

Integrating Family Planning and HIV/AIDS Services: Health Workforce Considerations

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The US Government's Global Health Initiative includes increased impact through strategic coordination and integration as one of its seven core principles (United States Government 2011). Consequently, governments and the international community are increasingly paying attention to evaluating health systems components as variables in integration approaches. Yet most of the evaluations of service integration models have virtually ignored the health worker as input to or output of integrated service delivery. This technical brief assesses the evidence on the role of health workers in the integration of family planning (FP) and HIV services and discusses key health worker considerations when integrating FP/HIV services, regardless of the integration model.

We undertook an initial literature review to explore the available evidence on the effects of FP/HIV service integration on the health worker. While the volume of peer-reviewed articles on this topic is not extensive, key sources include reviews by the Cochrane HIV/AIDS Group (Kennedy et al. 2011) and Church and Mayhew (2009). The gray literature also contains briefs and reports from implementing nongovernmental organizations (NGOs), as well as abstracts and presentations from international FP and HIV/AIDS conferences in 2011. The majority of the literature included in this review focused on integrating FP into HIV services. Given that many articles described NGO programs, this focus reflects the facility and/or service types with which the NGOs worked. None of the reviewed articles assessed whether integration of FP into HIV or HIV into FP is more effective.

Health workforce composition

Although there is very limited information on numbers, types, and distribution of health workers before and after FP/HIV service integration, the *perceived or actual shortage of staff* is a commonly stated challenge to integration efforts (Church and Mayhew 2009; Gitau et al. 2011; Hoke et al. 2011; Nielsen-Bobbit et al. 2011; Awadhi et al. 2011; Gilmer and Baughan 2010). Church and Mayhew (2009, 178) highlighted the "importance of staff having excess time before service integration begins if cost effectiveness or improved productivity is to be achieved after new services are added." A five-country study of FP/HIV integrated services by Family Health International (FHI) found that "up to two-thirds of providers had some 'non-busy' time during the day, indicating workloads do not preclude offering additional services" (FHI 2010a, 2).

Task shifting (also referred to as task sharing) changes a health worker's scope of practice and/or assigns responsibility for specific tasks to health workers with shorter training and fewer qualifications, when appropriate. In Kenya, "...nurses now commonly provide ARVs and can insert intrauterine devices (IUDs) and contraceptive implants. Some clinical officers can now perform tubal ligations on women seeking to prevent future pregnancies, something that in the past only physicians performed" (Scholl and Cothran 2011, 11). In Ethiopia, clinic nurses are able to "assess clients living with HIV, including for FP need, and are also allowed to prescribe ARVs and contraceptives to clients based on their needs and clinical eligibility" (ibid., 11). Ethiopia's Rural Health Extension Program and Urban Health Extension Program practice another type of task shifting that "allows nurses and health extension agents to provide Depo-Provera during home visits," (ibid., 11) reducing the burden of care at facilities. Although studies have identified negative effects that result from task shifting, such as inadequate compensation, decreased job satisfaction, and lower morale for more specialized health workers, as well as challenges in maintaining service quality standards (WHO 2006), this FP/HIV integration review did not find any discussion of such negative outcomes.



Partly because *community health workers* (CHWs) are often unpaid and do not undergo long-term training, many countries have placed CHWs at the center of task shifting efforts. CHWs can contribute to increased demand for and uptake of FP/HIV services when accompanied by well-designed training, supervision, and referral mechanisms. In countries such as Malawi, Rwanda, Tanzania, Zimbabwe, Kenya, Ethiopia, and Ghana, CHWs are trained to deliver FP and HIV counseling, provide referrals, and in many cases, provide commodities (Banda and Franco 2011; Nzabonimpa 2011; Banzi et al. 2011; Extending Service Delivery Project 2011; Pathfinder International 2005; Scholl and Cothran 2011; Pathfinder International 2011; Population Council 2001). These efforts often involved adding HIV support services to existing FP workloads, though bidirectional linkages also occurred. Programs in Zimbabwe, Kenya, Malawi, and Ethiopia found that CHW provision of integrated services had contributed to large increases in new FP clients (Extending Service Delivery Project 2011; Pathfinder International 2005; Nyirongo 2011; Scholl and Cothran 2011). The Extending Service Delivery Project (2011) in Zimbabwe also reported that the CHWs' work contributed to increases in contraceptive use and referrals to voluntary counseling and testing (VCT) centers, as well as changes in attitudes and knowledge about FP and HIV/AIDS.

Where additional human resources are needed, some tasks may also be delegated to *newly created cadres of health workers* who receive specific, competency-based training (WHO 2008). In Tanzania, Pathfinder International worked with district health management teams and health facility staff to recruit and train a volunteer cadre that initially provided only home-based HIV care and testing services (Banzi et al. 2011). With an increase in the proportion of married women using modern methods of contraception from 2004 to 2010, Pathfinder upgraded the skills of the cadre to include contraceptive and fertility counseling and distribution of pills and condoms. Adding FP services to the cadre's workload did not result in a loss of quality or in a reduction in the number of clients.

Health workforce development

Whether existing or new staff provide integrated services, *preservice education and in-service training* are critical to success. In many cases, providers who are expected to deliver integrated services have not been sufficiently trained and/or do not consistently do so. Several studies of integration found that providers had not received any training in FP (Nielsen-Bobbitt et al. 2011; FHI 2010b) or had limited or dated FP or HIV knowledge and skills (Farrell, Nagendi, and Efem 2011; Holt et al. 2011; Kennedy et al. 2011). This finding was supported by FHI's five-country study that determined that up to two-thirds of providers did not have sufficient training, many providers were unaware of key guidelines, and there were misconceptions about methods and recommendations (FHI 2010a). Even in an intervention trial in South Africa that was designed to train providers in contraception for HIV-positive women, the training content was not translated into expected service delivery outputs (Hoke et al. 2011). Although over 90% of female clients in a separate South African study reported discussing condom use with HIV providers, less than 50% reported discussing non-barrier FP methods (Schwartz 2011). Conversely, Kinagwi and Kibet (2011) suggest that one of the contributing factors to a 123% increase in enrollment in four facilities in Kibera, Kenya, was increased staff capacity to

provide integrated services. Indeed, several studies have found that providers prefer integrated care for sexually transmitted infections and HIV, training for which enhances their own skills (Fullerton, Fort, and Johal 2003; WHO 2003; Stein, Lewin, and Fairall 2008; Liambila et al. 2008). Community support and investment in provider training and supervision have been identified as success factors for integrated services (Kennedy et al. 2011), and providers have also expressed the need for more training on FP/RH issues (Church and Mayhew 2009; Awadhi et al. 2011; Church, Simelane, and Mayhew 2010).

Productivity and performance of health workers

While it is common for health workers to express concerns about their working environment, *occupational hazards* are frequently cited as a source of demotivation in the context of FP/HIV service integration, affecting both the ability and willingness to deliver integrated services:

In settings with high HIV prevalence, the impact of the HIV pandemic has been shown to have a considerable impact on staff capacity and motivation. HIV-related illness among staff is an additional barrier to service provision [...], and in some countries attrition of staff due to HIV/AIDS is deemed a serious system-wide constraint [...]. Furthermore, within [sexual and reproductive health] facilities with newly integrated HIV services, the fear of occupational exposure and negative attitudes toward HIV-infected clients make some providers unenthusiastic about providing these services [...] (Church and Mayhew 2009, 177).

Providers often cite *high workloads* as a disadvantage of FP/HIV integration. Interviews with providers and program managers elicit responses such as, "There are too many patients and too few health care workers" (Scholl and Cothran 2011, 11). In six studies that focused on providers' experiences with integration, managers were concerned with both high workloads and the effect they may have on service quality (Dudley and Garner 2011). Adding services to already high workloads can even risk "crowding out" other existing health services (United States Government 2012, 8). Workload issues may also contribute to staff attrition.

One of the nurses who left here was complaining about that, since this ART thing started coming here, there's more work.... Some of the nurses left the hospital because they were tired of that.

Health worker, Swaziland
(Church, Simelane, and Mayhew 2010)

In interviews with providers in 68 Ethiopian facilities offering integrated FP/HIV services, Mengistu et al. (2011) found that high seasonal workload, particularly in VCT clinics, and high turnover of trained staff were issues. Several recent studies cite providers' fear that providing integrated services is too time-consuming (Nielsen-Bobbitt et al. 2011; Kuria 2011; Awadhi et al. 2011), which might lead to burnout (Church, Simelane, and Mayhew 2010). One study found that FP/HIV service integration was not strongly associated with increased CHW productivity, possibly because the CHWs need more time per client than before integration (Creanga et al. 2007). As a

result, the study recommended allocating resources to increase the number of CHWs. More research is necessary to confirm this finding, as it has implications for task shifting efforts.

As Church and Mayhew (2009, 177) note, “[d]espite these constraints, a few studies have documented program improvements and successes where service integration is properly supported and supervised.” The Integra Project launched *peer mentoring* to build integration capacity by “promot[ing] sharing of information between health workers to improve quality of care” and “introduc[ing] change in service delivery without removing staff from their workplace” (Ndwiga, Warren, and Abuya 2011, slide 4). Results included improved access to hormonal contraceptives; improved knowledge, skills, and use of long-term FP methods; an increased range of FP/HIV services at both FP and HIV facilities; and improved confidence and motivation. Further, Ndwiga, Warren, and Abuya (2011, slide 12) found that “peer mentoring is acceptable and feasible among first level health workers.” However, Hoke et al. (2011) found that while an intervention trial in South Africa was designed to provide on-the-job coaching to support FP service provision and referrals, some health workers did not follow the coach’s guidance. Nonetheless, several studies recommend supportive supervision and some form of mentorship (Gilmer and Baughan 2010; Mengistu et al. 2011; Pathfinder International 2011), to which Melaku et al. (2011) attributed the success of provider-initiated counseling and testing at FP units in health facilities in Ethiopia.

Support is also essential to enabling CHWs to effectively provide integrated FP/HIV services. In Tanzania, Zimbabwe, and Kenya, Pathfinder International promoted and trained former CHWs to act as supervisors (Banzi et al. 2011; Extending Service Delivery Project 2011; Pathfinder International 2005). Monthly oversight meetings were held with current CHWs to exchange information, review progress and problems, and develop plans. This approach helped maintain quality assurance and manage CHW workloads (Extending Service Delivery Project 2011). In addition, establishing an *effective referral system* that links CHWs to health facilities was repeatedly identified as a key success factor for FP/HIV service integration (Banzi et al. 2011; Extending Service Delivery Project 2011; Pathfinder International 2005; Scholl and Cothran 2011; WHO 2009).

I never thought I could train anyone, bring so much change in our facility, let alone become popular for my good work.

Mentor

(Ndwiga, Warren, and Abuya 2011, slide 13)

Health worker attitudes toward clients

Provider attitudes toward clients can constitute serious challenges to integration. Staff who are unwilling to engage in discussions of sexuality with clients can inhibit service integration (Kennedy et al. 2011). Health workers in prevention of mother-to-child transmission (PMTCT) and HIV treatment settings have a tendency to emphasize condoms and neglect other contraceptive

methods (FHI 2010b; Schwartz 2011; Mbatia et al. 2011), and some health workers have misconceptions about the appropriateness of other contraceptive methods for people living with HIV (PLHIV) (FHI 2010a). Some providers believe that PLHIV should not enjoy healthy sexual relationships or become pregnant (FHI 2010a and 2010b; Holt et al. 2011; Wilcher 2011; Gilmer and Baughan 2010; Agadjanian and Hayford 2011). Studies in several African countries, including South Africa and Mozambique, found that health workers often believe that young women shouldn’t have sex and therefore shouldn’t use condoms or even receive FP services; some providers also believe that young women tend to ignore FP information anyway (Holt et al. 2011; Gilmer and Baughan 2010; Agadjanian and Hayford 2011).

If you are not married why [is there any need to] use a condom?

HIV counselor

(Holt et al. 2011, slide 9)

Provider attitudes unrelated to clients’ sexual behavior are also significant in the context of service integration. Agadjanian and Hayford (2011) considered how sociocultural challenges affect provider-client relationships for FP/HIV services in southern Mozambique. Nurses felt that their salaries and benefits, such as adequate housing, were not commensurate with their increased responsibilities under integration. In addition, nurses have typically completed higher educational levels than have their clients, and many come from urban areas. Negative stereotypes about “backward” rural people therefore persist, such as: rural clients are incapable of making and carrying through optimal decisions about their reproductive health, including choice and use of FP methods; female clients are completely controlled by their husbands; rural HIV-positive women do not disclose their status to their husbands out of fear; and rural men are opposed to fertility regulation and FP use. Agadjanian and Hayford recommended that policies focus on educating staff to foster greater understanding and sensitivity of social and cultural obstacles to FP among the rural population.

Yet health workers’ understanding of the benefits of integration may contribute to their *job satisfaction*. Health workers interviewed for several studies noted that integration can lead to an increase in client uptake of services and reduce the need for multiple return visits or referrals, which clients may not seek after leaving the first facility (Nielsen-Bobbitt et al. 2011; Scholl and Cothran 2011). Health workers in Kenya and Swaziland reported that due to the increased efficiency of services, client satisfaction improves, which in turn has a positive effect on health workers’ own satisfaction (Kuria 2011; Scholl and Cothran 2011; Mengistu et al. 2011). Indeed, Awadhi et al. (2011) found that 97% of health providers surveyed in Tanzania supported FP/VCT integration. Church, Simelane, and Mayhew (2010) described providers as “enthusiastic about the concept and potential benefits of integrating [sexual and reproductive health] into HIV services.”

Participatory planning

Staff ownership and involvement in decision-making contributes to successful integration (Kennedy et al. 2011). Church and Mayhew (2009, 177) note that “[p]roviders’ and managers’

involvement in planning for integrated care also has been shown to improve providers' satisfaction with and motivation for offering these services." Engaging a wide stakeholder base at national, regional, district, and community levels, including organizational leaders, community leaders, and government, during integration program planning and implementation is widely acknowledged to be a crucial step in integrating services (Farrell, Nagendi, and Efem 2011; Gitau et al. 2011; UNAIDS 2010; WHO 2009; United States Government 2012). Involving community members helps them understand the purpose of and access FP/HIV services and serves as motivation for CHWs to maintain positive reputations by providing high-quality services (Extending Service Delivery Project 2011). In planning for integration programs, the Integra Project (Ndwigwa, Warren, and Abuya 2011) held advocacy meetings with health managers at all levels to ensure buy-in on areas such as selection criteria for the mentors and mentees; key competencies required for FP/HIV integration; and required training, including HIV testing and counseling and long-term FP methods. In Zimbabwe, regular coordination meetings helped facility-based providers have ownership of integration and work more effectively with CHWs (Extending Service Delivery Project 2011). As the international development, public health, and evaluation communities have learned, participation is critical to sustainability of projects and project benefits. Stakeholders—including formal and community health workers—need to be involved from the beginning so that they are invested in the success of integrated FP/HIV services.

Recommendations

Numerous benefits of FP/HIV service integration have been demonstrated, including increased access to both types of services, improved quality of care, and enhanced program effectiveness and efficiency (UNAIDS 2010). Yet while service integration is a key Global Health Initiative principle, its potential cannot be fully realized until there is a richer, widely disseminated evidence base not only on how integration affects service providers and other health workers, but also on how best to maximize positive effects and mitigate negative consequences.

We therefore recommend that to optimize service integration efforts, program managers and decision-makers should consider the following key questions during the planning, implementation, and evaluation stages:

- Negative effects of task shifting on health workers have been documented in other contexts. *Which model(s) of task shifting would minimize these negative effects in the FP/HIV service integration context?*
- Some health workers expressed enthusiasm for improving their skills and a desire to receive training, mentoring, and supportive supervision. *What training, mentoring, and supervisory methods are most effective for ensuring provider capacity to deliver integrated services, during either preservice education or in-service training?* For example, are there eHealth or mHealth methods that are more effective and/or efficient?
- Integration program designs must take into account potential conflicts between health workers' attitudes toward clients and the intended delivery of integrated services. *Which integration trainings have effectively incorporated content on provider attitudes toward clients, and what factors contributed to their success? What performance support mechanisms, such as clinical mentoring and supportive supervision, have reinforced positive attitudes toward clients during service delivery?*
- Service integration may have unintended effects on health worker morale and job satisfaction, and in turn, on performance and productivity, when health workers feel unsupported. *How should performance support mechanisms, such as compensation packages and supportive supervision, be structured to address health worker needs and increase the acceptability of service integration efforts by health workers? What lessons can be learned from CHW support mechanisms?*
- Coordinating service integration efforts with health management teams can facilitate incorporation of client feedback, which can in turn contribute to boosting health worker morale. *What are the characteristics of successful coordination models with health management teams in service integration contexts? What role does the health worker, including the community health worker, play in these models?*

Health workers already play a key role implementing service integration efforts. Enabling them to fulfill this role requires that they also be more deeply involved in planning, monitoring, and evaluating FP/HIV service integration.

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