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Hands up! Political commitment to SRH and HIV integration

Supportive policies are needed to facilitate the uptake of integrated services. An enabling environment can be created and sustained by a variety of factors, including the political will of 'champions' to respond to the latest evidence, and advocate for policies that encourage greater linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and service delivery levels.

The preliminary research findings from the Integra initiative – combined with reflections from the process of implementing the research – shows how policy-relevant research has the potential to create such an enabling environment. The research is exploring the extent to which integration can:

- decrease unmet need for family planning;
- increase access to comprehensive SRH and HIV services;
- act as a modality for reducing stigma; and
- maximise the efficiency of services provided.

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A spotlight on Kenya

The Kenyan Ministry of Health initiated the process of integrating reproductive health (RH) and HIV services more than a decade ago, when initial efforts were made to integrate HIV counselling and testing during pregnant women's antenatal visits. An Integration Technical Working Group (TWG) was formed in 2002, and co-chaired by the Department of Reproductive Health (DRH) and the National AIDS and STIs Control Programme (NAS COP). It coordinates all the efforts between partners working on RH and HIV integration in an attempt to leverage resources and advance the research agenda for evidence-informed programming.

“ We have made a lot of progress through the RH and HIV TWG and other countries are learning from us. ”
PROGRAMME OFFICER, NAS COP

Findings from the Integra initiative were presented in Nairobi in January 2010 and February 2012. A lack of effective coordination of RH and HIV integration activities between the national, regional and district levels was identified, and therefore, one of Integra's policy priorities has been to bridge these structures and strengthen

implementation and policy support across the different levels. For example, based on an increase in long-term contraceptive use (from 3.1% at baseline to 7% after one year) in response to the Integra mentoring programme, the DRH has recommended mentoring as a strategy, amongst others, to improve contraceptive prevalence rate from the current 46% to 60% by 2015.

“ I cannot wait for this project [Integra] to end so that we can scale it up. ”

PROGRAMME MANAGER, DRH

The TWG has witnessed the inclusion of RH and HIV integration and different capacity development interventions (such as mentoring) in various policy documents such as: *National Health Sector Strategic Plan (2005–2010)*; *Kenya National AIDS Strategic Plan III (2009/10–2012/13)*; *National Reproductive Health Policy (2007)* and *Strategy (2010 /2015)*; and *National RH and HIV Integration Strategy (2009)*.

For further details on the Kenya example above, contact the IPPF Africa Regional Office and the Population Council in Nairobi. Issue 3 of the newsletter will include a spotlight on Malawi and issue 4 will include a spotlight on Swaziland.

Missed opportunities for meeting reproductive and HIV needs in Kenya and Swaziland: evidence from community surveys

J. MAK, I. BIRDTHISTLE, S. MAYHEW – INTEGRA RESEARCH TEAM

Background: Integration of SRH and HIV services is expected to improve quality, uptake and efficiency of services. However, little is known about service needs at the population level and whether such needs are being met.

Method: We determined the need for family planning (FP) and HIV services among 1,100 men and 1,431 women aged 18–49 who participated in household surveys in Kenya and Swaziland in 2009. Met FP service need associated with fecund, sexually active respondents who reported not wanting children within a year and used a contraceptive method with all partners. Respondents had HIV service need if they reported multiple partners had never had an HIV test. HIV needs were met if condoms were used with all partners.

Results: FP need was high (71% of women and 67% of men in Kenya; and 80% women and 70% of men in Swaziland) and largely met – 80% women and 79–85% men. Unmet need was a result of non-service use for men and missed opportunities for women who accessed a health facility but did not receive FP services. HIV service need was lower (21–22% among women; 54% and 63% men in Kenya and Swaziland respectively) but largely unmet – 100% women and 95% men in Kenya; 97% women and 92% men in Swaziland. Unmet need was again due to non-service use (62% women 68% men in Kenya and 68% women and 74% men in Swaziland) while missed opportunities accounted for 31% women 21% men in Kenya; and 21% women 8% men in Swaziland.

“Nowadays we communicate...” What providers think about integrating HIV and reproductive health services in Kenya and Swaziland

R. MUTEMWA, S. MAYHEW, M. COLOMBINI, J. KIKUVI AND J. KIVUNAGA – INTEGRA RESEARCH TEAM

Background: Despite widespread integration of HIV and SRH services, little attempt has been made to understand the impact on frontline providers delivering these services. This study explored providers’ experiences of integrated HIV and SRH service delivery.

Method: In-depth interviews were conducted with 56 frontline providers of integrated HIV and SRH services at maternal and child health (MCH)/FP units of public facilities in Kenya and Swaziland. Data were coded using Nvivo 8 and analysed using thematic analysis.

Results: Providers expected that integration would increase their workload but improve their capacity to offer quality services. In practice, most providers reported delivering services in a combination of provider-level (provider gives several services to a client in one room) and unit-level integration (clients move between rooms/providers, but in the same part of the facility e.g. MCH unit). Experiences of actual integration were mixed. Many said it had increased their workload but they found ways to cope – such as through better team-working and load-sharing. Providers valued skills enhancement, more variety and challenge in their work and better job satisfaction through increased client-satisfaction. However, they felt that their salaries were poor; they faced increased occupational stress through increased workload/waiting times and were able to spend less quality time with clients.

Do sexual and reproductive health services provide an entry point for HIV services in high prevalence settings? A client flow analysis from Swaziland

I. BIRDTHISTLE, J. KIKUVI, W. ZHOU, R. MUTEMWA, K. CHURCH, S. MAYHEW – INTEGRA RESEARCH TEAM

Background: HIV prevalence exceeds 40% among pregnant women in Swaziland. SRH care thus provides an entry point for HIV services, here and in other high HIV-prevalence settings, yet little is known about integration of SRH and HIV services or how provision can be improved.

Method: Client flow assessments were conducted over five days in eight public health facilities in Swaziland in 2009 and 2010 (total 6,428 clients) to determine the extent to which clients receive HIV testing, counselling or treatment with FP or post-natal care (PNC) services, before and after implementation of an intervention designed to strengthen integration. Facilities were purposively selected as intervention or comparison sites.

Results: In four intervention facilities, the proportion of clients receiving HIV services rose from 15.7% to 18.1% (p=0.03) among 2,567 clients in 2009 and 2,216 in 2010 with significant increases in HIV counselling and testing but not treatment. In comparison facilities, HIV services were received by 20.4% of 853 clients in 2009 and 19.2% of 792 clients in 2010 (p=0.54). In all facilities, HIV services were most often received alone, or with child services (e.g. immunizations) and antenatal care (ANC) – the most common reasons for women’s attendance, and less frequently with FP or PNC. Integrated HIV and ANC services increased in intervention facilities by 2010 (3.5% to 5.6%, p< 0.001), while integration with other services declined. Integration did not increase in comparison facilities over time.

CONCLUSIONS: Findings suggest high levels of unmet HIV service need at the population level because of poor service use for both sexes and missed opportunities for integrating HIV services within FP and other services women already receive.

CONCLUSIONS: The success of integration depends on those delivering services. Most staff are supportive of integration but formal support mechanisms are needed to help providers cope with higher stress and workloads. Lessons can be learned from providers reporting good teamwork to cope with increased workload. Long waiting times are problematic but may be resolved by reorganization of care.

CONCLUSIONS: Some provision of HIV services with SRH care occurred at all facilities, indicating a capacity to integrate, yet few women receive integrated services. The best opportunities for HIV integration may lie with ANC and child welfare, given their frequent use. While HIV services increased modestly in intervention facilities, the programme’s effectiveness will remain limited until more women attend PNC and greater emphasis is placed on integration with FP.

PROVIDER AND CLIENT PERSPECTIVE

BY LUNGILE MABUZA

I am a living testimony that integrated services work. Besides being a client at Family Life Association of Swaziland (FLAS), I'm also a service provider. I provide voluntary counselling and testing services to clients. In this role, I believe I have helped many women living with HIV, some of whom had lost hope, and have helped them to gain it back through encouraging them and sharing my story with them.

As a young woman living with HIV, it is gratifying to say that integrated services, which I have accessed at FLAS have been of a high quality, user-friendly, free from stigma and provided by well trained and friendly staff. The services address a wide range of needs for women living with HIV. At the FLAS facility I have been able to receive antenatal care, family planning and anti-retroviral therapy (including treatment of opportunistic illnesses). Being enrolled in the prevention of mother-to-child transmission (PMTCT) programme at FLAS and seeking counselling enabled me to give birth to an HIV-free baby girl 24 months ago. I appreciate the support I received from both my family and colleagues during that time. The most exciting moments in my work is when I counsel women to voluntarily take the HIV test, help and advice them.

As a provider living with HIV it is easy for me to identify with my clients' challenges. They find it more comfortable to talk to me about their situations, as I share my life experience with them, and most importantly some of the challenges I overcame through receiving continuous care, treatment and support.

I would like to encourage young women, especially in the developing world, where resources could be scarce, and stigma could be high, to seek treatment and other health services early. By doing this, together we can achieve zero new infections and zero AIDS-related deaths.



MESSAGES FROM PARTNERS AND PROGRAMME MANAGERS

“ Our learning from the joint UNAIDS/UNFPA project on linking sexual and reproductive health and rights (SRHR) and HIV in seven countries in southern Africa have so far been very positive in terms of the commitment from policy-makers and the fact that integration is mentioned in most policies and strategies. However, when translating the political commitment, as expressed in supportive policies, we find that an overall 'vertical' mindset, including among donors, still exist. The need for a strong leadership to lead the transition from policy to practice is key to the success of scaling up access to SRHR and HIV-related integrated services.”

ASA ANDERSSON, REGIONAL PROJECT COORDINATOR
UNAIDS/UNFPA project on linking HIV and SRH in southern Africa

“ Good services need to be supported by good policies, and that's why SRH and HIV integration – which focuses at the service level – needs to be supported by a wider linkages agenda that incorporates policies, advocacy and community engagement. People need comprehensive approaches because sex and HIV are interrelated. We know that integrating SRH and HIV services is an important part of the global response to HIV. We know it makes good people sense – it can reduce stigma and it can reach out to a 'broader audience' and increase the uptake of HIV and SRH services for a diverse clientele. We know that SRH and HIV integration can provide an effective way to more efficiently use scarce resources, both human and economic.”

TEWODROS MELESSE, DIRECTOR-GENERAL
International Planned Parenthood Federation (IPPF)

INTEGRATION can REDUCE Stigma



“Integration is not a mirage; it is doable.”

DR TIMOTHY ABUYA



“In research, to integrate is to give equal consideration to different voices and perspectives, including those of clients, community members and service providers. To integrate is to desegregate.”

DR ISOLDE BIRDTHISTLE

MEET THE TEAM

Dr Timothy Abuya is a Senior Analyst at the Population Council, Nairobi, Kenya

I am involved in providing technical support for systematic evaluation of the Integra initiative. This involves updating tools, providing support in training the field team and analyzing operations research data to generate robust evidence on the relative benefits of different models of integrating SRH and HIV services. In addition, I am involved in writing journal articles and other dissemination materials targeted at different audiences to communicate and enhance utilization of research findings.

Jackline Kivunaga is a Research Coordinator at the Population Council, Nairobi, Kenya

As a member of the Integra team, I have been recruiting, training and supervising research staff to collect quality data. The main area of focus has been finding out the community perceptions, client's views, providers' attitudes and health facility capacity to implement the integration of HIV and SRH services.



In order to achieve positive results in Integra research activities, I have been working closely with the

Ministry of Health staff and community leaders at the selected programme sites. So far, my experience on this project indicates that the different models of integrating HIV and SRH services is an opportunity for clients to utilize a wide range of services in one visit.

“Integration is a critical driver for provision of quality health services.”

JACKLINE KIVUNAGA

Dr Isolde Birdthistle is a lecturer in Epidemiology at London School of Hygiene and Tropical Medicine (LSHTM)

I joined the Integra team after working in the area of HIV prevention among girls and women, through research collaborations with UNICEF and others. I have the interesting role of investigating the data arriving from field sites in Kenya and Swaziland. As we comb through the vast quantities of data – drawn from client tracking, cohort interviews, and household surveys – answers to Integra's original research questions are beginning to emerge. But it's not that simple, and the methodological challenges are what make the work so interesting. We are giving a lot of thought to the most appropriate analysis for Integra's non-randomised design – drawing from current thinking on quasi-experimental research as well as Integra's unique design, data and delivery.

Joshua Kikuvu is a Fieldwork Research Coordinator in Swaziland

I have been working with the Integra initiative since August 2009. My overall responsibility is to coordinate

research activities in the country and also represent the Integra research project in Swaziland. This involves participating in the development, refining and translating of data collection tools; recruiting, training and supervising data collectors; acting as liaison with national level project partners on project activities; monitoring and evaluating Integra activities in Swaziland (data collection, report-writing); and managing the budget.



“Integra has given me the opportunity to witness the burden of HIV to a society and nation. Therefore, the issues we're investigating and the interventions we're experimenting is much more than a job. Working in this 'live experiment' means that you have to be adept at adapting as the 'experiment' changes. In my language (Akamba from Kenya), we say that 'you can never climb a tree from the top'.”

JOSHUA KIKUVU

EVENTS

PAST EVENTS

National Leaders Conference on Family Planning, Population and Development, Malawi. 8–9 May 2012

Integra team members participated in the first conference of its kind in Malawi.

Integra Research and Integration Indicators Meeting, London. 11–15 June 2012

UPCOMING EVENTS (see website for latest details of presentations)

AIDS 2012: XIX International AIDS Conference, Washington DC, USA. 22–27 July 2012

IAEN: International AIDS Economic Network (7th AIDS and Economics Pre-Conference) Washington DC, USA. 20–21 July 2012

Integration for Impact Conference, Nairobi, Kenya. 12–14 September 2012

American Public Health Association (APHA) Annual Meeting and Exposition, San Francisco, USA. 27–31 October 2012

Global Symposium on Health Systems Research (HSR), Beijing, China. 31 Oct–3 Nov 2012

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