resource and interest factors. With these problems in mind, the framework in Figure 3.2 will be used as a simple guide to potential links between processes taking place at different times and in different places. The novelty of the approach taken in this research lies in the combination of theoretical concepts with existing secondary data on policy developments around the world and new empirical data from a case study in South Africa. Its contribution should be in understanding how health policy gets made in low income countries and

how improvements in HIV/STD and women's reproductive health services can best be achieved in different settings.

3.6 Conclusion: evidence for policy developments from case studies

In conclusion, based on the theoretical literature, a conceptual framework has been developed for analysing policy development for integration of HIV/STD and PHC services. The rest of this thesis will present empirical evidence on the processes of policy development for integration in low income countries. Evidence was difficult to gather since many studies were static and short term by nature yet policy processes are dynamic in time and place. Information was therefore gathered instead from comparative case studies and multiple, indirect sources to validate hypotheses and assumptions (see methods section, Chapter 1 and Dolowitz and Marsh 1996). In this study, the principal case study was South Africa. As described in Chapter 1, this was a country which, until 1990, was isolated from the international community and ruled by a minority, racist government. After 1994, however, a number of dramatic changes took place which were relevant to the study of integration, including: the election of a democratic government and consequent political and administrative transformation; an extremely rapid rise in HIV prevalence; and strong promotion of comprehensive, integrated and free PHC. It therefore provided an interesting setting for investigating the ways national policy makers participated in or responded to the new international agenda for integrating HIV/STD management with PHC.

Before moving to South Africa, however, experience elsewhere with the development of policies to integrate HIV/STD management with PHC will be examined. This is because, although South Africa provides very interesting insight into policy developments, it is by no means typical of low income countries, especially sub-Saharan Africa, having both greater resources and a unique recent political history. Similar studies in Ghana, Kenya and Zambia will be used to draw out comparisons with South Africa in terms of their links with the international community, their health policy and programme backgrounds and their various epidemiological profiles. This will be preceded by analysis of the international agenda setting process for integration, in order to set the scene for transfer of policies to national level.

Proving that policy transfer has taken place requires evidence of three things: that '*policy makers are aware of policies elsewhere, that they utilise that information within domestic policy debates and conflicts, and that this utilisation can help explain policy adoption.*' (Bennett 1997a: 213). The evidence in the case studies presented in Chapter 4 was often suggestive rather than indicative of the transfer process, since none of the studies set out to gather such evidence specifically. The thesis therefore examined the roles of penetration by external actors in national policy processes and the

extent to which there was evidence that elite networks had been established to enact new reform. The aim was to construct a picture of how transfer took place, including actors involved and their relationships, given poor available empirical data and little knowledge about the applicability of conceptual frameworks to such settings. In South Africa, the aim of field work was to develop a picture of the setting of the agenda for integration. In this process, indigenous priorities were combined with international concerns to incorporate HIV/STD services into PHC. Evidence of transfer related more to elite networking or harmonisation than to penetration or coercion.

Evidence on adoption and implementation of policy was easier to gather than on its transfer, since it tended to be a more central concern of mainstream health policy studies in low income countries. However, such evidence was often descriptive and related to the success or failure of policy rather than to the process or politics of implementation *per se*. Again, it had to be gleaned from reports and statements in the literature where possible, while comprehensive analysis of policy debates or consultations with peripheral cadres remained rare. In South Africa, much more detailed information was gathered on the process by which implementation was achieved at provincial, district and facility levels, including the political processes involved.

3.7   Summary

- In this chapter, there were two main aims: to present a broad introduction to the concepts and models of policy analysis; and to review literature specifically on the processes of agenda setting, policy transfer and implementation. Since most models were developed for policies in Northern countries, the review also took care to distinguish those aspects which contributed to understanding the very different situation of low income settings.

- The literature showed that, in specific political, economic and cultural contexts, actors and networks, and the structures which determine their relationships, were instrumental in determining how policies develop. Elite theory showed that, although they were apparently participatory and plural, networks usually reflected existing socio-political relationships and inequalities. Particularly in low income countries, policy making often involved only a small group of national actors communicating with international policy bodies, usually through intermediaries, and excluding both lower level implementers and the communities they claimed to represent.

- The activities of networks and actors were studied in relation to a number of policy processes, of which agenda setting at international and national levels and implementation at national level were key to this research. Literature on agenda setting posited three interest streams which could be tracked over time: how the **problem** was perceived; what potential **solutions** were identified; and what the **political context** of policy decisions was. The role of policy intermediaries and

technical experts in determining the solutions available to policy makers was an under researched area of policy.

- Links between international and national policy levels and how policies got transferred between them were then addressed. Policies get transferred through both voluntary agreements and coercive mechanisms. Coercive mechanisms could be direct or indirect. Coercion was more likely in low income country settings where imbalances in resource availability influence relations between international and national actors. Different aspects of policy could be transferred, including technology, process and institutional arrangements, and ideology. These could be both outcomes and determinants: a particular ideology could be transferred in itself as well as facilitating (or not) the transfer of related technology. Policies were transferred through a number of mechanisms, including emulation, elite networking, harmonisation and external penetration.

- Early analysis of implementation took a top down, mechanistic view which saw it as taking place sequentially from policy agenda setting and formulation. Later analysts suggested that a more bottom up approach could take better account of the networks of policy actors involved in determining implementation. Implementation takes place at many different levels (international, national and local) and by many different actors (state, private and NGO). Communication between these levels and actors can be through a range of formal and informal mechanisms.

- More recent theories examined the institutional arrangements for implementation, leading to better understanding of the relationship between different stages in the policy process. This was useful for work in areas where agenda setting and policy formulation have taken place under coercive conditions. Here, the disjuncture between policy intent and implementation and between appropriate institutional responsibilities could be large.

- Finally, an innovative approach was developed that incorporated these concepts into one overall framework which could be used to test their usefulness for understanding the specific policy of integrating HIV/STD services with PHC in selected countries in sub-Saharan Africa. This amalgamation of the political science concepts of agenda setting, policy transfer and implementation with empirical data from low income countries aimed to shed more light on how policies develop and why they are not always implemented according to plan.

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CHAPTER 4: INTERNATIONAL DEVELOPMENTS IN POLICIES FOR INTEGRATION

4.1 Introduction

Having defined the problem in Chapter 2 and established a conceptual framework in Chapter 3, this chapter examines existing literature and case studies which shed light on what is known about the ways in which international policies to integrate HIV/STD and MCH/FP services were transferred to national level. It starts by reviewing literature on the processes by which the international agenda for integration was set, including the actors and networks involved, their interests and influence over the policy process. It then moves on to examine how this agenda setting process was replicated at national level, with a focus on sub-Saharan Africa. The extent to which policies were indigenously developed or adopted from elsewhere are discussed. Finally, evidence on the process of implementing integrated HIV/STD and MCH/FP services is examined, taking into account national policy formulation and the effect this process had on subsequent programme feasibility.

4.2 International agenda setting and policy development

During the 1990s, there were two related **problems** which received global attention: the HIV/AIDS pandemic; and women's reproductive health. A number of **policy alternatives** were identified, of which integrated management of STDs addressed both the above problems and therefore received prominence. A wide range of international actors and networks were involved in promoting the approach and, although their **political interests** varied, consensus was maintained. The aim is to describe the process by which the international agenda was set before moving on to analyse how it was reflected in low income countries' policies.

4.2.1 Problem recognition

By the end of the 1980s, it had become evident that the impact of HIV/AIDS on mortality in sub-Saharan Africa would be huge. Focusing events for this new agenda included epidemic figures from East and Southern Africa showing exponential rises in infection rates; behavioural surveys also indicated little or no evidence of change in high risk exposure (Abdool Karim et al. 1991; Lindan et al. 1991; Kapiga et al. 1995). Similarly, during the 1980s and 1990s, concerns over population growth lessened partly because, in many low income countries, fertility had fallen (United Nations 1988; Cleland et al. 1993; Cohen 1993; Cleland et al. 1994) and partly because of a lack of decisive evidence for the harmful consequences of growing populations (Cassen 1994; Ahlburg et al. 1996). During the same period, attention was being focused beyond fertility and contraception to the wider

health problems arising for women in the reproductive process. These included maternal mortality (Rosenfield & Maine 1985; Kwast 1993; AbouZahr *et al.* 1996; Rosenfield 1997; Maine & Rosenfield 1999) as well as unsafe abortion, unwanted pregnancy and the sequelae of STDs (Germain *et al.* 1992; WHO 1992; Koblinsky & Nachbar 1997). Furthermore, women's rights to voluntary and safe sexual activity and subsequent childbearing were increasingly recognised as an important but neglected area of international human rights (Cook 1993; Ravindran 1993; Tomasevski 1993; Petchesky & Judd 1998). In addition to concerns over women's health, the poor quality of services available to them was also identified as a major problem (Jain *et al.* 1992). This combination of ideas emanating from these different problem streams led to a growing consensus in the 1980s that issues around reproductive and sexual health and health care had been neglected.

Those concerned with these problems were mostly public health professionals based in mainstream international organisations: universities and think tanks; Northern government donor agencies, such as the USAID and the UK Department for International Development (DFID); United Nations (UN) agencies, such as the UN Population Fund (UNFPA), the WHO and the World Bank; and large non-government foundations, such as Ford and Rockefeller. However, in addition to these public health professionals, the international women's movement[19], economists[20] and other development activists also participated in defining the problem (Ketting 1993; Finkle & McIntosh 1994; Lane 1994). Shifting rationales for FP were therefore reflected in a changing balance of rhetorical power between different networks (Germain & Kyte 1995). For example, reproductive and sexual rights received even higher profile at the International Women's Conference in Beijing in 1995 than at the 1994 ICPD thereby placing the issue in the mainstream of international feminist concerns (Cook and Fathalla 1996).

Dissent over this new agenda arose among environmental groups, for example, at the 1992 Rio environment conference[21], and religious bodies, with the Vatican attempting to derail the ICPD over

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[19] The term 'international women's movement' is used to denote the many feminist groups and points of view that were most influential in determining the reproductive health agenda; at the same time, it must be recognised that these were a diverse set of actors and organisations with different interests and positions. It is their coming together during the pre-ICPD period that is of interest here (McIntosh & Finkle 1995).

[20] The group here refereed to as 'economists' brings together a wide range of actors linked by a common interest in a neo-liberal intellectual approach to population and development. They dominated the international population debate throughout the 1950s to 1980s and included economic demographers and some international aid organisations, as well as the World Bank. Through a common interest in reducing population growth they were later linked with environmentalists and some public health professionals, especially those working in FP. By grouping them together here, the intention is to contrast their thinking on population issues with that of other groups, such as the women's movement.

[21] At the 1992 Rio Conference on Environment and Development, women's groups clashed with environmental groups over the extent to which population growth was highlighted as a major environmental problem. Environmentalists called for more attention to population control but women's groups successfully garnered support among low income country governments to remove such issues from the agenda. This set the scene for similar debates at the ICPD (Antrobus *et al.* 1994; Hartmann 1994; Chen 1995).

its opposition to abortion and sexual rights for young people (*Washington Memo* 1994). Furthermore, many economists, whose ideas had dominated international development thinking for 20 years, rejected the human rights claims of the women's movement (McIntosh & Finkle 1995). However, between the public health professionals, pushing for greater recognition of the HIV/AIDS/STD epidemics and reductions in maternal mortality, and the international women's movement, reproductive health was promoted as one of the top international priorities for the 1990s and beyond.

Evidence for the process by which problems around reproductive health gained recognition can be gleaned from sources such as the content and rate of international publications, the topics and number of international meetings and seminars and media interest (Palmer *et al.* 1999). In the academic community, there was an increase in attention to reproductive health and HIV/STDs during the 1980s and 1990s. For example, a Medline search on the key words 'reproductive health' generated a total of 151 entries for the period 1980-89 but 955 entries for 1990-99; similarly, an equivalent search based on the key words 'sexually transmitted or STD or STI or HIV or AIDS' generated 28,352 and 93,585 references respectively. During the mid 1990s, international meetings of academics and donors working in public health, population studies and HIV/STDs all included sessions on reproductive health where they did not before (for examples on integration, see: Ndhlovu and Achola 1996; Lush 1997; Lule *et al.* 1998; Wawer 1998). NGOs involved in population or FP advocacy published a huge literature on the subject (for example, see: Hardee and Yount 1995; International Council on Management of Population Programmes 1996; Conly and Epp 1997; Family Health International 1998), thereby sustaining media attention, especially to HIV/AIDS and women's reproductive health. Finally, and perhaps most importantly, in the period preceding the ICPD, such US-based women's groups as the International Women's Health Coalition (IWHC), were instrumental in stimulating and co-ordinating a global feminist consensus on the need to improve health services for women (McIntosh & Finkle 1995). This consensus gave weight to efforts to persuade other powerful actors, especially economists, of the need to address women's health and HIV/STDs.

4.2.2 Generating policy alternatives

During the mid 1980s period, FP programmes, driven by population control targets[22], were increasingly perceived as potentially coercive in their drive to get women to accept contraception (Marks 1988; Askew 1989; Bose 1989; Inter Parliamentary Union 1989). By the end of the 1980s, these programmes had been heavily criticised, and there were calls for a reorientation in the way

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[22] Targets have long been associated with FP programmes, especially in Asia. They have included those set at national or provincial level, for example, numbers of births averted through contraception or declines in national fertility (Isaacs 1995). They have also sometimes been applied at provider level, such as in India, where in the 1970s and 1980s, health workers were set targets for the number of IUD or sterilisation acceptors, and were also paid per case accordingly (Bose 1989).

contraceptive services were provided (Germain & Kyte 1995). Similarly, at the end of the 1980s, initial optimism in the battle against HIV, based on the successes of mass education and treatment policies in the US and Europe, gave way to pessimism, based on the failure of known means of control in low income countries, especially sub-Saharan Africa (World Bank 1997). In particular, barrier methods for preventing infection remained steadfastly unpopular in sub-Saharan Africa and, despite widespread knowledge of the disease and its risk factors, sexual behaviour did not change (Abdool Karim et al. 1991; Lindan et al. 1991; Kapiga et al. 1995). Thus policy makers were faced with improved predictions of the devastating effects of HIV but little in terms of effective ways to mitigate them.

In this difficult context, delegates from over 180 countries around the world met at the 1994 ICPD in Cairo to affirm a commitment to improving reproductive health, particularly but not exclusively among women (United Nations 1995). The ICPD itself was a significant international focusing event at which government delegations were accompanied by representatives of around 1200 international NGOs with interests from a wide range of contexts and ideologies around the world (US Network for Cairo 1994; Sadasivam 1995). This was more than ten times the number of NGOs at the 1974 Bucharest Population Conference (*Population Today* 1999). The ICPD Programme of Action thus depicted an unprecedented consensus among international women's groups, economists and public health professionals over the need to address reproductive ill health through re-orienting health care away from meeting demographic targets and towards a primary level service designed to meet the needs of individual women (Lane 1994). This consensus was reaffirmed a year later at the Beijing Fourth World Conference on Women[23] (United Nations 1995; Cook & Fathalla 1996).

The package of reproductive health services through which these needs were to be addressed was broad, including: pre and post labour care plus obstetric management; contraception; prevention and management of reproductive tract infections, including HIV/STDs; abortion; reproductive cancer control; infertility treatment; and prevention of violence (McGinn et al. 1996). Services were also recommended to be provided through existing PHC facilities, on the assumption that, where there is a common interest in promoting safe, voluntary and informed decisions about reproductive and sexual health, care should be integrated. This approach was supported by the publication in 1995 of the successful results from the trial of syndromic management in PHC in Mwanza, Tanzania (Grosskurth et al. 1995; see Chapter 2). Although this was a single trial in a specific rural African setting, the dramatic 40 per cent reduction in HIV incidence it achieved had a high impact within the HIV policy community. As a result, calls for integration became widespread among international organisations

(Pachauri 1994; Hardee & Yount 1995; USAID 1995; Mayhew 1996). For example, a Medline search of the key words 'integrat* and (sexually transmitted or STD or STI or HIV or AIDS)' generated 179 entries in the period 1980-89 but 1,294 in the period 1990-99 .

Almost immediately, however, the problems of moving from the rhetoric of a United Nations conference to the reality of service delivery in low income country settings were acknowledged (Hardee & Yount 1995; International Council on Management of Population Programmes 1996). Lack of evidence for effectiveness or feasibility of many of the interventions advocated was seized on by a range of actors, who included: FP advocates, worried about loss of funds to broader reproductive health (Cleland 1996; Murphy & Merrick 1996; Potts & Walsh 1999); religious groups, opposed to contraceptive use or sexual rights (McIntosh & Finkle 1995); women's groups in low income countries, concerned about inappropriate application of health blueprints (Basu 1996; Basu 1997); and economists, with concerns about lack of adequate funds or analysis of financial implications (Finkle & McIntosh 1996; Conly & Epp 1997; Mitchell *et al.* 1999). Despite this substantial and varied dissent within large parts of the network which would be centrally involved in reproductive health, the approach was confirmed in the ICPD Programme of Action and commitments were made by international donors and national governments to fund relevant activities (Lane 1994).

4.2.3 Politics of decisions

To understand the process of establishing such a consensus, the actors involved and their networks of communication and political interests will now be examined. The two networks which were particularly important in determining this agenda were the international women's movement (described above) and the international donor community[24] (McIntosh & Finkle 1995). In the period leading up to the ICPD, there was a strong effort by the international women's movement to publicise their agenda of shifting the rationale of FP programmes from population control to improving women's health (Germain & Kyte 1995; McIntosh & Finkle 1995). Such organisations as the IWHC and Development Alternatives for Women (DAWN) were established during this period and were significant in mobilising support for the new agenda through a series of international meetings (McIntosh & Finkle 1995). Through the IWHC, and other similar bodies, links with NGOs in low income countries were strengthened in order to foster support for the new agenda and to present it as a

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[23] Chapter 4 (Strategic Objectives and Actions), Section C (Women and Health), paragraphs 89-111 of the Platform of Action of the Fourth World Conference on Women confirms the agreements reached at Cairo on the reproductive health and rights of women.

[24] The international donor community is made up of both bilateral donor government agencies and the multilateral UN organisations. While each agency has a slightly different mandate and set of priorities, and some are inter-governmental, they can be characterised as generally representing the views of the rich countries which finance them. Members of the communities described above (economists and public health professionals) often make up their technical staff.

global goal rather than one of rich countries alone (Germain & Kyte 1995). These networks were in theory facilitating global participation in determining the agenda; in reality, drafts of the Programme of Action were prepared in New York and reflected priorities set by actors there (McIntosh & Finkle 1995; Petchesky 1995).

In 1992, a more receptive political environment in the US was presented by the replacement of the Reagan administration by Clinton. In this context, US-based feminists were able to raise attention to the low status of women and its relationship with both poverty and demographic outcomes. They thereby contributed to the changing emphasis of FP programmes from population control to meeting women's health needs (Germain 1987; Hartmann 1987; Garcia-Moreno & Claro 1994). Similarly, in a shifting international political economy, low income country feminists attacked neo-liberal development models which had increased poverty and hardship for women (Sen *et al.* 1994). These activities culminated in the publication in 1993 of the Women's Declaration on Population Policies just before the second official Prepcom[25] for the ICPD. Pressure and advocacy continued up to the conference and the wide recognition of the reproductive health agenda was the direct result of these efforts (McIntosh & Finkle 1995). As a result, senior decision makers in international donors were persuaded that the new approach was feasible and appropriate to the time: for example, there were an unprecedented 35 UN-sponsored preparatory meetings and consultations held all over the world in the years before the conference (McIntosh and Finkle 1995; see also issues of *Population and Development Review*, 1992-93). At these regional and national meetings, government and civil society groups met together to determine priorities for the conference and to discuss and amend early drafts of the Programme of Action. By the time of the conference, only a few controversial issues remained to be resolved, including statements on abortion, sexual rights and adolescent reproductive health (McIntosh & Finkle 1995).

Northern governments initially took a conservative stance and rejected the efforts of the international women's movement to shift attention from FP to a broader package of care (McIntosh & Finkle 1995). This was a reflection of neo-liberal economic concerns which guided development thinking in the 1970s and 1980s, during which time FP has remained in the medical domain. Public health professionals and economists dominated the international agencies in this period (Dixon-Mueller 1993). The US, long the most important funder of population activities, was, however, in a position to take on a new role, with the decline of the new-right and the arrival of the Clinton administration (McIntosh & Finkle 1995). In addition, key individuals were able to bridge the two networks, in

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[25] Prepcom became the term used for a series of three formal preparatory committees which were held in the four years prior to the ICPD at regional and international level; they aimed to forge consensus and gain representation from a wide range of actors around the world at an early stage of development and drafting of the Programme of Action.

particular, Nafis Sadiq, a Muslim woman who became Executive Director of UNFPA in 1987, and who was the organiser of the ICPD (McIntosh & Finkle 1995). Thus, although conflict remained over how the new agenda was to be funded, there was considerable agreement within the donor community too that it was time to reorient FP programmes away from population control and towards women's health. This shift was chiefly a result of pressure from the international women's movement but it also reflected evidence that other health problems, most dramatically HIV/STDs, were of paramount importance and that FP programmes could no longer ignore this public health context (Murphy & Merrick 1996). Furthermore, despite the apparent increased costs associated with expanding from FP to reproductive health, many of the additional services being recommended fell within packages of care which had already been acknowledged to be high priority by economists in such important publications as the World Bank's *World Development Report* (1993). As a result, by synthesising the rights rhetoric of the women's movement with an economic language which reflected the priorities of the donor community, both networks achieved consensus.

Having established consensus over goals, these actors faced the daunting task of translating words into recommendations for the ICPD Programme of Action. In recommending that new activities should be integrated, the Programme of Action acknowledged pre-existing PHC infrastructure and employed similar language to that of the early PHC movement. Since its origin in the 1960s and 1970s, PHC had been guided by five principles: equitable distribution; community involvement; focus on prevention; appropriate technology; and a multi-sectoral approach (Walt & Vaughan 1982). It was grounded in a broad theory of development which rejected economic modernisation as the only means to human well-being and placed good health firmly at the centre of an economic growth-equity-productivity nexus. Many of these concepts reappeared in the ICPD Programme of Action (Lane 1994; UNFPA 1995): chapter eight starts with a discussion of PHC (para.8.1). In earlier chapters, to improve reproductive health, governments committed to involve civil society (especially women's groups) in programme design (para.7.9), to focus on prevention of reproductive ill health (para.7.2) and to promote a multi-sectoral approach (para.7.9). However, while the reproductive health agenda reflected an unprecedented consensus among women's groups around the world on the association between gender equity and health, the predominantly rich country members of these groups generally expressed less concern with related links between poverty and health (Basu 1996). Similarly, where PHC was grounded in the human right to good health, reproductive health care derived from the right of women and men to safe and voluntary sex and reproduction (para.7.3; Cook and Fathalla 1996).

Furthermore, in the Alma Ata declaration of 1978, public health professionals advocated comprehensive PHC as part of a broader political and economic development agenda (WHO 1978). However, since then, in an increasingly neo-liberal global political context, these ideals ceded to

selective care based on what were perceived to be economically efficient service packages. This shift also reflected the growth in influence and financial commitment of richer and more economically-motivated international actors, such as the World Bank. The failures of PHC therefore came under intense scrutiny, especially the unrealistic nature of the original objectives, given levels of public sector expenditure, and the difficulties of ensuring equitable resource allocation (Chen 1986; Rifkin & Walt 1986; McPake *et al.* 1993; Collins & Green 1994; Kalumba 1997).

More recently, major reforms were initiated in many countries to try to increase efficiency in health service financing, expand access to PHC and improve the quality of services (Berman 1995; Janovsky 1996). As part of this effort, international donors emphasised basic packages of care which were considered to be cheap and cost effective and should therefore be available to all. The most heavily promoted of these packages included services which primarily target women and their children, namely maternal health, immunisation, FP and treatment and prevention of STDs (World Bank 1993). In ideal conditions, these packages were to be delivered through strengthened PHC systems, centred on decentralised district administrations which would have enhanced autonomy and responsibility, reflecting international concern to improve governance and efficiency simultaneously. In reality, however, many reforms have been driven more by the need to cut costs and increase efficiency than to improve quality of care or local accountability (Mills 1998). This has taken place in an environment of declining funds for health care among both low income country governments and donors.

Despite consensus, therefore, international funding for expanded reproductive health fell behind commitments, although governments increased their spending on reproductive health. For example, the total global annual cost of implementing the ICPD Programme of Action was estimated to be US$17 billion, of which two thirds was to be met by national governments and one third by donors. Five years later, while governments had come reasonably close to their commitments, donors had met only small proportions of theirs. In 1996, the US committed US$2.2 billion but gave US$640 million (29 per cent), the UK committed US$380 million but gave US$100 million (26 per cent) and Japan committed US$1.4 billion but gave a mere US$100 million (seven per cent) (Potts & Walsh 1999). However, although their funding levels came closer to commitments, there was little evidence on the policy response of different national governments to the ICPD agenda. Particular questions remained over: the extent to which the international agenda truly reflected a plurality of interests from around the world; the process by which international and national actors communicated around these issues; and the effects of these processes on implementation of new policies and programmes in different country settings. These are examined in the next sections.

4.3 Policy developments for integration at national level

In this study, evidence for developments in national policies for integration was drawn from two sources. First, it came from case studies of integration in three sub-Saharan African countries, Ghana (Annan & Dzikunu 1998), Kenya (Njeru & Njoka 1998) and Zambia (Mutungwa & Nkwemu 1998; see also Lush *et al.* 1999; Mayhew *et al.* In press-a; Mayhew *et al.* In press-b; Lush *et al.* Submitted), which took the unusual approach of focusing specifically on the process of developing policies for integration of HIV/STD and MCH/FP services. Second, evidence was gleaned from other studies of integration which did not focus particularly on policy processes but which had incidental published information of this kind. Two reviews had already been conducted of these studies (Mayhew 1996; Dehne & Snow 1999), although neither focused on policy processes *per se*. Case studies came primarily from sub-Saharan Africa, since this was where the rationale for incorporating HIV/STD care into MCH/FP services was strongest and where most of the relevant research had been conducted.

Given this general background, what follows is an analysis of the limited literature available on how different developing countries addressed the problem of integration of HIV/STD services with MCH/FP in the post-ICPD period. Analysis of this evidence was guided by three assumptions: (i) that in many countries, there was a strong push to formulate policies for integrating HIV/STD and MCH/FP services; (ii) that this push was generally the result of external interests rather than the independent rise of integration onto national public health agendas; and (iii) that implementation of national policies developed in this way was top down and thus relatively ineffective.

4.3.1 National policy communities setting agendas in reproductive health

At international level, as described above, the policy community involved in setting the agenda for integrated services was broad, including: governments, multilateral institutions, bilateral donors, women's groups and academics from a range of disciplines. If a similar process of agenda setting were to take place at national level, relevant policy communities could be expected to include not only the MOH but also: other government actors, including Ministries of Education and Finance; NGOs representing different interests from civil society; local academics researching and producing evidence on reproductive health problems and potential solutions; and women's rights advocates. Among these different actors, a wide range of interests would be expected to arise and, in a relatively open decision making context, each actor would use mechanisms to gain attention to and support for their priorities. Such mechanisms might include media or lobbying organisations specifically designed to bring issues to the attention of both legislators and the general public. While actors would clearly have different degrees of power over the policy process, broad legitimacy for participation in policy arenas would be drawn from their claims to represent the interests of different sections of civil

society. In general, those representing the interests of more powerful social groups could be expected to find it easiest to get their views heard and acted on.

In Thailand, a wide range of actors were included in a formal network established by the government to implement the ICPD recommendations and incorporating NGO, private sector and academic interests (Tahir & Auamkul 1998). Similarly, in Cambodia, the Reproductive Health and HIV/STD divisions of the MOH worked closely together as well as with a range of NGOs to develop policies through a series of technical meetings and working groups (Goodburn & Long 1997). However, evidence from case studies in sub-Saharan Africa painted a different picture and this breadth of participation was rarely a feature of the policy process in these countries. In general, the MOH was the lead actor in developing reproductive health policy and there was limited participation by other actors. Much of the policy activity for integrating HIV/STD and MCH/FP services therefore took place within MOHs, where, although integration almost by definition requires the collaboration of a wide range of managers, the many divisions who might have been interested were also not represented at policy fora. This lack of consultation was to some extent the legacy of a 20 year history of separate financial and administrative management of different areas of health care (Lush *et al.* Submitted). For example, in Ghana, Kenya and Zambia, separate bodies, responsible for MCH and HIV/STD control respectively, had been established in the MOHs, along with population offices outside MOHs to oversee FP policy. Thus, although PHC advocated a comprehensive, horizontal system of health service management (see Chapter 2), services in these three countries had long been managed by separate offices, otherwise known as vertical programmes.

The main problem with this legacy was that it tended to prevent collaboration on policy development through reducing opportunities for policy-makers in different divisions to network around their similar interests. In reality, there were incentives for health managers to remain specialised and isolated which often arose because of resource limitations and competition for limited funds. Thus, communication between MCH or Reproductive Health divisions and infectious disease control divisions was weak. For example, in Zambia, an official suggested that national vertical programme structures led to: *'fragmented services; provider biases towards either MCH/FP or STD/HIV services; and confusion for users, providers and managers of services at all levels over how to relate integration to human, financial and administrative resources.'* (Mutungwa & Nkwemu 1998: 43). Similarly, in Ghana, there was a *'duplication of effort between levels and units; competition between programmes for resources; lack of co-ordination between programmes and the MOH; and slow implementation of programmes'* (Annan and Dzikunu 1998: 32). In Kenya, while HIV control policies were formulated by the National AIDS and STD Control Programme with the *'knowledge, blessings and occasional participation'* (Njeru & Njoka 1998: 10) of the MOH's PHC department, HIV/STD activities were not seen as a central concern of this programme (Lush *et al.* Submitted).

Furthermore, bureaucratic protocols hindered the flexibility needed by managers to form networks around a particular policy issue. For example, the director of the MCH division was often of higher rank than the person responsible for STDs within the infectious disease control division, inhibiting communication.

In Ghana, Kenya and Zambia, outside government, very little evidence was found of participation in policy networks by women's groups or other NGOs with interests in the reproductive health agenda (Annan & Dzikunu 1998; Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). One of the most powerful non-government actors in sub-Saharan Africa is the church but, since the church has, on the whole, taken an international stance against much of the reproductive health agenda, participation in national policy was limited to opposing certain more controversial aspects, such as sex education. Some NGOs, such as the Family Planning Associations or USAID collaborating agencies[26], began to expand and sometimes integrate their own activities; however, the relationship between these NGOs and government offices was built more on the role of NGOs in supplementing government services than on their ability to participate with government on macro-policy development. For example, while the Planned Parenthood Association of Zambia was attempting to expand traditional FP activities to incorporate HIV/STD care, in line with government intentions, its participation in developing national guidelines for these expanded services was limited (Mutungwa & Nkwemu 1998). Similarly, in Kenya and Uganda, developments at NGO clinics for integrated services were funded by USAID with technical assistance from the Population Council and Pathfinder but not the government (Twahir et al. 1996; Mukaire et al. 1997). Medical, technical or academic experts also often worked in relative isolation in research centres or hospitals and were rarely consulted by MOHs on broad policy issues, especially those relating to PHC, which carried low prestige in medical circles. In Ghana, Kenya or Zambia, there was also no evidence of functioning medical associations which could legitimately represent the views of a caucus of constituent members at policy debates.

In all three countries, the media was notable for its lack of attention to reproductive health issues, including HIV/STDs, and for its weak participation in critical debate with government (Annan & Dzikunu 1998; Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). Printed and television media tended to be controlled by government or opposition political parties and thus were rarely able to present unbiased opinions to the general public. The result was that, while women's or other interest group representatives were almost certainly present, their ability to get their voices heard at the policy table was restricted by lack of means to lobby legislators or stimulate public debate on the issues. This may also have been related to a general reluctance both among political leaders and society at

large to discuss sensitive aspects of HIV/AIDS and STDs. Since the beginnings of the epidemic in Africa, the debate was politicised, with a considerable section of popular opinion maintaining that HIV originated in the US or elsewhere and continuing to blame the outsider for its spread (Webb 1997). Many myths surrounded the disease and those who confessed to infection suffered extreme levels of stigma, which could be life threatening. There were almost no examples of well-known African leaders admitting to AIDS as a cause of illness or death. Similarly, political leaders were unwilling to pin their names to any campaign associated with such an issue (Goldin 1994; see also Chapter 2).

The one group of non-government actors who participated in health policy networks in Ghana, Kenya and Zambia were the international donors, ostensibly acting in support of the MOH. In Ghana in 1998, 40 per cent of public health expenditure was contributed by donors (Annan & Dzikunu 1998), and figures for Kenya in 1997/98 and Zambia in 1997 were 74 per cent and 50 per cent respectively (Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). As a result, donors also influenced decisions through their relative resource power. Donors active in this area of policy were a diverse group, including bilateral agencies, such as USAID or DFID, as well as multilateral agencies, such as UNFPA or the World Bank. Each brought with them a different set of interests, which they tried to build into national policy, and a different degree of influence over government attempts to comply with their conditions for support.

Although some donors had already made explicit statements in support of integrating reproductive health services with PHC at international level, their projects at national level did not reflect this commitment. For example, in Ghana, USAID provided US$45 million for FP and AIDS prevention in 1995 but the project was designed to sit outside other MOH programmes and did not include integrated services (Mayhew *et al.* In press-a). Other donors were less interested in reproductive health *per se* but had a particular interest in HIV/AIDS. For example, in 1995-2000, the World Bank in provided US$40 million to the Kenya National AIDS and STD Control Programme for STD management through PHC clinics. Again, however, the project was being implemented outside normal MOH systems (Mayhew *et al.* In press-a). Both these projects therefore increased the isolation of those MOH programmes which managed health services which donors prioritised, irrespective of whether the government in question had set similar priorities.

Donors were also characterised by concern over their own domestic demands for accountability and transparency and thus in effect were working for '*two clients simultaneously*' (Lafond 1995: 65). One

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[26] These international NGOs receive the vast majority of their funds for international activities from the US government aid programme. They include, among others, the Population Council, Family Health International,

outcome of this concern was that bilateral donors often channelled significant sums through NGOs; for example, USAID spent US$125 million globally on AIDS in 1998 but 70 per cent of this went to NGOs (Delay 1998). To address donor demands for clear, quantifiable and measurable achievements, in Ghana, Kenya and Zambia, government programmes which relied heavily on donor funds were driven more by the exigencies of those funds and less by improving quality of services for clients. This approach led to top down design and implementation of policy, including separate management of services right down the line (Mayhew *et al.* In press-a). Provincial and district managers were rarely included in national debates over which policies to implement, or when and how to implement them. Failure to involve local actors in decision making processes dominated by external actors led to unsustainable efforts, such as a UNICEF[27] syphilis screening project in Zambia which, despite successes in lowering syphilis prevalence among pregnant women in project areas, was discontinued after UNICEF's funds stopped in 1998 (Mutungwa & Nkwemu 1998). Similarly, although a World Bank STD project in Zimbabwe led to markedly better availability of drugs in clinics than in other countries (Askew *et al.* 1998), the sustainability of such efforts was questionable.

Relationships between governments and donors had developed in a context of great political and economic instability throughout the 1980s and 1990s. In Kenya, despite a long history of support to the country, relations between donors and Moi's government were marked by conflict and distrust (Maina 1998). While bilateral and some UN agencies increased their funding of NGOs in response, other multilaterals, such as the World Bank, which is more tied to government funding channels, instead made regular threats of or actual withdrawal of funds (Mayhew *et al.* In press-a). In Ghana, poor economic performance in the 1980s led the government to become almost completely dependent on foreign assistance, provided through prescriptive institutional and macro-economic reform packages. In the 1990s, however, donor-government relations were slowly improving, through stronger policy initiatives of the government and improved trust by the donors (Hiscock 1995; Annan & Dzikunu 1998). In Zambia, donors had only recently begun to contribute significantly to government spending since the previous one-party state was unpopular with many Northern powers (see for example Lee and Walt 1995). However, by the late 1990s, the relationship with the new Chiluba government was souring due to unease with lack of transparency in the political process (Mutungwa & Nkwemu 1998).

Each of these cases demonstrates how reproductive health policy did not develop through locally driven collaboration between national networks of policy interest groups. Instead, while apparently a relatively administrative issue itself, integrating reproductive health frequently became mired in the

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and Pathfinder International.
[27] UNICEF is the UN Fund for Children.

high politics of donor-government relations. This was exacerbated by the needs of donors to be perceived to act on their reproductive health policy agendas. However, as with other areas of health which are pushed by donors, reproductive health has all the classic problems of unsustainability, weak government ownership and thus reduced effectiveness. Nevertheless, some policy development did take place in this environment and in the next section, some of the events which marked them will be discussed.

4.3.2 Focusing events for policy development

International focusing events were discussed above; here the discussion will be limited to an investigation of other events which took place at national level which could have contributed independently to national policy development. Since reproductive health is not a high politics issue, and therefore is unlikely to be affected by episodes such as national elections, the events examined below relate more to developments taking place within the health sector, including workshops and new evidence on reproductive ill health or potential solutions for it.

The ICPD itself had a huge impact on the policy agendas of many countries. In the immediate aftermath of the conference, the governments of Ghana, Kenya and Zambia, all of which had sent delegates to Cairo, searched for practical steps they could take to demonstrate commitment to the new goals (Annan & Dzikunu 1998; Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). In many countries in sub-Saharan Africa, however, this process was inhibited by extreme poverty, lack of health policy flexibility and donor-dependence of governments. However, one key change was in the names of the MOH divisions responsible for delivering reproductive health services. For example, in Zambia the Family Health Unit changed its name to the Reproductive and Child Health Unit in 1996 (Mutungwa & Nkwemu 1998). Similarly, in Cambodia, the MCH unit changed its name to the Reproductive Health Unit (Goodburn & Long 1997).

Beyond superficial name changes, however, the evidence suggests that many governments were unsure how to proceed with developing national programmes of action in response to ICPD: 'Jamaica did a lot to support ICPD, but the translation of those programmes back home has been spotty.' (official in Jamaica, quoted in Hardee et al. 1999: S7). Donors therefore stepped in quickly to capitalise on the political consensus achieved at the ICPD and worked closely with governments to drive new national reproductive health agendas. In sub-Saharan Africa, integration of FP and STD management services were central to this agenda, given the HIV crisis ravaging the continent. To take the agenda forward, a number of conferences were funded by donors to attract different policy actors to this new agenda. They included the 'Setting the African Agenda I' conference held in Nairobi in 1995 under the auspices of USAID and its collaborating agencies (Hardee & Yount 1995).

Despite its ambitious title, this workshop largely involved NGOs; for example, although a small number of MOH officials attended from around the continent, including one from the Kenyan MOH, none came from Ghana or Zambia[28]. A similar workshop was held by the International Council on Management of Population Programmes in Addis Ababa in 1996, funded by UNFPA, the Swedish Development Agency and the Ford Foundation (International Council on Management of Population Programmes 1996).

Other focusing events included the publication of a range of new sources of information on HIV/STD prevalence and potential solutions to the problem. For example, in Thailand in 1991, new data showed that HIV had spread beyond high risk groups into the general population. The government responded quickly by establishing a high level national AIDS committee, consisting of government, NGO and private sector representatives and chaired by the Prime Minister (Tahir & Auamkul 1998). In sub-Saharan Africa, an important focussing event was the trial of syndromic management in Mwanza, Tanzania (see Chapter 2). However, despite being located in Tanzania, the impact of the trial on local policy was almost entirely through international networks of academics and policy makers: results were published in prestigious journals (Grosskurth et al. 1995); and strong links were established between the researchers and decision makers in international donors (Philpott 1999). Few policy makers in Ghana, Kenya or Zambia were aware of the trial, except at the most senior level, where communication with international policy networks was relatively strong. In addition, poor communication between national HIV/STD control staff (who were often STD experts and thus aware of the Mwanza results) and staff in MCH/FP divisions weakened the potential for this study to enhance national debate on appropriate responses to the trial.

Other sources of information included the increasingly efficient output of national HIV/AIDS surveillance systems, which by 1996 were producing relatively accurate data on trends in ante-natal HIV prevalence, albeit often based on a limited number of sites (UNAIDS & WHO 1998a; UNAIDS & WHO 1998b; UNAIDS & WHO 1998c). Many of these surveillance systems were, however, funded by UNAIDS[29] and accorded low priority in government circles. Some other epidemiological prevalence studies had been conducted in the three case countries, especially in Kenya and to some extent Zambia (see for example: Piot et al. 1987; Tembo et al. 1990; Laarie 1995; Rutgers et al. 1995; Simooya et al. 1995; Fylkesnes et al. 1997). However, many of these focused on particular populations, such as sex workers, miners or truck drivers, and therefore were difficult to relate to the

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[28] This conference was followed up by Setting the African Agenda II in Nairobi in 1998 at which difficulties with implementing integrated services were recognised and some withdrawal from the agenda by international agencies took place. This took place after the field work which informed these case studies and hence its impact on national policies was not assessed.

[29] UNAIDS was founded in 1994 as a UN body to co-ordinate the activities of seven UN agencies in the area of AIDS. It replaced the previous GPA based within WHO.

prevalence of disease and need for services in the general population. Relatively few such studies had been conducted in Ghana, where what limited evidence there was suggested that HIV/STD prevalence remained low except in small pockets of high risk activity, such as around mines. Finally, few of the traditional demographic or FP information sources covered other aspects of reproductive health. The DHS had optional modules on HIV/AIDS and maternal mortality: for example, in Kenya in 1993, they included an AIDS module (National Council for Population and Development 1994); in Zambia in 1996, they conducted both AIDS and maternal mortality modules (Central Statistical Office 1997); and Ghana in 1993 had neither (Ghana Statistical Service 1994). Even when they were included, however, these modules did not produce good evidence on HIV prevalence. Furthermore, although government statistical agencies undertook field work, the DHS is funded entirely by USAID, with technical support from international collaborating agencies.

A small number of operations research studies of integration were also conducted, mainly by the US-based Population Council through its MCH/FP Situation Analyses surveys and other one-off service evaluation studies which included some attention to HIV/STD services (Askew *et al.* 1998). The STD service related results of these have, however, only recently been fully analysed and, in general, present a negative view of the feasibility of integration. This suggests that although the Situation Analyses did produce useful information on MCH and FP services, their impact on national policy development in STD service integration in the mid 1990s was limited. Other operations research had been undertaken by a range of NGO or academic institutions (see examples in: Mayhew 1996; Dehne & Snow 1999). For example, in Cambodia, a national Knowledge, Attitude and Practice survey in 1995 demonstrated a low level of use of but a high level of unmet need for reproductive health services, leading to a more rapid scaling up of programme activities than had been previously planned (Goodburn & Long 1997).

The objective of examining all these potential focusing events was to assess the extent to which they contributed to national debate on how to transform the abstract commitment to change generated at the ICPD into recommendations for short and medium term priority activities. Priorities in most countries appear, however, not to have been determined by local discussion and debate but instead to have reflected the issues as perceived by international policy networks and their national level representatives. International actors both spearheaded workshops and conferences on the issue, and paid for participants to attend, and funded most of the evidence to support new priorities. Where independent studies related to integration were conducted in country, channels of information tended to flow directly up from the studies to international policy communities and then down again to national governments via donor agency activities.

4.3.3 Publications for reproductive health policy

Focussing events interact with networks of actors to generate new policy initiatives. These are often reflected in policy documents or other publications which promote a new policy approach. For example, in Thailand in 1991, soon after the new HIV/AIDS committee was established, new policies to integrate HIV/STD services with existing MCH/FP emerged which, as a result of consultations with experts in government, NGO and academic organisations, focused particularly on HIV counselling and testing (Tahir & Auamkul 1998). In sub-Saharan Africa, despite the large number of international actors involved in setting the agenda for integration, MOHs in Ghana, Kenya and Zambia took major responsibility for developing policies to operationalise integration. Within the MOH, the lead department in reproductive health policy was always that which had previously been responsible for MCH/FP, with support from HIV/STD departments in producing protocols and guidelines for clinical management of disease (Annan & Dzikunu 1998; Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). This structure of responsibility suggests that reproductive health was generally seen as an extension of existing MCH/FP services rather than a radically new paradigm. It also indicates that external international actors promoting integration found it easier to work with departments they already knew well, through earlier support for FP and MCH activities, than to engage with a new set of MOH actors, in HIV/STD control programmes.

The policies which were developed as a result of these new initiatives were wide ranging. In all three case countries, there was a rapid production of draft and final policies relating to reproductive health (Table 4.1). While superficially impressive, this output was achieved through a succession of donor-funded national policy development workshops which tended to reduce consultation to a limited national policy elite, sometimes supplemented by key figures from lower management tiers but rarely incorporating widespread comment on feasibility of or support for new programmes. For example, in Kenya, in 1995-96, UNFPA funded the initial activities by the Department of Family Health in the MOH to develop a reproductive health strategy (Njeru & Njoka 1998). Such workshops not only excluded many key managers from consultation but also prevented those who did attend from undertaking important day-to-day management of both old and new programmes[30]. NGOs were not invited to participate either: for example in Uganda, an NGO with 48 clinics and 162 village health workers was unaware that the government had issued syndromic management guidelines (Mukaire et al. 1997). A survey of NGOs involved in providing MCH/FP and/or HIV/STD services in preparation for the 'Setting the African Agenda I' conference in 1995 confirmed that few NGOs had well developed policies for integration at that time (Kisubi 1995).

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[30] During field work in Zambia, a new Minister of Health was appointed who immediately decreed that all workshops should cease for an unspecified period to allow managers to consolidate policies already agreed and formulated.

Table 4.1 Major reproductive health policies in Ghana, Kenya and Zambia and their institutional origins

Country	Policy	Institutional origin (within MOH)
Ghana	National Reproductive Health Service Policy and Standards, 1996	Mother and Child Health Unit
	STD Management Guidelines, 1996	National AIDS Control Programme
	Adolescent Reproductive Health Policy, 1996	National Population Council
	National Reproductive Health Service Protocols (Draft – 1998)	Mother and Child Health Unit
	National AIDS Policy (Draft – 1998)	National AIDS Control Programme
Kenya	Sessional Paper on HIV/AIDS, 1996	National AIDS Control Programme
	National Reproductive Health Strategy	Division of Family Health
	Reproductive Health Policy Guidelines and Standards for Service Providers, 1997	Division of Family Health
	Sessional Paper on Population and Development (Draft – 1998)	National Council on Population and Development
	Adolescent Reproductive Health (Draft – 1998)	Division of Family Health
	Safe Motherhood (Draft – 1998)	Division of Family Health
Zambia	Family Planing in Reproductive Health: Policy Framework, Strategies and Guidelines, 1997	Reproductive and Child Health Unit
	Population Policy, 1997	National Council on Population and Development
	National Population and Development Programme of Action, 1997	National Council on Population and Development
	Reproductive Health Policy (Draft – 1998)	Reproductive and Child Health Unit
	Safe Motherhood Policy (Draft – 1998)	Reproductive and Child Health Unit
	HIV/AIDS and STDs Policy and Strategies (Draft – 1998)	National AIDS Control Programme

Source: Lush *et al.* Submitted.

Donors also came to the workshops prepared with their own independently developed plans for implementing reproductive health. For example, DFID and USAID jointly sponsored a workshop on 'Implementing Reproductive Health Programmes' in New York in 1995, at which those attending represented entirely international policy networks rather than national interests (Ashford 1995). Furthermore, where these agencies had previously been supporting MCH/FP, they preferred to engage in new activities which built on rather than replaced existing projects. Thus although donors claimed to be co-operating with government efforts to develop their own reproductive health programmes of action, they brought to the table firm ideas of what should appear in those programmes and, most importantly, what they would be prepared to support financially.

4.4 Implementing integrated services

As Grindle and Thomas (1991: 121) point out, *'however difficult and politically risky it is to decide to introduce a reformist initiative, the process of implementing and sustaining that decision is likely to be even more fraught with difficulty and risk'*. To shed light on the process of implementation, it is

necessary to examine the various different stages or levels (including national, provincial, district and facility) at which it takes place, as well as its context. To this end, five aspects of the process of implementation of integration of HIV/STD and MCH/FP services will be examined below: tensions between conceptual and operational definitions of policy; availability of financial, technical and managerial resources; the health sector context of implementation; process of implementation in facilities; and delivering integrated services.

4.4.1 Tensions between conceptual and operational definitions of policy

Despite all the national activity reported above, its very rapidity meant that plans for operationalising new programmes fell behind and it was rarely clear how national staff intended provincial or district managers (or NGOs) to implement their new policies (Annan & Dzikunu 1998; Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). Prior to most policy initiatives, a 1995 Pathfinder survey of organisations in 14 African countries demonstrated that what services did exist were concentrated in urban areas and were mostly clinic based. Some FP programmes were already screening for STDs but MCH programmes rarely did. Syndromic management algorithms were not used properly and laboratory diagnosis was still preferred although rarely available. Finally, most programmes did not have policies on dual protection or other condom promotion messages (Kisubi 1995). Dehne and Snow (1999) found that Latin American countries had generally progressed further than sub-Saharan Africa on integrating services, especially counselling and risk reduction, while Asia provided the fewest cases of integration, other than Thailand.

The first problem of implementation was defining integration at different levels of the health system and for different types of provider or manager. This led to policy makers at different levels and providers having different concepts of what it meant (Dehne & Snow 1999; Lush *et al.* Submitted). For example, at service level in Kenya, a nurse defined integration as when preventive and curative reproductive health services are provided '*in one room, by the same person, at the same time, throughout the week*' (Njeru & Njoka 1998: 19). In Ghana, by contrast, service integration was perceived as a means of improving collaboration between providers in their efforts to make services more accessible to clients (Annan & Dzikunu 1998: 25). In reality, in many settings, integration meant adding new activities to existing services, such as FP or ante-natal care, which continued to be run separately. For example, in Kenya, despite the definition above, a manager stated that '*in reality, these services are run vertically in three departments; outpatient, MCH/FP and HIV/STD*' (Njeru & Njoka 1998: 7). Likewise, in Uganda, clinic staff simply added HIV counselling to FP services in order to counter criticism from the community of their singular focus on FP (Mukaire *et al.* 1997). Despite these debates, in sub-Saharan Africa, consensus emerged that, at service level, integration meant the addition of the following four sets of activities to MCH/FP: case finding and treatment of

STDs; syphilis screening at ante-natal care; HIV testing and counselling; and information, education and communication to prevent infection and high risk behaviour (Dehne & Snow 1999).

A second problem with operationalising integration was the failure to develop an adequate legislative framework for ensuring services were feasible. For example, Ghana had clarified that nurses could prescribe STD drugs (Annan & Dzikunu 1998) but, in Kenya, while in theory such prescribing was legal, in practice this information had not been disseminated, leading to ambiguities at clinic level (Njeru & Njoka 1998). For example, in an NGO clinic in Mombasa, nurses could examine and diagnose an STD but could not prescribe relevant drugs, although their government sector colleagues could (Twahir *et al.* 1996). In Zambia, nurses were allowed to prescribe drugs but only in the absence of a doctor (Mutungwa & Nkwemu 1998). Not all STD drugs appeared on essential drugs lists which have traditionally guided primary level treatments by nurses. The issue appears mundane but in fact generated considerable debate since, on the one hand, doctors' representatives were reluctant to concede further opportunities for non-medics to prescribe (which can be profitable) and, on the other hand, nurses' representatives were unwilling to agree that their staff should undertake new services without increased pay or other incentives (Mayhew *et al.* In press-b). Even in Ghana, hierarchies between nurses and doctors often prevented nurses using drugs they were allowed to prescribe (Mayhew 1999).

A third problem was the lack of clear technical guidelines for training staff or managing new services. Ghana, Kenya and Zambia had all developed STD management guidelines, although not all included syndromic management, dissemination was largely only in pilot project areas and training was incomplete. Thus while some clinical staff had received *ad hoc* training in STD management, usually in pilot project areas, nursing and midwife colleges had yet to incorporate syndromic management into their main curricula (Mayhew *et al.* In press-b). Furthermore, even where dissemination did take place, the involvement of district managerial staff in planning, supporting and supervising subsequent implementation of new services was limited so follow-up was hampered. Technical guidelines for areas of integrated HIV/STD management other than syndromic management were even less well disseminated, including condom promotion, risk assessment and partner notification (Mayhew *et al.* In press-b).

4.4.2 Availability of financial, technical and managerial resources

Lack of clarity extended to financial, technical and managerial resources, all of which should have been allocated through a process of negotiation and prioritisation between different actors in different departments and levels of the MOH structure. In Thailand, for example, results from pilot integration projects became available in 1993 and a careful programme of expansion was then planned, starting in

hospitals in two provinces and eventually reaching sub-district facilities nationally (Tahir & Auamkul 1998). In sub-Saharan Africa by contrast, rapid policy reform led to inadequate allocation of necessary resources for expanding services, improving commodities supplies, training staff and increasing attention to reproductive health at district levels of the health system. Furthermore, where resources had traditionally been managed by vertical administrative structures, there was little evidence of change in orientation towards a more integrated, horizontal approach which could have facilitated greater co-operation between managers of different activities (Mayhew *et al.* In press-b). Although there was some consensus that, even where services were integrated, a specialised technical office guiding policy was desirable (see also Hellberg 1995 and Liese 1995), where different specialised units were involved, they were not communicating properly. Thus, previous systems of separate national allocation of budgets and other resources to particular items or activities continued to exist, although this led to both duplication (for example, in supply systems for contraceptives and STD drugs) and gaps (for example, condoms being supplied to FP clinics but not to STD clinics).

Failure to involve local managers in decision making over resources was exacerbated by the demands of donors who continued to insist on separate systems for implementation and monitoring of expenditure under projects they supported. For example, in Kenya and Zambia, STD drugs and test kits were procured by donors on behalf of the government and distributed directly to dedicated district staff (Mutungwa & Nkwemu 1998; Njeru & Njoka 1998). In Ghana, STD drugs were integrated into general MOH supplies but contraceptives were bought separately by UNFPA and USAID and remained outside this system (Annan & Dzikunu 1998). Similarly, donor funds for particular activities also flowed directly from national programmes directly to dedicated district staff. For example, in Kenya, World Bank STD project money flowed from the National AIDS and STD Control Programme to District AIDS and STD Co-ordinators. In Ghana, a similar system was in place for district FP funds (Mayhew *et al.* In press-b). Such vertical resource and drugs flows were necessitated by inefficient government systems but also encouraged staff not to collaborate so they could retain control of as much power as possible in their domains.

Thus, while both government and donors had made strong commitments to integration at national level, in response to international calls for a shift in emphasis in reproductive health programmes, the process of implementation was severely hampered by traditional systems of administration. There was little evidence that, in national policy debates, these problems were anticipated. Indeed, in the absence of consultation with the managers who deal with such issues on a daily basis, it was unlikely that the rapid developments in national policy could ever have accounted for them adequately.

4.4.3 Health sector context of implementation

Policy developments for reproductive health were also taking place at a time when health sector budgets were stagnant or declining for some time, along side major institutional reforms. Health sector reforms were immensely complex and it is not the intention to deal with all aspects in detail here. The principal areas in which reproductive health policy development was affected were: changes in structure and mandate of national health programmes; and devolution of responsibility to districts.

Health reforms were in many cases pushing MOHs to integrate all their management systems. Thus, in theory, financial and logistical aspects of different programmes would be handled centrally with only technical support being retained in dedicated, specialist programme offices. To facilitate this, both Ghana and Zambia were in the process of transforming their MOHs by separating the national policy making functions from those responsible for guiding implementation. In Zambia in 1998, the Reproductive and Child Health Unit remained unsure where it would eventually be placed in the new administrative structure (Interview Reproductive and Child Health Unit, April 1998). Staff were also confused over who would be responsible for implementing their policies under the new system and how to communicate with them.

Structural reforms were supported by some donors and were promoted through new mechanisms of financial support, known as sector-wide approaches (SWAps). Under SWAps, governments prepared strategic sector policies with overall budgets which donors could then choose to support through central baskets of funds (Cassels & Janovsky 1998). Implementation of health services under SWAps would then become increasingly the responsibility of the MOH with relatively less interference by donors. SWAps therefore potentially had huge implications for the management of reproductive health services. However, despite substantial support among donors for this new approach, some areas of health care in Ghana, Kenya and Zambia remained outside the SWAps, including FP and frequently HIV/STDs. There were two reasons for this: first, certain key bilateral donors (especially USAID) were unwilling to provide assistance through baskets; and, second, where donors were keen to prioritise particular areas of health care (for example, USAID focuses predominantly on FP and HIV/STDs), they preferred to exert influence through procedures they could more easily control. Thus, despite the increase in SWAps, some donors continued project funding, especially for priority areas like reproductive health.

Major institutional reforms were also taking place at lower administrative levels in all countries, especially in the districts where most financial and administrative managers were in the process of rationalising their systems to become more efficient and sustainable. With national reproductive

health managers committed to separate programmes in order to retain donor support, tensions were created between the goals of decentralised, locally accountable, integrated health service delivery and the reality of vertical, technical and financial inputs for particular reproductive health activities (Mayhew *et al*. In press-b). For example, in Ghana, the MCH Unit technical staff had failed to take into account of sector wide changes in financial management which meant that they would be unable to distinguish their programme's expenditure within budget line items such as drugs or transport (Annan & Dzikunu 1998). Furthermore, where national programmes responded to the problem by appointing district personnel specially to deal with FP or HIV/STD services, other district staff tended to view these areas as outside their mandate, thereby increasing the isolation of reproductive health from mainstream health systems.

The focus of reformers on efficiency, sustainability and cost-effectiveness also meant that reproductive health managers were increasingly expected to justify their policies in these terms. STD treatment is a highly cost-effective intervention (World Bank 1993; Aitken & Reichenbach 1994) and, in general, integrated delivery of HIV/STD services was also assumed to be more cost-effective than separate delivery, since it reduces staff time involved in duplicating examinations and medical histories while drugs costs remained the same (Lule *et al*. 1998). However, estimates from evaluations in Mombasa, Kenya and Busoga, Uganda did not take account of the capital investment required to develop clinics to ensure appropriate levels of privacy and client flow between services (Ladha *et al*. 1996). If laboratories and adequate staff training and drugs supply were also included, limited health resources would quickly become over-stretched. For example, in Bangkok in 1995, Family Health International estimated that it cost clinics US$19-25 per patient to provide STD services while total health spending was only US$20 per head in the country (Blaney 1998). The epidemiologic context was also found to affect cost-effectiveness in Bangladesh, where low STD prevalence compromised the sensitivity and specificity of syndromic management algorithms, and increased levels of over-treatment and over-spending on drugs (Hawkes *et al*. 1999). Thus, although careful choices needed to be made between different potential interventions, their cost and their effectiveness in MCH/FP settings, there was scant evidence that many programme managers had analysed choices on a small scale before expanding programmes to national level.

4.4.4 Process of implementation in facilities

In addition to confusions at national and district levels, integrated service delivery was inhibited by further problems in health facilities, in particular, the low pay, morale and motivation of providers and the lack of appropriate physical infrastructure and equipment for expanding services. Many reproductive health service providers had also long been affiliated to the same vertical programmes which were having such difficulties reforming at national level, and trained as specialist staff for

clinics which may be in dedicated rooms in a facility or even in separate facilities (see Chapter 2). Integrating HIV/STD services with MCH/FP therefore required these cadres to undertake a whole new range of activities, seldom facilitated by concomitant improvements in salary and working conditions.

There was little evidence for such improvements in Ghana, Kenya and Zambia. Even in pilot initiative areas, there was incomplete implementation, and nationally representative data confirms that, elsewhere, it was very weak (Askew et al. 1998). Integrating services required a number of key inputs, including: staff trained in STD management, HIV counselling and MCH/FP service delivery; new guidelines disseminated; information and counselling materials; a complete stock of drugs and commodities in place and routinely maintained; and physical infrastructures ensuring privacy and high quality care. In addition, referral mechanisms should have been in place for blood tests and further treatment when necessary.

Table 4.2 Percentage of health facilities with key programme inputs

Country Input	Ghana (N=20)	Kenya (N=16)	Zambia (N=20)
Facilities with at least one staff trained in syndromic management (%)	12	81	81
Facilities with at least one staff trained in AIDS counselling (%)	44	81	63
Facilities with at least one staff trained in FP (%)	69	75	81
Facilities with syndromic management guidelines on site (%)	38	81	19
Facilities with HIV/STD/condom IEC materials on site (%)	100	38	31
Facilities with complete stocks of recommended STD drugs (%)	100	0	75
Facilities with condoms in stock (%)	100	94	88

Source: Lush et al 1999.
N.B. field work was undertaken in pilot study sites which included general STD management in Kenya, syphilis screening in Zambia and FP and STD integration in Ghana.

In Ghana, district and facility interviews showed that the main problems they had had were in training providers and only 12 per cent and 44 per cent of facilities in pilot integration districts had staff trained in syndromic management of STD and HIV/AIDS counselling respectively (Table 4.2). Similarly, in Zambia, there had been more attention to training than to ensuring that educational materials and drugs were in the facilities. In Kenya, a higher proportion of staff in facilities in the pilot project area had received training but no facilities had the full complement of drugs, contraceptives and educational materials supposed to be available.

In-depth interviews revealed further problems with prescribing drugs, since even if drugs were available in the facilities, they were rarely available to MCH/FP clinic staff to prescribe (because legislation had not been clarified or doctors prevented it). This meant that clients still had to sit in another queue in order to receive the drugs, whether or not the MCH/FP nurse had diagnosed an STD. Similarly, training in counselling was extremely variable and counselling materials of limited utility since they were often in the wrong language or inappropriate to clients who attended MCH/FP clinics (Mayhew et al. In press-b). Where providers were trained, they were frequently moved around by district managers without the knowledge of reproductive health programme staff so that trained providers were not evenly distributed between facilities. Finally, referral mechanisms were extremely weak in all countries since often there were no specialised facilities to refer to or no functioning system for transporting blood or clients. Furthermore, where referrals did take place, there were no proper information systems for managing clients between different facilities.

These data are taken from sites where pilot initiatives for integration were taking place. Data from Situation Analyses were collected earlier, in 1995-96, but were nationally representative. They confirmed that, although the areas visited above had only limited success in implementation, they were better than average in each of the three countries (Askew et al. 1998). In general, the Situation Analyses showed poor availability of drugs and utilities, such as light, waste disposal and water, and very low levels of provider training. For example, in Ghana, 29 per cent of providers had received basic training in STD management but only seven per cent had been trained in syndromic management. Similar figures for Zambia were 28 per cent and 15 per cent and for Kenya were nine per cent and eight per cent respectively. In Botswana, 31 per cent of providers had received syndromic management training and in Zimbabwe, the figure was 39 per cent (Baakile et al. 1996; Askew et al. 1998).

Other case studies further demonstrated difficulties with preparing MCH/FP facilities and providers for expanded HIV/STD activities. In Mombasa, the Mkomani clinic committed to integrated HIV/STD and MCH/FP services but was structurally unable to provide adequate privacy (Twahir et al. 1996). The clinic's efforts were also hampered by lack of adequate training of staff or compensation for added tasks. In Uganda, the Family Life Education Project (FLEP), funded by USAID through the Busoga Diocese of the Anglican Church, also had training problems with clinic staff who were more aware of treatment aspects of syndromic management than important risk assessment stages (Mukaire et al. 1997). In India, an evaluation of doctors treating STDs showed poor quality of care as a result of complex treatment guidelines and inadequate training (Mertens et al. 1998). Similarly, in South Africa, Harrison (1998) found that despite national policy for syndromic management, only six per cent of clinics had algorithms and only nine per cent of simulated clients were correctly managed in full (given correct treatment, condoms and partner notification cards).

Other work in India showed how, even where clinicians were adequately trained, frequent redeployment by administrators unaware of the specifics of reproductive health programmes further disrupted service availability (Population Council 1998).

4.4.5 Delivering integrated services

Given this set of service inputs, what achievements had been made in actual delivery of integrated services? The Situation Analysis data generally show a low availability of STD services at MCH/FP clinics. Between 21 per cent (in Ghana) and 36 per cent (in Zambia) of facilities had any kind of STD services on offer (Mayhew *et al.* In press-b). However, figures for actual service provision were lower: between 17 per cent (in Ghana) and 87 per cent (Zimbabwe) of staff interviewed reported that they had actually treated STDs in the previous three months, most of which were syndromically managed. The data also showed poor promotion of condoms for STD prevention, despite being mentioned as FP methods: between four per cent (Zimbabwe) and 31 per cent (Botswana) of clients received dual protection messages (Askew *et al.* 1998).

Table 4.3 Percentage of MCH/FP facilities undertaking STD management activities

Activity	Country	Ghana (N=20)	Kenya (N=16)	Zambia (N=20)
Syphilis screening in ante-natal care (%)		0	70	56
Pelvic exams for new FP clients (%)		2	6	0
Ocular prophylaxis for gonorrhoea for new borns (%)		0	56	50
Condoms recommended to prevent HIV/STD transmission (%)		100	100	100
Partner notification activities (%)		0	50	100

Source: Lush *et al* 1999.
N.B. field work was undertaken in pilot study sites which included general STD management in Kenya, syphilis screening in Zambia and FP and STD integration in Ghana.

The case study data also showed minimal STD service provision in MCH/FP consultations (Table 4.3). Pelvic exams were performed for new FP clients in a few clinics in Kenya and Ghana but never for returning clients; ante-natal syphilis screening took place in the majority of clinics in Kenya, around a half in Zambia but none in Ghana; and prophylaxis against ocular gonorrhoea for new borns was performed in half of facilities in Kenya and Zambia but none in Ghana. All providers responded that they promoted condoms for HIV/STD prevention but DHS data revealed very low levels of condom use in the population and condoms were rarely made freely available for anybody (including men) to take from the clinic. Finally risk assessment, partner notification and other counselling activities were almost never undertaken for MCH/FP clients, despite being a key component of WHO

recommended syndromic management algorithms, and many providers reported in interviews feeling uncomfortable discussing these issues (Mayhew *et al.* In press-b).

Other case studies confirmed these difficulties. In the Mombasa Mkomani clinic, providers found risk assessment too sensitive and symptoms of STDs were rarely discussed, unless the client herself brought them up (Twahir *et al.* 1996). Since clients' knowledge of STD symptoms was poor, there were frequent missed opportunities for screening and treatment. Information, education and communication activities were similarly weak and clinical activities such as syphilis screening and STD treatment suffered from high costs associated with tests and recommended drugs, where clients were expected to pay for them. Similarly in the FLEP in Uganda, despite commitment to integration, few clients received any information about HIV/STD, syphilis screening or treatment according to national guidelines and algorithms (Mukaire *et al.* 1997). These findings suggest that integrating HIV/STD and MCH/FP services requires more than just simple training courses and drugs. Providers need to be able to deal with a wider range of extremely sensitive issues with their clients, for which in these cases they were ill-equipped (see also Schneider 1994).

4.5 Conclusions

This review suggests that, at international level, the agenda for integration was set through a highly politicised process of problem identification and development of appropriate and acceptable solutions. In addition to addressing the twin problems of HIV/AIDS and women's reproductive health, the policy solution of integrating HIV/STD management fitted well with the political and economic imperatives facing the various international public health actors. To garner political support, the women's movement successfully developed a rhetoric of health and human rights which matched other trends in international public health thinking. Both PHC and reproductive health communities referred to the need to increase participation by groups not usually represented in public health decision making; and both were concerned with increasing the quality of health care in response to the needs of these groups. Such rhetoric supplemented the neo-liberal thinking which had dominated the international donor community for the preceding 20 years, as new-right politics declined in Northern countries.

In section 4.3, three assumptions were developed about the process of developing policies for integration in low income countries in response to this international agenda. The first, that in many countries, there was a strong push to integrate previously separate MCH/FP and HIV/STD services, was shown to be partially true in that new policies were published in many countries during the post-ICPD period. This was especially the case in sub-Saharan Africa, where the twin problems of HIV/STDs and women's reproductive ill-health were particularly severe. Nonetheless, there was little

evidence for wide national networks of interested actors participating in debates about the advantages of integration and the extent to which new international policies would fit their particular context. Neither were there national level focussing events to which policy makers responded with new ideas for addressing particular problems.

Instead, the second assumption, that this was a process driven largely by external interests, was borne out in the evidence. Thus, in order to show progress on their commitments at the ICPD, and based on limited evidence from one successful trial in Tanzania, donors pushed national governments to formulate policies for integrating HIV/STD services with PHC. This took place through encouraging governments to develop projects in line with donor priorities by offering to fund substantial proportions of national health budgets. These projects were, however, often established outside mainstream MOH activities, thus contradicting rhetoric about integrated approaches. They rarely took place in response to national priorities but rather to those set at international level. As a result, they did not always fit the context well and were seldom sustainable beyond the period of external funding.

Translating words into action therefore proved difficult and limited evidence suggested that at national level, action on ICPD recommendations stalled. As posited in the third assumption, implementation of programmes was top down and ineffective for a number of complex reasons. First, there was widespread confusion as to the real meaning of integration, not helped by the contradictions of the international community described above. Second, financial, political, managerial and technical resources allocated by governments and donors to such policies were completely inadequate and local managers were rarely involved in debates over implementation. Third, the context in which policies were developing was extremely restrictive, due to declining overall health budgets and radical administrative and financial reforms. Together, these constraints led to extremely slow progress on service delivery and little impact in terms of improved access to integrated care for the general population. The overall lesson from this chapter is therefore that a policy which is determined internationally with little consultation and simplified for district managers to implement as quickly as possible will ultimately result in ineffective, inefficient and unsustainable services. In particular, failure to account for context, especially resource constraints, lack of government ownership and the strong role of external actors, hampered policy development. In the next two chapters, these processes will be examined in South Africa to analyse the similarities and differences with those presented here.

4.6 Summary

- The development of an international agenda to integrate services was marked by a shift in relative power among actors associated with reproductive health. In particular, those who had traditionally promoted population control policies such as target-driven FP programmes, lost power to those who were more interested in promoting an approach to health which focused on women's needs and rights to safe and voluntary sex and reproduction. Actors included international women's groups, international donors and the public health community. The decline of the new-right in the USA and the rise of a more rights oriented approach to health facilitated the consensus.

- At national level, governments and their donors searched for ways to respond quickly to the new agenda. Little information was available on how to formulate or implement appropriate reproductive health policies and integration seemed to be a relatively simple and practical way forward. National policy developments were not driven by local initiatives or agendas. Instead, they largely reflected the priorities of international actors based on information, research and politics. There was little evidence for the input of national NGOs into policy development or the role of any media in promoting reproductive health issues. Policy communities were made up primarily of MOH actors and donors, and within these groups mainly of those previously responsible for FP. Communication with HIV/STD departments over policy development was weak.

- Reproductive health policy developments were also disrupted by on-going complex structural changes as part of major health sector reforms. The most important areas of change were in the roles of national health programmes and the decentralisation of powers and responsibilities to district administrations. Policy formulation was thus top-down and implementation was at best patchy and at worst non-existent. As a result of this top down process, many clinics did not have the capacity to provide a properly integrated service. The right commodities or drugs were not always available in clinics and staff were not always adequately trained in syndromic management or HIV/STD counselling. Integration was perceived more as an add-on to existing MCH or FP services rather than a reorientation of activities towards a comprehensive sexual health service.

4.7 References

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CHAPTER 5: NATIONAL POLICY DEVELOPMENT FOR INTEGRATION IN SOUTH AFRICA

5.1 Introduction

Chapter 4 reviewed existing literature on international agenda setting and national responses and suggested that, in most sub-Saharan African countries, the context in which policy formulation and implementation took place was an important determinant of success. Important contextual factors included the role of external donors and levels of support for the policy at national and local levels. However, these issues were rarely studied in depth leading to gaps in understanding of how health policy develops in different contexts. To address this issue, this chapter presents results of field work conducted in South Africa in May to August 1998. The research was conducted partly in Johannesburg and Pretoria and partly in Pietersburg, the administrative capital of the Northern Province, where the process of implementation of national policies was investigated at provincial, district and sub-district levels. Field work focused on policy developments during the period 1994-98. Research methods were described in detail in Chapter 1. Briefly, a policy analysis framework was used, and in-depth interviews were conducted with key actors at national and provincial levels as well as critical examination of policy documents. In addition to the policy analysis, qualitative interviews and a structured survey were conducted at district and sub-district levels in order to investigate processes by which policies formulated at national and provincial levels were actually implemented.

In South Africa, health services under the new government were managed by a decentralised structure: the national Department of Health (DOH) was responsible for strategic policy development and technical guidance; provincial DOHs were responsible for all implementation functions. For the purposes of this research, this structure implied that, while agendas were often set and key decisions taken at national level, these would not lead automatically to service reform. Different stages of the policy process therefore needed to be examined independently, within their respective contexts. Chapter 5 addresses policy development issues at national level, focusing particularly on the roles of the offices responsible for guiding HIV/STD and reproductive health policy. Since these processes were taking place at a time of political, economic and administrative transformation, this context is also described in detail. In particular, the main priority of the DOH at the time of this research was to develop an integrated, comprehensive PHC service to improve equity in access to care. This had substantial implications for the way HIV/STD and reproductive health policy developed. The activities of a large and varied community of external actors advising and contributing to these policy developments is also be discussed, including international donors, academic and specialist institutions

and NGOs. Chapter 5 therefore documents two areas of national policy making: first, the political, economic and general health care situation in South Africa and the emergence of the HIV epidemic as a major public health priority; and second, the processes of agenda setting and policy formulation for integration of HIV/STD services with PHC at the national level, including the actors involved, their interests and networks and the political and economic context in which they were working.

5.2 The setting: South Africa since 1994

5.2.1 Political developments since 1994

In the four year period between South Africa's first democratic election in 1994 and this study in 1998, the country underwent enormous political, economic and structural change. These changes stemmed from the dramatic shift in balance of power away from the former white administration, which catered entirely to the needs of some 13 per cent of the total population, to incorporate representation of all sectors of society. The effect was far reaching: after 1994, people of all racial and ethnic origin were free to live throughout the country, including former autonomous and independent states (previously known as homelands); land could be owned by any person in any place; and all political parties were free to participate in open and full elections.

The process which led to this unfolding of apartheid began several years before the 1994 election with the release of Nelson Mandela from prison and the opening of formal talks between the apartheid government and the previously banned African National Congress (ANC). This prepared the ANC and the country for what would be a momentous period of transition and, in the first election in 1994, the ANC won 63 per cent of the national vote plus majorities in seven of the nine provinces (Welsh 1999). In 1996, the government consolidated this power and published a new, strongly liberal-democratic constitution. Since then, the ANC has continued in government under Thabo Mbeki after winning the 1999 elections.

Initially the ANC formed a tripartite alliance with the South African Communist Party and the Congress of Trades Unions (COSATU). After 1994, however, this early alliance came under considerable strain as the ANC moved rightwards in political and economic outlook, alienating its old allies (Welsh 1999). Other political groups, such as the old National and Democratic parties, also adapted, expanding their once exclusively white membership and forming oppositions which were no longer based solely on ethnic power. In the 1999 elections, the Democratic Party replaced the National Party as the largest single opposition to the ANC in parliament, although its total vote remained small. The Inkatha Freedom Party also lost regional power in KwaZulu/Natal and formed a coalition with the provincial ANC after the 1999 election. Between 1994-99, new parties formed from unexpected alliances between groups who were previously split along ethnic lines. These

included some bizarre alliances between extreme right wing white groups and black radicals but also the United Democratic Movement, set up by disaffected members of the ANC and National Party. These new political groups demonstrated an important shift away from ethnic politics and towards politics based on socio-economic alliances, although this shift remains to be credibly supported in the population (Spence 1999). Informal opposition was also vibrant in South Africa during this period, including a strong and critical press, many active NGOs, a variety of independent political and economic think tanks and, above all, a sophisticated and vocal middle class. These groups participated openly in the political process through formal channels and the high levels of political violence seen before 1994 declined (Spence 1999).

The new system of proportional representation in parliament was rooted in agreements negotiated prior to the 1994 election between the ANC and the National Party. This system, known as the Government of National Unity, ensured that all parties were represented in government and also that cabinet seats reflected the multiplicity of political groups coexisting in the country. Along with the tripartite alliance, it ensured that early democratic politics in South Africa were marked by consensus and coalitions rather than divisive arguments over policy development. In 1998, the ANC itself remained a liberation movement in character; as such it had a highly centralised structure which did not fully function as a political party. Tensions between the centralising tendencies of such a structure and the relative independence of some parts of the system, such as provincial administrations, were evident throughout its first five years in power (Spence 1999).

A quasi-federal system was established with one national and nine provincial governments. Provinces were made responsible for implementing most public functions, including health, while the role of national government was set to determine policy frameworks, including norms and standards. Initial relations between provincial and national governments were characterised by power struggles due to the lack of specific allocation of powers in the constitution (Gilson et al. 1999; interviews with DOH and other officials[31]). In 1996, in response, a system of fiscal federalism was instituted, under which the national government had to collect and distribute revenue to provinces equitably but had no power over allocation of resources within provinces. This led to substantial problems with implementation of policy in the provinces where governments were much weaker and supported by bloated, inefficient or corrupt bureaucracies (Gilson et al. 1999). In response to popular pressure to curb these problems, the government committed to losing 300,000 surplus staff from the bureaucracy, although the sunset clauses, negotiated to protect the jobs of staff of the apartheid administration, prevented early progress (Welsh 1999; interview with DOH official).

Provinces were also mandated to initiate a process of devolution of power to local administrations. However, in 1998, local government remained weak with little history of involvement in community affairs to build on. Civil society had entered a state of flux as a result of: loss of foreign money previously channelled to the anti-apartheid movement; shifts of many leading NGO staff into government positions; and dependence on government contracts compromising freedom to criticise government policy (Welsh 1999).

Despite these on-going issues, and although turnout at the 1999 elections was disappointing, politics in South Africa was a vibrant and participatory affair. This vibrancy suggested that national sectoral policy, such as in health, would also be characterised by widespread participation in public affairs. However, political problems, inefficiency and incompetence in provinces could also hinder implementation. Furthermore, the stalled progress on devolution of power to local district administrations had potentially negative implications for the effective delivery of health services.

5.2.2 Social and economic progress since 1994

During this political transition, the economy remained relatively strong. The ANC put considerable effort into wooing the business community and persuading them that earlier communist convictions had mellowed. They aimed to strike a careful balance between liberalisation, deregulation and privatisation of the economy, and responding to popular pressure for rapid social and economic change (Blumenfeld 1999). Nevertheless, problems which had arisen in the apartheid years continued to plague economic development, including: the distortion of economic performance by the institutions of apartheid; economic isolation since the 1940s through both white minority choice and sanctions; and uncertainty about future economic policy and stability limiting inward investment. These were combined with continuing problems of massive inequalities in income and wealth, human capital deficits, on-going structural adjustment and the effects of international events such as the falling gold price, the Asian economic crisis and el Niño.

In 1996, the government shifted its economic policy from the initial Reconstruction and Development Programme (RDP) to the Growth, Employment and Redistribution (GEAR) programme, which focused more directly on macro and micro-economic policy (Gilson *et al.* 1999). Subsequently, however, GDP growth declined along with reductions in investment and savings and rising unemployment. Criticisms of economic policy have highlighted slow privatisation of nationalised

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[31] Throughout Chapters 5 and 6, reference will be made to policy interviews conducted during field work in May-August 1998 and March 1999. A complete list of those interviewed is in Appendix A. In the text, they will remain anonymous and only identified by their type of institutional affiliation.

industry and the failure to resolve employment problems between unions and business (Blumenfeld 1999). Despite wanting to placate big business, the government maintained a controversial policy of affirmative action in order to increase the participation of formerly disadvantaged groups in all sectors. This policy ranged from favouring blacks for certain jobs to regulations requiring certain types of property and business ownership. However, in 1998, these policies had not had marked success and the government was threatening to clamp down on token appointments being made without handing over real power or responsibility.

Structural changes reflecting political and economic shifts had taken place at all levels, from society as a whole, to communities and families. Scrapping restrictions on movement and allowing ownership of property by all led to increased migration to urban areas by people in search of better paid employment. There was a rising urban, black middle class gaining formal employment in a range of public and private sectors and either remaining resident in black areas or moving into previously white residential areas. There were ambitious housing development plans being laid by the government, especially in urban areas: in 1996, the government allocated R769 million (US$154 million[32]) to housing development, topped up by R10,006 million (US$2,001 million) to come from the private sector (Central Statistics Service 1997). Improvements in water and electricity supplies in black communities also took place (Blumenfeld 1999).

Expanding access to education and health services, however, progressed much more slowly. Inequalities in South Africa between different population groups remained vast: for example, variations in the Human Development Index between provinces showed that, whereas Western Cape and Gauteng provinces had indexes of 0.826 and 0.818 respectively (similar to Venezuela), Eastern Cape and the Northern Province (with indexes of 0.507 and 0.470 respectively) were on a level with neighbouring Zimbabwe. In 1995, ten per cent of the population received 57 per cent of the national income with the poorest 40 per cent of the population getting only four per cent (McIntyre *et al.* 1995). These large inequalities reflected the economic and political situation – Gauteng had long been the home of the industrial heartland of the country with Johannesburg and many of the wealthy mining areas. By contrast, the Northern Province had incorporated parts of two former autonomous territories (or homelands) plus one nominally independent state, Venda. These areas were known to be extremely poor and under-served by public services: in 1991, people age 25 and over in Gauteng had an average nine years of schooling compared to five in the Northern Province (Central Statistics Service 1997). Similarly, in Gauteng in 1994, there were nine general practitioners per 10,000 population, compared to one in the Northern Province. Overall state expenditure on health and

welfare declined from 11 per cent of the total budget expenditure in 1990/91 to ten per cent in 1996/97 (Central Statistics Service 1997). Among provinces, in 1995/96, health expenditure as a proportion of total provincial expenditure ranged from 13 per cent in the Northern Province to 33 per cent in Gauteng. By 1997/98, figures had remained stable in all provinces except the Northern Province, where it had risen to 18 per cent (McIntyre *et al.* 1998).

In addition, for the majority of South Africans in these areas, very little had changed over the four year period in terms of access to power, financial security and improved living standards. Unemployment rates were extremely high, at nearly 30 per cent nationally and over 40 per cent in the Northern Province and Eastern Cape (according to a survey in 1995, quoted in Central Statistics Service 1997). Between 1994 and 1996, the percentage of black households owning a television rose from 42 per cent to 48 per cent; among whites, the figure was 97 per cent (Central Statistics Service 1997). Forty-one per cent of blacks in the 1995 survey had no access to a telephone, compared to nine per cent of whites.

Despite these problems, in 1998, there was great room for optimism in South Africa. It was by far the wealthiest country in sub-Saharan Africa and the only one which could boast a truly industrial economy. With a total population of nearly 38 million, according to the 1996 census (Central Statistics Service 1997), and a life expectancy of 63 years (in 1991), the labour force was young, relatively well educated and had lower mortality than elsewhere. So long as the political situation remained stable it was likely that living standards would begin to improve for the majority in the medium term.

5.2.3   Relations with the international community

South Africa's relations with the US and Europe shifted dramatically in the 1994-98 period, helped by the ANC's moves away from socialist ideals and towards neo-liberal economic values. In addition, the African renaissance, a concept promoted by the then Vice President Thabo Mbeki, suggested a new role at the centre of regional politics (Evans 1999). Thus, although the ANC's continued allegiance with pariah states such as Cuba and Libya was difficult for some Northern donor countries, they were eager to support South Africa as a Southern success story.

Relations with donors mirrored these changes: pre-1994, contact with the international community had been poor, with South Africa excluded from the UN in 1964 as part of international condemnation

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[32] Throughout Chapters 5 and 6, Rand figures were converted to US dollars at the rate of 5 Rand to the dollar, although, during the period of the study, the Rand suffered a severe drop in value to more than 6 Rand to the dollar, making budgets smaller in dollar terms. The currency subsequently stabilised at this lower level.

of apartheid. Aid at this time focused on support to anti-apartheid organisations, including the mass democratic movement, and was combined with punitive sanctions. After Mandela's release and the un-banning of the ANC in 1990, sanctions were revoked and new aid to the formation of government, such as for the election process, became termed transition support (Schneider & Gilson 1998; interviews with donor officials). This period was characterised by shifts from NGO to government funding, increases in economic development oriented support and the opening of bilateral and multilateral donor offices. South Africa became the largest recipient of both EU and US aid in sub-Saharan Africa, mostly for privatisation and trade (Barber 1999).

However, South Africa never became donor dependent and actual sums of aid remained insignificant in the overall GDP. Similarly, international influence over policy formulation was minimal. In January 1997, a total of US$3.8 billion had been pledged to South Africa for the period 1994-99. Of this, 15 per cent was grant, 13 per cent technical assistance (making only two per cent of the overall budget), 14 per cent was loans and 51 per cent concessionary finance. Donors varied in their approach to supporting political and economic transition. For example, the Scandinavians generally financed the central RDP fund where as the EU preferred to finance the government budget itself. US and UK donations, by contrast, primarily went directly to service providers, such as in health (Schneider & Gilson 1998).

5.2.4 Gender relations and women's economic disempowerment

Gender relations and the poor status of women were another aspect of the social and economic milieu which were important for reproductive health. Partly as a legacy of the apartheid system and partly as a result of cultural norms, in 1998, women in South Africa suffered low status compared to men, especially in the black population, and had poor opportunities and access to economic and social resources. Under apartheid, restrictions imposed on the black population often meant that men had to migrate to urban areas or to mines for employment. Residential rules, however, prohibited women and families from accompanying them and restricted women to rural homeland areas or townships (Ginwala 1995). This severely limited their access to employment, property ownership or other sources of financial security. Further limitations were imposed through apartheid's system of job allocation and discrimination according to sex and race, under which black women were rarely able to find employment outside agricultural, domestic service, teaching or nursing sectors (Groener 1998).

Cultural factors compounded these economic restrictions, including traditional barriers to women's empowerment and values attached to their subordination to men. Combined with black men's insecurity and frustration under the apartheid system, these traditional norms placed great strain on relationships and enhanced women's vulnerability. Family structures were eroded by constant

separation through migration; other community support systems disintegrated with no access to productive land or other sources of income. Cultural practices such as traditional medicine further contributed to reproductive ill health; for example, media reports in 1998 suggested that child rape was perpetuated by myths that it would cure AIDS (*Media and Gender Monitor* 1998). As a result, women, especially younger women, frequently had to resort to providing sexual favours to older men in return for subsistence financial support (interview with NGO official). Where young men migrated from their rural homes to mining areas and lived in residential hostels, women also migrated to provide sexual services (Abdool Karim *et al.* 1995).

In the 1990s, these factors contributed to extremely high levels of domestic violence, abuse and rape: under apartheid only rape of white women was a crime (Armstrong 1994); in 1994-95, South Africa was reported to have the highest rates of rape in the world (*Communique* 1997); and a survey in Khayelitsha found that most women expected to be beaten by husbands or partners (Wood *et al.* 1998). Comparatively lax restrictions on male behaviour led to high levels of sexual partnership outside long-term relationships and concomitantly high rates of transmission of HIV and other STDs. The lack of power women had to negotiate protection from infection through use of condoms, and the poor availability of female controlled methods of protection (Preston-Whyte 1995), further exposed women to infection (Hlatshwayo & Stein 1997). Other reproductive health effects included high fertility among teenage women, since cultural norms required them to prove their fecundity, and subsequently high drop out rates from school, furthering their economic isolation.

The legal status of women under the 1996 constitution changed dramatically, with their rights explicitly protected and defended vocally by numerous women's activist groups, such as the Women's National Coalition. In addition, South Africa ratified the Convention for the Elimination of Discrimination Against Women (CEDAW) in 1995 and passed the Prevention of Family Violence Act (Stuart 1997). Nevertheless, the legal system retained many features of the apartheid patriarchal regime. These were particularly poignant for rape victims, given their high numbers, and included: failures by police forces to take rape seriously (and frequent reports of rape and violence by police towards women; Nowrojee & Manby 1995); lenient sentences for convicted rapists (*Communique* 1997); and continued failure by both courts and the general population to view marital rape as a crime. In addition, while the 1990s saw improvements in many areas of human rights, they also saw increases in gender-based violence (Maitse 1998).

5.2.5   The HIV/AIDS and STD epidemics

One of the major threats to the economic and social development of South Africa was the HIV/AIDS epidemic. This disease spread extremely rapidly in South Africa after the late 1980s and there was a

marked failure on the part of government to address necessary prevention and care issues during this time (interview with HIV/STD researcher).

Figure 5.1 HIV/AIDS in South Africa, 1996-97
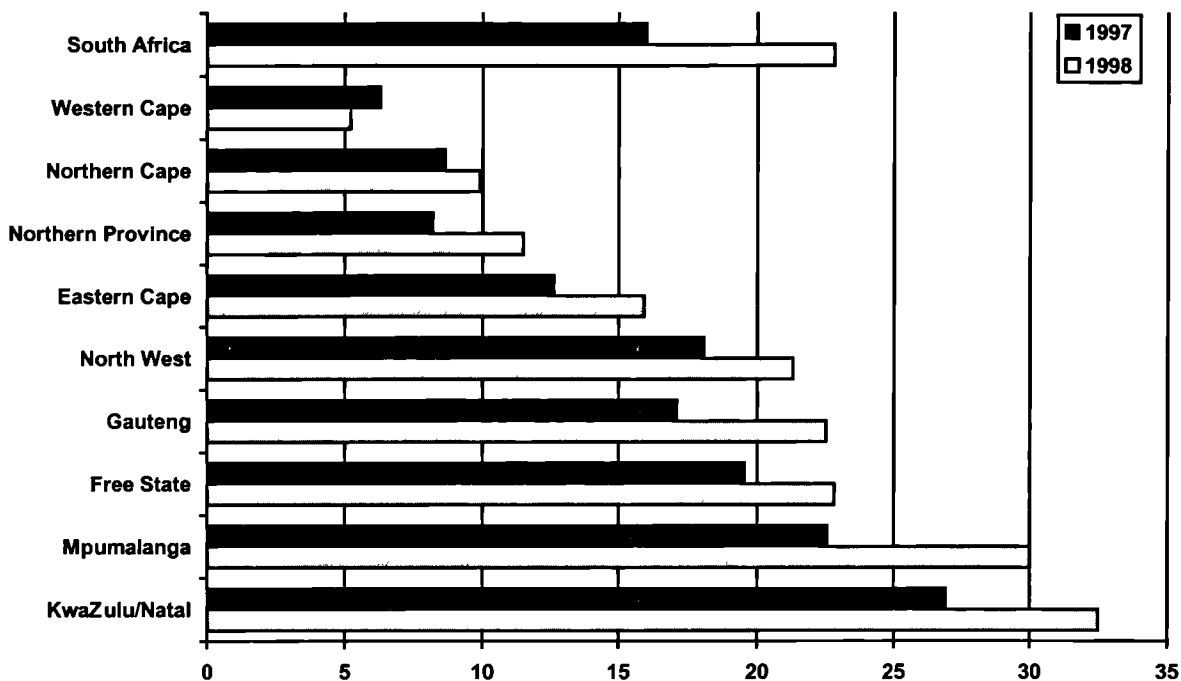
Source: Department of Health 1999.

According to the ninth national HIV survey of women attending ante-natal clinics, HIV prevalence was 23 per cent nationwide in 1998, up from 16 per cent in 1997 (Department of Health 1999). There was considerable variation by province, with the highest rates being found in KwaZulu/Natal (33 per cent) and the lowest in the Western Cape (five per cent; Figure 5.1). As elsewhere in sub-Saharan Africa, prevalence was highest among women in the 20-24 age group followed by the 25-29 year olds. Among men, peak prevalence was in the late 20s and early 30s age groups. The epidemic spread rapidly among all groups, starting in the late 1980s. Its geographical distribution was closely related to economic activities: the first cases were found in KwaZulu/Natal and were associated with the industrial ports at Durban and Richards Bay. During the 1990s, the infection spread along major trucking routes and was associated with migrant workers' hostels, often found near mines. South Africa experienced two quite separate epidemics known as Type 1 (predominantly white, homosexual infection) and Type 2 (mainly black and heterosexual infection) but the latter was by far the more significant by the mid-1990s. In 1997/98, the epidemic also shifted from a silent spread of HIV infection to a visible AIDS epidemic: by 2005, it has been estimated that there will be nearly a million AIDS orphans in South Africa (Abdool Karim *et al.* 1997).

There were also high levels of infection with other STDs in South Africa and these diseases were found to be endemic in the sexually active population (Table 5.1). Ante-natal data from 1997 showed prevalence of syphilis to be 15 per cent in KwaZulu/Natal, again the highest in the country (Department of Health 1998a). In a 1996 review of epidemiology and data collection for STDs in South Africa, ulcerative infections, mostly caused by syphilis and chancroid were found in five to 15 per cent of ante-natal clinic attenders while the average rate of gonorrhoea infection was eight per cent, of which 13 per cent were resistant to penicillin. A further 16 per cent of ante-natal women were found to be infected with chlamydia and vaginal infections were found in between 20 and 49 per cent (Pham Kanter *et al.* 1996).

Table 5.1 Estimates of prevalence of STDs in South African women, 1990-96

Disease	Date and reference population	Prevalence (%)
Syphilis	1990, women at ante-natal care, Cape Town	5
	1992, women at ante-natal care, Durban	8
	1993, women at gynaecology clinics, Durban	14
	1994, women in rural Orange Free State	12
	1996, women in rural Northern Province	5
	1996, women in rural KZN	8
Gonorrhoea	1992, women at MCH/FP, Durban	4
	1993, women at gynaecology clinics, Durban	3
	1996, women in rural Northern Province	3
	1996, women in rural KZN	4
Chlamydia	1992, women at MCH/FP, Durban	5
	1993, women at gynaecology clinics, Durban	9
	1996, women in rural Northern Province	12
	1996, women in rural KZN	8
Herpes	1993, women at gynaecology clinics, Durban	3

Source: Pham Kanter *et al.* 1996.

In contrast to the epidemic figures, the government response to HIV/AIDS was muted (The Economist 1998). Although prior to the 1994 election, AIDS was highly politicised and policies were progressive, after then, efforts of the government went largely in vain (interview with HIV/STD researcher). As elsewhere in sub-Saharan Africa, both politicians and the general public found open discussion of HIV/AIDS extremely difficult and it was associated with high levels of stigma (Webb 1997). Given the politicisation of the epidemic in the public mind, political leaders were ambivalent about taking a public stance on any campaign (interviews with donor and NGO officials). Relations between political and technical actors involved in HIV/AIDS were, and remain, tense and interventions which were perceived to be from outside easily attracted accusations of racism or cultural insensitivity (various *Healthlink* email reports 1999; interview with donor official).

At the time of field work, there was much debate over the reasons for public failure to respond to the need for large scale, mass information programmes, promotion of safe sexual practice and provision of technically appropriate preventive and palliative health care. Criticisms included: the lack of commitment to the issue from senior politicians and bureaucrats outside the health service (interview with donor official); the failure of provincial authorities to take responsibility for expanding health services and incorporating HIV/STD management (interview with DOH official); the focus on high profile (but doomed) curative breakthroughs to the cost of simple preventive measures (interview with HIV/STD researcher); and the lack of action at an overall economic and social level which could mitigate the effects of poverty leading indirectly to high risk behaviour patterns (interview with reproductive health researcher). Many of these criticisms could be met with the excuse that the restructuring which took place in South Africa rendered the implementation of effective new programmes difficult and of low priority. As Schneider pointed out: *'The formulation of AIDS policy has been described as highly political in industrialised societies, but once decided, implementation appears to be a largely administrative affair. In contrast, initial policy making and mobilisation of resources in South Africa were relatively straight forward. The real politics has been in the implementation.'* (Schneider 1998a: 9).

5.2.6 Family planning and maternal and child health in South Africa

Birth rates in South Africa started to fall in 1960 and then fell steadily until the present time in all population groups (Kaufman 1997). In 1995-98, total fertility in South Africa was nearly three children per woman (Medical Research Council 1999); as elsewhere, women in rural areas and with lower education had higher fertility than urban, better educated women. Furthermore, provincial differences showed higher rates in the formerly black provinces, Eastern Cape, KwaZulu/Natal, Mpumalanga and the Northern Province. Among rural, African women with no education, fertility was 4.5 children per woman compared to just under two for white women. Low fertility was achieved through widespread use of FP: overall, 49 per cent of women were using a modern method in 1998, the most popular being injectable hormonal contraceptive (Medical Research Council 1999). Again, there were wide differences in contraceptive use by education and ethnic background. Black women were much more likely to use injectables than white or Asian women, a legacy of the apartheid population programme.

Between 1993-98, 94 per cent of women who were pregnant reported receiving ante-natal care, about a third of which was from a doctor with the rest provided by a nurse or midwife (Medical Research Council 1999). A slightly smaller proportion, 84 per cent, received assistance at delivery, again, just over a third from a doctor (Medical Research Council 1999). For both ante-natal and delivery care,

there were wide differentials: those living in Gauteng or the Western Cape provinces, with higher education or who were white or Asian, were more likely to receive care from doctors. Inequities in maternal health services meant that maternal mortality remained high in 1998, at 150 deaths per 100,000 live births (Medical Research Council 1999).

The population policy of the apartheid years was explicitly racist, designed to control growth in non-white populations and keep races residentially separate (Kaufman 1997; interviews with reproductive health researcher and NGO official). In 1974, a national FP programme was established, including free services to all through Department of Health (DOH) and local authority health services. From the early 1980s, population policy was driven by the desire to reduce fertility to promote economic development. Dedicated FP clinics were established throughout the country offering all modern contraceptive methods. These services were targeted mostly at blacks, however, since whites and Asians tended to use private sector services instead. Since 1990, FP services had been integrated with PHC activities (Chimere-Dan 1993). In 1994, the ANC started a consultative process of developing a population policy, focusing on the contribution of population dynamics to improved living standards and equity and touching on urbanisation, housing and social development (Department of Welfare and Population Development 1998; interview with reproductive health researcher). FP, meanwhile, became the prerogative of the DOH, under their new Maternal, Child and Women's Health (MCWH) programme (interview with DOH official).

Prior to 1994, maternal and child health services were provided separately from FP through PHC facilities, again segregated along racially divided lines. Black populations were served by basic clinics, run from traditional district hospital administrations. White and Asian populations, meanwhile, generally relied on private physicians for care. Public sector PHC was run by separate administrations depending on its location: in the former homelands, semi-autonomous authorities directed activities through a hospital-based system; in urban areas, metropolitan local authorities were responsible for health care for black township populations.

5.3 Strategic policy development at national level

Having set the scene in terms of the political and economic context, the role of external donors and prior developments in HIV/STD and MCH/FP, this section discusses the process of policy formulation in the new DOH. It starts with a general discussion of the transformation of the health system post-1994, and the expansion of PHC, and then moves to the specific issue of developing HIV/STD and MCH/FP services within this broader system.

5.3.1 Health sector developments post-1994

When the ANC came to power, it was determined to address some of the pre-existing inequities in health care provision and at the time of field work this remained the principal priority of the Minister of Health (interviews with HIV/STD researcher and donor official). Under the apartheid regime, at eight per cent of GDP, spending on health care was high, relative to other middle income countries, but in reality benefited mainly the white population (The Economist 1998). This expenditure focused on expensive, prestigious and high technology interventions for which the medical establishment was widely renowned: 60 per cent of total resources in the health sector were spent in private care, serving only 23 per cent of the population; 44 per cent of spending went on academic tertiary hospitals (McIntyre *et al.* 1995). Meanwhile, the black population had lower access to health care and poorer public health facilities such as water. In 1994, only a fifth of the black population had piped water in their homes and malnutrition was rife among children. These failures were reflected in mortality statistics showing that life expectancy among whites was 73 years in 1991 compared to 60 years among blacks (Central Statistics Service 1997).

In 1994, soon after gaining power, the ANC instituted a process under which the entire health system would be reviewed with the intention of radical restructuring at national, provincial and local levels in order to provide comprehensive, equitable health services to all. Under the RDP, a number of health-related Presidential Lead Projects were announced, highlighting the priority accorded to health by the ANC (Gilson *et al.* 1999). In general, policies were formulated through highly consultative processes, which have been described variously as '*anarchic*' and '*proactive*' (interviews with HIV/STD researcher and donor official). Comments on draft policies were often solicited from stakeholders throughout the country, including: provincial and local governments; NGOs; community representatives; and academic institutions. For example, the population policy consultation process spearheaded by Barbara Klugman, Director of the Women's Health Project of the Department of Community Health at the University of the Witwatersrand, was widely commended for its inclusion of all actors and interests (Department of Welfare and Population Development 1998).

The agenda for health reform was set early in two key documents: the *Reconstruction and Development Programme* (African National Congress 1994a) and the *National Health Plan for South Africa* (African National Congress 1994b). These documents contained plans to reunite the fragmented national, local government and former homeland administrations. While the dismantling of the apartheid health system started well before the 1994 elections, the new Government of National Unity significantly shifted focus away from attempts to address racial inequity in provision of hospital services and towards a principal goal of providing PHC as a basic human right to all South Africans. In order to achieve this, the ANC initiated a radical review of health services covering themes of a

unitary health service, hospital-based curative care, PHC, human resources development, financing of health care and public participation in health (Schneider & Gilson 1998). Early policy documents also focused mainly on developing PHC and district systems (Department of Health 1995a; Department of Health 1995b).

The first and most significant restructuring took place with the creation of a single national DOH, replacing a disparate range of national, provincial, and homeland authorities formerly responsible for organising and providing health services for different sectors of the population. The functions of the new DOH were defined as: to provide leadership in policy development, including national norms and standards; to build capacity of provinces to ensure effective implementation; to ensure equity in allocation of resources to provinces; to manage national resources for health strategically; to provide health services which could not be delivered cost-effectively at subnational levels; and to legislate appropriately to provide mandates for policies (Department of Health 1994; interview with DOH official).

The DOH was led by the first Minister of Health, Nkosazana Zuma, a senior and popular politician[33] with a recognised history of participating in the development of health services, particularly for poorer sectors of society. During her period in office, she cut government expenditure on high technology care and committed the DOH to providing free health care to pregnant women and children under six. She weathered a number of political storms, many related to HIV/AIDS, but nevertheless remained popular both with the people and with senior members of the government. However, within the DOH and among other health professionals, there was less consensus on her achievements, largely due to her politicisation of key issues which would otherwise have been seen as technical problems to be solved within the Department. Again, some of these controversial debates occurred around the government's response to the HIV/AIDS epidemic (interviews with HIVSTD researchers). Others related more broadly to her shifting of power away from the traditional medical establishment and towards PHC and health system managers.

At the same time, similar restructuring took place in the nine newly formed provinces of the country with the establishment of provincial health departments with principal responsibility for ensuring effective implementation of national policy. Evidence emerged early on of difficulties in relationships between provinces and national administrations in terms of tensions over leadership and responsibility for various functions (Health Systems Trust 1995; interviews with DOH and provincial officials). In addition, the provinces faced enormously complex political and administrative hurdles in unifying their bureaucratic structures and incorporating staff from widely varying administrative

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[33] She was promoted to Minister of Foreign Affairs after the 1999 election.

backgrounds. South African managers had generally been oriented towards inefficient bureaucratic functions rather than effective mechanisms for service delivery. The problems inherent to transforming them from managers of inequitable health care programmes to promoters of comprehensive PHC systems were probably underestimated (Human & Strachan 1996; interview with human resources consultant).

In April 1997, the White Paper on the Transformation of the Health System was adopted (Department of Health 1997a). Under it, the proposed National Health Bill gave a clear mandate for health system restructuring and further development of district health systems. More attention was also paid to the problems provincial health departments had in implementing programmes due to issues beyond their control in other provincial departments (such as Finance, Works etc.). In addition, to address provincial demands for autonomy, changes in the way the provincial budgets were allocated took place in which provinces were to receive a block grant determined according to population size (Gilson *et al.* 1999). Under the new system, where as the provincial health budget used to be under the control of the national DOH, from the beginning of fiscal year 1997/98, decisions over division of the block grant between provincial line departments became the discretion of provincial governments (interview with HIV/STD researcher). The national DOH thus retained little control over either equity in health expenditure or allocations to particular health activities within the provincial health budget (interview with DOH official).

Despite problems at provincial level, the core of the new PHC approach remained the development of more democratic, representative structures of health management at local level. One of the main functions of the provincial health departments in the early years of the new government was therefore to support and enable the development of district health systems which would become the main vehicles for delivery of comprehensive PHC services. The principals which guided this process included: overcoming fragmentation of services; ensuring local accountability for service provision; increasing efficiency; decentralising decision making; providing a comprehensive package of services; encouraging intersectoral collaboration; promoting equity; and ensuring sustainability (Health Systems Trust 1995; interview with provincial official). To achieve these goals, agreement was reached that in the long term, district health systems would be under the control of local government. In the short term, however, the provinces were approaching the issue in a variety of ways, including immediate local authority control, provincial control or autonomous district health authority control. Most provinces had completed the determination of their health district boundaries by 1997 and many district managers were appointed (Health Systems Trust 1997).

Substantial efforts also went into establishing district management structures, including reorganising and upgrading facilities into a PHC system in which each local area would be served by a health

centre with peripheral clinics, mobile clinics and health points (interview with provincial official). By June 1996, R190 million (US$38 million) of the RDP budget had been used to upgrade and build health centres and clinics (Health Systems Trust 1996). In addition, each district was to have one non-specialist community hospital to which health centres could refer. However, various policy issues hampered the development of functional district PHC systems. These included: disputes over governance of the district system; the relationship between the state and local authorities; the form of representation of local communities; the disparity of salaries and conditions of service between large metropolitan local authorities and provincial administrations; and the relationship between districts and community hospitals (interviews with DOH officials).

In sum, between 1994-98, the health sector underwent radical restructuring at national, provincial and local levels. The over-riding goal, however, was to deliver comprehensive, integrated and equitable PHC. From the perspective of integrating HIV/STD or MCH/FP services, this provided a very different context from that elsewhere in sub-Saharan Africa. How the DOH addressed this issue is discussed in the next section.

5.3.2 Structure and function of the national Department of Health

In the period 1994-98, there were many changes in the structure of the national DOH, including frequent staff shifts and long term vacancies in critical positions. In 1998, at the time of field work, the position of Director General of the DOH was vacant, as a result of a clash between the former Director General and the Minister over an educational play about AIDS (see section 5.3.3). Under the Director General were two Deputy Directors General, one responsible for policy and planning and the other for regulation, services and programmes. It was under this latter Deputy Director General that responsibility for the majority of PHC activities lay. The Chief Director National Health Programmes, controlled six national health programmes: MCWH; Nutrition; Mental Health; HIV/AIDS and STDs; Chronic Diseases and Disability; and Communicable Diseases. The focus of this research was primarily on the MCWH Directorate, headed by Eddy Mhlanga, and the HIV/AIDS and STDs Directorate, headed by Rose Smart (although she resigned during the field work period).

The principal roles of national programmes were monitoring, surveillance, support and advocacy (interview with DOH official). Some of these programmes were also represented at provincial health departments although, in 1998, the specific functions of these provincial positions had yet to be fully developed or legislated (interview with DOH official). Furthermore, as of financial year 1997/98, the DOH no longer maintained budgetary control over provincial health departments since the provincial financial allocation to health then began to come through the provincial Treasury rather than direct from the national DOH. As such, there were frequent ambiguities in the extent to which the national

level actors could get involved in intricate planning of activities at provincial level (interviews with DOH officials). While they could determine norms and standards, they had few mechanisms with which to compel provinces to implement specific activities, other than enacting new legislation – a lengthy and complex procedure. The independence of the provinces within a quasi-federal system was strongly defended by the new constitution and was protected fiercely by the provinces themselves when necessary (interviews with provincial officials).

This anomaly was not specific to health but afflicted all line departments in the country. In 1998, it was becoming an area of major domestic political conflict as public services failed to deliver on promises (interviews with HIV/STD researcher and DOH official). Responsibility for this failure had not been resolved and was batted back and forth from province to national levels (Van Zyl 1998). Communication between different programmes at different levels also affected the extent to which particular staff were able to act independently within specific health programmes (interviews with DOH officials). As shown below and in Chapter 6, it led to significant gaps between intended policy and actual service delivery.

5.3.3 Activities of the National AIDS Programme

In 1992, the National AIDS Co-ordinating Committee of South Africa (NACOSA) was established as a joint initiative of the ANC and the then Department of National Health and Population Development in order to develop a national AIDS strategy. In 1994, after consultation with a wide range of stakeholders, a new National AIDS Plan was endorsed by the new Minister of Health and was accorded the status of Presidential Lead Project within the RDP, in recognition of the seriousness of the epidemic for South African development (Schneider & Stein 1997; interview with HIV/STD researcher).

The vertical health programme was established in January 1995 with the assistance of R50 million (US$10 million) in foreign funding (interviews with HIV/STD researcher and donor official). It included the national Directorate, nine provincial offices and local health structures, as well as 15 AIDS Training, Information and Counselling Centres (ATICC) of the local authorities and affiliated NGOs. The role of the National Directorate was to:

'provide the leadership, direction, guidance, technical assistance and support and, where possible, the resources necessary for the other partners to fulfil their roles, in the process developing principles, policies, norms and standards and strategies which are technically and ethically sound; facilitating communication; and supporting implementation. In addition, the National Directorate will facilitate co-ordination of activities and decision-making to promote

information exchange, build alliances and co-operation in order that projects and programmes are complementary, collaborative and reinforce one another' (Extract from Strategic Plan 1996/97-2000/1, as quoted in Department of Health 1998b: 2)

After its establishment, the HIV/AIDS and STD programme was driven by a set of guiding principles and three goals:

1. to reduce STD and HIV transmission;
2. to reduce the impact of the disease at personal, family and community levels; and
3. to mobilise national, provincial, international and local resources.

Like other national programmes, staff at the Directorate HIV/AIDS and STDs had a difficult job working with the provinces to develop appropriate capacity and structures for implementation of the programme. STD activities within the programme were co-ordinated through a series of meetings between national and provincial managers (interview with DOH official). These included: the STD core group (every six to eight months); the barrier methods group (quarterly); the workplace forum on HIV/AIDS (two weekly); a communications forum (quarterly); and national AIDS meetings (every six months). There was considerable overlap in membership of these meetings and many other *ad hoc* formal and informal interactions between managers took place.

In general, the STD programme was seen as a relatively successful component of the National HIV/AIDS and STD Plan (interviews with HIV/STD researchers). The Directorate established an STD core committee, chaired by Professor Ron Ballard of the South African Institute for Medical Research (SAIMR), which aimed to ensure that everyone with an STD had access to good quality care. Syndromic management guidelines were developed and disseminated in 1995 (Department of Health 1997b). However, despite concerted efforts to train a large number of providers in syndromic management of STDs and to distribute protocols to most government facilities around the country, the STD core committee was felt to *'lack teeth'* (interview with HIV/STD researcher). The committee's inability to communicate priorities to national and provincial managers had led to bureaucratic complacency towards expanding STD activities to include: syphilis testing in clinics; routine screening of FP clients; and assistance with partner tracing and notification. Without these activities, it was difficult to foresee any great reductions in STD prevalence in the population.

In 1996/97, a high profile review was conducted by the Medical Research Council of the HIV/AIDS and STD policies and programmes (Department of Health 1997c). It found that commitment within the MOH was high and that there were a large number of NGOs and community-based organisations (CBO) involved in the fight to reduce transmission and improve the lives of people with HIV/AIDS.

In addition, STD management at clinics was found to be generally good. On the other hand, the review also found that there was '*no visible commitment outside the Ministry/Minster of Health at either national or provincial level*' (Department of Health 1997c: 12) and that HIV/AIDS and STD services were poorly integrated with other activities both within and outside the Department. In particular, the activities of the HIV/AIDS and STD programme had been severely disrupted by on-going restructuring of provincial and local administrations, a view confirmed in many interviews. The review recommended that there should be increased attention to these issues at all levels, from the Deputy President's office to local district administrations, including line departments other than health. It also recommended increased collaboration between the HIV/AIDS and STD and TB programmes.

After the review, particular attention was paid to how to mobilise greater political commitment to AIDS issues and senior members of government came under fire in the media and among external policy actors for not contributing to the cause. Some critics did, however, acknowledge that, in the context of South Africa's massive transformation since 1994, it was hardly surprising that the programme received rather less attention than might be desired from senior political figures (interview with HIV/STD researcher). Even in the Directorate HIV/AIDS and STDs, the emphasis was on policy formulation and administrative restructuring at the expense of programme implementation (Department of Health 1997c; Schneider 1998b). Staff in the DOH had to learn a wide spectrum of new bureaucratic procedures which hindered speedy delivery on plan objectives. Communication within departments was weak, let alone between the enormous number of stakeholders and actors needed for an effective HIV/AIDS and STD programme.

With the epidemic growing ever faster, however, there were signs of renewed energy for generating a concerted effort to deal with the problems which would inevitably afflict the country as a result of failure to control its spread. For example, in 1998, in response to a report by the Gauteng provincial AIDS co-ordinator, the provincial government allocated R47 million (US$9.4 million) to the provincial AIDS programme, a sum which was nearly as large as the national allocation (HIV Management Services (Pty) Ltd. 1998; interview with HIV/STD researcher). Unfortunately, at national level, attempts to rejuvenate the programme continued to be held back by the high profile fiascos of Sarafina and Virodene[34] which curtailed opportunities for fast tracking AIDS activities

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[34] Sarafina II was the second of two plays written to spread information and awareness about HIV/AIDS. With R14 million (US$2.8 million) provided by the EU, it became mired in controversy around the large sum of money paid to the author, given cheaper proposals from elsewhere, and the lack of accountability within the HIV/AIDS and STD Directorate for its effectiveness. A number of high ranking officials resigned or lost their jobs during the fiasco and the Directorate suffered a significant loss of public image. The then President Mandela himself became involved (Interview with Brian Williams May 1998). Virodene was a different scandal in which a group of medical researchers attempted to get ethical permission to proceed with trials of a

through bureaucratic procedures: '*neither politicians nor public leaders want to become associated with a "losing team".*' (Department of Health 1997c, Volume 2: 3; interviews with HIV/STD researcher and donor official).

Table 5.2 National HIV/AIDS and STD goals, programmes and budgets

Goal	Programmes	Budget
To prevent HIV and STD transmission	• life skills programmes targeted at youth • mass and targeted communication strategies • STD management • barrier methods (including procurement) • targeted interventions (CSWs, truckers, initiation, prisoners)	R1,600,000 R12,065,000 R2,052,000 R22,092,000 R185,000 **R37,994,000**
To mobilise and unify national, provincial, international and local resources	• mass mobilisation and partnerships • expanded response • public relations and advocacy • involvement of people with AIDS • NGO/CBO partnerships	R605,000 R390,000 R20,000 R115,000 R3,330,000 **R4,460,000**
To reduce the personal and social impact of HIV infection	• Care, counselling and support • Integration of HIV and TB • Reduction of maternal to child transmission • Gender and HIV/AIDS • HIV/AIDS and development • Legal and human rights	R1,078,000 R390,000 R70,000 R200,000 R120,000 R100,000 **R1,958,000**
Programme support	• Capacity building • Surveillance and research • Co-ordination of the National AIDS Programme • Personnel and administration	R40,000 R1,593,000 R150,000 R4,458,000 **R6,241,000**
	TOTAL	**R50,653,000**

Source: Department of Health 1998b.

In response to some of these criticisms, the HIV/AIDS and STD programme developed a new operational plan for 1998/99 in which a wide range of medium term objectives were developed for implementation by the HIV/AIDS and STD Directorate (Table 5.2). The emphasis of these goals and programmes was on support for implementation of activities by other organisations, primarily the provincial departments of health, NGOs and other private sector organisations. However, as stated clearly in the introductory comments to the operational plan (Department of Health 1998b: 3), the objectives were determined according to a predicted total budget of R100 million (US$20 million) for

potential new drug for treating HIV despite little evidence from preliminary tests of any effectiveness, and instead evidence of significant toxic side effects. Politicians (in favour of any trial which might prove hopeful) clashed with the Medicines Control Council (MCC) (against it on grounds of lack of scientific evidence) and the

the year 1998/99 while the confirmed budget allocation was cut to R50,653,000 (US$10 million). At the time of the research, it had not been made clear which of the planned activities were to be retrenched in order to meet this reduction in funds, since a range of new activities were planned in line with the increased allocation. In addition, at the time of publication of strategic and operational plans, the programme remained unsure about international assistance from USAID and DFID, partly due to international negotiations over a planned drugs bill.

In mid 1998, also in response to the National AIDS Review recommendations, an inter-ministerial AIDS committee was established under the then Deputy President, Thabo Mbeki[35]. It was given a budget of approximately R50 million (US$10 million), almost exactly the sum which was cut from the allocation to the DOH HIV/AIDS and STD programme above. However, the individual responsible for this programme was physically located at the DOH within the existing Directorate and, while the emphasis was on inter-sectoral collaboration, no specific role was determined by the time of this research. Shifting the programme to the office of the Deputy President was an approach long espoused by a number of stakeholders, on the assumption that it would enhance the political visibility of the programme and thereby increase its potential effectiveness. However, little real thought seems to have been given to how it would function as a co-ordinating and supporting body once outside the DOH (interview with HIV/STD researcher). Although the involvement of other actors was desirable, most planned activities remained within the remit of provincial Departments of Health while the office of the Deputy President had no constitutional authority over activities in line departments at either national or provincial levels. In addition, the development of a parallel implementation plan for this officer undermined unity in government and contributed to further insecurity in the DOH, already heightened as a result of intense media scrutiny and criticism (Schneider 1998b).

5.3.4 Activities of the Directorate Maternal Child and Women's Health

The Directorate MCWH took primary responsibility for the bulk of the free health care programmes provided in South Africa. The Directorate was run by a public health physician turned administrator who was responsible for developing a programme according to the terms of reference of the MCWH committee. The programme was established in 1994, despite government reservations about creating a vertical programme with objectives which were so central to any integrated PHC programme (interview with reproductive health researcher). The Directorate had a mandate to develop standards and guidelines to ensure that health services became more equitable, cost-effective and responsive to

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Chair of the MCC resigned under political pressure to give the go-ahead to trials. The drug in fact never did enter trial phase.

[35] This remained in the office of the new Vice President, Jacob Zuma, after the 1999 elections.

the most needy sectors of the population (Department of Health 1995c; Table 5.3). They also undertook to consult widely with developing operational plans for implementation at provincial level (interview with DOH official).

Table 5.3 Goals for Maternal Child and Women's Health

Sector of population	Goals
Mothers	• To ensure access to high quality ante-natal care, and quality care during and after delivery to mothers and their babies. • To implement a population-based system of service delivery of mothers and their babies which strives to achieve agreed objectives.
Children	• To enable each child to reach his/her maximum potential within the resources available, and to enable as many children as possible to reach adulthood with their potential uncompromised by illness, disability, environmental hazard or unhealthy lifestyle.
Adolescents	• To ensure access to relevant and appropriate information, community support and health services, which enable adolescents to cope with the rapid physical and psychological changes that occur during this period, and which exposes them to the dangers of aberrant psycho-social behaviour and disorders.
Women	• To achieve optimal reproductive and sexual health (mental, physical and social) for all women and men across the life-span of individuals. • To raise the status of women, their safety, health and quality of life.

Source: Department of Health 1995c.

Since, in the RDP, most of the priorities of the MCWH Directorate were clearly laid out as part of the overall health goals of the government, the Directorate was in effect responsible for providing leadership for most of the core aspects of the government's PHC approach: 'The people-centred approach of the RDP resonates perfectly with the philosophical underpinnings of Alma Ata.' (Department of Health 1995c: vii). However, with their strong links to the RDP agenda, they also appeared to incorporate many of the priorities of other programmes within the PHC division, including 'effective measures against HIV/AIDS and sexually transmitted diseases' (Department of Health 1995c: vii). Within the Directorate MCWH, improving reproductive health was explicitly seen as a priority, including violence and abuse against women and adolescent health issues (Department of Health 1995c). This commitment became most visible with the passing of the Choice on Termination of Pregnancy Act in 1996, liberalising abortion in a context of women's rights to make their own decisions about their bodies (Fonn et al. 1998). In addition, at the time of research, there was a draft new contraceptive policy in the process of development, with the intention of removing any reference to population control and improving technical guidelines (interview with reproductive health researcher).

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The goals of the MCWH programme were both broad and vague, compared to those of the HIV/AIDS and STDprogramme. Accordingly, the specific aims of the MCWH programme were diffuse: there were 34 in total, ranging from '*to promote the growth and development of children*' to '*to empower and involve both women and men in the reproductive process*' (Department of Health 1995c). However, these ambitious aims were not reflected in programme indicators and targets, which related to more feasible achievements. Thus, at each stage of policy formulation, greater realism about potential for service delivery was introduced. Interestingly, the programme did commit itself to on-site testing for syphilis at ante-natal care as well as services for rapid HIV/STD screening (interview with DOH official). Other HIV/STD related activities mentioned in the MCWH programme document included treating STDs syndromically and providing prophylaxis for neonatal ocular gonorrhoea infections.

In order to achieve these goals, the Directorate outlined a conceptual framework which incorporated a complex interplay of population needs, level of service (from clinic to tertiary hospital) and level of administration (from local to national). Furthermore: '*it must be stressed that these service elements will be delivered through integrated services...a unity in location, unity in facility, unity in personnel, and unity in time of provision.*' (Department of Health 1995c: xiii). However, just two pages later, the same document gave details of how MCWH units should exist at every administrative level, right down to sub-district, with authority flowing vertically from the national office. Many assumptions were made about programme-specific capacity at these various levels which were far from realistic. In short, the rationale for this Directorate was confused: on the one hand, it wanted to accord priority to familiar MCH interventions; on the other hand, it was also caught up in the rhetoric of integrated PHC, which implied a horizontal approach to management and service delivery, with no specific priorities within an overall basic service.

5.3.5 National health programmes and integrated primary health care

There was a clear rationale for maintaining technically strong programmes at national level and there was potential for them to provide a useful role in supporting PHC systems and services at provincial and district levels. However, there were three areas in which national programmes and integrated PHC had failed to develop their complementary roles fully: (i) communication between programmes at national level was weak; (ii) programmes failed to take into account implications for them of the strong push to integrate PHC; and (iii) national programmes failed to provide adequate support to provinces.

Looking first at communication between programmes, according to the National AIDS Review and many of those interviewed, there were no clear mechanisms for interaction between the HIV/AIDS

and STDs and other Directorates on a daily working level, although a focal point for intersectoral collaboration had been established. The only specific examples of communication between the HIV/AIDS and STD and other programme given in the review were: a clash with the nutrition programme over breast feeding policy for HIV positive mothers (Department of Health 1997c, Volume 2: 5); and difficulties with co-ordinating health promotion activities with the Directorate Health Promotion and Communication. Some integrated activities were, however, established with other government departments, in particular, the life skills programme with the Department of Education and activities in prisons with the Department of Correctional Service.

Similarly, despite overlapping interests, there was little evidence from any of the interviews or operational plans of communication between the Directorate MCWH and the HIV/AIDS and STD programme. According to the Director MCWH in an interview, 'when their work involves women the two Directorates work together'. However, the means by which this was to be achieved, either at national or provincial level, was not explicitly stated and some external interviewees expressed frustration with the lack of co-ordination. It is not clear why this should have been, although potential influences included the small numbers of staff, lack of interest in HIV/STDs on the part of MCWH and lack of clear vision as to what the role of the MCWH programme should be. Given the awkward rationale for the Directorate MCWH it was not surprising that its links with other sections of the DOH were limited. Possibly, it would have been easier for the HIV/AIDS and STD programme to work with an already comprehensive PHC department than with a wide range of equally separate programmes. If this were the case, then problems for integration at national and provincial levels would be inevitable although, at district level where PHC management was destined to be more horizontal, integration would be more feasible.

This leads into the second problem, which was that a major feature of both the MCWH and HIV/AIDS and STD programmes in 1998 was that they had not been able to define their roles as vertical structures in the face of strong, high-level promotion of integrated and comprehensive PHC (interviews with DOH officials and researchers). The PHC concept was coupled with efforts to decentralise responsibility for management and decision making to new district health structures and an intensive programme of district system development. This was also taking place at a time in which provincial autonomy over both political and bureaucratic mechanisms was increasing. The over-riding priority was to improve equity in the health system through changes in financing and provision of care (Gilson 1997). The level of commitment to integrated health care derived from a deep political desire on the part of both Minister Zuma and senior bureaucrats to improve access to care among the poor (Utshudi-Lumbu 1993). It was also driven by concern to avoid the mistakes of international, donor driven, vertical programmes (interviews with DOH official and researcher). The agenda was equally strong in some provinces, especially those dominated by ANC governments, and

it overshadowed attempts to prioritise particular areas of care in real terms (interview with provincial officials). As Chapter 6 will show, the ideology of integration in the provinces led to neglect of vertical programme agendas and some provinces had failed to appoint HIV/AIDS and STD or MCWH managers until 1996 (interview with HIV/STD researcher).

In this context, the HIV/AIDS and STD and MCWH programme managers failed to adapt their tactics to a situation in which national policy makers no longer directly determined the activities of provincial managers (interview with HIV/STD researcher). Thus, where as it was possible for national health programmes to get their issues onto the agenda at a central political level, including the highest offices, this did not lead automatically to a coherent strategy for implementation. Indeed national programmes reported difficulties in persuading the provinces to implement national policies, despite quarterly meetings to pass on new directives (interview with DOH official). Direct communication was further hindered by rank differences between programme staff at national and provincial levels, which necessitated the involvement of more senior provincial officials in essentially vertical programme issues (interview with DOH official). These problems were not restricted to HIV/AIDS and STDs or MCWH but also affected such programmes as mental health (Lee et al. 1997). As one senior donor representative put it, while national policies are good examples of best practice, according to WHO guidelines, provincial management capacity for implementation remains a major problem. A DOH official also reported problems with ensuring antibiotics were available in clinics for STD management, since drug delivery was dependent on often inefficient provincial logistics systems and, even when they did arrive, they could be used for treating other ailments. Drugs donated by external donors, such as the EU, were specially labelled for STD use but provincial depots were still thought likely to distribute them for generic purposes. Another official cited the Termination of Pregnancy Act (passed in 1997) as an example of where national consensus had been reached on a controversial area but provincial implementation had varied enormously, depending on whether the relevant manager accepted termination of pregnancy.

The final, related problem was lack of support to provinces from national technical staff. This meant that, instead of providing expert advice on operationalising strategic goals at local level, managers remained occupied in Pretoria, producing a multitude of guidelines containing more detail than necessary (interviews with donor officials). Guidelines were of limited utility since they did not take into account South Africa's extremely varied provincial capacity to implement (Department of Health 1997c). Thus, provinces, such as Gauteng, which historically had stronger financial and managerial resources, continued to show better results on implementation (interview with DOH official). In interviews, provincial officials also expressed unhappiness with the volume and rapidity of policy change into which they had little input and for which they received limited support in implementation. For example, criticism arose over the failure of the AIDS programme to provide technical support to

provincial staff, especially given the national dearth of specialised personnel with the skills appropriate to lead programme development (interview with HIV/STD researcher). In response, various actors were pushing for the establishment of centres of excellence in STD and HIV care at national and possibly provincial level to co-ordinate service developments (interview with DOH official). However, this ran counter to government commitment to integrated PHC rather than vertical approaches.

5.4 Role of external actors in HIV/AIDS and STD and MCWH programmes

5.4.1 International donors

The South African health sector was the recipient of financial assistance from a number of external funding sources. In the early 1990s, in preparation for the new government, the DOH sent health attachés to Geneva and Brussels to make links with international health policy bodies including WHO and the EU (Schneider & Gilson 1998). In the post-1994 period, the health sector attracted considerable funds under transition support, as an area through which donors could promote equity. Between 1994-99, a total of US$250 million in external support was pledged to the South African health sector, although this comprised a mere one per cent of the total health budget. In general, problems of donor co-ordination and interference in formal policy processes were far less acute in South Africa than in other sub-Saharan African countries. Accordingly, the influence of external assistance on the policy process was felt less at a strategy stage and more at implementation stages, especially in provinces, where knowledge about donor project management and reporting mechanisms was low. The main problem was in disbursement of funds, with donors keen to spend more than the DOH was able or willing to absorb (Schneider & Gilson 1998; interviews with donor officials). Donors, nevertheless, claimed that their funding requirements were less rigorous in South Africa than elsewhere, reflecting their desire to fund South African activities and their relative novelty in the country's health sector (Schneider & Gilson 1998; interviews with donor officials).

The principal donors were the EU, US and UK, all working within government policy frameworks, although funds went mostly to provincial offices or NGOs (interview with donor official). In health, the EU provided funds for AIDS programmes, health system development and hospital management, through non-project assistance to purchase non-government services (interview with HIV/STD researcher). The US focus was mostly on the Eastern Cape where USAID funded the Equity Project to develop PHC systems (Schneider & Gilson 1998; interview with donor official). Increasingly, US funds were being channelled towards HIV/AIDS and establishing offices in South Africa for large international reproductive health NGOs, such as the Population Council or Family Health International (interview with HIV/STD researcher). These efforts were, however, hampered by

political tensions arising over South Africa new drugs bill[36] (interview with donor official). The UK, meanwhile, established around 150 projects through its DFID office in Pretoria. These targeted three provinces: Northern Province, Northern Cape and Northwest. They increasingly focused on reproductive health, funding most NGOs involved in this area, and public sector management capacity development in the provincial departments of health (interview with donor official).

The HIV/AIDS and STD programme received substantial aid from external sources which largely funded vertical activities outside PHC (interview with DOH official). For example: AIDS received the largest slice of EU aid in a 1994 contract with the DOH; USAID provided US$10 million in 1998 for technical assistance and programme development; DFID provided technical assistance; and the Belgian government helped to establish an STD reference centre (Schneider & Gilson 1998; interviews with HIV/STD researchers and donor officials). UNAIDS had also recently established a new team in South Africa, also responsible for STDs. In total, 60 per cent of funds going towards HIV/STD control were from external sources, although, despite this, policy remained largely locally developed (Schneider & Gilson 1998).

Although MCWH had no vertical programme funds, as found for HIV/AIDS and STDs, the interference of outside agencies showed in the emphasis on specific agendas, despite a commitment in the RDP that the government's goals were one and the same as those of Alma Ata. For example, UNICEF had been influential in the original establishment and strategy of the MCWH Directorate (interview with reproductive health researcher) and UNFPA was important in promoting reproductive health issues in South Africa and the DOH, including co-ordinating and funding NGO activities (Schneider & Gilson 1998). Some donors focused their attention on implementation of reproductive health programmes through provincial and NGO services. For example, DFID funded provincial activities in the Northern Province, Northern Cape and Northwest Provinces, using the Women's Health Project of the University of the Witwatersrand as its executing agency (interview with donor official).

Other donors funding reproductive health included major international charitable foundations, such as the Ford Foundation, the Wellcome Trust and the Henry J. Kaiser Foundation, as well as some smaller bilateral agencies. The WHO and other UN agencies, including the World Bank, played a relatively minor role in the South African health sector generally and were not involved in reproductive health or HIV/AIDS activities. The exception was UNFPA, which funded DOH reproductive health services

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[36] The South African government was trying to pass a bill which would allow the DOH to purchase generic drugs at internationally competitive prices. To counter this move, the pharmaceutical industry lobbied the US government to prevent the bill, which interfered with bilateral aid and trade negotiations (various *Healthlink* email reports 1999).

and supported other population activities such as the new population policy and the 1996 census (Schneider & Gilson 1998).

5.4.2 Non-governmental organisations[37]

NGOs received wide recognition and applause as major participants in the development of HIV/STD activities in South Africa. The origins of many components of the current programmes lay in activities by NGOs in the pre-1994 era, in particular the National AIDS Plan and strategies of the Directorate HIV/AIDS and STDs at the DOH. NGOs had: *'provided education and prevention, community care and support, high profile advocacy and lobbying, and have helped to inject a vision of non-discrimination, human rights and community participation into the national planning process. There are also numerous community-based organisations, workplace structures and churches with an expressed interest in AIDS.'* (Schneider & Stein 1997). Large numbers of NGO stakeholders remained in a variety of HIV/STD related activities (Department of Health 1997d).

NACOSA was originally established in 1992 as a collaboration between the ANC and the then Department of National Health and Population Development to draft the National AIDS Plan, develop a vertical programme through the regions and local structures, and establish a national AIDS council. It had a broad membership, including business sector, trades unions, religious organisations, health workers, the government and NGOs. Its mission remained to facilitate the implementation of the National AIDS Plan through inter-sectoral collaboration and empowering and mobilising society, including people with AIDS (Department of Health 1997d; interview with HIV/STD researcher).

The AIDS Consortium was also established in 1992 at the Centre for Applied Legal Studies of the University of the Witwatersrand with the initial objective of raising awareness, advocacy and working towards non-discrimination for people with AIDS. Since then it had continued to emphasise the human rights aspects of its activities and also provided a useful information source for media and NGOs on HIV/AIDS issues. It did, however, have problems in communicating with community based organisations, especially in rural areas and under-resourced provinces (Department of Health 1997c).

Other NGOs included the National Association of People with AIDS and a range of trades unions and business organisations. Despite their potentially large role, trades unions had largely ignored the HIV/STD epidemics although, in the early 1990s, there were a number of policy statements from

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[37] NGOs are defined here as those organisations based outside government but with an interest in and influence over policy. They therefore included service providers (both for- and not-for-profit), advocacy groups, academics, media, trades unions, business organisations and community-based organisations.

COSATU and the National Union of Miners. Similarly, the business community had not co-ordinated efforts to make workplace AIDS policies or institute non-discriminatory practices (interview with HIV/STD researcher). Some of the larger companies did have a code of conduct and the South African Chamber of Business had developed a sample code. Insurance companies had also been involved in providing advice to their corporate clients on AIDS and the workforce.

Various academic institutes were involved in HIV/AIDS or STD work, including the SAIMR, the MRC, the Universities of Natal, Cape Town and Witwatersrand and a host of other smaller units. Their activities ranged from microbiological trials to operations research of new clinical approaches. The Centre for Health Policy, based in the Department of Community Health at the University of the Witwatersrand, had conducted a number of operations research studies into the activities of private providers of STD services. Staff here were also active on various HIV/AIDS or STD committees, including the National AIDS Review, and had undertaken several influential analyses of the AIDS policy process (see Schneider and Stein 1997, Schneider 1998a and Schneider 1998b). The SAIMR had been instrumental in designing and disseminating the syndromic management guidelines throughout the country. Staff were well respected internationally and contributed actively to strategic and technical guidance for the HIV/AIDS and STD Directorate. The MRC and the University of Natal were joint holders of a Wellcome Trust-funded programme of research into HIV/STD and other reproductive health issues. Based in Durban and at a rural field site in KwaZulu/Natal, they were undertaking substantial research into service quality, effectiveness and impact as well a population-based epidemiological and demographic surveillance.

In the period 1994-98, there were a number of difficulties in developing the role of AIDS NGOs, especially since many of the key people driving their activities had taken up positions in the new government (interview with HIV/STD researcher). Relations between NGOs and government departments became increasingly strained as government actors felt the sting of external criticism of their programmes while NGOs remained dependent on government funding for their survival (Schneider & Stein 1997). Other external actors criticised the government's emphasis on integration which was hindering the establishment of specialist technical centres of excellence which could contribute to policy development. Meanwhile, as the government played a more active role in service delivery for the population, the major NGOs, in particular NACOSA, had to reassess their role and focus more carefully on complementing rather than replacing government services. Unfortunately, areas where government services were weakest also tended to be those of low NGO activity (interview with HIV/STD researcher).

While NGOs focused more on advocacy activities than providing clinical services, private general practitioners were seeing an estimated five million STD cases each year in South Africa. However,

an assessment of quality of these services found low compliance with government standards and syndromic management protocols were rarely followed by doctors (Dartnall *et al.* 1997). As a result, the treatment being provided was often ineffective. By contrast, at workplace clinics, rather few STD services were being provided, indicating a major opportunity for expanding STD treatment (interview with DOH official). In addition, where nurses were allowed to prescribe at workplace clinics, they were more likely than general practitioners to be following syndromic management guidelines. While these services could have provided the key to reducing the extremely high burden of STDs in South Africa, little had been done to communicate with private doctors over guidelines, drugs or quality of care. In addition, little attention was being paid to STD risk assessment or management during private ante-natal or FP consultations (interview with HIV/STD researcher).

A quite different network of NGOs was involved in MCWH and reproductive health advocacy and services from those in HIV/STDs. These NGOs were concerned far more with women's health and rights issues than with the HIV epidemic gripping the country and had different sources of funds. In addition to those listed below, there were many small, local NGOs involved in community based projects to improve women's status and access to services.

One of the main national NGOs in this women's health network was the Planned Parenthood Association of South Africa (PPASA), the organisation which had replaced the Family Planning Association of South Africa which had delivered services to poor black communities under the apartheid government's population policy. PPASA focused primarily on adolescent health services and ran several reproductive health clinics in the Northern Province, with DFID funding. In addition they were recruiting teachers and peer educators for condom promotion among the youth and were involved in advocacy for women's reproductive health, including supporting the Choice in Termination of Pregnancy Bill and participating in development of the new contraceptive policy (interview with NGO official).

Reproductive health initiatives were taking place within a range academic institutions, including the MRC and the Universities of Natal, Cape Town and the Witwatersrand, of which two deserve special mention. The Women's Health Project, based in the Department of Community Health at the University of the Witwatersrand, was more directly involved in advocacy as well as operational research. Nominally part of the university, it split to become a self-supporting NGO in order to have the freedom to pursue a non-academic agenda. It had strong links with the international reproductive health community, including participating actively in the ICPD and ICPD+5 processes and directing consultations for the development of the new population policy. Staff were also monitoring the South African government's adherence to such international agreements as the Beijing Fourth International Conference on Women Platform of Action and the CEDAW. Within the country, they were actively

involved in the Northern Province with a project to assist the provincial government with implementing integrated reproductive health services (interviews with reproductive health researchers).

The Reproductive Health Research Unit (RHRU), based at Chris Hani Baragwanath Hospital in Soweto, was the principal research organisation dedicated to epidemiological and operational research into new methods of contraception, termination of pregnancy and STD control. With 16 projects in the field in 1998, their contribution to developments in policy formulation and implementation was strong, including ensuring that the new contraceptive policy took the HIV/STD context into account. Nevertheless, it was committed to input on specific issues, such as development of vaginal microbicides or use of female condoms, rather than general women's health and rights advocacy *per se* (interview with reproductive health researcher). In 1998, the director of the RHRU was appointed chair of the MCC after her predecessor's resignation in the wake of the Virodene controversy.

In general, reproductive health NGOs were therefore concerned with quite different aspects of reproductive health from those active in HIV/AIDS and STDs. Communication between the two networks was limited except among the more academic organisations. Women's health activists in South Africa could be proud of their efforts, which had led to a radical constitution specifically protecting the rights of women. Their agenda was not one of complex clinical interventions or rapid technological change but instead focused on issues of gender relations and how to achieve greater freedom and safety for women in South Africa. AIDS activists, meanwhile, had little to boast of and instead were facing one of the most dramatic rises in infection ever seen but few tools with which to address it. Unlike women's rights, there was little evidence of political support for their agenda – to the contrary, what political involvement in AIDS their was had often led to fiasco. These two groups therefore had little in common and were careful to distance themselves from each others' agendas.

Relations between these many different NGOs and government were affected by both the type of external organisation (and its aims) and the government department involved. Thus, although the national policy process could be characterised as generally open to external influence, the ability of different organisations to get their views heard varied considerably. A particular feature of the HIV/AIDS and STD community was that academic institutions had closer links to government circles than other types of NGO. This was largely due to the recent changes in government and the trend at the DOH towards recruiting senior technical staff from academic positions. In reproductive health, by contrast, the Directorate MCWH was less technically oriented and, similarly, external organisations focused on advocacy for policy change rather than technical advances. Health policy networks were therefore highly fluid at the time of this research, in line with the rapid political changes taking place throughout the country and participation in national decisions over standards and guidelines was

relatively wide. Far fewer of these external organisations, however, were able to engage in constructive debate over implementation at provincial level, as will be seen in Chapter 6.

5.5 Conclusion

In this chapter, agenda setting and policy formulation for integration were discussed in the South African national context, which was quite different from the rest of sub-Saharan Africa. Overall, there was much more evidence than elsewhere for a process, like that described by Leichter (1979), of issues and ideas reaching the attention of policy makers and then interacting with open political debates to attain relatively stronger or weaker positions on the policy agenda. Thus providing comprehensive and integrated PHC received attention in terms of both information on huge inequalities in health status in the population, along with international evidence that PHC was the solution, and its ideological proximity to the ANC's commitment to greater equity. The main structures and functions of the new DOH were established around achieving this goal. Reports of rapid growth in the HIV/AIDS epidemic and women's poor reproductive health, by contrast, received considerable attention among academics, NGOs and international actors but failed to garner adequate political support. Nevertheless, at the DOH, these areas were priorities through establishing national programmes responsible for strategic and technical guidance in these areas. Sitting between these priorities, the specific issue of integrating HIV/STD services with PHC was seen as a minor technical issue by politicians and senior bureaucrats and therefore received insufficient attention to make it a central component of HIV/AIDS and STD control, MCWH or PHC. Nonetheless, because integration of PHC in general was such a high priority, inclusion of HIV/STD services for women in the overall package was never a significant problem. What was far more problematic was to ensure that, within the integrated management structure, especially at provincial level, sufficient care would be taken with complex technical detail to ensure effective implementation and service delivery.

Although this process was driven by a wide range of participating actors and interests, both within and outside government, it was also heavily influenced by the specific context of political and economic transformation of the country. These issues were examined in detail in this chapter because of the scale and rapidity of transformation and its coincidence with the spread of HIV. The political and ideological background introduced complexity into both PHC and HIV/STD policy, and widespread consultation was necessary to generate consensus on new policy issues. Similarly, the constant restructuring of administrative and legislative institutions led to much uncertainty and insecurity among government officials making prioritisation and effective planning difficult.

Reflecting this atmosphere of transition, participation by external actors in health policy decision making also led to a number of flourishing networks which interacted both formally and informally.

Thus, many of those in senior positions in the new government had previously been in academic departments or NGOs and maintained close links with their former colleagues. At the time of this research, these relationships had largely been positive and there was a sense of great optimism and energy in enacting rapid, radical change to achieve greater equity in the delivery of health services. Non-government actors also maintained strong links with international agencies and thus acted as intermediaries between global health policy developments and those taking place in South Africa.

In terms of policy transfer, the evidence in this chapter suggests a largely independent process of agenda setting took place, with indigenous political debates setting the scene for interaction between national and international actors over specific technical issues. This led to much less emphasis on a policy for integration of HIV/STD services with PHC *per se* than elsewhere in sub-Saharan Africa. Instead, because PHC was better established than elsewhere, introducing HIV/STD care into these services was seen as a technical issue. However, signs of change were evident already, including the greater penetration of health policy networks by international actors, particularly in the areas of HIV/AIDS and reproductive health, through increased funding and influence over the activities of NGOs. Furthermore, there was a gradual process of realisation among government officials that the business of running the country was extremely difficult, especially given the economic and political constraints the country faced. This had already led to a slight cooling of relations between the DOH and their perceived critics in both the national and international communities.

Finally, the agenda setting process meant that when it came to formulating national standards and guidelines for health services, such priorities as AIDS or women's health had to compete for resources with expanding access to comprehensive PHC. At national level, debate over these issues was complex but sophisticated. Responsibility for implementation, however, lay at provincial level, where there were fewer signs of open and informed debate and structural reform had progressed less smoothly. As seen in Chapter 3, where policy goals and technical features are complex and required reforms are substantial, policies are known to be more difficult to implement (Cleaves 1980). To ensure that implementation proceeds according to plan, significant political, managerial, technical and financial resource inputs are needed (Grindle & Thomas 1991). In Chapter 6, experiences with implementation will be examined more closely in the Northern Province, in order to understand how the processes of agenda setting and policy formulation were (or were not) followed through into delivery of much needed services.

5.6   Summary

- At the time of this research, South Africa was undergoing a period of huge political, economic and structural change resulting from the transition from the apartheid administration to the new

democratically elected government. Nine provincial administrations had been established in a quasi-federal system but the bureaucracy remained inefficient. Economically, the country remained strong although significant problems emerged, especially a weakened currency, unemployment and rural-to-urban migration. Social inequalities between black and white populations were huge and gender inequalities were high.

- Many of these political and economic factors contributed to the rapid spread of HIV/AIDS, to 23 per cent of ante-natal clinic attenders in 1998. Little effort went into preventing this spread, largely because of competing demands on the attention of government officials. Integration of HIV/STD services with PHC had received some attention, in the context of high-level political commitment to integrating all PHC.

- However, since 1994, the health sector, along with other areas of government, had undergone significant structural transformation at national, provincial and local levels. This inhibited the formulation of standards and guidelines at national level for implementation by provincial administrations. It also led to weak co-ordination between the national HIV/AIDS and STD programme on the one hand and the MCWH programme on the other.

- Participation by external actors in national policy processes was high, including both national NGOs and international agencies. Their interests did not, however, always coincide with those of the government, leading to a complex process of consultation and negotiation. Links between the international agenda for integration and that in South Africa, however, were stronger than those with elsewhere in Africa, largely due better connections between international and national actors over technical aspects of policy.

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CHAPTER 6: IMPLEMENTING INTEGRATION IN THE NORTHERN PROVINCE, SOUTH AFRICA

6.1 Introduction

In Chapter 5, agenda setting and policy formulation processes for integrating HIV/STD and PHC services in the South African national context were discussed. The objective for the first part of this chapter is to understand the processes by which policies developed at national level were implemented in one province in the country. The health care implementation activities of the provincial health and welfare department in the Northern Province are therefore presented, in the context of socio-economic and political developments in the period 1994-98. The Northern Province was the poorest of the nine South African provinces and had perhaps some of the greatest political and bureaucratic hurdles to leap in the transformation from apartheid to democratic state. The aim was therefore to investigate how policies got implemented in this setting. In addition, the on-going restructuring of the health services and how national programmes were reflected in these new administrative systems are examined.

The second part of the chapter presents the results of field work into the delivery of integrated HIV/STD and PHC services in clinics around the province. The main objective of the field work undertaken at sub-district level was to inform the policy making process by shedding light on gaps between, on the one hand, policy intent, as shown in policy statements, operational plans and interviews, and, on the other, service delivery. To meet these aims, the research was conducted at a small number of sites using largely qualitative methodology to facilitate insight into complex logistic, managerial and attitudinal problems affecting providers and their clients. These methods did not aim to provide a fully representative description of HIV/STD activities in the province but rather to explain why political, social and financial forces interrupted implementation of policy by focusing on the processes by which policies were transmitted through the management system.

The analytical framework used in the chapter was derived from the discussions of implementation in Chapter 3. Looking at policy development processes at provincial, regional, district and sub-district levels, results cover the resources available for implementation, including political, technical, bureaucratic and financial. In addition, the process of implementation was examined in terms of whether it was top down or bottom up in orientation. The roles of different actors in this process and patterns of interaction between them were also covered. The outcome of implementation efforts were studied in terms of both clinic activities, including staff knowledge and attitudes with respect to the policy in question, and its impact on changes in patients' attitudes and behaviour. Finally, processes

of monitoring, evaluation and feedback in the province were examined to further understand how policy reforms were instituted.

6.2 Setting the scene: politics and economics in the Northern Province

In 1998, some of South Africa's most complex and intractable problems were to be found in the Northern Province. With a total population of 5.1 million in the 1996 census, it was overwhelmingly poor and 92 per cent of the population resided in rural areas. The people of the Northern Province were from a range of ethnic and linguistic backgrounds. Amongst the black population, around 57 per cent was North Sotho speaking, a further 23 per cent spoke Shangaan and 12 per cent spoke Venda (Health Systems Trust & Department of Health 1996). Approximately five per cent of the population was white and largely Afrikaans speaking, although there were also some English speaking whites amongst the rural farming communities. Demographic indicators for the Northern Province were poor: in 1996 the neonatal mortality rate was 15 per 1,000 births; and the maternal mortality rate was 53 per 100,000 births (Health Systems Trust & Department of Health 1996). Life expectancy in the province was 63 years in 1991 (Central Statistics Service 1997).

Economically, the Northern Province was South Africa's poorest and, according to the Central Statistics Service (1997), had the lowest human development index at 0.471 in 1991, compared to 0.677 nationally. Other figures shed more light on the extent of poverty: the province's people had obtained the lowest mean number of years of schooling in the country, at under five years in 1991 compared to nearly seven nationally. Forty-one per cent of the working age population was unemployed in 1995, compared to 29 per cent nationally, and the figure was even higher among women. Economic activity in the Northern Province was heavily dominated by public sector employment, although mining and agriculture were also important areas of work. The Bushveld region contained some of the world's richest reserves of platinum, chrome and vanadium as well as deposits of copper, titanium, nickel and iron ore. Agricultural produce included citrus fruit, avocados and mangoes, as well as cattle and game ranches which attracted tourists as well as providing for the farmers. However, the province had the lowest gross geographic product in the country at R2,700 per head in 1994 compared to R9,500 nationally (Central Statistics Service 1997).

Politically, the picture was complex as, under the apartheid government, the area now in the province had been administered by four separate bureaucracies, the Gazankulu and Lebowa independent homelands, the Venda self-governing state and the Transvaal provincial administration (TPA). Prior to 1994, the homelands corresponded roughly to the linguistic groups described above although there were also a number of townships near to the formerly white cities in which a mixture of ethnic groups resided. The capitals of these administrations were Giyani, Lebowakgomo, Thohoyandou and

Pietersburg respectively although the territories were not contiguous, so that the administrative capital of a homeland could be far removed from some of the services it was responsible for managing. In 1994, the ANC won 92 per cent of the vote across the province on a platform which stood against ethnic polarisation. The province was split into 48 Transitional Local Councils to which members were elected by the local population. The large number reflected the political realities which the provincial ANC government had to face in merging the many pre-existing political and administrative bodies. They did not, however, necessarily fit within boundaries of administrative districts (see Section 6.3.1 below). Since 1994, a number of ethnic tensions emerged both in parliament and within the administrations, with Venda and Shangaan speaking people raising concerns of discrimination by the majority North Sotho speakers (Ratshitanga 1998). These ethnic tensions in government were exacerbated by financial problems in the province: at the end of financial year 1997/98, the Northern Province was R777 million (US$156 million) in debt.

6.3 Bureaucratic, financial and technical transitions at the Department of Health and Welfare

6.3.1 General administrative background

Previous apartheid policies ensured that funding levels in the former homelands were well below those in formerly white areas, resulting in gross inequalities in service provision in all areas of public activity. In terms of health care, curative services predominated and the TPA had been responsible for managing 10 out of the 42 hospitals in the province as well as all the curative and preventive care in its territories. The homeland administrations of Gazankulu, Lebowa and Venda had their own services to run and local authorities provided a limited range of preventive services in urban areas (Health Systems Trust & Department of Health 1996).

Since 1994, health services in the province had been re-oriented towards reducing some of these large inequities in access to care. Principal responsibility for this process lay with a new provincial Department of Health and Welfare (DHW). The DHW was led by Dr. Nicholas Crisp, Superintendent General, a highly respected administrator who had worked previously in the province as the head of the former national DOH. The DHW had offices in seven administrative health and welfare regions, Bushbuckridge, Bushveld, Central, Lowveld, Northern, Southern and Western. The principal role of regional offices was to lead the decentralisation of responsibility down to district health and welfare offices, according to the constitutional obligation to devolve line functions (interview with human resources consultant). However, ambitious plans for service and programme developments had been hindered by the overall financial difficulties of the province.

Although, at the time of field work, district administrative structures had not been established, all decisions concerning their boundaries and personnel had been taken and appointments were being made (interview with DHW official). Once the process was complete, there were to be a total of 25 Health and Welfare Districts in the province, each with a population of 2-500,000 (Figure 6.1; Harrison 1997). These were delineated separately from the local political bodies, the Transitional Local Councils (TLC), and each health and welfare district would contain more than one TLC. Attempts were made, however, to ensure that a TLC would be completely within one health and welfare district[38]. Health services in these districts were to be managed by District Health and Welfare Management Teams (DHWMT) in co-operation with District Health Committees providing representation of political and community structures. Once the DHWMTs were in place, the regional stratum of administration would cease to exist.

The administrative restructuring of the health services was underpinned by a commitment to improve equity in access to health care, in line with the objectives of the national RDP. As such, the boundaries between health districts were determined according to rational administrative and management requirements rather than historical political or ethnic divisions (interview with DHW official). Factors such as accessibility, roads, urban centres and population density were taken into account in order to promote equity through wider distribution of services among people formerly cut off from much public service provision (Health Systems Trust & Department of Health 1996).

Since 1994, involvement by provincial parliamentarians in health care had not been significant, although there had been some attention to HIV/AIDS, including by the then Premier, Ngoako Ramathlodi (interview with DHW official). According to the National AIDS Review, in 1997, the Premier mandated that all departments should incorporate HIV/AIDS and STD prevention efforts in their programmes. In 1998, the Member of the Executive Committee for health, Dr. Hunadi Mateme, was relatively new to the job and had also expressed a commitment to increasing attention to the HIV/AIDS and TB epidemics in the province. However, by the time of field work, these commitments had led to limited practical involvement in programme activities, often only on special occasions such as World AIDS Day (Department of Health 1997).

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[38] Since the DHW had had more time to plan its district boundaries than the original political process, some changes were taking place to TLCs to fit in with rational health and welfare boundaries. In addition, the DHW was well ahead of other administrative departments in district establishment and it was expected that Education and other departments would follow their boundary examples (interview with DHW official). After field work, however, the whole process of devolution to districts stalled due to political difficulties around the 1999 elections.

Figure 6.1 Map of Northern Province Health and Welfare Districts, 1993

Phalaborwa
73 269

Levubu Shingwedzi
189 156

Giyani
265 468

Mutale
192 361

Hoedspruit Makwu
147 563

Bushbuck Ridge
505 996

Thohoyandou
124 141

Malamanburg / Letaba
336 840

Dilokong E Tubatse
231 076

Nzhelele / Tshipise
159 936

Elm
225 676

Mopketsi / Bolobedu
309 234

Noko Tau / Fetakgomo
232 655

Tubatse / Kgwerlu /
Steelpoort
152 542

Louis Trichardt
105 831

Dikgale / Soekmekaar
105 542

Mogotou /
Lepele
/ Nebo North
273 576

Bochum / Dendron
125 330

Tzaneen / Mashashane
244 790

Zebediela / Lebowakgomo
208 539

Moletjie Mankle
236 332

Koedoesrand / / Rabone / Bekenberg
253 116

Naboomspruit Potgietersrus
145 146

Ellieras
118 300

Warmbaths Nylstroom
146 112

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The new service was planned according to the *National Health Plan for South Africa* (African National Congress 1994) in which the PHC approach was given heavy emphasis, including provision of free preventive, curative and rehabilitative health care to all pregnant women and children under the age of six. In addition, at PHC clinics, all services were provided free of charge and efforts had been made to improve referral systems from these primary providers to secondary and tertiary hospital services (interview with DHW official). Although the national programmes maintained personnel at the provincial office, vertical service delivery structures had been completely dismantled with the exception of the malaria response programme, which was based at Pietersburg and served the whole province in the case of specific outbreaks. PHC services were thus comprehensive and delivered according to the supermarket or one-stop approach wherein any patient arriving at any time could receive all services required (interview with DHW official).

Table 6.1 Distribution of health facilities by region, Northern Province

Indicator	Bushbu-ckridge*	Bushveld	Central	Lowveld	North	South	West	Total
Districts	1	2	4	5	6	5	2	25
Population	408,708	117,062	576,746	916,292	623,122	887,199	321,688	4,127,999
Clinic	-	18	54	85	117	78	23	375
Mobile clinic	-	19	24	36	48	36	9	172
Health Centre	-	1	3	10	7	6	5	32
District hospital	1	2	3	5	5	4	2	22
Second hospital	1	1	0	1	1	1	1	6
Provincial hospital	0	0	1	0	0	0	0	1

* Bushbuckridge region has been disputed territory and consequently has less available data on services; hence the incomplete data for this region in this table.
Source: Northern Province Department of Health and Welfare 1998.

Health facility distribution in the Northern Province reflected the transition from the pre-existing health system under the former administrations, in which hospitals were the focus of all district activities, to a district health system, in which much upgrading and re-commissioning of facilities had taken place (Table 6.1). In some cases, the upgrading was not complete and, in many facilities, despite the buildings having been improved, new staff complements had not yet been met (interview with DHW official). Hospitals had been redeployed so that, in every district, there was one district hospital and, in every region, at least one secondary hospital. Similarly, each district was made up of a number of local service areas (or sub-districts) in which the health centre was the focal point for PHC activities, including a number of peripheral clinics under its control. Outside the DHW, the

Northern Province had few private medical providers since most people were too poor and few were covered by health insurance. There was only one private hospital, in Pietersburg.

Although facilities were relatively well distributed across the province, the quality of care remained low, largely due to the lack of basic amenities at the facilities. In 1996, according to a DHW Situation Analysis, 23 per cent of health centres and clinics lacked grid electricity and another 23 per cent lacked any telephone. Water supplies were poor, with 70 per cent having an adequate water supply, 56 per cent having adequate waste removal and only 42 per cent having hot water (Health Systems Trust & Department of Health 1996). Despite the poor infrastructure, these clinics were dealing with large caseloads and each nurse was seeing on average 32 patients per day (Health Systems Trust & Department of Health 1996). In 1996, the following services were available comprehensively at 70 per cent of health centres and clinics: ante-natal and postnatal care; FP; child immunisation and curative care; and treatment of TB and STDs. By 1998, FP and STD services were available every day at over 80 per cent of facilities (Buthelezi *et al.* 1998).

6.3.2 Politics of primary health care: integrated versus vertical services

This section will discuss the formulation and implementation HIV/STD and MCWH activities within the PHC programme in the Northern Province in response to these problems. The main focus of research was on the provincial DHW and the various divisions which had responsibility for these activities. Responsibilities for HIV/STD and MCWH activities and the extent to which there was interaction with other divisions in co-ordinating the different activities will be discussed. In addition, the extent to which the provincial office was addressing issues of how national programmes could meet their goals through the integrated PHC system were assessed, as well as the positions of the various actors on this problem.

Within PHC, both MCWH and HIV/STD services were a priority in the Northern Province. According to the Health Systems Trust in 1996, 70 per cent of facilities offered a comprehensive package of MCWH services and 80 per cent of deliveries took place in hospital (Health Systems Trust & Department of Health 1996). However, there were 15 neonatal deaths per 1000 live births and 53 maternal deaths per 100,000 live births, both unacceptably high. By 1998, 55 per cent of women in the province were using contraceptives (Medical Research Council 1999) and 12 per cent of ante-natal clinic attenders were HIV positive (Department of Health 1999).

To meet these needs, the Division Districts and PHC was established at the DHW, headed by Chief Director, Rose Mazibuko, a former academic and NGO director with strong political connections. Her main role was strategic guidance and liaison with national and provincial senior management

over policy development in PHC. Under the Chief Director was the Director Districts and PHC, then Nelly Manzini, who had more direct responsibility for the day to day running of the various programmes in the Division. The title of the Division indicated its priorities: to implement PHC services through an integrated district system. Principal responsibility for establishing the districts, however, lay with the Superintendent General (interview with DHW official).

Provincial responsibility was perceived by senior managers to be to communicate the advantages of an integrated system to both providers and clients at sub-district level (interviews with DHW officials). Particular concerns were expressed over how to encourage community participation in health service development, either through established political structures, such as the TLCs, or through better information being provided by district health management teams to clinic committees and other community representatives. One official emphasised how '*people are gradually realising their political rights and wanting to participate. They are starting to think politically and see their context in an historical perspective, not so fatalistically.*'. These issues related to the development of clinic committees, based on traditional community consultation mechanisms (such as traditional healers and leaders) and designed to respond to clients' perspectives on services received. Providing information about health and health care to these committees was reported to be a priority activity of the provincial office (interview with DHW official). In this view, nurses in clinics were being oriented towards development activities, rather than purely service delivery, and to respond more positively and conscientiously to the expressed needs of their clients.

In addition to this community orientation of PHC, there were five PHC programmes which reflected national programme priorities (see Chapter 5): MCWH; Communicable Diseases; Nutrition; Environmental Health; and PHC services (Figure 6.2). Within these programmes, responsibilities lay mainly in the areas of training, technical support and liaison between national policy makers and district health service providers. Programme staff complements were small: each programme was headed by a Deputy Director, some, but not all, of whom had an Assistant Director underneath them responsible for specific tasks. Part of the explanation for the small staff in programmes was that commitment to developing an **integrated** system of service delivery and management was extremely high, especially from senior provincial managers. This related to the national debate over what sorts of health services could best meet the requirements of the transformation process in terms of reducing inequity in service access. Vertical programmes were strongly associated with the former white administration, particularly the national health services' FP and TB programmes. Former homeland governments did not subscribe to vertical, disease-oriented programmes and the staff at the DHW were well versed in arguments against such structures (see Chapter 2 for these; interview with DHW official).

Figure 6.2 Organogram of Directorate District and PHC Services, Department of Health and Welfare, Northern Province

DIRECTORATE DISTRICT AND PHC SERVICES
PURPOSE: TO HANDLE DISTRICT AND PHC SERVICES
FUNCTIONS:
1. Control communicable diseases
2. Support the rendering of maternal, child and women's health and reproductive health
3. Promote PHC services
4. Monitor nutritional services
5. Regulate epidemiological services

1 Director/1 Secretary

SUB-DIRECTORATE
COMMUNICABLE
DISEASES SERVICES

PURPOSE: TO CONTROL
COMMUNICABLE
DISEASES

FUNCTIONS:
1. Manage and co-ordinate the rendering of communicable diseases services
2. Monitor HIV/AIDS/STD intervention
3. Provide management services to control TB

1 Dep. Dir. Comm Liaison
1 Medical Officer
1 Ass. Dir. Comm Liaison
2 Admin Clerk Grade 1

SUB-DIRECTORATE
MATERNAL, CHILD AND
WOMEN'S
HEALTH & REPRODUCTIVE
HEALTH SERVICES

PURPOSE: TO SUPPORT THE
RENDERING OF MATERNAL,
CHILD AND WOMEN'S HEALTH
AND REPRODUCTIVE HEALTH
SERVICES

FUNCTIONS:
1. Plan, organise and monitor the rendering of maternal health services
2. Provide child health and E.P.I services
3. Organise reproductive and women's health services
4. Attend to school health services

1 Dep. Dir. Health Services
3 Ass. Dir. Nursing Services
2 Admin Clerk Grade 1

SUB-DIRECTORATE
PHC SERVICES

PURPOSE: TO PROMOTE
PHC SERVICES

FUNCTIONS:
1. Improve PHC services
2. Render health promotion services
3. Provide community rehabilitation services
4. Manage and co-ordinate PHC in the districts

1 Dep. Dir. Health Services
3 Ass. Dir. Nursing Services
2 Chief Comm Liaison Officer
3 Admin Clerk Grade 1

SUB-DIRECTORATE
NUTRITION SERVICES

PURPOSE: TO MONITOR
NUTRITIONAL SERVICES

FUNCTIONS:
1. Promote nutritional services
2. Manage and co-ordinate nutritional services in the regions and districts
3. Support and give advice

1 Dep. Dir. Dietary Services
3 Ass. Dir. Dietary Services
2 Admin Clerk Grade 1
1 Data Typist Grade 1

SUB-DIRECTORATE
EPIDEMIOLOGY SERVICES

PURPOSE: TO REGULATE
EPIDEMIOLOGY SERVICES

FUNCTIONS:
1. Render epidemiological services
2. Conduct epidemiological surveys
3. Execute epidemiological services in the regions and districts
4. Co-ordinate responses to epidemics

1 Dep. Dir. Health Services
2 Ass. Dir. Comm Liaison
2 Data Typist Grade 1

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In addition to political objections to vertical structures, the dire financial straits of the DHW limited the options for supporting intensive, single-issue programmes, even in response to national priorities such as HIV/AIDS or TB. Instead, the DHW opted to address these priorities through an integrated management system in which every staff member was part of a team. Within this team, one particular person might take responsibility for ensuring that a particular sphere of activities (for example, HIV/STDs) was addressed but all members had to contribute to achieving all objectives (interview with DHW official).

The result of this slow progress towards integrated, comprehensive PHC services was, however, that the remaining vestiges of vertical programmes were completely over-stretched. The responsibilities of both the MCWH and HIV/AIDS and STD managers, as allocated by national programmes, were diverse, making co-ordination difficult even for the most experienced managers. There was a clear feeling that too much was being expected of these positions by senior provincial management and that either more staff or greater attention to developing a team approach were needed (interviews with DHW officials). Relations with national programmes continued to be cordial but cracks were beginning to show as provincial transformation concerns increasingly diverged from the rapid national policy developments[39]. There was a perception at provincial level that, given low capacity, they were not receiving the support they needed from the national programmes. On the contrary, some national activities, in particular the constant demands on provincial managers' time for attending quarterly meetings in Pretoria, as well as other policy workshops, were thought to disrupt provincial activities severely (interview with DHW official). Poor relations between national and provincial staff were exacerbated by the 1997 changes in provincial financing (see Chapter 5) such that national programmes had almost no legitimacy among provincial programme staff and limited authority to direct their activities.

In parallel to these issues around relations with national programmes, the provinces had also not sorted out exactly how their programme managers were supposed to provide vertical support for horizontal implementation, including line authority over a team of officers under them. Particular confusion stemmed from the delayed establishment of the principal implementing organs, the districts, making it difficult for vertical programmes to know who to support and how (Schneider & Stein 1997). In the absence of districts, responsibility for implementation, or lack of it, was falling on officers who had not been given sufficient staff or training to undertake full activities. In the context of administrative restructuring, this resulted in defensiveness and unwillingness to open doors to outside intervention. As one official put it, *'people are threatened by change: we need to try things*

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[39] For example, the Assistant Director HIV/AIDS and STDs resigned soon after this study citing constant pressure and criticism with no support (interview with DHW official).

out and work within the new approach. If it doesn't work, then we can stop but we haven't tried properly yet.'.

Confusion over roles and responsibilities for HIV/STD activities was also related to the different grades of the respective programme managers. Under protocol restrictions, it was difficult for a more junior Assistant Director to work closely as a team member with a more senior Deputy Director and inevitably the priorities of the latter position took precedence. For example, on paper, the Assistant Director HIV/AIDS and STDs was responsible for ensuring training in STD syndromic management and distribution of protocols at clinics (interview with DHW official). In practice, however, the Deputy Director MCWH was closely involved in training nurses in STD screening and treatment, since they had been incorporated into FP training in the provinces (in addition to special syndromic management training activities). This overlap in responsibility led to confusion over mandates and less efficient management of the training programmes.

6.3.3 Technical and financial resources for primary health care

The overall budget of the PHC Division in the 1998/99 financial year was R1,720,000 (US$344,000; Table 6.2); as a proportion of the provincial health budget, it had remained at 53 per cent since 1994 (interviews with DHW officials). It was intended to cover management activities of provincial staff, such as training and technical support for regional or district activities, rather than any service delivery activities. It included, for example, transport, workshops and per diems etc. and had shrunk over the last few years in line with overall cuts in the provincial budget. As of financial year 1997/98, all implementation functions had been incorporated into regional budgets but provincial managers continued to assist regional managers in determining what financial resources they needed to implement programme activities. For each programme, there was a business plan which included budget breakdowns and was accompanied by operational plans, giving details of activities to achieve set objectives (Department of Health and Welfare 1997).

Table 6.2 Budget allocations for Division Districts and PHC, 1998/99 financial year

Programme area	Amount allocated, Rand (US$ in parentheses)	
Administration	320,000	(64,000)
Equipment	370,000	(74,000)
Provincial personnel	200,000	(40,000)
Professional services	260,000	(52,000)
Stores	570,000	(114,000)
TOTAL	**1,720,000**	**(344,000)**

Source: Department of Health and Welfare 1997.

The Sub-Directorate MCWH was organised around the achievement of three programme goals: to provide FP, advice and improve family styles and quality of life through planned families; to organise, develop and improve the provision of genetic services; and to ensure access to quality and comprehensive maternal and child health and integrated health services (Department of Health and Welfare 1997). The total budget in the business plan was R36,238,000 (US$7,247,600), which included regional implementation, although the final allocation was not available at the time of interview[40]. Under the Deputy Director was an Assistant Director responsible for running school health programmes, including life skills, which covered HIV/STD prevention education. Responsibility for implementing these programmes in services lay at regional level so, at provincial level, the main activities were: training of trainers and nurses; contributing to national policy formulation and developing policy guidelines; disseminating information; developing abortion services; developing services for youth; expanding community based FP distribution; developing male involvement programmes; and liasing with relevant regional, district and community committees (Department of Health and Welfare 1997; interview with DHW official).

The Assistant Director HIV/AIDS and STDs was under the Deputy Director Communicable Diseases and was responsible for realising the goal of 'decreasing the prevalence of HIV/AIDS and STDs among the population of the Northern Province' (Department of Health and Welfare 1997; interview with DHW official). The objectives of the programme were: to implement life skills programmes targeted at youth; to use mass media to popularise key prevention concepts in AIDS; to provide appropriate management of patients seeking treatment for STDs; to provide appropriate care and support for people living with AIDS and their families; and to increase access to barrier methods. The budget of the provincial office itself was R2,665,000 (US$533,000); if regional level activities were also included, it totalled R8,107,000 (US$1,621,400). Again, this was the requested amount rather than the final allocation. Activities of the provincial office included: attending national policy formulation and dissemination fora; conducting workshops for dissemination to regional HIV/AIDS and STD co-ordinators; organising training of providers in new protocols and treatments; liasing with the media and other government departments for advocacy; developing community based and NGO activities; and distributing barrier methods and training personnel in their use (Department of Health and Welfare 1997).

Provincial goals were dictated by the national AIDS programme and provincial staff were aware that these priorities would have been influenced by external funders (Interview with DHW official). Indeed, special additional funds were provided to the province directly from the national AIDS programme at the DOH in Pretoria. These funds derived from donor support to the AIDS programme

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[40] None of these operational budgets include provincial or lower administrative staff salaries.

and covered a range of activities to take place outside the PHC system, such as NGO support, training of lay counsellors and community-based support to people with AIDS. However, the province had been slow to implement these special tasks, mainly because of staffing limitations (although new appointments had been budgeted for with the extra funds, posts had not been filled due to bureaucratic delays). As a result, the DHW nearly lost the additional funds by failing to spend as appropriate (interview with DHW official).

Comparing the plans of the MCWH Sub-Directorate with those of the Assistant Director HIV/AIDS and STDs sheds light on the extent to which these two sets of activities had failed to integrate at provincial level. For example, the operational plan of the MCWH Sub-Directorate referred to the provision of HIV/STD prevention and treatment programmes, although details of these activities were not given and there was no reference to collaboration with the Assistant Director HIV/AIDS and STDs in planning them. A similar problem arose within the life skills programme of the Assistant Director School Health, in which no mention was made of the HIV/AIDS and STDs programme, despite references to and a budget for STD activities (Department of Health and Welfare 1997).

Provincial programme staff were not able to provide national programmes with sufficiently accurate estimates of provincial capacity for implementation to ensure that programme guidelines were realistic and feasible. Neither were they fully qualified to undertake their provincial role as specialist technical advisors for an integrated system of implementation. Programme staff therefore had difficult jobs to reconcile the specific and ambitious goals of their respective programmes with the more generalist approach of the PHC system (interview with DHW official). Under integrated PHC, given the technical complexities of some programmes' issues, details tended to get devalued by comparison with more pressing financial and logistical problems. Lack of communication both between programmes and between programme staff and financial or other administrative staff was one key issue facing the PHC Division (interview with DHW official).

6.3.4 Bureaucratic resources for implementing national plans

In general, managerial capacity in the provincial PHC Division was low, especially at more junior staff levels, and little management training had been undertaken in the province (interview with human resources consultant). There was seldom emphasis on these qualities in the recruitment process. This problem was not unique to the Northern Province DHW. According to a 1996 report on management capacity for transforming the health sector, one provincial manager identified a 'need to know how to manage turbulence, how to set up new organisations, how to experiment, how to manage people, how to delegate and supervise; we need more entrepreneurial financial management

skills, and we need to know how to manage our in tray and daily tasks compared with more strategic management.' (quoted in Human & Strachan 1996: 5).

Following a visit by senior provincial staff to the UK National Health Service, management development at the DHW had received assistance from DFID. A consultant was hired, along with the University of the North, to design an institutional development system for use by the province. However, in 1998, there had still been no systematic management training and instead they relied on *ad hoc* courses. The Human Resources Directorate in theory had a system for identifying people for a range of different courses, covering technical issues as well as general management. However, implementation of the new system had been delayed and the unit for running it had not been established at the time of research (interview with human resources consultant).

Staff in the PHC Division had therefore received limited training in how to develop business and operational plans, although these were now available for each programme Sub-Directorate. As a result, plans were not user-friendly, implying that their development was seen as a separate, independent process rather than an integral part of the day to day management of strategic objectives. Some of the major problems lay in the areas of communication and financial management. For example, the following conversation took place between the researcher (LL) and the Deputy Director MCWH (MCWH):

LL: *What is your overall budget for 1998/99?*

MCWH: *About 36 million Rand.*

LL: *Does this include regional activities? What does it cover?*

MCWH: *It is only in the business plan in theory. The real budget is determined elsewhere and is only 26 thousand Rand. It comes from up there, from the big plan.*

The Deputy Director was unable to explain either the basis on which the original estimate had been developed, or the decision to make this huge cut in her budget. Neither was she able to comment on which parts of the operational plan would be affected by the cut in terms of activities planned or subsequently retrenched.

Part of the confusion stemmed from shifts in the system by which PHC activities were undertaken and funded. While the PHC programmes had retained responsibility for technical support to implementation, all administrative responsibilities had been given to management divisions, including finance, human resources/personnel, drugs/supplies, planning, information and transport (interview with DHW official). Communication between PHC staff and management staff was extremely poor and there were significant cultural differences between the two groups: first, PHC staff were principally clinical in background, made up of senior nursing staff, as opposed to administrators in the management divisions; second, PHC staff were almost exclusively female, while those in

management divisions were more commonly male. In addition, the reduced control of PHC staff over budgets had limited their ability to influence the activities of mainstream management, further contributing to the weak relationship between programme plans and implementation.

6.3.5 Interactions between provincial and regional staff

There were a host of formal communication mechanisms in the form of meetings between various PHC staff at provincial and regional levels. For the purposes of this study, the important meetings were: a weekly senior management meeting at provincial level; a monthly PHC divisional meeting including regional staff; a monthly HIV/AIDS and STD meeting with regional HIV/AIDS and STD co-ordinators; and a monthly MCWH meeting with regional MCWH and reproductive health staff (interviews with DHW officials). All provincial PHC staff attended the PHC meetings with regional staff but it did not appear that programme staff attended any programme-specific meetings other than their own. The exception to this was that the provincial Assistant Director TB had started to attend the HIV/AIDS and STD meetings as these programmes were being encouraged to co-ordinate their activities.

In terms of visits by provincial staff to the regions, the provincial PHC Division had started to make team visits in order to limit the impact of provincial interruptions on regional activities and to promote an integrated approach from the top (interview with DHW official). Other than these visits, there were many informal communications between staff about day to day operations of the programmes and regions. However, it was clear that these took place far more frequently within programmes than between them. Inequalities in power cloud every kind of relationship and those in the DHW were no exception. The impact on communication was high, whether in communicating strategic policy at provincial level or in passing on messages about treatment protocols or training opportunities at facility level. The staff of the DHW were extremely conscious of status and protocol, often due to the history of previous administrations rather than any overt attempts to restrict communication by the current system (interview with researcher). For example, mirroring problems between national and provincial officers, relationships between provincial PHC staff and regional general management were also hindered by lack of line authority. Thus, although the provincial Assistant Director HIV/AIDS and STDs could meet with her regional counterparts, both officers had relatively limited power over budgets or clinic management with which to ensure programme objectives were met (interviews with DHW and regional officials).

Members of the provincial senior management were keenly aware of these issues but the real problems arose lower down the system among middle managers in the programmes and regional administrations. Despite intentions to create a system of implementation which was more responsive

to local needs, the process of communication of programme plans was top down in orientation. Thus, policies formulated at national level were communicated ultimately to facilities, passing through provincial and regional PHC line management along the way. Formal or informal opportunities and mechanisms for staff at lower administrative levels to participate in decision making remained limited, even in terms of provincial plans for implementation of national policy (interviews with regional officials).

6.3.6 Process of transition from regions to districts

Provincial restructuring of administrative, financial and logistical systems continued to have a substantial impact in all spheres of policy development and implementation. The basic concept was similar to that in other countries: that day to day administrative planning and decision making should take place closer to the sites of service implementation in the hopes that it would achieve greater accountability to local needs.

Figure 6.3 Organogram of Northern Province Health and Welfare Districts
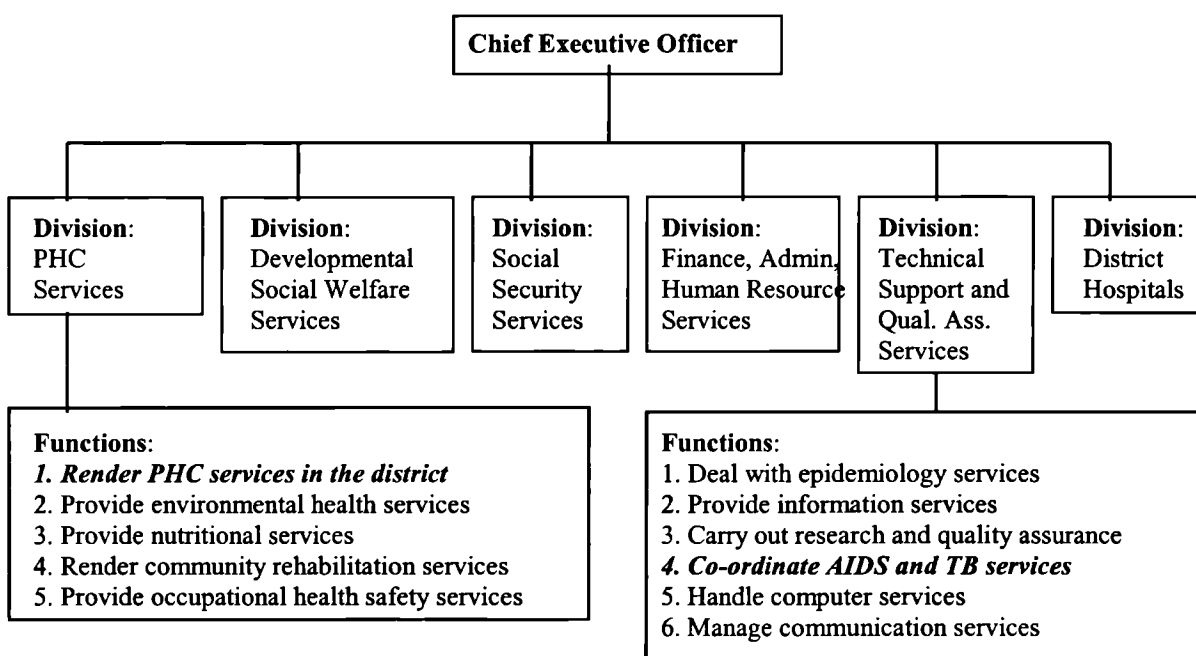
Source: adapted from Department of Health and Welfare 1998b.

In the Northern Province, as stated above, 25 districts were established with organograms and, within these districts, staff appointments had been pencilled in (Figure 6.3). This was achieved by first creating job descriptions for each new district post and then finding the person who best fit the post from within the existing administrative structures (interview with DHW official). No new staff appointments were made, partly due to a freeze on hiring of staff. The key positions for this study

were the Assistant Director PHC and the Chief Community Liaison Officer 'Global Emergencies', with responsibility for TB, HIV/AIDS and STDs (highlighted in Figure 6.3).

As discussed elsewhere, in conceptualising the role of the Assistant Director PHC, staff at the provincial DHW were ideologically committed to a fully integrated and comprehensive PHC system at district level. The status of the PHC co-ordinator would be equal to that of the hospital superintendent general, as befit the responsibility for improving the health of a large catchment population (interview with DHW official). This was proving to be an uneasy scheme since it was new to provincial staff that nurses or administrators should be on equal footing with medical superintendents (interviews with regional and hospital officials). Underneath the Assistant Director PHC would be Community Liaison Officers, the descendants of existing community matrons, who would each be responsible for a local service area, or health centre plus its peripheral clinics.

The Chief Community Liaison Officer TB/HIV/AIDS/STDs post arose as a result of a tussle between the national TB programme and the provincial PHC Directorate. As the districts were set up, the national TB programme, and other TB specialists in the province, raised concerns over how the TB programme activities could be carried out in a comprehensive system, given the assumptions in WHO Directly Observed Treatment, Short Course (DOTS) models of a district co-ordinator[41] (interviews with DOH official and researcher). Pressure was brought to bear on the province to appoint a person with specific responsibility to ensure implementation of programme objectives. Partly in order to ensure the success of this lobby, the TB programme started to emphasise the potential for integration with the activities of the HIV/AIDS AND STD programme (Rawlinson 1998). Despite reluctance to create such a potentially vertical post, the DHW had recognised the priority accorded to TB and HIV/AIDS and included it.

In 1998, nevertheless, thinking on how to develop this position was under-developed: *'The officer will be primarily concerned with STD/HIV/AIDS and TB service monitoring and quality assurance. This will entail direct access to any part of the health and welfare service and direct reporting to the District Manager. The services are of a sensitive nature and address "global emergencies".'* (Department of Health and Welfare 1998b). This person would be outside the main PHC Division (Figure 6.3) as a staff position with direct access to the chief executive officer of the district. At the time of research, no formal decisions had been taken over what exactly the job description for this position would entail or how they would function within the integrated system (interviews with researchers and human resource consultant). Not all of the hospital or regional staff were aware of

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[41] According to WHO algorithms, DOTS requires that district TB control activities are co-ordinated by a dedicated district-based TB control officer.

this new post in the district management structure and, as a result, they were unwilling to comment on how they thought the activities could best be performed (interview with regional and hospital officials).

Involvement of programme staff beyond senior provincial management in these decisions had been minimal. In particular, programme staff interviewed had not been consulted for their views on the activities of the district TB/HIV/AIDS/STD co-ordinators or whether this was a feasible task to expect of one person (interviews with DHW officials). The decision was presented as a *fait accompli* in the regions and many regional staff were not even aware of its recent introduction into organograms. One official, who had been given this position in a new district set up, was not aware on applying that the position would hold responsibility for communicable diseases. This failure to consult led to what have been described elsewhere as *'expressions of alienation and resentment'* (Schneider & Stein 1997: 50) among middle managers, who were threatened by what they felt was an almost total lack of information on the process of devolution. In addition, the fact there were many activities which constituted a comprehensive HIV/AIDS and STD programme, or indeed a comprehensive TB programme, which would probably have been better done outside busy PHC facilities had apparently been given little thought.

6.3.7 Establishing a district: example of transition in 'Halegratz'

At the time of our study, the only semi-functioning district was the Haenertsburg/Letsitele/ Gravelotte/Tzaneen (Halegratz) district, which had been the provincial pilot since 1996 and was receiving assistance from the Initiative for Sub-District Support (ISDS) of the Health Systems Trust (Department of Health and Welfare 1998c). Appointments had been made to the new district management team but, in the absence of the Chief Executive Officer, the district was not yet fully established at its headquarters. In recruiting for the district positions, no external hiring was allowed due to the freeze on public sector employment in the face of currently available personnel (23,000 employees in the Provincial DHW; interview with DHW official).

Services were being provided through a re-oriented local service area system and the CN Phatudi Hospital was the district hospital, with three local service areas referring to it. Analysis therefore focused on managers who were still in regional positions but trying to work as though in district establishments. During interviews, we addressed the dynamic situation and questioned managers on how they thought their roles would be different in a district set up.

In Halegratz, there was evidence that the insecurity amongst staff over the way their new positions would function was the greatest impediment to proper management of services. There were

misgivings about relationships between staff from different previous administrations and future job security which recurred in comments from many people: '*decentralisation of services to the districts will be good once there but the process is disturbing*' (interview with regional official). Key messages from staff in Halegratz were that it was important to sell the concept of the district health area to staff and to allay fears about change and loss or power under the new system. In achieving this, the community liaison officers and the hospital secretaries were crucial figures in knowing where staff were posted, what their concerns were and how to move forward. In addition, political differences arising from continued allegiance to former administrations and labour unions had played a large part in creating problems for implementing the new organograms. There was evidence at provincial level of an awareness of the problems staff had in understanding the process of district establishment and efforts were being made to improve communication to all levels of staff (interview with DHW official).

A number of lessons could be drawn from the experience in setting up this district, including: lack of a district Chief Executive Officer; lack of a coherent DHWMT; insecurity in new positions; failure to define role of vertical programme within the integrated system; poorly defined activities for HIV/AIDS and STD co-ordinator; insufficient communication between PHC and HIV/AIDS and STD managers; and insufficient communication between managers and facilities.

Clearly, the establishment and management of districts would have a far more pronounced impact on medium term developments in HIV/STD and MCWH services than any of the actors or policies of the national programmes. New district systems, if executed well at local level, had the potential to revolutionise health care delivery more than any provincial DOTS programme or vertical HIV activity could ever hope to. It was therefore crucial that services were analysed in this context, rather than being seen simply as extensions of national, vertical policies. In the next section, these issues will be analysed in greater depth, based on field work in four of seven regions in the province.

6.4   Findings from regional/district field work

6.4.1   Field work aims and setting

As stated in Chapter 1, field work took place in May to July 1998 in collaboration with the DHW[42]. To follow up on findings about the process of implementation, field work at region/district level in four regions focused on the outcome of policies to integrate HIV/STD services with PHC, defined in three ways: (i) at service level, for example, exploring the extent to which individual MCWH clients received HIV/STD services; (ii) at facility level, for example, assessing the availability of HIV/STD

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[42] See Chapter 1 for a detailed description of field work methods.

specific drugs and promotional materials at facilities; and (iii) at local service area level, for example analysing communication between and integration of services available at different types of facilities. In addition, the establishment and functioning of regional and district support for services were closely investigated.

Four out of seven regions were selected in the province to be included in the field work, on the basis that they had the largest populations: Central, Lowveld, Northern and Southern. In each region, facilities were selected in consultation with the regional PHC managers to ensure that they would be representative of future service structures in districts. Given the transitional stage from regional to district administrations, the five facilities were selected so that, once districts were established, they would all be together in one district local service area[43]. Samples were also selected to be representative of both urban and rural areas as well as taking into account the history of programme administration under the various different governments in the Northern Province in the period prior to 1994 (Table 6.3; see also shaded areas on Figure 6.1).

In the Central region, the Moletsie/Matlala District was selected, a predominantly rural area close to Pietersburg. Many of the men in this district migrated to urban areas, including Gauteng, for employment and there was little agricultural activity on the infertile land. It was formerly under the Lebowa homeland administration and the district system was not yet functioning fully. WF Knobel Hospital was the district hospital in this area and Moletsie Health Centre was selected as the focal local service area. Some of the clinics in the local service area were closer to Seshego, a township outside Pietersburg, than WF Knobel and were therefore referring to the hospital there.

In the Lowveld, the Haenertsburg/Letsitlele/Gravelotte/Tzaneen (Halegratz) District was selected because it was the provincial pilot district for demonstrating the establishment of the new system. It was specifically chosen for its complex political and social history, and existing services were formerly under four separate health administrations: Gazankulu, Lebowa, Local Authority and the TPA. The region was characterised by extreme social and economic inequality and the main economic activity was large scale farming, especially avocados and citrus. Most residents of the former homeland areas were employed on these farms and there were on-going racial and economic tensions between the farm owners and poorer farm workers in this area. In this district, difficulties emerging from administrative transition had disrupted execution of the new system and, despite its head start, it was already slipping behind other regions in establishing district management teams. In this study, CN Phatudi Hospital and Nkowankowa Health Centre were selected for field visits.

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[43] A local service area was made up of a health centre with several clinics referring to it; a district would contain around three local service areas, all referring to one district hospital.

In the Northern region, the Mutale/Masisi/Vutshwema District was formerly entirely under the administration of the quasi-independent Venda State. The region was little touched by white influence despite its fertile soils. Thohoyandou, the capital, enjoyed a diverse economy reflecting a range of agricultural, business and government employment opportunities, although many men still emigrated in search of better salaries elsewhere. By contrast, the Mutale local service area, which fell within the area of Donald Fraser Hospital, was predominantly rural and some of the villages were extremely remote and had little access to basic infrastructure, such as tarred roads, water mains, telephones or electricity.

Table 6.3 Description of field work sites

Region	District	Former adminis-tration	Total popula-tion	Total static clinics	Hospital in study	Health centres and clinics in study
Central	Moletsie/ Matlala	Lebowa	192,524	16	WF Knobel	Moletsie Health Centre Lonsdale Clinic Perskebult Clinic Semenya Clinic
Lowveld	Haenertsburg/ Letsitele/ Gravelotte/ Tzaneen	Gazankulu Lebowa Local authority TPA	273,691	29	CN Phatudi	Nkowankowa Health Centre Letsitele Clinic Mhlava Clinic Mkhutsana Clinic
Northern	Mutale/ Masisi/ Vutshwema	Venda	155,392	22	Donald Fraser	Mutale Health Centre Shakadza Clinic Thengwe Clinic Tshikundamalema Clinic
Southern	Lebowakgomo /Zebediela	Lebowa	168,443	19	Groot-hoek	Lebowakgomo Health Centre Dithabaneng Clinic Lebowakgomo Clinic Unit R Clinic

Source: Department of Health and Welfare 1998a.

Finally, in the Southern region, we visited the Greater Lebowakgomo/Zebediela District. This area incorporated the regional capital, Lebowakgomo, which was also the capital of the former Lebowa homeland. There was little evidence of economic activity and the land was poor. The principal employment opportunities locally were in government so many men emigrated for more lucrative work, returning home only irregularly. The majority of the health services selected in this local service area were urban or peri-urban and were well connected to the main roads and infrastructure of the region. They were referring to Groothoek Hospital. Since this region had been one of the poorest served under the apartheid regime, significant structural development had been needed at the clinics and many had new buildings and recent increases in nursing staff

6.4.2 Bureaucratic resources at region/district level

The manager in charge of PHC activities at regional level was the Deputy Director PHC, whose role was to link provincial strategic and operational plans with implementing facilities by providing technical assistance, training, supervision and logistical support (interviews with regional officials). Regional PHC managers did not have control over infrastructural development of facilities, drug supplies or the salaries of the staff in facilities, which fell instead under regional human resource, logistics, drugs or finance managers. Underneath the Deputy Director were a number of Assistant Directors and more junior positions. MCWH was not represented as a specific programme, being fully integrated with the PHC activities. HIV/AIDS and STDs, by contrast, did have a co-ordinator in all four regions, at Community Liaison Officer level (Department of Health 1997).

Table 6.4 Basic findings from regional offices and district hospitals

Region • Hospital • Indicator	Central WF Knobel •	Lowveld CN Phatudi •	Northern D Fraser •	Southern Groothoek
Total population of region	576,746	916,292	623,122	887,199
Total PHC budget, Rand (US$ in parentheses)*	223,000 (44,600)	205,303 (41,061)	106,000 (21,200)	1,893,000 (378,600)
HIV/AIDS and STD budget, Rand (US$ in parentheses)	128,000 (25,600)	105,000 (21,000)	76,000 (15,200)	284,000 (56,800)
Number of nurses trained in syndromic approach in region	492	68	140	500
Number of nurses trained in HIV counselling in hospital	0	4	1	3
Number of syphilis tests at hospital, May 1998	±800 (total)	335 (from clinics)	937 (total)	±800 (total)
Total number of clients seen at hospital, May 1998	4,939	2,831	4,730	7,646
Total number of STD cases seen at hospital, May 1998	147	45	0	293
Number of STD drugs or FP methods out of stock at hospital	0	0	1	0

* The PHC budgets in this table vary widely and clearly do not all reflect the same activities. Part of the confusion stemmed from the recent transfer of all implementation resources from provincial to regional offices so that they had relative independence in determining how the budget got apportioned to the various programmes. However, comparing the regional HIV/AIDS and STD budgets also shows how much they could vary even for fairly easily defined sets of activities.

There had been quite large increases in regional financial responsibility, with decentralisation of implementation budgets to regional offices during the previous financial year (interviews with

regional officials). Budgets were small but varied hugely between regions (Table 6.4), even within PHC and HIV/AIDS and STDs, which would have been expected to be fairly similar per head of population. Regional directors were accountable for planning and implementing and, in consultation with the provincial office, were able to vire funds between programmes (interview with DHW official). There was, however, evidence of a number of problems with managing these complex programmes, in the absence of a coherent training programme to develop the managerial capacity: for example, budget management appeared weak, particularly in areas outside programme control, such as salaries, drug logistics and clinic budgets. Despite provincial assistance in developing operational plans and budgets, there was considerable variation between regions in terms of the activities undertaken in the area of PHC and HIV/STDs and in the capacity of managers to implement these activities.

Clinics were also planning to manage their own budgets in future. Needless-to-say, In Charges[44] had very poor financial management capacity and needed training; in the meantime, clinic budgets were being overseen by community matrons (interviews with regional officials). They were, however, constrained by the province's financial difficulties: for example, in Tzaneen sub-district, the average clinic budget for 1998/99 was R357,000 (US$71,400) which was not enough for the clinic salaries, repair of equipment, laboratory tests or printing record cards it was expected to cover (Department of Health and Welfare 1998c: 11). During interviews, clinic staff also complained of being over-committed on other management activities, particularly reporting of service delivery. This retained many features of the previous administration and nurses spent precious hours filling in forms for different monitoring exercises each day. They rarely knew the purpose of the information or received any feedback on its use.

The locus of all activities was the community matron, who managed the local service area and was accountable for the health status of its population. In the regions, communication over service delivery was principally through a monthly meeting between the programme heads and the community matrons (interviews with regional officials). Thus, it was through these cadres that facilities were linked to the outside world, that training was organised and supervised and that logistics were managed: i.e. that the vision of the PHC district was achieved. Under future district management, community matrons would gain the title community liaison officers, and would have a managerial orientation, while a chief professional nurse located at the health centres would be responsible for clinical supervision of facilities. However, there was little evidence at provincial level that much thought had been given to training this new cadre either in management skills or how to be

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[44] As explained in Chapter 1 the person in charge of a PHC facility was known as the In Charge. She was usually a senior nurse, sometimes with management training.

accountable for a population's health. It was acknowledged that they would require technical support from the provincial office for programme content and general management but how this support would be provided was unclear (interviews with DHW officials).

The HIV/AIDS and STD co-ordinators at regional level were responsible for providing technical support for integrated delivery of HIV/STD services at PHC facilities and hospitals (interviews with regional officials). In addition to this support role, they also delivered condoms to a range of sites, including facilities, and promoted awareness and advocacy for HIV/STD within the community and among political leaders. Specific innovative activities included: working with youth groups both in and out of schools; education programmes and condom distribution for truck drivers and commercial sex workers; organising community based support groups; and arranging confidential care for people with AIDS.

It was clear that the diverse functions of the HIV/AIDS and STD programme would have been unsustainable in the absence of adequate support from provincial staff to enable regional co-ordinators to undertake all the necessary activities. Regional managers outside the HIV/AIDS and STD programme were not helping to integrate these services into PHC and communication between the PHC managers about HIV/AIDS and STD programme activities was weak. For example, one regional Deputy Director PHC was unable to tell us in an interview whether or not pregnant women were tested for syphilis or what the name of the test was. Elsewhere, a manager of the PHC services was unable to provide detailed information on HIV/AIDS and STD activities or training programmes, referring us to the HIV/AIDS and STD co-ordinator, who was not in post at the time of interview. In another region, there was confusion both at the regional office and the hospital over how HIV/STD services were supposed to be managed within an integrated system. The result of the confusion was that HIV/STD activities outside the facilities themselves had more or less ceased: training programmes were not functioning; condom distribution was limited; and education materials were not widely available. There was a perception that some, but by no means all, of these problems would be relieved after transition to districts, due to their smaller area and population (interviews with regional officials).

6.4.3 Roles of district hospitals

District hospitals' OPDs increasingly focused on referrals from other facilities, especially since the introduction of free health care at clinics, accompanied by cuts in hospital budgets, and their HIV/STD patient loads had dropped as a result of this change (Table 6.4). However, in interviews, clinical staff reported seeing an increased number of HIV-related patients in the wards, especially among people who were working in Johannesburg or their partners. STD treatment at hospitals was

rarely syndromic: the doctors we interviewed had not always heard of this approach and, instead, relied on diagnostic tests from the laboratory before treatment. This created inefficiencies in treatment since the laboratories could not guarantee same day results, particularly late in the day.

Other aspects of hospital HIV/STD activities were also less than satisfactory. Condoms were not promoted widely by doctors and were not always freely available in OPDs. HIV universal precautions were not in place in all wards and providers remained concerned about knowing when a patient was HIV positive, despite a heightened awareness of confidentiality legislation. Referrals to hospitals from the facilities for STD treatment were made with a letter although, as with other referrals, facilities rarely received feedback from the hospitals (interviews with clinic staff). Hospitals had considered introducing discharge notes for patients but were concerned about the time implications for doctors. Hospital doctors had no other means of communication with clinics other than through the community matrons (interviews with hospital officials).

Hospitals were continuing to support integrated PHC services in the district in a number of logistical ways, such as providing drugs, conducting diagnostic tests and (sometimes) providing a community doctor on rotation to facilities[45]. They provided few MCWH services on site, except where a special clinic had been established. They were, however, no longer supervising the clinical activities or managing budgets of PHC facilities in their areas, a decision which, in some cases, had caused rifts between hospital and regional managers as well as between nurses and doctors. Evidence from interviews in most hospitals showed that the doctors and hospital managers were not entirely happy with the new management systems. Particular antagonism was felt towards the new district structures in which the medical superintendent of the hospital would have equal status to the chief of PHC. Hospitals had lost further power as financial and clinical management was devolved to the health centres and regional teams. In addition, they were no longer serving their traditional populations and facilities as the new districts did not necessarily reflect former administrative boundaries (interviews with hospital officials).

The hospital pharmacist was in charge of drugs supplies throughout the district and obtained supplies directly from the provincial depot. In theory, drugs were delivered to the clinics every two weeks in response to orders placed. In practice, there were frequently problems in the system, including delays and failure to deliver what was requested. However, if there were stockouts between deliveries, the pharmacist was able to make emergency deliveries. There were a limited number of tests performed by the hospital laboratories on behalf of clinics, such as testing ante-natal clients' blood for syphilis

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[45] As found by the Health Systems Trust (Buthelezi *et al.* 1998), visits by doctors to clinics took place in an *ad hoc*, irregular manner around the province.

serology. However, there were anomalies between the number of tests recorded by the hospital laboratories and the number of ante-natal clients being seen by facilities, implying that tests were not being performed routinely, as claimed in interviews with all levels of staff. In addition, there was some evidence that hospitals were cutting back on tests performed by laboratories as they were too expensive under the new hospital budgets.

The hospital HIV test counsellors were providing an important service, since there was no HIV test counselling in other public sector facilities. In only one hospital were there no counsellors and patients were referred to Pietersburg for counselling if necessary. Most counselling clients already had symptoms of HIV disease and usually tested positive (interviews with hospital officials). Because of confidentiality rules, counsellors found it difficult to follow people up once they had been discharged into the community but efforts were made to help people cope with a normal life and communicate with their families where appropriate. In addition to providing counselling for testing, some counsellors were involved in setting up local support groups for people with AIDS and for arranging condom distribution in the community. They were also visiting facilities to assist with AIDS awareness campaigns and life skills in schools.

6.4.4 Outcome of implementation: clinical activities

Figure 6.4 Average number of clients at facilities in May 1998 (n=16)
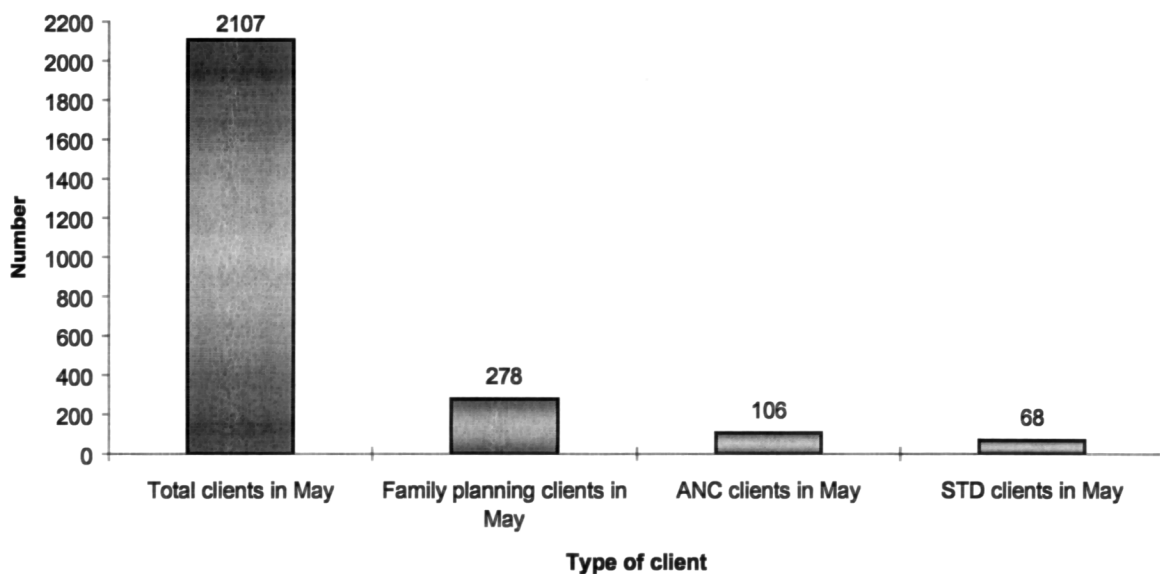
This section of the results will describe which services were being provided in the PHC facilities (excluding hospitals) and whether they were integrated with each other[46]. In this study, the average total number of clients seen at each facility in the month of May 1998 was 2,107 (Figure 6.4), although this figure varied widely between facilities, from 847 to 8,462. This meant an average of 286 clients per provider per month which appeared low compared to an average of 536 patients per provider per month found in another sample of facilities at around the same time (Buthelezi et al. 1998). Health centres did not necessarily see more patients than clinics, probably reflecting the transitional nature of services at the time as some clinics were being upgraded to become fully functioning health centres. Of the clients seen in May 1998, on average 16 per cent were FP clients, six per cent were ante-natal clients and four per cent were STD clients. Again, there were fairly wide variations between facilities in these figures.

Figure 6.5 Percentage of facilities with logistical and resource inputs (n=16)
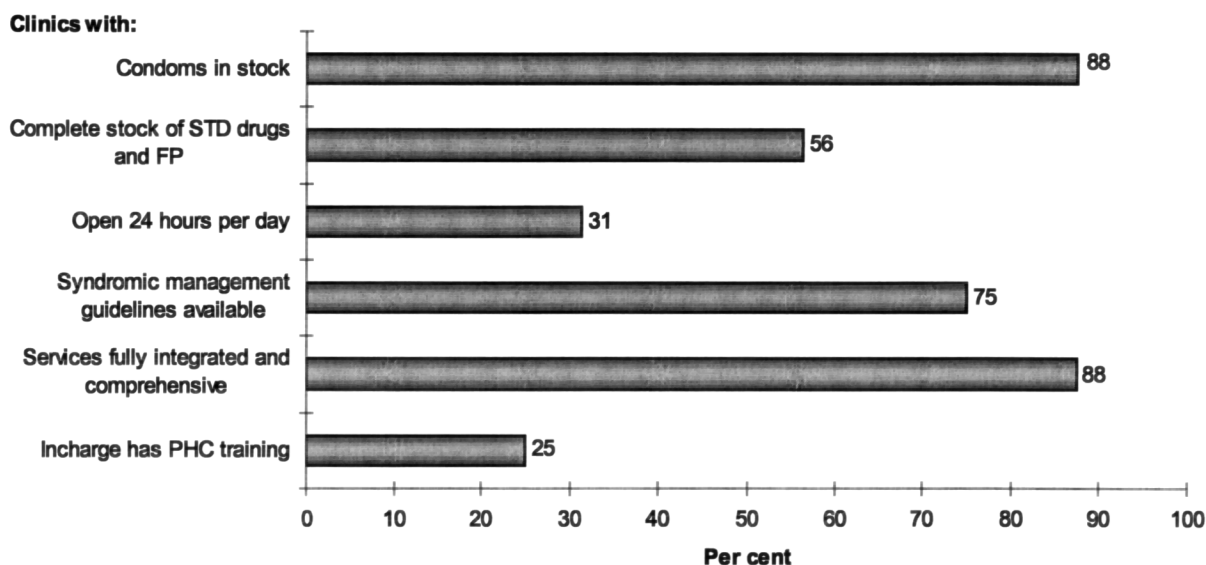
Moving to basic logistical issues at the clinics relating to HIV/STD services, around a quarter of In Charges had received PHC training and were therefore better qualified for managing complex services[47]. In addition, nearly a third of clinics were open 24 hours a day while the rest were open 7.30am to 4pm Monday to Friday and usually for some time at the weekends (Figure 6.5). The distribution of syndromic management protocols was widespread: the figure of 75 per cent refers to the availability of the 'Training Manual for Management of a Person with a Sexually Transmitted

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[46] Throughout, it should be remembered that, where possible, results were obtained from clinic record systems. Elsewhere, they were based on verbally reported activities by the In Charge and her staff, not on independent observation of clients and the services they received. As such, they should be regarded as the most positive indicators of services in the clinics and health centres.

Disease' (Department of Health 1996) and in facilities where this was not available, there was almost always a poster or leaflet with the syndromic management protocols in brief. Similarly, distribution of condoms to clinics was strong and only 13 per cent (or two) clinics had no condoms on the day of our visit. However, others did report problems with the supply at other times. By contrast to this, among the drugs we investigated (taken from the STD treatment protocols and the contraceptive list[48]), there were fairly frequent stock outs. In total, only 56 per cent of facilities had a complete stock of these drugs and several had more than one drug out of stock. This partly reflected the timing of the study which coincided with a payment failure at the provincial drugs depot.

Figure 6.6 Percentage of facilities with appropriately trained staff (n=16)
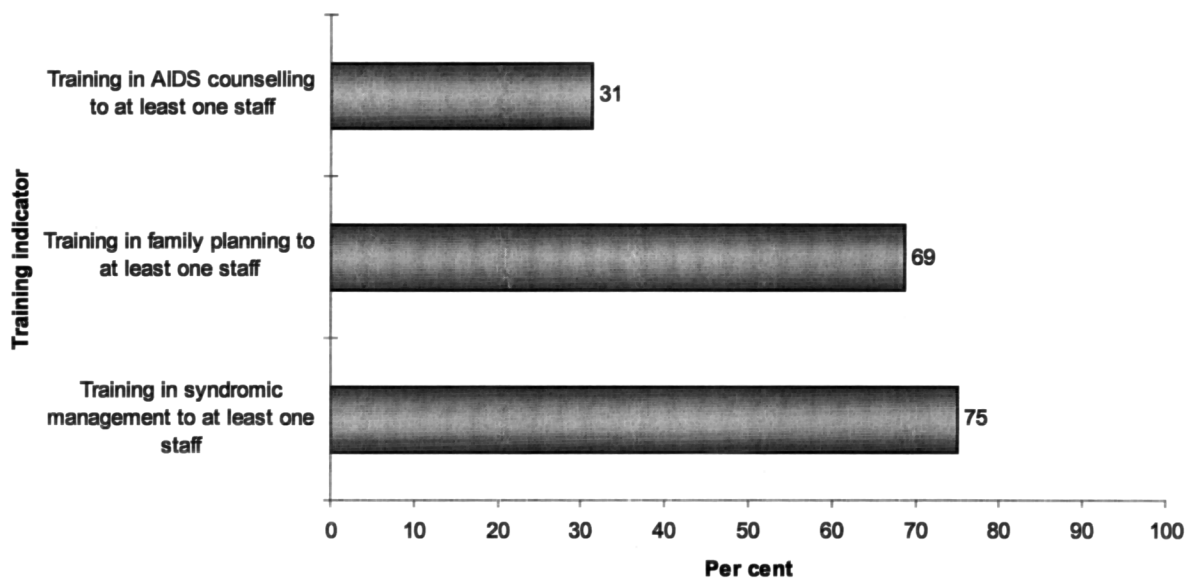
One of the main areas of focus of the provincial PHC Directorate had been on training nursing staff in HIV and STD management areas, including HIV test counselling, syndromic management of STDs and FP. According to provincial staff, the training was still on-going and, in these 16 facilities, there was evidence that not all of the training was provided in a fully co-ordinated manner (Figure 6.6). In 75 per cent of facilities, at least one member of staff had received formal training in syndromic management of STDs. In 69 per cent of facilities, at least one staff had been trained in FP, which was important for understanding and promoting barrier methods. Coverage of training in HIV test counselling was much lower, with only 31 per cent of facilities having a trained counsellor on site; even those facilities with a trained counsellor were not able to take blood for HIV testing. One nurse

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[47] PHC training was an additional three year course which senior nurses could take, qualifying them to manage clinical services and facilities to a greater degree than most nurses are usually expected to be capable of.

[48] List of drugs included: benzathine penicillin, cyprofloxacine, doxycycline/tetracycline, erythromycin, metronidazole, oral contraceptives, and injectable contraceptives. No IUDs or HIV/STD tests were available at

commented, '*Pre-test counselling is easier than post- because it is difficult to face a positive person. I don't think I can handle this. Pre- is easier as we have more information to give. I would grab an opportunity for counselling training.*' (Southern region).

Another commented on the system for sending people for training as '*very bad news*' (nurse, Lowveld region), referring to the lack of needs-based planning for training attendance. For example, while 75 per cent of clinics had at least one member of staff with syndromic management training, some facilities had more than one (up to four) while others had none at all. These anomalies were taking place within single local service areas: for example in the Mutale area, there were four nurses at the health centre with training but two of the three peripheral clinics visited had none at all.

The figures above refer to formal provincial training courses rather than in-service training since there was also evidence from both interviews and focus groups that in-service training was not adequate for providing high quality HIV/STD management. Nurses themselves reported not being satisfied with in-service training: '*We have never had systematic training, just in-service training at the hospital. This gives you something but is not adequate. This is too serious.*' (nurse, Northern region). Inadequate training led to poor knowledge of HIV/STD behavioural issues and symptoms. For example, on indications of STDs: '*There is changing of colour, not well ordered. If she says she has lack of appetite. If she doesn't look well generally - then she is at risk of an STD. Other men have no feelings for that woman.*' (nurse, Northern region). Other problems arose in the treatment of male STD clients and interesting insights into these issues were obtained from male nurses interviewed in facilities: '*If it is a male, they get violent if you ask them about STDs, so we use male nurses to establish a proper relationship. Then they admit it slowly. If you tell them directly, it will be terrible - we need to dig about symptoms until he says, "Yes, I do have this."*' (male nurse, Northern region).

In addition to the above indicators of general clinic inputs, a number of specific HIV/STD service outputs were also investigated (Figure 6.7)[49]. Of these services, the only one which all clinics claimed to be doing was taking blood for syphilis screening. However, there were reports from elsewhere, including hospital laboratories and regional staff, that this syphilis screening service was not functioning properly. For example, the figure for syphilis tests performed in May 1998 at Knobel hospital shows that they were not nearly meeting the needs of clinics in that district (780 in our four facilities alone, compared to 800 in total at the hospital supposedly serving 16 clinics; Table 6.4). In particular, even where blood was taken at clinics, the system for transporting blood to and from

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any of the clinics in the study. Spectinomycin, listed on the national syndromic management protocol, has been replaced with ceftryaxone in this province, which was not included on the list.

hospital laboratories did not always ensure that blood arrived in time to be useful. While careful attention was paid to how the blood was taken, less care was taken over how results were received back and how to ensure that the clients returned for their results plus any necessary treatment. According to the National AIDS Review, the turnaround time on these tests can be anywhere between two days and two weeks (Department of Health 1997: 153). Congenital syphilis was also still being reported as a notifiable disease, suggesting attention to screening for this infection remained a priority.

Of the other services investigated, far fewer facilities were able to provide positive answers. In particular, rather few HIV/STD services were taking place routinely for FP clients: for example, in only 44 per cent clinics were first time FP clients reported to receive a full pelvic examination during which STD signs could be identified (Figure 6.7). For returning clients, and in the remaining 56 per cent of clinics, the nurses relied on self reporting of symptoms and it was clear that they did not always draw clients' attention to the possibility of symptoms.

Figure 6.7 Percentage of facilities offering specific HIV/STD services (n=16)
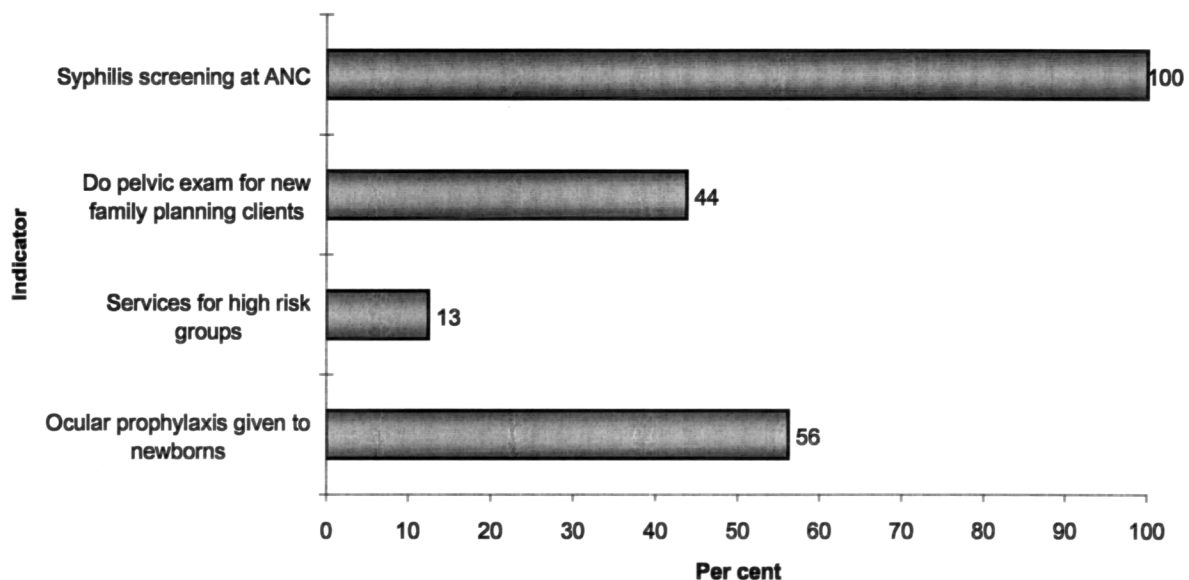
Routine prophylaxis against ocular gonorrhoea for new born babies was reported to take place in only 56 per cent of facilities (Figure 6.7). Furthermore, few clinics (13 per cent) were engaged in specific activities for high risk groups in their areas[50]. In informal discussions, there were examples of other innovative activities, especially with local schools, where teachers were enthusiastic to get involved

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[49] These included: routine syphilis screening of ante-natal clients; routine screening of new FP clients; services for high risk groups; routine prophylaxis for ocular gonorrhoea in new borns; partner notification; condom promotion; and educational materials.

[50] For example, distributing condoms to shebeens, truck stops or commercial sex workers.

with the nurses. For example, '*Nurses usually come to our schools. As teachers, we have courses which we attend where [HIV/STDs] are included, so we freely discuss at work. It is not necessary for me to come to the clinic.*' (client and teacher, Southern Region). Another example of innovative collaboration between nurses and teachers was found at a clinic in the Central Region, where the In Charge had a good relationship with local teachers and was visiting the schools regularly to provide information, condoms and refer students to the clinic where necessary.

Partner notification slips were available in facilities in the Southern and Northern regions and in addition in one clinic of each of the Lowveld and Central regions, where they had designed their own versions (Figure 6.8). However, none of the facilities was keeping records of how many partners actually returned with these slips, since they could take them to any health service. Generally, there was a feeling of hopelessness in the partner notification system, given difficulties clients, especially women, had in discussing these issues with partners[51].

Figure 6.8 Percentage of facilities with HIV/STD education activities available (n=16)
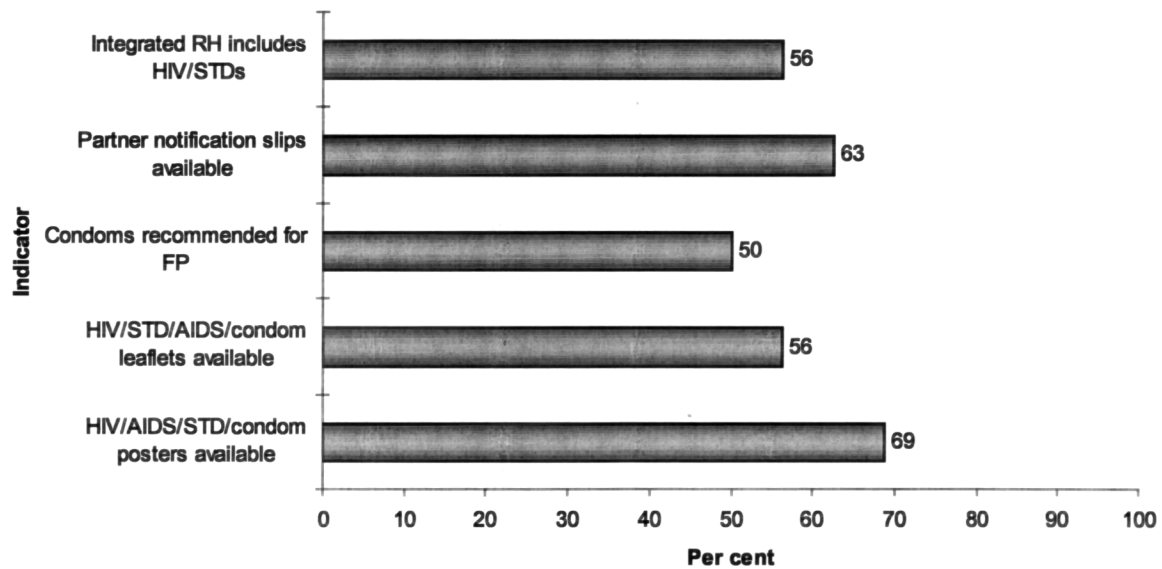
The other indicators in Figure 6.8 refer to health promotion knowledge and activities at the facilities. A key finding was that, among many staff, understanding and knowledge of STD impact, aetiology and links with HIV were weak and that this influenced the kind of health promotion activities which were taking place. The extent to which HIV/STD issues were conceptually integrated into broader MCWH was reflected in the figure of only 56 per cent of In Charges including these diseases in their definition of integrated reproductive health services. During focus groups, staff were asked to discuss

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[51] Indeed, partner notification in low income countries is notoriously difficult to implement with return rates as low as a third even in trials specifically designed to maximise them.

the range of STDs which were likely to present at their clinics as well as the links between HIV and other STDs. The principal diseases mentioned were gonorrhoea (*idrop*) and syphilis (*tshofela*), while chancroid and herpes were occasionally mentioned and chlamydia only once. Knowledge of symptoms was usually quite strong but there were also some incorrect responses, for example, '*If the condition or diseases remains untreated then they will have the same problem: impotence.*' (nurse, Lowveld). On the links between these diseases and HIV, it was rare for the precise mechanism or relationship to be understood. Instead, vague concepts were presented: '*ones that are not responding to treatment, then they become HIV positive.*' (nurse, Southern Region); '*HIV is part of STDs which means if a client is not well counselled about STDs, they will be at risk of HIV.*' (nurse, Northern Region).

In half the facilities, there was a firm commitment to promoting condoms as a method of FP although all staff were conscious of the difficulties women have in negotiating condom use with their partners. For example, '*Most women know that men have a negative attitude to condoms so they think that if they introduce the matter he will fight her. She is going to lose the husband because it means she thinks he is unfaithful so he will get angry.*' (nurse, Lowveld); and '*It is taboo for women to say "Let's use a condom". Even myself, I will wonder "Why today?".*' (male nurse, Northern region). Both nurses and clients reported men's preference for '*meat to meat.*' or '*flesh to flesh*'. Nevertheless, most facilities distributed condoms freely with boxes placed in the main waiting areas for anybody to take. Posters on HIV/STD or condoms were available in 69 per cent of facilities, although almost always in English rather than the appropriate local language. This was despite the availability of materials in North Sotho, Shangaan and Venda from ATICC in Pietersburg which were supposed to be distributed through the HIV/STD co-ordinators in each region (interviews with ATICC officials; see section 6.6.2). Leaflets and pamphlets which clients could remove were only available in 56 per cent of facilities although a far greater number reported having had them at some point in time, indicating problems with the distribution system.

6.4.5 Context of health services: stigma and fear among clients

In the interviews with clients at clinics around the province, there was also evidence of incomplete understanding of the kinds of diseases which can be transmitted sexually, how to mitigate risk and exposure to these diseases, and what kinds of services are available to help. In general, knowledge was higher amongst younger clients but the only specific diseases clients had ever heard of were AIDS, syphilis (*tshofela*) and gonorrhoea (*idrop*). In addition, the extent of knowledge was confined largely to being able to name the disease while understanding of symptoms was limited (unless the client had personal experience). For example, '*I have heard from the clinic health education that [AIDS] takes a long time to show.*' (client, Northern region); '*One who is suffering from AIDS*

develops a rash and sores.' (client, Northern region); or *'They explain that one gets headache, stomach ache, sores all over the body, TB-like cough.'* (client, Lowveld region). In the Central region, knowledge was lower than elsewhere: *'I only heard about [AIDS] but never met anyone who could give me details about it.'* (client, Central region). HIV/AIDS was also strongly associated with witchcraft, and was seen in the context of general poverty in the province (interview with ATICC official May 1998). Among blacks, the latent period between infection with HIV and the appearance of symptoms led to denial (including among nursing staff); among whites, HIV/AIDS was seen as a problem for blacks only.

On the other hand, there was an overwhelming expression of real, personal risk and fear about these diseases, combined with an inability to protect oneself against the results of partners' infidelity while away from home: *'Ha! It is a fearful disease. My husband is not staying with me and he might have lovers in Johannesburg and come and infect me.'* (client, Northern region). Another commented: *'Because I am married, I have no more fear but I suspect the possibility of being infected because my husband works in Johannesburg.'* (client, Central region). Some women admitted to their own infidelities: *'Even myself, I do not have one partner and my partner does not have relations with me alone. No condom is used.'* (client, Southern region).

Condoms were generally perceived to be useful for protection against HIV or STD transmission and knowledge of their use was high. Actual use, however, appeared to be less common, often because women were unable to persuade their male partners to participate. For example, *'I have no knowledge of women in the community using condoms. It is traditionally only men who brings condoms, not women. It is difficult to determine specific purpose for these condoms because traditionally men never discuss with women about condoms.'* (client, Lowveld region). Younger people did, however, seem to be using them more, particularly in pre-marital partnerships: *'I never used condoms although they are used by children as they are always in the house.'* (client, Central region). Overall, most clients were aware that male condoms were available at the clinics and many spontaneously expressed enthusiasm for female condoms.

Part of the reason for this incomplete knowledge of HIV/STDs can be surmised by looking at the problems of health promotion reported in the facility results above. In addition, clients were asked whether they had discussed these issues with nurses at facilities. Their responses demonstrated that the nurses were discussing HIV/STDs in their health promotion talks but that the information was restricted: *'Each time, nurses only tell us that there is a disease called AIDS and we must use condoms.'* (client, Southern region). Others went further: *'The wish is there [for information] but there is fear because the nurses are not friendly and their approach is harsh. That is why we are all afraid.'* (client, Lowveld region). On the other hand, clients also reported a strong desire for more

information: '*Many people do not trust that these diseases exist. They think it is just what people think. I would like to discuss these issues with the nurses.*' (client, Lowveld region); or '*I have never met anyone [who has discussed these issues] but I listen to the radio and it is where I got the information. I would like to discuss with the nurses, especially gonorrhoea because I want to know more.*' (client, Lowveld region).

In addition, few of the clients interviewed were actually aware that STD services were available at the clinic where they were being interviewed. When asked whether STD treatment was available at the clinic, 34 out of 45 clients interviewed responded that they did not know. The exception to this was the Lowveld region where clients seemed better informed about services on offer. There was also no evidence that STD services would be stigmatised or undesirable at facilities. On the contrary, '*it would discourage isolation: integrating these services will assist so that people will see these diseases as no different from other diseases.*' (client, Northern region); and '*if [services] can be brought here, we will avoid resorting to traditional healers, who are failing.*' (client, Northern region). A further question showed that around a third of clients were unaware of where they could get an HIV test while the others variously mentioned the clinic, the hospital or private laboratories and doctors.

Both clients and providers reported some use of the private sector for treatment of STDs. In particular, traditional healers were popular for treating STDs, including HIV, and often clients only came to the clinic when these sources had failed. Men in particular visited private physicians in preference for their STD treatment. There was no evidence of engagement with these private providers from any level of the programme except some limited syndromic management training activities for doctors by the SAIMR (interview with HIV/STD researcher).

6.4.6   Issues of integration in a local service area

The issue of what was happening within facilities has now been addressed. The integration of services available in any one facility with those in other facilities in the local service area, including clinics, mobile services, the health centre, the district hospital as well as outreach services from the regional or district office, is discussed below. The crucial link between investigating the respective roles of vertical and horizontal **management**, at provincial and national levels, and the outcome, in terms of whether **services** are integrated is how managers operate at local level. In addition to the facilities, the roles of three key figures will be examined: the Deputy Director PHC and the HIV/AIDS and STD co-ordinator at the regional office and, most important of all, the community matron.

In order to ensure integration between facilities, the most important factor was communication which facilitated understanding of the complex demands of different programme activities within the context of integrated PHC. In addition, since clinic staff often felt isolated and of low morale, including them in local area decisions and systems provided an important link with the outside world (interviews with clinic staff). At the time of the study, there were few opportunities for formal meetings between staff of different facilities. In some regions, there were quarterly meetings between all In Charges but the norm remained that meetings tended to be coincidental, often occurring only when another event, such as a training programme, had been organised. Links between hospitals and other facilities for patient referrals also tended to be weak and all facilities reported wanting more information from hospitals on services rendered. Other forms of communication existed both in terms of direct telephone or radio phone links as well as transport for drugs, emergency cases and diagnostic tests. However, there was frequently evidence of breakdowns in these communication systems, especially when no telephone was available (Department of Health and Welfare 1998c). Three specific communication issues were examined: transport and drugs logistics; the role of the community matron; and the role of the regional HIV/AIDS and STD co-ordinator.

The availability of transport affected the PHC system in a number of ways. First, the services were dependent on transport to maintain effective communication between the hospitals and peripheral facilities for delivery of drugs, fetching and distributing diagnostic tests, and emergency services. Second, the mobile services[52] were dependent on effective transport to get to their service points in remote areas. Third, beyond these direct service activities, some regional staff needed transport to carry out their work, including the community matrons, the HIV/AIDS and STD co-ordinators and the PHC management team. Financial problems in the province had resulted in restrictions on regional travel and the effect on communication channels was substantial (interviews with regional and hospital officials). Drugs were usually distributed on time although there was a variety of problems, including: delivering a smaller number of packages than requested; not including enough pills in an individual package; charging clinic budgets for drugs requested rather than those delivered; late delivery; and stock outs in the hospitals themselves (interviews with clinic staff). On the whole, when stocks were low region wide, stocks at the hospital pharmacies and health centres were protected above those at facilities. Mobile clinics usually functioned effectively and had few transport problems since their vehicles were stationed at health centres. Regional staff had more difficulty with transport since they were subject to stringent restrictions on kilometres for monthly travel and also had to share vehicles with a larger number of staff. For example, one HIV/AIDS and STD co-ordinator reported being allowed to travel only 1,500 km per month, which was not sufficient to cover a whole region.

The community matron was supposed to visit each facility at least once every two weeks and to spend at least two hours discussing service development with staff. In interviews, however, it was rare for this to be the case: according to one In Charge, the supervisor came once every one or two months and stayed for around 30 minutes. During this time, '*she checks cleanliness of clinic and checks books so it is up to date and also checks the way we pack medicine and if we are using expiry date medicine and the cold chain. She comes to check we are on duty on time.*' (nurse, Northern region). Furthermore, '*we don't have meetings with her, she is busy and won't respond to requests for meetings. She only comes about once a month as she passes by. We would like a meeting with all clinics once per month.*' (nurse, Lowveld region). By contrast, in some other clinics visited, the supervisors spent an unnecessary amount of time (sometimes visiting every day). During visits it was rare for supervisors to focus on particular disease issues or to follow up on in-service or provincial training received by nursing staff. In one region, there was an exception, since the community matron doubled up as the hospital HIV test counsellor which meant that her supervisory visits did focus particularly strongly on HIV/STD issues.

The role of the regional or district HIV/AIDS and STD co-ordinator in maintaining emphasis on these national priority diseases had not been fully formulated at policy level and this gap was reflected in the disparate activities found in the four regions of this study. According to one HIV/AIDS and STD co-ordinator, the job included: '*AIDS campaigns; counselling; condom distribution; education material distribution; some home visits; and NGO collaboration*'. This was perceived to be an extremely demanding set of activities and, in one region, there was a tussle within the communicable diseases team over who should be responsible for the HIV/AIDS and STD programme, given reluctance to undertake such difficult activities. Technical and managerial support was needed from a range of sources, including the provincial and national HIV/AIDS and STD programmes as well as the regional PHC Sub-Directorate. In the absence of knowledge on how to develop such a support structure, there was a distinct lack of priority accorded to this role. '*It is not my feeling that there has been an aggressive promotion for AIDS but there is a positive attitude.*' (interview with hospital official). The regional office interviews confirmed that managers were reluctant to take ownership of the HIV/AIDS and STD programme and frequently referred to the HIV/AIDS and STD co-ordinator when asked for details of its activities. Activities under MCWH programme were generally better understood by senior management and, where HIV/STD was integrated with MCWH, there was a more general involvement by regional staff. The biggest gaps in activities arose for HIV/STD

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[52] A few mobile clinics operated in the province, especially in the Lowveld where they visited farm workers on site. Staff of mobile clinics were attached to clinics and were interviewed where available to get their views on integration. These results have not been presented in detail here.

activities which take place outside the PHC facilities, such as advocacy, community awareness raising and condom distribution.

6.5 Interface between local experience and provincial policy

6.5.1 Monitoring programme achievements

Monitoring and evaluation of programme achievements against objectives was almost non-existent (interview with DHW official). This was partly because the provincial information system was poorly developed and retained assorted elements of the former administrations. However, it also reflected a lack of attention to what the activities were supposed to achieve: for example, provincial training programmes were not evaluated to assess impact on service delivery. Operational plans did contain performance indicators but they did not describe how these indicators were supposed to be measured or, if measured, how they could be interpreted in relation to activities (Department of Health and Welfare 1997). For example, one indicator of the Sub-Directorate MCWH's achievements was a reduction in the maternal mortality rate of five per cent, something which would be difficult to measure and hard to attribute to any one intervention. Indicators were also in no way designed to reflect an integrated service: each Sub-Directorate had a list of programme specific indicators and there was no general list of objectives for the whole Division or team.

Facilities, meanwhile, dedicated considerable time to completing a wide range of reporting forms and books to meet the requirements of different provincial and national programmes for service delivery records. One clinic In Charge estimated that she spent two hours each day engaged in such activities. Similarly, hospital information systems revolved around forms which were not user-friendly and did not collect information which would be useful to hospital managers themselves. Staff completing reporting forms were rarely aware of what purpose the information was being collected for and how they themselves might benefit from it.

A District Information Systems Commission (DISC) had been established by the DHW with a mandate to investigate current information use and co-ordinate efforts to develop a more rational system. In a preliminary analysis, problems they identified include: information is centred on hospitals; data had little value in decision making; content or flow of information was not useful in a decentralised structure; there were large gaps in information; and feedback was non-existent (District Information Systems Commission 1998). In addition, the requirements of national programmes were felt to be onerous and provincial staff were keen to stop facilities collecting information for which they had no need themselves (interviews with researchers).

6.5.2 Feedback systems in the province

The main problem was that there was no evidence of any culture of information (District Information Systems Commission 1998) which would facilitate use of existing data until an improved management information system was in place. Information that did exist flowed extremely poorly between different officials who might have been interested; flow of information was usually vertical and upwards, and rarely lateral or back down again in the form of feedback to those collecting the information. Thus, even for those indicators which were being monitored by the provincial office, there was no feedback to regions or facilities on trends in health care provision or what had been achieved in the population. Feedback from national programmes on the data collected in their name was even weaker. There were no particular staff at provincial or any other level dedicated to the processing, analysis and feeding back of information. Furthermore, staff in divisions with priority information needs, such as drugs supplies or district management, were not involved in decision making about what information should be collected.

The DISC initiated the development of an improved information system, in the broader context of improving feedback within the province on the achievements and challenges of implementation. This was a consultative process in which they garnered the views of a wide range of stakeholders on the kinds of information they would find useful (interviews with researchers). A new hospital information system had already been piloted and evaluations of this pilot were anticipated at the time of research, which would feed into a provincial scale up. For the Directorate Districts and PHC, they had started to develop ways of using currently existing data, in combination with census data, to construct population-based models for needs analysis (interview with researcher). In addition, in consultation with those district managers already in post, they were beginning to design a new district information system which would feed into the planned integrated district PHC management. This system would include lateral as well as vertical flows of information, thereby contributing to improvements in communication between programmes, between programme staff and general managers, and between managers and providers.

6.6   Technical support from other actors in the Northern Province

There were various independent organisations outside the DHW involved in HIV/STD and reproductive health activities in the Northern Province. On the whole, co-ordination between these bodies and the DHW was weak and little effort was made to influence their activities or provide an overall framework in which they could function (interviews with researchers and NGO officials).

6.6.1 The Pietersburg/Mankweng Complex

The provincial referral hospital was administered separately from the DHW and occupied two sites, one at the former white hospital in Pietersburg and the other at the township hospital in Mankweng (known together as the Pietersburg/Mankweng Complex). The hospitals provided general outpatient services as well as referral wards for medical and surgical patients. There were no specialist STD or genito-urinary medicine services available in the provincial complex (or elsewhere in the province) and it was felt that these would have been highly stigmatised if provided through a specialist system (interviews with hospital officials). The complex was to become attached to MEDUNSA[53] as a teaching hospital also affiliated with the University of the North. In 1997, 927 HIV cases were recorded at the two hospitals, a considerably higher figure than in 1996. The STD caseload was, however, low because they were mainly treated at the clinics. The ante-natal clinic at the hospital was very small, since these services were now all provided at health clinics, and no information on HIV/STD services rendered there was collected.

In addition to treating HIV and STDs where possible, both hospitals offered a counselling service for people coming for HIV tests or when they were referred from the OPD with signs and symptoms of HIV/AIDS. The Mankweng HIV counselling unit reported around eight to ten patients each day, depending on what had been happening in the OPD (there were some specialist clinics which referred larger numbers of cases, for example, gynaecology). With the help of the ATICC, they were expanding the number of staff trained in counselling so that it could take place on wards if necessary rather than only through the special unit (interviews with hospital and ATICC officials).

Patients referred by doctors for HIV tests were given pre- and post-test counselling, during which the disease was discussed and information about possible services was given. In addition, assistance was offered for communicating disease status with partners, family and the rest of the community. The counsellors maintained links with ATICC, where they could refer HIV positive cases for further counselling and support if necessary. They attended some provincial meetings on the AIDS programme to discuss issues of further expanding the provincial HIV/AIDS activities. They also attended meetings with the Central Region office to discuss HIV/AIDS activities in the region.

There was an active infection control committee at the complex which HIV counsellors also attended. The complex was in the process of developing standards for infection control, including universal precautions against HIV infection, for use throughout the province. Otherwise there was little evidence of leadership, in terms of either providing a referral service for HIV/STD cases which could

not be managed at district hospitals or demonstrating treatment protocols or counselling for HIV/STD cases.

6.6.2 Other provincial state actors outside the Department of Health and Welfare

One of the principal and most important functions of HIV/AIDS and STD co-ordinators outside the PHC services was programme advocacy among local political leaders, both traditional and governmental, who did not yet perceive these diseases to be major development issues (Department of Health 1997). Despite efforts to get political and other community leaders involved in programme advocacy at regional and district level, there was limited involvement by either the TLCs or other administrative departments, although in some regions they did attend regular regional management meetings. Each district council had a counsellor responsible for health but, as there were large numbers of TLCs in each region (and would be more than one in each health and welfare district), it was difficult to co-ordinate efforts to involve them (interview with DHW official). In addition, these councils were supposed to facilitate the activities of clinic and community health committees in order to make constructive demands for service improvements according to community needs. Although these committees were in existence, there was little evidence either of specific HIV/STD activities by them or of approaches from regional management to encourage them. Local authorities in the municipal areas, meanwhile, appeared to have been positively obstructive[54] and had not participated in the integrated PHC system as a whole (interview with DHW official).

ATICC was part of the local authority services rather than under the DHW, although its budget came from the DHW, a structural problem which was criticised in the National AIDS Review (Department of Health 1997). Their total budget was R410,000 (US$82,000) and it was mainly used to train DHW staff in counselling for HIV test clients: in 1997, they trained around 300 nurses in 25 hospitals in the province (interviews with ATICC officials). No doctors had been trained but they did train lay counsellors and community based peer educators. They maintained links with NGOs in the province providing HIV related services and provided some services for high risk locations, such as truck stops, shebeens and commercial sex workers. In addition to their training activities, they provided a counselling and support function on site in their office in Pietersburg and clients were referred to them from the hospitals and facilities in the area as well as from private practitioners. Through these

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[53] MEDUNSA, based in Pretoria, was the principal centre for training of black medical students under the apartheid regime. At the time of research, it was expanding activities and opening satellite units in collaboration with other former black universities based in poor areas such as the Northern Province.

[54] One of the problems of restructuring was that, under apartheid, health care employees of former municipal authorities (run by a national DOH) had received higher salaries than provincial staff of similar grades. They were understandably reluctant to relinquish this privilege and join an overall integrated system of health service delivery. Similarly, their compliance with nationally determined policy reforms was limited.

activities, they were trying to establish care and support groups in the community for people with AIDS.

Their links with the DHW were not strong and both their Director and the DHW Assistant Director HIV/AIDS and STD reported minimal contact: '*there has been no co-ordinating meeting in the last two years.*'. Their activities did not overlap much, however, since ATICC focused so much on counselling training which the DHW did not cover. ATICC staff reported a need for better co-ordination and leadership in developing advocacy throughout the province, including provincial and regional staff and those of NGOs and other relevant actors.

The Department of Community Health of MEDUNSA had a satellite unit based at the Pietersburg/Mankweng Complex, with a mandate to provide technical support to the DHW. It was directed by Kobus Herbst, a higly respected academic with particular interest in information systems. Other staff focused on general health service issues and there was a TB technical advisor. In addition, the unit was instrumental in gathering together a group of provincial academics to develop a health care research agenda for the province[55]. There were no specific HIV/STD or reproductive health activities at the unit and their main activities were to co-ordinate rather than conduct research in these areas as well as to advise relevant staff at the DHW.

6.6.3 Non-government actors

Not mentioned here is the work of many smaller, local NGOs and CBOs, some of which were active in promoting awareness of HIV/AIDS and developing community based support and information organisations. According to the National AIDS Review, there were nine NGOs with HIV/AIDS activities in the Northern Province, and they received small grants from the national and provincial AIDS programmes, organised through the regional HIV/AIDS AND STD co-ordinators. The review concluded, however, that only two NGOs were '*functionally useful and both are under-supported*' (Department of Health 1997: 144). Among the larger, national NGOs active in the province, the majority were receiving funds from DFID which had prioritised the Northern Province in its own activity plan (interview with donor official). Their activities varied in the extent to which they co-ordinated or consulted with the DHW in planning, design or implementation.

The Women's Health Project of the Department of Community Health, University of Witwatersrand had a long involvement with the province mainly through a research study examining issues of quality

[55] Held in July 1998, this workshop aimed to increase collaboration between the many different health care researchers in the province and to improve communication between researchers and policy makers. In addition,

of care in reproductive health services, funded by DFID. In 1998, they focused on how services were organised and the kinds of training received by nurses for dealing with reproductive and women's health. Their results were influential in the province, particularly in recognising that improving reproductive health services would depend on enhancing more general areas of health service management and delivery. They had focused attention on logistical support, improved training and reorientation of the providers' approach to service delivery (Fonn et al. 1998). They had embarked on a new project to assist the province in developing their own means of evaluating quality of care, using methods which tracked the amount of time a client spent at a facility and what happened to them while there (interview with reproductive health researcher).

The RHRU of Baragwanath Hospital, Soweto had also examined quality of care in reproductive health with DFID funding but in a more specific study focusing on promoting barrier methods, including introducing female condoms[56] and emergency contraception in a few trial facilities in Venda. Condom promotion activities were accompanied by a facility based tool called 'Client Oriented Provider Efficient (COPE)', designed to assist facility In Charges in improving the quality of services they provided. They were also establishing a new reproductive health distance learning programme, through which nurses could attend workshops on specific topics while doing most of their studying on site. In addition, they were involved in provincial DHW activities, including assistance with developing operational plans based on national government contraceptive policy guidelines (interview with reproductive health researcher).

The PPASA had one main project in the Northern Province, providing adolescent health services in a health centre in the Lowveld region, including STDs, contraception and HIV counselling but not termination of pregnancy, again with DFID funds. They also ran a peer education programme, training young people to discuss safe sex and condom negotiation with their peers. Through these activities, they encouraged schools and peer educators to act as community-based condom outlets. In general, their youth centre was a success and the young people in the area found it more acceptable to use services where they would not meet older people whom they knew and where their treatments were confidential. Issues like partner notification for STDs and community involvement, however, remained a problem due to high levels of stigma and shame associated with these diseases. PPASA had been asked by the DHW to replicate their activities in five facilities around the province, with DFID/UNFPA funding (interview with NGO official).

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it aimed to promote research training for junior researchers from formerly disadvantaged universities who were interested in health care issues.

[56] A limited number of female condoms were made available cheaply to South Africa which were promoted among high risk groups (interview with reproductive health researcher).

The Department of Microbiology at the SAIMR in Johannesburg had spearheaded the training activities in the Northern Province on STD syndromic management in conjunction with the national DOH. During 1997, they trained 15 trainers, mainly FP nurses, who were supposed to go on to train others throughout the province. As part of this activity, they also drafted a mechanism for instituting STD surveillance at facilities in the province and ran functions at which doctors and managers were sensitised to HIV/STD issues. However, these activities had not proved sustainable in the absence of external motivation and support (interview with HIV/STD researcher) and there was no standardised recording and reporting system for epidemiological data on STDs or HIV/AIDS (Department of Health 1997). SAIMR had also conducted clinical and microbiological research into STDs in the province based at Elim Hospital in the Northern region and Tintswalo Hospital in Bushbuckridge.

6.7 Conclusions

In this chapter, efforts to implement integrated HIV/STD and PHC services were examined in the context of one of South Africa's poorest and most complex provinces. The political and economic context in the province at the time of research had a significant impact on attempts to implement this policy during the process of administrative restructuring which affected all areas of activity at the DHW. Managerial, technical and financial resources were severely limited, resulting in little focus on introducing new policy in response to national directives. The lack of support received from national HIV/AIDS and STD or MCWH programmes in designing effective implementation strategies also resulted in failures to manage the training, drugs and logistics programmes necessary to ensure adequate service delivery.

This was associated with problems relating to the complex nature of the policy and confusions over how HIV/STD or women's health services should interact with the integrated PHC approach. Operationalising HIV/STD care is difficult, as we have seen elsewhere, and requires significant resources to deal effectively with the wide range of activities. However, commitment to integrated PHC was, if anything, stronger in the Northern Province than at national level, and improving this overall service took precedence over any other activity at the time of the research. Efforts by the HIV/AIDS and STD and MCWH Directorates or outsiders to encourage more attention to priority services were perceived as a hindrance to this broader goal and senior managers remained convinced that the best way to attend to such issues would be through their improved PHC approach. National HIV/STD and MCWH policies were therefore not implemented effectively in the Northern Province largely due to preoccupations with broader issues of improving equity and accessibility of the basic PHC service in the context of major restructuring.

Lack of attention to HIV/STD and MCWH policies was reflected in patchy delivery of services at facility level throughout the province. While some components of the HIV/STD management package were widely available, such as syphilis screening for pregnant women, even these were not being effectively delivered. Others, such as condom promotion, HIV/STD counselling and pelvic examinations were much less likely to be available and, even where they were, knowledge of them was low among clients at facilities. The context of stigma and fear associated with these diseases affected both clients' attitudes to such services and providers' ability to deliver sensitive messages and care. Lack of supervision or managerial support from DHW regional or district staff compounded these problems.

Despite the open political atmosphere at national level, the culture of the Northern Province administration remained one of top down implementation. While lip service was paid to consulting community representatives, NGOs or local administrations, operationalising this vision in the early post-apartheid years proved difficult. Overwhelming problems remained among middle managers with entrenched ideas of hierarchy, status and empires, fostered during years of inefficient, corrupt and inequitable management of apartheid health care systems. The few senior managers with vision were swamped by the enormity of the task of transformation, which dominated all provincial discourse on health policy development, above any national health priority (interview with DHW official). In this context, the achievements of the provincial office in initiating implementation of integrated HIV/STD, MCWH and PHC perhaps stand to receive some congratulations.

6.8   Summary

- The Northern Province was the poorest of South Africa's nine provinces with a largely black, rural population which had suffered under years of inequitable apartheid policies. There were various ethnic groups who had formerly resided in two separate homelands, an autonomous state and the white Transvaal province. Demographic and health indicators were poor. In the 1994 elections, the ANC won an overwhelming majority in the provincial legislature and merged the political and administrative boundaries of the former separate political units. Nevertheless, economic problems remained significant with little employment in the province, substantial migration and great income inequalities between whites and blacks.

- Between 1994 and 1998, the principal focus of the DHW was to manage a massive administrative restructuring programme, including merging five former bureaucracies and establishing 25 new DHWMTs. In parallel, there was strong commitment to improving equity in service provision through a comprehensive, integrated district PHC system. A major clinic upgrading programme was underway simply to ensure adequate staff, infrastructure and logistical facilities were in place. In this context, the HIV/STDs and MCWH programmes struggled to maintain the high

priority accorded them at national level. Low managerial capacity in combination with weak mechanisms of control over implementation led to wide gaps between policy intent and outcome.

- One of the key findings at the facilities visited was that services were, almost exclusively, provided in a fully integrated, supermarket approach. As part of this approach, therefore, some HIV/STD services were always available, as long as the clinic was open, and there were few restrictions on attendance for specific services. However, it was also clear that there was by no means a comprehensive HIV/STD service being provided in these local service areas. The outcome was seen in the poor awareness of HIV/STD symptoms or service availability among clients.

- External actors in the province were weak mainly due to the socio-political legacy of the apartheid era. There were few local NGOs active in this area in the province and most of those that did exist were not functioning fully. National NGOs, such as PPASA, were active in the province, although often with external funding and little contact with the DHW.

- The province continued to maintain a top down approach to implementation in which little feedback on programme achievements took place and consultation over policy development and planning was poor. Despite the vision of senior managers, there were many more hurdles to cross in transforming the DHW from the inefficient apartheid administration to one in which population needs were at the forefront of concerns. National priority programmes for HIV/AIDS and STDs and MCWH had failed to adapt their recommendations to this context and had not taken weak capacity for implementation into account. Much more communication and co-operation was needed between national and provincial officials over service improvements.

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CHAPTER 7: DISCUSSION AND CONCLUSIONS

7.1 Introduction

In Chapter 1, aims of the research were established to analyse: (i) rationales for and process of setting global policy agendas; (ii) international experiences with formulating and implementing policies in response to a global agenda, with a focus on sub-Saharan Africa; (iii) agenda setting and policy formulation in South Africa; and (iv) gaps between national policy intent and implementation in the Northern Province, South Africa. To meet these aims, the specific objectives of this research were:

1.　to define 'integration' as it was used in reproductive health after 1994 and analyse the origins of the concept, potential benefits for service users and limitations to the approach;

2.　to conceptualise links between the international agenda setting process and health policy processes at national level, including similarities between national and international agenda setting, the process of transfer from international to national levels and factors affecting subsequent implementation in services;

3.　to analyse how integration emerged onto the international health agenda, through the activities of different networks of policy makers and their political relationships;

4.　to document and analyse the processes of policy formulation and implementation for integration in sub-Saharan African countries (using secondary data particularly from Ghana, Kenya and Zambia), characterised by extreme resource constraints, heavy donor influence and poor management capacity;

5.　to compare these experiences of agenda setting and policy formulation with those in South Africa, a country with very different political, economic and social circumstances;

6.　to assess the process of implementing policies in the Northern Province, South Africa and to understand how a strong commitment to integrated PHC affected HIV/STD control efforts; and,

7.　to assess how well theoretical models fitted the data on international health policy agendas and national policy formulation and implementation, what the outcome was in terms of service provision and health impact and what lessons could be drawn for analysing other international health policies.

To address these objectives, this concluding chapter reflects on what has been presented in the preceding six chapters and draws lessons from the theoretical and empirical information which have broader relevance for the disciplines of reproductive health research and policy analysis. Thus, the

primary focus is on understanding the policy processes which led to the development of integrated HIV/STD and PHC services in South Africa, with empirical field work data at the core of the chapter. This data is compared with evidence from literature on international policy development and national experiences elsewhere in sub-Saharan Africa. In addition, the information is used to comment on technical reproductive health issues, in order to contribute to debates on how to implement the recommendations of the ICPD in 1994.

The analysis proceeds according to the conceptual framework developed in Chapter 3. This framework was developed by drawing on a huge review of literature relating to agenda setting, policy transfer and implementation. Models from the new public administration and new institutionalism were used, both of which draw on many theoretical disciplines, including sociology, political science, economics, anthropology, organisational management and history. The vast majority of the literature in all these areas relates to policy areas other than health and to Northern rather than Southern country settings. Inevitably, therefore, the review process involved a critical evaluation of those aspects of each of the theoretical models which were useful for understanding this particular policy in the complex settings of low income countries.

In Chapter 3, Figure 3.2 summarised in a simplified format how this conceptual framework would be used to analyse the field work and literature review data. Here, the intention is to expand on this theme and to highlight those areas where the framework presented was useful as well as those where available theoretical models were inadequate for the data. While potentially superficial from the point of view of any one of the disciplines above, the justification for this selective approach is that the combination of a technically complex policy being developed at international and national levels in a context of extreme resource constraints merits an eclectic analysis. By combining insights from a range of conceptual origins, therefore, a deeper understanding of the problems of HIV/STD policy formulation and implementation in low income countries was achieved. This approach successfully fills gaps in the literature on health policy in low income countries and on the processes by which HIV/STD policies developed during the 1990s.

7.2 How do agendas get set in different international and national settings?

7.2.1 Problem, solution and political streams

For integration of HIV/STD services with PHC, international developments in thinking around the problem and solution streams took place rapidly between the mid 1980s and mid 1990s, as seen in Chapter 2. The sudden rise of the HIV/AIDS epidemic became a concern due to its large potential impact on economic development at individual, household and industrial levels. Evidence of an association between STDs and HIV transmission drew STDs to a similarly high position on the

international health agenda. Meanwhile, concern increased over the many problems women continued to experience during the reproductive process and the failure of FP and MCH services, in particular, to address these needs. As a result, there was a new emphasis on addressing the problems of HIV/STDs and women's reproductive health through a range of both new technologies (mainly syndromic management of STDs) and new approaches to health care delivery (including integration of previously separate services).

The process by which international consensus was reached on these initiatives was, however, a complex and politically charged one with a wide range of different actors and organisations debating the relative merits of traditional and new public health approaches (Chapter 4). Actors brought with them predominantly neo-liberal ideologies, although the radical right wing politics of the 1980s waned during this period, making way for the more welfare-oriented thinking of the 1990s. This included a heavier emphasis on the particular problems experienced by women, especially among the poor, and resulted in new coalitions between women's groups around the world, where earlier feminist debate had been dominated by Northern women's concerns. These coalitions were able to exert considerable pressure on international policy actors, including inter-governmental agencies and Northern bilateral donor agencies. These agencies therefore shifted their attention away from macro-economic goals, such as reducing population growth rates, and towards individual welfare goals, including mitigating reproductive ill health. So-called hidden actors, including academics and public health professionals, played an important role in generating the evidence on which these efforts were based.

In South Africa, national policy development for integrating HIV/STD and PHC services took place through a process of amalgamation of an indigenous agenda for integration of PHC with the international priority accorded to HIV/STDs and women's reproductive health (Chapter 5). This took place within a context of rapid and radical upheaval to society which affected all areas of policy. Thus during the political and economic changes in the mid 1990s, the Minister of Health was able to define an integrated approach to PHC service delivery as a central component of the new government's attempts to increase equity in provision of health care, in line with broader policy goals set out in the RDP. This, in combination with making services free, became the cornerstone of the transformation of the DOH, with most other restructuring efforts aiming to deliver these services more effectively. Consensus on the approach was widespread in the country and the Minister, a popular and successful politician, personally drove the process.

Nevertheless, South Africa also faced a devastating new epidemic in HIV/AIDS. Despite evidence from the process of developing PHC that policy makers had the capacity to deal with such a crisis, they did not respond adequately (Chapter 5). For example, although AIDS efforts were given the

political status of Presidential Lead Programme, few resources were allocated to relevant activities. In this vacuum, international aid agencies stepped in, including UNFPA, USAID and DFID, funding the AIDS programme almost in its entirety (Chapter 5). It was therefore not surprising that the international agenda for integrating HIV/STD services with PHC was seized on by those actors in South Africa who were concerned with raising funds in this area. Supported by the agencies most closely involved internationally, the South African HIV/AIDS and STD programme was developed and funded with service delivery planned to take place through PHC. Priority was also given to particular interventions which had been highlighted at international level, including syndromic management of STDs, and training in this technique was conducted by non-government groups as well as through government programmes.

Elsewhere in the world, evidence for enthusiasm for integration was limited. In some Southeast Asian countries, governments established networks of interest groups in order to forge consensus over the new approach. In sub-Saharan Africa, however, despite the crisis nature of the HIV/AIDS epidemic, there was much less evidence for the indigenous development of agendas for either integration or HIV/STD management. Unlike South Africa, governments had not made strong commitments to improving PHC; similarly, neither women's reproductive health nor HIV/AIDS had received much attention among policy makers and few NGOs were active in promoting these issues either. Nevertheless, in many sub-Saharan countries, it was apparent that some effort had gone into developing policies for integrating HIV/STD services with PHC, raising questions over how these issues did reach the agenda.

The answer appears to have been in the role played by external agencies in working at national level to develop policies in response to international priorities. In many of the countries documented in the literature, governments were heavily dependent on external funds in the health sector (Chapter 4). They were therefore vulnerable to having their health agendas influenced, since in order to get funds, they were usually required to comply with the wishes of their benefactors. For their part, despite much literature suggesting that without local support policies were unlikely to be successful, donors did little to stimulate debate on HIV/STDs or women's reproductive health, preferring instead to view their work as largely technical rather than political. In sum, although all sub-Saharan governments ratified the ICPD Programme of Action which prioritised these issues, there was little evidence that this led subsequently to an indigenous process of determining ways to put policy into practice. In the absence of such a process, blueprints developed at international level served to guide policy development and policies in many countries in sub-Saharan Africa ended up looking remarkably similar.

Models on agenda setting from the literature, particularly Kingdon's (1984), were useful in analysing processes at global level. Its focus on political relationships between different actors and the complexities of developing new policy solutions meant that its explanatory power was high. Nevertheless, because the model was developed for national settings, there were some major limitations for looking at international policy development. The most important of these was that the way agenda setting is linked to implementation was less clear than if looking at national policy development. This weakness had two significant implications: first, it did not fully explain why a particular policy reached the agenda at a certain time; and, second, the isolation of those actors setting the agenda from those supposed to implement it could result in limited support and legitimacy for the new approach (see Hall *et al.* 1975 on legitimacy and support, Chapter 3). These ideas will be further examined in the next two sections.

7.2.2 Why do policies arise at certain times: the role of focusing events?

A focusing event, as described by Birkland (1998) and in Chapter 3, was a concept which described the way certain sudden events led to the focusing of policy minds towards particular problems, solutions or objectives. In health, such events included sudden epidemics or the release of new data showing an epidemic increase in disease; they also included the development and publication of new interventions, significantly better or cheaper than their predecessors. For integration, it was clear that there were focusing events which contributed to the strength of the international agenda, including the ICPD in 1994, the publication in 1995 of the results of the trial of syndromic management of STDs in Mwanza, Tanzania and the release in 1998 of national level HIV prevalence information for the first time by UNAIDS. These events fed into the political process by affecting decision makers' perceptions of priorities and ways to address them.

In South Africa, focusing events in some ways mirrored those at international level, although there were also differences. Major events included the release of detailed HIV prevalence data showing extremely rapid increases in infection rates, particularly in some parts of the country. Others were more negative and included a South African institute's claim to have developed a new cure for AIDS, which ultimately led to the Virodene scandal, and the Sarafina II corruption scandal (Chapter 5). In general, however, such events were so much less significant than the major political and economic upheavals facing the country during the same time period, that their ability to focus the minds of policy makers was compromised. Despite the election of a new government in 1994, the potential opportunities this might have provided for action on HIV/AIDS was missed. Even within health, HIV statistics failed to grab the attention they deserved because they usually failed to present the full impact of the disease on the economy and lives of the people. Similarly, while women's reproductive

health did receive some attention, particularly domestic violence, rape and abortion, integration itself was seen as a technical issue which would have merited little interest from senior political figures.

Elsewhere in sub-Saharan Africa, national focusing events would also have been expected, including national research results, conferences or media interest. However, instead, just as agendas were set largely by the activities and interests of international actors, so policy reforms responded more to international focusing events. Thus the rapid development of new policies, and new structures to implement them, reflected the influence of international actors, keen to see movement in response to the events discussed above: the ICPD; new interventions; and new evidence on the impact of HIV/AIDS. There was little evidence of a national debate over either broader HIV/STD and reproductive health issues or specifically integration, and they were not perceived by national actors as particular priorities.

In public health, focusing events are often derived from the publication of new data or the development of new interventions to improve health; these events are rarely exciting enough to stimulate significant policy change. In other areas of policy, focusing events such as earthquakes, war or sudden political revolution have been described (Birkland 1998), which clearly have greater potential to grab the attention of policy makers. Even the release of new data on a drastic epidemic like HIV/AIDS cannot compete with the sudden nature of such phenomena, unless it is taken up by the media to raise popular opinion in favour of radical action. As a result, this concept, while helping to understand the response of policy makers to particular international or national events or information, provided only limited insight into the process by which such information was absorbed.

7.2.3 Elite versus plural participation in decision making

Agenda setting is essentially about the generation of new ideas and the feeding of these ideas into a political process. When analysing in Northern national settings, as most models do, the participation of different groups, including both mainstream actors and policy entrepreneurs, follow relatively well-known patterns of liberal-democratic political systems. However, when discussing the setting of agendas at **international** level for implementation in many different **national** settings, patterns of participation are likely to be very different. For example, multi-lateral organisations in theory represent the interests of many states, and thus also in theory, the people within those states. However, because these links are tenuous, decisions taken at global level are rarely legally binding to sovereign states. In addition, such organisations are often dominated by states with greater resource power and at national level, where they have unclear constituents or responsibility for implementation, they can therefore exert far greater power than might be expected.

One way these issues were analysed in this thesis was in the extent to which participation in setting agendas reflected elite or plural political systems. At international level, generally, policy making proceeded through the efforts of a highly restricted international elite, including representatives of government development agencies, multi-lateral organisations and technical specialists such as members of the international women's movement or public health professionals (Chapter 4). At the ICPD, however, great effort was made to encourage the participation of a wider range of actors in determining the new policy agenda. Particularly for women's reproductive health, an important feature of the international policy process was the participation of groups, such as international and local NGOs, who had not previously been involved in international meetings. This unprecedented number of NGOs continues to give reproductive health a legitimacy which other health policies cannot claim. Furthermore, in theory, having been so closely involved, NGOs were in strong positions to lobby governments to keep to the commitments they ratified in signing the Programme of Action.

Nevertheless, although participation was high compared to previous international efforts, to some extent it remained a gloss on reality, since many of the goals of ICPD were not the priorities of low income countries' governments but those of international activists. This was especially true of the international women's movement which gained its legitimacy as a representative of women around the world through myriad links with local women's groups, rather than through democratic systems associated with governments. However, as in a democratic system, the legitimacy derived from the participation of a wide range of women's groups did not reflect uniform support for these policies around the world and the process of consensus building masked dissent. In the post-ICPD period, when the details of policies such as integration were developed with the assistance of technical specialists, little work went into understanding the implications of these issues for the feasibility of policies at national level. Despite the role of NGOs at the ICPD itself, in most low income countries, governments remained responsible for the bulk of public health care and their marginalisation from international debates was important for subsequent policy feasibility.

In South Africa, as at international level, actors involved in setting reproductive health agendas were largely outside government, despite the potential links with government PHC services. Those setting the AIDS agenda were also mostly based in academic and NGO agencies, and thus separated from the DOH's PHC priorities and activities. There was little consensus on the best means to address HIV/STDs and little acknowledgement by PHC managers that one of their most important outputs should be to mitigate these epidemics. These problems of communication were also seen in the women's health agenda, which was also driven by a select (but different) group of non-government actors and supported by external agencies. In each case, the response of the DOH was to establish national programmes (HIV/AIDS and STDs and MCWH respectively), apparently according priority

to particular issues but simultaneously splitting them off from the mainstream management and finance divisions of the DOH.

Furthermore, both HIV/STDs and women's reproductive health activists were well connected with international actors through technical, scientific networks and international women's groups. Much of the scientific community in South Africa, even during the apartheid regime, was well respected internationally and, since 1994, had participated fully in international technical networks. Thus while the agenda for PHC integration was set by actors working largely within government, the agendas for HIV/STDs and women's reproductive health were promoted mainly by those outside government, with strong links to external, international actors. Having said this, at least at national level, government and non-government actors in South Africa in the mid 1990s were closer than might have been expected, since many of the new bureaucrats and politicians had themselves recently been working outside government, as anti-apartheid activists. Where the links were less strong was in the provinces, where the administrations were dominated by bureaucrats, tarred by association with the old regime, and weak civil society organisations. Some efforts were made to include these actors in the agenda setting process but their low management capacity and traditionally hierarchical styles made full participation difficult.

Thus, in South Africa, both national and international actors participated in a vibrant and pluralist agenda setting process. Individuals both inside and outside government contributed to policy, interacting through formal and informal consultations based on a history of close links at a personal level. Problems of policy development could be attributed partly to the sheer weight of on-going reform and partly to the legacy of apartheid in limiting participation by peripheral administrative cadres and civil society groups in determining feasible policy. Thus the context of policy development was a crucial determinant of the success of integration of HIV/STD services with PHC.

In other sub-Saharan countries, the network involved in policy development was much more elite than in South Africa. Although all countries had attended the ICPD and ratified its Programme of Action, there was little evidence that this had been followed up with national agendas for HIV/STD management or women's reproductive health. Participation of lower administrative cadres or local NGOs was minimal and the national elite in each country was dominated by the MOH, with particular divisions, such as newly-named Reproductive Health Units, taking the lead. Even consultation within the MOH with those responsible for HIV/STD management was limited, partly due to hierarchical differences which inhibited cross-departmental communication. Specific policy interventions and approaches, such as integrating HIV/STD management with PHC, were clearly introduced by external actors.

These countries were also more dependent than South Africa on external support to the health sector, particularly in PHC. In this area of policy, the main donors were USAID, DFID and UNFPA although others, such as UNICEF and the World Bank, also played a part. Donors were often represented by technical specialists, usually short term and sometimes positioned as advisers within the MOH. Their role was more powerful since, in the absence of concrete evidence on ways to implement integration, they had better access to international information and lessons from experiences elsewhere. Nonetheless, despite explicit international commitments to integration, many of these donors found it difficult to follow through and continued to fund vertical projects. This pattern was reflected in the broader picture of health sector reform and financing where, although many countries were moving towards sectoral systems of external funding, some projects were retained where donors wanted to prioritise particular spheres of health care.

7.3 What was the role of policy transfer in policy development at national level

In this section, relationships between international and national policy networks and processes is examined in terms of: the actors involved; evidence for transfer of ideas and technology; the extent to which transfer was voluntary or coercive; and constraints to effective transfer. The aim is to understand how relationships between international and national actors framed the development of these policies through processes of learning, information exchange, negotiation and, sometimes, coercion. The way these relationships have affected different aspects of policy is also addressed.

7.3.1 Differences between national-national and international-national transfer

Much of the theory described in Chapter 3 was developed for understanding policy transfer between Northern settings; thus, countries were characterised as drawing lessons from each other based on perceived similarities in conceptual and technical approaches. A key concept was the importance of ideological closeness between most Western European and North American countries, all of which had liberal-democratic political systems with neo-liberal economic policy. To understand how policy makers learnt from each other, Bennett (1991) classified policy convergence as occurring through various non-mutually exclusive processes, including emulation, elite networking, harmonisation and penetration. According to this theory, where policy makers perceived their settings to be relatively similar, convergence was more likely to take place through emulation or elite networking, since policy elites would be drawn together by their common ideas. Where settings were very different, penetration was likely to be a more useful explanation, since it implied a more active role on the part of actors from the place or time where the policy originated.

In this study, a major difficulty with applying the available models to empirical data was that policies were often being transferred from international organisations to low income countries, instead of

between two countries. By definition, these settings were very different, since a nation state could have little in common structurally with an international organisation. For example, international organisations in health policy, such as WHO or the World Bank, rarely implement programmes but confine themselves to agenda setting and policy formulation stages of the process. Furthermore, although international organisations are governed by their constituent member states, these do not have equal influence over their activities and such organisations tended to be dominated by Northern states with higher relative resource power. Links between international agencies and member states over what appeared to be technical, sectoral issues were therefore coloured by the context of international relations, as played out within the boards of the international agencies.

Links between bilateral donor agencies and recipient governments tended to be affected by a different set of political institutions, covering bilateral relations between two nation states. Here, the main problems affecting health policy development were that employees of bilateral donor agencies found themselves working for two different masters: their country of origin; and the country in which they were posted. This created further imbalances in the setting of agendas since the international health policy agendas of one nation state got brought to the negotiating table of another. Where the negotiations did not go in favour of the bilateral donor, they could bypass government health care systems and use those of NGOs. Alternatively, governments of low income countries could be put under considerable pressure to comply with the requirements of bilateral agencies' mandates, often developed in their headquarters in the North. This problem could also be balanced by the commitment of bilateral agency staff to the country in which they were posted and their knowledge of the context in which they were working.

In South Africa post-1994, rapid changes in political and economic outlook on the part of the new ANC government meant that ideologically they fell in line with the Northern governments which dominated decision making in international organisations. According to the models, this should have facilitated the transfer of health policy between the two levels and, as might be expected, national health policies did stick closely to international guidelines. However, the agenda for integration of PHC was largely indigenous, since, by the early 1990s, most international actors had given up on the PHC approach (although it had been the main theme of the 1978 Alma Ata declaration). Furthermore, since very few countries had ever successfully implemented a fully comprehensive, integrated PHC service, along the lines of that in the Northern Province, South Africa, there were few places from which to draw lessons. On the other hand, other policies, such as syndromic management of STDs, did originate from South Africa's links with the international community. These links could be characterised as a combination of **elite networking** and **harmonisation**: the activities of the South African NGO and academic communities coincided closely with those of international colleagues and

policies were developed in harmony with the latest international agreements such as the ICPD Programme of Action or WHO's guidelines for management of STDs.

In most other low income countries, there was more evidence for a strong role of international organisations and their technical staff in facilitating transfer of policy. Policies were transferred from international to national policy networks through a range of mechanisms, including: workshops organised by international organisations, mainly for international NGOs active in these countries; donor-government project negotiations; and dissemination of new information, including epidemiological surveillance and operations research. The most important mechanisms for policy transfer were therefore: **elite networking**, in which national donor representatives and government officials formed policy communities to take decisions on reform of MCH/FP and HIV/STD policies; and **penetration**, in which external actors exerted influence through their relative resource strength to ensure that their interests were expressed in national policy. The greater dependence of these countries' governments on external support to the health sector increased their vulnerability to the imposition outside agencies' priorities. This may have also reflected their reduced power in international agencies and with respect to the activities of bilateral agencies.

7.3.2 Policy transfer as drawing lessons from experience

According to most of the literature, policy transfer should also have been based on lessons drawn from experience of either one national programme or, frequently in health, a trial in a particular setting (Dolowitz & Marsh 1996). Networks of policy makers would then have distilled this experience to draw out the interesting aspects of policy which could be transferred to their setting. Careful analysis would be made of the context in which the policy was supposed to be implemented and the changes which would be required in order to adapt the policy to that context. In this scenario, international agencies would be seen as intermediaries facilitating the flow of information between two contexts. However, in the evidence presented in Chapters 4 and 5, policy recommendations were based not on national experience but on trials or pilot studies with limited evaluation of the process of scaling operations up to national level. Furthermore, those doing the transferring, policy intermediaries (donors, consultants and NGOs), did not have much experience with running national services and the government officials and managers involved in the execution of services were little involved in agenda setting and formulation.

In South Africa, there was some evidence that the model of policy makers assessing policies elsewhere and incorporating those aspects which seemed most useful did fit with reality. The DOH used the concept of integration, originally developed at Alma Ata in 1978, to redesign PHC, and incorporated HIV/STD management into this package. Furthermore, they developed a quite different

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approach to integration of reproductive health from that elsewhere, in response to their own specific epidemiologic and political context. Particular attention was therefore paid to free services and equity but less to the effectiveness of specific components of PHC.

However, many South African policy makers had little experience in government and had spent years in exile or in NGO and academic institutes fighting for political change. As a result, although their links with international networks were strong at agenda setting and policy formulation stages, this did not always translate into effective mechanisms for implementation. Thus, although South Africa as a whole differed substantially from most other sub-Saharan African countries, large variations within the country in administrative history, population structure and epidemiology meant that, in some places, implementation and service delivery were as weak as among other countries in the region. In this respect, the relationship between national policy makers and provincial/district implementers in South Africa had parallels with the relationships between international and national policy makers elsewhere.

In other sub-Saharan countries, there was little evidence of careful analysis of the extent to which policies in one place or time would appropriate in another, or what the impact of different contexts would be. On the contrary, policies showed evidence of being remarkably similar in many different contexts, often completely inappropriately. For example, in countries where both ante-natal care and FP use as well as HIV/STD prevalence were high, the rationale for integrating these services would be relatively strong, since there would be plenty of MCH/FP clients, many of whom would have had STDs given their high prevalence. However, where HIV/STD prevalence were high and ante-natal care well attended but FP use very low, as in many East and Central African countries, although HIV/STD services would be a priority, FP services would not be the place to access the most clients. Ante-natal services, nevertheless, would see more HIV/STD cases. Finally, where HIV/STD prevalence was also low, as in most West African countries, prioritising a service from which so few could potentially benefit would not be the best way forward. Nevertheless, the types of policy formulation which took place and the range of actors involved was remarkably similar in all sub-Saharan countries (Lush *et al.* Submitted), suggesting that some kind of process of convergence must have taken place, although models of transfer and lesson drawing were not very useful for understanding policy development.

7.3.3 Process of transfer: coercive or voluntary?

To understand the difference between Bennett's four possible mechanisms of transfer or convergence, a continuum from voluntary to coercive mechanisms can be conceptualised (Chapter 3). Both complete voluntarism and absolute coercion were rare in international health policy and countries lay

at different points on the continuum, according to: how dependent on foreign resources they were; how active they were in generating their own policy agenda; what the political and economic context was; and how far they themselves prioritised the particular issue in hand.

In South Africa, attempts were made by outsiders to influence national policy processes with mixed success. On the whole, the process of learning lessons from international agencies and actors was voluntary, i.e. experience from elsewhere fed into an indigenous process of problem identification and search for potential solutions (Chapter 5). External expertise was sought where necessary and sometimes international agencies facilitated or funded such technical assistance. For the development of integrated, comprehensive PHC, the major difficulties were in restructuring and reorienting the national health services rather than introducing new interventions. Here, external actors played a role in advising on how to implement administrative reform but not in dictating what future organisational structures should look like. Where external actors were more powerful was in establishing and funding vertical activities, such as the HIV/AIDS and STD and MCWH programmes. Here, the interests of international agencies clashed more with national agendas and, similarly, there was more evidence of pressure being brought to bear on the DOH to manage these programmes in particular ways.

In other low income countries, international actors behaved coercively in order to get their agendas into national policy. International efforts generally focused on developing and applying gold standards for service delivery, such as WHO's guidelines for management of STDs (WHO 1991; WHO/GPA 1994; WHO 1995). In theory, these should have been adapted to particular national contexts although, as seen above, policies in different settings ended up looking remarkably similar, suggesting that donors did exert powerful influence over the conception and design of new policies. However, national elites contributed to the situation by failing to execute a process by which policies could have been adapted to their national setting or to present alternatives if they genuinely disagreed with the donor approach. Thus, while most sub-Saharan African governments were exposed to coercive elements to transfer, in that they were dependent on donor funds, few made much effort to develop their own policies in response to other problems they had identified. This suggests that many donors ended up in the difficult position of wanting to engage in a more participatory debate with government over policy strategy but failing to generate sufficient interest on the part of national actors. In this situation, donors were not overruling indigenous policy but filling a policy vacuum.

These results raise an important issue, however, that requires substantial future research: did the process of transfer in fact **create** this policy vacuum, especially where it was further towards the coercive end of the continuum. Such an outcome could result from the attention of national actors being too heavily occupied with responding to outside concerns to develop indigenous alternatives.

These issues are increasingly being questioned by international agencies, such as the World Bank (World Bank 1995; World Bank 1997; Stone 1999). The evidence presented in this thesis suggests that the policy transfer framework could be a useful way of furthering our understanding of how governments might protect themselves better from such penetration and develop alternative ways of managing external resources and advice.

7.4 Aspects of policy which were transferred

Much has been written about the way donors exert their power to ensure technology transfer. Dolowitz and Marsh (1996), however, suggested that there were other aspects of policy which could also be transferred, including the process of implementing new policies and the ideological context in which they develop. What was more subtle, was that these other aspects could be both outcomes of transfer and determinants of the transfer of technology. For integration, all three aspects of policy were important: ideology included the neo-liberal, feminist or public health agendas which drove much of the reproductive health debate internationally; technology included the content of integrated services, such as syndromic management of STDs, condom promotion or partner notification; and process included the way policies were implemented, such as through horizontal or vertical management at different levels of the health service.

7.4.1 Ideology

International policies for integration were strongly driven by the two ideologies of women's health and rights and PHC. In the process of building consensus around the new goals, however, those adhering to these ideologies used a language that powerful neo-liberal actors might understand: thus, improved women's health was presented as a key way to achieve better labour productivity, better child health and reduced fertility. Nevertheless, as shown in Chapter 4, in some camps the new agenda was heavily criticised for being too ideological. In particular, the lack of evidence for particular health interventions contributing to a broader spectrum of economic objectives was highlighted as a central weakness of the reproductive health approach (Cleland 1996).

In South Africa, the same two ideologies influenced integration policy and links between international and national ideological agendas were strong (Chapter 5). In particular, participants in the national debate over improving the rights of women were strongly connected to international networks of women's groups and also contributed to developments in international thinking. The PHC debate, however, appeared to be more strongly related to international agendas of 20 years ago and there was little evidence that this position was the result of transfer of ideology from the international level. On the contrary, the DOH acted highly independently of international influence at this time and resented such interference in setting its agendas (Schneider & Gilson 1998). The national context of rapid

structural, economic and political change also created many windows of opportunity for policy makers to introduce radical reform, and the health sector was no exception.

In most other countries, there was little evidence for international ideologies being reflected in national agendas at all. Activities, such as women's groups against population control or media pressure for action on HIV or safe motherhood, which might have indicated the role of ideology in framing reproductive health policy developments, were minimal. There was, however, evidence of opposition to some of the goals of reproductive health, particularly among religious groups, who had also been active at the ICPD. Nevertheless, international actors involved in national policy apparently made little effort to counter such opposition through stimulating any alternative ideological views. In general, the issues under question were seen as too sensitive for political leaders to get involved with and external actors did not see it as their role to alter this view. Ideological commitment to reproductive health therefore represented a key difference between the South African and other sub-Saharan African contexts for transfer of more technological aspects of policy.

7.4.2 Technology

For the transfer of technologies for integration, the primary focus was on syndromic management of STDs, a new intervention developed largely at international level[57]. Evidence from the trial was published in international journals (Grosskurth et al. 1995; Gilson et al. 1997) and there was little attempt to confirm that the intervention could work on a national scale before making dramatic changes to international recommendations for STD management. Part of the explanation for this was the strong link between successful implementation of syndromic management of STDs with reducing the incidence of HIV transmission, a goal to which the international community was strongly committed (Chapter 2).

In South Africa, syndromic management was transferred relatively effectively and was rapidly adopted in national policy as a core element of both STD and HIV/AIDS control programmes, including developing algorithms based on WHO guidelines, adapted to include appropriate drugs and training for nurses (Chapter 5). Key national actors led this process through their strong links with international actors and convictions that evidence for the syndromic approach was sufficient to suggest rapid national implementation. Technology transfer was also facilitated by the context of ideological commitments to improving women's reproductive health as well as by the need to develop a more comprehensive HIV/STD control programme. However, the approach fitted less well with the

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[57] Although the key trial took place in Mwanza district in Tanzania, it was run by a large international NGO, the African Medical Research Foundation, with support from international academics (LSHTM) and funded by

ideology of PHC, since strong attention to disease-specific issues was out of line with the prevailing emphasis on an integrated approach to service delivery. The outcome was that, while state-of-the-art policies for syndromic management were developed at national level, and disseminated around the country, less enthusiasm was generated in provincial and district administrations which were more concerned with restructuring and improving PHC than introducing specific new interventions. As seen in Chapter 6 and discussed below, this led to problems with implementation.

Elsewhere, despite lack of transfer of ideology, national policies were formulated much in line with this new international approach and syndromic management was incorporated into new policy documents. Both STD control managers and reproductive health managers incorporated syndromic management into their new policies and, as a result, training in new techniques was widespread and integrated with FP, if not much with other areas of PHC. Nevertheless, in the absence of significant state political or ideological commitment to women's health, PHC or HIV/STD control, technology transfer was necessarily heavily driven by donor activities, including policy development workshops, technical assistance with training, project funding and drugs procurement. This process led to less government ownership of policy and questions were raised over sustainability of the new approach, especially as it was scaled up from pilot studies in limited areas to national implementation.

7.4.3 Processes and systems

In order to achieve integrated management of HIV/STDs and the introduction of syndromic management technology, three things were required: a commitment to integrated PHC; strong technical expertise; and the systems in place to allow these two approaches to work together. This complex issue was not fully recognised internationally and the main focus was on introducing specific technologies with less attention to **how** to implement. As a result, little transfer of practical recommendations for the process of integration took place in most countries.

Constraints to transfer also arose, such that despite the efforts of those trying to influence the process, policies did not always get developed as planned. According to Dolowitz and Marsh (1996), such constraints included having too many, complex goals, with unclear outcomes and effectiveness and inadequate resources for implementation. In addition, information on how to implement and likely side effects should be available. Integration of HIV/STD and MCH/FP services failed on almost all counts: as seen in Chapter 2, integration was a complex undertaking with many goals and unclear outcomes. There was little evidence on its cost or cost effectiveness and what evidence there was on side effects of programmes suggested that these would be significant, particularly for managers

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international organisations (EU and DFID); there was little evidence for involvement by the Tanzanian government in its design or implementation.

traditionally used to working in separate programmes with related incentives not to collaborate too widely.

In South Africa, high level political commitment to the ideology of integrated PHC did, however, overcome these constraints, leading to careful lesson drawing over how to restructure health administrations to deliver services better (although not specifically reproductive health). In achieving this, there was clear evidence of voluntary transfer of experience with reforming health sectors, including international visits by senior managers to see other health administrations. New technologies, such as syndromic management, introduced around the same time but by different policy actors, should have fed neatly into this process. However, the overwhelming nature of health sector reform in South Africa and the rapidity with which it was taking place made it difficult for national HIV/AIDS and STD or MCWH managers to keep up with changes to provincial administrative systems. Similarly, those directly involved in administrative reform did not have the time or capacity to attend to the technological complexities of HIV/STD control (or any other specific area of health) which led to poor communication over priorities for service delivery (Chapters 5 and 6).

Elsewhere in sub-Saharan Africa, new policy goals were developed and documents were drafted summarising the new approach, with the assistance of international agencies and resources. However, despite some new MOH structures, little effort went into developing systems and processes to implement an integrated approach. Basic problems included: lack of clear definition of integration; failure to legislate appropriately to allow nurses to prescribe STD drugs; and lack of clear technical guidelines for managers or training programmes (Chapter 4). Development of such systems was further weakened by other areas of donor influence, such as maintenance of parallel vertical programmes or support for health reforms, which indirectly restricted the way integrated services could be implemented. These issues will be further addressed below.

7.5 Evidence on implementation of policies

There were many potential links between transfer and implementation, not least that where a policy was successfully transferred, i.e. recipient actors participated in and owned its adoption, it was more likely to be implemented well. Furthermore, the emphasis within the transfer literature on considering different aspects of policy, especially the processes and systems required to deliver a reform, resonated closely with concerns in the literature on implementation. Again, however, there were caveats to using models developed in Northern settings to understand processes in low income countries. The policy formulation-implementation gap in the latter settings was wide but little understood and many assumptions made about capacity, governance and civil service responsibility

based on Northern settings were unsatisfactory. The section starts with a discussion of rational/linear models for understanding implementation and moves on those which focus more on required and available resources.

7.5.1 Rational, top-down model of implementation

In Chapter 3, Hogwood and Gunn's (1984) ideal type model of rational, linear implementation was presented as a way of conceptualising conditions under which policies were more likely to be successful. In terms of this model, and based on the findings of this study, few conditions were fulfilled by the new approach to integrated HIV/STD management (Table 7.1).

Table 7.1 Extent to which integration meets Hogwood and Gunn (1984) conditions

Hogwood and Gunn condition	Extent to which integration meets condition
1. The external context should be suitable	PARTIALLY TRUE: in some countries studied, the context was suitable but in others less so, depending on epidemiology and health care use (Chapters 2 and 4).
2. Adequate time and resources should be available.	NOT TRUE: adequate financial, managerial, technical or political resources were rarely available in sub-Saharan Africa or even in South Africa, a richer setting (Chapters 4 and 6).
3. The right combination of resources should be available.	NOT TRUE: ditto (Chapters 4 and 6)
4. The policy should be based on a valid theory of cause and effect.	NOT TRUE: HIV control through STD control in PHC settings based on one trial in a particular setting; women's health not specifically addressed in the trial (Chapter 2).
5. The relationship between cause and effect should be direct.	NOT TRUE: women's health and HIV control were complex, high-political goals, both of which were supposed to be met through STD control rather than directly (Chapter 2).
6. Dependency relationships should be minimal.	NOT TRUE: achieving integration of services would require significant restructuring of health services, which took place in South Africa but not elsewhere (Chapters 4-5).
7. There should be understanding of and agreement on objectives.	PARTIALLY TRUE: internationally, and at national level in South Africa, there was wide debate. Elsewhere, top down implementation and lack of consultation (Chapters 4-6).
8. Tasks should be fully specified.	NOT TRUE: no evidence of careful evaluation of steps required to achieve integration and trial did not adequately address these issues (Chapters 4 and 6).
9. There should be perfect communication and co-ordination.	NOT TRUE: major communication problems between national policy makers and those responsible for implementation in most countries, including South Africa (Chapters 4-6).
10. There is perfect compliance with authority.	NOT TRUE: implementers did not comply with policy decisions. In South Africa, provincial autonomy prevented effective action on national plans (Chapters 4 and 6).

However, Hogwood and Gunn themselves pointed out that these conditions are rarely fulfilled and that instead implementation often becomes a top down process of decision making which fails to take into account the many difficulties arising at different levels of the system. In a more bottom up process, implementation would involve '*interaction and negotiation, taking place over time, between*

those seeking to put policy into effect and those upon whom action depends' (Barrett & Fudge in Hogwood & Gunn 1984: 207). Thus, a wide range of stakeholders would be included in the policy debate and their interests taken into account when planning and budgeting for new activities. Such stakeholders should include those at national level, in the various divisions of the MOH involved in reproductive health. They should also include cadres from other parts of the health system, such as district managers, providers and, above all, those involved in running the logistical, administrative and financial systems on which reproductive health programmes depend. Where this does not take place, senior policy makers run the risk of policy failure due to lack of ownership and commitment at important lower levels.

In South Africa, developments in policies to integrate HIV/STD and PHC services were taking place at a time of great political and economic upheaval (Chapters 5 and 6). This context influenced the process of implementation every bit as much as agenda setting and policy transfer. Thus while national policy makers were concerned to consult widely in introducing new health policies, reform of administrative structures inhibited the extent to which true bottom-up policy making was possible. In particular, under the new federal system introduced in 1994, implementation of health care was the principal responsibility of provincial administrations with the national DOH maintaining a standard setting and strategic role only. By the time of this research, budget decisions had been devolved to provincial level, widening the gap between planned health reform at national level and the resource allocation process. In the Northern Province, these problems were especially acute for a number of reasons, including: the legacy of five inefficient and corrupt health administrations from the apartheid system which had to be merged into one; a general population which was overwhelmingly poor, black and rural; and provincial government debt restricting policy choices (see Chapter 6).

In this context, managers in the provincial DHW were understandably preoccupied by the restructuring process. Thus, while efforts were made by national programme managers to involve provincial programme staff in national policy debates, this was to some extent resented since staff were so over-stretched. Consultations came to be seen as preventing managers from getting on with their daily tasks, especially since they felt they were under-qualified for their responsibilities, had little support from senior management and did not have adequate assistance. In effect, managers were expected to be in two places at once: contributing to national policy formulation on the one hand; and managing day-to-day programme activities in the province on the other. Poor communication between provincial programme staff and the general management, including human resources, drugs supplies and finance, exacerbated their already weak capacity for implementation.

At lower administrative levels, in the regions and districts (where they existed), similar problems were played out. Here, managers were rarely asked to contribute to national policy debates. Their

perceptions of the process showed a top down system under which they received instructions from provincial line managers in the HIV/AIDS/STD or MCWH programmes, often with little apparent concern for the broader picture of transformation which region/district staff were struggling with. Minimal understanding of the objectives of integration or the complexities of incorporating the wide range of necessary services into PHC compounded problems of poor management capacity and great job insecurity. Furthermore, their exclusion from national debate meant that little of their local knowledge was incorporated into programme design and policies were not adapted to particular settings or populations.

The results at service level were seen in patchy implementation of different HIV/STD services within a rapidly evolving PHC delivery system in facilities throughout the province. Nurses in clinics had usually been trained in syndromic management of STDs but were much less aware of the broader picture of HIV/STD control or reproductive health, except where specific non-government projects covered their clinics. Generally, the perception among both providers and their clients was that these services would be a good thing but that staff capacity to undertake a wide range of new activities was limited. In particular, the sudden introduction of free PHC in clinics had increased work loads and disrupted traditional programme activities, including FP, TB and mental health. The system had yet to develop mechanisms for prioritising certain services within the largely curative care they now delivered.

Elsewhere, policy making was strongly driven by the interests of national actors, especially MCH/FP and HIV/STD control programme managers and the donors who financed the bulk of their activities (Chapter 4). These actors formed tightly knit networks of decision making which were informed primarily by international events and research rather than realistic assessments of national context and feasibility. Networks functioned rapidly and efficiently, supported by donor funds and MOH enthusiasm to attract them, irrespective of the likelihood of implementation. As a result, when it came to implementation, the district managers responsible were hardly aware of the ICPD, let alone integration or the high levels of priority which had been accorded to these areas of health care by national actors. They also had other priorities of their own, including radical changes in administrative and financial systems. Despite calls for local responsiveness, community orientation and bottom-up processes from international reproductive health and health reform agendas, the opposite was the case, with priorities determined at a national level and little room for flexibility in response to local variations or needs.

At each level of the health system, programme implementation became increasingly divergent from that intended. Thus by the time the new programme reached the clinics, there was a strong emphasis on syndromic management, a technical and clear intervention, while other crucial elements of

HIV/STD control were largely ignored. The main lesson of the implementation process was therefore that taking a policy, which was determined on high with little consultation, and simplifying it for district managers to implement as quickly as possible, led to ineffective, inefficient and unsustainable services.

7.5.2 Resources for implementation

The aim of this section is to understand better the reasons for weak implementation and why creating a more bottom up process is so difficult in low income countries. To achieve this, the process of implementation is analysed further in terms of Grindle and Thomas' (1991) model of financial, technical, managerial and political resource availability and allocation (Chapter 3).

Looking first at financial resources, the striking feature of integration was that so little information was available to policy makers on the costs of different approaches (Chapter 2). Furthermore, the likely costs of increasing service availability to a wider range of clients had not been estimated. Policy for integration was therefore developed with little attention to the financial resources required and reflected ideological as opposed to realistic agendas. In South Africa, there were more financial resources available than elsewhere in sub-Saharan Africa, although the Northern Province had less (Chapter 6). In this context, sufficient funds were available to purchase drugs and equipment and most facilities were well enough supplied to provide an appropriate level of care. Even here, however, services were already overwhelmed by the large numbers of new clients coming for free PHC, and nurses continued to receive poor remuneration and support, with low morale the result. At management levels, staff of HIV/STD and MCWH programmes did not have sufficient financial resources to undertake their activities. Furthermore, financial management capacity was extremely weak and, despite plans to devolve budgets right down to clinic level, little effort had been made to train staff appropriately. Elsewhere in Africa, health sector financial resources were severely restricted, leading to heavy dependence on unsustainable, external funds for developing policies for integration (Chapter 4). This context had already contributed to problems with obtaining drugs. Combined with lack of government ownership of policies, it created a difficult environment in which to introduce reform.

Turning next to technical resources, Grindle and Thomas highlighted the specialised guidance, training and commodities procurement required to ensure effective implementation of particular areas of policy. In this research, both the availability of technical resources and the relationships between technical actors and those primarily responsible for implementation, in human resource, finance and supplies divisions of the MOH, were considered. In South Africa, technical resources for integration were widely available at national level but severely lacking at provincial implementation level

(Chapters 5 and 6). Thus, at national level, as seen above, policy formulation was informed by international experience and expertise through networks of actors involved in transferring appropriate policies to the South African setting. In provinces, by contrast, programmes were run by staff without the necessary qualifications to understand the complexities of the new policy. For example, there was not a single HIV/STD expert throughout the Northern Province to provide advice and guidance on policy implementation because political commitment to integrated PHC mitigated against specialised services or programmes.

Technical expertise was even more limited in other countries in sub-Saharan Africa, hence their dependence on international policy advisers. Thus, the intermediaries in the process of transfer of lessons from international spheres also performed the role of advising governments on technical aspects of policy development, from drugs procurement to training programmes. In order to achieve this role, the external donors who usually paid for such technical advice found it expedient to establish powerful vertical programmes for controlling, auditing and monitoring specific areas of health care. In theory, these programmes were supposed to channel technical expertise into integrated management systems. However, in practice this was extremely difficult to achieve, partly because of the context of health reform all over the region, in which much managerial time was taken up with restructuring services and management, to the cost of specific interventions (see Chapter 4).

Many of the same issues were captured by Grindle and Thomas' category of managerial resources, which incorporates the human resources and time allocated to a particular policy. As already pointed out, capacity for implementing radical reform was weak everywhere in sub-Saharan Africa. However, international actors, engaged in rapid international policy developments (see Chapter 4), often made radical recommendations for restructuring the way services were managed in addition to demanding the delivery of new services. Such recommendations put high levels of pressure on weak management systems, already vulnerable after years of sectoral reform. Thus, where countries were more vulnerable to sudden changes in international policy, by virtue of dependence on external funds, they were more likely to have had policies coercively transferred and problems with implementation.

Because of its relative independence from international policy agendas, and thus lower exposure to coercive transfer, South Africa did not experience the same pressures from external sources of support to implement rapidly. However, such problems were mirrored in the relationship between centre and provinces. Thus, where the central DOH was producing strategic guidance on new interventions and sometimes how to implement them, it had difficulty with ensuring effective implementation at provincial level. Part of the reason for this in the Northern Province was that provincial senior managers were reluctant to commit adequate human resources or time to the specific activities required to integrate HIV/STD services with PHC. Their position was that since their whole system

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was being integrated, such services should be managed by general managers, and delivered by general nursing staff, rather than specialists. However, at the time of this research, they had failed to develop a mechanism through which general managers and providers could be alerted to national priorities or kept up to date on rapid changes in approach (Chapter 6).

These issues were related to the final category of resources: political. In South Africa, despite strong ideological commitment to women's health and integrated PHC, the process of consultation around how to implement HIV/STD policies was weak. Senior national politicians saw such issues as managerial or technical and often caused further disruption rather than helping to achieve consensus. Provincial politicians were rarely motivated to put their weight behind specific policies, despite the recognition that HIV/AIDS was a national crisis. Similarly, local consultation efforts tended to focus more on the formulation of national policy agendas rather than addressing problems of the provinces with implementation. Political resources were therefore usually focused at the agenda setting stage of policy development rather than implementation and involvement of local representatives in determining ways to implement was minimal. Political resources were also dedicated to broader system transformation and equity in health care rather than specific policies such as HIV/STD management. The stigma associated with HIV/AIDS continued to impinge on the freedom and willingness of political leaders to back much needed publicity campaigns.

Elsewhere, there was an almost total lack of evidence of mobilisation of political resources either at national level to support implementation or at local levels where implementation was actually taking place. This restricted the participation of implementers in policy decisions and contributed to the top down nature of the process. It may also have reflected the process of transfer itself, since in the context of coercive transfer, the lack of ownership of policy by government led to its being situated politically outside the normal concerns of the state and bureaucracy. As in South Africa, this was exacerbated by the reluctance of political leaders to be associated with such a culturally and politically sensitive issue. Thus the failure in these countries to transfer the ideological components of integration to national level led to weak commitment to technical or process aspects of policy, and it was at the implementation stage that this weakness became clear.

7.5.3 Implications for effectiveness and impact of service delivery

Although this discussion of policy processes is informative for understanding how policies develop, it is also important to return to the concerns of effectiveness, since the particular policy under question was supposed to address one of Africa's most pressing development issues: the HIV/AIDS epidemic. Thus, in this section, evidence from this research on the outcome of policy processes in service delivery will be reviewed. At the time of field work, syndromic management of STDs had acquired

an almost mythical status in the battery of HIV/STD control efforts, due to the striking success of the Mwanza trial and its apparent cost-effectiveness. In the period since then, the rationale for integrating this intervention with PHC weakened as policy makers realised that PHC was generally attended mostly by women and that syndromic management for women was largely ineffective.

Right from the start, however, some international policy makers were aware that syndromic management alone could never meet expectations for HIV/STD control or women's reproductive health. It was always known that other aspects of HIV/STD control also needed to be integrated with PHC, including condom promotion, awareness raising and counselling and, possibly, partner notification; indeed these were included in the Mwanza trial itself. Recently, these other interventions have received greater prominence as the international agenda has shifted away from syndromic management (Shelton 1999). What is curious, however, given that these limitations were known all along, is that in much of sub-Saharan Africa, such huge effort went into developing policies for integration which neglected key activities. A number of reasons for this neglect are suggested by the research presented in this thesis: that the development of international agendas led to over-simplification of what are by nature highly complex areas of health care; that the process of transfer further restricted policy recommendations to small nuggets of information, especially where it was coercive; that lack of government ownership of policy led to limited appraisal of the appropriateness of new interventions in different settings; and, finally, that lack of feedback from those supposed to implement reforms led to unrealistic assumptions about what could be delivered in health clinics.

For policy analysts, it is worth considering that these issues are particularly pertinent in health, compared to other policy sectors, since the technical complexities of interventions are rarely understood fully by those outside an exclusive international elite. This elite is somewhat ephemeral, constantly changing and often governed by personal relationships developed over long periods of association. Its character derives largely from its foundation in research and academia rather than in experience with implementing health care in low income countries. Links between it and those with greater practical responsibility are often *ad hoc* and characterised by controversy rather than consensus. Power relations between the international technical elite and national managers are coloured by intermediate relationships with international funding bodies.

By contrast with this international elite, the effect of policy development failures was felt in clinics where, as seen poignantly in South Africa, staff were left more confused and their patients more sick than necessary. In a country in which around a quarter of pregnant women now test positive for HIV, and in which sufficient resources are available, it is a tragedy that both providers and clients continue to exhibit the lack of awareness found in Chapter 6. Failure on the part of national and international policy makers to communicate the intricacies of service requirements adequately to health care

managers meant that, in a situation of dramatic epidemic and radical political change, a window of opportunity was missed.

7.6 Over-riding issues and concepts to explain these patterns of policy development

What has been described above is an extremely complex picture of interactions between different stages of the policy process, each dependent on networks of actors working to influence decisions according to their interests. Especially in South Africa, decisions were being made in a rapidly evolving context, including complete political and economic transformation affecting every sphere of public life. Furthermore, the evolution of context was itself partially a function of the way the actors interacted in networks, creating the dialectic between agency and structure which is at the core of so much social science theory. Before concluding, therefore, two over riding issues are discussed: first, the role of networks and the actors comprising them; and, second, the institutional framework which guided the functioning of these networks and the broader policy process. These issues were also addressed by Brinkerhoff (1997) in a model which described the context of policy, the institutions involved, patterns of interactions between actors and their impact on policy effectiveness (Chapter 3).

7.6.1 Networks, structures and actors

There were three aspects of the networks studied in this research which were significantly different from much of the literature on this topic: they spanned international and national level policy communities rather than involving intra-national or bilateral relations; the participation of significant numbers of policy intermediaries; and the exclusion of implementers from setting agendas and formulating policy. In the first area, there were many important influences on national policy which originated from the international sphere. Thus whether through the gradual diffusion of ideas, the rigours of global markets, or the imposition of international agreements, national decisions were strongly affected by global events and discourses. Global policy discourses were substantively different from those which took place at national level, in terms of who was involved in generating ideas, who was responsible for carrying out any recommendations and who was likely to be affected by the resulting policies.

This had implications for the kinds of actors involved in policy networks and the power relations which guided their relationships. In most low income countries, with health sectors dependent on external resources, it was accepted that the international actors who provided resources also influenced how such resources should be spent. Although lip-service was paid to local ownership or involvement, the reality was often less satisfactory with parallel decision making networks established to meet donor demands. The South African setting was quite different: there was some evidence of donor influence but far more apparent was the relative independence of policy makers in day-to-day

decisions over resource allocation. Similarly, national networks consisted largely of national level actors and operated independently of international agendas. Nevertheless, networks were influenced by the prevalent international ideas in a variety of ways. Thus while it would be wrong to argue that South Africa was compelled to take particular decisions, actors were clearly under some professional obligation at least to consider international gold standards when designing new policies. National actors were therefore affected by both national and international discourses when making their decisions and, when expressing interest in particular policy issues, could draw on international experience if required. Although the literature on transfer or convergence of ideas and technology contributed to analysing these processes, it did not address adequately the particular circumstances of low and middle income countries and their relations with the international sphere.

One key aspect of the functioning of networks in health policy in low income countries was the second area to be addressed here: the role of intermediaries, or the actors who formed the interface between international and national levels. Intermediaries were based in academia, NGOs, think tanks, or international organisations. They had many different roles, leading to varied agendas and modes of working. Their participation in networks was under-emphasised in theoretical models where the focus was mainly on relations within or between government actors. However, their role was important, both at international level, in influencing policy agendas, and at national level, in putting policy into practice.

Interactions between intermediary and government actors in networks were determined by their relative interests in and power over decisions taken within the network. Where governments were stronger themselves, intermediaries were better assimilated but had more restricted functions to provide technical advice or advocacy on specific areas of interest. This was the case among the myriad NGO and academic participants in policy decision making in South Africa. Here, **national** intermediaries served as the interface between international and national policy and were in a strong position to adapt international agendas to their local context. Where governments were relatively weak, as in most other sub-Saharan African countries, the role of intermediaries was less well co-ordinated but much broader, including greater involvement in formulation of policy and decisions over resource allocation. By contrast with South Africa, the intermediaries linking international and national agendas were often **international** themselves, with different implications for the way in which international agendas would be interpreted for particular national settings.

The third area to be examined in relation to networks stood in contrast to the inclusion of policy intermediaries and was the relative exclusion of implementers from national policy networks. There was a considerable literature on the participation of implementers in decisions, some of which was addressed in this study. What was rarely covered was the possibility that **the participation of**

international actors in national policy networks itself contributed to the greater exclusion of a wider range of national actors, such as those responsible for implementation. In South Africa, where the participation of international actors was relatively limited, those responsible for implementation in the provinces were consulted over many aspects of policy development. In addition, they were given considerable constitutional independence over resource allocation. Problems arose, however, because bureaucratic and financial resources were completely over-stretched by multiple commitments and priorities.

Elsewhere in sub-Saharan Africa, there was almost no evidence that those responsible for implementation had been consulted over policy decisions or included in the elite networks making them. Although not specifically addressed here, one possible reason for this exclusion was the dominance of international actors in these networks and their relatively weak mechanisms of communication with implementers based in provincial or district offices. Thus, efforts to involve local administrators were rarely truly participatory and frequently took place well after key decisions had been taken, leaving little opportunity for real input. They could not be characterised as networks, since inclusion was determined by invitation and according to top-down perceptions of hierarchy and responsibility. Furthermore, since resource allocation in most of these countries remained highly centralised, local actors had little bargaining power with which to influence national policy.

7.6.2 Institutions of governance

One of the most important elements of the context within which these networks were functioning was the political institutions which determined systems of governance in each country. In South Africa in the 1990s, these institutions were evolving rapidly from a racist state of limited participation into a broad-based liberal-democracy. Many political actors were particularly keen to promote widespread participation, and the political process in South Africa was notable for its reliance on processes of consensus building rather than conflict (see Chapter 5). This affected every area of policy, including health: the new government clearly took responsibility for provision of health services, and constitutional systems of legitimacy and accountability were enacted to promote these efforts. Similarly, intermediaries became adept at working with the new institutional establishment and actively contributed to the dynamic process of its development.

However, these special characteristics of the 1990s in South Africa could never be said to be representative of elsewhere in the region. In many countries, by contrast, there was little scope for optimism over the performance of political institutions to guide policy processes. Many governments were poor, had little democratic legitimacy and were based on systems of patronage rather than popular support. Accountability at either local or national levels for delivery of health services was

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limited. Furthermore, donor-dependence itself introduced different problems of accountability. Despite professing worthy intentions towards the countries in which they worked, donors were more accountable to those providing their funds (either rich country governments, in the case of multi-lateral donors, or their own tax payers, in the case of bilateral agencies) than to those they were designing policy for. Although the systemic reforms donors were also promoting in the 1990s ostensibly aimed to address these problems (Berman 1995; Janovsky 1996), such efforts have in general been more successful where the government was itself more committed to strengthening institutions (Brinkerhoff & Goldsmith 1995).

This institutional weakness, and the fact that intermediaries were often outside the national political system, led to frustration among international actors with the slow progress of policy development. They responded by working outside mainstream policy processes on priority issues; the vertical programmes of the 1980s were largely created by external donors in this way, after slow progress through the community-oriented and equitable ideals of PHC (Lush et al. 1999). Similarly, despite commitment to integrated reproductive health approaches at international level, many donors continued to support vertical programmes nationally. A major question remained, however, over whether in the methods used to promote their interests, donors actually inhibited the development of indigenous policy processes through the evolution of appropriate institutions. Thus governments which were distracted by the resources associated with donor priorities may have been less able to focus on developing their own systems of responsibility and accountability for equitable, affordable and high quality service provision.

Arguably, for addressing a crisis like HIV/AIDS, issues such as sustainability or ownership are secondary in the fight to control the spread of the epidemic: effective, targeted efforts in the short term may be more effective than longer term approaches[58]. In direct contrast, in South Africa, high priority was accorded to long term development of proper democratic institutions and appropriate allocation of responsibility for service delivery, with emphasis on provincial autonomy and ownership of policy. However, for addressing specific policy problems, such as HIV/AIDS, this proved inadequate. With the benefit of hindsight, it is clear that South Africa was extremely unlucky that its HIV/AIDS epidemic coincided so precisely with this period of transformation. The challenge now is for the government to use its new political systems to allocate sufficient resources and mobilise wide participation to fight this epidemic. Elsewhere, external funders' initiatives to hasten attention to HIV/AIDS effectively countered national political intransigence. However, policies formulated in this way were never implemented due to lack of resources and accountability at lower levels.

7.7 Conclusions

By meeting the aims set out in Chapter 1, this thesis has added to the theoretical understanding of policy analysis in low income countries and increased knowledge on reproductive health policy development in these settings. An initial review of the conceptual literature on agenda setting, policy transfer and implementation led into an eclectic approach in order to render models developed for Northern settings appropriate for low income countries. This culminated in the conceptual framework shown in Figure 3.2. In this concluding chapter, further discussion of the application of this framework to new empirical data demonstrated how the research presented had filled significant gaps in understanding of how policies develop in these contexts.

By bringing together a huge amount of theoretical literature and published information and combining it with new research in a highly complex setting, this research made conceptual contributions to several areas of policy analysis. These included: agenda setting at international level, especially interactions between different international policy elites; differences in the relationship between agenda setting and implementation in Southern compared to Northern settings; the functioning of international organisations in low income countries, and ways in which international involvement disrupts national political institutions; the relationship between agency and structure, particularly the extent to which actors in low income countries adapt policy to their own context when transferring it from international levels; and, finally, the relationship between international and national policy processes on the one hand and effective service delivery on the other.

The overarching conclusion on the policy development process in low income countries was that, the more governments were dependent on international public health finances, the more they were vulnerable to external interests influencing policy decisions. External interests in this case were founded on rather weak evidence that the policy in question would be effective but strong international ideological consensus on its priority. In much of sub-Saharan Africa, this had important effects on the feasibility, quality and accessibility of services. In South Africa, where such dependence was limited, agenda setting and policy formulation took place through national networks and interests. However, despite these efforts, the context of political and economic transformation inhibited effective implementation in the provinces. Nevertheless, this analysis suggested that, once the country stabilised, there would be greater room for optimism that public health services could improve.

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[58] Where an epidemic is growing exponentially, it is more important to address it early and effectively, while prevalence remains low, than to wait for sustainable systems, which might only function when prevalence is already high.

There were also new findings on the development of reproductive health policies. First, integration of HIV/STD services with PHC rose swiftly onto the international health policy agenda, driven largely by ideological forces, and the startling results of a single trial, rather than by careful analysis of its likely effectiveness or feasibility in low income countries. This agenda was rarely reflected in national policy agendas, except in South Africa, where there was strong commitment to integrated, comprehensive PHC, which indirectly contributed to integrating HIV/STD services in the overall package. Second, it was extremely difficult to integrate services effectively since this required significant injections of financial, political and managerial resources. Where these were not available, the policy was essentially not feasible; even in South Africa, with substantially more resources than elsewhere in the region, integration was severely taxing the health system. Third, integration efforts tended to concentrate on a limited set of interventions, emphasising clinical over preventive measures and focusing on simplified algorithms rather than developing a more holistic approach to preventing and managing HIV and STDs or improving women's reproductive health. Finally, given these problems, integration was often not the best way to achieve these goals, especially in contexts of low HIV/STD prevalence or low FP use. Either targeted approaches outside PHC were required, or a different constellation of services needed to be integrated, which included prevention, risk assessment and health promotion activities.

This thesis has made substantial conceptual and empirical contributions to understanding the processes of policy development for reproductive health in low income countries and, in so doing, it has highlighted some major short comings in the literature. Many of these deserve research attention and have potentially significant roles in promoting more effective approaches to public health and thereby improving human well-being. In addition, given relatively limited knowledge of political processes in low income countries, there is a rich source of historical and contemporary political, economic and cultural information to be uncovered by future students. Below is a summary of two key areas which should prove both intellectually stimulating and of public benefit.

The first area relates primarily to policy analysis itself and understanding policy development in low income countries, the networks involved and the institutions which guide their work. First, the process of agenda setting deserves far more attention, especially at national level and how it relates to implementation. Second, relations between international and national actors and the functioning of networks which span these two levels are areas which have only very recently received adequate attention. Third, the process of penetration of national policy processes by international actors and its impact on elitism and exclusion of implementers from important policy decisions is an area which should shed light on the current unsatisfactory relations between low income country governments and their benefactors.

The second area relates more closely to the experiences of low income countries, both in terms of the specific reproductive health policies they have been trying to develop and the context within which this has been taking place. There is no question of the importance of the political context in low income countries for determining health policy: while it may be easier to conceive of public health as a purely technical field, this is no longer acceptable given the kind of evidence presented here and increasingly elsewhere. Much more work is needed to apply understanding of political processes to health policy, even in a country like South Africa where the health policy process is deeply self-conscious about its context. Finally, on a related point, the relationship between ideology and technology is particularly pertinent for reproductive health itself, an area of public health which reaches some of the most sensitive and politically charged aspects of human life.

By participating in the process of expanding theoretical knowledge in these areas, this thesis also aspired to contribute in some small way to improving public health around the world. The ravages of HIV/AIDS will be with us for some time and, in sub-Saharan Africa, will be one of the biggest hurdles to much-needed improvements in standards of living this century. Women will also continue to bear the brunt of sickness related to normal, reproductive events and, in the Northern Province of South Africa, as elsewhere, many of them will remain without access to health care they deserve. Although the research did not advance new technology or more cost-effective interventions, the intention was to provide insight into how such technology or interventions as exist could better reach those who need them. By understanding reasons for failure to develop the right policies or to implement them, policy makers in sub-Saharan Africa and their international colleagues might learn from the mistakes of the past and thereby start to make headway against these enormous burdens of ill health.

7.8 References

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APPENDIX A: PEOPLE INTERVIEWED IN SOUTH AFRICA

National (Pretoria/Johannesburg)

Ron Ballard	Head, STD Reference Laboratory, South African Institute for Medical Research, Johannesburg and Chair of STD Core Committee in National AIDS Programme. 21 July 1998 and 2 March 1999.
Kim Dickson	Deputy Director, Reproductive Health Research Unit, Chris Hani Baragwanath Hospital, Soweto. 29 June 1998.
Sharon Fonn	Deputy Director, Women's Health Project, Department of Community Health, University of Witwatersrand, Johannesburg. 22 July 1998.
Janet Frohlich	Senior Researcher, Medical Research Council, Pretoria. July 1998.
Lucy Gilson	Deputy Director, Centre for Health Policy, Department of Community Health, University of Witwatersrand, Johannesburg. July 1998.
Harry Housler	TB Co-ordinator, Directorate HIV/AIDS and STDs Department of Health, Pretoria. July 1998.
Barbara Klugman	Director, Women's Health Project, Department of Community Health, University of Witwatersrand, Johannesburg. 5 May 1998.
Julian Lambert	Senior Advisor: Health and Population, UK Department for International Development, Pretoria. 12 May 1998 and 5 March 1999.
Steve McGarry	Reproductive Health Consultant, Pretoria. February 1998.
Eddy Mhlanga	Director, Directorate Maternal, Child and Women's Health Directorate, Department of Health, Pretoria. 11 May 1998 and 5 March 1999.
Tatiana Ndondo	Deputy Director, Planned Parenthood Association of South Africa, Johannesburg. 29 June 1998.
Graham Neilsen	STI Co-ordinator, Directorate HIV/AIDS and STDs, Department of Health, Pretoria. 13 May and 20 July 1998.
Helen Schneider	Director, Centre for Health Policy, Department of Community Health, University of Witwatersrand, Johannesburg. 12 June and 23 July 1998.
Kinh San Tint	Researcher, Women's Health Project, Department of Community Health, University of Witwatersrand, Johannesburg. 5 May 1998.
Brian Williams	Professor of Epidemiology, Miners' Board of Health, South African Institute for Medical Research, Johannesburg. 13 May 1998.
Ken Yamashita	Health Advisor, US Agency for International Development, Pretoria. 5 March 1999.

Northern Province (Pietersburg)

Charles Badenhorst   District Health Information Systems Commission, Department of Community Health, MEDUNSA, Pietersburg/Mankweng Complex, Pietersburg. 21 May 1998.

Jack Barker   TB Consultant, Mankweng Hospital, Pietersburg/Mankweng Complex, Pietersburg. 28 May 1998.

Hannah Barker   Researcher, Satellite Department of Community Health, MEDUNSA, Pietersburg/Mankweng Complex, Pietersburg. 22 May 1998.

Nicholas Crisp   Superintendent General, Northern Province Department of Health and Welfare, Pietersburg. February and 20 May 1998.

Sarah Galane   Deputy Director, AIDS Training, Information and Counselling Centre, Pietersburg. 19 May 1998.

Kobus Herbst   Director, Satellite Department of Community Health, MEDUNSA, Pietersburg/Mankweng Complex, Pietersburg. 22 May 1998.

Elsie Hoffman   Health Information (Infection Control/AIDS Counselling), Pietersburg Hospital, Pietersburg/Mankweng Complex, Pietersburg. 28 May 1998.

Tanyane Mariba   Deputy Director General, Health Care Branch, Northern Province Department of Health and Welfare, Pietersburg. 21 May 1998.

Essina Mabitsela   Deputy Director, Maternal, Child and Women's Health, Northern Province Department of Health and Welfare, Pietersburg. 6 May and 13 July 1998.

Lydia Maloba   Health Information (Infection Control/AIDS Counselling), Pietersburg Hospital, Pietersburg/Mankweng Complex, Pietersburg. 28 May 1998.

Nelly Manzini   Director, Directorate Primary Health Care and Districts, Northern Province Department of Health and Welfare, Pietersburg. 14 July 1998.

Rose Mazibuko   Chief Director, Division Primary Health Care and Districts, Northern Province Department of Health and Welfare, Pietersburg. 8 June 1998.

Sinah Mhlangu   Assistant Director, Policy and Research, Northern Province Department of Health and Welfare, Pietersburg. 6 May 1998.

Joyce Mogale   Deputy Director, Laboratory Services, Northern Province Department of Health and Welfare, Pietersburg. March 1999.

Jeff Muschell   District Health Information Systems Commission, Department of Community Health, MEDUNSA, Pietersburg/Mankweng Complex, Pietersburg. 21 May 1998.

Lorna Papo   Assistant Director, HIV/AIDS and STDs, Northern Province Department of Health and Welfare, Pietersburg. 20 May and 14 July 1998.

Ottilia Raselomane   Health Information (Infection Control/AIDS Counselling), Pietersburg Hospital, Pietersburg/Mankweng Complex, Pietersburg. 28 May 1998.

Salome Rathete   Assistant Director, TB, Northern Province Department of Health and Welfare, Pietersburg. May 1998.

Jakes Rawlinson   Consultant TB Advisor, Satellite Department of Community Health, MEDUNSA, Pietersburg/Mankweng Complex, Pietersburg. 22 May 1998.

Herbie Smith   Director, AIDS Training, Information and Counselling Centre, Pietersburg. 19 May 1998.

Maritjie van Niekerk   Human Resources Consultant, Northern Province Department of Health and Welfare, Pietersburg. 20 May 1998.

Districts/Regions in the Northern Province

Central Region (May-June 1998):

M. Masipa, Regional Director; D.A. Montjane, Deputy Director: PHC; D. Matji, Reproductive health co-ordinator; C.A. Makgopa, Chief Pharmacist; F. Moloisi, Assistant Director: Information and Epidemiology; M. Moloi, Medical Superintendent; Dr Zulu, OPD Clinician; M. Selepe, Incharge HIV Centre; D. Choshi, Counsellor HIV Centre; M.B. Sepuma, Acting Incharge; S. Mpyana; J. Moloto; F. Mashalane; M.F. Segodi, Incharge; E. Mphago; P. Mphela; H. Mathapo; C. Mailula, Incharge; J. Chochi; C. Dipela; F. Madikoto; M. Motya; K. Ramalla, Incharge; Ms Semenya; Ms Mokhonyana; Ms Mokgoebo; Ms Molepo; Ms Kgoogo; Ms Mathobela.

Lowveld Region (June 1998):

J. Mufamadi, Regional Director; M. Mdluli, Deputy Director: PHC; T. Mabunda, Assistant Director: TB; E. Shabalala, Deputy Director: Health Care; Dr Nsabue, Acting Medical Superintendent; D. Nkuna, Secretary; Dr Kabai, OPD Consultant; Ms Mabitsela, Matron; Ms Mahlatji, Community Matron; Ms Phuni, Chair, HIV Committee; Mr Mabasa, Pharmacist; Mr Phaswana, Microbiologist; S.C. Mapimele, Incharge; O. Baloyi; F. Mamyika; Y. Mafada; C. Sekgobela; G. Machaimana; E. Bruma, Incharge; G. Balogi; G. Mushwana; S. Mukhawana; I. Häfner, Incharge; M. Moake; B. Ngobeni; H. Nhlangwana; A. Mushwana, Incharge; Ms Mukhawa; D. Mongwe; T. Mohlaba; G. Mhelembe; O. Mohlaba; B. Shilovane; G. Shiburi; G. Mboweni.

Northern Region (July 1998):

A. Mavhusha, Regional Director; J. Netshilindi, Deputy Director: Primary Health Care; V. Mapaha, Chief Professional Nurse; K. Maholwane, Deputy Director: Health Care Services; M.J. Tshishonga, HIV/STD Co-ordinator; M. Maumela, Information and Epidemiology; E.M. Labuschagne, Regional Pharmacist; C. Luvhengo, Community Matron; Dr Ddungu, OPD Consultant; Dr Kiggundu, Superintendent General; Ms Maumela, Matron; S. Ndou, Laboratory Technician; L. Mathivha, Acting Incharge; J. Rasalawenavho; E. Natshivhongwani; T. Munonde; V. Netshandama; F. Makhomu; V. Tsivhani; T. Makhesha; V. Netshisaulu, Incharge; M. Munyai; E. Makana; R. Makuya; M. Mavhungu; L. Nyoni, Incharge; C. Nemalamangwa; F. Mashathini; E. Masevhe; A. Nduvheni; J. Maphozana, Incharge; T. Munzhalale; A. Musetsho; F. Netshimboni.

Southern Region (June 1998):

W. Shilumane, Regional Director; M. Shabalala, Acting Deputy Director: PHC; M. Maredi, Deputy Director, Health Care; Dr Masudi, OPD Consultant; Ms Segage, Matron; Dr Spivack, Medical Superintendent; Ms Mangoale, Infection Control; Ms Dibetso, Groothoek Health Ward HIV/STD Co-ordinator; L. Maja, Incharge; A. Muroa; N. Mogale; D. Maphutha; J. Ledoaba; A. Metlabe; R. Thage; E. Chidi; M. Mojapelo; M. Mashego, Incharge; D. Maredi; M. Tshabalala, Incharge; M. Matata; R. Letoaba; G. Mafokate; M. Sechabe; G. Thoka, Incharge; M.S. Ratsoma; S.L. Sgobudo; C.E. Chokoe.

APPENDIX B: QUESTIONNAIRES AND RESEARCH GUIDELINES

Below are the protocols used in district field work in South Africa. For the other three countries, similar protocols were used with minor changes to drug regimes, training programmes etc. There are five separate protocols as follows: the district office questionnaire; the district hospital OPD questionnaire; the MCH/FP clinic In Charge questionnaire; the MCH/FP clinic staff focus group guidelines; the MCH/FP client in-depth interview guidelines (see Chapter 1).

QUESTIONNAIRE FOR DISTRICT OFFICE

DISTRICT NAME: _____

DISTRICT OFFICER: _____

DATE: _____

TIME: _____

"We would like to ask you some questions about the services available in this region which are providing reproductive health care. By reproductive health care, we mean services which meet needs for management of HIV and other sexually transmitted diseases as well as those for family planning and other aspects of MCH. We are particularly interested in services for women of reproductive age but would also like to know about services for men or younger women where they are linking with mainstream primary health care. Our focus is on the extent to which these services are currently providing integrated reproductive health care or whether such programme changes have been planned.

We are also interested in whether managers at the Region have been developing processes to plan new services. We would like to find out the problems you have encountered in terms of costs, financing, administration and logistics as well as innovative ways you have found for coping.

At any point, if you feel that there is relevant information we have not covered in our questions, we would welcome your additional comments."

A. INTRODUCTION

1.   **In this region, which person holds the following responsibilities? Please describe briefly their activities (name and position):**

(i)   MCH/FP

(ii)   STD management

(iii)   HIV prevention and management

3.   **Awareness/availability of policy documents (as found in policy analysis)**
[list policy documents and directives from provincial/regional office]

(i)

(ii)

(iii)

4.   **What, if any, activities have taken place in your Region in response to these documents? What changes are planned?**

4. Process of integration of reproductive health care in the Regions.

(i) Training

(ii) Drugs logistics

(iii) Increased costs incurred

(iv) Financing

(v) Management links

5. Funding of reproductive health care in Region. [process of obtaining funds; where they come from; how they decide where or how to spend them; special donor projects; can line items be transferred]

6.   Definitions and minimum recommendations for STD service provision (taken from WHO/GPA 1993)

(a) Please could you explain how you would define integrated reproductive health services?

(b) Are treatments for STDs available in this Region? (Please describe the treatments)

(c)   Is STD treatment available in MCH, ANC and FP services in this Region? (What does this include - syndromic, risk assessment, drugs etc.)

(d) Where is the nearest referral centre for STDs with laboratory backup?

(e) Do you test all, some or zero ANC attenders for syphilis serology? (evidence)

(f) Do new-born children receive ocular prophylaxis for gonorrhoea?

(g) Do you address high-risk behaviour groups separately with STD services?

B. RESOURCES AND LOGISTICS

7. **Resource allocation and flows for different components of integrated services** [to be used as a checklist for information - may need to visit Regional Finance Office]

Name of agency/source	Name of project/service	Reference time period	Amount (currency:)
Central government vertical programmes: **MCH:** **HIV/STD:**			
Central government general management **Transport:** **Drugs:** **Staff salaries:**			
Donors: **DFID:** **UNFPA:** **UNICEF:** **Other:**			
General other			

8. **Are you able to transfer funds between line items?**

9.   Decentralization of financial and administrative decisions

(i) To what extent and how have you been affected by the increases in administrative decision making at regional level. What about decentralization to the new districts?

(ii) What has been the impact of increased financial responsibility at regional level?

(iii) What has been the involvement of local political representatives in health care decision making in this region?

(iv) What will be the new line of authority for making financial and administrative decisions?
  (a)   within district

  (b)   coming from region/province

(v) What has been the role of Local Authorities in making health or reproductive health service decisions?

10.   Logistics at Regional level
(i) How many vehicles are available in the Region for reproductive health services (plus type)?:
  (a) exclusive use

  (b) shared use

(ii) How does the Regional office obtain drugs?

    (a) Where do supplies of drugs come from?

    (b) What is the system for obtaining supplies from the central medical stores (administration, frequency etc.)?

    (c) During the last 6 months, have you had stock out of any contraceptive supplies at regional level (add details)?

    (d) During the last 6 months, have you had stock out of any STD drug (add details)?

    (e) Is the Region able to purchase drugs locally?

(iii) How does Regional office supply drugs to facilities?

    (a) What happens if there are stock outs?

    (b) Are providers able to purchase drugs locally (how much)?

11. Drug stocks and flows at Regional level (contraceptives, STD diagnostics and treatments)

Question	Planned stocks (# months)	Existing stocks (# months)
Oral contraceptives		
Condoms		
IUDs		
Injectables		
Other methods		
STD tests (from policy analysis) 1. 2. 3. 4. 5.		
STD drugs (from policy analysis) 1. Cyprofloxacine 2. Doxycycline/tetracycline 3. Erythromycin 4. Benzathine penicillin 5. Metronidazole 6. Imidazole 7. Spectinomycin		
HIV tests		
Other consumables: Gloves Specula Sterilising equipment		

C. TRAINING

12.   In-service training programmes for integration completed for MCH/FP providers

Question	Number Staff Planned	Number Staff Completed
Syndromic management of STDs		
Syphilis screening		
Risk assessment for sexual behaviour		
Counselling skills		
Partner notification / referral		
Specific donor training activities		

13.   For MCH/FP staff who have received training in integration of STD management, is there an adequate supervision and support system from the Region? [open ended questions on problems?]

D. COUNSELING, IEC AND CONDOMS

14.   Condoms

(i)   process of distribution in Region

(ii)   availability at MCH/FP clinics

(iii)   availability at STD services

(iv)   condom counselling at STD services

(v)   particular distribution schemes (including private sector/social marketing)

E. LINKS WITH REGIONAL FACILITIES REFERRAL PATTERNS

15. **Record keeping for reproductive health.** [check on clinic level data available at District for availability of information on client numbers, types of treatment and drugs used]

Clinic 1

Clinic 2

Clinic 3

Clinic 4

F. GENERAL ATTITUDES

16.   Do you think that your regional drugs bill has increased with reproductive health services being integrated?

17.   Do you think that your Regional salary costs have increased with reproductive health services integrated?

G. OUTPUT INDICATORS

18. Types of physical services available in the Region and links between them

Type of service	Available in region headquarters	Available elsewhere in region	# users per month (men and women)	# Doctors providing services	# Nurse/ midwives providing services	# Days of opening per week	# Hours of opening per day	Formal referral links with FP/MCH clinics
Dedicated STD clinic/staff in hospital OPD								
HIV testing in hospital								
Laboratories for diagnosis/ screening from MCH/FP outlets								
Syphilis screening at antenatal clinic								
Other STD screening at MCH/ FP clinic								
Other STD treatment at MCH/ FP clinic								
HIV testing at MCH/FP clinic								
Private sector reproductive health services								
Adolescent services								

13

Questionnaire for District Office

QUESTIONNAIRE FOR OUTPATIENTS DEPARTMENT

REGION NAME: ——————————————————————

HOSPITAL NAME: ——————————————————————

STD IN CHARGE NAME*: ————————————————————

DATE:————————————————————————

TIME:————————————————————————

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* Either In-charge of OPD or, where available, person responsible for STD/HIV services specifically, either at OPD or external site.

"We are conducting research into services available in this district which are providing reproductive health care. By reproductive health care, we mean services which meet needs for management of HIV and other sexually transmitted diseases as well as those for family planning and other aspects of MCH. We are particularly interested in services for women of reproductive age but would also like to know about services for men or younger women.

We are also interested in whether providers in the District have been developing processes to implement new services. We would like to find out the problems you have encountered in terms of costs, financing, administration and logistics as well as innovative ways you have found for coping.

At any point, if you feel that there is relevant information we have not covered in our questions, we would welcome your additional comments."

A. INTRODUCTORY QUESTIONS

1.   In this hospital, which person holds the following responsibilities? Please describe briefly their activities (name and position):

(i)   MCH/FP

(ii)   STD management

(iii)   HIV prevention and management

3.   Availability of therapeutic guidelines (as found in policy analysis, e.g. syndromic management, flow charts, algorithms, etc)

(i)

(ii)

(iii)

4. **Process of integration of reproductive health care in the hospital.**

(i) Training

(ii) Drugs logistics

(iii) Increased costs incurred

(iv) Financing

(v) Management links

5. **Funding of reproductive health care in this hospital** [process of obtaining funds; where they come from; how they decide where or how to spend them; special donor projects; can line items be transferred]

6. **Definitions and minimum recommendations for STD service provision (taken from WHO/GPA 1993)**

(a) Please could you explain how you would define integrated reproductive health services?

(b) Are confidential and effective treatments for STDs available at this hospital?

(c) Is STD treatment available in MCH/FP services elsewhere in this Region?

(d) Where is the nearest referral centre for STDs with laboratory backup?

(e) Do all ANC attenders at this hospital get tested for syphilis serology? (evidence)

(f) Do new-born children at this hospital receive ocular prophylaxis for gonorrhoea?

(g) Do you address high-risk behaviour groups separately with STD services?

B. GENERAL STOCKS AND FLOWS (DRUGS AND EQUIPMENT)

7.   Drug stocks and flows at this hospital (contraceptives, STD drugs and other consumables)

Question	Planned stocks (# months)	Existing stocks (# months)
Oral contraceptives		
Condoms		
IUDs		
Injectables		
Other methods		

STD tests (from policy analysis)
 	
    1.
 	
    2.
 	
    3.
 	
    4.
 	
    5.		

STD drugs (from policy analysis)
 	
    1. Cyprofloxacine
 	
    2. Doxycycline/tetracycline
 	
    3. Erythromycin
 	
    4. Benzathine penicillin
 	
    5. Metronidazole
 	
    6. Imidazole
 	
    7. Spectinomycin		

HIV tests		

Other consumables:
 	
    Gloves
 	
    Specula
 	
    Sterilising equipment
 	
    Audio privacy
 	
    Visual privacy
 	
    Syringes		

8.   What is the process for ordering more of these stocks from the Regional/provincial office?

9.   Are you able to purchase drugs, tests or other consumables on the open market in the case of stock outs at the hospital?

C. TRAINING

10.   In-service training programmes for integration completed for providers of STD services

Question	Planned	Completed
Syndromic management		
Syphilis screening		
Risk analysis for sexual behaviour		
Counselling skills		
Partner notification / referral		
Specific donor training activities		

D. COUNSELLING AND IEC (ESPECIALLY CONDOMS)

11.   Are education materials available providing information on MCH/FP and STD services at this hospital? (Evidence and location of materials.) How are they used?

12.   Are education materials specifically for condoms available at this hospital? (Evidence and location) How are they used?

13.   What is the attitude of OPD staff to condom promotion and counselling? Are condoms used for family planning?

14.   Do providers demonstrate how to use condoms with their clients (men and women)?

15.   Do providers at the MCH/FP clinic in this hospital recommend condoms for family planning purposes?

E. LINKS TO MCH/FP CLINICS AND PROVINCIAL/REGIONAL SERVICES

16.   What kind of management links does this hospital have with STD services at provincial level?

17.   For what kinds of tests or treatments would you refer clients to provincial services?

18.   How many clients each month do you refer up to provincial/regional services for further tests or treatment? What is the process of referral and are you ever informed about the treatments they received?

19.   What kind of management links does this hospital have with other MCH/FP services in this Region?

20.   How many clients do you receive each month who have been referred from MCH/FP services at this hospital or in this region? What is the process of referral and is there any means of informing their clinic of origin about the treatment received?

21.   Are there any clinics which are just for men in this hospital or elsewhere in the Region? What are their links with: (a) this OPD; and (b) general MCH/FP services?

F. ATTITUDES TO INTEGRATION

22. Do you think it is a good idea to link STD services with MCH/FP services in the hospital? How could these links be improved?

23. What are the implications for your staff of integration, in terms of costs and workload? What will be the likely impact of these considerations on the success of integration?

24. What do you think would be the attitudes of your clients to integrated services?

25. How would you increase integration of STD services with MCH/FP services in clinics around the Region? What implications would such service expansion have on workload at this hospital?

26. Do you make any efforts to involve or notify the partners of your infected clients (referral slips; counselling on partner discussions; etc.)? If not, would this be possible?

G. OUTPUT INDICATORS (USERS; CONDOMS)

27. Please could you give us the following output information for services available at this hospital:

Indicator	Number in last full month with records

Clients seen:
    (a) men
    (b) women	

Clients referred to province	
Condoms distributed	
STD tests performed	
HIV tests performed	
STD treatments performed	
IEC materials given out	
Referrals from MCH/FP in hospital	
Referrals from other MCH/FP in Region	

QUESTIONNAIRE FOR MCH/FP CLINIC

REGION NAME: _____

CLINIC NAME: _____

IN CHARGE NAME*: _____

DATE: _____

TIME: _____

* Either In-charge of overall clinic activities or person responsible for MCH/FP services specifically.

"We are conducting research into services available in this district which are providing reproductive health care. By reproductive health care, we mean services which meet needs for management of HIV and other sexually transmitted diseases as well as those for family planning and other aspects of MCH. We are particularly interested in services for women of reproductive age but would also like to know about services for men or younger women.

We are also interested in how providers in the District have been developing processes to implement new services. We would like to find out the problems you have encountered in terms of costs, financing, administration and logistics as well as innovative ways you have found for coping.

At any point, if you feel that there is relevant information we have not covered in our questions, we would welcome your additional comments. "

A. INTRODUCTORY QUESTIONS

1.   In this clinic, which person holds the following responsibilities? Please describe briefly their activities. Are these activities included in their job descriptions? Which of these are the most important in your view, in terms of magnitude of the problem amongst your clients?

(i)   MCH/FP

(ii)   HIV/STD management and referral

(iii)   HIV/STD prevention and education

2.   Existence of specific integrated reproductive health services (e.g. maternal syphilis screening)

3.   Awareness/availability of policy documents or directives from provincial/regional office (as found in policy analysis).

(i)

(ii)

(iii)

4. **Process of integration of reproductive health care in the clinic.**

(i) Training

(ii) Drugs logistics

(iii) Days/hours of opening for different components of reproductive health

(iv) Increased costs incurred

(v) Details on guidelines for STD/HIV prevention and treatment

5. **Supervision and support for reproductive health care in this clinic (number of visits/frequency of visits)?**

6. **Definitions and minimum recommendations for STD service provision (taken from WHO/GPA 1993)**

(a) Please could you explain how you would define integrated reproductive health services?

(b) Are treatments for STDs available at this clinic? (Please describe these treatments)

(c) Is STD treatment available in MCH/FP services elsewhere in the Region?

(d) Where is the nearest referral centre for STDs with laboratory backup?

(e) Do all or any ANC attenders at this clinic get tested for syphilis serology? (evidence)

(f) Do new-born children at this clinic receive ocular prophylaxis for gonorrhoea?

(g) Do you provide any services for high-risk behaviour groups with STD problems?

B. GENERAL STOCKS AND FLOWS (DRUGS AND EQUIPMENT)

7.   Drug stocks and flows at this clinic (contraceptives, STD drugs and other consumables)

Question	Planned stocks (# months)	Existing stocks (# months)
Oral contraceptives		
Condoms		
IUDs		
Injectables		
Other major methods		
STD tests (from policy analysis)		

STD drugs (from policy analysis)
 	
   1. Cyprofloxacine
 	
   2. Doxycycline/tetracycline
 	
   3. Erythromycin
 	
   4. Benzathine penicillin
 	
   5. Metronidazole
 	
   6. Imidazole
 	
   7. Spectinomycin		

HIV tests		

Other consumables:
 	
   Gloves
 	
   Specula
 	
   Sterilising equipment
 	
   Audio privacy
 	
   Visual privacy
 	
   Syringes		

8.   What is the process for ordering more of these stocks from the District office?

9.   Are you able to purchase drugs, tests or other consumables on the open market in the case of stock outs at the clinic?

10.   Are storage facilities adequate (locked, clean, efficient turnover of drugs to prevent expiry)?

C. TRAINING

11.   Have any staff at this health centre received the following types of training?

Total number of staff:

Question	Planned	Completed
Syndromic management		
Family planning		
Syphilis screening		
Risk analysis for sexual behaviour		
Counselling skills		
Partner notification / referral		
Specific donor training activities		

D. COUNSELLING AND IEC (ESPECIALLY CONDOMS)

12. Are education materials available providing information on MCH/FP and STD services at this clinic? (Evidence and location of materials.) How are they used?

13. Do staff at this clinic feel comfortable discussing sex and STDs with their clients? Do clients want these issues discussed during general health consultations?

14. Are education materials specifically for condoms available at this clinic? (Evidence and location.) How are they used?

15. What is the attitude of clinic staff to condom promotion and counselling? Are condoms used for family planning?

16. Do providers demonstrate how to use condoms with their clients (men and women)?

17. Do providers at this MCH/FP clinic recommend condoms for preventing STDs?

E. LINKS TO DISTRICT AND PROVINCIAL/REGIONAL STD/HIV SERVICES

18. What kind of management links does this clinic have with STD services at provincial/regional level?

19. For what kinds of tests or treatments would you refer clients to regional/provincial services?

20. How many clients each month do you refer up to provincial/regional services for further tests or treatment? What is the process of referral and are you ever informed about the treatments they received?

21. Are there any clinics which are just for men in this Region? What are their links with this clinic?

F. ATTITUDES TO INTEGRATION

22.   Do you think it is a good idea to link STD services with MCH/FP services in the clinic? How could these links be improved?

23.   What are the implications for your staff of integration, in terms of costs and workload? What will be the likely impact of these considerations on the success of integration?

24.   What do you think would be the attitudes of your clients to integrated services?

25.   How would you increase integration of MCH/FP services in clinics around the Region with STD services at the Provincial/Regional hospitals? What implications would such service expansion have on workload at this clinic?

26.   Do you make any efforts to involve or notify the partners of your infected clients (referral slips; counselling on partner discussions; etc.)? If not, would this be possible?

27.   Do you routinely screen family planning clients for STDs? What about those to have an IUD inserted? Do you experience problems with this service?

G. OUTPUT INDICATORS (USERS; CONDOMS)

28. Please could you give us the following output information for services available at this clinic:

Total patients seen in last full month:

Indicator	Number in last full month with records
FP clients seen	
ANC clients seen	
STD clients seen	

Family planning methods distributed:
    (a) condoms
    (b) oral contraceptives
    (c) IUDs
    (d) injectables
    (e) others	

STD tests/screening performed
    (a) syphilis
    (b) chlamydia
    (c) gonorrhoea
    (d) others	

Clients referred to province/regional hospital	

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│                                                                           │
│  FOCUS GROUP GUIDELINES:  PROVIDERS AT MCH/FP CLINIC                       │
│  ─────────────────────────────────────────────────                       │
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│                                                                           │
│  DISTRICT NAME: ─────────────────────────────────────────────            │
│                                                                           │
│                                                                           │
│  CLINIC NAME: ──────────────────────────────────────────────             │
│                                                                           │
│                                                                           │
│  DATE: ─────────────────────────────────────────────────────             │
│                                                                           │
│                                                                           │
│  TIME: ─────────────────────────────────────────────────────             │
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│                                                                           │
│  LIST OF PARTICIPANTS (NAME AND GRADE): ─────────────────────             │
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│         ───────────────────────────────────────────────────              │
│                                                                           │
│         ───────────────────────────────────────────────────              │
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│         ───────────────────────────────────────────────────              │
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└─────────────────────────────────────────────────────────────────────────┘
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"We are conducting research into services available in this region which are providing reproductive health care. By reproductive health care, we mean services which meet needs for management of HIV and other sexually transmitted diseases as well as those for family planning and other aspects of MCH. We are particularly interested in services for women of reproductive age but would also like to know about services for men or younger women where they are linking with mainstream primary health care. Our focus is on the extent to which these services are currently providing integrated reproductive health care or whether such programme changes have been planned.

We are also interested in how providers in the Region have been developing processes to implement new services. We would like to find out the problems you have encountered in terms of costs, financing, administration and logistics as well as innovative ways you have found for coping."

GUIDELINES - TOPICS TO BE ADDRESSED IN FOCUS GROUP:

1. What training has been received by nurses at this clinic for:

- family planning
- STD management

2. Knowledge about STD/HIV:

- What are the main diseases involved?
- How can we prevent them?
- How can we treat them (have you heard about syndromic management?
- What is the link between HIV and other STDs?
- When do you need to refer STD or HIV cases to the regional hospital?

3. Counselling of patients:

- What do you do if somebody wants to use a condom?
- What do you do if you think somebody has an STD?
- What do you do if you think somebody has HIV (pre and post testing)?
- How would you define sexuality?
- What problems do women have discussing STDs and condoms with their partners?
- How do you assess if a woman is at high risk of STD infection?

4. Issues of integration:

- When did all these STD services start at this clinic?
- Has it increased, decreased or not affected the work at the clinic or for yourself personally?
- What recommendations would you make for further improvements in the service?

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│  IN DEPTH INTERVIEW GUIDELINES:  CLIENTS AT MCH/FP CLINIC                 │
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│  REGION NAME:  _____          │
│                                                                           │
│                                                                           │
│  CLINIC NAME:_____           │
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│  TIME:_____           │
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│  NAME OF PARTICIPANT:_____             │
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└─────────────────────────────────────────────────────────────────────────┘
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"We are conducting research into services available in this region which are providing reproductive health care. By reproductive health care, we mean services which meet needs for management of HIV and other sexually transmitted diseases as well as those for family planning and other aspects of MCH. We are particularly interested in services for women of reproductive age but would also like to know about services for men or younger women where they are linking with mainstream primary health care. Our focus is on the extent to which these services meet the needs of local women and men and whether there are changes which you would prefer to see in the services you receive."

INTERVIEW:

1.   Have you heard about diseases which can be transmitted during sexual intercourse?

2.   Do you think you are at risk of becoming infected yourself?

3.   Do you know where you can obtain STD treatment or tests in this region?

4.   Do you know if STD treatment is available at this clinic?

5.   Would you like more treatments and tests for STDs to be available at this clinic?

6. **What do you know about HIV/AIDS infection and how to prevent it?**

7. **Do you know where you can get an HIV test in this region?**

8. **Have you or anybody you know ever discussed issues of sexuality or HIV/STD with the nurses here? Would you like to be able to discuss these issues with the nurses here?**

9. **How do you think STD/HIV services would affect existing MCH and family planning services here?**

10. **Do many women in this community use condoms for either family planning or protection against HIV/STD infection? Where can they be obtained and what problems are there with using condoms?**

APPENDIX C: PAPERS RELATED TO THE WORK IN THIS THESIS

The following papers were based on work which related to that in this thesis. They include academic journals, book chapters, policy or NGO newsletters and conference presentations. All were published or submitted during the period of registration for doctoral research.

Cleland, J. and L. Lush (1998). *Prevention of unwanted pregnancies and of sexually transmitted infection: the linkages*. Mumbai: International Conference on Reproductive Health .

Lush, L. (1997). Integrating services: from rhetoric to action. *Development Research Insights* **21**: 3.

Lush, L. (1997). *Understanding policy barriers and opportunities for integrated reproductive health services in Africa*. Beijing: General Conference of the International Union for the Scientific Study of Population .

Lush, L. (1998). *Integrating HIV/STD services with MCH and family planning: a new framework for analysis*. Liverpool: Third European Conference on Tropical Health .

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