Integrating family planning into HIV voluntary counselling and testing services: feasible and acceptable in Africa

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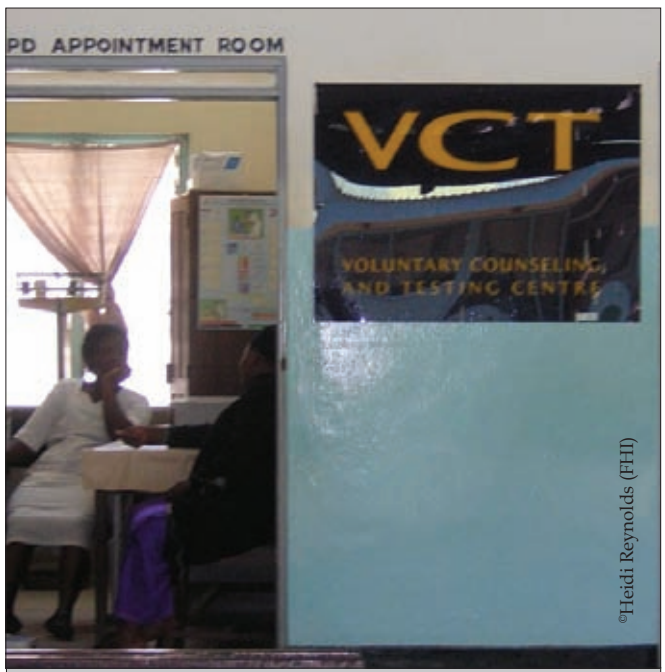
In most settings, family planning and HIV/AIDS services have traditionally been offered through separate, vertical programmes. Family planning services have primarily targeted married women of reproductive age, while HIV/AIDS services have targeted men and women at high risk of HIV infection. But service integration has potential benefits such as allowing more comprehensive services and expanding access to services.

Integrating family planning into HIV/AIDS services, in particular, offers a rare opportunity to reach people with contraceptive needs who may not normally visit a family planning clinic. It can, therefore, also prevent unintended pregnancy and avert mother-to-child transmission of HIV.

As efforts begin to shift toward such integration, voluntary counselling and testing (VCT) centres are emerging as primary targets for integration. VCT services have become one of the most common means of preventing, detecting, and improving access to care and support for HIV/AIDS. And VCT services are expanding with support from the 5-year US President's Emergency Plan for AIDS Relief, which focuses on fighting the HIV/AIDS epidemic in 15 resource-poor countries, mostly in Africa.



Integrating family planning into HIV voluntary counselling and testing (VCT) services is an opportunity to help prevent unintended pregnancy and avert mother-to-child transmission of HIV. Shown is a nurse at a VCT centre at Kilifi District Hospital, Coast Province, Kenya.

The idea of integrating family planning into VCT services is still relatively new, and, generally, implementation is just beginning. But two particular experiences from Africa have shown that such integration is feasible and acceptable, and large-scale integration efforts have been launched and expanded there.

The Uganda experience

One of the first and best-known examples of integrating family planning into VCT services involves the AIDS Information Centre (AIC) in Uganda. Opened in 1990 as a single site offering only VCT, the AIC now offers VCT integrated with multiple reproductive health services to thousands of clients each year at six main sites. Receiving about 250 clients daily at these sites, the AIC is one of the largest non-governmental providers of VCT services in the country.

First provided at the main Kampala facility in 1993, family planning services have been offered at branches in the cities of Jinja, Mbarara, and Mbale since 1995. A typical visit to one of these branches includes pretest counselling, HIV testing, HIV prevention counselling, delivery of test results obtained on-site, and post-test counselling, all in a single visit lasting from 45 to 90 minutes. Counsellors mention the AIC's family planning services in both pretest and HIV prevention counselling, where they also demonstrate correct condom use. During post-test counselling, counsellors offer free condoms and advice on how to negotiate condom use. Reproductive health volunteers are also in the waiting room throughout the day, providing family planning information, identifying particular family planning needs, and referring clients to counsellors who can meet those needs. Male and female condoms, spermicides, diaphragms, oral contraceptives, and injectable contraceptives are all provided at the AIC. If clients request other methods, they are referred to other centres.

The impact of integration on AIC clients' reproductive health has not been assessed. But data from the AIC indicate that condoms are the most popular contraceptive method, with almost a third of family planning clients using condoms plus another, more effective method for dual protection against unintended pregnancy and HIV infection.[1] Demand for family planning has increased over time, and approximately 8% of clients at the four main sites offering family planning services accessed those services in 2002.[2]

The Kenya experience

The Uganda experience demonstrates the feasibility and acceptability of integrating family planning into VCT services. But more evidence of these services' effectiveness in responding to the contraceptive needs of clients without detracting from HIV services has been needed. Family Health International and partners recently conducted operations research to help generate such evidence.

Kenya is a promising setting for integration because its Ministry of Health already has an ambitious programme to expand VCT services. Nearly 300 VCT centres have been registered, and Kenya is one of few countries to have developed country-specific VCT guidelines. The government also recognises the benefits of family planning; Kenya was identified in a recent analysis as one of six countries to mention family planning in its VCT guidelines.[3]

With technical assistance from Family Health International and AMKENI (a national service delivery project led by EngenderHealth) and in collaboration with other partners, the Kenya Ministry of Health developed and in 2002 began implementing a national strategy to provide family planning services at all VCT centres in the country.[4] The strategy highlights four potential levels of integration, each contingent on available resources at individual facilities. The first level includes — in addition to traditional VCT services — the provision of basic pregnancy risk assessment and counselling services and the availability of oral contraceptives and condoms on-site. The fourth level, in which all contraceptive methods are available on-site, is viewed as a long-term goal since it would require enormous additional resources for most centres.[5]

The operations research was conducted between August 2004 and March 2005 to evaluate the effects of an integration intervention among 14 VCT centres that offered at least the first level of integration.[6] The intervention included advocating integration and sensitising stakeholders to its benefits, developing an integration training curriculum, training VCT providers in integration, and making supervision visits to trainees for added support.

Family planning data were collected both before the intervention (June 2004) and after the intervention (April/May 2005) through observations of nearly 700 client-provider interactions and nearly 900 interviews with VCT supervisors, providers, and clients. The following are among the major findings:

- After the intervention, providers were significantly more likely than they were at baseline to discuss a client's desire to have more children. They were also more likely to discuss family planning with their clients and significantly more likely to counsel them about family planning services that were available outside of the VCT centres.
- More clients chose a contraceptive method and providers offered clients their method of choice more often at follow-up than at baseline, but these differences were not statistically significant.
- VCT quality of care was relatively unchanged between baseline and follow-up. The mean length of counselling sessions and the mean waiting time for clients to see a provider increased slightly, but neither difference was statistically significant. Also, providers and clients agreed that the addition of family planning services either did not change or improved VCT quality of care.
- Nearly a third of VCT clients were found to be at risk of unintended pregnancy. Approximately 8% of women who visit VCT centres were also estimated to be infected with HIV and be at risk of unintended pregnancy.

Although a large proportion of VCT clients were at risk of unintended pregnancy, the intervention did not significantly increase contraceptive method choice and distribution. These and other results have important implications for scaling up integration in Kenya and for informing integration efforts elsewhere. Future advocacy efforts should stress the large proportion of VCT clients at risk of unintended pregnancy, and trainings and supervisions should develop provider skills in screening for pregnancy risk so that providers can target counselling on informed choice to clients who need it. And, because the level of intervention implementation was low, VCT quality of care and contraceptive method choice, distribution, and uptake should be closely monitored as integration efforts strengthen.

References

1. Joint United Nations Programme on HIV/AIDS (UNAIDS). *Knowledge is Power: Voluntary HIV Counselling and Testing in Uganda. UNAIDS Best Practices Collection.* Geneva, Switzerland: UNAIDS, 1999.
2. AIDS Information Center (AIC). *Annual Report 2002.* Kampala, Uganda: AIC, 2002.
3. Strachan M, Kwateng-Addo A, Hardee K, et al. *An Analysis of Family Planning Content in HIV/AIDS, VCT and PMTCT Policies in 16 Countries. POLICY Working Paper Series No. 9.* Washington, DC: The Futures Group, 2004. Available: http://www.policyproject.com/pubs/workingpapers/ws-09.pdf.
4. Family Health International (FHI). *FHI Briefs: Integrating Family Planning and Voluntary Counseling and Testing Services in Kenya.* Research Triangle Park, NC: FHI, 2004. Available: http://www.fhi.org/en/RH/Pubs/Briefs/VCTKenya.htm.
5. Kenya Ministry of Health. *Strategy for the Integration of HIV Voluntary Counseling and Testing Services and Family Planning Services.* Nairobi, Kenya: National AIDS and Sexually Transmitted Disease Control Program and Division of Reproductive Health, 2004.
6. Reynolds H, Liku J, Gitau M, et al. *Integrating Family Planning Services into Voluntary Counseling and Testing Centers in Kenya: Operations Research Results.* Research Triangle Park, NC: Family Health International, 2006. Available: http://www.fhi.org/en/RH/Pubs/booksReports/FPVCTKenya.htm.

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