STEPS TO INTEGRATION • ISSUE 7

Integra

Strengthening the evidence base and good practice for integrating HIV and SRH services



This Steps to Integration series provides a guide on how to integrate HIV and sexual and reproductive health (SRH) services based on findings from the Integra Initiative.

The Integra Initiative is a research project on the benefits and costs of a range of models for delivering integrated HIV and SRH services in high and medium HIV prevalence settings, to reduce HIV infection (and associated stigma) and unintended pregnancies. It was managed by the International Planned Parenthood Federation (IPPF) in partnership with the London School of Hygiene & Tropical Medicine (LSHTM) and the Population Council.

Findings from the project show that integrating HIV and SRH services has the potential to:

- ✓ Increase uptake of health services
- ✓ Increase range of services available
- ✓ Improve quality of services and efficient use of resources
- ✓ Enable health systems to respond to client needs and improve overall client satisfaction

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Human resource capacity for integrated SRH/HIV care

Health managers play an important role in deciding how their facility is structured, organised and run and in supporting their trained staff to operate in an integrated manner. The motivations and actions of individual health providers are critical for ensuring that clients leave with an integrated package of care. This brief focuses on the importance of the healthcare provider; the impact of integration on provider workloads; that integration of services must remain flexible and be adjusted based on the needs and capacity of each individual facility and the use of capacity-building tools as a strategy for enabling integration, specifically peer mentoring.

Provider workload and efficiency

Does integrating SRH and HIV services increase individual provider workload or reduce it by more efficiently redistributing service provision?

To answer this question, Integra conducted a descriptive analysis of human resource integration through task shifting/sharing and staff workload, seeking to describe the level, characteristics and changes in human resource integration in the context of wider efforts to integrate services.

The results of the study indicated that integration is associated with a range workload effects, depending on the facility context. Overall, human resource integration was more likely to be improved in facilities which also improved other elements of integration, such as integrated use of physical space.[i] While there was no overall relationship between integration and workload at the facility level, more integrated facilitates did display a significantly lower provider–client ratio for certain services than for the same services in less integrated facilities. In a number of settings, there were differences found in workload between different services within facilities, implying that this under-utilization of human resources can be improved through re-allocation of staff duties across services within sites.

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Personal experiences of providers

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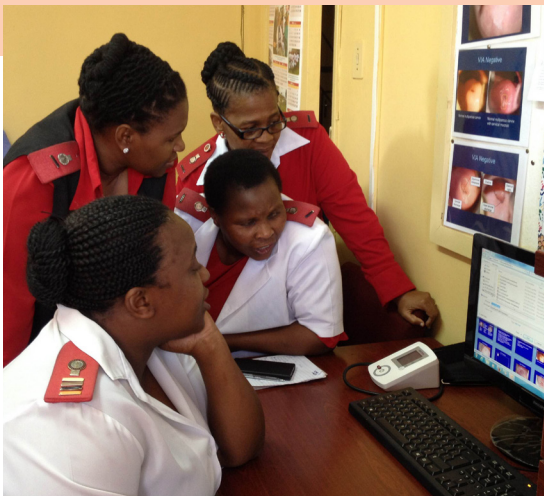
Providers hold perceptions about integration based on personal experience or on anecdotes, and these perceptions (positive or negative) can greatly influence their commitment to and acceptability of integrated service delivery. Integra sought to understand to what extent these provider perceptions influence the success of integration.

The experiences that providers had had with actual integration were mixed, partially as a result of whether they had been a part of provider-level integration or unit-level integration. On a personal level, providers appreciated the skills enhancement, the increased variety and challenge in their work, and improved job satisfaction through increased client satisfaction. However, they also perceived that the integration resulted in increased workplace stress (from having an increased workload, spending less quality time with clients, and treating more very poor or sick clients) and that their salaries were low compared to the increased scope of services they were providing. On an operational level, providers reported increases in service uptake, reduced client loss, and increased willingness of clients to take an HIV test. Yet the majority also reported that there were infrastructural and logistical challenges, increased workloads and waiting times, and too-low staffing levels.

It is clear from these reports that provider experiences with various forms of integration are mixed. Yet it can be argued that the significance of the benefits of integration outweigh the challenges, and furthermore, that the challenges are such that ongoing assessment recalibration of integration processes in individual facilities can help to alleviate them.

For example, the question of increase in provider workload is the one most typically raised anecdotally and in research as an obstacle to integration, but for Integra providers reported that their workloads being both aggravated as well as alleviated by integration efforts. In some cases the increase in workload was not the result of integrative redistribution of service duties, but rather was due to an increase in client volume as a result of better and more complete services being offered through integration.

The facilities which reported decreases in workload show that integration need not inevitably lead to an increased workload. Investment in human resource numbers prior to integration efforts and strategically managing workload by redistributing client load were noted as key to mitigating longer waiting times and increased provider stress. It was frequently noted that a lack of institutional systems that support integration made the process of integration inconsistent and slow to be successful, as it required more fine-tuning and troubleshooting than may have otherwise been the case.



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Peer mentorship as a capacity-building tool

Integrating services requires that providers have a greater range of medical and coordination skills, yet knowledge gaps exist among frontline providers that constrain their ability to provide essential services. Traditional approaches to build their capacity (e.g. offsite training workshops) are costly, aren't conducive to knowledge-sharing among colleagues, and interrupt service provision. Integra designed, tested and adapted protocols for peer mentorship as a capacity-building tool to support service integration in order to improve service providers' skills, knowledge, and capacity to provide quality integrated HIV and SRH services. There is no universally agreed-upon definition of mentorship, but generally speaking, mentoring refers to an interactive, facilitative process meant to promote learning and development in a less-skilled individual through the formal or informal support of a more-skilled individual.

Integra assisted the Kenya Ministry of Health in the design of the mentorship training programme, and used qualitative assessment to gather data on provider experiences with and perceptions of mentoring before, during, and after the mentorship training programme was implemented.

The mentorship programme was overall a successful and well-liked method of improving provider skill sets. For further information about the benefits, critical enablers and challenges in implementing a peer mentorships approach, see Steps to Integration Issue 2: Peer mentoring: an effective strategy for integrating HIV and SRH services.

Integra Papers

i. Sedona Sweeney et al. 2014. "The impact of HIV/SRh service integration on workload: analysis from the Integra initiative in two African settings." Human Resources for Health 2014, 12:42.

ii. Richard Mutemwa et al. 2013. "Experiences of health care providers with integrated HIV and reproductive health services in Kenya: a qualitative study." BMC Health Services Research 2013, 13:18.

iii. Charity Ndwiga et al. 2014. "Exploring experiences in peer mentoring as a strategy for capacity building in sexual and reproductive health and HIV service integration in Kenya." BMC Health Services Research 2014, 14:98.

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