Author's response to reviews

Title: How does HIV/SRH service integration impact workload? A descriptive analysis from the Integra Initiative in two African settings.

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Version: 2
Date: 4 June 2014

Author's response to reviews: see over
6 April, 2014

Dear Sir/Madam,


We would like to thank both reviewers for their thoughtful comments and suggestions. We have responded to each comment in the text below, and referred to changes made in the text where relevant.

Yours sincerely,

Sedona Sweeney
(on behalf of co-authors)
Referee 1

Page 2

Line 6: Where is this assumption of staff being underutilized coming from?

There is some evidence from costing studies of the under-utilisation of human resources in LMICs, but we accept that this is too broad a statement; we have therefore changed this wording.

Line 9: What is meant with resource integration? Do you mean ‘human resource integration’? That term still is not clear to readers (at least not to readers from the HRH community). How does it link e.g. to more commonly used terms such as ‘task-shifting’? Does it concern adding new tasks to the package of services, or shifting an HIV task from one person - focusing primarily on HIV - to another one - focusing on MNH and now including HIV?

In the context of human resources, we define integration as the provision of multiple services by one staff member. This can be realised either through moving services from a stand-alone staff member or department to one providing both on SRH and HIV services, or through adding services to the basic package offered by a staff member without dropping their pre-existing tasks. We have added this definition in line 26 in the introduction and in to our conceptual and analytical framework in the methods section and revised this wording.

Line 15: Definition of structural integration not clear.

We’ve omitted references to ‘structural’ integration, and refer simply to integration for clarity.

Line 17: Extra MNH staffing or extra HIV staffing?

This refers to extra SRH/HIV staffing, however staff can be placed either within the HIV department or within the MCH unit. We have changed the wording in line 17 to reflect this.

Line 18: The word used in the introduction was 'efficiency'. Does efficiency equal productivity?

Efficiency does not equal productivity – we’ve changed the wording to ‘efficiency’ for consistency.

Page 3

Line 7: How is this linked to the statement on underutilized staff in the introduction?

We have changed the wording here to better reflect our premise that workload may vary across settings.

Line 8: Should a distinction be made here between workload (at the individual level) and efficiency (at the workforce level)? Like is done in Figure 1 (the 2 boxes leading to economies of scope). The idea is that integration is more efficient at the workforce level, but the question is how this impacts on the workload at the individual level, right?

Yes, this is exactly what we are investigating. Our premise is that workload varies across settings – in some cases there is the risk of staff being overworked, while in other cases there may be excess capacity and staff would be able to take on additional duties without risking burnout. We are therefore attempting to see if we can identify where this excess capacity may occur, and if HIV/SRH integration is a case of the former situation or the latter. We have changed the wording of the introduction to better reflect this idea (lines 7-9).

Line 13: Could you back this assumption up with arguments / references? Overall there is a shortage and a risk of burn out and lack of quality, yet MCH staff is underutilized. This needs some additional explanation.
We have changed the wording slightly and added references which point to the assumption that integration could improve the cost-effectiveness of service provision through more efficient use of staff time.

Line 23: What is meant by ‘multiple service provision’? Should it be read as the opposite of integrated service provision or as the same as integrated service delivery? Below it is explained that it is the same, but here it is not immediately clear.

By ‘multiple service provision’, we mean integrated service provision (ie. provision of multiple services by one staff member). We have clarified this wording.

Line 26: Could you specify ‘wider efforts’?

By ‘wider efforts’ we mean efforts in other aspects of integration, including physical resource integration and increased availability of services. We have clarified this wording.

Page 4

Line 9: Why were these services selected? Non-core according to whom / what?

Often countries see FP/ STI/ HIV as part of e.g. ANC/PNC/EOC services. When you look at the PMNCH list of essential interventions for example, most of these services should be integrated into MCH?

Does this mean:
- that these services are not part of the MCH package in the countries?
- that these services are formally part of the package, but not provided?
- that these services are provided to preg, but by other cadres?
- STI/ HIV/ FP services provided at other moments than around pregnancies and childbirth?

We defined ‘core’ services as those which were consistently offered within the standard care package across all health facilities. ‘Non-core’ services are HIV/STI services not consistently offered within MCH departments. We’ve added these definitions in lines 12 and 15.

Page 5

Line 5: In WISN language: staff workload components and activity standards.

Referee 3 has made the point that because we do not follow WISN methodology, we should not refer to our workload ratio as a WISN ratio. We have therefore changed reference to the ‘WISN ratio’ to ‘workload ratio’ throughout, and therefore here we have chosen to keep ‘staff time utilization’ rather than change to the WISN language ‘staff workload components and activity standards’.

Line 5: Which ones? All 40? Public/ private? Urban/ rural? Underutilized or overworked staff?

We evaluated all 40 Integra project sites – we have now clarified this.

Line 8: Still not clear what the authors are referring to exactly when referring to ‘the broader context of HIV/SRH integration’.

We have expanded our discussion of integration above (Page 4 line 22 through page 5 line 17), so hopefully now this is clearer

Line 12: these services being the core and non-core services defined above, so being a value of 1-8?

In large settings, with many FTE working on MCH, is a nominator of 1-8 sensitive enough to make a difference in ‘integration’?
This measure evaluates only non-core services, so it would take a value between 1 and 5 – we have now clarified this. As most facilities only have a few staff working within MCH unit, we believe a value between 1-5 will be sensitive enough to make a difference.

Line 13: At the facility level, right? so, the total FTE at the facility * % of FTE dedicated to MCH/HIV? How was the latter % of FTE allocated to MCH calculated?

The total number of staff FTE available in the facility during the baseline and endline time periods was sourced from facility records and observations, and confirmed through interviews. We have clarified this.

Line 14: How were these elements considered / taken into account?

Improvements in these elements of structural integration were evaluated against improvements in HR integration, in order to determine whether there was any interaction across the various aspects of integration. We have now clarified this.

Line 23: think this is a very strong point: to make activity standards based on expert opinion, but informed by reality.

We agree – it is helpful to base measurements on reality, especially as practical implementation can often be quite different from official recommendations!

Page 6

Line 16: What was the cut-off point for 'more integrated', 'less integrated' etc? "Improvement", could it also mean that the number of FTE working at a facility is reduced, e.g. due to attrition? In that case it would not be a purposeful improvement?

We have now included the values in the text. Our cut-off points were stratified by facility type, to account for higher patient loads at larger/urban facilities. We found no significant difference in staff FTE, or changes in staff FTE from baseline to endline, between the 'more integrated' and 'less integrated' or between 'most improved' and 'least improved' facilities, so any improvement in our integration measure is unlikely to be due to attrition.

Page 7

Line 13: how was broad structural improvement measured?

By 'broad structural improvement', we mean improvement other aspects of integration including physical resource integration and range of services available. We have clarified this.

Page 8

Line 3: this is part of the definition of wide context of integration which is not explained before. Maybe better to explain the concept and measurement earlier.

We have expanded our discussion of integration in the methods section on page3, so hopefully this is now clearer.

Line 10: did the author consider to make the difference between PNC 1-3, ANC 1-4 etc?

No, we did not make any distinction between first visits / revisits in PNC and ANC. This is indeed a limitation as some visits may take longer – we have added this in our limitations.

Line 21: Does this mean that the denominator in the indicator for HR integration increased?
Yes. However this also means that the denominator for the workload measure will increase – so should not have an effect on our comparison of integration and workload.

Page 9

Line 2: Which facility characteristics played a role here? Urban / rural location? Type of facility? Other?
Workload for these services were higher across all facility types. We have clarified this.

Line 21: Which could also mean that number of staff increased due to increased utilization?
We found no significant difference in staff FTE, or changes in staff FTE from baseline to endline, between the ‘more integrated’ and ‘less integrated’ or between ‘most improved’ and ‘least improved’ facilities. We therefore have reason to believe that any variances in staffing levels between facilities of the same size/type had no effect on the HR integration measure. We have added two sentences to address this.

Referee 3

1. Major Compulsory Revisions: The authors site the WISN Ratio through-out the paper, however the WHO WISN method was not used. The paper cannot call the ratio of the number of actual:required health workers the WISN Ratio without using the actual WISN methodology. They can use a ratio of actual to required workers without calling it the WISN Ratio. The WHO WISN method suggests that a time motion study can be used to complement the WISN method to see how closely the WISN activity standards compare to actual time it takes to deliver these services, but the time motion study is not a WISN method.

   We have changed references to the WISN ratio to ‘workload ratio’ throughout, and clarified in the methods section that we use an adaptation of the WISN methodology, rather than the WISN methodology itself.

2. This time motion study also does not indicate what components of a service were considered standard (e.g. what is included in the standard for an ANC visit -history, blood pressure, weight, etc.) and were these services observed. With integration where could the economies of scale be appreciated because of similar activities needed to be performed for both services (e.g. blood pressure only needed to be done once).

   As Integra was implemented in a ‘real-world’ setting, in a number of facilities with varying standards of practice, we did not define standardized components of a service but rather observed HR integration as it was implemented. We do, however, identify a few potential sources of economies of scale and scope through integration – on page 3 line 18, and page 5 lines 15 through 24. We have also expanded our discussion the conceptual and analytical framework for integration on page3, to provide a clear description of the type of integration we are evaluating.

3. Major Compulsory Revisions: The methods section does not clearly state how the integration of services is being tested by this study. It is not possible to tell which services were being integrated and how they were going to be measured. Were there different combinations of services integrated that were being tested to see which yields the best results?

   We defined integration as any combination of ‘core’ and ‘non-core’ services being provided together. The ‘core’ and ‘non-core’ services we identify are on page 4, lines 12-17. We have expanded our discussion of ‘integration’ in the methods section, and further described the standard of care in Kenya and Swaziland to provide a better picture of this.
4. In the results section it was difficult to follow what the before and end-result differences were for different types of integration. I would suggest making the methods section clear about the starting point and what services were being integrated and how you were going to measure the results of this integration effort.

   We have clarified the methods section to include more information on our indicators of HR integration, and which services we are evaluating on page 5 lines 1-10, and page 6 lines 3-8.

5. **Minor Essential Revisions**: Integration means many things in the literature today. The authors need to define how integration in being used in this study.

   We have expanded our discussion of integration in the methods section on pages 4 and 5.

6. **Minor Essential Revisions**: It appears that the observations were done at the end of the study and that there was not a before and after observation. If my understanding is correct, the authors should clarify why the observations were only done at the end of the study without a baseline.

   This is indeed a limitation of the study, and we have added this to our limitations section on page 14, lines 7-13.

7. Additionally, Table 2 on observations needs to be labeled as to when the observations were performed. It appears from these observations in Table 2 that none of the services observed were integrated.

   We have now labelled this.

8. **Discretionary Revisions**: The text does not clearly indicate the definition of the less integrated and more integrated facilities. I think if the methods section is clarified this section on less and more integrated will be more meaningful.

   We have clarified our definition of these categories in the methods section – this is on Page 7, lines 7-18.