

# Integrating Family Planning Services into HIV Care and Treatment Clinics through the Facilitated Referral Model

**BACKGROUND:** In 2006, an FHI assessment of HIV care and treatment clinics (CTCs) in areas of Tanzania found high levels of unmet need for family planning (FP) among sexually active female clients. As part of its response to this finding, the Tanzania Ministry of Health and Social Welfare (MOHSW) targeted the CTC as a platform for offering FP services. In 2008, the National AIDS Control Programme (NACP) and the Reproductive and Child Health Section (RCHS) of the MOHSW requested FHI's assistance to develop and test a facilitated referral model to integrate FP and HIV care and treatment services through CTCs. FHI collaborated with the MOHSW to implement the model with funding from the Tides Foundation.

## KEY POINTS

An analysis of the facilitated referral model at 12 study facilities in Tanzania found that it had a positive overall effect on family planning (FP) use among CTC clients and that FP/HIV integration through CTCs can boost method use.

Despite the achievements of the facilitated referral model, flaws in implementation were found, including inconsistent client screenings, discrepant reports on how often clients were accompanied to FP services, and incomplete tracking of FP referrals.

Adherence to the model can be advanced by simplifying the screening procedure, reviewing the process of accompanying clients, and moderating the workload demands documented by facility staff.

## Methods

Facilitated referrals are enhanced referrals for additional health services that consist of specific actions designed to aid referral completion. The facilitated referral for this model included seven service delivery steps (Figure 1). Implementation involved 12 facilities in the Iringa and Morogoro regions, selected for high client loads and co-location of CTCs with FP clinics. Prior to the intervention, each facility received a site visit from FHI and MOHSW staff to collaborate on site-specific model implementation.

In September 2009, 69 CTC and FP staff from the 12 study facilities attended the intervention trainings led by MOHSW master trainers. Trainings covered the facilitated referral model, screening for FP need, and FP counseling for women with HIV/AIDS. Supervisors received additional training on supportive supervision. In November 2009 and January 2010, MOHSW and FHI staff completed supportive supervision visits to each facility to provide feedback and resolve any potential concerns.

## Evaluation

With funding from the U.S. Agency for International Development (USAID), FHI partnered with the Muhimbili University of Health and Allied Sciences (MUHAS) to evaluate the facilitated referral model implementation. The evaluation was designed to assess the effectiveness, feasibility, process, and cost of the intervention.

The evaluation was a quasi-experimental, pre- and post-test, cross-sectional study design. CTC clients, CTC and FP providers, and CTC and FP supervisors were interviewed at the 12 study facilities. The baseline surveys took place in August 2009. After five months of implementation, the post-intervention surveys were held in February 2010. Data were collected to calculate the costs of the intervention activities relevant to scale-up.

## Figure 1: Service delivery steps of the CTC/FP facilitated referral model

1. **Screen:** CTC staff screen all female CTC clients for their fertility intentions and current FP use to determine the risk of unplanned pregnancy.
2. **Counsel:** Depending on clients' fertility intentions, CTC staff provide counseling either on FP options or safer pregnancy and ways to minimize HIV transmission to an infant.
3. **Refer:** CTC staff provide a referral for FP services using a CTC referral form.
4. **Record:** CTC staff record the referral in the CTC patient record form using codes in the "Pregnant" and "Referred To" columns.
5. **Accompany:** A CTC staff member or other staff trained in service integration and client confidentiality accompanies a CTC client to the FP clinic.
6. **Access:** A CTC client accesses and receives FP services in a timely manner.
7. **Monitor and follow up:** CTC and FP staff monitor and follow up on referrals and services through monthly meetings and tracking of completed referrals.

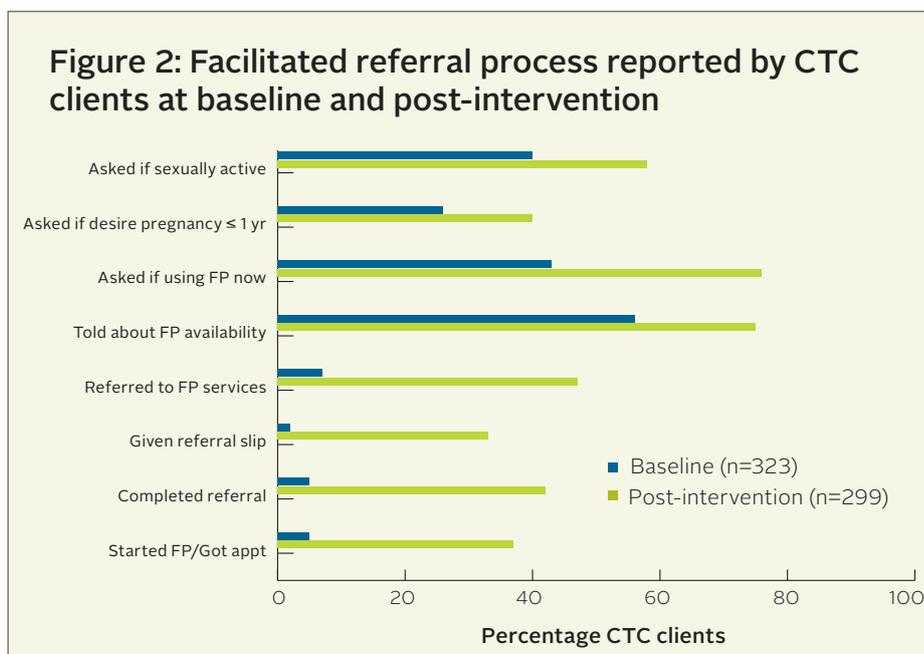
An analysis of the model implementation found that the facilities successfully implemented the seven steps of the facilitated referral model (Figure 2). As a result, it had a positive effect on FP use among CTC clients in the 12 study facilities. Method-specific FP use increased among recently sexually active clients, especially injectable and pill use. Reported consistent condom use increased, and dual-method use more than doubled. There was a decrease of 4 percent in unmet need for FP; however, this decrease was not statistically significant even when additional factors (e.g., facility type and WHO stage of HIV progression) were adjusted for.

Also, CTC clients reported more screening for unmet need and discussing all FP methods with their CTC providers. After the intervention, 40 percent more clients received referrals and half of referred clients reported being accompanied by CTC staff to FP services. Ninety percent of referred clients received a method and 80 percent acquired the method the same day of their referral. Finally, clients said they faced few problems accessing FP services, although 25 percent of clients said that the FP clinic was too busy.

CTC and FP staff found their main challenges in carrying out the facilitated referral model were "shortage of staff" (43 percent) and "additional workload" (28 percent). They also suggested a longer training period to improve the intervention outcomes. Both CTC and FP staff suggested that FP services should be available in the CTC. Clients also preferred to receive future FP services in the CTC, either from CTC providers (48 percent) or by FP providers located within the CTC (33 percent).

Notwithstanding the achievements of the facilitated referral model, there were flaws in implementation. For example, not all CTC clients were screened at every visit, and not all of the questions on the screening job aid were used during some screenings. Most clients with unmet need were not properly identified during the screening process, and only 17 percent received an FP referral. CTC clients and providers gave differing reports on how often clients were accompanied to FP services. Also, 30 percent of CTC providers were not tracking their screening and referrals on the patient record forms.

A majority of CTC providers reported that the facilitated referral model increased their workload (60 percent) and time spent with their female clients (62 percent). FP providers noted that integrating services increased their overall workload, thereby increasing the use of FP commodities and



supplies. Despite these increases, few providers characterized them as the main challenges to implementation.

**Intervention Costs**

Total costs of the intervention relevant for scale-up—facility site visits, the provider training, and supervision visits—were TZS 39,726,686, or an average cost of TZS 3,310,557 per facility (approximately US\$2,185). These interventions also required a total of 297 person-days of facility staff time and 164 person-days of MOHSW non-facility staff time. (New service delivery practices did not require providers to spend additional time at the facility.) According to service statistics reported over a five-month period in 11 facilities, there were 643 new acceptors of modern FP methods—other than condoms—or 11.7 new acceptors per facility per month. This equates to a cost of approximately TZS 61,783 per new FP acceptor (approximately US\$41), not including staff time.

**Recommendations**

This facilitated referral model increased FP referrals and method use among CTC clients attending the study facilities. Although the results were mainly positive, several issues with the model and general service delivery need to be addressed before considering scale-up to additional facilities.

Implementation must be simplified and this work should begin with the screening process. Client screening should be streamlined and applied more consistently to better identify those with unmet FP need. The process of accompanying clients should be reviewed, as only half of referred clients reported being

escorted to their referral. Moderating the time and workload demands mentioned by the facility staff may also boost adherence to the model. Next, ensuring that there are adequate supplies of FP methods will facilitate successful referral completion. To help providers feel better prepared to implement integrated services, the service provider training should be modified. Also, the standardized system for monitoring FP referrals must be maintained, because variations were evident in how the systems were applied.

About four out of five CTC clients indicated that they were most interested in receiving FP services from the CTC. CTC and FP staff suggested shifting FP services to the CTC to improve the model and integrated services. However, shifting FP services may not alleviate many of the main challenges identified by facility staff, and a balance must be found that addresses the needs of CTC clients, the increased service and resource demands on the CTC providers and their facilities, and the costs of implementing integrated FP and HIV care and treatment services.

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