Integrating Family Planning into HIV Voluntary Counseling and Testing Services in Kenya: Progress to Date and Lessons Learned

By Family Health International
in collaboration with the Kenya Ministry of Health

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Introduction

In Kenya, as in most countries, family planning services and HIV voluntary counseling and testing (VCT) services have traditionally been offered separately. However, health policy-makers have begun to recognize the opportunities missed and efficiencies lost in this parallel approach. Family planning plays an important role in HIV/AIDS prevention, and VCT can reach clients who do not typically seek out family planning services as well as HIV-positive women who wish to prevent unintended pregnancy.

Integration of services may also help to once again focus attention on family planning. In recent years there have been dramatic increases in HIV funding and programming, while funding for family planning programs has remained stable, despite increasing numbers of women of reproductive age and a substantial unmet need for contraception.

It was within this context that Family Health International (FHI), with funding from the U.S. Agency for International Development (USAID), undertook a study on the feasibility of integrating family planning into VCT services in Kenya. When the results proved generally positive, the Kenyan Ministry of Health (MOH) charged FHI and other partners with determining the best way to implement integration in VCT centers across the country.

This report documents the process of assessing the feasibility of integration, bringing together stakeholders, developing an integration strategy, and implementing that strategy. It summarizes successes, challenges, and lessons learned at each step of the process. The document is not intended to provide exhaustive detail, but rather to highlight key steps and milestones.

Background

HIV/AIDS in Kenya

Kenya has the fourth highest proportion of HIV-infected people among countries worldwide.[1] By the end of 2003, about 1.2 million Kenyans were living with HIV, and approximately 150,000 people died of AIDS that year. In Kenya, HIV disproportionately affects women: the ratio of infected women to men is 1.5 to 1, and HIV prevalence among girls aged 15 to 19 is seven times that of boys in the same age group. HIV/AIDS is also the leading cause of orphaned children in Kenya. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that at the end of 2003, nearly 650,000 children under the age of 17 had lost at least one parent to AIDS.[2]

To address the epidemic, in 1999 the government of Kenya established the National AIDS Control Council to implement a multisectoral HIV/AIDS policy. One of the key intervention strategies identified was the promotion and provision of voluntary counseling and testing (VCT) services to all Kenyans who want to know their HIV status.

[1]Family Health International. *Country Assessment: Kenya. Family Planning Needs in the Context of the HIV/AIDS Epidemic.* Research Triangle Park, NC: Family Health International, 2004.

[2]UNAIDS, UNICEF, and WHO. *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Kenya.* 2004. Available: http://www.who.int/hiv/pub/epidemiology/pubfacts/en/.

Evolution of Integrated Services

Between 2000 and 2004, demand for VCT services grew rapidly, and the Kenyan government opened 400 VCT sites across the country. In 2001, the Ministry of Health (MOH) issued national VCT guidelines and a training manual to standardize service delivery and quality. These guidelines included a statement encouraging VCT providers to offer basic family planning (FP) information or appropriate referrals. However, little was known about the capacity of VCT sites to provide family planning services and, in practice, VCT and family planning were operating as separate programs.

Over time, though, the MOH's National Aids and STD Control Program (NASCOP) and the Division of Reproductive Health (DRH) acknowledged that integrating family planning and VCT held many potential benefits:

- Contraception is a key strategy in preventing mother-to-child transmission of HIV, and VCT is an obvious opportunity to reach HIV-positive women who wish to prevent unintended pregnancy.
- VCT attracts men and youth, who are not traditionally reached by family planning services.
- Delivery of family planning messages and services to VCT clients will help improve contraceptive prevalence by reaching more people.
- There could be cost efficiencies in combining services, assuming that clients need both services.

By recognizing that sexual behavior was the defining risk factor for both HIV infection and unintended pregnancy and showing that services in both areas complemented each other, the DRH hoped to leverage funding for reproductive health services through linkages with HIV/AIDS services.

"Why integration? Because it's only logical. Our mantra is 'no missed opportunities,' and when you separate the programs, you do miss opportunities. The separation of services is programmatic and organizational, but from a pragmatic point of view you're dealing with just one individual who needs both services."

– Dr. Joel Rakwar, AMKENI

Assessing Feasibility and Bringing Stakeholders Together

The Feasibility Study

To identify opportunities for and challenges to integration, FHI, NASCOP, and the DRH, along with other partners, conducted a study at 20 VCT centers in Kenya's Coast and Western provinces in June 2002. The study methodology consisted of (1) interviews with VCT supervisors, providers, and clients and (2) observations of client-provider interactions and providers' time management skills. The research team gathered information about potential demand for family planning services among VCT clients, acceptability of such services among clients and VCT staff, readiness of VCT staff to provide additional services, and feasibility of integrating family planning into VCT services.

FHI began conducting training for research assistants who would collect this information from the field and then started approaching collaborating agencies (CAs) for permission to conduct the feasibility study at some of the VCT sites they supported. Contacting various CAs individually proved difficult, so FHI, through NASCOP's Main VCT Committee, invited all VCT partners to attend a stakeholders' forum in hopes of securing their support.

Debate and Compromise Among Stakeholders

The stakeholders' forum provided an opportunity for VCT partners to air and discuss concerns about integration generally and the feasibility study specifically. Many VCT-implementing agencies were wary of integration. Earlier efforts in Kenya to integrate services addressing sexually transmitted infections (STIs), family planning, and maternal and child health had met with limited success. The explosive growth of VCT and the growing demand from a public better informed about the benefits of knowing one's HIV status left agencies pressed to meet the

> ***"Sometimes people forget that important first step: Someone has to conceptualize a problem and then get key people to agree that it is a problem."***
>
> *- Crispus Kamanga, U.S. Agency for International Development*

need for counseling and testing, even without adding family planning to their list of services. Some of the attendees wondered why integration of family planning should take precedence over integration of other services, such as care and treatment for tuberculosis. Finally, some VCT providers also feared that the addition of family planning would dilute the HIV prevention, care, and treatment messages.

Several agencies had concerns about the study's data collection methods. FHI had begun training research assistants to interview clients and providers and to observe counseling sessions, and the stakeholders felt that these methods were intrusive and would violate confidentiality. There was also debate about whether research assistants who were not trained in VCT would adequately understand technical issues facing VCT clients and providers.

A compromise was reached: stakeholders acknowledged that any type of quality assurance or operations research on VCT would require observation (with informed consent) of counseling sessions, and that VCT counselors--rather than research assistants--be trained to observe sessions and collect the data required for the study.

Study Findings

In short, the study found that:

- Most clients approved of providing family planning services with VCT.
- The majority of VCT staff thought that most of their clients would benefit from some level of family planning services.
- In some cases, counselors' knowledge of contraceptive methods was lacking or out of date.
- Counselors were concerned that adding family planning services would increase VCT session time and their workload.
- The number of clients being referred for family planning services was low.

- Only slightly more than half of the counselors told clients that condoms prevent pregnancy.
- More than 40 percent of sexually active VCT clients reported that they did not use modern contraceptive methods.

Researchers concluded that integration was generally feasible and would likely benefit clients. However, decisions on whether, and to what extent, to integrate services should be made at the facility level, since counselor training, referral mechanisms, and contraceptive supplies varied greatly across facilities.

Challenges, Successes, and Lessons Learned

- Approaching stakeholders individually to get consensus was difficult and time-consuming.
- Although initially contentious, the stakeholder forum was valuable because it resulted in stronger partnerships and more support for the feasibility study and FP/VCT integration.
- The study provided evidence that VCT clients were interested in receiving family planning services, and its findings served as the foundation for Kenya's integration strategy. The findings also helped convince CAs, the DRH, and NASCOP that integration was feasible.

Developing a Strategy for FP/VCT Integration

After being presented with the integration study's positive results, NASCOP's Main VCT Committee immediately formed a subcommittee on FP/VCT, which was charged with developing a national integration strategy. The subcommittee was composed of VCT and family planning experts from NASCOP (subcommittee co-chair), the DRH (co-chair), FHI (facilitator), JHPIEGO, AMKENI, Centers for Disease Control (CDC), Kenyatta National Hospital, KICOSHEP, and the National Leprosy and Tuberculosis Program.

Based on the feasibility study's findings, the subcommittee developed a strategy for integrating family planning into VCT and vice versa. (Integration was defined as: "the incorporation of some or all of the different FP services into existing VCT services and vice versa.") The group decided, however, to first concentrate on integrating family planning into VCT and developed a strategy flexible enough to allow each VCT site to determine the degree of integration that was possible, given its resources and capabilities. Assessment of risk for STIs and unintended pregnancy, provision of counseling on contraceptive methods, and referral for methods not available at the VCT center were included in the strategy for all sites. The sites differ, however, in regard to the contraceptive methods they are equipped to provide, as categorized by the following levels:

- Level I: condoms and pills
- Level II: condoms, pills, and injectables
- Level III: condoms, pill, injectables, and intrauterine contraceptive devices (IUCDs)
- Level IV: a full range of contraceptives

The strategy recommended that all VCT centers achieve at least the first level; the fourth level was viewed as a long-term goal.

Key activities that would be necessary to achieve integration included:

- Achieving consensus and commitment among program implementers
- Building the capacity of VCT programs to provide FP services

- Creating awareness and demand for FP services among target VCT populations
- Developing monitoring, evaluation, and operations research initiatives to assess effectiveness and ensure sustainability of the programs

The subcommittee presented the strategy to the Main VCT Committee, which gave its approval.

"It was extremely important to get buy-in from the [MOH's] Main VCT Committee so that we could comfortably say, 'The MOH supports this.' Having that mandate was a powerful tool."

– Margaret Gitau,
Kenya Ministry of Health,
National AIDS and STD
Control Program

Challenges, Successes, and Lessons Learned

- After learning the results of the feasibility study, the NASCOP's Main VCT Committee asked an important question: "Now what?" By swiftly charging a group with developing an implementation strategy, the MOH ensured that research would be put into practice.
- Developing the strategy required consensus among key VCT and FP stakeholders. Agreement among these agencies, and the MOH's stamp of approval, ensured a sense of ownership of the initiative and a commitment to implementation.

Implementing the Strategy

Achieving Consensus and Commitment among Program Implementers

Subcommittee members agreed that the most effective way to build support for integration was to work through the MOH's existing administrative structure. The subcommittee held sensitization meetings in all eight provinces with the MOH's top provincial- and district-level medical personnel, representing doctors, nurses, health administrators, and reproductive health and HIV coordinators. The subcommittee presented the strategy, requested feedback, and asked attendees what challenges they anticipated that their provinces and districts would face in integrating family planning into VCT.

Challenges, Successes, and Lessons Learned

- The sensitization meetings were essential to securing support for integration at the district and provincial levels.
- Participants provided important feedback about factors that would likely affect the success of integration in their districts.
- The meetings were successful in creating awareness about integration and preparing participants for the upcoming training sessions. However, additional efforts would be necessary to raise awareness at the clinic level among program managers.

Building Capacity

Readiness of Sites and Staff to Integrate Services

The feasibility assessment revealed that VCT providers' clinical backgrounds varied widely and were associated with the type of facility in which they worked. Providers in larger health facilities had more clinical training—and were more likely to be able to provide family planning services—than did providers in stand-alone facilities. Providers at these smaller facilities were also less likely to have a robust referral network. Feedback

from the sensitization meetings corroborated the assessment's findings that VCT sites varied significantly in their readiness to integrate services. Some lacked necessary equipment and supplies, while others lacked space and staff.

In order to target those providers who would be in a position to put their new skills into practice, the MOH required that the subcommittee conduct pre-training site assessments to identify VCT sites that demonstrated a high workload, low staff turnover, ample supply of family planning commodities, and readiness to integrate. Voluntary counseling and testing counselors from these sites were then selected to participate in the integration training.

Training Materials

Independently, but informed by the lessons learned from the feasibility study, JHPIEGO and EngenderHealth/AMKENI had started developing VCT training materials. JHPIEGO developed an orientation package about FP/VCT integration for nonclinical FP/VCT providers, whereas AMKENI created an integration training manual geared toward clinical providers. The manuals covered information on:

- Benefits of integration
- The different levels of integration
- Assessing clients' risk for unintended pregnancy
- Counseling issues related to HIV and contraception
- Reproductive physiology
- Contraceptive methods with an emphasis on condoms and dual method use
- Helping clients make informed choices

Training and Supportive Supervision

In November 2004, the subcommittee trained 18 trainers of trainers—provincial reproductive health (RH) and VCT trainers of trainers—from four provinces. A month later, eight of these trainers (four of whom specialized in reproductive health and four in VCT), under the supervision of master trainers, trained 39 VCT providers from the same four provinces.

Feedback from those involved in the training indicated that the process of using two manuals was cumbersome, that there was substantial overlap, and conversely that one or the other manual included key elements important for all providers. At the request of the DRH and NASCOP, the subcommittee began combining the manuals. The new "harmonized" manual was subsequently used to train more trainers and providers in the scale-up phase of the project in March 2005.

In March 2005, the MOH and JHPIEGO provided supportive supervision of newly trained providers to ensure that they were implementing the integration principles they had learned.

Scale-Up

The subcommittee trained an additional 20 trainers, some of whom worked with subcommittee members to train 61 more VCT providers. In total, during the original intervention and scale-up, training was provided to 38 trainers of trainers and 101 providers, who represented all eight provinces in Kenya. In addition to USAID, the President's Emergency Plan for AIDS Relief provided funding for training.

Challenges, Successes, and Lessons Learned

- Although pre-training site assessments added another step to the process, the goal was to ensure that newly trained providers would have an opportunity to practice their skills.
- Pre-training assessments have become customary, and the MOH has developed a checklist to standardize the information collected during the assessments.
- However, some VCT providers who had been trained in integration were later deployed to provide other kinds of health services, mostly due to staff shortages and high client demand for curative services.
- Combining the two integration manuals proved challenging. However, the MOH's need for one standardized curriculum, and the government's leadership in the process, ultimately ensured success of the "harmonization." The MOH's endorsement of the final curriculum will further encourage efforts to sustain integration beyond the life of the initiative.

Creating Awareness about and Demand for Family Planning Services

The feasibility study indicated that VCT clients were open to receiving family planning services at VCT centers. To further inform clients about family planning services and the benefits of receiving those services at VCT centers, FHI produced a client brochure in collaboration with the integration subcommittee. Produced in Kenya, the brochure encourages VCT clients to consider their family planning needs and to discuss them with their VCT counselor. Approximately 3,000 brochures will be made available at VCT centers where providers have been trained in integration.

> ***"Generally speaking, the clients don't need to be convinced about the benefits of integration. They're all the happier to go to a one-stop shop. We just need to let them know what's available to them."***
>
> *- Dr. Marsden Solomon, DRH*

Operations Research

In April 2005, five months after the first providers were trained in integration, FHI interviewed clients, providers, and facility managers and observed client-provider sessions to document the extent to which integration had been implemented. At this point, the number of sites eligible for the study declined from 20 to 14 because the MOH determined through the pre-training site assessments that six of the original 20 sites were not eligible.

To assess the effectiveness of the intervention, these four indicators were measured.

(1) **Provider knowledge and attitudes.** It is important to know whether the intervention improved VCT providers' family planning knowledge and attitudes, because these are key precursors to behavior change among clients.

(2) **Provision of family planning services.** To assess the family planning services provided in VCT, researchers relied on managers in-charge, provider and client reports, and observations of client-provider interactions.

(3) **Referrals.** Because it is not realistic to expect all family planning services to be available in VCT facilities, research also documented any improvements in referral practices.

(4) **Demand for contraception.** Researchers measured client demand and potential demand for contraception by assessing their risk of unintended pregnancy, noting whether providers were adequately identifying clients in need of contraception, and observing whether clients accepted family planning methods and referrals from VCT providers.

Indicators were also compared by sex to assess whether pregnancy prevention messages were being provided to men as well as women, since VCT is a unique opportunity to reach men.

Another objective of the study was to monitor the quality of VCT to ensure that introducing family planning into VCT did not compromise the quality of VCT services. The quality of VCT was monitored mainly through observations of client-provider interactions.

Challenges, Successes, and Lessons Learned

- Providers' knowledge of family planning increased as a result of the intervention, as did the likelihood that VCT clients would receive family planning messages during counseling and testing.
- However, many providers did not receive training and many of those who had been trained did not implement the integration practices they had learned; thus, the intervention did not appear to affect uptake of contraception among VCT clients.
- Despite VCT's potential as an opportunity to reach men, providers were less likely to discuss family planning with men than with women, and even less likely to discuss these issues when couples attended VCT sessions together.

- The quality of VCT services, measured by the length of the session and client perceptions, was not negatively affected by the introduction of family planning.
- So that integration of FP and VCT services is implemented more consistently and effectively, VCT providers need to strengthen their skills on pregnancy risk screening, and training and supervision should be implemented consistently among all VCT providers at the same VCT center.

Conclusions

The public health impact of the intervention is difficult to measure and is still being assessed, but the effort has been successful in several ways:

- The MOH's DRH and NASCOP both support the effort and share a sense of ownership in sustaining it. In fact, the DRH has highlighted the need to link FP and VCT services in the *Family Planning Guidelines for Service Providers (2005)*. In addition, the National Reproductive Health Policy states: "to contribute to the reduction of the HIV/AIDS burden and improvement of RH status of the infected and affected, the Reproductive Health Programme will 1) ensure integration of HIV/AIDS information and services into RH services at all levels of health care, and 2) ensure adequate capacity at all levels of provision of integrated quality RH services in the context of HIV/AIDS."
- The integration training materials developed as part of the intervention have been adopted by the MOH and will ensure high-quality, standardized training of VCT providers.
- Operations research demonstrated that integration of family planning does not diminish the quality of VCT services. It also showed that training in integration of services can improve provider knowledge and attitudes about family planning.

However, the following substantial challenges remain:

- Although providers generally approved of integration and understood its concepts, implementation was weak.
- Providers and health facility managers require supportive supervision to ensure that they maintain and improve their skills, that their facilities are stocked with the supplies needed to provide both family planning and VCT services, and that staff actually implement integration policies and practices.

- More providers need to be trained in service integration principles.
- MOH officials fear that a shortage of staff in health facilities could negatively affect provision of integrated services due to competition with other services considered more critical.
- Focused and sustained advocacy efforts are needed to further increase demand for integrated services among clients, to secure commitment to integration among program managers, and to encourage the continued support from both reproductive health and AIDS services stakeholders.
- Resources are limited and scale-up will require substantial donor involvement.

This project has raised awareness throughout Kenya and beyond about the potential benefits of integrating services and leveraging HIV/AIDS funding to improve reproductive health while preventing HIV transmission. Several other countries, including Nigeria and Zimbabwe, have shown considerable interest in VCT and family planning integration and are examining the Kenya model to see what elements of its program can be adapted or replicated. Other cooperating agencies are expressing interest in integrating services, and work is under way to further assess the costs of and barriers to integration. And in 2007, FHI will continue working in Kenya with the integration subcommittee to train more VCT providers, to ensure that supportive supervision is conducted, and to continue collecting monitoring and evaluation data.