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NATIONAL FAMILY PLANNING-HIV PROGRAMME INTEGRATION IN JAMAICA

Creating a New Sexual Health Agency

This publication was prepared by Dara Carr and Kathy McClure (consultant) of the Health Policy Project.

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EXECUTIVE SUMMARY

This case study documents the Jamaican government's efforts to reorganize its national HIV and family planning programmes to deliver greater cost savings, efficiency, and sustainability. This effort has entailed the integration of Jamaica's National HIV/STI Programme into its National Family Planning Board (NFPB) to create a statutory agency for sexual health. This process marks the end of Jamaica's national, stand-alone programmes in HIV and family planning; the functions previously carried out by its national programmes, with the exception of treatment and clinical services, have been folded into the new integrated entity, the NFPB-Sexual Health Agency.

In undertaking this reform, the Ministry of Health (MOH) found a dearth of guidance about national-level integration. Thus, the ministry requested assistance from the USAID- and PEPFAR-funded Health Policy Project (HPP) to assess lessons to date in Jamaica and to map next steps in the process. From June through August 2013, HPP designed and implemented an assessment of the integration progress with dual aims: informing the ongoing process in Jamaica to help define next steps, and documenting the experience for decisionmakers in other countries seeking more sustainable programming models for HIV and family planning. The assessment entailed a desk review and interviews with 18 stakeholders from government, civil society, and donor agencies.

This case study covers the integration process from initiation in 2010 through early implementation in 2013. The major justifications cited for the integration include: programmatic synergies and cost savings; improved sustainability; and alignment with Jamaican and international principles, including a shift away from stand-alone to more integrated programmes. The ministry projects cost-savings of JM$ 64 million (about US$ 632,000) per fiscal year by eliminating overlapping staff and functions in areas including finance, procurement, research, outreach, and monitoring and evaluation.

As of 2014, the new agency was officially approved and the ministry relocated HIV programme staff to the offices of the National Family Planning Board. The NFPB-Sexual Health Agency's major divisions and subdivisions are:

- Monitoring, evaluation, and research
- Technical support to programmes
  - Prevention
  - Care and support
- Enabling environment and human rights
- Administration
  - Human resources
  - Finance
  - Procurement
  - General administration

The National HIV/STI Programme's treatment and service delivery functions are being folded into the MOH's broader treatment programme for communicable diseases. The HIV/STI Programme's administrative structure remains intact as required for the management of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In HPP's interviews with stakeholders, a common concern was how the new integrated entity would meet the needs of key populations with the highest HIV burdens. Presently, the integration process has not affected clinical services, either in family planning or HIV. However, one of the mandates of the NFPB-Sexual Health Agency is to foster greater integration at the level of service delivery. This suggests the

future actions of the agency could affect how services and support are delivered to all clients, including key populations.

The NFPB-Sexual Health Agency has a division for Enabling Environment and Human Rights, which will address stigma and discrimination and other issues of concern. The MOH's planning documents describe the division's main function as "…to establish an enabling environment that would reduce stigma and discrimination related to sexual and reproductive health issues, especially for persons infected with and affected by HIV/AIDS, and address gender inequalities through empowerment of women. Advocating for an appropriate legislative and policy framework for this enabling environment within the workplace and the wider society is a key strategy along with establishing monitoring and evaluation systems to ensure adherence to this framework will be a key responsibility of this unit."

Although the integration process is still underway, some lessons from Jamaica's experience to date include the following:

- Integration proved different than a merger. It resulted in a new organization warranting a new strategy.
- Highly committed government champions were necessary to propel a process requiring time, ongoing attention, and funds.
- Planning and implementing an evidence-informed process took three years. Experts were needed to advise on legal, governance, organizational, and other issues.
- Major stakeholder concerns included maintaining mechanisms for civil society participation, focusing on key populations with the highest burden of HIV, and balancing between HIV and family planning priorities.
- Integration elicited stakeholder optimism and fears. Regular assessment and communications with both internal and external stakeholders are critical for addressing concerns.
- Change management and communications are key for addressing potential integration "stalling points": reducing staff and addressing HIV-family planning (FP) programme differences and asymmetries.
- Leadership of the new agency requires a "bridge-builder" with grounding in both HIV and family planning.

The assessment outlined an action plan for completion of the process that has four major work streams: leadership and governance, policy and legal framework, management and operations, and communications. The ministry is implementing the plan in 2014 and 2015 with its own funds and support from USAID, UNAIDS, and UNFPA. Next steps for the NFPB-Sexual Health Agency include facilitating service-level integration. Progress to date in this area has been uneven in Jamaica, partly due to perceived gaps in decision-making authority for service-level integration.

Although much remains to be done, the ministry has accomplished a great deal. Prior to integration, the NHP and NFPB had separate offices, budgets, strategies, management, staff, activities, and financing. Integration has involved rethinking HIV and family planning strategies, policies, and programmes. It has also required vision, leadership, funds, strong partnerships, and unflagging commitment among stakeholders.

Jamaica has led the way for other countries interested in more innovative and sustainable programming models for family planning and HIV. But while integration has strengthened institutional sustainability, particularly for the HIV programme, evidence is still needed to demonstrate the anticipated cost savings, efficiencies, and outcomes. The authors hope the Ministry of Health will continue to review and assess its integration process, identifying both the opportunities and challenges of such a bold governmental reform.

INTRODUCTION

"[In Jamaica,] there was absolute commitment…to find a quiet, elegant way to accomplish what needed to be done."

—Stakeholder from international donor agency

In the next decade, many middle-income countries will need to assume an increasing share of costs for their family planning (FP) and HIV programming. In Jamaica, external donors presently fund more than 90 percent of the HIV programme, including treatment. As an upper-middle-income country, however, Jamaica faces major declines in external assistance for its programme. One major donor, the U.S. Agency for International Development (USAID), graduated Jamaica from FP assistance in 2008 (Bertrand, 2011). The Jamaican government's fiscal challenges constrain its ability to increase its contributions in public health. The question for Jamaica and other countries in similar situations is how to reduce expenditures while maintaining the gains in FP and HIV that took decades to achieve, including increases in the use of FP and HIV services and decreases in HIV-related mortality.

In recent years, the Jamaican government has taken creative and resourceful action to help sustain its national programming in family planning, HIV, and other sexually transmitted infections (STIs). This effort involved integrating its National HIV/STI Programme (NHP) into its National Family Planning Board (NFPB) to create an agency for sexual health. This entity, the NFPB-Sexual Health Agency (SHA), operates as an independent statutory agency under the auspices of the Ministry of Health (MOH). With its sexual health mandate and national scope, the NFPB-SHA is one of the few, if only, examples of its kind within the region and globally. It is expected to help the Jamaican government realize cost savings and gains in efficiency and effectiveness (Harvey, 2012)

In undertaking this reform, the Ministry of Health found a dearth of guidance about national-level integration. Thus, at the request of the Ministry, the USAID- and PEPFAR-funded Health Policy Project (HPP) assisted in assessing lessons to date in Jamaica and mapping next steps for the integration process. This case study is intended to document the Jamaican experience and help inform the efforts of other countries seeking more sustainable models for their family planning and HIV programmes. It should be particularly useful for decisionmakers interested in why and how a country might undertake this type of reform. The study describes a process that began in 2010 and, as of 2014, is still ongoing (see Annex A for a timeline of integration activities); it covers planning through early implementation of the process.

METHODOLOGY

This case study is based on a review of relevant documentation and on stakeholder interviews conducted in Jamaica. The following documents were reviewed: Integration Committee meeting minutes; reports produced by consultants addressing different dimensions of the integration, including legal, governance, organizational development, and vision and strategy issues; concept papers submitted to the Integration Committee and to the Cabinet of the Government of Jamaica; and notes from the MOH's Annual Review meeting in October 2013. HPP also consulted published papers on FP-HIV integration for context and history.

In 2013, the HPP team conducted formal interviews with 18 stakeholders from the Ministry of Health, nongovernmental organizations, private consultancies, USAID, UNFPA, and UNAIDS, to elicit their perspectives on the integration process (see Annex B for list of stakeholders interviewed). The stakeholder interviews were semi-structured, and used a discussion guide (contained in Annex C). The HPP team requested stakeholders' consent to include the interview findings and their names in this report.

The stakeholders interviewed included individuals directly involved in the integration process and interested observers. The interview list was developed by HPP staff in close consultation with the MOH. The HPP research team was unable to interview a number of important family planning stakeholders because the NFPB Board voted not to support this effort—the board members indicated they felt the case study was premature.

HISTORIC OVERVIEW

"The writing was on the wall for some time but then the situation became critical."

—Integration committee stakeholder

In reproductive health, an important ideal is to provide clients with a comprehensive and accessible array of integrated services. Although 179 governments embraced this ideal in 1994 at the International Conference for Population Development, implementing it has proven challenging (United Nations, 1994; William et al., 2004). Jamaica's *Strategic Framework for Reproductive Health within the Family Health Program 2000–2005* advocated an integrated package of family planning, maternal and child health, STI, and HIV and AIDS services. In response, a number of efforts were made to integrate these services; some were successful but others lost momentum or foundered due to one or more barriers (Skyers et al., 2012). One identified barrier was a lack of clarity regarding lines of authority for service-level integration within Jamaica's decentralized system. Other barriers included operational, staffing, infrastructure, capacity, and cost issues (POLICY Project, 2005; Williams, 2012).

Historical Overview: Key Dates

1970: National Family Planning Act establishes NFPB

1989: National HIV Programme initiated

2004: UNAIDS launches "Three Ones" principles

2008: Jamaica graduates from USAID assistance

2010: Public sector rationalization plan calls for closure of NFPB

Jamaica reclassified by World Bank as Upper-Middle-Income Country

At the national level, integration of family planning and HIV/STI programming did not gain traction until 2010. At this juncture, the sustainability of both the Ministry of Health's NFPB and NHP came into question. In different ways, broad economic forces threatened the two entities, inspiring leaders within the MOH to brainstorm a way to achieve another challenging but widely embraced ideal: cutting costs while improving efficiency and effectiveness.

Jamaica faces intense pressure to cut costs. From 2008 to 2013, more than 90 percent of funds for the NHP came from donors including The Global Fund to fight AIDS, Tuberculosis and Malaria; the World Bank; and USAID and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Classified by the World Bank as an upper-middle-income economy in 2010, Jamaica is constrained in obtaining further international donor assistance. For HIV funding, this means reduced support from the Global Fund and other funders and increased requirements for government contributions (Carr, 2011; The Global Fund, 2012).

External assistance for family planning is also limited. Jamaica graduated from most USAID family planning support in 2008, having met a number of population and programmatic benchmarks. At that time, for example, Jamaica's modern contraceptive prevalence rate was 66 percent and its total fertility rate was 2.1 children per woman (Clifton et al., 2008) USAID has a number of criteria for assessing a country's "readiness" for family planning graduation; among the key threshold indicators are a total

fertility rate of less than 3.0 and a modern contraceptive prevalence rate of at least 55 percent (Bertrand, 2011).

With an unwieldy public debt burden of at least 140 percent of GDP the Jamaican government is limited in its ability to boost spending in public health (International Monetary Fund, 2013). As an upper-middle-income country, Jamaica is also ineligible for debt relief from major multilateral institutions. Servicing its debt has left the government little room for spending in health, education, and infrastructure (Ministry of Finance and Planning, 2013)

In 2009, just before the MOH embarked on the integration process, Jamaica's fiscal crisis was particularly severe according to UNDP. The cost to service the debt was US$ 3.55 billion out of a government budget of US$ 6.14 billion. After factoring in the cost of government administration, US$ 864 million was available for social programmes and infrastructure improvements. In 2010, Bruce Golding, then prime minister, said:

> Every year for many years, we have been spending more than we earn. Every year, we have to borrow to make up the difference, so, each year, the debt gets bigger and bigger and each year we have to set aside more money to pay the interest on that debt… For the last 10 years, all of the taxes we collect have had to be used to service that debt. So, before we can pay one teacher or nurse or policeman, before we can patch one pothole, before we can put one bottle of medicine in our hospitals or provide one school lunch for a needy child, we have to borrow more money, piling up the debt even further and the cost of servicing that debt even higher. (Hurley et al., 2010, p.5).

With a severe fiscal crisis unfolding, the government of Jamaica undertook a public sector reform process in 2010. In July, it submitted to Parliament a proposal for its rationalisation of the public sector (Green Paper # 01/2010). One recommendation was for the NFPB, a statutory organization of the MOH, to be subsumed within the central ministry, which would mean dissolution of the NFPB and the dispersion of its staff across various MOH divisions. Another recommendation was to merge two governmental entities involved in the purchase and distribution of pharmaceuticals throughout Jamaica: Health Cooperation Limited into the National Health Fund.

Within the MOH, the proposal sparked the concern of Dr. Kevin Harvey, then a senior medical officer leading the National HIV/STI Programme. One potential result of the proposed closures was the disruption of critical commodity procurement and distribution activities. The NFPB procured and distributed contraceptives for the Regional Health Authorities while Health Cooperation Limited procured and distributed antiretroviral drugs for government-run facilities across the island.

Harvey saw deeper issues at work as well, with the HIV programme potentially following a trajectory similar to that of the NFPB. The NFPB, empowered by the National Family Planning Act of 1970, received strong assistance from external funders for about thirty years. Its efforts, especially its national campaigns to promote a two-child norm in the 1970s and 1980s, met with considerable success. As Harvey noted, "The family planning programme was very successful, maybe too successful." Jamaica's success on key population indicators meant that NFPB lost much of its external aid and shrank as its mandate narrowed.

Unless the MOH took action, Harvey believed the NHP could be similarly threatened. Formed in 1986, NHP experienced about twenty years of strong growth and from about 2008 onward, mobilized approximately US$ 60 million. Most of this cycle of grants and loans, however, would be finished by 2013 or 2014. Facing reductions in external assistance, a major challenge for NHP was its lack of legal independent status. As a project within the MOH, most staff members were on two-year contracts supported by project funds from USAID, the Global Fund, and the World Bank (FocalPoint Consulting

Ltd., 2013). In 2009, the government supported 20 NHP posts through its own funding, heightening sustainability. Still, this was a fraction of the 70 or more total posts in the unit.[1]

The possibility of NHP being absorbed into the ministry—and losing its distinct identity—meant its remaining staff members would be dispersed across divisions and handle multiple other responsibilities. The MOH is not organized by specific illnesses—the NHP falls within the Health Promotion and Protection Division. Some government stakeholders believed integrating the NHP within the MOH could adversely affect the response to HIV and AIDS. Embedding it within the centralized government administration could result in more cumbersome decision making and implementation. They also believed folding NHP into the MOH would be less attractive to international donors, who might hesitate to provide funds to the government's pooled consolidated fund rather than a dedicated entity such as the NHP.

Another issue related to the cap on government spending and borrowing that was instituted through Jamaica's agreement with the IMF. In 2009, this cap prevented the government from spending all its allocated funds for approved activities (Carr, 2011). The NFPB was better insulated from these "fiscal space" constraints by virtue of being an independent statutory agency of the MOH and having a recurrent expenditure line in the national budget. As a statutory agency, it is also able to generate and retain funding beyond the Ministry of Finance's annual allocation.

Consideration of these and other factors led Dr. Harvey to consult with Dr. Sheila Campbell-Forrester, then the chief medical officer, about how to make the NFPB and NHP more sustainable. They decided that the best way forward was to retain NFPB to roll out both family planning and HIV/STI programming. Integration of the NHP and the NFPB appeared to offer multiple advantages. The administration and operations of each entity were independent, though they addressed similar issues that affected some of the same populations. By combining forces, costs could be cut and efficiency increased. Integration could save NFPB from dissolution and make the HIV programme more sustainable.

There was one problem with the integration plan: The hard-pressed government was proposing to eliminate NFPB while the MOH's integration champions wished not only to save it, but to expand it.

[1] The exact number of posts is difficult to calculate because most are funded by projects and vary based on project duration and staff turnover. Using the staff list in the appendix of Peter Carr's options appraisal report ("Updated Final Report on the Governance Consultancy for the Integration of the National Family Planning Board and the National HIV/AIDS Programme-Jamaica"), the authors counted 79 total NHP posts. As of mid-December 2012, FocalPoint Consulting estimated 75 total NHP posts in its Organisational Structure Report of May 2013.

MAKING THE CASE FOR INTEGRATION

"The hierarchy was creative, flexible, and problem solving."

—Integration stakeholder

Dr. Harvey and Dr. Campbell-Forrester actively sought support for the integration concept among a range of stakeholders. They met with senior officials and managers throughout government as well as donors and UN agencies. The first milestone came when the Permanent Secretary of the MOH agreed to set up a committee to formally appraise different options for NFPB. In 2010, Dr. Harvey, then head of the NHP, organized the integration committee, which he co-chaired with Dr. Olivia "Peaches" McDonald, then NFPB executive director. The committee began with 14 members, including representatives from MOH, NFPB, USAID, UNAIDS, UNFPA, and UNICEF, and its initial mandate was to assess options for NFPB and NHP. Eventually, the committee assumed responsibility for all major strategic decisions related to the integration process (Ministry of Health, n.d.).

Dr. Harvey and Dr. McDonald prepared an early position paper for the committee that recommended integrating NHP into NFPB. The major justifications were that integration could offer

- Programmatic synergies and cost savings
- Improved sustainability for NHP through the structure and governance framework offered by NFPB, plus better capacity to attract grants and international development assistance
- Alignment with Jamaican and international principles

In terms of the principles, HIV fit solidly into the sexual and reproductive health framework elaborated in Jamaica's Vision 2030. An integrated agency also aligned with the internationally embraced "Three Ones" principle for HIV programming, which calls for one agreed action framework, one national coordinating authority, and one agreed country-level monitoring and evaluation plan (World Health Organization, n.d.b). Additionally, UNFPA was a strong supporter of a national coordinating authority for sexual and reproductive health.

Toward a More Sustainable Programming Structure

Another important justification cited for integration was that global health experts considered vertical HIV programmes to be less effective and integrated approaches to be more favorable for health outcomes (Levine, 2007; Atun et al., 2008). In Jamaica, integration would entail shifting away from a more "vertical" national programming structure—in this case, a stand-alone, disease-specific entity with a separate budget and administration—toward a more horizontal approach (Williams, 2012) A horizontal or integrated approach typically connotes programmes that are fully embedded within the health system, address interrelated health issues through integrated care, and deliver services through the same facilities that offer routine or general healthcare. In practice, few programmes are entirely vertical or integrated; most contain vertical and horizontal elements, as is the case in Jamaica (Atun et al., 2008; Wilson, 2009).

Worldwide, HIV programmes in lower-income countries tend to be primarily vertical. Responding to the crisis posed by HIV, donors supported these programme structures to quickly reach millions of people with high-quality prevention, care, and treatment services. The research literature affirms that vertical programmes tend to offer advantages in circumstances where health systems are weak; resources are targeted to a high-priority health issue; a rapid response is necessary; clients are hard to reach; accountability is critical in terms of donor funds, goals, objectives, and measurable outcomes; and the delivery of complex services warrants a highly skilled staff (Atun et al., 2008).

Empirical evidence on the comparative benefits of more vertical versus more integrated or systemic approaches is mixed (Atun et al., 2008; Wilson, 2009). One major concern is sustainability, because vertical or stand-alone programmes tend to rely heavily on external donor assistance (Atun et al., 2008; Taylor, 2007). According to some public health researchers, other disadvantages may include vertical programmes monopolizing funding and staff at the expense of other health conditions, weakening primary care, and resulting in fragmented services and missed opportunities for holistic treatment. Others, however, posit that vertical programmes can achieve disease-specific objectives while also strengthening primary healthcare and health systems (Institute of Medicine, 2009).

In Jamaica, the verticality of the HIV/STI programme has been attributed, at least in part, to donor requirements for keeping HIV resources separate from other funds and for measuring the effects of specific donor contributions on beneficiaries (Harvey, 2012). Rather than undermine primary care, the NHP is credited with working through the healthcare delivery system to strengthen the National Public Health Laboratory; make antiretroviral medication free of cost to patients; and train health staff to deliver various prevention, care, and treatment services (Carr, 2011). At the national level, however, the vertical approach may have proven too costly for Jamaica to sustain in an era of declining external assistance and a government in fiscal crisis.

Other justifications for integration cited the benefits to clients of blending clinical services in HIV and family planning, including improved accessibility of services and reduced stigma (Integration Committee, 2010a). But discussions with at least one stakeholder involved in the early process suggested that NHP-NFPB integration was not initially intended to integrate HIV and family planning service delivery. That is, it did not aim to affect NHP's extensive service delivery operations. In terms of family planning, NFPB was no longer directly involved in clinical service delivery, having ceased its mobile clinical services in the mid-1990s. The government had integrated family planning services into primary care in 1974 (Harvey, 2012).

Integration Committee Engagement and Support

Early on, integration committee members and others discussed some potential challenges of integration, including high initial costs and weakened programmes (Integration Committee, 2010b). Some stakeholders anticipated staff loss from NHP due to the lower wages for government positions. Although on the same pay scale as the government, project-supported NHP personnel on contracts earn higher pay to compensate for a lack of benefits.

Overall, the integration committee decided the advantages of integration outweighed the potential drawbacks and embraced the idea of saving NFPB to roll out sexual and reproductive health programming. The donors and development partners on the committee took an active role in advocating to save NFPB and integrate NHP within it. For example, the U.S. Mission director and U.S. Ambassador collaborated closely with the MOH champions to make the case for integration to senior officials within the Jamaican government. In 2010, Dr. Harvey and the U.S. Ambassador met with the prime minister to discuss this issue. The version of the public sector master rationalization plan the Jamaican government submitted to Parliament in May 2011 made no mention of NFPB being subsumed into the MOH.

Representatives from USAID, UNAIDS, and UNFPA were actively engaged throughout this process, providing expertise to the committee, including material on integration experiences in other countries. They also helped review and fund the work of consultants whose efforts helped propel the process forward. UNAIDS funded a legal consultancy and UNFPA supported a governance consultancy. USAID provided funds for an administrative person to support the committee's work. In 2011, the U.S. Government instituted conditions on PEPFAR assistance to Jamaica to keep the process moving forward, including: modifying the Public Health Act, developing a national HIV workplace policy, and establishing one national authority for HIV/STIs and family planning.

Without the support of these partners, the costs of integration might have been insurmountable for the government. Although the Ministry of Health does not have a formal accounting, integration-related expenses to date include four major consultancies (legal and policy review, options appraisal, organizational development, and vision and strategic planning), administrative support, staff time, the refurbishment of offices, the purchase and commissioning of new equipment, and the relocation of NHP staff into NFPB offices.

Evidence that Informed Decisionmaking about Integration

In December 2010, the integration committee began commissioning work from different experts to inform its decisions and recommendations. The first two consultancies involved a legal review and an assessment of integration options. Following these efforts, the MOH conducted a costing exercise to estimate savings from integration. In 2011, the committee commissioned two additional major consultancies, one on organizational development and the other in strategic planning, to set the foundation for implementation. This body of work shaped the committee's recommendations and formed the basis of a concept paper, "Integration of the National HIV Programme within the National Family Planning Board to create a Sexual Reproductive Health Authority for Jamaica," submitted to the Cabinet in 2012 for high-level approval of the integration concept.

Legal Review

In 2010, a legal expert determined that transferring the NHP to the NFPB could be achieved with minimal legislative and other effort (Chambers, 2011). As a unit within the MOH, the NHP had no independent legal status. The NFPB's legal status and powers, as defined by the National Family Planning Act of 1970, allowed it to take on any mandate to which the Minister of Health and the NPFB Board Chairperson agreed. By contrast, forming a new statutory organization for both entities would require a costly, time-consuming process of transferring contracts and other assets and closing the NFPB, which would involve numerous complex decisions such as how to manage pension funds.

The legal expert's comparison of the powers of the two organizations found differences and areas of overlap. One difference was the level of autonomy in administration and financing. NFPB managed its accounts, invested funds, and owned property, including two commercial buildings and one office building for staff. NHP had less official autonomy than NFPB, but had considerable delegated authority. However, it owned no property and had a MOU with another governmental entity for its warehousing needs.. Another major difference was that NHP managed a substantial service delivery effort while NFPB was no longer directly involved in this area.

The legal expert made the following recommendations:

- Transfer NHP programme elements from the MOH to NFPB after determining which aspects of the programme should remain within the MOH, the Regional Health Authorities, and other ministries, departments, and agencies.
- Brand or market the new entity so stakeholders understand its broader mandate while leaving its underlying legal identity the same.
- Institutionalize change incrementally through administrative mechanisms, which would limit risk and disruption. This would mean, for example, retaining the NHP brand initially.
- Rationalize staff to reduce duplication and integrate the administrative, financial, research, and human resource units.
- Alter the governance structure of the NFPB to include more members from different stakeholder groups, which would entail legislative amendment of the Schedule to the NFPB Act of 1970.

- Add a definition of "family and population planning" to the NFPB Act that is broad enough to encompass HIV/STI prevention and other issues.

Integration Options Appraisal

A health system expert conducted a formal options appraisal of the integration process (Carr, 2011). His assessment found that NHP and NFPB shared many explicit and implicit policies and principles, including agreement on the importance of universal access to services through the public sector and of eliminating financial, social, legal, and other barriers to accessing services. Both entities emphasized the primacy of human rights and confidentiality in service delivery and had functions and staff in prevention; monitoring, evaluation, and research; and finance, accounting, and procurement. Organizationally, however, there were two important NHP areas that had no formal, equivalent NFPB departments: enabling environment and human rights (Carr, 2011).

Carr found the two entities shared programming approaches as well as a focus on safe, responsible sexual behavior. They deployed similar tactics, including the mass media, health education, training, monitoring and evaluation, and research to inform decision making for programmes and the reproductive health sector. Both organizations worked through the healthcare system with the Regional Health Authorities.

Operationally, both entities were part of government and operated with similar systems and processes. There were differences in structure and governance (see organizational charts in Annex D, Figures 1 and 2). The executive director of the NFPB reported to a Board of Governors, while the head of the NHP was situated within a chain of MOH authority that included a division head, the chief medical officer, the permanent secretary, and the minister of health. As such, the executive director of the NFPB had more decision-making autonomy than the head of the NHP, though the NHP head also held the title of executive director, suggesting some independence within the MOH hierarchy.

Finally, the health systems expert examined two options for NHP: integrating it within the MOH or integrating it within NFPB. Prior to the expert's report, the weight of opinion appeared to support folding NHP into the MOH. In 2006, for example, KPMG recommended integration of NHP into the MOH structure via a new Division of AIDS, Chronic and Communicable Diseases (Carr, 2011). Around 2011, the MOH directorate proposed that NHP be integrated within the existing Division of Health Services Planning and Integration (Carr, 2011).

The health system expert's assessment, however, concluded that the better path forward was to integrate NHP into NFPB. He based his recommendation on the following criteria (Carr, 2011).

- Ease of implementation
- Impact on the direction and thrust of the programme;
- Financial sustainability of both programmes;
- Integration of the programme into Reproductive Health Services;
- Efficiency and effectiveness in the management of the programmes; and
- Anticipated employee acceptance

The only criterion where the first option—folding NHP into MOH—scored higher than NHP-NFPB integration was integration of the programme into Reproductive Health Services. Carr noted that key reproductive health programmes would remain in the MOH head office, potentially resulting in inadequate integration with NFPB programming.

The three criteria with the largest difference in favor of NHP-NFPB integration were (Carr, 2011)

- Impact on the direction and thrust of the programme
- Efficiency and effectiveness in the management of the programmes
- Anticipated employee acceptance

The reasoning was that if NHP was folded into the MOH, it would likely be subsumed under other head office programmes. The lack of a stand-alone unit could result in a loss of focus, with staff morale and team spirit adversely affected by not having a distinct identity. An increase in bureaucracy could also result because NHP would lose some of its decision-making independence. A related risk was in merging NHP's resources with those of the Ministry, which was financially pressed and could opt to temporarily use funds for other purposes or delay the release of funds. Additionally, without dedicated staff members for managing programme activities, donors might be less inclined to provide funding.

Cost-Saving Estimate

The Ministry of Health engaged in an exercise to estimate cost savings related to integration. The anticipated savings in salaries was estimated at JM$64,153,336 or US$632,551 per fiscal year (see Table 1). The projected savings derive from an anticipated reduction in overlapping functions and staff in areas including finance, procurement, research, outreach, and monitoring and evaluation. As of early 2014, implementation of integration has not progressed far enough to assess any savings.

Table 1: Current and Proposed Salary Costs

	Pre-Integration, 2012	Proposed Integrated Entity
NFPB	JM$49,790,509 US$490,934	JM$134,908,023.87 US$1,330,192
NHP	JM$171,270,805.87 (excluding RHA staff) US$1,688,728	JM$22,000,000 US$216,920
Total	JM$221,061,359.87 US$2,179,662	JM$156,908,023.87 US$1,547,111
Projected savings per year		JM$64,153,336 US$632,551

Source: Harvey, K. 2012. *Integration of the National HIV Programme within the National Family Planning Board to Create a Sexual Reproductive Health Authority for Jamaica: Concept Paper*. Kingston, Jamaica: MOH. US$ estimates have been rounded, using exchange rate of US$1/JM$101.42, retrieved August 27, 2013, from www.boj.org.jm.

DEFINING THE NFPB-SEXUAL HEALTH AGENCY

A key task in 2012 was finalizing a concept paper to submit to the government's Cabinet Office. The paper outlined the case for integration, requested official designation for the new entity, and sought approval of proposed amendments to the Schedule of the National Family Planning Act to expand and change the composition of the NFPB Board. The MOH submitted the concept paper to the Cabinet Office in October 2012; it was approved in March 2013.

The Evolving Name

Early in integration planning, some stakeholders hoped the new entity would take a comprehensive approach to sexual and reproductive health by addressing maternal and child health, family planning, HIV and other STIs, gender-based violence, adolescent health, and more. As the integration process evolved, however, it became evident the new entity would not take this approach. The concept paper on integration submitted to the Cabinet noted that a more comprehensive approach would have required major redeployments of staff, programming, and other costly changes (Harvey, 2012). Instead, the new entity would focus on sexual behaviour as it related to family planning and HIV/STI transmission. The common denominator between the entities was unprotected sexual behaviour.

In the Cabinet submission, the MOH requested an official designation for the new entity as the National Authority for Sexual Reproductive Health and HIV and AIDS programming. The Ministry used the term "sexual reproductive health"—absent the usual "and"—to connote a more narrowly defined scope than is typically associated with sexual *and* reproductive health. By October 2013, however, the integration committee determined that the term "sexual health" better captured their vision for the new entity.

In making this decision, the committee considered the working definition of sexual health outlined by the World Health Organization:

> "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."(World Health Organization, n.d.a).

In October 2013, the integration committee announced the integrated entity would be called the NFPB Sexual Health Agency of the Ministry of Health (NFPB-SHA) (Harvey, 2013).

Mission and Goals

The integration committee commissioned two major consultancies to help define the NFPB-SHA. (For clarity, this report refers to the new entity as the NFPB-SHA. Prior to October 2013, however, the working name for the integrated programme was the NFPB-Sexual Reproductive Health Authority.) The first consultancy helped elaborate a vision, mission, and strategic plan for the new entity. The second produced a human resources transition policy, guidance on organizational structure and positions, and manuals for procurement, and finance management, and accounting.

The proposed mission for the new entity represents a departure from the missions of the pre-integration NHP and NFPB. For example, there is no specific mention of family planning or HIV/STIs in the draft mission; these have been subsumed under the umbrella of sexual health (see Table 2). The proposed new

strategic objectives or goals of the new entity (see Table 3) echo the mission statement, taking a broader, more development-oriented approach to health. These goals highlight the protection of human rights, an enabling environment that protects gender equity, scale-up for universal access, and the development of strategies that affect sexual risk behaviour and cultural norms. These goals also explicitly mention monitoring and evaluation for decision-making and management, which marks a difference from the existing goals outlined for NFPB and NHP.

Table 2: Mission Statements

NFPB Mission	NHP Mission	Draft Mission for New Integrated Agency (proposed May 2013)
To enable individuals to achieve good reproductive health (family planning and reproductive health outcomes) through the provision of high- quality, voluntary family planning and health and family life education services implemented efficiently and effectively (National Family Planning Board, n.d.).	To significantly reduce the number of men and women newly HIV infected and to mitigate the impact of HIV on the people of Jamaica through universal access to HIV prevention, treatment and care; an effective multisectoral response; and an enabling, supportive environment free of stigma and discrimination (FocalPoint Consulting Ltd., 2013).	To enable individuals to attain their reproductive health goals through an integrated system of healthcare that provides universal access to comprehensive services in an enabling and supportive environment enhanced by multisectoral partnerships (FocalPoint Consulting Ltd., 2013).

Table 3: Strategies/Goals

NFPB, 2011–2015	NHP	New Integrated Agency, 2013–2017 (proposed May 2013)
• Achieve more effective synergy between the HIV prevention and family planning programmes • Empower adolescents and youth to take responsibility and reduce sexual risk taking behaviours • Promote self-efficacy and the complementary roles of males through the availability of and access to Reproductive Health information and services • Organise and implement activities to enhance and	• Reduce the number of new HIV infections through the establishment of a supportive policy/legislative environment • Strengthen mechanisms for the treatment, care and support of persons living with and affected by HIV/AIDS through a policy and legal framework and an enabling environment • Mitigate the socioeconomic impact of HIV/AIDS on individuals, families, communities and the nation through policy	• Create a sexual and reproductive health authority that integrates the NHP within the NFPB • Protect fundamental human rights and empower the Jamaican people to make healthy choices through an enabling environment that promotes gender equity • Scale up universal access to sexual and reproductive health services • Develop best practices for providing appropriate treatment, care, and

promote the visibility of the family planning programme • Implement initiatives to effect continued reduction in the unmet need for family planning and the proportion of unplanned pregnancies (National Family Planning Board, n.d.)	and a legal framework • Foster an enabling policy, regulatory and legislative environment around HIV/AIDS issues including strengthening and sustaining a comprehensive, multisectoral response • Affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS	support in HIV/AIDS/STI and Family Planning services • Develop, promote and support health promotion and behaviour change strategies that impact sexual risk behaviour and cultural norms in order to prevent unplanned pregnancies and reduce transmission of new HIV and other STIs • Improve monitoring and evaluation for decision making and programme management

The proposed mission and goals of the NFPB-SHA will undergo further change. The vision-development consultancy involved merging the NHP and NFPB strategies into one harmonized plan and deleting any overlaps (Integration Steering Committee, 2012). But key integration committee stakeholders came to believe that the integration of NHP into NFPB proved different than a merger. They believe it has produced a new organization warranting a completely new strategic plan that goes beyond the "sum of two parts." Thus, in October 2013, with the approval of the Ministry of Health's senior leadership, the integration committee approved a plan to develop a new strategy for the NFPB-SHA.

In October 2013, the integration committee also further defined and sharpened the focus of the NFPB-SHA. The three primary aims of the NFPB-SHA would be to

- Improve contraceptive choice and safety
- Reduce STIs, including HIV
- Promote healthy sexuality involving adolescent health and reducing harmful practices

The HPP team was unable to gather information on the perspectives of the NFPB Board and staff about the evolution in thinking about the NFPB-SHA.

Scope, Structure, and Activities

As proposed in the Cabinet submission, the NFPB-SHA would serve as a hub for coordination, guidance, research, monitoring, and the facilitation of policy development and programming implemented through government ministries, departments, and agencies (Harvey, 2012). Thus, various ministries and agencies would continue to implement programmes in sectors such as education, tourism, industry, and labour. Treatment efforts would not be affected by integration.

The integration entails a reorganization of units and divisions into the NFPB-SHA, but does not result in the loss of any functions or services (see Table 4). Notably, the NFPB-SHA will have a new division for enabling environment and human rights. Planning documents indicate the division's main function will be to

> "…establish an enabling environment that would reduce stigma and discrimination related to sexual and reproductive health issues, especially for persons infected with and affected by HIV/AIDS, and address gender inequalities through empowerment of women. Advocating for an appropriate legislative and policy framework for this enabling environment within the workplace and the wider society is a key strategy along with establishing monitoring and evaluation systems to ensure adherence to this framework will be a key responsibility of this unit."

Another major change is a division for technical support to programmes, encompassing prevention, care, and support (see Figure 1).

For HIV programming, the integration would mean greater organizational distance from service provision and other MOH programmes such as family health. The NHP's treatment and clinical services are not being integrated into NFPB-SHA. These functions are being integrated into the broader treatment programme for communicable diseases. The ministry is retaining NHP's administrative structure, as required for managing grant funds from the Global Fund.[2] Structurally, the integration does not affect the National AIDS Committee or Jamaica's Country Coordinating Mechanism, which manages Global Fund–related activities. The functions of these entities, however, may evolve over time, especially as assistance from the Global Fund declines.[3]

Table 4: The reorganization of NFPB and NHP into NFPB-SHA

Pre-Integration Structure	NFPB-SHA Division (Sub-division)
NFPB Departments	
Policy formulation, monitoring, and evaluation	Monitoring, evaluation, and research
Outreach	Technical support to programmes (Prevention subdivision)
Finance	Administration (Finance subdivision)
Human resources and Administration	Administration (Human resources and general administration subdivisions)

[2] Harvey, Kevin, e-mail message to Dara Carr, February 22, 2014.
[3] Ibid.

Pre-Integration Structure	NFPB-SHA Division (Sub-division)
NHP Units	
Policy, enabling environment, and human rights	Enabling environment and human rights
Prevention	Technical support to programmes (Prevention subdivision)
Treatment, Care, and Support	Technical support to programmes (Care and support subdivision) Treatment will be integrated within the MOH's treatment programme for communicable diseases
Monitoring and evaluation	Monitoring, evaluation, and research
Administration	Administration
Procurement	Administration (Procurement subdivision)
Finance	Administration (Finance subdivision)

The Cabinet submission proposes the NFPB-SHA would take on activities such as

- Implementing programmes that benefit multiple sectors, e.g. the National Sexual and Reproductive Health Survey
- Piloting innovative initiatives, e.g. HIV and AIDS workplace policies across sectors
- Conducting promotional activities to raise awareness of sexual health issues
- Providing technical support for sexual health initiatives across the public and private sectors
- Monitoring and evaluating the effectiveness of sexual health programmes and identifying gaps in service delivery
- Facilitating the development of an enabling environment for sexual health and related rights
- Coordinating or supporting cross-sectoral consultative, technical, or working groups

Additionally, the NFPB-SHA would be expected to help mobilize, coordinate, and manage grants and loans to support sexual health activities (Harvey, 2012).

Governance

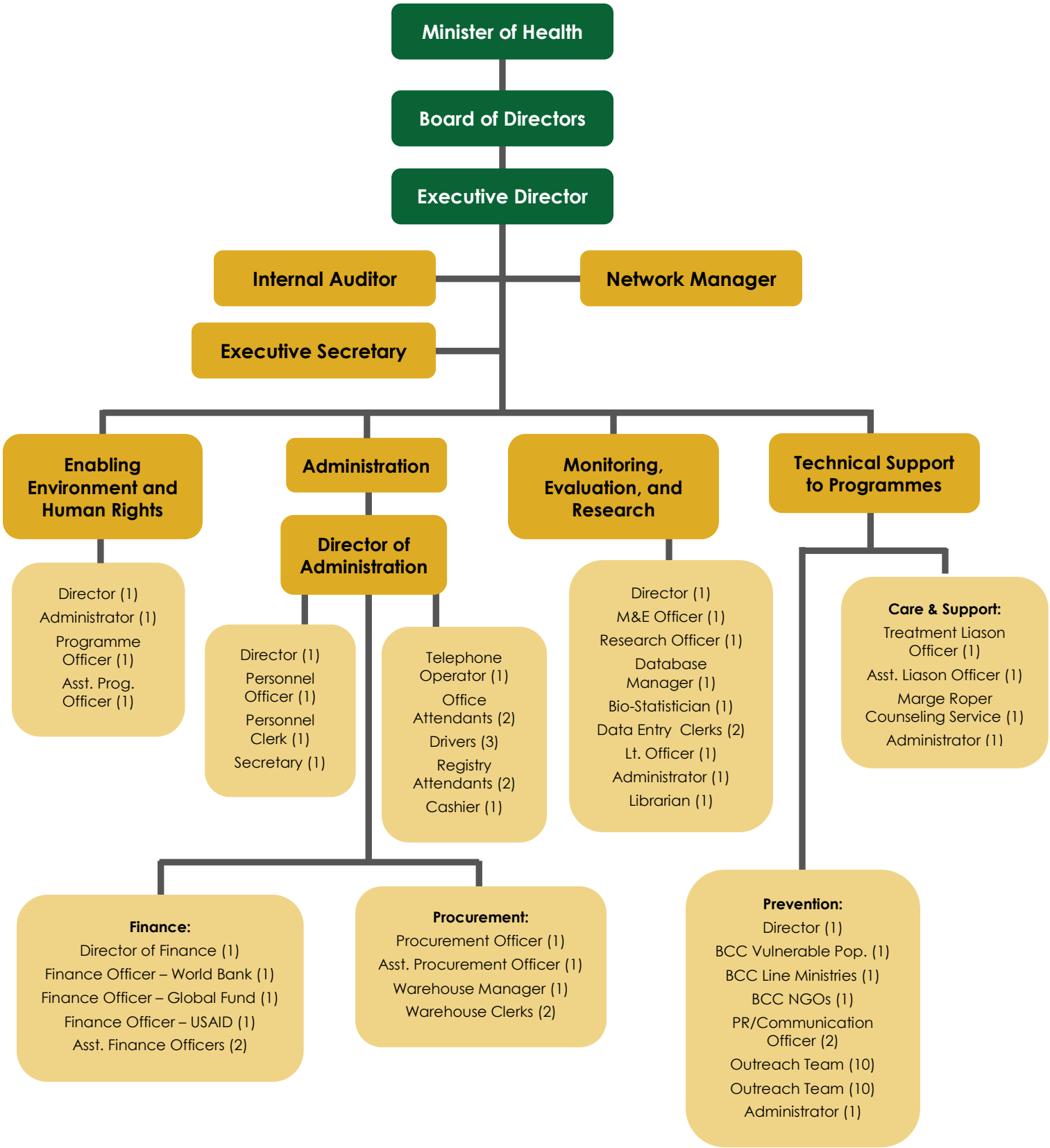
As was the case for NFPB, the minister of health will appoint the executive director of the NFPB-SHA and its board members. The Schedule of the 1970 National Family Planning Act will be altered, allowing the board to expand from 4–11 members to 6–12 members. As of August 2013, the NFPB board had nine members. The NFPB-SHA board also will retain strong ties to the central government with at least 51 percent of members coming from the public sector, including

- A nominee of the permanent secretary of the Ministry of Health
- The chief medical officer of the Ministry of Health
- The principal financial officer of the Ministry of Finance
- A representative from the Ministry of Education
- Representatives of other ministries, departments and agencies that implement sexual health–related programmes and policies (Harvey, 2012)

The remainder of the board will include

- Representatives of civil society organisations, multi-sector committees or coalition groups that implement sexual health programmes or represent interests within the sexual health sector
- An attorney-at-law called to the Jamaican Bar or a comparably qualified legal specialist
- Other parties whose expertise or exposure will bring value to the development of family and population planning and sexual health policy

Figure 3: Proposed Structure and Functions of the NFPB-SHA (as of October 2013)



STAKEHOLDER RESPONSES TO INTEGRATION

The plans for integration were largely developed by government staff collaborating closely with representatives from USAID and UN agencies. The integration committee had no representatives from the nongovernmental sector from 2010 through to Cabinet approval in 2013. One of the integration planners said the committee had decided to limit its membership until the integration concept was officially approved by the Cabinet.

In 2012, in the run-up to the Cabinet submission, the MOH organized a half-day consultation in Kingston with representatives from 22 entities, including academia, nongovernmental organizations, government, international development partners, USAID, and UN agencies. Although the governance consultant had met with different stakeholders, this was the first formal event to unveil the concept to a broader group. The major questions raised by participants included the following:

- How would the minister of health select board members who would oversee the new entity?
- How would the new entity address the needs of key populations with the highest HIV burdens?
- How would the entity be funded?
- How would staffing issues be handled? (Integration Committee, 2012)

These questions foreshadowed some of the concerns expressed by the stakeholders HPP interviewed in July and August of 2013.

After the Cabinet approved of integration in March 2013, implementation began in earnest. NHP staff members moved into NFPB's building, which had been refurbished for their arrival. A new interim executive director for NFPB, Sannia Sutherland, was hired following the retirement of NFPB's long-time leader, Dr. McDonald. With a great deal of preparation completed, the MOH decided to assess the status of integration and chart the next steps forward.

In June 2013, the Ministry of Health sought HPP's assistance to elicit perspectives on integration from a broad stakeholder group and to develop a road map for finalizing the process.

Stakeholder Concerns During Early Implementation

In July and August 2013, HPP interviewed 18 stakeholders from government, civil society, private consultancies, donors, UN agencies, and other development partners. As mentioned previously, an important gap in this exercise was the lack of interviews with stakeholders from NFPB. In July 2013, the NFPB Board of Governors, led by chair Dr. Sandra Knight, voted not to support the MOH's documentation effort, preventing the HPP team from formally interviewing the NFPB Board and staff. Although the integration process had been underway for about three years, the NFPB Board felt the case study was too early.

Despite the NFPB Board's decision not to participate, the Ministry of Health determined that HPP should proceed with the stakeholder interviews. Overall, most stakeholders interviewed expressed optimism regarding the integration and thought that, if done well, it would result in greater sustainability for NHP and NFPB, operational efficiencies, cost savings, programmatic synergies, and ultimately, benefits for clients. Stakeholders universally agreed the new structure would boost resource mobilization. Some believed it would help "breathe new life" into family planning and combat "HIV fatigue" or the sense that people were tired of hearing about HIV and its implications.

Stakeholders did agree that the process was only partially completed. As one stakeholder noted, the entity was "well-positioned," but the process was far from over. In terms of the work ahead, a number of themes emerged from the stakeholder interviews, which are outlined below.

The goals and purpose of the new entity

Many stakeholders expressed uncertainty about the nature and goals of the integrated entity and brought their own ideas to bear on the NFPB-SHA. During the interviews, representatives from civil society expressed the need for more information and discussion about the NFPB-SHA. As one stakeholder said, "We need a chance to ventilate or reflect on the decision." Now that the Cabinet has approved the concept, another stakeholder said, it was "time for more substantive conversation and input among a broader group."

An important expectation among many stakeholders was that integration at the national level would facilitate greater integration at the service level. As one stakeholder said, "This shouldn't just stop at the national level." This was a common sentiment among those interviewed: "It's a needed move. All these issues are connected. We need to deliver a holistic package of services for better sexual health." Another stakeholder envisioned the ultimate success of this process as the "extent to which a client can enter a facility anywhere and receive a suite of healthcare services that are integrated."

MOH follow-through and buy-in

A common perception was that the current status of integration was "two programmes under one roof." As one stakeholder noted, "they can't remain separate and siloed." Another serious concern was that the process might stall with the admittedly difficult work of staff reductions: "The need to reduce staff, that's where the problem is going to be…" Some stakeholders expressed an expectation for a smaller workforce: "I want to see a lean, mean machine." Another said ideally the integration would produce "a pared-down, new entity that has all the elements needed for cross-fertilization of knowledge and skills."

Some stakeholders wondered about the extent of buy-in for the integration process within the Ministry of Health: "Is MOH fully vested in the merger? I don't sense how it's working through the levels." For some stakeholders, the integration process might have been overly identified with the efforts of one MOH champion. They saw a need to "institutionalize" the process, demonstrating MOH buy-in throughout its levels and expanding the number of MOH staff taking the process forward.

Balance and focus

One of the concerns among family planning stakeholders was the sense of NFPB being subsumed into the HIV programme, which has had greater visibility and a larger scope, scale, and funding base. Prior to integration, NHP had more than 70 staff members while NFPB had roughly 37. In 2009–2010, the NFPB budget was JM$124,071,790 or US$1,461,705. (Using an exchange rate from 2010 of JM$84.88 for US$1[4]) By contrast, NHP expenditures in 2009–2010 were approximately US$14 million. Further, among the leaders overseeing integration, one stakeholder observed there was "no family planning person to cross-fertilize this effort."

A number of HIV stakeholders expressed concern that their goals and priorities would be diluted in the NFPB-SHA. As one noted, "The gains made around HIV could get diluted in a bigger, broader entity. Will rights-based principles be lost?" There were many concerns about the priority of issues such as homophobia and stigma and discrimination in the new entity. A number of stakeholders were unaware the new integrated entity would have an Enabling Environment and Human Rights Division.

[4] Rate retrieved in August 2013 from www.exchangerates.org.uk/US$-JM$-31_12_2010-exchange-rate-history.html

Differences between NHP and NFPB

One stakeholder noted that the vision is for "a cohesive team with the same objectives." A key question raised during the interviews was how to achieve cohesiveness between two markedly different entities. Stakeholders described a number of technical, managerial, operational, funding, and other asymmetries between NHP and NFPB. By most accounts, NFPB has struggled in recent years. As one stakeholder noted, "family planning as a stand-alone issue is lower in priority." The 2011–2015 NFPB Strategic Plan also describes its challenges:

> "…the Board struggled to maintain visibility of its programmes, which at times created some level of disquiet among members of the public. It was observed that while the organization was performing its legislative functions dutifully and in some instances even surpassing targets, many of its target audiences were unaware of its outreach and public education initiatives. This unfortunate situation was a direct function of workforce and work plan misalignment and a lack of adequate funding to support the type of public education campaigns that could match the media blitz created by cash-rich entities, jostling for prime air time." (National Family Planning Board, n.d., p.16)

A major pressure point among HIV stakeholders was how NFPB would address the needs and interests of key populations most affected by HIV, including sex workers, men who have sex with men, and people who inject drugs. Referring to the NFPB, one stakeholder said, "The enabling environment and human rights are not part of their world view." Another said, "I hope they will continue along the vein of meaningful inclusion of vulnerable populations." Stakeholders also expressed concerns about the new entity taking a multisectoral approach: "The HIV programme solicits input from different sectors. I've not seen NFPB solicit multisectoral input."

Civil society participation

For many stakeholders, it was not clear how the perspectives and needs of civil society would be addressed by the NFPB-SHA. This comment was typical: "How much civil society input will take place? We don't want our experience of engagement with the HIV programme to be lost." Another stakeholder voiced a common feeling: "Civil society needs to be included in a meaningful way.… In areas including strategic direction, service delivery, research, and procurement and other distribution mechanisms."

Civil society stakeholders also expressed concerns about the new entity's governance. As one stakeholder noted, "The existing structure of the national response to HIV allows continual integration of new players into the response…but the NFPB Board is set by law, enshrined in law, and doesn't have the flexibility to include a range of players.… It will be appointed by the minister of health and approved by the Cabinet."

Leadership and strategy

The issue of who would lead the NFPB-SHA was of interest to many stakeholders. Who could bring a strong understanding of both family planning and HIV/STIs to the role? There was an observed need for someone who understood the social determinants of health. One stakeholder suggested the need for a strong team builder and leader who could bring people together, help them adjust, and mobilize a broad range of stakeholders.

A common set of questions related to the policy and strategy of the new authority. As one stakeholder asked, "How is sexual and reproductive health being defined?" Another suggested that, "We need a new policy and strategy" to support the new entity.

A number of questions focused on how the entity will relate to other divisions and programme areas within the MOH, the regional health authorities, and other ministries. One stakeholder pointed out there was "a lot of horizontal work to be done." A common question was, "How will this new architecture

involve regional health authorities?" Some stakeholders wondered if the new entity would result in changes in reporting and lines of authority with regional staff.

Management, assessment, and learning

Some stakeholders noted the importance of identifying and assigning an individual to manage the integration process, which was a full-time job. Another common theme was the need to monitor and assess the integration process. One stakeholder commented, "How do you merge two entities at the governance level? It is not well-documented." Many noted that monitoring would be important to guide the inevitable course corrections needed. Assessment could also help investigate assumptions about the benefits of integration, as noted by one of the respondents: "Will this merger boost family planning activity? Under what conditions? Will the HIV programme benefit from the operational and implementation arrangement of NFPB? There is a need for systematic assessment."

NEXT STEPS FOR COMPLETION OF THE INTEGRATION PROCESS

Based on the stakeholder interviews, HPP worked with the MOH to develop a road map for finalizing the integration process. The road map identified four major work streams for completion: leadership and governance, policy and legal framework, management and operations, and communications. The plan reflects stakeholder concerns expressed in each area. In October 2013, the integration committee began assigning staff to the activities outlined in the road map.

The priorities for leadership and governance include identifying the head of the NFPB-SHA and expanding the board to be more inclusive and multisectoral. Another priority is expanding the MOH's integration committee to include civil society representatives. In terms of legal and policy activities, a key step is gaining official approval of the new NFPB-SHA board plans and new posts. Other important agenda items are developing a new sexual health policy and NFPB-SHA strategic plan.

The road map identifies a number of critical activities in management and operations. A priority is to develop and implement a change management strategy, which will help ensure the "two programmes under one roof" become one and that inefficiencies are reduced. Other important activities include identifying a staff person to manage the integration process; developing procurement and supply chain plans; and rolling out new manuals, job descriptions, and other organizational documents. The road map also calls for developing and implementing a monitoring and evaluation strategy.

One of the major integration challenges identified by stakeholders related to communications. For example, number of stakeholder concerns might have been allayed by communication about the divisions of the NFPB-SHA, especially the Division of Enabling Environment and Human Rights, and the planned mechanisms for civil society input. High on the priority list is the creation of a communications plan that includes a vision for the NFPB-SHA, a branding strategy, and a roll-out plan for stakeholders from MOH, NFPB, civil society, and others.

In a meeting held in October 2013, the MOH agreed that the NFPB-SHA will be responsible for guiding service-level integration. The MOH has identified numerous benefits of service integration, including better access to treatment and services for clients seeking care for a range of sexual health issues, reduced stigma and discrimination, and general improvement in the quality of care.

Although integration may realize cost savings at the national level, the MOH noted "a huge investment" will be required for integrated service delivery.[5] Making family planning, reproductive health, and HIV services available in the same location during the same visit and perhaps by the same provider will involve an array of major changes. It will require new training, job descriptions, infrastructure, systems, practices, and mindsets. Cost is a major barrier. Jamaica already faces steep rises in expenditures related to HIV, largely due to the cost of treatment. From 2013 to 2017, the MOH projects steady increases in the funding gap between estimated costs and total available funding (Harvey, 2013).

[5] Kevin Harvey, interview by Dara Carr, Sunset Jamaica Grande Hotel, October 17, 2013.

LESSONS TO DATE

"Jamaica is a country to learn from…
Jamaica approached integration in a visionary way."

—Integration stakeholder

Since the process is still unfolding, the lessons below are associated with the planning and early implementation phases of integration. Key facilitators of the integration process have included the following:

- Leadership and engagement. The integration concept was originally conceived by two leaders within the Ministry of Health, Dr. Kevin Harvey and Dr. Sheila Campbell-Forrester, who responded to the serious challenges faced by the NHP and NFPB with creativity, resourcefulness, and persistence. After Dr. Campbell-Forrester retired, Dr. Harvey continued to champion the integration process. Their efforts benefited from commitment and flexibility among government officials, programme directors, and managers. Donors also engaged as active partners in problem solving. As one stakeholder noted, "Everyone was involved in brainstorming to find an effective solution."
- Donor support. The support of key donors and development partners throughout the integration process—particularly USAID, UNFPA, and UNAIDS—has been critical. This support went well beyond helping finance aspects of integration. Contributions ranged from helping advocate for integration with high-level government officials to regularly attending the integration committee meetings and reviewing consultant reports. From the start in 2010, key donors and development partners were fully involved in helping inform, guide, and fund this process.
- Contextual factors. Financial pressures were key drivers of change. Facing declines in external assistance and a fiscal crisis, the ministry committed to a reform process that has required ongoing advocacy, time, and effort to implement. Integration champions also cited the principles for "gold standard" programming to justify changes and cultivate support among different stakeholders.

Lessons from implementation to date include the following:

- Integration versus merger. Integration proved different than a merger. Initially, it may have appeared that integration meant merging two entities and eliminating any duplication. Over time, however, it became clear to the integration committee that the new agency was more than "the sum of its parts" and warranted a new vision, mission, and strategy.
- Planning. Planning and implementing an evidence-informed process required a serious commitment of time and resources. The integration committee sought counsel from various experts to help inform its decision making. The process began in 2010 and, as of 2014, is still ongoing. The costs to date have included staff time, consultancies to inform decision-making about the process, administrative support, equipment, refurbishment of offices, and staff relocation.
- Management. Having a focused committee to plan and guide integration seemed to work well in Jamaica. It might have been helpful to include one or more NGO representatives on the committee during the planning phase, given later concerns raised by civil society representatives. The committee benefited from having administrative support for organizing meetings and other tasks, but stakeholders noted the need for a person to manage the overall process.

- Communications. The integration process elicited stakeholder optimism as well as fears and misperceptions. As the process progressed, communication gaps with stakeholders became evident, particularly those from civil society and the NFPB Board. Many civil society stakeholders, for example, were unaware that the NFPB-SHA would address human rights and an enabling environment. The departure of the long-time NFPB executive director Dr. McDonald likely contributed to communication gaps and other issues with the NFPB Board. Creating a communication strategy early in the planning process might have helped allay some concerns. Formally sensitizing key stakeholders rather than relying on informal and internal communication networks may also have improved awareness.
- Change management. Many stakeholders noted that instituting a formal change management process within NFPB-SHA would be essential for the ultimate success of the agency. This process would help address two potential "stalling points" for integration: reducing staff and dealing with HIV-FP programme differences and asymmetries.
- Leadership. Many stakeholders raised questions about what kind of executive director would best suit the NFPB-SHA. The general thinking was that the new agency would require a strong "bridge-builder" with grounding in both HIV and family planning.
- Monitoring and evaluation. Further assessment will be needed to examine whether the integration process will help Jamaica realize greater efficiencies and cost savings. Additionally, monitoring and evaluation also will help inform course corrections that may be needed.

Moving Forward

Health stakeholders in Jamaica note that much has been written about integration at the point of service delivery, but little is documented about national-level programme integration. The integration process in Jamaica has been a complex undertaking. Prior to integration, the NHP and NFPB had separate offices, budgets, strategies, management, staff, activities, and financing. Integration has involved rethinking HIV and family planning strategies, policies, and programmes. It has also required vision, leadership, funds, strong partnerships, and unflagging commitment among stakeholders.

Jamaica has led the way for other countries that are interested in more innovative and sustainable programming models for family planning and HIV. While integration has strengthened institutional sustainability for the HIV programme, evidence is still needed to demonstrate the anticipated cost savings, efficiencies, and outcomes. The authors hope the Ministry of Health will continue to assess the integration process, highlighting both the opportunities and challenges of such a bold governmental reform.

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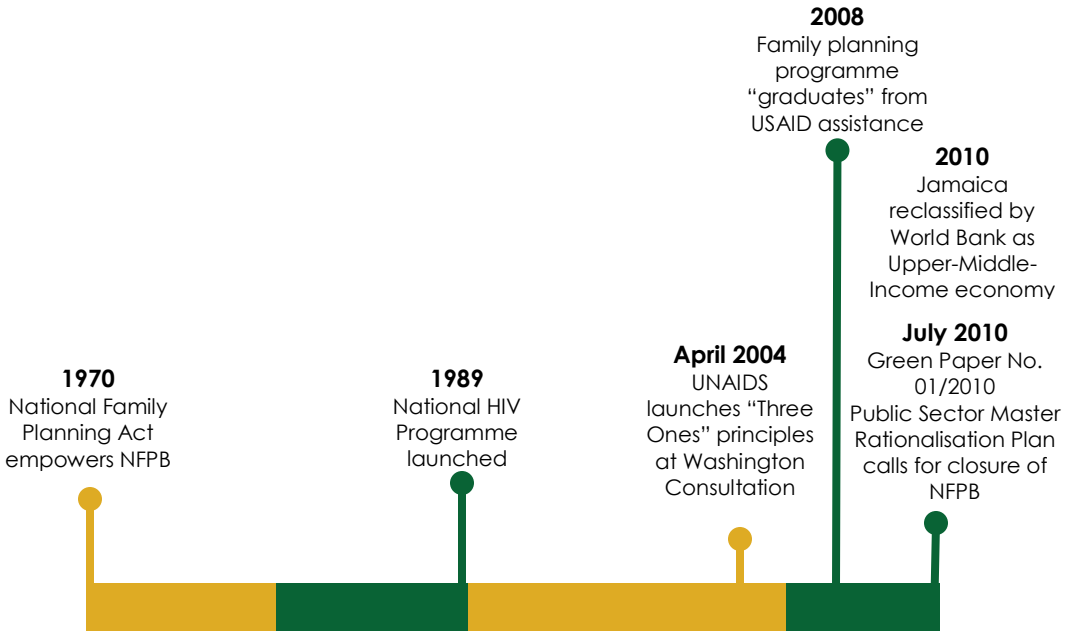
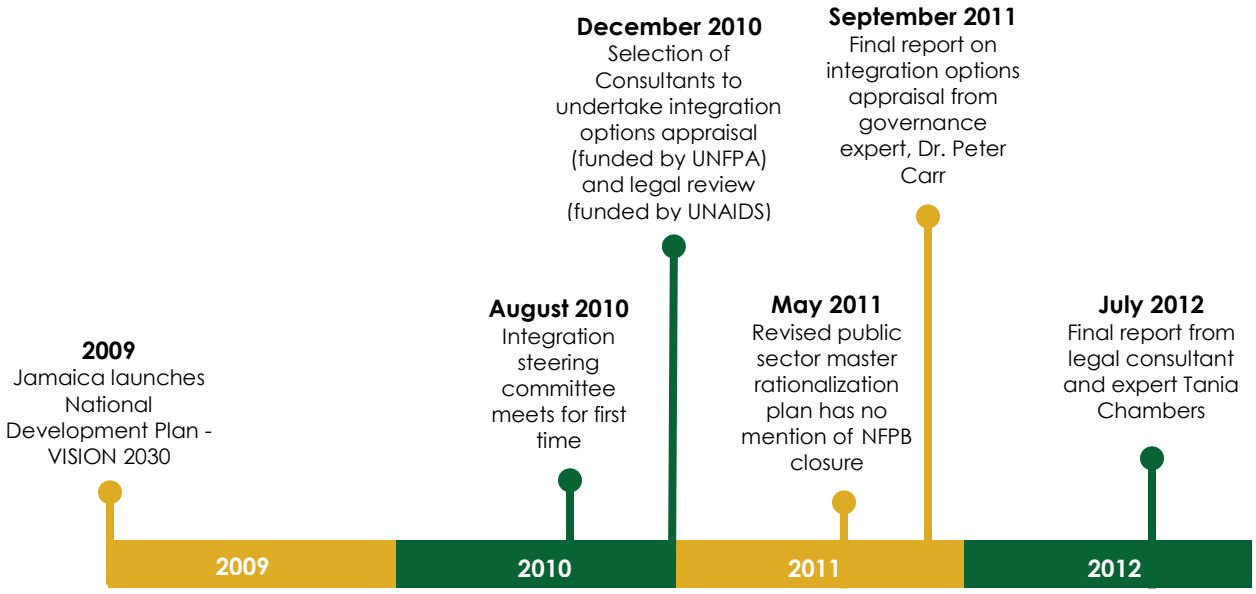
ANNEX A: TIMELINES

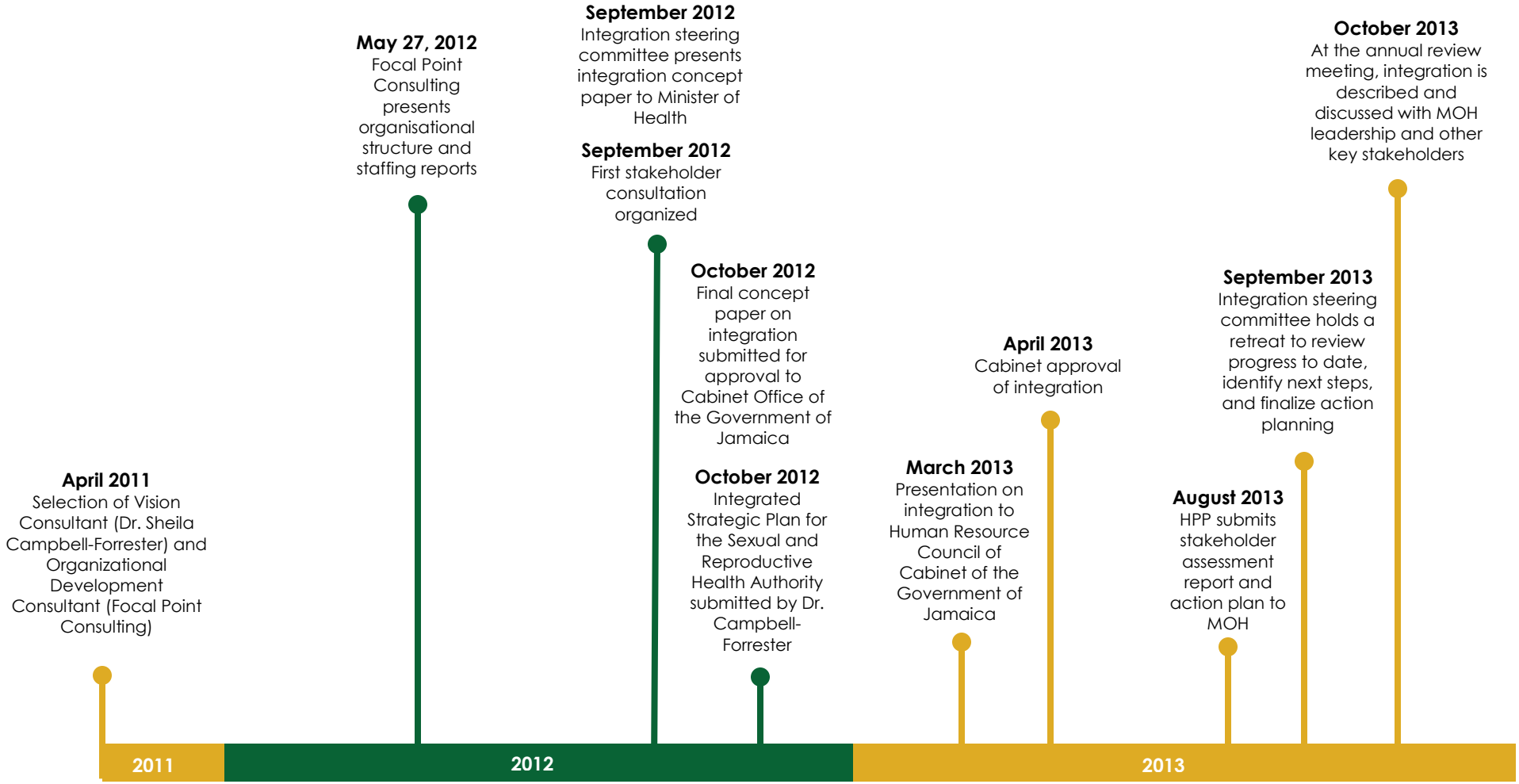
Key Dates: Historical Overview



Key Dates: Making the Case for Integration



Key Dates: Defining the NFPB-SHA, Stakeholder Response, and Road Map for Completion



ANNEX B: LIST OF STAKEHOLDERS INTERVIEWED

No.	Name	Title
1	Dr. Kevin Harvey	Senior Medical Officer, Jamaica National HIV/STI Programme (JNHSP)
2	Dr. Olivia (Peaches) McDonald	Former Executive Director, National Family Planning Board
3	Ms. Denise Herbol	Mission Director, USAID
4	Dr. Jennifer Knight-Johnson	Project Management Specialist (Health), USAID
5	Ms. Jeannette E. Vail	Supervisory Program Officer, USAID
6	Dr. Pierre Somse	UNAIDS Country Coordinator
7	Mr. Marvin Gunter	Regional HIV Advisor, UNFPA
8	Dr. Sheila Campbell-Forrester	Former CMO, Ministry of Health and developed interim National Strategic Plan for integrated entities
9	Mr. Ivan Cruickshank	Policy & Advocacy Director, Caribbean Vulnerable Communities Coalition (CVC)
10	Mr. Ian McKnight	Chairman, Jamaica AIDS Support for Life (JASL) & Executive Director, CVC Coalition
11	Ms. Kandasi Levermore	CEO, Jamaica AIDS Support for Life (JASL)
12	Mrs. St. Rachel Ustanny	Executive Director, FAMPLAN (IPPF Affiliate)
13	Mr. Peter Carr	Health Systems Consultant (prepared document on feasibility of integration)
14	Ms. Joi Chambers	Adolescent Reproductive Health Officer, MOH Integration Committee Member
15	Dr. Karen Lewis-Bell	Director, Family Health, MOH Integration Committee Member
16	Dr. Yvonne Munroe	Programme Development Officer, Family Health Services, Ministry of Health
17	Mr. Ainsley Reid	GIPA Coordinator, NAC/JN+
18	Dr. Karen Hilliard	Former Mission Director, USAID Jamaica

HPP team member Kathy McClure also met with the NFPB Board in August 2013 to discuss the documentation of the integration process and request their participation in the stakeholder interviews.

ANNEX C: STAKEHOLDER DISCUSSION GUIDE

Case Study on Creating an Integrated Sexual and Reproductive Health and HIV/STI Programme in Jamaica

In-depth Interview Guide

Informed Consent

Verbal Informed Consent Language

Thank you for meeting with me to discuss the process that Jamaica undertook to integrate its National HIV/STI Unit and National Family Planning Board. I would like to hear about your perspectives on this integration, the process the country has undertaken to achieve it, your role/your organization's role in the process, and your perspective on the challenges and advantages of the merger. The interview will take up to 60 minutes. You may choose to allow me to include your name and the name of your organization in my notes and in the report that is developed based on our discussions or you may choose to keep your responses anonymous.

Do you authorize the Health Policy Project (HPP) to use quotes and information from our discussion in reports and other published documents?

___ YES, verbal consent was received

___ NO, consent was not received. *Comments or notes made during this conversation should not be used in the report or any documentation produced by HPP.*

Do you authorize HPP to use your organization's name in a list of all key informants that I am interviewing in Jamaica? This list may be used in a report or other publicly available documents.

___ YES, verbal consent was received

___ NO, consent was not received. *Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.*

Signature of interviewee: _____

Signature of interviewer: _____

If you have any questions about this interview, please contact Ken Morrison at KMorrison@futuresgroup.com or (202) 215-5088 (U.S.) or Sandra McLeish at smcleish@futuresgroup.com or at 5853166 (Kingston)

Interview Guide

Note: The questions below, intended to be guides for discussion rather than specific questions to be asked of each interviewee, will be adapted depending on the stakeholder interviewed and their, or their organization's, role in the process.

1. How did the decision to integrate the HIV/STIs and Family Planning programmes take place? What factors went into the decision? What were the major justifications for the merger?

2. What is the organizational structure and governance for the integrated program? What are the pros and cons of the proposed structure?

3. How are stakeholders, including any stakeholders outside of Jamaica (e.g., donors), being engaged in the process of integration? Has the level of stakeholder participation been satisfactory to all stakeholders? Are beneficiaries in the program areas being consulted? If not, please describe.

4. What are next steps in the integration process, and what is the time frame for completion?

5. What are the policy or legal implications of the merger? How are these being addressed?

6. What are the key challenges in merging national strategies? How are these being addressed? What are the opportunities available?

7. Specifically, what are some of the concerns related to staffing and potential job loss? How are these being handled?

8. Are there any financial implications, including funding opportunities, of integrating the programs? If so, please describe.

9. What have been the implications for service delivery, at the HQ as well as decentralized level?

10. Do you anticipate operational efficiencies will be gained from the merger?

11. How will the integration impact clients and the services they receive? Is it anticipated to affect clients? If so, please describe.

12. What advice, if any, do you have for other countries considering integrating their Family Planning and HIV and AIDS programmes?

Thank you for your time.

ANNEX D: ORGANISATIONAL CHARTS OF PRE-INTEGRATION NFPB AND NHP

Figure 1: Pre-integration Organizational Structure of NFPB

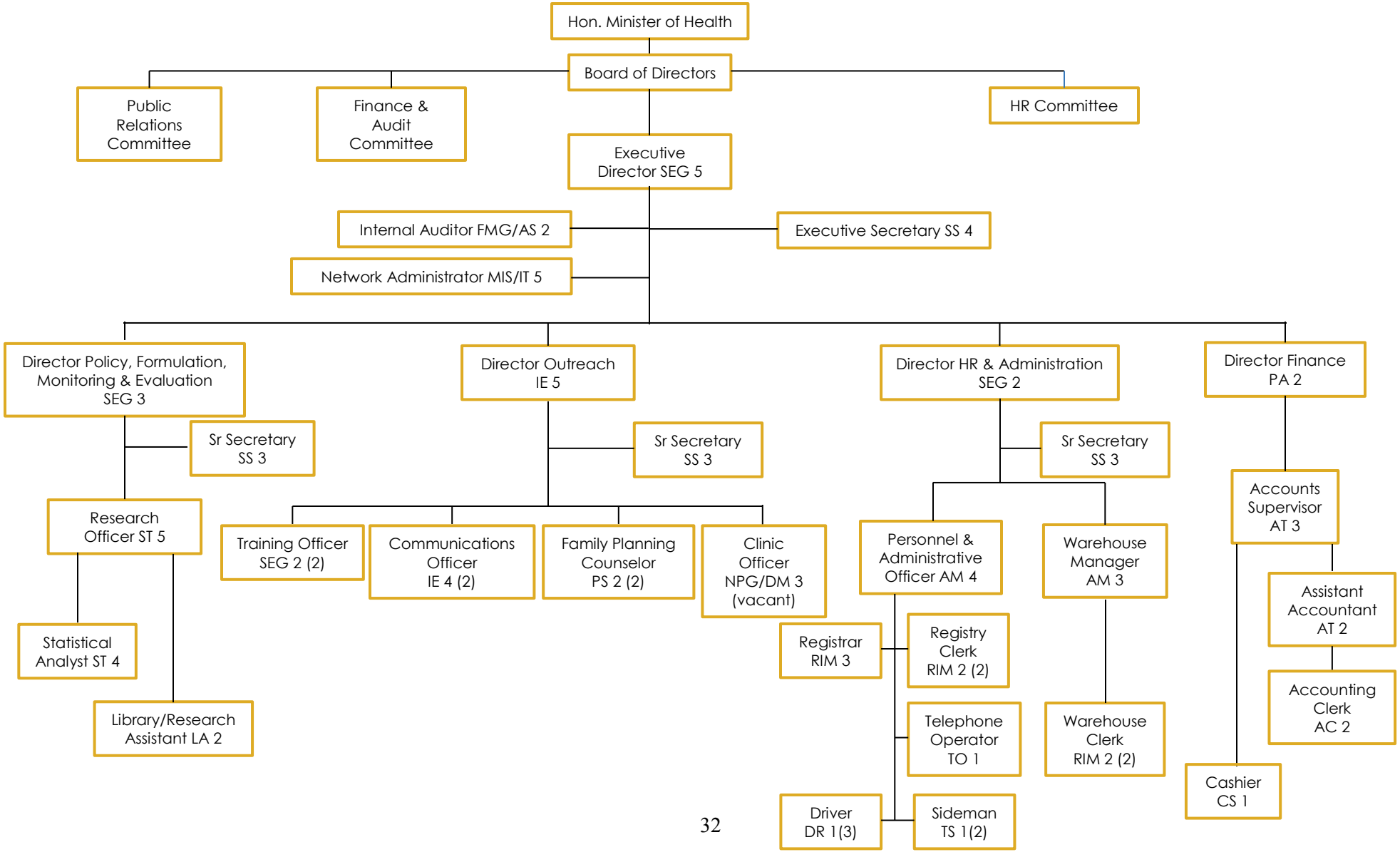
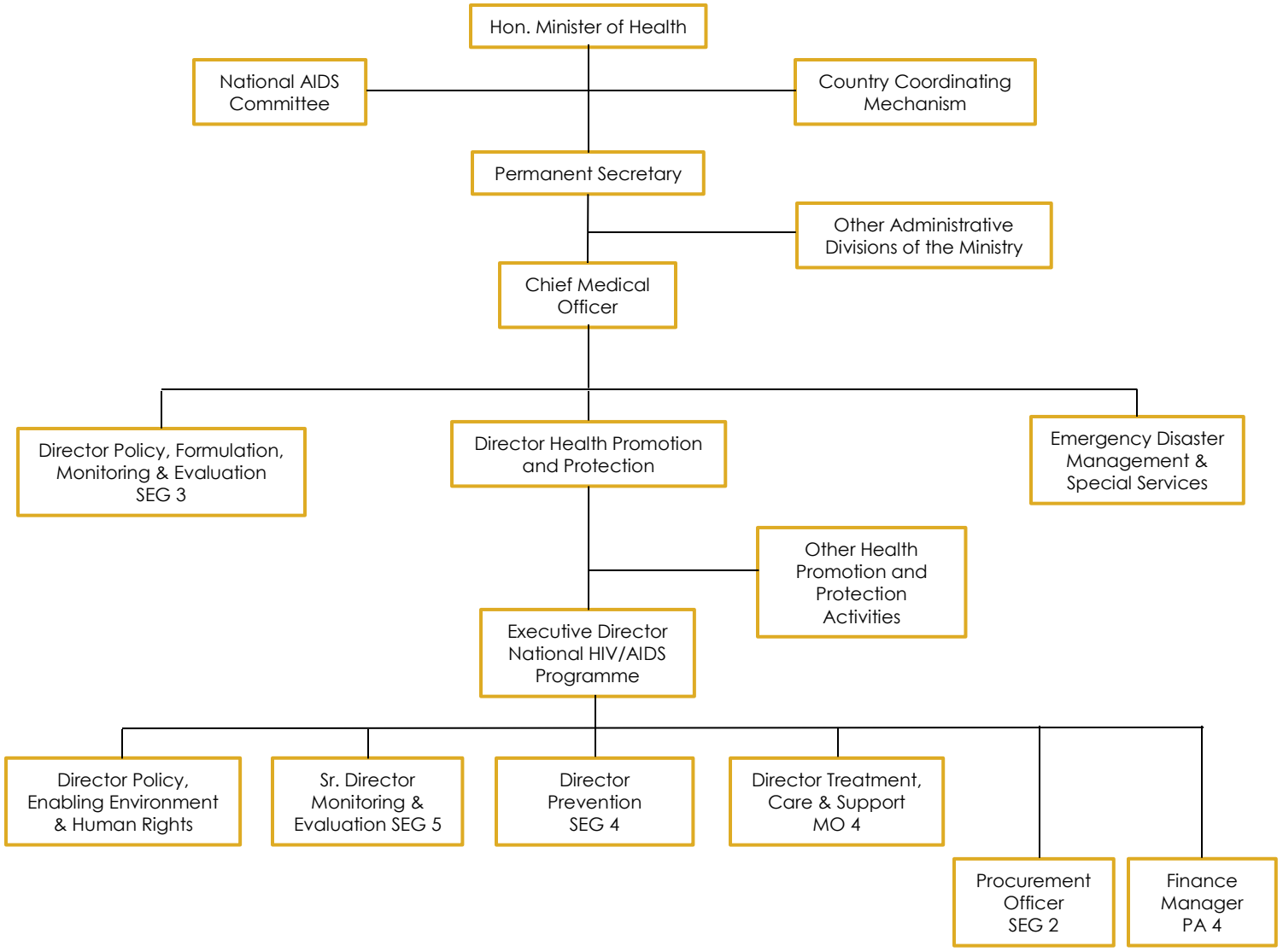


Figure 2: Pre-integration Organizational Structure of NHP



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