



# GHAIN SUPPORT TO RH-HIV INTEGRATION IN NIGERIA

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## INTRODUCTION

**N**igeria, with a population of more than 150 million, has the highest number of people living with HIV in West Africa and the 3rd highest number of HIV positive individuals worldwide. Nigeria's HIV prevalence was an estimated 4.1% among antenatal clinic attendees in 2010 (FMOH, 2010). The country's contraceptive prevalence rate for modern methods among married women remains low (10%) and unmet need for contraception is high (20 %) (NPC, 2009).

There is broad international consensus that linking family planning (FP) and HIV services is essential for meeting international development goals and targets, including the United Nations Millennium Development Goals. Family planning reduces the number of unintended pregnancies and abortions, improves maternal and infant health and also prevents vertical transmission of HIV. Family planning services which include family planning information, counselling and provision of a FP method, has been shown to be a cost-effective addition to prevention of mother-to-child transmission (PMTCT) programmes. Integrating services also provides the opportunity to increase male and youth involvement in reproductive health and HIV services.

As access to antiretroviral treatment has substantially increased, HIV infected clients - many of whom are married or cohabiting with their partners - are living longer and feeling better. HIV providers are finding repeat unintended pregnancies among PMTCT clients and unintended pregnancies among ART clients in their programs. The integration of FP and HIV services is an evidence-based approach to averting unintended pregnancies of HIV clients (Kennedy CE, et al, 2010). HIV providers should be equipped with the skills and knowledge to discuss fertility desires and contraceptive methods for women and couples with HIV. Moreover, linking family planning with voluntary HIV testing and counseling (HTC) services expands access to FP to both HIV positive and negative clients, reaching a segment of the population that may not attend traditional family planning services, such as men or sex workers.

Prior to integration efforts in Nigeria, HIV and FP services have been provided separately in the same facility. HIV services were provided in one unit by a set of providers and FP services were provided in a separate unit by a different set of providers. The number of providers in each facility varied depending on its size, and it was not uncommon for the same providers to multi-task in several units such as provide ANC, PMTCT and FP services.

In 2004, USAID/Nigeria provided the Global HIV/AIDS Initiative of Nigeria (GHAIN) project funding to support the provision of integrated FP and HIV services. Family planning in the context of FP-HIV integration in Nigeria is commonly referred to as reproductive health and HIV in integration. GHAIN then supported the provision of integrated RH-HIV services in 141 facilities across Nigeria.

## GHAIN RH-HIV STRATEGY

GHAIN's strategy for integration of HIV and RH services targeted three objectives:

1. Create an enabling environment for integrated RH/HIV services;
2. Improve the capacity of HCWs to provide integrated RH and HIV services; and
3. Improve provision and uptake of RH/HIV integration services in project sites.

It was expected that this strategy will increase access and uptake of reproductive health services

During Year One of the project, GHAIN focused on designing a program to best meet the holistic reproductive health needs of uniformed services personnel and their dependents. This was accomplished by building relationships among three major bilateral health programs: 1) GHAIN; 2) Enabling HIV & AIDS, TB and Social Sector Environment Project (ENHANSE); and 3) Community Participation for Action in the Social Sectors (COMPASS). Progress during the first year was slow, since each bilateral partner had already invested heavily in designing their specific work plans and meeting their first year deliverables. As a result, Year One activities focused on mobilizing partners to support and commit resources to an integrated demonstration project for uniformed services.

In the second year, GHAIN concentrated on supporting the Federal Ministry of Health (FMOH) to identify, develop and implement the most appropriate RH-HIV integration model for Nigeria. In January 2006, the FMOH, with assistance from GHAIN and other partners including ENHANSE, began this process by convening an Integration Technical Working Group (ITWG) to explore opportunities for integrating services to provide better care for clients. The ITWG met biannually and was composed of representatives from the FMOH, members of academia, GHAIN, Packard Nigeria and other NGOs. Next, a rapid programmatic assessment was conducted to gather strategic information to assist the FMOH in defining a way forward to offer integrated HTC and FP services.

Drawing from results of the programmatic assessment and FHI's lessons learned in the integration of family planning into HIV Testing and Counseling (HTC) in Kenya, the FMOH developed national guidelines for reproductive health and HIV service integration. The guidelines provided state-of-the-art and standard practices in integration of RH and HIV services. The national guidelines for RH-HIV integration were presented to national stakeholders and finalized and adopted in August 2007. Existing monitoring and evaluation tools were also adapted to capture HIV referrals within the FP unit and presented to the ITWG.

Also during Year Two, GHAIN developed a work plan to establish a demonstration project for integrated RH and HIV services in four uniformed services' medical facilities, located in Abuja and Lagos. The plan built upon the complementary strengths of the GHAIN and COMPASS programs as well as the US Department of Defense, and offered an important opportunity for testing integrated services models among the uniform services.

GHAIN further expanded its RH-HIV integration efforts in Year Three; the project reprogrammed funds to support broader RH-HIV integration efforts within a selection of GHAIN supported HIV/AIDS care and treatment service points. The availability of funds increased FHI's ability to quickly respond to both new and existing opportunities for integrating RH and HIV services within USAID-funded programs in Nigeria. This allowed GHAIN to play a key leadership role in supporting innovative programming efforts for RH-HIV integration.

At the facility level, the RH-HIV integration strategy included two main models: the one-stop shop model and referral-based model. At sites operating the one-stop shop, FP providers had the capacity to provide both FP and HIV testing and counseling services during the same visit at family planning clinics. On the other hand, in sites operating the referral-based model, FP providers offered FP services and HIV counselling only (not HIV testing) and referred clients to a separate co-located HIV testing unit within the same facility. In addition, providers at HIV service points (ART, PMTCT and HTC) offered family planning information and referred consenting clients to the FP clinic for the full range of FP services.

Regardless of the model, both approaches included integration of FP and HIV testing and counseling services; strengthening the FP component of PMTCT programs; and addressing the FP needs of HIV positive clients (including those on ART) in GHAIN's HIV care and treatment and FP referral sites.

GHAIN developed a RH-HIV integration package of services, which included a range of advocacy/sensitization, training, and technical support activities:

#### **Advocacy to key stakeholders.**

GHAIN staff led advocacy efforts targeting hospital management and state and LGA health officials across the country. These advocacy visits aimed to create awareness of RH-HIV integration and thus stimulate a buy-in and ownership of RH-HIV integration amongst key stakeholders and partners at the state, facility and community levels.

#### **Training and sensitization of health care workers.**

To strengthen capacity for provision of quality services, trainings and on-site sensitization meetings were held. In addition to building the skills of service providers to provide



integrated RH-HIV services, these activities also helped to address quality improvement audit issues on documentation and family planning commodities. Health care workers from both FP and HIV service delivery points (ART, PMTCT and HTC) were trained on the delivery of quality integrated services. In addition, FP providers in facilities implementing the one-stop-shop model receive on the job training on HIV testing and counselling.

GHAIN also began training community based workers in 2010. These workers provided community based FP and HIV information, made referrals to higher levels and mobilized their communities to attend the local health center for FP and HIV testing and counseling services.

#### **Minor renovation and provision of supplies.**

Some facilities received minor renovations, such as partitioning of general clinic space, painting of clinic walls, and provision of furniture, fans, air conditioners, cupboards and examination couches. All FP clinics were provided with basic FP supplies including speculums, lamps, IUCD insertion kits and other equipment.

#### **Mentoring and supportive supervision including ensuring compliance with USAID's statutory and policy requirements.**

GHAIN staff provided mentoring and supportive supervision at all supported sites once a quarter. GHAIN's mentoring package included guidance to facility staff at both FP and HIV service points. At the FP unit, staff were advised on effective approaches for integrated FP and HIV counselling, provision of condoms, proper documentation in the FP-HIV registers, completing referral forms, and tracking the referral feedback loop to ensure completed referrals between FP and HTC. At HIV service points, providers were encouraged to screen HIV positive clients for FP need, provide basic FP information, provide condoms and refer clients for comprehensive FP services at the FP clinic. GHAIN also monitored the provision of services to ensure that they were implemented in accordance with USAID statutory and policy regulations.

#### **Quarterly meetings of RH-HIV focal persons.**

GHAIN coordinated quarterly meetings of RH-HIV focal persons were held to identify obstacles to providing integrated services and explore solutions to these issues. RH-HIV integration focal persons were facility-based service providers from both FP and HIV service delivery points.

**Provision of job aids and standard operating procedures (SOPs).**

Based on the national RH-HIV guidelines, GHAIN developed integrated FP-HIV job aids and standard operating procedures (SOPs) at FP services points.

**Standardization and strengthening of referral linkages from FP clinic to HIV service delivery points and vice-versa.**

Prior to RH-HIV integration, referrals between FP and HIV service points (ART, PMTCT and HTC) tended to be verbal and undocumented. Following implementation of RH-HIV integration, existing referral systems were strengthened through provision of referral tools and through regular mentoring, monitoring and supportive supervision by GHAIN zonal RH teams.

**Establishing effective monitoring and evaluation systems.**

GHAIN developed an innovative M&E system to capture integrated FP and HIV data (O.Chabikuli et al, 2009). With approval from the RH-HIV ITWG, GHAIN adapted and piloted the National Daily FP register to capture linkages between FP and HIV service points (O. Chukwujekwu et al, 2010). Data was first entered daily in the adapted RH-HIV integration and the referral registers at integration sites. Data was then reported by facility staff in the monthly summary forms (MSF) based in the FP and HTC units. MSF were collected monthly by GHAIN M&E officers and data entered into GHAIN's central database, District Health Information System (DHIS) at the zonal level for uploading to the country office level once the data had been verified.

In 2010, FHI made efforts to expand the access to integrated RH and HIV services at the community level. Community-based integrated RH-HIV services were piloted alongside IMNCH in Udi and Yakurr local government areas in Nigeria. The project aimed to generate demand for RH and HIV services and was delivered within the community by volunteers. These volunteers were trained and provided tally cards to record the provision of services. They were also supported to mobilize for HCT and PMTCT services. In addition, they had capacity built to provide information on family planning services and symptoms of STIs and provide condoms for dual protection. The community volunteers were linked with their primary health facilities in their communities for commodities and to report data. Communities were engaged through advocacy and mobilization activities in order to create awareness and empower men and youth in sexual and reproductive health issues and rights.

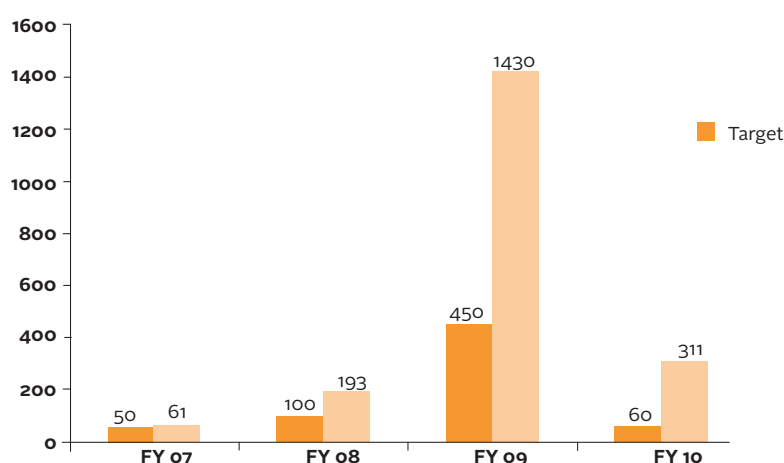
## PROGRAM ACHIEVEMENTS

**G**HAIN achieved its objectives in furthering RH and HIV integration in Nigeria at both the policy and service delivery levels.

**Objective 1:** Create an enabling environment for integrated RH/HIV services. GHAIN provided financial and administrative support to the FMOH for RH-HIV ITWG meetings. In collaboration with UNFPA and ENHANSE, GHAIN also provided financial, technical and logistical support to conduct and publish the national programmatic assessment for family planning and HIV counseling and testing integration in Nigeria. GHAIN also supported the development and national and state-level dissemination of the National RH-HIV integration guidelines.

**Objective 2:** Improve the capacity of HCWs to provide integrated RH and HIV services. To prepare for integration, GHAIN staff led advocacy efforts to 354 stakeholders across the country and trained 3979 healthcare workers at FP and HIV service points to provide integrated FP and HIV services, as well as community health workers (see Figure 1). As FH-HIV integration was scaled up, the project consistently exceeded its target for training of providers. Additionally, 69 FP units were renovated during the GHAIN project. The minor renovations enabled a conducive environment for providing integrated RH-HIV services at target facilities.

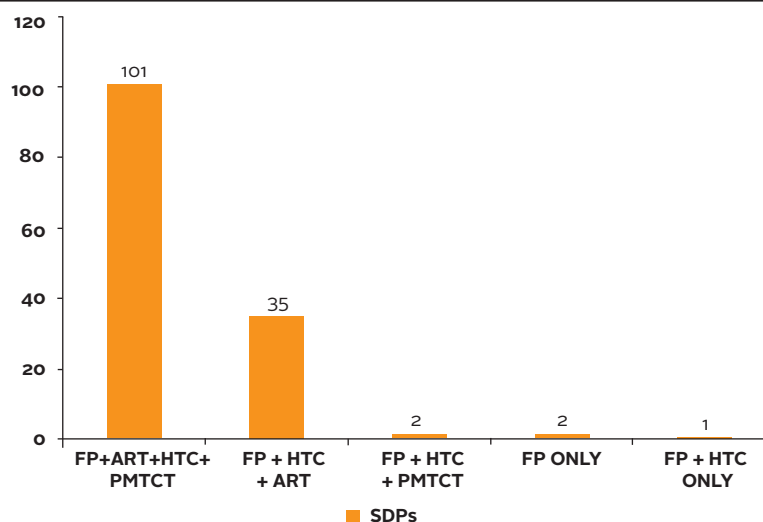
**Figure 1.0 Number of service outlets**



The project successfully integrated RH and family planning services in 141 sites across 36 states plus the Federal Capital Territory (FCT) in Nigeria. The sites included primary (n=8),

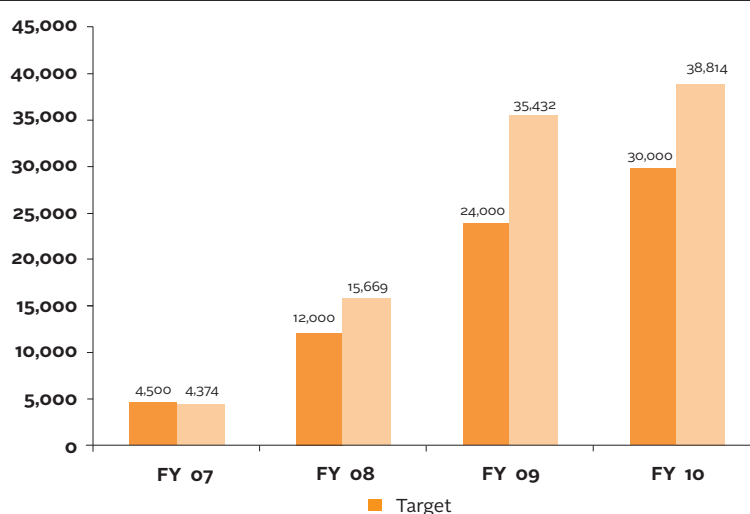
secondary (n=123), and tertiary health facilities (n=10); they offered a range of HIV services (see Figure 2). By the end of the project, 36% of sites (n=51) operated as one-stop shops, while the remaining sites (n=90) implemented the referral-based model.

**Figure 2: Breakdown of FP-HIV Service Delivery Points**

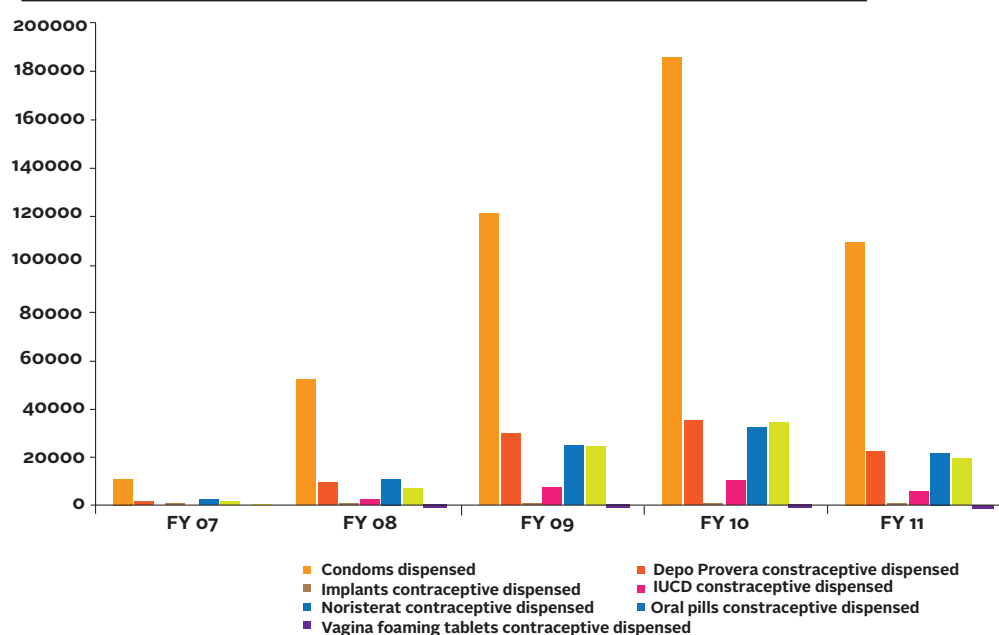


**Objective 3:** Improve provision and uptake of RH/HIV integration services in project sites. A total of 381,387 counseling visits for RH/FP counseling services took place at GHAIN supported facilities from February 2007 to April 2011. Of these visits, 32,337 clients were referred for HTC from a FP service point while 75,376 were referred for FP services from a HIV service point. RH-HIV integration service delivery resulted in achieving a couple year of protection of 167,970 years (see Figure 3); a cumulative total which exceeded the set target by 34%. As shown in Figure 4, uptake of condoms was the preferred method, followed by Depo Provera, Noristerat, and oral contraceptives.

**Figure 3: Couple Year Protection Achieved in GHAIN-supported FP-HIV Sites**



**Figure 4: Breakdown of method uptake in GHAIN supported FP-HIV sites**



## DISCUSSION

When integration of RH and HIV services within GHAIN began, all supported sites operated a referral-based model of services. That is, clients presenting for FP were given information on HIV and referred for HTC if they consented. However, during the course of implementation, it was observed that a considerable proportion of clients were being lost in the referral system. Some FP clients being referred for HTC services were not completing referrals. In order to mitigate this trend, in 2009 FP providers at selected GHAIN sites were trained to provide HIV testing and counseling services onsite at their clinics, thereby becoming one-stop shops.

In April 2011 an internal review of data of 40 selected sites – 20 one-stop shop sites and 20 referral-based sites - demonstrated a 46 % higher uptake of HTC services among FP clients compared with sites operating referral-based models (M. Saleh et al, 2011). Moreover, 100% of clients who accepted HTC in the one-stop shop model were tested, while only 77% of those who accepted HTC were eventually tested within the referral model. This data suggests that the one-stop shop model is a more effective means of integrating HTC and HIV services in the GHAIN sites.

Another strategy used by GHAIN to address lost clients and reduce missed opportunities for FP services was the introduction of a community integration approach. This strategy built on FHI's experience implementing community-based projects, such as the Integrated Maternal Newborn and Child Health (IMNCH) pilot, Community Based Access to Injectable Contraceptives (CBA) and HIV/AIDS, SRH and TB (HAST) projects. These pilots demonstrated that community-based approaches are effective in reaching people and raising their awareness of health issues.

During the implementation of the RH-HIV integration, there were several lessons learned. Initially there was a poor sense of ownership of the project amongst officers in a few states because family planning and reproductive health were not considered priorities for many health personnel. In order to obtain the buy-in and support of FP coordinators for RH-HIV integration, GHAIN provided RH-HIV integration training to each state-level FP coordinators in Nigeria. As described earlier, GHAIN also conducted advocacy to key stakeholders in the state and led joint site monitoring visits with state FP or RH coordinators.

There were additional lessons learned related to service delivery. First, staff shortages, attrition of trained personnel, and health worker strikes were common. The need to mitigate this shortage was addressed through the implementation of the two models of integration, either one-stop-shop or referral-based models, based on the capacity of the individual sites. Next, FP services and referral of HIV positive clients were not always seen as priority among HIV services providers; therefore, there were gaps in referral for FP and documentation of FP services. Lastly, persistent stock outs of FP commodities in the country negatively affected the provision of RH-HIV services.

Overall, GHAIN's success in the introduction and scale up of integrated RH-HIV services in Nigeria is largely due to four key elements:

1. creating an enabling environment across all levels;
2. GHAIN's vast reach and scale;
3. efficient use of resources; and
4. collaboration among implementing partners.

***Creating an enabling environment for RH-HIV services across all levels in Nigeria.*** GHAIN supported the Federal Ministry of Health during the project through the establishment of an Integration Technical Working Group. This support led to the development and dissemination of guidelines for integration of RH-HIV services in Nigeria. The project also supported the FMOH in generating strategies and work plans that introduced integrated services within the Nigerian health system.

Moreover, GHAIN advocacy efforts raised awareness amongst key stakeholders across the country about the importance of integrating FP and HIV services in Nigeria.

**Greater reach and impact.** With funding through the PEPFAR program, GHAIN was one of the predominant providers of HIV services in Nigeria with 118 comprehensive ART sites in all 36 states and the FCT. Thus there was the opportunity of a large number of potential HIV positive clients with reproductive health needs. GHAIN's RH unit had the opportunity to incorporate family planning into the care and treatment (C&T), PMTCT, and ARV services from the start of the program.

**More efficient use of resources.** GHAIN integration strategies were implemented within GHAIN's service delivery system in a cost-effective manner by linking services within facilities that had existing sub-agreements with GHAIN. The project's RH team strategically took advantage of cost-sharing opportunities by linking with activities and trainings for HTC, PMTCT, and ART that were already included in GHAIN implementation plans and budgets.

**Increased collaboration with USAID and Non-USAID IPs.** From the beginning of the project, GHAIN engaged other partners to collaborate implementation of integrated RH-HIV services. More recently GHAIN has collaborated extensively with UNFPA and the Planned Parenthood Federation of Nigeria to disseminate RH-HIV integration guidelines and support Nigeria's country assessment of the sexual and reproductive health (SRH) and HIV linkages.

Despite the evidence which show integration of RH and HIV is beneficial for both HIV positive and HIV negative individual, many programmes do not take advantage of these benefits. Recommendations to address these issues include:

1. Ensure strengthened collaboration between the RH and HIV partners through a common platform such as the RH-HIV integration TWG to assist the development of a collective RH-HIV linkages programme agenda.
2. Engage policy makers and key stakeholders to ensure government buy-in and ultimately sustainability.
3. Promote community participation in RH-HIV integration to increase awareness of and access to integrated services.
4. Leverage resources with various programme areas (HIV and MNCH) to strengthen linkages between services and promote cost effectiveness and sustainability.

## CONCLUSION

**G**HAIN's approach to RH-HIV integration was comprehensive and inclusive - spanning national level health officials to community health volunteers - and reaching all 36 states plus the FCT. Despite challenges in the health system and health provider attitudes, GHAIN effectively introduced the provision of integrated RH-HIV services at facility and community levels. GHAIN's experience has demonstrated that with sufficient advocacy, government support, training, and technical support, integrated RH-HIV services are feasible. Lastly, data comparing the client uptake of HTC services between the one-stop shop and referral-based models in GHAIN supported sites suggests that the one-stop shop model is more effective than a referral-based model for integrating HTC and FP services. This evidence indicates that clients are more likely to accept HTC when the same provider offers both services and should be used to inform the design of future RH-HIV integration programs.



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