Overview of Research Components in Swaziland

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Integra Project

• To strengthen the evidence on the benefits and costs of a range of models for delivering integrated HIV and SRH services

– What are the benefits in terms of:
  • Numbers of clients
  • Profile of clients
  • Range of services accessed by clients
  • Quality of services
• What is the impact of integration on:
  – HIV related risk behaviour
  – HIV related stigma
  – Unintended pregnancy

• What is the cost, feasibility and cost-effectiveness of integration?
  – What is the cost of integrating service provision?
  – How do costs vary by model of integration?
  – Does integration result in economies of scope?
Model 1: HIV FP (Kenya)

Care for all clients seeking FP

All Family Planning clients
Balanced Counseling Strategy (BCS) to identify contraceptive options
Screening and management for STI
Counseling for STI/HIV prevention
Testing for HIV
FP issues
Screening for cervical cancer (VILI/VIA)

Care according to status

HIV negative
Health promotion
Risk factor exposure
Risk assessment (routine)

HIV positive
CD4, Haemogram, SGPT/ALT creatinine
Clinical staging
CTX prophylaxis
Monitoring x 3 - 6 monthly
Opportunistic infections
Adherence counseling
Counseling on side effects
Model 2: HIV → SRH Models

1. PNC model: Integrating HIV prevention counseling and offering HIV testing into strengthened maternal and infant postpartum care services, including FP with linkages to comprehensive care for those found to be HIV+ (Kenya & Swaziland)

2. VCT and STI services integrated with FP services for youth (Swaziland & Malawi)

3. FP and RH services integrated into HIV centres (Swaziland)
Standard PNC service:

**Timing:** Usually delivered on discharge if hospital delivery, with 6 week check.

**Content:**
- Immunisation
- Growth monitoring/child welfare
- FP at six weeks post partum

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Integrated PNC & HIV services:

**Timing:** within 48 hours of delivery, plus 7 day, and 6 week visit at facility

**Content:**
- Standard PNC plus:
  - Mother and baby physical examination to detect danger signs, complications, anomalies
  - Infant feeding counselling
  - Postpartum FP counselling and provision
  - Screening for cervical cancer (at 6 weeks)
  - HIV CT (mother and baby)
  - HIV prophylaxis for mother and baby
  - Infant male circumcision counselling

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ART service:

Offer range of HIV & SRH services, including:
- CD4 testing
- Clinical staging
- ARV prophylaxis
- CTX prophylaxis
- Monitoring (every 3 - 6 months)
- Management of OIs
- Counselling on side effects
- Adherence counselling
- FP counselling
- Condom promotion/provision
- Provision of short-term methods

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Referral to other departments:
Ob/Gyn unit for complications; sick child clinic; FP unit for long-term FP methods
Model 3: Integrated SRH services (FLAS)

- Family planning, maternal and child health (MCH services)
- HIV testing, HIV care
- STI care
- Cervical cancer screening,
- Services for youth.

Model 4: Comparison of integrated and stand-alone HIV care models

- Compares two fully integrated SRH-HIV services, with two stand-alone HIV care facilities
Study design issues

• Integration complex
  • Number of services
  • Integrated physical and human resources
  • Client flow

• Integration already exists (referrals)

• Real world
  • Integration policies changing
  • Confounders - stock outs etc
  • Human resources moving
  • Controls could not be randomised
Study design outline

• Broadly pre-post test controlled, but:
  – Definition of integration
    • number of services, index
  – Process evaluation
    • health facility assessments and periodic surveys
    • mixed methods research, understanding provider and client perceptions
  – Client/ facility (cohorts/ costs) and community level (household surveys) impact
  – Focus on different groups (HIV+)
Research Activities
(integration and comparison sites)

Facility assessments (all) (1/yr) & client-flow (1/yr)
- Checklist, provider interviews, client-provider observations, exit interviews
- Additional *qualitative* provider interviews

Community surveys (Y2 and Y4)
- Additional *ad hoc qualitative* studies

Cohort surveys with PNC users; (Y2 – Y4 & Y5)
- Cross-sectional survey with HIV+ users (Y2)
- Additional *qualitative* client interviews

Economics Y2 and Y4
SWAZILAND

Integrating PNC services in Swaziland

- Mbabane
- Manzini
- Nhlangano
- Hlatikulu

No formal integration

- Mankayane
- Piet Retief
- Moolman

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<table>
<thead>
<tr>
<th>INTERVENTION SITES</th>
<th>COMPARISON SITES</th>
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<tbody>
<tr>
<td><strong>Model 2: HIV/FP/PNC</strong></td>
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<tr>
<td>Mbabane Public Health Unit (PHU)</td>
<td>Nhlanganano Health Centre (HC)</td>
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<tr>
<td>King Sobhuza II PHU</td>
<td>Dvokolwako HC, Matsanjeni HC</td>
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<td>Mankayane PHU</td>
<td>Sithobela HC</td>
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<td>RFM Hospital (MCH-FP unit)</td>
<td>Hlatikhulu/ Mkhuzweni PHU*</td>
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<td><strong>Integrated SRH clinics (FLAS)</strong></td>
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<td>IPPF/FLAS Manzini Facility</td>
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<tr>
<td>IPPF/FLAS Mbabane Facility</td>
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<td><strong>HIV case study clinics</strong> (case study)</td>
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<td><strong>Integrated sites</strong></td>
<td><strong>Stand-alone sites</strong></td>
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<td>IPPF/FLAS Manzini Facility</td>
<td>Lamvelase HIV Centre</td>
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<td>King Sobhuza II PHU</td>
<td>RFM Hospital ART Unit</td>
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<td>Data collection tools</td>
<td>Baseline 2009 n=</td>
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<td>--------------------------------------------------------</td>
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<td>Health facility inventory</td>
<td>8/2</td>
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<td>Observations of client–provider interaction</td>
<td>237/121</td>
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<tr>
<td>Client exit</td>
<td>234/121</td>
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<td>Provider knowledge</td>
<td>50/9</td>
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<td>Client Flow Analysis</td>
<td>4463</td>
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<tr>
<td>Cross–sectional survey with HIV+ users</td>
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<tr>
<td>Periodic activity review</td>
<td>8</td>
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<tr>
<td>PNC cohort</td>
<td>Baseline: 1401</td>
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<tr>
<td>Community survey</td>
<td>416 Men</td>
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Community Survey

• Both women and men in Manzini;
  – Demand/use patterns for SRH/HIV services
  – SES

• Other data available:
  – sexual partner information
  – contraception and HIV testing
  – use of services and all local facilities (including travel and user costs)
  – stigma information
  – personal views about facilities
  – reasons for use and knowledge of services
  – perceptions of service providers
Qualitative Provider Interviews

June 2010:

• 24 qualitative interviews:
  – to explore experiences of integrated service delivery including structures and support; psycho-social issues faced by providers giving care to HIV+ people.

• Possible: FGDs with providers at all facilities at the same time as the final facility assessment in 2012
  – to explore service provision and supervision issues (normative culture at facility level)
Cohort data

Quantitative sample
- Socio-economic status
- Pregnancy and fertility knowledge and intentions
- PNC/FP/HIV services
- FP use
- Barriers to seeking care,
- HIV knowledge
- Client costs

Qualitative sub-sample
- 2011: Interviews with PNC HIV+
  - To explore experiences of HIV+ people seeking care incl. adherence, stigma
- 2012: Interviews with mixed respondents (selected on basis of analysis of data trends after R3):
  - HIV+ clients to explore what happens in terms of sexual and service-seeking behaviour between testing positive and accessing ART
  - Clients reporting unintended pregnancies while on FP method, depending on disclosure in the cohort baseline survey. To explore what happened in terms of ‘contraceptive failure’
Economic Analysis

• Baseline costing study/ periodic activity review - (April 2008 - March 2009)
  – To explore resource use to produce SRH/HIV services
  – Measure costs of different SRH/HIV services
  – Assess current levels of efficiency
  – Explore relationship between cost, efficiency and integration
• Cohort/ communities
  – Patient cost information
• Follow up study (April 2010-March 2011)
  – To assess the impact of integration on costs (economies of scope)
  – To conduct a limited assessment of cost effectiveness (source of evidence of effectiveness from community and cohort studies)
Index of Integration: Cross-cutting: combines economics & HFA data

Purpose:

• Theoretical: Contribution to conceptual understanding of integration

• Practical:
  – to measure integration effectively at each study facility to be able to relate this (statistically) to outcomes such as unit costs, client uptake and client satisfaction
  – To help us describe, interpret and place our results from the pre-post test analysis
Methods challenges and what we hope to achieve

• Building a ‘whole picture’

Cost and efficiency, but also, health & behaviour outcomes, processes, consequences for providers and clients of services
For more information on the research components please contact:

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