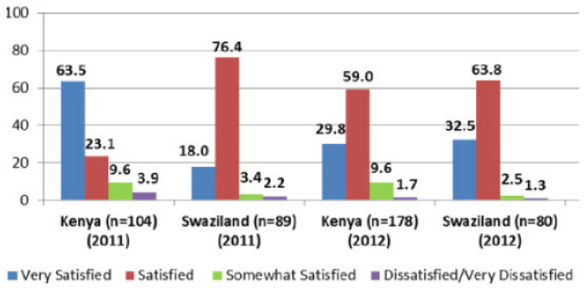
> I think with integration, you are able to serve the client better and capture each and every detail of a patient (holistically). [The client] will not go home with a certain problem unattended. That is very satisfying. --Enrolled Nurse, Swaziland

Client satisfaction and waiting time

Overall, in Kenya and Swaziland, the majority of clients were either very satisfied or satisfied with the services received at the end of the project in 2012 (Figure 3).

Figure 3:



In both countries, the average waiting time before seeing a provider was nearly similar. In Kenya, the average time was 40 minutes and in Swaziland it was 38 minutes, however, this difference was not statistically significant.

> Now a lot of our clients are not afraid to tell you about their status as you're providing care to [them], like they would tell you that they're taking ARVs so whatever treatment you give them you should have that in mind. Also the statistics have gone up since [integration started]. We now have a lot of babies who are being tested because the mothers are concerned. Then, when it comes to PNC [I] think it is better now because a lot of babies were dying after delivery maybe because they didn't know their [HIV] status, so basically there's a lot of change --Registered Nurse Swaziland

Key Messages

- Integration of HIV into PNC services can improve the quality of client-provider consultation sessions. Overall, quality of care is not negatively affected by integrating HIV and postnatal care. Integration seems to have a positive effect on quality of postnatal care in both countries.
- From a qualitative point of view, the picture from provider experiences appears mixed. However, providers do find integration beneficial to themselves and the service delivery. That is, integration can have a positive motivating effect on staff and can lead to better sharing of workload - these are important opportunities that deserve to be built on.
- Quality of care is complex. While some of the elements may be determined by the provider, a lot others are determined by public health policy beyond the facility. The Ministry of Health needs to create a coherent policy environment, spearhead strategic planning and ensure availability of resources for implementation at the lower levels. Health facility staffing norms, technical support, costing and reporting procedures, salary and incentive schemes, clinical supply chains, and resourcing of health facility physical space upgrades, all need attention.

Integra Papers

i. Mutemwa R., Mayhew, S.H., Colombini, M., Busza J., Kivunaga J., and Ndwiga C. (2013). Experiences of health care providers with integrated HIV and reproductive health services in Kenya: a qualitative study. BMC Health Services Research, 13:18.

ii. Warren, C., Mayhew, S.H., Vassall, A., Kimani, J.K., Church, K., Obure, C.D., Friend du-Preez, N., Abuya, T., Mutemwa, R., Colombini, M., et al (2012); Study protocol for the Integra Initiative to assess the benefits and costs of integrating sexual and reproductive health and HIV services in Kenya and Swaziland. BMC Public Health, 12(973).

iii. Population Council 2011. The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings, Second Edition, Washington, DC: Population Council.

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STEPS TO INTEGRATION • ISSUE 5

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

www.integrainitiative.org

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The effect of integrating HIV services on quality of postnatal care

Introduction

Addressing the postnatal needs of new mothers is a neglected area of care throughout sub-Saharan Africa. Unintended pregnancies during the first 12 months following delivery and vertical transmission of HIV during labor and delivery are some of the challenges faced by women during the extended postpartum period. Many women want to delay or avoid another pregnancy, but are not using a modern contraceptive method.

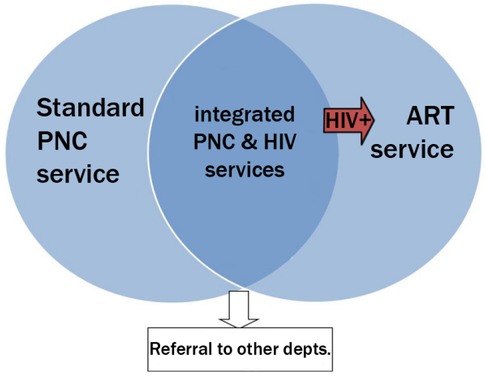
Few developing countries have mechanisms in place to ensure that mothers and their newborns are assessed early and monitored during the initial six-week period as recommended by WHO, which contributes to discontinuity of services received during pregnancy and delivery and limits linkages to other key services for new mothers, including family planning, HIV testing and counselling, and HIV care for women and their infants living with HIV.

This overview provides evidence on the quality of postnatal care after facility-level integration of HIV and postnatal services in Kenya and Swaziland.

The Intervention

The postnatal model of integration encompassed the full constellation of services for both mother and baby during the first few days and weeks after delivery. The model included mother and baby physical check: mother's blood pressure, pulse temperature, respirations of both mother and baby, examine baby undressed, examine mother's breasts and perineum (or cesarean scar) and signs of aneamia; counsel on breastfeeding, family planning, essential newborn care and self-care, provision of contraceptives for mother, immunisations for baby, (re)testing and counseling for HIV for mother, testing baby for HIV (if mother HIV positive), counseling for follow up care.

Following a needs assessment in each facility, the core intervention activities at facility level were: training providers using the mentorship approach (see Step 2); Balanced Counseling Strategy Plus Toolkit – which includes an algorithm and counseling cards for FP, PNC and HIV; re-arranging the consulting rooms and client flow through the facility – following discussion with the facility staff; procurement of basic equipment and ensuring sufficient commodities and supplies to conduct PNC; develop a referral strategy between MCH and HIV units.



Defining quality of care

To assess quality of care of PNC services, a structure-process-outcome model was adapted (Table 1). Data were summarized for each individual aspect of quality (that is, summative a score generated for each component of structure-process-outcome).

Table 1: Model for Assessing Quality of Care of PNC Services

Component	Attribute of Quality of care
Structure: (attributes of health care setting)	Infrastructure/supplies/trained personnel
Process: (actual care delivered)	Clinical/technical quality (history taking, physical examination, information given to client, range of services offered: family planning, HIV/STI, and documentation), Interpersonal relations (interaction with clients)
Outcome: (interaction of health care system with users)	Waiting time, client satisfaction, client understanding of services

Improvements in the Quality of Postnatal Care 2009-2012

KENYA

Figure 1 shows, there was an increase in quality of PNC with each component improving in Kenya between 2009 and 2012. However, the composite score hides some remarkable increases for individual variables.

Infant Care:

- Twenty percent more health providers were observed counselled mothers on infant feeding (53.3% to 73.1%; p<0.001) between 2009 and 2012.
- Twice as many providers were observed asking the mother if she was managing with breastfeeding (29.6% to 62.9%; p<0.001).
- Providers more frequently checked baby's temperature (19.6% to 44.6%; p<0.001), and baby's respirations (18.6% to 27.4%; p<0.001).
- Providers more frequently discussed danger signs to look out for in infants, such as breathing difficulties (12.6% to 28.5%; p<0.001) and feeding difficulties (13.1% to 34.4%; p<0.001).

Maternal Care:

- More providers were observed taking client's temperature (26.1% to 33%; p<0.01) and client's blood pressure (36.2% to 50.8%; p<0.001).

Fertility Advice:

- Twice as many providers counseled mothers on return to fertility (14.1% to 30.3%; p<0.001), and return to sexual activity (23.1% to 41.2%; p<0.001).
- More providers discussed the health benefits for mother and baby when birth spacing (44.2% to 48.1%; p<0.05).

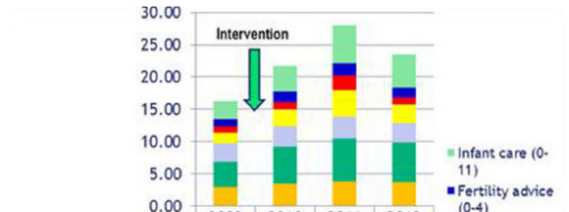
Availability and use of Postpartum Register:

- Nearly twice as many providers who were observed had a postpartum register (42.7% to 83.9%; p<0.001) and more providers who recorded information in the registers (83.9% to 93%; p<0.001).

STI/HIV Risk Assessment:

- There was an increase in the proportion of providers who discussed HIV (24.7% to 35.1%; p<0.001) and STIs and/or HIV risk factors (7.1% to 17%; p<0.001) with the client.

Figure 1: Quality of PNC composite scores in Kenya (0-57)



	2009	2010	2011	2012
Infant care (0-11)	2.7	4.1	5.9	5.2
Fertility advice (0-4)	1.1	1.6	1.9	1.5
STI/HIV risk advice (0-12)	1.0	1.1	2.2	1.1
Maternal care (0-11)	1.7	2.6	4.2	2.9
History taking (0-7)	2.9	3.2	3.3	2.9
Bulding rapport (0-8)	3.9	5.7	6.7	6.2
Documentation (0-4)	2.90	3.5	3.8	3.7

SWAZILAND

Overall, in Swaziland, the quality of PNC improved over the four years following the integration intervention (Figure 2). Similar to Kenya, significant improvements in individual indicators were observed between 2009 and 2012.

> I'm satisfied with providing care to the clients as some of them come back and say thanks and some come back for other services--Registered Nurse, Swaziland

Infant Care:

- More providers counseled mothers on infant feeding (52.3% to 82.6%; p<0.001), but the proportion of providers who discussed how the mother was managing with breastfeeding reduced slightly (62.4% to 60.9%; p<0.001).
- Improvements were observed in the proportion of providers who checked baby's temperature increased (20.7% to 57.8%; p<0.001) and baby's respirations (21.5% to 39.1%; p<0.001).
- Providers more frequently discussed danger signs in infants, such as breathing difficulties (18.1% to 45.3%; p<0.001) and feeding difficulties (22.8% to 46.6%; p<0.001).

Maternal Care:

- More providers were observed taking client's temperature (20.3% to 42.6%; p<0.01) and client's blood pressure (54.9% to 72.3%; p<0.001).

Fertility Advice:

- There were significant increases in the proportion of providers who counseled mothers on return to fertility (27.4% to 31.1%; p<0.001) and return to sexual activity (25.3% to 32.9%; p<0.001).
- More providers discussed the health benefits for mother and baby when birth spacing (30% to 49.7%; p<0.05).

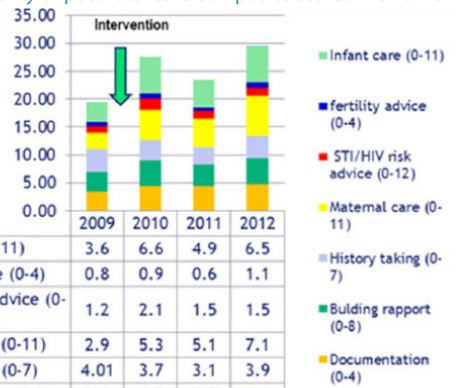
Availability and use of Postpartum Register:

- More providers had a postpartum register (62.9% to 95.5%; p<0.001) and recorded information in the register (73.8% to 96.2%; p<0.001).

STI/HIV Risk Assessment:

- Similar to Kenya, there was an increase in the proportion of providers who discussed HIV (25.3% to 46.2% (p<0.001) and STI and/or HIV risk factors (10.5% to 15.9%; p<0.05) with the client.

Figure 2: Quality of postnatal care composite scores in Swaziland (0-57)



	2009	2010	2011	2012
Infant care (0-11)	3.6	6.6	4.9	6.5
fertility advice (0-4)	0.8	0.9	0.6	1.1
STI/HIV risk advice (0-12)	1.2	2.1	1.5	1.5
Maternal care (0-11)	2.9	5.3	5.1	7.1
History taking (0-7)	4.01	3.7	3.1	3.9
Bulding rapport (0-8)	3.6	4.5	3.7	4.8
Documentation (0-4)	3.40	4.5	4.5	4.7

Benefits and challenges of integration as reported by providers in Kenya and Swaziland

In Kenya and Swaziland, healthcare providers reported a number of benefits and challenges of integrated HIV and SRH service provision at both individual and operational levels (Table 2).

Table 2: Summary of benefits and challenges of integration as reported by health providers in Kenya and Swaziland

Benefits	Challenges
Increased job satisfaction • Increased client satisfaction • Personal skills enhanced • Experiential learning • Professional stimulation	Poor work conditions & support • Low salaries • Lack of psychosocial support for occupational stress management • Structural problems
Improved Communication, performance & Systems • Improved communication among staff • Increase in client repeat visits • Increase in service uptake • No more multiple queues per visit for the client • Increase in willingness to take HIV test among clients • Convenience: reduced room-to-room movement by staff during service provision • Decrease in numbers of clients who leave before being attended during a visit • Reduced pressure on under-staffed facilities • Reduced workload per provider	Lack of systems adaptation to support integration • Increase in workload per provider • Burdensome clinical recording • Long session times • Long waiting times for clients • Lack of clinical supplies, equipment, room-space, and erratic water & electricity supply • Lack of guidelines on user-fee management • Too many registers