Strengthening the evidence base for integrating HIV and SRH services

Do integrated services perform better than specialist sites at meeting the SRH needs of people living with HIV?

Experiences of a qualitative cohort of HIV clients at ART initiation in Swaziland

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1) Study background & aims

Much attention has been paid to the clinical management of HIV, yet little is understood about the impact of different service models on client experiences and satisfaction. The integration of sexual and reproductive health (SRH) with HIV services has become a policy focus in recent years, and is being widely promoted by international health agencies. Studies suggest integration can increase access to services for people living with HIV (PLHIV) and SRH services and may be less stigmatising for clients and sanar-care deliverers in a context unconnected with HIV/AIDS.  

A mixed methods study is being conducted in four HIV clinics in one town (Manzini) in Swaziland to explore the process of health care delivery at stand-alone and integrated HIV sites (see Figure 1). The larger study asks whether integrating HIV and SRH services offers an effective model of care for HIV patients, through a comprehensive analysis of integrated and stand-alone HIV service delivery models.

This poster presents findings from the second part of the study, in-depth interviews with clients from the sub-study aim to explore the sexual and reproductive needs of people living with HIV (PLHIV) as they initiate ART (in particular family planning (FP) needs), to examine service responses to these needs within the different models of care, and to explore perceptions to clinic-based stigmatisation.

2) Methods

• In-depth interviews with clients from 4 clinics in Manzini, Swaziland: 2 stand-alone ART (SA) clinics and 2 integrated clinics (IC) (see Table below).
  - Clients were interviewed at 3 points in time: (i) on the day of ART initiation; (ii) 6 months after ART initiation; (iii) 6 months after initiation.
  - 12 clients were interviewed at Round 1, and 10 clients were interviewed at Round 2 and 3. Overall, 6 clients were lost to follow-up due to death or loss of contact.
  - Semi-structured interviews were conducted in English and interpreted and translated into English.

• Thematic analysis was conducted using Atlas Ti with a coding framework developed using both deductive and inductive methods that was continuously revised through the analysis process. Summary findings, concepts and themes were started according to theme and clinic type to aid the analysis.

3) Results part 1: The client

Many clients have unmet SRH needs, which change over time on ART:

• There were substantial reported unmet SRH services across all sites, both integrated and stand-alone, including many cases of unintended pregnancies and limited use of effective contraceptive methods in those not desiring a pregnancy.

• Most clients had been counselled about pregnancy, and we found no reports of negative methods, because I don't see why I would use them when I don't have a child” (female, integrated clinic)

• Most clients reported being ready for ART at the time of ART initiation; a quarter were coupled with multiple ill health problems meant that FP was not an important consideration for clients at that time. 

• Many also admitted problems in consistent condom use, entertaining new relationships where they would have to disclose their status and negotiate condom use.

An over-reliance on condoms:

• Clients often rely on marriage as their contraceptive protection and many strongly felt that condoms were only effective as a contraceptive method for women.

“Since I tested I haven't been back on the injection, because I used to do it back in 2005 when I used to sleep with a condom. Now that I've tested I haven't gone back in family planning. I've decided to use the condom” (female, stand-alone clinic)

Other forms of FP were considered by some participants only appropriate for those with children: "If I had a child I think I would use condoms. If I was going to have a child then I would use some form of contraception. I don't know why I don't use them” (female, integrated clinic)

However, while some were happy to rely on condoms, others were more fearful about their efficacy, in particular those in insecure/independent relationships. Many also admitted problems in consistent condom use, even when they had brought their partner to the clinic for counselling. Those not in relationships feared entering new relationships where they would have to disclose their status and negotiate condom use.

“I just keep thinking about a situation where I meet another person and they let me know, but I don’t find out that they don't want to use a condom with me. What then? Or how do I tell them about my status? I'm just not ready for that right now” (female, integrated clinic, 6 months after treatment initiation)

Clients desire both integrated and ‘specialist’ care:

• Many clients across all sites indicated a preference for further specialist service, and complained of having to visit multiple rooms or facilities to receive the package of services they desired.

• However, many were aware of the implications of receiving a broader package of care, specifically the additional waiting time that might be required, and felt fearful of keeping others waiting.

• Most of those at stand-alone sites were against the idea of integrating HIV care with other health services, and felt health care provision was more efficient at their specialist site.

4) Results part 2: The services

Service response: success in positive prevention & pregnancy counselling

Most are operated by nurses on multiple occasions to use condoms. Several clients who had been inconsistent or failed condom users in the past now felt empowered to be a condom user:

• Most participants had been counselled about pregnancy, and we found no reports of negative attitudes among providers about future child-bearing with HIV.

But responses to client SRH needs remain inadequate in all sites:

Several of those in need of FP services had failed to discuss it with providers, suggesting that services could play a much more active role in promoting FP services.

R: I haven't told anyone *about my status+ I only tell those that I find at the clinic when I go collect my pills, they talk about their situations and I also find myself sharing mine” (female, stand-alone clinic)

Several care models may be inhibiting integration goals:

• Some clients at integrated sites had been referred internally for FP, but had failed to attend the service, indicating that ‘facility-level’ integration may be problematic.

• Clients reported service fragmentation across all sites. This included fragmentation of HIV care among nurses, doctors, counsellors, lab technicians, and pharmacists, but also to access to other SRH services. 

• Women patients often seem to suffer most from service fragmentation. Figure 1 shows a service use trajectory of a woman at an integrated site who had failed to coordinate her pregnancy and ART visits.

Stand-alone clinics may not be more stigmatising than integrated sites:

• While some clients at integrated sites felt the separated service and preferred being managed by nurses, others felt that they didn’t feel ashamed, others reported occasions where their status had been disclosed or felt their privacy was compromised:

“I haven't told anyone [about my status] only tell those that I find at the clinic when I go collect my pills, they talk about their situations and I also find myself sharing mine” (female, stand-alone clinic)

Clients are generally satisfied with their own treatment site:

• We found high levels of client satisfaction in this group. Several compared care in their HIV clinic favourably to other local health services. Clients seem to value adequate elements of quality of care over the specific model of service delivery (e.g. waiting times, friendliness of providers, personal trust in the provider). Those at integrated sites appreciate privacy and access to a range of services; those at specialist sites appreciate companionship from other HIV patients.

5) Discussion & conclusions

• Integrated sites do not seem to be performing better than stand-alone clinics in addressing the widespread unmet SRH needs that were identified in this group. This may be due to the standardised approach to ART initiation, in which post-ART initiation protocols on FP are largely controlled by the internal referral to the ART clinic counselling service. Further investigation, but suggests that STI counselling may need to be conducted onsite by an ART provider to be done successfully.

• It is encouraging that ART services seem to be successful in promoting condom use. This highlights the positive role that health care services can play in HIV prevention through sustained contact with health services. However, condom promotion may be entirely displacing counselling on other FP methods, and thus greater attention is needed on dual protection.

• Integrated services may not be so successful in reducing stigma when confidentiality is breached in the initial consultation. The salutary impact found from other HIV patients in waiting areas at stand-alone sites is important and captivated on by all service models. The reluctance of clients at stand-alone sites to support integration with health services underlines their satisfaction with this model of care.

A follow up quantitative survey has followed this study, investigating the response of the service models of care to client SRH needs. Contact authors for more details.