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Strengthening the evidence base for integrating HIV and SRH services

"Nowadays we communicate..." What providers think about Integrating HIV & reproductive health services in Kenya and Swaziland

Richard Mutemwa, Susannah Mayhew, Manuela Colombini, Joshua Kikuvi, Jackline Kivunaga, Charity Ndwiga - *on behalf of the Integra Team*

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IPPF International Planned Parenthood Federation

London School of Hygiene & Tropical Medicine

Population Council

Methods

Overall Purpose:

develop indepth understanding of provider ongoing experience with providing integrated HIV/AIDS and reproductive health services: *workload, supervision and support, occupational stress, job satisfaction, clinical recording*.

- Targeted frontline providers involved in actual provision of health services, ***not*** managers
- Indepth interviews using semi-structured tool in the intervention sites in Kenya & Swaziland
- Opportunistic sample: interviewed providers on duty on the days of fieldwork, who volunteered to participate
- 32 IDIs conducted in Central & Eastern Provinces (Kenya) in June/July 2010
- 24 IDIs conducted in Mbabane, Manzini, Mankayane (Swaziland) in October/November 2010

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Overall impressions

- No obvious differences between Kenya & Swaziland
- Generally, good understanding of integration among providers interviewed
- Staff generally enthusiastic about integration but weighed down by the challenges
- Integration does affect the work environment around the provider, with significant individual level and *reported* operational level benefits
- However, implementation is currently hampered by significant systemic challenges

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Reported Models of integration in practice

Operational integration model	**Provider(s) client receives service(s) from in one visit**	**Room(s) client receives service(s) from in one visit**
Provider-level integration	Client receives all required services from one provider	Client receives required services in one room
Unit-level integration	Client receives required services from different specialist providers *Client may receive more than one service within each specialist unit*	Client receives required services in different rooms
'Mixed' integration	Client receives more than one service from one provider	Client receives required services in different rooms

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Benefits of integration – *individual level*

- Enhanced job satisfaction: from providing better quality service to clients which leads to receiving more regular positive feedback from clients.

"I think with integration, you are able to serve the client better and capture each and every detail of a patient (holistically). (The client) will not go home with a certain problem unattended. That is very satisfying."

- Enhanced skill range: through training and the broader environment of clinical experience in which staff currently operated – which also enhances awareness

"..because I'm able to see more clients than I used to and get more experience... because I'm dealing with different clients with different issues...it is building me as a nurse, profession-wise. So I'm more satisfied".

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Benefits of integration – *individual level*

- Enhanced professional stimulation and reduced dreariness: from constantly changing clientele and new health problems

"...where there is no integration there is that boredom because of doing one thing and there is no change. In integration...it keeps on rotating in your mind...and you enjoy the work."

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Benefits of integration – *operational level*

- Improved attitudes towards work and working relationships among staff

"Nowadays we communicate...and that's been really helpful I think. You don't feel alone on the job. It never used to happen before."

- Increased service uptake

"Client numbers have definitely gone up... (For example) if you are working in the (child welfare clinic) you can now (expect to) see around 100 children per day..."

- Reduced queuing for clients – no longer queuing three or four times at different provider rooms per visit

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Benefits of integration – *operational level*

- A Few Reports of Reduced workload due to:
  - Increased investment in staff numbers to support implementation
  - Ability to prescribe long-term FP methods
  - Redistributed client-load per provider

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Challenges – *individual level*

- Poor remuneration that doesn't match workload:

"Let's not talk about salary they are peanuts, this is voluntary work we are doing!."

- Lack of psychosocial support to help cope with occupational stressors:

"Sometimes you meet extreme cases that really leave you crushed...not able to cope. Sometimes the situation (you are dealing with is so severe) you ask yourself how that could happen to a human being...".

"sometimes when the situation is worse I get emotional…and sometimes it discourages you it's like you're not doing your best (for that person)"

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Challenges – *operational level*

- Increased workload - two main causes:
  - staff shortage: *integration meant increasing the number of clients per provider as clients get re-distributed among the same number of staff as used to serve before integration*
  - Inadequate physical space: *for facilities with staff but are unable to allocate workload because of lack of rooms*
  - Compounded by amount of clinical reporting that necessarily accompanied increase in client numbers per capita

- Poor clinical recording due to increased workload & fragmented register system:

"It is a challenge because you find that you have so many registers, like now you find that you have separate STI register, you have the FP register, you have the post natal register, so it is a challenge to (make entries) in all those books for each client…".

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Challenges – *operational level*

- Increased waiting & session times:

  "They complain that we are keeping them (waiting) and yet when you are with a client, you must give that client the integrated service. But...they feel that you are (unnecessarily) keeping them waiting (outside)."

- Lack of appropriate medical equipment, inadequate drugs and other supplies, and inadequate consultation room space; in many cases also poor water and electricity supply

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Challenges – *operational level*

- Lack of clear guidelines for charging service user fees in the new context of integration, to avoid cross-subsidisation between services

"Direct FP outpatients pay 20 Shillings for the (FP service). But clients who come for other services we are supposed to offer them FP as well and we don't know whether to charge them, so (it means) we have so many other FP clients who get these services for free...which are paid for by few."

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Final Observations

- Need to address issues around workload: low staffing levels and inadequate physical room space in facilities are major underlying causes
- Resolving the long waiting-time problem almost entirely depends on addressing the workload problem
- Clinical information system needs re-alignment with integration: currently routine assessment of performance of integration cannot be reliably conducted
- Need to address the problem of occupational stress. formalising regular debriefing sessions in the workplace may provide a start.
- Successful integration requires a health system-wide commitment at both planning and implementation levels. The central Ministries of Health need to create coherent policy environments & ensure availability of resources for implementation at the lower levels.

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Asante Sana...!

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