HIV integration with Family Planning and Reproductive Health in Rwanda

Anicet NZABONIMPA, MD

FP/HIV Integration-MOH

2011
• Pronatalist mind (1994 genocide)

• >40% health centers are faith-based

• High cultural value # of children
  – Fertility rate: 4.6, DHS 2010

• Generalized HIV epidemic
  – 3% prevalence in general population
  – 4.3% among pregnant women

• Limited access to FP-RH services
  – For youth/adolescents
  – During week-end
  – At workplace

• Rapid scale up of HIV services
  – PMTCT, VCT and ART
  – Integration with FP-RH-MCH
Concept of integration

Goals:
• To increase the utilization of health services especially related to MCH
• To support FP and HIV/AIDS programs operating effectively

Objectives:
• To reach > 1 client at the same time
• To provide > 1 service at the same time, in the same place and by the same provider
To simplify the patient flow at the health facility level
Provide a comprehensive care to the clients
Strategic Domains

- Policy
- Planning and advocacy
- Training/Education/Sensitization
- Tools development guidelines
- Reorganization of services/patient flow
- Supply/Commodity management system
- Coordination
- Monitoring and Evaluation
Review of Existing documents and Tools

- Integration of HIV messages into all MCH documents (policies, protocols, manuals, norms, ...)
- Integration of FP indicators in HIV tools
- Integration of FP, HIV, Immunization and Nutrition activities:
  - HIV prevention messages, FP methods delivered to mothers during Mother and Child Week, 2 times in year
  - Exposed infant follow up integrated in Immunization card
  - Immunization booklet integrating the Exposed Infant Follow up
  - Handbook on FP integration into other MCH services
  - FP Screening tool for HIV+ people
Education and Sensitization

• To build capacity at all levels in FP/HIV and RH (public and private, HF and community, local authorities, opinion leaders and NGOs)

• Use of mass media for popular mobilization: Public and Private
  – RH in general (FP, HIV, SGBV, MCH programs)
  – Education against rumors on RH (including FP, HIV)

• Messages on RH(double protection) placed on buses used by public and private transport companies
Providing FP methods with other services?

<table>
<thead>
<tr>
<th>Point of services</th>
<th>FP services</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>A</td>
</tr>
<tr>
<td>Maternity, Postnatal care</td>
<td>A, (IUD in post-partum?)</td>
</tr>
<tr>
<td>Immunization + Exposed infant follow-up + VCT, PMTCT</td>
<td>A, B</td>
</tr>
<tr>
<td>Pre ART and ART(HIV clinic)</td>
<td>A, B, C</td>
</tr>
</tbody>
</table>

A- Counseling and referral
- Counseling on FP
- Referral to FP unit

B- Short-term FP methods
- Pills
- Condoms
- Injections

C- Long-term FP methods
- Implants
- IUD

D- Sterilization
- Tubal ligation
- Vasectomy
## Providing HIV Services in other activities?

<table>
<thead>
<tr>
<th>Point of services</th>
<th>HIV services</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC, FP, Youth services</td>
<td>Counseling, Testing</td>
</tr>
<tr>
<td>Maternity, newborn care</td>
<td>Counseling, Testing, C&amp;T</td>
</tr>
<tr>
<td>Immunization + Exposed infant follow-up, Nutritional centers</td>
<td>Counseling, Testing, C&amp;T</td>
</tr>
<tr>
<td>Hospitalization(PIT, TB)</td>
<td>Counseling, Testing, C&amp;T</td>
</tr>
</tbody>
</table>
Community involvement

• Community Based Distribution of FP-RH products at village level by CHWs:
  – Education for BCC
  – Condom promotion and distribution
  – Pills provision
  – Injectable provision

• Coordination
  – Health Community desk in MCH/MOH
  – Staff in charge of Community program at each Health Facility
  – CHWs are elected among population in general elections
  – Integration of HIV and FP aspects in the training manual of Community Health Workers (CHWs)
Accessibility to RH services for youth and adolescents

- Create youth corners in health facilities
- Extend RH services to youth friendly activities at all levels including YFCs
- Integrate RH in schools curriculum
- Make available services at high schools
- Create linkage between schools administration, health facilities, local administration and parents’ networks

Trend in Fertility

TFR for women age 15-49 for the 3-year period preceding the survey

RDHS 2005: 6.1
RIDHS 2007-08: 5.5
RDHS 2010: 4.6
Current Use of Modern Methods

Percentage of currently married women using any modern method

<table>
<thead>
<tr>
<th>Method</th>
<th>RDHS 2005</th>
<th>RIDHS 2007-08</th>
<th>RDHS 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any modern method</td>
<td>10</td>
<td>27</td>
<td>45</td>
</tr>
<tr>
<td>Pill</td>
<td>2</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Injectables</td>
<td>5</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Implant</td>
<td>&lt;1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Male condom</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
New supportive strategies in Rwanda

- Strong community-based program: CHWs managed and supported trough cooperatives
- Community based health insurance (CBHI) for all
- HIV and FP related services: free of charge
- Evaluation of Performance contract at all levels
- Performance based financing (PBF) in Health Sector at all levels: MOH, HF, Community(CHWs and Clients)
- Integration of MCH services; ie MCH week twice a year
- MCH technical working group and Sub groups: Nutrition, FP, Community, SGBV,
  Maternal and child death audit in HF's and in community.
Thank you very much

Merci beaucoup
Public sector perspectives on FP/HIV integration in Kenya

By Dr. Shiphrah Kuria

Division of Reproductive Health, Ministry of Public Health & Sanitation
Presentation Outline

- Background Information
- Objective/Justification
- Implementation
- The evaluation
- Results (provider perspectives)
- Next steps
- conclusion
Background

- Population: 40 million\(^1\)
  - 64% below 24 yrs
- HIV prevalence 6.8%
  - Women 8.4\(^2\)
- CPR 46%, TFR; 4.6
- FP unmet need 25%
- FP unmet need for HIV infected; 50\(^3\)

\(^1\)Census 2009; \(^2\)KAIS 2007; \(^3\)KDHS 2008-9
Why integration

• Improved access to the services
• Reduce missed opportunity
• Increase the uptake of the key services
• Reduce unmet need for FP especially for the infected
• Leverage on resources especially for FP/MNCH
Integration of RH and HIV services in Kenya began in 2002. A strategy for the integration was developed in 2007. The strategy was launched in 2010 to provide the framework for coordinated integrated services.
Implementation

• Two modes;
  – On stop shop; services offered by one service provider in one room during the same consultation
  – One stop supermarket; services offered by several service providers (in several rooms) under one roof during the same consultation

• Minimum package defined
Implementation

• Dissemination in the regions

• Orientations and capacity building ;
  – Trainings, OJT, mentorship, job aids

• Supplies provision;
  – FP commodities, HIV test kits, registers, tools

• Re organization/renovations of clinics

• Social Mobilization;
  – outreaches, health talks
The assessment

- Public service providers in all the regions
- Providers acknowledged benefits of integration
- Had reservations on feasibility
- shared challenges in their perspective
Provider Perspective; benefits

• Broader range of clients attracted
• Reduced patient time in the facility
• Increases efficiency
• Reduces stigma
• Closer provider relationship
• Holistic approach
Provider Perspective; challenges

• Time-consuming

• Increased workload

• Prolonged client stay at the health facility
Provider perspectives; Challenges

• Human Resource
  – Inadequate skills
  – Poor deployment
  – Shortage

• Infrastructure (space, equipment)

• Poor collaboration and PPP

• Commodity insecurity
Provider Perspective; Barriers

- Inadequate male partner involvement
- Insufficient monitoring & evaluation systems
- Lack of ownership of integration program
- Inadequate collaboration and PPP
Next steps

• Accelerate Implementation of the minimum package

• Build capacity for supplies chain management

• Continue capacity building for service providers

• Strengthen support supervision
Conclusion

• Despite challenges integration is feasible and beneficial

• Must be evidence based

• It is important to fully involve the health workers for buy in and full benefits
At sunrise everything is luminous but not clear.

-Norman Maclean-
INTEGRATION OF FAMILY PLANNING SERVICES INTO HIV CARE AND TREATMENT IN NYANZA PROVINCE, KENYA: A CLUSTER RANDOMIZED TRIAL

Dr. Maricianah Onono
Nyanza Research Coordinator
KEMRI
FP/HIV Integration Study: AIM

Does an integrated model of FP provision at HIV care & treatment centers better address the FP needs of HIV-infected people than the existing non-integrated model?
STUDY SITES & POPULATION

- 18 Rural Health Facilities in Nyanza province
- Randomization done in ratio of 2:1
- Fully integrated to standard referral

Total population
- 18959: integrated
- 12612: referral (control)
DEFINING INTEGRATION IN THE STUDY

- At “intervention” sites clients will then be extensively counseled about contraception and will be provided any needed contraceptive methods on site.

- At “control” sites, clients will be provided with contraceptive services through the centers’ standard mechanisms, which generally involve referral to an affiliated family planning program that may or may not be on-site.


**STUDY TIMELINE**

### Phase 1
**Baseline Data**
(3-6 months)
Baseline data on contraceptive use and unintended pregnancies
(Completed)

### Phase 2
**Design**
(3 months)
**Intervention**
(Completed)

### Phase 3
**Intervention Implementation**
(3 months)
Implement FP Integration 12/18 sites
(Completed)

### Phase 4
**Follow-Up**
(12 months)
Data abstraction:
Contraceptive use and unintended pregnancies
(Ongoing)

**Provider Interviews**
(Completed)
**Client Interviews**
(Completed)

**Client Interviews**
(Completed)
**Provider Interviews**
(Completed)

Training to strengthen FP/HIV integration at already integrated sites
FP/HIV INTEGRATION: 4-PRONG MODEL

- MOH Collaboration
- Knowledge Attitude and Practice Surveys
- In-depth interviews with providers and clients

FP/HIV Integration

- Community Education
- Capacity Building of HCW
- Logistical Support & Supervision
- Monitoring & Evaluation
PRONG 1: COMMUNITY EDUCATION

- Education
  - Community and Clinic Health Assistants provide FP health talks in HIV clinics

- Information, Education, and Communication
  - Culturally-sensitive materials
  - Posters
  - Pamphlets
  - Demonstration kits with available FP methods

- Community Advisory Groups in each district
PRONG 2: CAPACITY BUILDING OF HEALTH CARE PROVIDERS

- On-the-job training using the Family Planning National Orientation Package for HIV Service Providers

A trained nurse offering FP counseling during World Contraception Day
TRAINING MODULES FOR HEALTH CARE PROVIDERS

- Clinic logistics (flow of clinic, roles of staff)
- FP services for HIV-infected clients
- Effective contraceptive counseling
- Overview of FP methods
- Safety and Infection Prevention
- Implants and IUCDs
  - Medical eligibility
  - When and how to insert
  - Side effects and proper management
  - Video of insertion and removal
  - Practical training using booked clients
**Provider Knowledge**

- **Kisumu East**
  - Pre Test: 56%
  - Post Test: 78%

- **Nyatike**
  - Pre Test: 62%
  - Post Test: 83%

- **Rongo**
  - Pre Test: 68%
  - Post Test: 84%

- **Suba**
  - Pre Test: 48%
  - Post Test: 71%

Legend:
- Blue: Pre Test
- Red: Post Test
PRONG 3: LOGISTICAL SUPPORT & SUPERVISION

- Logistical support
  - Ensure adequate supply of commodities and equipment, proper documentation and reporting

- Supportive supervision & mentorship
  - Improve clinic flow (including clinic reorganization) on FP counseling and provision
PRONG 4: MONITORING & EVALUATION

- Provider Client observations
- Integration assessments
- Knowledge, Attitudes and Practices (KAP) surveys with providers and clients
- Cost Analysis
## Integration Assessments

- Facility inventory every 3 months
  - Trained staff
  - Services available
  - Infrastructure
  - Equipment
  - Supplies
- Clinic flow

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there at least one clinician working at the PSC today who has received trainings in * Pills and Depo?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there at least one clinician working at the PSC today who has received trainings in * IUCDs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there at least one clinician working at the PSC today who has received trainings in * Implants?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are PSC and outpatient services integrated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are CCHAs are available to assist clinician(s) today?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did CCHAs conduct FP health talk today?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Who provides FP counseling to PSC clients?                             | Same Provider | Someone else at PSC | Staff at MCH
TWO MODELS OF INTEGRATION

Kiosk
Small volume facilities
FP/HIV services provision in 1 room, by 1 provider

Supermarket
High volume facilities
1 room within HIV clinic for FP provision
VISIT FLOWSHEET FOR FULLY INTEGRATED FP AND HIV CARE AND TREATMENT

WALK IN: PSC

RECEPTION:
• Client gives appointment card to the receptionist
• Retrieve client files
• Put appropriate OpenMRS forms in the file

CCHA BENCH:
New clients: Enroll new clients
All clients:
• Collect and document vitals
• Complete required fields on Open MRS forms
• For clients interested in OR already on FP, flag PSC file with a blue sticker and pull FP file (or start a new one).
• Write PSC ID on FP file (upper right hand corner)

PSC WAITING BAY: Health talks by CCHAs

ANC referral
• Issue condoms

If pregnant

CLINICAL BENCH:
• Physical exam and history
• HIV care and management
If sexually active,
• Collect data on sexual history, FP, & obstetric history on OpenMRS forms
• Counsel based on physical exam, vitals, history, and FP desires
• Provide condoms
• If interested FP services, provide patient education, answer questions or concerns, and provide desired method
• If method is not available, refer to the nearest location using referral form
• If using FP services – complete FP file and register
• Schedule follow-up visit based on PSC and FP needs

Phlebotomist or Lab Tech
• Provide counseling on adherence to ARVs and timing of DMPA injections and oral contraceptive pills

Pharmacy

CCHA Bench
• Receive date for follow-up visit.
CHALLENGES

High MOH staff turnover and transfers, staff attitudes, Reluctant involvement of men

Inadequate/Inconsistent supply of FP commodities – Implants
Lack of space, cost of FP to patients

• Inadequately informed patients
• Limited method mix
Successes

Increased Contraceptive Awareness

- Increased Contraceptive Access
- Increased method mix

Collaboration with MOH & increased commitment

- Facility level
- District level
- Provincial level
- National level
ACKNOWLEDGEMENTS

- Bill & Melinda Gates Foundation
- TIDES Africa Fund
- Kenya Medical Research Institute (KEMRI)
- University of California San Francisco (UCSF)
- Ministries of Health (MOH (2))
- Division of Reproductive Health (DRH)
- National AIDS and STI Control Program (NASCOP)
THANK YOU!

It always seems impossible until it’s done.

Nelson Mandela
Evaluating integration of family planning services into HIV care and treatment in Nyanza Province, Kenya

Dan Grossman
December 2, 2011
Baseline data collection

- Mixed-method interviews conducted among 31 HIV care providers (not presented here)
- Baseline contraceptive knowledge, attitudes, and practices surveys conducted among 978 HIV-infected clients
- In-depth interviews conducted among 60 HIV-infected clients
- Analysis of clinic-based data on contraceptive prevalence
Fertility Desires

HIV+ clients not using more effective contraception* were asked whether they would like to have more children in the future.

**Women (n=358)**
- **53%**: Prefers no more children
- **21%**: Sooner than 2 years
- **16%**: Prefers to wait 2 years+
- **10%**: Other

**Men (n=402)**
- **49%**: Prefers no more children
- **21%**: Sooner than 2 years
- **12%**: Prefers to wait 2 years+
- **19%**: Other

*Hormonal, intrauterine, or permanent methods*
Desire to delay/end childbearing: Qualitative findings

- Deteriorating health
- Impaired immunity
- Premature death
- Perinatal HIV transmission
- Financial hardship
- Inability to care for existing children
- Provider counseling
- **Men:** often due to concerns over financial ability to care for children

“Having the HIV virus has brought fear in me; you see I am the sole caretaker of my children. This has affected me because HIV may kill me abruptly before my children become of age where they can take care of themselves.”
Reported Use of Family Planning Methods (self or partner)

More effective methods: Pills, injectables, Implants, IUCD, Tubal Ligation, and Vasectomy
Less effective methods: Condoms, natural family planning methods
No method reported

Women (n=450)
- 41% (Less Effective)
- 26% (More effective)
- 33% (No Method)

Men (n=485)
- 66% (Less Effective)
- 18% (More effective)
- 16% (No Method)
Correlates of highly effective FP method use among female clients

<table>
<thead>
<tr>
<th>Measure</th>
<th>% using effective method</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None or primary</td>
<td>34%</td>
<td>Ref</td>
</tr>
<tr>
<td>Secondary or more</td>
<td>67%</td>
<td>5.7 (2.5-13.0)</td>
</tr>
<tr>
<td>HIV status of partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive</td>
<td>38%</td>
<td>Ref</td>
</tr>
<tr>
<td>HIV-negative</td>
<td>45%</td>
<td>1.91 (0.8-4.8)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>34%</td>
<td>0.36 (0.18-0.75)</td>
</tr>
<tr>
<td>Fertility preference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desires child 0-12 months</td>
<td>16%</td>
<td>0.15 (0.05-0.5)</td>
</tr>
<tr>
<td>Desires child 13-24 months</td>
<td>29%</td>
<td>0.88 (0.2-4.4)</td>
</tr>
<tr>
<td>Desires child 2+years</td>
<td>43%</td>
<td>Ref</td>
</tr>
</tbody>
</table>

Controlling for age, SES measures, employment, marital status, ARV use, parity, number living children.
Factors that limited uptake of FP: Qualitative findings

- Health concerns
- Myths and misperceptions
- Distance to FP clinic
- Unreliable stock/staffing
- Women: partner opposition
- Men: services do not meet men’s needs

“On the day she went she didn’t get the services as the provider was away. When she went the next time she was still away, that happened on four different times then on the fifth visit she got the services.”

“You see us as men, our options are limited, it is the women who have variety of options to choose from..”
Receptivity to Integration

People not using more effective contraception* were asked: “Do you think you (females)/ your partner (males) would be more likely to use a family planning method like birth control if it were available here at the PSC (HIV clinic)?”

Women (n=359)

- Yes: 71%
- No: 27%
- Don’t Know: 2%

Men** (n=364)

- Yes: 22%
- No: 10%
- Don’t Know: 68%

* Hormonal, intrauterine, or permanent methods
** Partnered men
Baseline prevalence data from patient records: Dec '09 – Feb '10

<table>
<thead>
<tr>
<th></th>
<th>Female n = 2593 (%)</th>
<th>Male n = 1364 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current contraceptive use</strong></td>
<td>1273 (49.1%)</td>
<td>796 (58.4%)</td>
</tr>
<tr>
<td><strong>Current FP method</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any modern method</td>
<td>1179 (45.5%)</td>
<td>743 (54.5%)</td>
</tr>
<tr>
<td>Single method only:</td>
<td>1117 (43.1%)</td>
<td>729 (53.4%)</td>
</tr>
<tr>
<td>Condoms</td>
<td>751 (29.0%)</td>
<td>670 (49.1%)</td>
</tr>
<tr>
<td>Injectables</td>
<td>281 (10.8%)</td>
<td>41 (3.0%)</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>36 (1.4%)</td>
<td>7 (0.5%)</td>
</tr>
<tr>
<td>Oral Contraception</td>
<td>22 (0.8%)</td>
<td>6 (0.4%)</td>
</tr>
<tr>
<td>Implants</td>
<td>16 (0.6%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>IUCD</td>
<td>6 (0.2%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>Two or more methods</td>
<td>62 (2.4%)</td>
<td>14 (1.0%)</td>
</tr>
<tr>
<td>Abstinence only</td>
<td>9 (0.3%)</td>
<td>7 (0.5%)</td>
</tr>
<tr>
<td>Other only</td>
<td>16 (0.6%)</td>
<td>2 (0.1%)</td>
</tr>
</tbody>
</table>
Design of cluster randomized trial

• 18 clinics in Nyanza Province, Kenya
• Stratified based on size
• Randomized in 2:1 ratio
  – 12 integrated FP into HIV services
  – 6 control sites where clients requesting FP at HIV clinic were referred to MCH clinic
FP Study

Phase 1
Baseline Data
(3-6 months)

Phase 2
Design Intervention
(3 months)

Phase 3
Intervention Implementation
(3 months)

Phase 4
Follow-Up
(12 months)

Client and Provider Interviews
Contraception and pregnancy data abstraction

Endline Client and Provider Interviews
Contraception and pregnancy data abstraction
Outcomes of cluster RCT

• **Primary:** contraceptive prevalence; prevalence of use of highly effective contraceptives
  (source: clinic records)

• **Secondary**
  - Unintended pregnancy rate (source: clinic records)
  - Knowledge of contraceptive methods
    (source: endline KAP survey)
  - Satisfaction with FP services (source: endline KAP survey)
  - Incremental cost (or savings) associated with integrated model (source: cost study)
Dissemination plan

- Baseline findings submitted (or will soon be submitted) for publication
- Results of cluster RCT expected in mid-2012
- Planning East Africa conference for Sept/Oct 2012
INTEGRATION FOR IMPACT
REPRODUCTIVE HEALTH & HIV SERVICES
IN SUB SAHARAN AFRICA

September 12th - 14th, 2012

www.integration2012.org

Nairobi, Kenya - Safari Park Hotel

www.safaripark-hotel.com