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The effect of integrating HIV services on quality of postnatal care

Integra Initiative

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Key Messages

• Integration of HIV into PNC services can improve the quality and efficiency of care  
  provided to clients. This is particularly true in settings where there is a high prevalence of 
  HIV. 

• 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 sourcing of health facility physical space upgrades, 
  all need attention.

Figure 3:

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).

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 us about their status as you’re providing care to them. Like would tell you that they’re taking ARTs 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

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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 & HIV; and 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.

### Challenges

- Twenty percent more health providers were observed counseled 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.

### 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.

**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.

**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).
- More 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 (26.1% to 33%; p<0.01) and client’s blood pressure (36.2% to 50.8%; p<0.001).

### Fertility Advice

- There were significant increases in the proportion of providers who counselled 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.

**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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Increased job satisfaction</td>
<td>Poor work conditions &amp; support</td>
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<tr>
<td>Improved client satisfaction</td>
<td>Low salaries</td>
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<tr>
<td>Professional stimulation</td>
<td>Lack of psychosocial support for occupational stress management</td>
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<tr>
<td>Improved Communication, performance &amp; Systems</td>
<td>Structural problems</td>
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<tr>
<td>Experiential learning</td>
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<tr>
<td>Increased communication among staff</td>
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<td>Increase in client repeat visits</td>
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<td>Increase in service uptake</td>
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<td>No more multiple queues per visit for the client</td>
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<tr>
<td>Increase in willingness to take HIV test among clients</td>
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<td>Responsible reduced room-to-room movement by staff during service provision</td>
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<td>Decrease in numbers of clients who leave before being attended during a visit</td>
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<td>Reduced pressure on understaffed facilities</td>
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<td>Reduced workload per provider</td>
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<tr>
<td>Increase in workload per provider</td>
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<tr>
<td>Burdensome clinical recording</td>
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<td>Long session times</td>
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<td>Long waiting times for clients</td>
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<tr>
<td>Lack of clinical supplies, equipment, room-space, and erratic water &amp; electricity supply</td>
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<td>Lack of guidelines on user-fee management</td>
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<td>Too many registers</td>
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Figure 2: Quality of postnatal care composite scores in Swaziland (0-57)