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Integration of sexual and reproductive health and HIV services

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Integra

Strengthening the evidence base and good practice for integrating HIV and SRH services

This **Steps to Integration** series provides a guide on how to integrate HIV and sexual and reproductive health (SRH) services based on findings from the Integra Initiative.

The **Integra Initiative** was a research project on the benefits and costs of a range of models for delivering integrated HIV and SRH services in high and medium HIV prevalence settings, to reduce HIV infection (and associated stigma) and unintended pregnancies. It was managed by the International Planned Parenthood Federation (IPPF) in partnership with the London School of Hygiene & Tropical Medicine (LSHTM) and the Population Council.

Findings from the project show that integrating HIV and SRH services has the potential to:

✔ **Increase uptake of health services**

✔ **Increase range of services available**

✔ **Improve quality of services and efficient use of resources**

✔ **Enable health systems to respond to client needs and improve overall client satisfaction**

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Integration of sexual and reproductive health and HIV services

Introduction

In Sub-Saharan Africa, there is a high rate of unintended pregnancy, particularly among HIV-positive women. What is more, the majority of HIV infections in this region are sexually transmitted or transmitted as a result of pregnancy, childbirth and breastfeeding.

Yet, despite the fact that unintended pregnancy and HIV are deeply co-relevant SRH issues, many health facilities do not provide health services that simultaneously address both sets of issues in meaningfully integrated ways. Often, women must seek services in facility environments with staff shortages, inadequate supplies, in an environment of non-confidentiality or stigma, or must seek services at entirely separate facilities.[i]

Providing adequate SRH services to all women requires that HIV services be available to treat women living with HIV, and to prevent its transmission in women who are HIV-negative. To better meet these needs, many have argued for the integration of SRH and HIV services by integrating human resources and enabling providers to offer multiple services. Integration is a promising avenue to improve sexual and reproductive health for a number of reasons. It has the potential to increase access and uptake of health

DEFINING INTEGRATION

Integration is different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This can include referrals from one service to another. It is based on the need to offer comprehensive and integrated services.[ii]

services, increase job satisfaction among providers, more efficiently and more effectively distribute facility workloads, and reduce facility costs by taking advantage of 'economies of scope' (joint production of goods/services) and 'economies of scale' (cost savings through an increase in the number of services delivered with the same level of staff).[i, iii] However, there is a relative lack of evidence on the benefits and costs of integration and which models could be most effective.

The Integra Initiative represents an effort to respond to this need for high quality evidence on the feasibility, effectiveness, cost, and impact of different models for delivering integrated HIV and SRH services in settings with high and medium HIV prevalence in sub-Saharan Africa. The entry points for SRH services included postnatal care and family planning consultations.

Key themes of SRH and HIV service integration

Recognizing that health service integration is not a binary process, but rather encompasses a continuum of coordination and collaboration and can include consolidating inter-unit processes and resources (including procurement, data collection and analysis, human resources, and physical infrastructure) the Integra Initiative examined several overlapping dimensions of SRH and HIV service integration. They included:

A. the impact of integration on provider workloads:

B. the importance of provider experiences with integration; and

C. the use of capacity-building tools as a strategy for enabling integration, specifically peer mentoring.

A

Provider workload and efficiency

Does integrating SRH and HIV services increase individual provider workload or reduce it by more efficiently redistributing service provision?

To answer this question, Integra conducted a descriptive analysis of human resource integration through task shifting/sharing and staff workload, seeking to describe the level, characteristics and changes in human resource integration in the context of wider efforts to integrate services.

The results of the study indicated that integration is associated with a range workload effects, depending on the facility context. Overall, human resource integration was more likely to be improved in facilities which also improved other elements of integration, such as integrated use of physical space.[i] While there was no overall relationship between integration and workload at the facility level, more integrated facilitates did display a significantly lower provider–client ratio for certain services than for the same services in less integrated facilities. In a number of settings, there were differences found in workload between different services within facilities, implying that this under-utilization of human resources can be improved through re-allocation of staff duties across services within sites.

However, it is important to note that this was more often the case where there was excess staff capacity. Some of these staff reallocations, in particular increased staffing of HIV-related services, may have come at the cost of reductions of staff available for other services such as postnatal care, and lead to greater imbalances in staff workload within a facility.[i] Integra found that none of the facilities were classified as 'overworked' either at baseline or at endline, however overall facility estimates of whether staff members are overworked does not necessarily mean that staff are not stressed. The success of integration (both in terms of staff workload and quality of services provided) varied greatly across facilities. It is clear that efforts to integrate should remain flexible and must be preceded by individualized investigation at the facility level regarding capacity to integrate services, and which dimensions of the facility need the most support in advance of integration.

B

Personal experiences of providers

Providers hold perceptions about integration based on personal experience or on anecdotes, and these perceptions (positive or negative) can greatly influence their commitment to and acceptability of integrated service delivery. Integra sought to understand to what extent these provider perceptions influence the success of integration.

The experiences that providers had had with actual integration were mixed, partially as a result of whether they had been a part of provider-level integration or unit-level integration. On a personal level, providers appreciated the skills enhancement, the increased variety and challenge in their work, and improved job satisfaction through increased client satisfaction. However, they also perceived that the integration resulted in increased workplace stress (from having an increased workload, spending less quality time with clients, and treating more very poor or sick clients) and that their salaries were low compared to the increased scope of services they were providing. On an operational level, providers reported increases in service uptake, reduced client loss, and increased willingness of clients to take an HIV test. Yet the majority also reported that there were infrastructural and logistical challenges, increased workloads and waiting times, and too-low staffing levels.[iii]

It is clear from these reports that provider experiences with various forms of integration are mixed. Yet it can be argued that the significance of the benefits of integration outweigh the challenges, and furthermore, that the challenges are such that ongoing assessment recalibration of integration processes in individual facilities can help to alleviate them.

For example, the question of increase in provider workload is the one most typically raised anecdotally and in research as an obstacle to integration, but for Integra providers reported that their workloads being both aggravated as well as alleviated by integration efforts. In some cases the increase in workload was not the result of integrative redistribution of service duties, but rather was due to an increase in client volume as a result of better and more complete services being offered through integration.

The facilities which reported decreases in workload show that integration need not inevitably lead to an increased workload. Investment in human resource numbers prior to integration efforts and strategically managing workload by redistributing client load were noted as key to mitigating longer waiting times and increased provider stress. It was frequently noted that a lack of institutional systems that support integration made the process of integration inconsistent and slow to be successful, as it required more fine-tuning and troubleshooting than may have otherwise been the case.[iii]

C

Peer mentorship as a capacity-building tool

Integrating services requires that providers have a greater range of medical and coordination skills, yet knowledge gaps exist among frontline providers that constrain their ability to provide essential services. Traditional approaches to build their capacity (e.g. offsite training workshops) are costly, aren't conducive to knowledge-sharing among colleagues, and interrupt service provision. Integra designed, tested and adapted protocols for peer mentorship as a capacity-building tool to support service integration in order to improve service providers' skills, knowledge, and capacity to provide quality integrated HIV and SRH services. There is no universally agreed-upon definition of mentorship, but generally speaking, mentoring refers to an interactive, facilitative process meant to promote learning and development in a less-skilled individual through the formal or informal support of a more-skilled individual.[iv]

Integra assisted the Kenya Ministry of Health in the design of the mentorship training programme, and used qualitative assessment to gather data on provider experiences with and perceptions of mentoring before, during, and after the mentorship training programme was implemented.[v]

The mentorship programme was overall a successful and well-liked method of improving provider skill sets. For further information about the benefits, critical enablers and challenges in implementing a peer mentorships approach, see Steps to Integration Issue 2: Peer mentoring: an effective strategy for integrating HIV and SRH services.

2

3

Steps to integrating SRH and HIV services in your facility

Based on the high-quality evidence gained through the Integra Initiative, if a health facility is considering integrating SRH and HIV services, it is important to think through the following in order to design an effective, realistic integration model:

1. **Advocate and build consensus among policymakers or programme managers at the regional or district level:** Advocacy and consensus building on the level and content of integrated services at each level of healthcare is important for the success of service integration. National reproductive health and HIV integration policies, strategies, and packages can also provide the contextual background for offering the integrated services.

2. **Conduct capacity assessments of the individual facility:** This is essential to determining the unique gaps that require support both before and during integration (including infrastructure and supply-chain issues, provider skill levels, and existing service dynamics). Pay particular attention to whether units have staffing shortages or surpluses, and to how services are allocated across staff within a facility, so that reallocation of service duties can efficiently and appropriately make use of existing and new human resources. Where feasible, additional staff should be planned for, or training and mentorship planned to transfer some skills to new staff (e.g. lay counsellor conducting HIV counselling and testing).

3. **Invest in physical infrastructure and drug availability/supply:** Ensuring a baseline of sufficient supplies and physical assets will help the entire facility function more effectively, especially when introducing a service integration scheme. Explore the possibility of re-organizing the available rooms to improve strategic (and where necessary, discrete) client-flow from one room to another.

4. **Include the experiences and opinions of providers throughout the integration process, including at the design stage:** Since providers will be the ones to carry out the service-level elements of integration, it is essential that their voices be brought into the design process and continually heeded throughout implementation. Successful integration requires a health system-wide commitment at both planning and implementation stages, and including providers throughout the process will help provider motivation as well as ensure that management of the integration process reflects the on-the-ground needs of the facility.

5. **Use a well-designed mentorship process as a capacity-building tool:** Mentorship programmes have been demonstrated to improve provider skills and improve the success of integration efforts.[iv] Challenges of this approach can be addressed by ensuring that the mentorship programme promotes flexibility and cooperation. If thoughtfully designed and implemented, mentoring has the potential to meaningfully combat problems of staff shortages by increasing the skills for existing staff, by existing staff, in a matter that is sustainable and cost-effective.

6. **Maintain flexibility in integration design:** As the integration process is carried out, it is important to constantly re-assess the value and realism of the model, and recalibrate it as needed to ensure the integration model is appropriate for the facilities' needs and abilities and sustainable in the long run.

7. **Ensure the integration process continues:** Integration is not a strategy that is implemented only once. The dividends of integration will not simply self-deliver after a single change; integration is instead an ongoing process that must be consistently supported and recalibrated as needed.

8. **Remain vigilant at the health systems level:** After the initial change to an integrated model, the health system itself continues to flux as it had previously: staff get transferred or change careers, resource allocation changes with national or regional budget priorities, new health problems emerge that threaten status-quo of existing service delivery set-up, global guidelines circulate that sometimes challenge the existing system's focus, etc. Therefore, a health programme (especially one that has newly integrated its services) must be constantly vigilant about effectively monitoring and responding to these 'weather' changes and make the necessary adjustments to the integration model.

References

i. Sedona Sweeney et al. 2014. "The impact of HIV/SRH service integration on workload: analysis from the Integra Initiative in two African settings." *Human Resources for Health* 2014, 12:42.

ii. Gateways to Integration Case Studies (2008) WHO, UNFPA, UNAIDS, IPPF.

iii. Richard Mutemwa et al. 2013. Experiences of health care providers with integrated HIV and reproductive health services in Kenya: a qualitative study." *BMC Health Services Research* 2013, 13:18.

iv. Charity Ndwiga et al. 2014. "Exploring experiences in peer mentoring as a strategy for capacity building in sexual reproductive health and HIV service integration in Kenya." *BMC Health Services Research* 2014, 14:98.