Delivering integrated HIV services: time for a client-centred approach to meet the sexual and reproductive health needs of people living with HIV?

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Introduction

As HIV care and treatment services have grown in number and strength in high-prevalence settings over recent years, there have been mounting calls to ensure more integrated and holistic approaches to HIV patient management [1]. This has included appeals to adopt a chronic care approach to HIV management within primary services [2,3], to integrate HIV with tuberculosis (TB) care [4,5], and to integrate sexual and reproductive health (SRH) services within HIV care and treatment services [6,7].

Within the SRH community, advocates have been calling for integration with HIV services for many years; an initial focus on the integration of HIV prevention and testing services into family planning, antenatal and postnatal care in the mid-1990s [8–10] was followed by a drive to integrate services for the prevention of mother to child transmission (PMTCT) within maternal healthcare [11]. More recently, the need to address the SRH needs of people living with HIV (PLWH) has been highlighted, within both HIV and SRH service contexts [12,13]. Not only does this population have unmet needs for contraception, but also for counseling on pregnancy planning, abortion, infertility and sexuality, among others [13–15]. HIV-positive pregnant women also have special needs, including both for PMTCT, as well as for their own care both before and after delivery [16]. Further, the SRH needs of HIV clients will vary over the course of the HIV/AIDS illness and treatment continuum, a focus on care continuity and integrated approaches is therefore clearly required [7,17–19].

What is unclear, however, is the feasibility of scaling-up an integrated approach at the service delivery level. Evidence on the impact of integrated SRH-HIV approaches on health outcomes is limited, with most data derived from uncontrolled cross-sectional or pretest/post-test studies that often fail to isolate the ‘integration’ impact from other concurrent interventions [20–22]. Studies suggest that integrated approaches can increase access to component services, reduce clinic-based stigma (by delivering HIV care in more generalist contexts), increase client satisfaction and even impact positively on outcomes such as condom use, unintended pregnancies and perinatal HIV infection [22].

However, there still remain many challenges to their effective implementation. We argue in the present article that there are two key structural characteristics of healthcare delivery in lower-income and middle-income

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countries (LMICs) that perpetuate the fragmentation of care and inhibit the delivery of holistic healthcare centered on patient needs. Firstly, within most LMIC health systems, care is organized around the functional separation of services, either by day of the week (for example, 'HIV treatment initiation day' or 'family planning day'), or more frequently by the physical separation of services into specialized consultation rooms, units or discrete facilities. Even in purportedly 'integrated' services, clients may still have to queue several times to receive different service components [23,24].

Secondly, the provision of patient care across a range of settings is generally task-oriented, that is, centered on the completion of a series of discrete and routinized tasks [25–28]. When care is focused on procedures such as weight monitoring, taking blood tests, completing standardized history forms or drug prescribing, the wider health and social needs of clients may be neglected. Providers, thus, consistently miss opportunities to integrate clinical care with other services, and may neglect more holistic health promotion activities.

We contend that a paradigm shift toward client-centered care is now required to overcome these aspects of fragmentation and achieve more integrated holistic care (see Table 1). Although client-centeredness is an essential component of the primary healthcare ethos, such an approach has rarely been applied at scale [29].

### Fragmentation of care: why does it persist within health services?

Common features of LMIC health systems contributing to the functional separation of care include staff shortages limiting consultation times; training inadequacies (including failure to train on integrated approaches); space constraints within facilities; poor intersectoral collaboration; and historical patterns of service funding and organization, including the predominance of vertical program structures [30,31]. Specialization, even at primary levels, is also a logical and cost-effective way to skill health providers, whereas almost all providers receive basic generalist training, smaller cadres receive in-service training in SRH and HIV care components.

Task-orientation is, in turn, linked to both the organization and culture of healthcare delivery. On an organizational level, it can be seen as a rational response to work pressures and widespread human resource shortages [27]. In busy outpatient clinics where queues are long and time is short, it makes sense for care to be structured around the delivery of routinized tasks performed by multiple health providers. In the context of HIV care, this may include tasks divided among adherence counsellors, pharmacists, phlebotomists, nurses and doctors, even within one visit [32] (personal observation in four HIV clinics in Swaziland, K Church). This helps ensure a fast flow of clients in and out the door, maintains ‘order’ by moving patients systematically and predictably through a series of clinical stations, and allows task-shifting to lower skilled cadres of providers [33,34]. It has also been argued that the privileging of task completion over more integrated forms of care acts to protect providers from the needs and demands of patients, which at times may be overwhelming, by ensuring that there are few opportunities for these needs to be expressed or addressed [27].

Task-orientation is also reinforced by cultures of practice within a biomedical model of care. Many healthcare consultations follow standardized routines derived from clinical protocols. Although such protocols are effective in improving aspects of clinical care, they can also result in care that is impersonal and highly medicalized. Within this model, clinical competence is judged primarily on adherence to procedures and protocols. Hierarchical and
Support is crucial. Systems to promote continuity of care for HIV patients may also need to be enhanced, including developing effective patient record systems for monitoring as well as referral systems that promote client access to component services. Current strategies in the organization of HIV services may also be opportune; policies promoting the down-referral of HIV patients to primary care [43,44] may free up time for consultations at the secondary and tertiary levels whereas a renewed emphasis on the quality of HIV patient care may facilitate improved communication.

At the provider level, sufficient time needs to be allocated to exploring and addressing patient needs. In many settings this may necessitate additional human resources. However, what is also required is a shift in culture, attitudes and expectations among providers. Providers need to be more open to clients’ needs and preferences, and to explore the wider context of their health issues. The ability to provide client-centered care may depend on a number of key interpersonal provider skills, including communication skills, empathy and sensitivity [41].

Evidence indicates that practitioners can be trained to deliver more client-centered care, and that this results in increased patient satisfaction [36]. Client-centered care can also lead to more integrated SRH-HIV care; for example studies show that training in client-centered family planning helps providers counsel on STI/HIV and promote condom use [45,46]. However, ways need to be found to better support providers to cope with the often underestimated demands of their work [47,48]. Tools and job aids, such as guidelines, screening tools, prompts within patient records or posters in consultation rooms can also be useful in shifting the focus of care.

**Conclusion**

In many countries, current healthcare systems and structures, including HIV care, are primarily organized to meet the needs of providers and the institutions in which they are based, rather than client needs. Although HIV programs have been successful in the rapid expansion of treatment services in high prevalence LMICs, more attention must now be paid to meeting the broader health and social needs of patients, including SRH needs.

Although many of the proposed solutions to disjointed HIV and SRH service delivery, such as policy development or provider skills training, may be prerequisites to expanding the scope of patient care, these will not necessarily translate into integrated care in practice. As we have proposed, organizational and cultural changes are needed that support a shift away from the functional separation and task orientation toward client-centered approaches. Until such changes are institutionalized, expanding access to component SRH care in the context of HIV services will likely remain piecemeal and ineffective at the larger scale.
It has not been our intention in the present article to dispute the need for specialism in healthcare or its organizational logic. It is clear that one provider cannot address all the complex healthcare needs of every client with HIV. Our argument, nonetheless, is that all types of health workers, whether HIV specialists or more generalist providers, need to look beyond their immediate set of tasks to explore, diagnose or identify the wide range of healthcare needs of HIV patients, and further to understand the context of those needs. It is this exploration that is conspicuously absent in the majority of health consultations worldwide, even within more generalist primary care.

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