Preparing for the delivery of microbicides: Lessons from the implementation of integrated reproductive health and HIV services in Kenya

STUDY TEAM

FHI 360 conducted this research in collaboration with the Ministry of Health of Kenya (National AIDS and STI Control Programme [NASCOP] and Department of Reproductive Health).

Objective

To measure the extent to which integrated services are delivered to targeted beneficiaries in public-sector health facilities as intended and to identify the health-systems-level factors that facilitate and impede effective delivery of integrated health services.

Background

Results from the CAPRISA 004 trial of tenofovir gel generated optimism about the significant role that topical microbicides could play in the HIV prevention package for women (1,2), though the scientific community awaits confirmation of the effectiveness of these products (3). To prepare for timely delivery of microbicides should they prove to be effective, managers need evidence to plan for the eventual provision of services. Because microbicides are likely to be added to existing health services as opposed to being offered as a stand-alone vertical program (5), examining the provision of other integrated health services can offer useful lessons.

In 2011, the Kenya Ministry of Health released a policy document entitled, "The Minimum Package for Reproductive Health/HIV Integrated Services (6)." Examining implementation of selected components of the minimum package provides a means of exploring the challenges to and potential solutions for successful microbicide service delivery. The three minimum package components that were examined are 1) HIV testing and counseling (HTC) offered within family planning (FP), 2) HTC offered within general outpatient department (OPD) services, and 3) care and prevention services provided to HIV-positive clients who are not eligible for ART, known as pre-ART services, within Comprehensive Care Centers (CCCs).

Methods

This descriptive, mixed-methods research study was conducted from October to December 2013 in Nairobi, Mombasa, and Kisumu counties. Data collection methods were observation of service delivery, client exit interviews, and semi-structured interviews. Observations and client exit interviews were conducted in 15 integrated facilities. Observations assessed the consistency with which the services were offered and the extent to which provider performance conformed to service delivery guidelines. Client exit interviews explored clients' need for the integrated services, whether they actually received integrated services, and their knowledge about follow-up actions.

Individual semi-structured interviews were conducted with providers and managers at integrated and nonintegrated facilities to explore the factors supporting and impeding implementation of the minimum package. Additionally, managers and policymakers at the county and national levels were interviewed to trace the root causes of barriers and facilitators encountered at the facility level.

Data on the delivery of all services from both client exit interviews and observations are reported below. The intention of reporting both sets of results is not to directly compare them but to illustrate the relative frequency with which clients received services.

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Results

Delivery of HTC within family planning and outpatient services

According to client exit interviews, 34% of FP clients and 25% of OPD clients reported that the provider mentioned getting tested for HIV on the day of the interview. Few women were actually tested on the day of the interview (11% of FP and 9% of OPD clients). Just over a third of FP (38%) and outpatient (35%) clients knew testing was available at the facility on the day of the interview. For 38% of FP visits and 45% of outpatient visits observed, research assistants documented that HIV test kits were not available for the client.

HIV prevention counseling was infrequently provided to both FP and OPD clients. Only 22% of FP clients and 14% of OPD clients said their providers gave them prevention messages. Among those who were tested on the day of the interview, 56% of clients exiting both FP and OPD facilities said they had received counseling on ways to prevent HIV transmission. Most facilities were observed to have condoms available during interviews; however, a small number of facilities rarely had any condoms. Very few clients from both services reported receiving condoms at the facility.

Provision of care and prevention services for pre-ART clients

Results indicate inconsistent provision of the full range of services comprising pre-ART services. During the visit on the day of the interview, the most commonly received service was the receipt of co-trimoxazole, an antibiotic given prophylactically to HIV-positive individuals to prevent common infections; 93% of interviewed pre-ART clients received this during their visit. Nutrition, HIV prevention, and FP were the next most commonly received services. Especially low were the rates of testing for cervical cancer (5%), tuberculosis (TB) prevention counseling (10%), and TB testing (3%).

Health systems issues that facilitate the roll-out of the minimum package

Positive attitudes expressed by county and national key informants toward the provision of integrated services facilitated the provision of the minimum package. These groups described multiple benefits of integration, including time savings for clients and providers, the opportunity to capture more clients, increased client satisfaction, and elimination of the need for clients to wait in more than one line.

Overarching health system constraints impeding the roll-out of the minimum package

Results from key informant interviews provide insight into the health-systems-level factors that impede effective delivery of integrated services. The vast majority of key informants at all levels spontaneously mentioned that staff shortages were a systemic problem at the facility level. One national-level key informant stated, "when you look at the shortage they have, there is shortage across board and every cadre…The issue of shortage is very critical so for integration we really need to look at the human resource aspect." Key informants also reported that staff shortages often left providers overburdened with clients.

Inadequate staff training was raised by key informants at every level of the health system and in each type of service explored in the study. Insufficient resources allocated to staff development resulted in providers not receiving in-service training for some services they are expected to deliver. Key informants reported that insufficient staffing was key contributor to longer client wait times, which obstructed the provision of integrated services. Another documented limitation related to training concerns was the communication of service delivery guidelines; only 24 of 64 facility-level providers and managers had heard of the minimum package before the interview.

Key informants reported a general lack of privacy and inadequate infrastructure in facilities, which made it difficult for health facility staff to deliver high-quality care. This was especially true regarding space for HIV counseling and the provision of sexual and reproductive health services such as screening for cervical cancer or IUD insertion. Key informants reported that there is often only one room for multiple types of services to be delivered, creating concern about client confidentiality.

Key informants also noted demand-side challenges specific to the provision of HIV-related services. Many noted that lack of attendance for pre-ART services was strongly linked to stigma associated with seeking care from a facility that offers HIV services.

"The largest challenge is stigma. Some new clients aren't comfortable with sitting in the area that is known as the CCC client area. Clients don't want to be seen coming to the clinic. On the provider side, the largest challenge is capacity. The workload causes providers to feel overwhelmed, not only providers feel overwhelmed but also lab technicians and pharmacists."

– Provider, CCC department

Discussion

Examining the roll-out of the minimum package of integrated RH/HIV services in Kenya revealed the effects of these new responsibilities on the busy public-sector health services. The provision of microbicides, when available, will place similar burdens on these services.

Family planning and outpatients services

HIV testing is not being offered systematically to FP and outpatient clients, and few clients actually receive testing. Most clients were not aware that HIV testing was available in the facility where they received services. Similarly, providers are not systematically providing HIV prevention counseling

and services within FP, and outpatient services HIV tests were unavailable for large numbers of clients. The failure to provide both prevention counseling and testing is a failure at the headwaters of the HIV prevention cascade.

Pre-ART services

Pre-ART services are not systematically delivering the range of services mandated in the minimum package to pre-ART clients. While the receipt of co-trimoxazole was high, less than half of clients reported receiving other preventive services such as discussions about FP or HIV protection for partners. Especially low were the rates of testing for cervical cancer, TB prevention counseling, and TB testing.

Health system weaknesses

Our data demonstrate the considerable—and familiar—challenges faced by the delivery of the minimum package of integrated RH–HIV services. Health systems continue to struggle with inadequate infrastructure, lack of commodities and supplies, and limitations in staff. Providers and managers indicated that they are constrained in offering more services to clients because of a shortage of providers, high workloads, and long waiting times for clients. In some cases providers and managers are not aware of service delivery requirements because updated guidelines have not been adequately communicated to them.

Conclusion

The challenges faced now by the provision of integrated health services raise the question of how to implement new services into existing, burdened health systems. In Kenya and other developing-country settings the successful integration of microbicides requires attention to persistent challenges within the health system as well as consideration to issues of stigma. Improvements to the dissemination of service delivery requirements, staffing, infrastructure, and availability of commodities must be addressed before microbicides can be successfully rolled out within public-sector facilities.

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