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Integration of services: Making integrated services a reality

Frontiers in Reproductive Health

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Legacy Series:

INTEGRATION OF SERVICES

Making Integrated Services a Reality

Integration of services refers to offering or combining a two or more services to meet several RH needs *simultaneously*, usually at the same time, same venue, and often by the same provider. This approach to organizing delivery of more than one service may be difficult to achieve in RH programs that historically have provided services individually, and may also be unacceptable to some clients. Alternatively, programs seeking to provide a more comprehensive RH service may establish or strengthen referrals between related yet separately-provided services that enable a client to receive the range of needed services, even if not simultaneously (Askew 2007; Kim et al.2007).

There are two main rationales for integrating services. First, many clients have needs for several services simultaneously; and second, there is an expectation providing integrated or linked services can be more efficient programmatically than providing services at separate visits. Surprisingly little empirical evidence exists to support these underlying rationales, or to guide policies and programs in organizing services effectively and efficiently. Lessons from FRONTIERS have demonstrated not only the demand for multiple services, but also the benefits of services integration, both to clients and to health systems. Findings from FRONTIERS studies also provide guidance on how to operationalize service integration. Some general findings arising from over 40 studies on integrating services include:

- ✓ There is often a need for FP information and services among clients of other RH services, including those for screening and treating sexually transmitted infections (STIs) including HIV/AIDS, and women attending for antenatal care (ANC), postpartum care, and postabortion care.

This paper is part of a series of eight *Legacy Papers* synthesizing major lessons learned in research conducted under the Frontiers in Reproductive Health Program (FRONTIERS).

The full set of *Legacy Papers* includes:

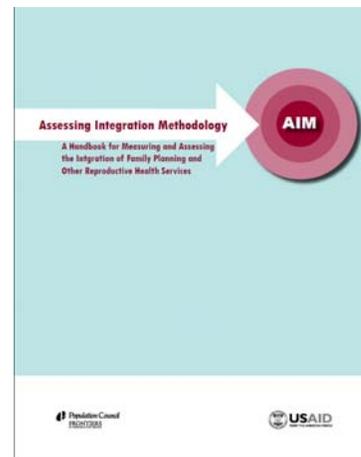
- **Capacity Building**
- **Family Planning**
- **Female Genital Mutilation/Cutting**
- **Gender**
- **Integration of Services**
- **Sustainability of Services**
- **Utilization of Research Findings**
- **Youth Reproductive Health**

The complete reports referenced in these papers are available online:

www.popcouncil.org/frontiers

- ✓ Offering services in one place, at one time and by the same provider may generally be preferable for clients and ensures needs are met in one visit. Referring clients for related services may be more feasible and less costly for some programs, but this may reduce effectiveness in ensuring clients actually receive services.
- ✓ Job aids, focused training and regular supervisory feedback are key for improving providers' ability to provide more comprehensive services.
- ✓ Systems-level policies, structures and procedures created for delivering services individually can create barriers to integrating services such as: inadequate or inappropriate training and supervision; single-service protocols and guidelines; lack of necessary infrastructure, equipment and commodities. While these can be overcome when implementing small-scale pilot projects, significant systems-level reorganization is usually needed if integrated service delivery is to be programmatically institutionalized and sustainable.
- ✓ Concerns about overloading providers are real, but rigorously testing and costing carefully selected combinations of services can demonstrate which interventions are and are not feasible and acceptable to providers and clients, and which lead to increased service use.
- ✓ FRONTIERS undertook more than 15 studies globally that diagnosed, assessed and evaluated efforts to organize and provide integrated or linked RH services. This experience has been distilled to develop a standardized methodology for undertaking health facility assessments of integrated services, entitled the **"Assessing Integration Methodology" (AIM)**.

Assessing Integration Methodology (AIM)



The AIM methodology is described fully in a recently published manual. It (a) explains the basic principles of conducting studies using AIM; (b) provides tips for data collection; and (c) makes available data collection instruments validated in projects throughout the developing world. The AIM manual is available in English at:

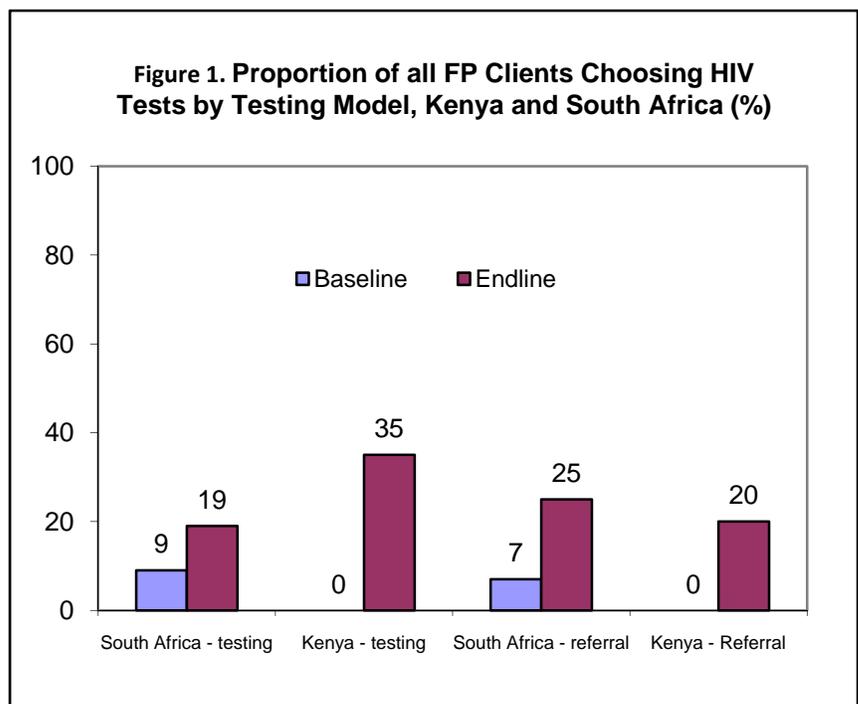
www.popcouncil.org/frontiers/projects_pubs/topics/SLR/AIM_Manual.html

Integrating HIV Prevention with FP Services Is Feasible, Can Improve Service Quality and Increase Use of HIV testing

FRONTIERS tested interventions to integrate information and services for preventing, detecting, and treating STIs, including HIV, with existing FP services in Kenya and South Africa (Liambila et al 2008; Mullick 2008a). In both countries, FP counseling was strengthened using the **BCS Plus** tool (*see below*), which also supported providers in counseling clients on HIV prevention and screening for STI symptoms. As part of HIV prevention, two models were tested: a ‘testing’ model, in which providers were trained to offer and provide HIV counseling and testing (C&T) during FP consultation; and a ‘referral’ model, in which providers offered HIV counseling and referred clients to C&T services, either in the same clinic or another offering VCT.

Findings in both countries showed integrating these services was feasible and acceptable to both clients and providers and that quality of care improved significantly, both in terms of the FP counseling and HIV prevention messages around safer sexual practices, condom use for dual protection, and the importance of HIV testing, especially when BCS + was used (*see below*).

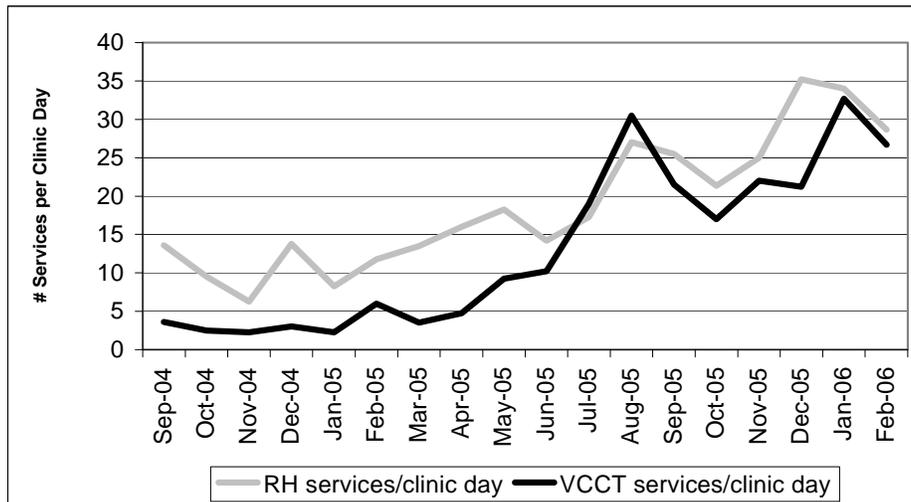
For both the testing and referral models, offering women testing greatly increased the proportion of FP clients choosing an HIV test (*Figure 1*). These proportions would have been much higher had all women been offered – only 30-40 percent of women in both countries were actually offered a test (on-site or by referral), but among those offered, over 90 percent accept. This further demonstrates the tremendous opportunities available for integrating HIV testing into FP services.



Integrating HIV C&T with FP/RH Services Can Both Increase Use of Both Services and Reduce Costs of Offering Them Individually

In West Bengal, India, the Child in Need Institute (CINI) tested effects of integrating HIV C&T and FP services (previously provided in separate locations) on clinic use and revenues. Workers conducted community outreach in villages near the clinics to inform potential clients of the integrated service, offered one day per week at the main CINI center. CINI also introduced a registration fee of about US\$0.50 per client. After introducing the intervention in June 2005, use of both services increased significantly: use of RH services increased from 12 per day to 25 services per day during the first nine months and use of HIV C&T services increased from four to 22 services per day (Figure 2). Approximately one-third of clients received both RH and C&T services.

Figure 2. Daily Volume of Services by Type, Before and After CINI Clinic Service Integration



When income from registration fees was compared to the variable cost of service provision, there was a small positive contribution margin (US\$0.07), indicating that the provision of integrated services added to program revenues rather than costing the program. Moreover, the average cost of providing these two services jointly was 144 rupees (\$3.28) per client, compared with 216 rupees (\$4.92) for both services when they were provided separately (Das et al. 2007).

Balanced Counseling Strategy Plus (BCS+) Helps Providers Integrate STI/HIV with FP Services

The Balanced Counseling Strategy Plus (BCS+) tool is an adaptation of the Council's successful BCS tool for use in settings with high STI/HIV prevalence. The tool comprises three job aids (an algorithm, information cards about contraceptive methods and STI/HIV issues, and method-specific client brochures) and guides a provider through a semi-structured FP consultation that also integrates STI/HIV prevention counseling and testing (Mullick et al. 2008b; León et al. 2008).

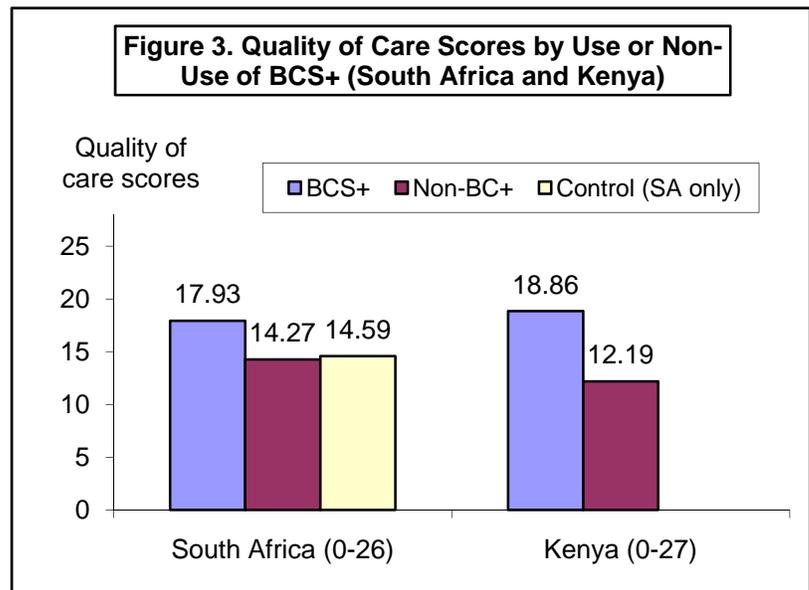


Figure 3 shows the overall quality of counseling for a combination of FP and STI/HIV issues, as measured on a scale of 0-27 in Kenya and 0-26 in South Africa, increased significantly when the provider used the BCS+ tool during the consultation. It is important to note, however, that although all providers had been trained in use of the BCS+, but there was some reluctance to do so – in Kenya, it was observed being used in 61 percent of consultations whereas in South Africa only 31 percent of consultations included use of this tool. Clearly supervisory efforts to ensure that it is used routinely would increase the overall quality of care for integrated services.

Integrating FP counseling and services into antenatal, delivery and postpartum services increases use of postpartum FP

Providing birth spacing and FP messages during antenatal care and postpartum care is feasible, acceptable to providers and clients, and leads to increased adoption of postpartum contraception. When a Honduran hospital offered FP methods to new mothers before discharge, 25 percent of women accepted. When the same hospital scheduled mother-baby visits for the 40th-day postpartum, contraceptive use increased even further to 45 percent (Vernon et al. 1993). Assessments of national programs that have adapted the WHO-recommended 'Focused Antenatal Care' model indicate FP messages are considered a key service within integrated package of services offered (Birungi and Onyango-Ouma 2006; Birungi et al. 2006).

Community-based services can be highly effective in ensuring continuity of care throughout the perinatal period. Interventions in Egypt (Abdel-Tawab, Loza, and Zaki 2008) and India (Khan, Sebastian, and Idnani 2008) showed messages on birth spacing and postpartum contraception, including lactational amenorrhea method (LAM), can be enhanced by linking them with maternal and child health messages communicated by community level health workers; and that such messages can lead to increased FP use. In Uttar Pradesh, India, a community-based intervention increased knowledge of LAM and other contraceptive methods and the proportion of women using LAM and making a transition to other contraceptive methods at six months increased from zero to 22 percent. Moreover, use of family planning at 10 months postpartum was 63 percent, compared to 32 percent in control areas (*Table 1*). In Kenya, community-based self-employed midwives trained to provide a package of maternal care services also provided a significant proportion of family planning methods – in some districts up to 19 percent of all pills and 20 percent of all condoms provided by the public health system were being provided by community midwives (Mwangi and Warren 2008).

Table 1. Contraceptive Use at Nine Months Postpartum in Intervention and Control Areas, Uttar Pradesh (%)

	Intervention (n=570)	Control (n=560)
Currently using FP	63***	32
Condom	44	23
Pills	15	7
IUD	2	0.2
Sterilization	1	1
Traditional	1	1
Currently not using FP	27	52
Currently pregnant	10**	16

p≤0.01, * p≤0.001

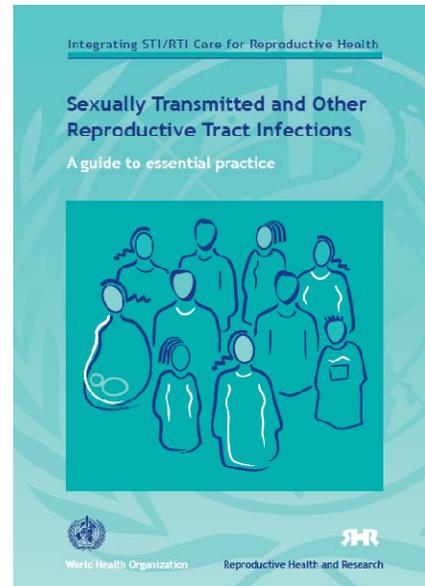
Offering a Variety of FP Methods and at Several Times During Postpartum Period Is Necessary to Satisfy Differing Contraceptive Needs of New Mothers

Globally, a variety of studies have shown the majority (about 80%) of women do not want another pregnancy within two years of giving birth, and about half of these would like to begin using contraception during the first 12 months (Vernon 2008). Women’s preferences for when to begin and what method are influenced by fertility intentions, parity, and knowledge of return to fertility. Increasing the number of methods offered to postpartum women does increase the proportion of women using contraception (Vernon 2008b; Quiterio et al. 2007; Rivero-Fuentes et al. 2008; Solís et al. 2008; Rivero-Fuentes 2008).

FP Needs of HIV-positive Women Postpartum Can Be Addressed During PMTCT Programs

Service providers often believe recommending consistent condom use for HIV-positive clients eliminates need for family planning counseling. However, an analysis of DHS surveys in 15 countries in Africa, Asia, and Latin America shows between 45 percent and 83 percent of couples who begin using condoms stopped using them 12 months later (Blanc, Curtis, and Croft 2002). A survey among women living with HIV and receiving special care in Haiti, the country with highest HIV prevalence outside Africa, showed only 34 percent were contraceptive users and that eight of every 10 women not using a method would like to use one. Twenty-one percent of noncontraceptive users stopped use because they did not have a stable partner; half of these women reported having sexual relations without using a condom during the past year (Rivero-Fuentes et al. 2008). There is also evidence among couples where at least one is HIV-positive and they are under health system care, condom use varies between 50 percent and 80 percent (Paiva et al. 2002). Taking these results into account, it is likely a significant proportion of HIV-positive clients are exposed to unwanted pregnancies if contraceptive services are not made available.

Studies in Kenya, Lesotho and Swaziland demonstrate it is feasible to provide comprehensive and quality services to postpartum women and infants in high-HIV areas. Following training in a focused yet comprehensive postpartum care package, the quality of care for mothers and newborns improved significantly in Swaziland. Family planning and counseling services also improved, and the proportion of women who received the method they wanted nearly tripled (from 28% to 70%) (Rutenberg and Beck 2004; Warren et al. 2008a; Birungi et al. 2006; Rivero-Fuentes et al. 2008; Vernon et al. 1993; Vernon 2008b; Mwangi et al. 2008; Warren et al. 2008b).



FRONTIERS partnered with WHO and FHI to produce the Guide for Essential Practice (GEP), which offers evidence-based and practical advice on how providers can counsel, screen, diagnose and treat women attending for RH services (e.g. FP, ANC, delivery, postnatal), etc. for sexually transmitted and other reproductive health infections. Guidance on reaching men and adolescents is also included. With technical assistance from FRONTIERS, these guidelines have been adapted in Kenya as the National RTI Guidelines. The guide is available at:

[www.popcouncil.org/frontiers/
meetings/whopub.html](http://www.popcouncil.org/frontiers/meetings/whopub.html)

Systematic Screening Leads to Increased Utilization of Services

Systematic screening is a tool for reducing unmet or unstated client need for service that can increase the number and type of services clients receive. Providers use checklists or brief questionnaires to identify each client need for RH or other services, and then either provide services immediately or give appointments or referrals.

Studies in Bolivia, Honduras, India, Peru, and Senegal showed use of a simple checklist increased average number of services received per client visit between 9 and 28 percent (*Table 2*). The technique has been adopted in Madagascar, the Philippines, and Rwanda at the request of USAID Missions. USAID has identified the technique as a priority best practice and plans its replication in other countries (Das et al. 2005; Foreit 2006; Foreit, Vernon, and Riveros Hamel 2005; Sanogo et al. 2005; Vernon and Foreit 1999; Vernon, Foreit, and Ottolenghi 2006; Vernon et al. 2005; León et al. 1998).

Table 2. Services Received per Client Visit: Screened vs. Unscreened*

Study	Not screened	Screened	Difference (%)
Bolivia	1.1	1.2	9
Honduras	1.1	1.3	18
India (large clinics)	1.6	2.0	25
India (small posts)	1.5	1.6	7
Peru	1.6	1.8	13
Senegal (urban)	1.2	1.4	17
Senegal (rural)	1.4	1.8	28

*Services per visit rounded one decimal place

Integrating FP Services with Emergency Treatment of Postabortion Patients

Many studies in a variety of countries of Africa, Asia and Latin America have shown counseling women about contraception and ensuring they receive desired methods before discharge significantly increases likelihood of use. Referral is consistently less effective and less acceptable to clients of postabortion family planning, as with most types of integration; and the more convenient the FP consultation, the more likely a woman is to accept FP (Billings, del Pozo, and Arévalo 2003; Dieng et al. 2008; EngenderHealth 2003; Savelieva 2002; Solís et al. 2008; Rivero-Fuentes et al. 2008; Medina et al. 2001; Wanjiru et al. 2007; Youssef et al. 2007).

Rape Survivors Can and Should Receive Integrated Services at District Hospitals

An intervention in South Africa tested feasibility of creating standardized and routine integrated post-rape care services centralized and coordinated in the outpatient department of a district hospital. Previously, rape survivors had to negotiate up to 10 different providers within the hospital. As a result of the procedural reorganization and staff training, quality of care improved significantly and substantially across all indicators: survivors were 27 percent more likely to receive pregnancy tests, 25 percent more likely to receive EC, 37 percent more likely to be HIV tested, and 57 percent more likely to received HIV post-exposure prophylaxis (PEP) (Kim et al. 2008).