Do integrated services perform better than stand-alone sites in promoting FP among people living with HIV?

A comparative case study from Swaziland

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Background: integration of HIV & sexual and reproductive health (SRH) services

- Recent calls to deliver a more holistic package of care to people living with HIV (PLWH), to overcome a verticalised approach
- Rationale: access to services, cost savings, client satisfaction, reduction in HIV-related stigma, PMTCT (through FP)
- While there is growing body of evidence on SRH needs in PLWH, current evidence on impact of integration is weak:
  - Few studies compare integrated with stand-alone models of care
  - Measuring the ‘extent’ of current service integration is challenging
  - Many studies fail to isolate the impact of service reorganisation from other concurrent activities
Study aim

To investigate whether integrating HIV care and SRH services is an effective model of health care for HIV patients through a comparative analysis of integrated and stand-alone HIV service delivery models in Swaziland.
Research objectives

1. To investigate the FP practices and needs of PLWH attending HIV care services at the four clinics
2. To investigate whether integrated care is associated with uptake of SRH services and unmet needs for FP
3. To explore the contextual factors influencing the delivery of integrated services within HCTx settings
Mixed methods research

- HIV client exit survey: cross-sectional (N=611)
  - Men and women aged 18 and over, attending for pre-ART or ART services
  - Clients identified using systematic random sampling (SRS)
  - Data entry through PDA software (SurveyPlus), imported into STATA 11.0
  - Chi², analysis of variance and multivariable logistic regression modelling

- In-depth interviews (IDIs) with 16 providers

- IDIs with 22 clients (m&f) at ART initiation with follow-up interviews at 2 and 6 months
  - Interviews in SiSwati, transcribed and translated
  - Thematic analysis using Nvivo 8.0 and charting of key themes by case
Participant response rate: 84.7%
Results

1. SRH needs of clients
2. Service response to SRH needs
3. Context of integration
Results: Description of clinic population

- ≥ 40 yrs
- 30-39 yrs
- 25-29 yrs
- < 25 yrs

Percent of all clients

Males (N=129)
Females (N=482)
Description of clinic population – client type

N=611
p<0.001

Clinic A: N=72
Clinic B: N=166
Clinic C: N=183
Clinic D: N=190

Most integrated

Most “specialist”

Pre-ART
ART initiation
ART refill
ART user consult
PMTCT
Results: unmet need for FP

Unmet need = 32%
(in DHS among all HIV+ women aged ≥29%)
Results: Current contraceptive use (women)

Clinic A

Clinic B

Clinic C

Clinic D

N=394
p= 0.035
Condom use consistency by type of FP user

- 45% of respondents classified as consistent condom users

![Bar Chart]

Consistent use in those using condoms for pregnancy prevention vs other reasons

- Uses for pregnancy prevention (N=263): Consistent user 77.95%, Inconsistent user 22.05%
- Uses for other reasons (N=223): Consistent user 39.01%, Inconsistent user 60.99%

p<0.001
Results

1. SRH needs of clients
2. Service response to SRH needs
3. Context of integration
Results: SRH Services accessed since positive HIV test

N=603 clients (women=476)
N=2345 services
Results: SRH service use (multivariable*)

<table>
<thead>
<tr>
<th>Service</th>
<th>Clinic Model</th>
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<tbody>
<tr>
<td>FP counselling (for women)</td>
<td>A</td>
</tr>
<tr>
<td>Condom provision</td>
<td>B</td>
</tr>
<tr>
<td>Counselling on pregnancy (for women)</td>
<td>C</td>
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<tr>
<td>Unmet needs for family planning</td>
<td>D</td>
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Outcome:
- Most integrated
- Most stand-alone
Results

1. SRH needs of clients
2. Service response to SRH needs
3. Context of integration
Results: Context of service integration

Clinic & policy factors

Physical infrastructure, supplies, client load etc.

Relations between clients and providers

Client factors & provider factors

How integrated does care become?
Key contextual influences

- Providers and in turn clients ACROSS ALL SITES influenced by a heavy programmatic focus on condom promotion among PLWH.

*I: what advice did they give you about family planning [...]?

*R: There wasn’t any, they just told me not to have sex without a condom because the people that I have sex with, if they don’t have HIV, I’ll spread it to them and also when I’m taking pills I can reinfect anybody [Female client, stand-alone site]

- FP counselling is focused at the time of ART initiation when clients may not be receptive to counselling messages:

even if you tell [clients] they have to start thinking about [FP], it’s basically the last of their problems most of the time. They only realize later on ...so you keep insisting that they go for [FP], but to them it’s an extra mile, they are really concerned about getting back to normal, living their lives, so I think that’s where we lose most of the contact [Provider, stand-alone clinic]
Key contextual influences

• ART providers are overwhelmed with ART....and may rely on internal referral processes for SRH to other rooms/”units”:
  “it’s not the only thing that you’re supposed to ask and you’re supposed to do, so you may overlook the family planning issue” [Provider, integrated site]

-- but internal referral doesn’t always work!

• Even partial integration may lead to de-skilling of providers and loss of confidence in abilities to deliver other services

• While providers perceive client benefits to integration, they perceive few personal benefits, and do not consider efficiency gains

• Care remains routinised and task-oriented, i.e. centred on delivery of routine tasks – exploring other client needs remains limited:
R: I don’t know what [vaccinations] my baby’s getting and when...
I: Oh [...] they don’t explain to you what your baby is getting and what it’s for?
R: They give you the card with all the information, where each injection is given [...]. Other than that, no they don’t say anything. If you’re a mum for the first time, you’re in trouble
I: (Laughing) so how come you don’t ask them to explain the shots?
R: It’s usually fast... and they usually say they are taking the baby to be weighed, but then they take the baby and do everything, so there is no time to ask a lot of questions
I: What about while they are doing it... you don’t ask questions?
R: Whoo! There’s not much you can talk about in there... they will just tell you “lift his armpit”, “turn him around” “rub him” “pick him up” and then it’s over and they have to attend to the next person

[Female client, integrated clinic]
Conclusions and research implications

• HIV clinics are doing a good job in promoting condoms among PLWH, but are condoms enough or always the right response? Dual method use may also need to be encouraged**
• FP counselling at ART initiation is not sufficient
• ‘ART providers’ need training to deliver basic contraceptives in their ‘ART rooms’; if this is not feasible, then routine referrals to a very NEAR-BY room should be available
• Integration needs to be supported by managers to ensure all staff are motivated and capacitated to deliver required services
• Limitations: Cross-sectional observational design, small no. clinics
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THANK YOU!

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