Innovation in measurement to assess health service integration & effect over time

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The Integra Initiative is:

- unique in the integration field in its breadth and depth;
- ‘embedded’ in a ‘real world’ setting so that the evidence generated is directly relevant to programmatic decision-making;
- a pioneering evaluation of whether the provision of integrated HIV and SRH services actually leads to reductions in HIV risk-behaviour, HIV-related stigma and unintended pregnancies;
- the first research to date to look at whether and how community attitudes towards SRH and HIV services are affected by their integration;
- the first full economic costing and efficiency analysis of integrated service delivery.
Models of Integration evaluated

Model 1: Integrating HIV into family planning services (Kenya only)

Model 2: Integrating HIV into post-natal care services (Kenya & Swaziland)

Model 3: Integrated HIV and SRH services (IPPF Clinics) (Kenya, Swaziland & Malawi)

Model 4: Comparison of integrated and stand-alone HIV service models (Swaziland only)

Non-randomised, quasi-experimental intervention evaluation in 42 clinics in Kenya and Swaziland
Integra Data Collection Activities

- Community (HH) Survey Baseline 2009 N=2588
- Community (HH) Survey Endline 2012 N = 3037
- Health Facility Assessment time-series 2009-2012 (42 clinics)
- Costing Baseline 2009-2010 (42 clinics)
- Client Flow time-series 2009-2012 N=9519 @ R0
- Costing Endline 2011-2012 (42 clinics)
- Cohort studies 2010-2012 N=4763 @ R0 + 75 IDIs
- Cohort IDIs with sub-sample of WLHIV 2010-2012 N=150
Population data show potential for integrated service delivery to reduce unmet needs

- Demand for, and use of, integrated services is very low but need is very high:

- Significant missed opportunities for meeting unmet needs in existing service users through provider promotion of integrated services:
  - 48% women in Kenya and 16% women in Swaziland who had an unmet need for HIV prevention had attended a facility to receive another SRH service but did not receive VCT
  - 10% women in Kenya and Swaziland who had an unmet need for FP had attended a facility to receive another SRH service but did not receive FP
  - Most men with unmet service needs were non-service users

- Community (Household) Survey, Central Province, 2009
The challenge of ‘embedded’ research

- ‘Real’ setting: comparison facilities contaminated:
  - by additional Govt/donor activities on integration
  - by staff actions at individual facilities
- Implementation of intervention varied across facilities
  - motivation, stock-outs, staff turnover etc.
- Degree of integration achieved & sustained at individual clinics varied and changed over time
- Women in cohort did not necessarily stay at recruitment facility

 … As a result the levels of integration achieved in the intervention facilities were not significantly different from those in comparison facilities.
An Innovative Solution

- Measure and account for *actual* degree of integration at each facility over time.

- Range of clinic-specific data available at different time-points = construct a multi-dimensional ‘Index’ to measure a continuum of achieved integration.

- Facility scores are generated and used to:
  1) assess the extent of service integration achieved within facilities and understand what drives this and
  2) evaluate the impact of the level of facility integration on the behavioural and health status outcome indicators.
Continuum of Integration Index scores (2009/10)
Facility ‘readiness’ is necessary but not sufficient for delivery of integrated services

The Index measures:
1) facility readiness (physical and human resource inputs on site and being used)
2) integrated delivery of services (does it happen/ how (room/facility)/on how many days each week)

Preliminary Index data show that these elements are not correlated so something else over and above ‘readiness’ is explaining whether integrated delivery happens...
Two dimensions to the Index: Facility readiness and actual delivery of integrated services → Appear to behave differently (opposite correlation with the overall Index)

Components of the Index
- Ref_ART
- Daily_range_clientflow
- Additional_svcs_room
- Additional_svcs_facility
- Total_MCHFP
- Total_PAR
- Staff_intgn
- Room_intgn

Baseline data and Endline data show the same pattern.
Facility ‘readiness’ is necessary but not sufficient for delivery of integrated services

- ... Individual provider competencies and attitudes,
- ... the systems/personal support providers get &
- ... influences of donors/NGOs/Government on commodity supplies, staff turnover etc. ... are critical in explaining differences between clinics.

- Integration is hard to sustain: improvements in clinic scores are not sustained over time.
Provider perspectives on challenges and benefits:

Where there is no integration there is that boredom because of doing one thing and there is no change. In integration [...] you enjoy the work. It boosts my morale, because the monotony is not there.

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.

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…

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

Ref: Mutemwa et al. 2013
Facility Integration may reduce unmet need for HIV/STI prevention

Data source: Women FP cohort data, Central Province, Kenya
N = 979 R2, 2011 and n = 914 R3 2012

NB: these are crude associations, still under investigation;
Facility Integration may improve HIV testing

Data source: Women FP cohort data, Central Province, Kenya n=1086 R0 2009 and

NB: these are crude associations, still under investigation;
Key Messages (preliminary)

- Integration and its evaluation are complex and take time
- Population data show potential for integrated service delivery to reduce unmet needs
- Facility ‘readiness’ is necessary but not sufficient for delivery of integrated services
- Providers, systems & external influences are critical
- Where facility integration does occur preliminary data suggests it may:
  - improve HIV testing among FP clients
  - reduce unmet need for HIV/STI prevention among FP clients
Thank You

LSHTM Research Team:


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Ongoing analysis for presentation in June

- Impact of integrated service delivery on:
  - HIV risk and prevention behaviours;
  - FP use and achieving fertility intentions;
  - Unintended pregnancies;
  - Stigma.

- Analysis of determinants of demand and of service-use to inform demand-creation

- Impact of integration on efficiencies and costs.