# National programmatic assessment for family planning and HIV counseling and testing integration in Nigeria

***Final Report***
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**Acknowledgements**

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**List of Abbreviations**

| | |
|---|---|
| ANC | Ante-natal care |
| ARH | Adolescent Reproductive Health |
| CHA | Community Health Agency |
| COMPASS | Community Participation for Action in the Social Sector |
| CT | HIV Counseling and Testing |
| ECWA | Evangelical Church of West Africa |
| FCT | Federal Capital Territory |
| FHI | Family Health International |
| FMOH | Federal Ministry of Health |
| FP | Family Planning |
| GHAIN | Global HIV/AIDS Initiative, Nigeria |
| ITWG | Integration Technical Working Group |
| LGA | Local Government Area |
| OCP | Oral contraceptive pill |
| NID | National Immunization Day |
| PHC | Primary Health Care |
| PPFN | Planned Parenthood Federation of Nigeria |
| RAPAC | Redeem Christian Church of God AIDS Program Action Committee |
| RH | Reproductive Health |
| WHO | World Health Organization |

## Executive Summary

Nigeria, with a population of more than 120 million, has the highest number of people living with HIV in West Africa and the 3rd highest number of HIV positive individuals worldwide. An increase in HIV prevalence has been chronicled over the last decade with national surveillance reporting an estimated 4.4% HIV prevalence among antenatal clinic attendees in 2005.[1] In response to the great need for HIV services in Nigeria, new programs are beginning and existing HIV programs are expanding.

Although family planning contributes to both mitigating the HIV epidemic and improving women's health, the country's contraceptive prevalence rate for modern methods among married women remains low (8%) and unmet need for contraception is high (17%).[2] In this environment, the opportunity exists to integrate family planning into HIV services in order to provide comprehensive reproductive health (RH) services and to reduce new infections. Given that most clients of HIV services are sexually active and of reproductive age, the integration of contraceptive services into these programs allows providers to holistically address clients' dual risks of HIV infection and unintended pregnancy. At the same time, the integration of HIV messages and services into family planning programs also serves to expand HIV prevention and treatment by capitalizing on an existing service delivery system. The integration of family planning and HIV services also provides both programs an opportunity to reach clients who might not seek stand alone reproductive health or sexually transmitted infection services.

In January 2006, the Federal Ministry of Health (FMOH), with assistance from FHI and other partners including ENHANSE, convened an Integration Technical Working Group (ITWG) to explore opportunities for integrating services to provide better care for clients.

The current environment in Nigeria is primed for supporting the FMOH to identify the opportunities for and challenges to integrating FP services and HIV services generally and CT programs specifically. The FMOH has embarked on a process for developing strategies and guidelines around RH-HIV integration. As a first step towards planning an integrated FP/CT program intervention, this project has gathered strategic information through a rapid programmatic assessment that will assist the MOH in defining a way forward to offer integrated CT and FP services.

Study Objectives:
This assessment gathered information to assess:

- The current unmet need for FP among female CT clients and the desire for CT among FP clients.
- The status of current referral relationships between FP and CT services.
- The acceptability of integrating FP and CT among FP and CT service providers and program managers and clients.
- The readiness of FP and CT services to integrate, including: current staff capacity, staff training needs, logistics and supplies, facility capacity, management and supervision support structures.

- Gather information about readiness to integrate FP and CT services into Antenatal Care (ANC), Adolescent Reproductive Health (ARH), and sexually transmitted infection (STI) clinics, where available.

Study design:

The study was a one-time cross-sectional survey of respondents in sites selected from a purposive sample. The study was intended as a rapid assessment to gather information from a variety of CT and FP services, but without the intention to generalize to a specific target population of sites or respondents. Additional key informant interviews were conducted at services that provided ante-natal care (ANC), sexually transmitted infections (STI), and/or adolescent reproductive health (ARH) services to explore the feasibility and acceptability of integrating RH and HIV services in these settings. The study was conducted in a total of 30 CT sites and matched FP sites in six states of the Federation spread across the six geo-political zone of the country. The study employed both quantitative and qualitative methods including surveys, observations and interview.

Study population:

At each service, interviews were conducted with FP and CT program managers and service providers and with FP and CT clients. In addition, interviewers requested providers to record the number and type of clients they served during the time the interviewers were in their facility, and how much time they spent with each client. Where available, service statistics were collected from each service (CT and FP) to complement the descriptive information gathered through the interviews. Where possible, ANC, ARH and STI program managers were also interviewed using an in-depth interview guide. The maximum number of interviews per service was 10: 1 program manager, 4 providers and 5 clients. Since there were two services per site (the CT service and an FP service), this made a maximum total of 20 interviews per site. Given that there were 30 facilities included in the assessment, the maximum number of possible interviews was 600 (20 interviews/site * 30 sites). Overall, 409 people were interviewed, giving a 68% success rate in identifying and interviewing possible respondents

Results

Potential demand:

Nearly half of the FP clients interviewed reported ever having been tested for HIV in the past, regardless of what type of facility they were at. In addition, nearly 90% of FP clients said they would like to have an HIV test done sometime in the future. About a quarter of female CT clients interviewed have an unmet need for family planning.

Referrals:

Despite the fact that most facilities visited during the assessment had both HIV counseling and testing and family planning services on-site, the rate of referrals from one service to another was very low. Only about half of services kept statistics on referrals (10/25 FP, 12/23 CT). Among those few services that had statistics, the mean number of referrals for FP clients to CT centers was 19 per month (range 0-121; median 7.5; n=10). The mean number of monthly referrals for CT client to FP services was 3 (range 0-10; median 3.5; n=12). Most clients were referred to public-sector secondary facilities.

Acceptability of integrated services:
The FP clients interviewed largely found that the idea of receiving HIV counseling and testing services in their FP clinic was acceptable (93%). They also reported being comfortable with receiving HIV counseling and testing from their FP providers (95%). Similarly, most CT clients (88%) reported that they would accept receiving FP services at the CT center and that they would be comfortable accepting FP from CT providers 92%. FP providers and managers thought that adding CT services in the FP clinic would be acceptable. CT providers and managers also said it was acceptable to require them to provide FP services to their CT clients. There was nearly universal agreement among providers and managers interviewed that it is important to provide HIV counseling and testing to FP clients and to provide family planning services to CT clients.

Readiness:
Both FP and CT providers and managers were very confident that they would have enough time to provide HIV counseling, family planning counseling and sexually transmitted infection (STI) services, like counseling and referrals, but they were less sure that there would be time to provide oral contraceptives, conduct HIV test and provide drugs for syndromic management for clients with symptoms of STI. Both FP and CT providers and managers expressed the opinion that training and re-training would be required to effectively provide integrated services.

Feasibility:
Providers and managers of both service types were asked how they thought integration of services would affect various aspects of the quality of services they provide at their center. Family planning providers and managers generally agreed that while their workload and the waiting time for clients would become worse, other aspects of their services would improve in quality, notably the flow of counseling and the comprehensiveness of services. CT providers and managers had nearly identical concerns about workload and waiting time and were equally optimistic about improvements in comprehensiveness and counseling flow.

Providers and managers from both kinds of services expressed concerns such as not having enough staff members, inadequate knowledge and skills, and a lack of equipment as anticipated challenges to service integration. Interestingly, managers from both kinds of services reported concerns about stigmatization which may arise from integration of counterpart services into their current schedule of services.

Conclusion:
The evidence from this programmatic assessment demonstrates strong support from providers, managers and clients for FP/HIV integration in both directions. However, there is need to address issues such of building the capacity of providers and managers to deliver quality FP and CT care, strengthening referral between services, and ensuring regular and adequate supply of FP and CT commodities before the commencement of service integration.

## Introduction and Background

Nigeria, with a population of more than 120 million, has the highest number of people living with HIV in West Africa and the 3rd highest number of HIV positive individuals worldwide. An increase in HIV prevalence has been chronicled over the last decade with national surveillance reporting an estimated 4.4% HIV prevalence among antenatal clinic attendees in 2005.[1] HIV prevalence varies dramatically by region and state, with prevalence reaching 10% in some areas.[1] In an environment where women of reproductive age carry a disproportionate burden of the AIDS epidemic, the prevention of unwanted pregnancies becomes essential for preventing mother-to-child transmission of HIV and reducing the number of children orphaned when parents die of AIDS-related illnesses. Access to contraceptive barrier methods such as the male and female condom is equally important as a way to provide dual protection against pregnancy and HIV transmission. Even though family planning contributes to both mitigating the HIV epidemic and improving women's health, the country's contraceptive prevalence rate for modern methods among married women remains low (8%) and unmet need for contraception is high (17%).[2]

In response to the great need for HIV services in Nigeria, new programs are beginning and existing HIV programs are expanding. In this environment, the opportunity exists to integrate family planning into these services in order to provide comprehensive reproductive health (RH) services and to reduce new infections. Given that most clients of HIV services are sexually active and of reproductive age, the integration of contraceptive services into these programs allows providers to holistically address clients' dual risks of HIV infection and unintended pregnancy. At the same time, the integration of HIV messages and services into family planning programs also serves to expand HIV prevention and treatment by capitalizing on an existing service delivery system. The integration of family planning and HIV services also provides both programs an opportunity to reach clients who might not seek stand alone reproductive health or sexually transmitted infection services.

Because resources are often scarce, practical decisions about where to initiate integrated services are often guided by factors other than need, including the health infrastructure, opportunities for linkages and referral networks, potential programmatic impact, and costs. Choosing HIV counseling and testing (CT) programs as the entry point for integrating FP provides increased access to family planning information and services for many clients, that normally don't access family planning services, particularly men and youth, who are sexually active and of reproductive age. Similarly, strengthening the HIV prevention aspects of family planning counseling facilitates HIV prevention messages reaching populations such as married women who might not normally heed such messages.

In January 2006, the Federal Ministry of Health (FMOH), with assistance from FHI and other partners including ENHANSE, convened an Integration Technical Working Group (ITWG) to explore opportunities for integrating services to provide better care for clients. The ITWG is also responsible for making recommendations to the FMOH about how to proceed with integration, and it is the ITWG that has requested the assessment summarized in this report.

Building upon promising models of integration can help decision makers overcome challenges and rapidly introduce and adapt programs to meet local contexts. The Kenyan experience of

integrating FP into CT programs, developed through collaboration between FHI, the Kenyan Ministry of Health, and other key stakeholders, may provide one such model for replication in the Nigerian context.[3] This model is characterized by integration of FP into CT centers only and included training CT counselors to provide both condoms and oral contraceptive pills (OCP) to CT clients. In an evaluation of the integration program, investigators found that the rate of CT counselors discussing FP with clients increased, however it was far from perfect. CT counselors were trained to provide OCPs, but in practice limited themselves to providing condoms and referring for other FP methods. Encouraging more referrals may also be a better model for Nigeria since overall uptake of FP is low and CT counselors may feel unsure of their ability to provide other methods.

The current environment in Nigeria is primed for supporting the FMOH to identify the opportunities for and challenges to integrating FP services and HIV services generally and CT programs specifically. The FMOH has embarked on a process for developing strategies and guidelines around RH-HIV integration. As a first step towards planning an integrated FP/CT program intervention, this project has gathered strategic information through a rapid programmatic assessment that will assist the MOH in defining a way forward to offer integrated CT and FP services.

**Study design**

The study design was a one-time cross-sectional survey of respondents in sites selected from a purposive sample. The study was intended as a rapid assessment to gather information from a variety of CT and FP services, but without the intention to generalize to a specific target population of sites or respondents. In response to the Federal Ministry of Health's request, additional key informant interviews were conducted at services that provided ante-natal care (ANC), sexually transmitted infections (STI), and/or adolescent reproductive health (ARH) services to explore the feasibility and acceptability of integrating RH and HIV services in these settings.

The objectives of this assessment were to gather information to assess:

1. The current unmet need for FP among female CT clients and the desire for CT among FP clients.
2. The status of current referral relationships between FP and CT services.
3. The acceptability of integrating FP and CT among FP and CT service providers and program managers and clients.
4. The readiness of FP and CT services to integrate, including: current staff capacity, staff training needs, logistics and supplies, facility capacity, management and supervision support structures.
5. Gather information about readiness to integrate FP and CT services into Antenatal Care (ANC), Adolescent Reproductive Health (ARH), and sexually transmitted infection (STI) clinics, where available.

The primary outcome measures were (1) the proportion of female CT clients that demonstrated an unmet need for FP and (2) the proportion of FP clients that reported a desire for counseling

and testing. As per the Nigeria DHS, a woman with unmet need is defined as a fecund female who reports that she does not want to have a child within the next two years and is not currently using any method of contraception to prevent or delay pregnancy.[2] FP clients who report that they would like to have an HIV test done sometime in the future were considered as having a desire for CT services.[1]

Secondary outcome measures included:

- The number of cross-referrals from CT to FP services and from FP services to CT.
- The proportion of managers, providers and clients that report the idea of integrating services is acceptable (e.g. favorable attitudes).
- The number of facilities that are ready with the capacity to integrate, and the number and types of gaps in capacity.
- The current number of clients served per day per provider.

The above outcome measures have also been stratified by whether the facilities are private or public sector and whether the facility is part of the GHAIN project or non-GHAIN project supported.

Description of the target population and selection criteria

The ITWG conducted site selection at a meeting on December 6, 2006. The sample was designed as a purposive sample of CT services. One FP service to which each CT service may refer clients was also included. The sample covered all six of Nigeria's geo-political regions. The following states were purposively selected for the assessment: Anambra, Bauchi, Cross River, FCT, Kano and Lagos. The site selection process followed these steps:

All HIV counseling and testing services were identified in each of the states:

- All identified CT services were stratified by whether they are GHAIN supported, or non-GHAIN supported, and by whether they are public or private sites to create a 2x2 matrix

| | **Public sector service** | **Private sector service** |
|---|---|---|
| **GHAIN supported** | | |
| **Non-GHAIN supported** | | |

- 1-2 CT services were randomly chosen within each cell of the matrix
- For each CT service, an FP service site was selected using the following prioritized criteria:
    - FP service that is in the same facility or an adjacent facility to the CT service
    - FP service with which the CT service already has an established referral relationship
    - FP service (public sector) within the closest geographical distance to the CT service

[1] Note: Ideally we would have assessed the need for HIV counseling and testing among FP clients. However, the questions used to measure this (e.g. how many sexual partners do you have?) were so sensitive that we believed it would have degraded the quality of the questionnaire to ask them of FP clients in this setting.

Initially 44 CT sites were selected for the assessment but due to limited resources available for field work, 30 CT sites ended up being used for the assessment. The total number of sites sampled after the assessment exercise had been concluded came to 35. The additional five sites were family planning referral sites. Some chosen sites had to be substituted in order to achieve the total number of interviews for the state. The reason for substitution was the absence of staff.

At each service, interviews were conducted with FP and CT program managers and service providers and with FP and CT clients. In addition, interviewers requested providers to record the number and type of clients they served during the time the interviewers were in their facility, and how much time they spent with each client. Where available, service statistics were collected from each service (CT and FP) to complement the descriptive information gathered through the interviews. Where possible, ANC, ARH and STI program managers were also interviewed using an in-depth interview guide. (Note: clients under 18 years of age were not interviewed.) The fieldwork was conducted by teams of two-three people. Each team consisted of at least one representative of the FMOH and a representative of either GHAIN or COMPASS. Each team was assigned to one state, and had five days for fieldwork. Teams had one full day per facility to complete interviews with managers, providers and clients in both services. In some cases, facilities were long distances apart and much of each day was taken up in traveling from one facility to the next. Provider and manager interviews were conducted in English. Client interviews were conducted in the language that was most comfortable for the respondent or the language that the respondent and interviewer had in common: English, Pidgin, Hausa, Igbo or Yoruba.

In HIV counseling and testing services, family planning services or other facility types included in the assessment, the team attempted to speak to the program managers and all of the providers available at the service that day, up to a maximum of 4 providers (and 1 manager). The team strove for diversity when choosing the 4 providers to interview to give the broadest possible view of opinions and situations included in the assessment.

An important part of the assessment consisted of interviews with clients. The team tried to speak to as many CT and FP clients as possible on the day they were at each service, up to a maximum of 5 clients per service. One barrier that the teams encountered was that CT and FP services are not offered every day at every facility. Some facilities have designated "clinic" days for CT or FP. If assessment teams reported to facilities during a non-clinic day, they were unlikely to find clients. Teams used various strategies to overcome this problem: in some cases the team phoned ahead and asked the facility to invite specific types of clients to come to the facility on the day fieldwork was planned, whether or not it was a clinic day; in other cases, team members re-visited facilities on the days of their FP or CT clinics in the afternoon after they had finished the interviews at the facility chosen for that day. (Note: asking providers to invite specific clients to participate in the assessment resulted in some selection bias, as providers would have been more likely to invite satisfied clients to participate.)

The assessment team enlisted the assistance of the service staff (managers and providers) to recruit clients who were willing to respond to the questionnaire. Service staff members were requested to refer eligible clients to one of the assessment team members for interview following

their regular consultation (either CT or FP) with a service provider. In the case of CT clients receiving their test results, service providers were asked to be sensitive to the client's feelings before referring him or her to an interviewer.

Since this study collected data for exploratory purposes only, no formal sample size calculations were performed. The number of sites included in the assessment was based on the purposive sampling criteria described above and logistical considerations. The maximum number of interviews per service was 10: 1 program manager, 4 providers and 5 clients. Since there were two services per site (the CT service and an FP service), this made a maximum total of 20 interviews per site. Given that there were 30 facilities included in the assessment, the maximum number of possible interviews was 600 (20 interviews/site * 30 sites). Overall, 409 people were interviewed, giving a 68% success rate in identifying and interviewing possible respondents (Table 2).

**Table 1: Interviews completed**

| | FP Provider | CT Provider | FP Client | CT Client | FP Manager | CT Manager | Total |
|---|---|---|---|---|---|---|---|
| Anambra | 5 | 14 | 26 | 22 | 5 | 4 | **76** |
| Bauchi | 13 | 8 | 25 | 19 | 6 | 3 | **74** |
| Cross River | 7 | 9 | 9 | 21 | 5 | 3 | **54** |
| FCT | 15 | 17 | 18 | 18 | 4 | 4 | **76** |
| Kano | 9 | 10 | 17 | 7 | 2 | 3 | **48** |
| Lagos | 13 | 16 | 18 | 25 | 4 | 5 | **81** |
| **Total** | **62** | **74** | **113** | **112** | **26** | **22** | **409** |

Assessment strengths and limitations

Please note that, due to the sampling technique of the sites, the results of this assessment cannot be generalized to all CT services or all FP clinics in Nigeria or in the six states included in the assessment. By purposively choosing sites, we tried to represent as broad a spectrum of situations as possible. The sample was not numerically random or representative of all of Nigeria. For example, the assessment conducted fieldwork in 5 CT facilities in Bauchi and 5 CT facilities in Lagos; however, the entire universe of CT facilities in Lagos is much bigger than in Bauchi State. The results of this assessment should be interpreted with caution and used in the spirit in which they were gathered – as information for developing integrated programs.

As described above, the assessment included facilities in six different states, public, private and NGO-run facilities, and facilities with and without support from the GHAIN project to generate maximum diversity in the responses. However, the analysis is not reported stratified by these categories due to the small and non-generalizable sample used.

Data collection

There were seven data collection instruments in total. Six were questionnaires: FP manager questionnaire, CT manager questionnaire, FP provider questionnaire, CT provider questionnaire, FP client questionnaire, and CT client questionnaire (see Appendix 1). The seventh data collection instrument was a self-administered Provider Service Log to assess start and end times

for each client consultation, the client's sex, and the purpose of the client's visit during the time the assessment team is at that particular service. Prior to each interview, potential respondents were requested to give oral consent for their participation. Consent forms and questionnaires were prepared in English for this study but the fieldwork team also did on-the-spot translations for clients in Pidgin, Hausa, Igbo and Yoruba. The translation of the consent language was discussed and practiced during the fieldwork training.

Data collector training

The assessment teams trained on the data collection instruments together during a four-day workshop in Abuja. The first day of the training was primarily taken up with the ethics training, the second day was spent reviewing the data collection forms (DCF), the third day was largely taken up with pre-testing the DCFs, and the training concluded in the morning of the fourth day with a discussion of field logistics and final interviewing tips. There were 13 participants – seven people from the Federal Ministry of Health (FMOH), three from COMPASS state offices, two from GHAIN state offices, one from GHAIN national office and a representative from the WHO country office.

The pre-test took place in two public facilities in Abuja: the State House Clinic and Wuse General Hospital. Following the pre-test, participants identified several challenges that were likely to come up during the fieldwork. First, it was apparent that private space would be difficult to find in most facilities. Participants agreed that they would seek as much distance from other people as possible to conduct interviews and that they would be sure to speak in lowered voices to avoid the possibility of being overheard. Another issue identified was the difficulty of finding the correct staff persons in the clinic on the day of fieldwork and getting their attention given the high volume of clients coming to most facilities. Participants counseled each other to remain patient while interviewing providers and to allow for interruptions if necessary. Above all, participants agreed that it would be important to be flexible and creative to complete the assessment successfully.

## Respondent characteristics

Providers and managers

The most common professional designation for all providers and managers interviewed was a nursing background (nurse, nurse/midwife, or public health nurses). Among CT providers and managers, a more diverse professional background was present, with laboratory personnel and social workers more common than in the FP services. (Table 2) Although interviewers attempted to speak to up to five FP and CT providers at each service, in cases where there were more than five providers, interviewers were instructed to try to speak to the broadest number of different types of providers present at the service on the days of the interviews. The sample of providers interviewed is therefore not representative of all providers in the services that took place in the programmatic assessment.

**Table 2: Professional Experience of Providers and Program Managers**

| | FP Providers N=60 | CT Providers N=73 | FP Managers N=25 | CT Managers N=23 |
|---|---|---|---|---|
| **Professional Designation** | N (%) | N (%) | N (%) | N |
| Nurse/Midwife/Public Health Nurse (PHN) | 37 (62) | 28 (38) | 15 (71) | 7 |
| Laboratory Personnel | 0 | 12 (17) | 0 | 0 |
| Community Health Extension Worker (CHEW) | 11 (19) | 4 (6) | 0 | 1 |
| Doctor | 5 (9) | 6 (9) | 4 (19) | 6 |
| Community Health Officer (CHO) | 2 (4) | 3 (4) | 1 (5) | 2 |
| Social Worker | 1 (2) | 8 (11) | 1 (5) | 4 |
| Counselor | 0 | 4 (6) | 0 | 0 |
| Administrative Personnel | 0 | 3 (4) | 0 | 0 |
| Other [1] | 1 (2) | 3 (4) | 0 | 3 |
| *Missing values (N)* | *3* | *2* | *4* | *0* |
| **No. years providing services** | | | | |
| Mean (Range) [2] | 7 (0.5-20) | 3 (0.5-12) | 11 (0.5-25) | 4 (0.5-18) |
| Median [2] | 6 | 2 | 10 | 3 |
| 1 year or less | 10 (17) | 23 (32) | 2 (8) | 3 |
| 2-5 years | 16 (27) | 41 (56) | 4 (16) | 16 |
| 6-10 years | 17 (28) | 8 (11) | 7 (28) | 3 |
| More than 10 | 15 (25) | 1 (1) | 12 (48) | 1 |
| Don't know/unsure | 2 (3) | - | - | - |
| **Most recent training (in FP for FP providers/managers, or CT for CT providers/managers)** | | | | |
| Past 12 months | 25 (42) | 51 (70) | 14 (58) | 12 |
| 1-2 years ago | 12 (20) | 16 (22) | 3 (13) | 7 |
| 3+ year ago | 20 (33) | 3 (4) | 6 (25) | 2 |
| Never | 3 (5) | 3 (4) | 1 (4) | 2 |
| *Missing value (N)* | - | - | *1* | - |

Note: Percentage totals may not equal 100 due to rounding

[1] Chief Nursing Officer, Psychologist, Catholic Priest Manager, MPH, Pharmacist

[2] Respondents who mentioned less than one year were grouped as 0.5 years

Unsurprisingly, CT providers and CT managers had been at their jobs for less time than FP managers and providers. Nearly half of FP managers had been providing FP services for more than 10 years. (Table 2) Given that CT providers and managers were newer in their jobs, it

follows that they would be more likely to have received training within the past 12 months than FP providers and managers. When providers were asked whether their counterpart topic was included in their training, we found that about half (51%) of FP providers said that CT topics were included in their most recent training, but only about one-third (34%) of CT providers said that FP topics were included in their most recent CT training.

Most of the family planning providers and managers interviewed were women. The genders were almost evenly split among the CT providers and managers interviewed. FP and CT providers were similarly aged, as are FP managers and CT managers. Managers tended to be older than providers. FP providers and FP and CT managers had a median of 3 children, while CT providers had a median of 2 children. FP providers and managers were more likely to have more than 4 children. Approximately 70% of the FP providers, FP managers and CT managers that were interviewed said that they had ever used a modern method of contraception, and less than half of CT providers said they had ever used a modern form of contraception. (Table 3)

**Table 3: Demographic characteristics of Providers and Program Managers**

| | **FP Providers N=60** | **CT Providers N=73** | **FP Managers N=25** | **CT Managers N=23** |
|---|---|---|---|---|
| | N (%) | N (%) | N (%) | N |
| **Sex** | | | | |
| Female | 52 (87) | 40 (56) | 20 (80) | 10 |
| Male | 8 (13) | 31 (44) | 5 (20) | 13 |
| *Missing values (N)* | *0* | *2* | *0* | *0* |
| **Average age (range)** | | | | |
| | 39 (23-57) | 37 (26-57) | 44 (31-57) | 44 (34-56) |
| **Number of children** | | | | |
| Mean (Range) | 3 (0-8) | 2 (0-8) | 3 (0-5) | 3 (0-6) |
| Median | 3 | 2 | 3 | 3 |
| None | 12 (20) | 28 (38) | 3 (12) | 4 |
| 1-2 | 16 (27) | 15 (21) | 5 (20) | 5 |
| 3-4 | 18 (30) | 22 (30) | 12 (48) | 10 |
| More than 4 | 14 (23) | 8 (11) | 5 (20) | 4 |
| **Currently using or *ever* used modern method of contraception** | | | | |
| Yes | 41 (68) | 34 (47) | 18 (72) | 16 |
| *Missing values (N)* | - | *1* | - | - |

Many of the roles and responsibilities of FP providers and CT providers overlap. (Table 4) For example, 40% of FP providers were also responsible for HIV counseling and testing. In addition, many FP providers (65%) and CT providers (37%) were also responsible for STI treatment.

**Table 4: Provider Roles and Responsibilities**

| | FP Providers N=60 N (%) | CT Providers N=73 N (%) |
|---|---|---|
| **What are your roles/responsibilities at this facility? *** | | |
| Family planning/child spacing services | 59 (98) | 13 (18) |
| STI treatment | 39 (65) | 27 (37) |
| Ante-natal care (ANC) | 36 (60) | 17 (23) |
| Labor ward | 28 (47) | 11 (15) |
| HIV counseling and testing | 24 (40) | 73 (100) |
| PMTCT | 22 (37) | 21 (29) |
| ART | 5 (8) | 11 (15) |
| PNC | 0 | 11 (15) |
| Other [(FP: 1; CT: 2)] | 13 (22) | 19 (26) |

Note: Only N's reported where sample size is fewer than 25

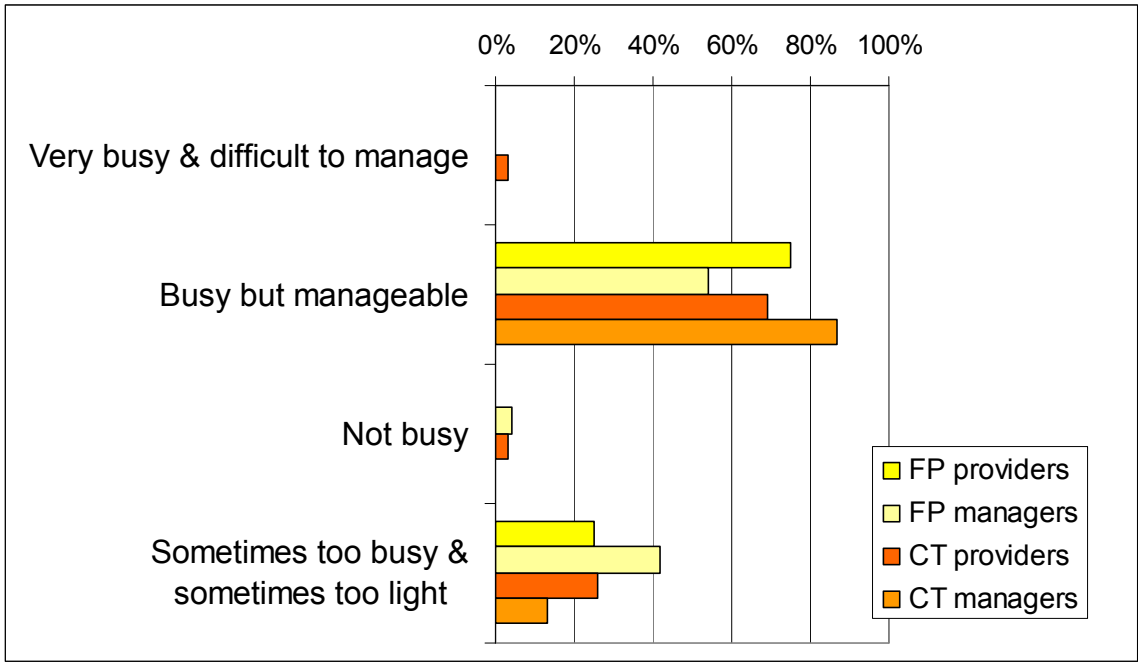
* More than one response possible

[(FP: 1)] Child health services (CHS), Dispensing drugs, General client management, Gynecology, Immunization, Pregnancy test, Social (mental) counseling

[(CT: 2)] Accident and emergency, Coordinate support group, Fertility counseling, General client management, Immunization, Manage theatre, Project officer, Referrals, RH counseling, Support for peer educator, Train laboratory scientists.

Most providers and managers interviewed responded that their current workload was busy but manageable. (Figure 1) About one-quarter of respondents also said that their work is sometimes too busy and sometimes too light. Almost no providers or managers said that their work was either not busy, or very busy and difficult to manage.

**Figure 1: Provider and manager perceptions of workload**



Clients

Out of 113 FP clients interviewed, very few were male (3%). (Table 5) On the other hand, men made up nearly 30% of the 112 CT clients interviewed. The average age of FP clients was 33 years (range 18-50), and the average age of CT clients was 32 years (range 18-80). Nearly 100% of FP clients reported they were married or cohabiting, while nearly one-third of CT clients reported that they were single and never married. (Table 5) There appeared to be a higher concentration of young people among CT clients with 23% being youth, than FP clients of which only 12% were youth. This may have been affected by the choice of assessment sites, however. For example, one site in Cross River State was at the University of Calabar and served primarily students.

**Table 5: Characteristics of Clients**

| | **FP Clients N=113** N (%) | **CT Clients N=112** N (%) |
|---|---|---|
| **Sex** | | |
| Male | 3 (3) | 31 (28) |
| Female | 110 (97) | 79 (72) |
| *Missing Values (N)* | *0* | *2* |
| **Age (in years)** | | |
| Mean (Range) | 33 (18-50) | 32 (18-80) |
| Median | 33 | 30 |
| 18-24 Youth | 14 (12) | 26 (23) |
| 25-49 Adults | 98 (87) | 79 (71) |
| 50 + Past Reproductive Age | 1 (1) | 7 (6) |
| **Marital status** | | |
| Married or cohabiting | 111 (98) | 65 (59) |
| Single, never married | 1 (1) | 34 (31) |
| Divorced/separated | 1 (1) | 5 (5) |
| Widowed | 0 | 7 (6) |
| *Missing value (N)* | *0* | *1* |
| **Number of children** | | |
| Mean (Range) | 4 (0-10) | 2 (0-12) |
| Median | 4 | 1 |
| None | 1 (1) | 44 (40) |
| 1 | 10 (9) | 18 (16) |
| 2 | 18 (16) | 15 (14) |
| 3 | 19 (17) | 8 (7) |
| 4 or more | 64 (58) | 25 (23) |
| *Missing values (N)* | *1* | *2* |
| **Highest level of education completed** | | |
| Did not attend school | 5 (4) | 6 (5) |
| Quaranic only | 6 (5) | 5 (5) |
| Primary | 19 (17) | 15 (14) |
| Secondary | 49 (43) | 47 (42) |
| Post-secondary | 34 (30) | 38 (34) |
| *Missing value (N)* | *0* | *1* |

Note: Percentage totals may not equal 100 due to rounding

Although they had a similar average age, FP clients reported having more children than CT clients. FP clients had a median of 4 children, while CT clients had a median of 1 child. Also, practically none of the FP clients reported that they had no children, whereas nulliparity was common among CT clients. The two types of clients were equivalent in terms of education levels achieved. With nearly three-fourths of assessment respondents reporting they had completed secondary school or higher, this sample of respondents is much better educated than average Nigerians, less than 20% of whom have completed secondary school or higher.[2]

**Site characteristics**

The assessment visited 30 CT sites and 29 matched FP sites (1 CT site in Lagos was not able to identify an FP referral site). Most FP sites and all CT sites provided services Monday-Friday. Only a few sites provided FP or CT services on the weekends. Eighty-eight percent of facilities had demographic information on their clients. Managers report that the average age of FP clients was 29 (age range 16-60; median 30), and the average age of CT clients was 31 (age range 10-89; median 30). On average, FP services had 4 service providers (range 1-7; median 3). CT services had an average of 9 service providers (range 2-30; median 6).

In order to smooth out expected monthly fluctuations in the number of clients served, the assessment collected three months of service statistics and calculated a three-month average. Among the facilities surveyed, there was a large range of numbers of clients served, with some FP clinics serving as few as 2 clients per month and some FP centers serving over 1000 FP clients per month. Due to this unusual distribution, the median number of clients per month is the most accurate measure of what was "typical" among the facilities. FP sites reported serving a median of 9 new clients and 29 resupply clients per month. (Table 6)

**Table 6: Family Planning Program Managers Reports on Service Statistics**

| | Month 1 | Month 2 | Month 3 | Three-month average |
|---|---|---|---|---|
| **New clients** | n=23 sites | n=23 sites | n=23 sites | n=23 sites |
| Mean (Range) | 29 (1-232) | 30 (0-254) | 27 (0-215) | 28 (1-234) |
| Median | 6 | 8 | 8 | 9 |
| **Re-supply clients** | n=23 sites | n=23 sites | n=23 sites | n=23 sites |
| Mean (Range) | 102 (0-1067) | 118 (0-1035) | 105 (0-781) | 108 (0-961) |
| Median | 25 | 25 | 27 | 29 |
| **Total clients** | n=23 sites | n=23 sites | n=23 sites | n=23 sites |
| Mean (Range) | 131 (2-1239) | 148 (2-1193) | 141 (2-921) | 140 (2-1107) |
| Median | 28 | 37 | 38 | 37 |

Note: There were 2 clinics with missing client data and 2 clinics with missing provider data.

The CT facilities chosen for the assessment were also very diverse, serving between 3 and 2000 clients per month. The median number of clients tested per month was 221. (Table 7) It also appears that a large majority (91%) of clients who received pre-test counseling also agreed to be tested for HIV.

**Table 7: Counseling and Testing Program Managers Reports on Service Statistics**

| | Month 1 | Month 2 | Month 3 | Three-month average |
|---|---|---|---|---|
| **Clients who accepted pre-test counseling** | n=20 sites | n=19 sites | n=19 sites | n=18 sites |
| Mean (Range) | 335 (3-1926) | 396 (1-2516) | 373 (7-2216) | 336 (4-2219) |
| Median | 234 | 200 | 200 | 201 |
| **Clients who accepted HIV testing** | n=20 sites | n=19 sites | n=20 sites | n=19 sites |
| Mean (Range) | 313 (3-1926) | 379 (1-2516) | 379 (7-2216) | 346 (4-2219) |
| Median | 234 | 204 | 199 | 221 |
| **Total clients** | n=20 sites | n=19 sites | n=20 sites | n=19 sites |
| Mean (Range) | 329 (3-1926) | 394 (1-2516) | 392 (7-2216) | 360 (4-2219) |
| Median | 234 | 206 | 201 | 222 |

Note: There were 2 clinics with missing client data and two other clinics had client data for only 1 month.

About half of FP service providers and managers reported having a stock out of contraceptive supplies in the previous 6 months. Stock outs were much less common in the CT services, reported by less than 20% of CT providers. (Table 8)

**Table 8: Reports on Stock Outs of Supplies**

| | FP Providers N=60 N (%) | FP Managers N=25 N (%) | CT Providers N=73 N (%) | CT Managers N=23 N |
|---|---|---|---|---|
| **In the last 6 months, how often were you unable to serve a client because the centre was out of contraceptive supplies/HIV testing materials?** | | | | |
| Never | 33 (55) | 14 (56) | 59 (82) | 14 |
| Sometimes | 22 (37) | 8 (32) | 12 (17) | 7 |
| Often | 3 (5) | 2 (8) | 0 | - |
| Very often | 2 (3) | 1 (4) | 1 (1) | 1 |
| *Missing value (N)* | *0* | *0* | *1* | *1* |

Note: Only N's reported where sample size is fewer than 25

## Study results

Services received and client satisfaction

About three-quarters of family planning clients were resupply clients, and approximately one-quarter were new FP users, as defined by the question of whether they had ever used a method to space pregnancies. Approximately three-quarters of FP clients received an FP method on the day of their clinic visit. The most common methods received or discussed by clients and providers on the day of the interview were injectables, the IUD, and oral contraceptives. Among those FP clients who did not receive an FP method on the day they were interviewed, the most common reason for not getting a method was that they had come to the clinic for a check-up of the FP method they were currently using. (Table 9)

**Table 9: Family Planning Clients' Reports About Service Provision**

| | All Clients N=113 N (%) |
|---|---|
| **Have you ever used a method in the past to space pregnancies?** | |
| Yes | 85 (76) |
| No | 27 (24) |
| *Missing value (N)* | *1* |
| **Did the provider give you a FP method today?** | |
| Yes | 84 (74) |
| No | 29 (26) |
| **Which method(s) did you receive or receive counselling about today? *** | |
| | n=99† |
| Injectable | 62 (63) |
| IUD | 38 (38) |
| Oral contraceptive pill | 30 (30) |
| Female condom | 21 (21) |
| Male condom | 20 (20) |
| Counseling on withdrawal | 6 (6) |
| Counseling on rhythm/periodic abstinence/standard days | 5 (5) |
| Counseling on abstinence | 4 (4) |
| Emergency contraceptive (EC) pills | 4 (4) |
| Diaphragm | 2 (2) |
| Sterilization | 2 (2) |
| Counseling on LAM | 1 (1) |
| Other [(1)] | 5 (5) |
| **Why didn't the provider give you a FP method today? *** | |
| | n=29 |
| Check up | 18 (62) |
| Unable to rule out pregnancy / not menstruating | 3 (10) |
| Still undecided or other "client reasons" | 2 (7) |
| Out of stock | 1 (3) |
| Referred to another site | 1 (3) |
| Other [(2)] | 5 (17) |

*More than one answer possible
† N is larger than number who reported receiving a FP method today because some people reported receiving counselling about methods (e.g. counselling on withdrawal, etc.).
[(1)] Check for any problem, foaming tablets, health education
[(2)] Removal of IUD/Norplant, another appointment, sick child/immunization

Twenty percent of FP clients also received HIV counseling on the day of their FP consultation, although only 5% reported they were actually tested for HIV during that visit to the facility. (Table 10) FP clients only rarely received other services on the day they went to the FP clinic.

**Table 10: Family Planning Clients' Reports About Service Provision**

| | All Clients N=113 N (%) |
|---|---|
| **What other services did you receive at this facility today? *** | |
| Education | 77 (69) |
| HIV counseling only | 22 (20) |
| Pregnancy test | 9 (8) |
| HIV test | 6 (5) |
| Postnatal visit | 5 (5) |
| Prenatal visit | 2 (2) |
| Distribution of condoms | 1 (1) |
| STI test | 1 (1) |
| Any other FP services | 5 (5) |
| Other [(1)] | 5 (5) |
| *Missing values (N)* | *2* |

*More than one answer possible
[(1)] Analgesic, blood pressure and weight, check-up, injectables

Seventy percent of CT clients received an HIV test on the day that they were interviewed for the programmatic assessment. Clients at GHAIN-supported facilities appeared more likely to receive an HIV test that day (77% of clients at GHAIN-supported facilities received an HIV test; 63% of clients at non-GHAIN supported facilities received an HIV test; data not shown). Besides pre or post-HIV test counseling, CT clients accessed very few other services at the facility on the day of their interview. Although only 5% of CT clients spontaneously mentioned that they had received FP counseling or an FP method on the same day as their visit to the CT center, when queried directly, 12% of CT clients said that the CT provider had discussed any FP methods with them that day. (Table 11) The most commonly discussed method was the male condom. Only six CT clients said they received a method; half of those clients received counseling on abstinence and two received male condoms.

**Table 11: Counseling and Testing Clients Reports on their Clinic Visit**

| | CT Clients N=112 N (%) |
|---|---|
| **I do not want to know any test results, but what services did you receive at this facility today? *** | |
| HIV test | 78 (70) |
| HIV pre-test counseling only | 68 (61) |
| General health education | 67 (60) |
| HIV post-test counseling | 59 (53) |
| Results of HIV test | 56 (50) |
| Referred | 8 (7) |
| Prenatal visit | 7 (6) |
| FP counseling and/or method | 5 (5) |
| STI test | 2 (2) |
| Postnatal visit | 2 (2) |
| Results of STI test | 1 (1) |
| Other [(1)] | 5 (5) |
| **Did the provider discuss any FP methods with you today?** | |
| Yes | 14 (12) |
| No | 98 (88) |
| **Did the provider give you a FP method today?** | |
| Yes | 6 (5) |
| No | 106 (95) |

* More than one response possible
[(1)] ART drugs, Couples counseling, Genotype, Other medical treatment, Vital signs recorded

Less than one-quarter of CT clients touched on subjects relating to FP during their counseling sessions with CT providers during their clinic visit. (Table 12) Providers appeared equally likely to discuss FP needs with both male and female clients.

**Table 12: Counseling and Testing Clients' Reports About Provider Consultation**

| **Did the provider… *** | **Female** **N=79** Yes N (%) | **Male** **N=31** Yes N (%) | *Missing sex response* *N=2* *Yes* *N* | **All CT Clients** **N=112** Yes N (%) |
|---|---|---|---|---|
| Discuss whether or not you want to have a child soon? | 19 (24) | 8 (26) | *0* | 27 (24) |
| Discuss how to prevent an unintended pregnancy? | 19 (24) | 7 (23) | - | 26 (23) |
| Discuss any FP methods with you today? | 9 (11) | 5 (16) | - | 14 (13) |

* More than one response possible

The primary reasons that both FP and CT clients chose the facility they were at included: the facility had the most convenient location, because the client had used that facility before, or because the client had been referred there by another health care provider. (Table 13)

**Table 13: Client Reports on How They Chose Facility**

| | All FP Clients N=113 N (%) | All CT Clients N=112 N (%) |
|---|---|---|
| **Why did you choose this specific Family planning/HIV counseling and testing facility to come to today? *** | | |
| Most convenient location/close to home | 22 (20) | 25 (22) |
| Been here before/regular client | 34 (30) | 24 (21) |
| Referred by other health care provider | 12 (11) | 23 (21) |
| Introduced by friends | 14 (13) | 18 (16) |
| Confidentiality/privacy of centre | 0 | 16 (14) |
| Good service | 0 | 15 (13) |
| Prefer government facility | 8 (7) | 0 |
| Because of IEC/BCC/print/radio/TV advertising | 1 (1) | 6 (5) |
| Partner/husband/wife sent | 16 (14) | 5 (5) |
| Service is free | 0 | 3 (3) |
| Self-referred | 0 | 3 (3) |
| Other [(1)] | 5 (4) | 4 (4) |
| *Missing value (N)* | *1* | - |

* More than one response possible

[(1)] I want the best, likes the place, no other FP clinic, providers work well, service is OK for me

Nearly 100% of CT and FP clients reported they were either satisfied or very satisfied with the services they received at the facility on the day of the interview (Table 14). It should be noted that privacy was difficult to obtain in many FP and CT centers, so dissatisfied clients may not have felt free to express their unhappiness with the services during the interviews. This result should be interpreted cautiously.

**Table 14: Clients Reports on Satisfaction with Services**

| | All FP Clients N=113 N (%) | All CT Clients N=112 N (%) |
|---|---|---|
| **I would like to know how satisfied you are with the services you received today.** | | |
| Very satisfied | 47 (42) | 71 (64) |
| Satisfied | 65 (58) | 39 (35) |
| Unsatisfied | 0 | 0 |
| Very unsatisfied | 0 | 1 (1) |
| *Missing value (N)* | *1* | *1* |

Condom education and distribution

All FP providers and 86% of CT providers said that they talk to their clients about using condoms. (Table 15) CT Providers were specifically asked whether they routinely give clients condoms during their CT sessions. Only 41% of CT providers reported that they routinely distribute condoms and only 13/23 CT managers said that condom distribution was among the services provided at their CT center. Of those 13 CT centers, 8 of them provide condoms for free (data not shown). Only about 60% of FP and CT providers said they educate their clients about condom use using penile or pelvic models.

**Table 15: Providers Condom Education and Distribution**

| | All FP Providers N=60 N (%) | All CT Providers N=73 N (%) |
|---|---|---|
| **Do you ever talk to FP/CT clients about using condoms?** | | |
| Yes | 60 (100) | 63 (86) |
| **Do you routinely give clients condoms during your CT sessions?** | | |
| Yes | n/a | 30 (41) |
| **Do you currently provide the following service to your clients?** | | |
| Educate the client on condom use by demonstrating condom use with a penile model or a pelvic model | 37 (62) | 43 (59) |

Although 100% of FP providers said they discuss condoms with their clients, only about half of FP clients reported that their FP provider had ever told them that condoms prevent HIV or other STIs. (Table 16) Only about a quarter of FP clients said they had ever been offered condoms by their FP provider. At the current visit, only 7% of FP clients and 6% of CT clients were offered condoms by their provider.

**Table 16: Clients' Reports About Provider Consultation**

| | All FP Clients (N=113) | | All CT Clients (N=112) |
|---|---|---|---|
| | Current visit | Ever provided | |
| **Did the provider…*** | N (%) | N (%) | N (%) |
| Discuss how to prevent HIV? | 38 (34) | 57 (51) ^ | not asked |
| Discuss how to prevent other STIs? | 41 (36) | 58 (52) ^ | not asked |
| Talk about abstinence as a way to prevent HIV and other STIs? | 32 (28) | 51 (46) ⊥ | not asked |
| Discuss about faithfulness between uninfected partners as a way to prevent HIV and other STIs? | 36 (32) | 53 (47) ^ | not asked |
| Offer any condoms? | 8 (7) | 27 (24) ^ | 7 (6) |
| Tell you that condoms prevent HIV? | 38 (34) | 52 (47) ┬ | 49 (44) |
| Tell you that condoms prevent other STIs? | 39 (35) | 59 (53) ^ | 59 (53) |
| Tell you that condoms prevent pregnancy? | not asked | not asked | 44 (39) |
| Discuss prevention of maternal-to-child transmission of HIV (PMTCT)? | 14 (12) | 35 (31) ^ | not asked |

* More than one response possible
^ One missing response
⊥ Two missing responses
┬ Three missing responses

## Unmet need for FP and desire for CT

Nearly half of the FP clients interviewed reported ever having been tested for HIV in the past, regardless of what type of facility they were at. In addition, nearly 90% of FP clients said they would like to have an HIV test done sometime in the future. (Table 17)

**Table 17: Desire for Counseling and Testing among Family Planning Clients**

| | FP Clients N=113 N (%) |
|---|---|
| **Have you ever been tested for HIV in the past?** | |
| Yes | 55 (49) |
| No | 58 (51) |
| **Do you think that you would like to have (an/another) HIV test done sometime in the future?** | |
| Yes | 100 (89) |
| No | 12 (11) |
| No response | 1 (1) |

Note: Percentage totals may not equal 100 due to rounding

Over half of CT clients report that they want to have another child in the future, and about one-quarter say that they want no more children. About 50% of CT respondents said they wanted to have a child in the next two years. Only one-quarter of all CT clients reported current use of a modern method of contraception. Among those who said they were interested in using a family planning method to delay or avoid pregnancy, less than half (44%) said they knew where to get a family planning method. Nine percent of CT clients were using a traditional method of family planning, and 64% were using no FP at all. (Table 18)

**Table 18: Counseling and Testing Clients Report on their Fertility Desires and Family Planning Use**

| | CT Clients N=112 N (%) |
|---|---|
| **Looking at the future, would you (and your partner) like to have (a/another) child, or would you prefer not to have any (more) children?** | |
| Have (a/another) child | 70 (63) |
| No more/none | 29 (26) |
| Says she/partner can't get pregnant | 0 |
| Undecided/don't know | 10 (9) |
| No response | 3 (3) |
| **How long would you like to wait from now before the birth of (a/another) child?** | |
| | n=83 |
| In the next two years | 43 (52) |
| After two years | 12 (14) |
| Don't know/unsure | 21 (25) |
| No response | 7 (8) |
| **Are you (or your partner) currently using any method of preventing or delaying pregnancy?** | |
| Yes | 40 (36) |
| **Would you like to start using a method to avoid or delay pregnancy?** | |
| | n=72 |
| Yes | 26 (37) |
| No | 37 (53) |
| No response | 7 (10) |
| *Missing values (N)* | *2* |
| **Do you know of a place where you could receive FP services?** | |
| | n=72 |
| Yes | 31 (44) |
| No | 38 (54) |
| No response | 1 (1) |
| *Missing values (N)* | *2* |
| **Where can you go to get FP services? *** | |
| | n=31 |
| This same health centre | 27 (87) |
| Other health centre (Government) | 8 (26) |
| Private health centre | 5 (16) |
| Chemist/Pharmacy | 4 (13) |
| Community-based distribution (CBD) worker | 0 |
| Other [(1)] | 2 (7) |

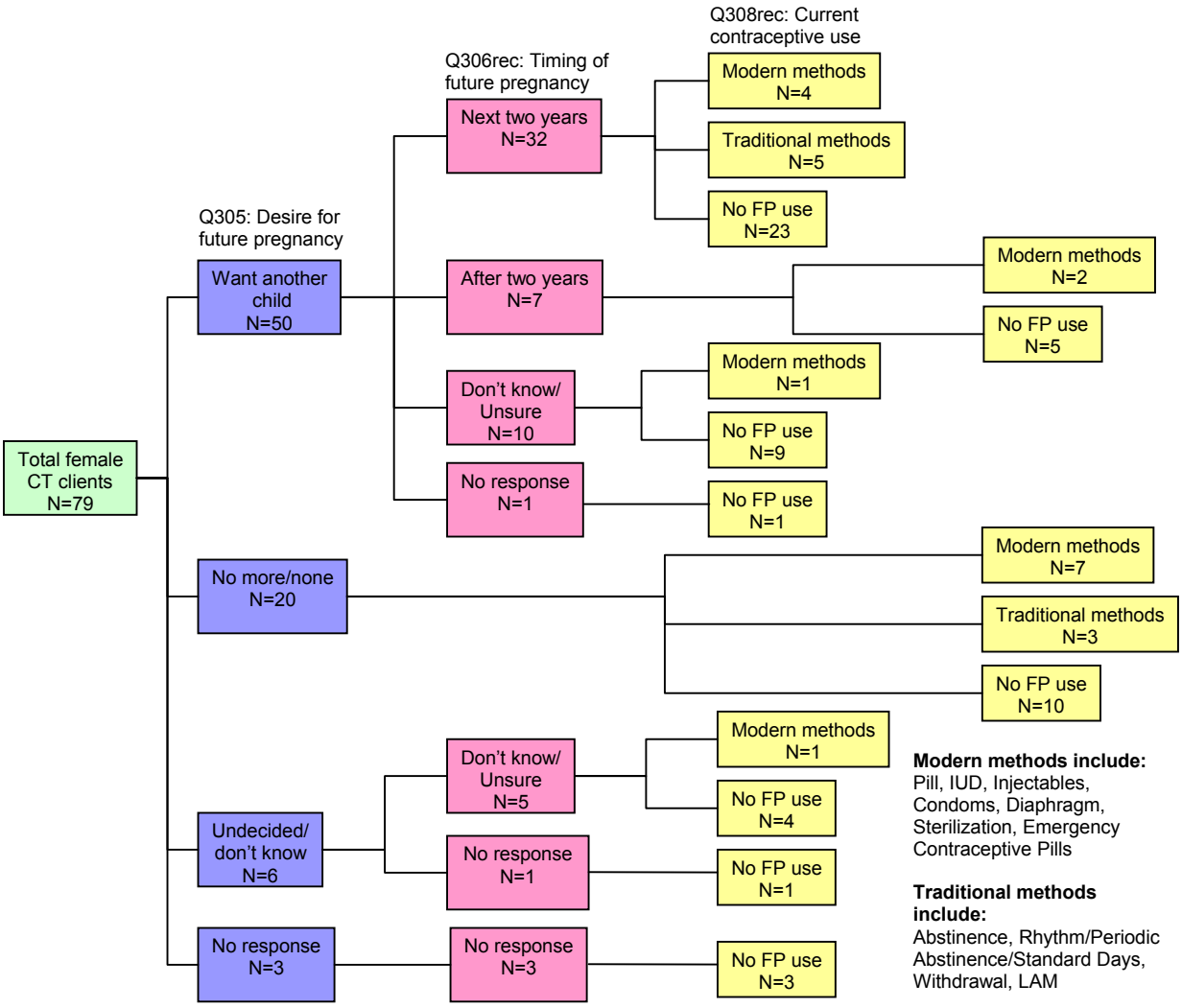
Note: Percentage totals may not equal 100 due to rounding; only N's reported where sample size is fewer than 25
* More than one response possible
[(1)] FBO, From school

According to the Nigeria DHS, a woman with unmet need is defined as a fecund female who reports that she does not want to have a child within the next two years and is not currently using any method of contraception to prevent or delay pregnancy. Interpreting this broadly, we find that 39% of female CT clients interviewed have an unmet need for family planning. (Table 19) Even removing the second and fourth categories (women who are unsure about when they want another child, or if they want another child), the total unmet need decreases to 23%, which is still above the national average of 17% unmet need. Figure 2 is a graphical depiction of how unmet need was determined.

**Table 19: Unmet Need for Family Planning among Counseling and Testing Clients**

| | Female CT Clients N=79 N (%) |
|---|---|
| **Unmet Need for FP** | |
| Want another child in more than 2 years, not using modern FP | 5 (6) |
| Want another child, unsure when, not using modern FP | 9 (11) |
| Want no more children, not using modern FP | 13 (16) |
| Undecided if want another child, not using FP | 4 (5) |
| **Total unmet need** | **31 (39)** |

**Figure 2: Current Unmet Need for Family Planning among Female Counseling and Testing Clients**



Using the four categories of unmet need detailed above in Table 19, we examined unmet need by marital status among the female CT clients. Over one-quarter of single women reported unmet need for FP, and 40% of married women reported unmet need for FP. (Table 20)

**Table 20: Unmet Need for Family Planning among Female Counseling and Testing Clients by Marital Status**

| | **Married or cohabitating** | **Single, never married** | **Divorced / separated** | **Widowed** | ***Missing marital status response*** | **Total Female CT clients** |
|---|---|---|---|---|---|---|
| | **N=45** | **N=22** | **N=5** | **N=6** | ***N=1*** | **N=79** |
| **Unmet FP Need** | N (%) | N (%) | N | N | *N* | N (%) |
| Yes | 18 (40) | 6 (27) | 2 | 4 | *1* | 31 (39) |
| No | 27 (60) | 16 (73) | 3 | 2 | - | 48 (61) |

Note: Only N's reported where sample size is fewer than 25

Referrals

Most facilities visited during the assessment had both HIV counseling and testing and family planning services on-site. The rate of referrals from one service to another was, however, very low. Only about half of services kept statistics on referrals (10/25 FP, 12/23 CT). Among those few services that had statistics, the mean number of referrals for FP clients to CT centers was 19 per month (range 0-121; median 7.5; n=10). The mean number of monthly referrals for CT client to FP services was 3 (range 0-10; median 3.5; n=12). Most clients were referred to public-sector secondary facilities, according to program managers.

The most common methods of referral for both CT and FP services were to issue a referral form, or simply tell the client where to go. Other methods were rarely used among the program managers interviewed for this assessment. Fewer than half the FP or CT services had a way of establishing whether their clients completed the referral (FP 9/25; CT 10/23).

**Table 21: Clients Report on the Referral Mechanism at the Facility**

| | FP Clients N=113 N (%) | CT Clients N=112 N (%) |
|---|---|---|
| **Do you know of a place where you could receive HIV testing?** | | |
| Yes | 82 (73) | n/a |
| **Did the FP/CT provider refer you elsewhere for CT/FP services today?** | | |
| Yes | 11 (10) | 2 (2) |
| No response | 0 | 1 (1) |
| **By what means did the provider refer you to CT/FP services?** | | |
| | n=11 | n=3 |
| Talk to you and tell you where to go | 10 (91) | 2 (67) |
| Other [(1)] | 1 (9) | 1 (33) |
| **How likely is it that you will go for the services you were referred to?** | | |
| | n=11 | n=3 |
| Very likely | 10 (91) | 2 (67) |
| Somewhat likely | 0 | 0 |
| Not very likely | 1 (9) | 0 |
| Not at all likely | 0 | 1 (33) |
| **What problems would stop you from going for the referral visit? *** | | |
| | n=11 | n=3 |
| Not enough time | 1 (11) | 1 (50) |
| Requires partner consent | 1 (11) | 0 |
| Other [(2)] | 5 (56) | 1 (50) |
| Can't foresee any barrier | 2 (22) | 0 |
| *Missing values (N)* | *2* | *1* |

Note: Only N's reported where sample size is fewer than 25
* More than one response possible
[(1)] Conduct test at the clinic
[(2)] Already been tested, Will always get tested, Not important to client

Of the few clients who did receive referrals for CT or FP services on the day they were interviewed by the assessment team, the majority of those clients reported that they were very likely to go for the services they were referred to. Twenty-one percent of CT clients and 11% of FP clients reported that they chose their CT/FP sites because they were referred there by another health care provider (Table 13).

Acceptability of integrated services

The FP clients interviewed largely found that the idea of receiving HIV counseling and testing services in their FP clinic was acceptable (93%). They also reported being comfortable with receiving HIV counseling and testing from their FP provider (95%). Similarly, most CT clients (88%) reported that they would accept receiving FP services at the CT center and that they would be comfortable accepting FP from CT providers 92%. (Table 22)

**Table 22: Clients Reports on Acceptability of Integrating Family Planning and Counseling and Testing Services**

| | FP Clients N=113 N (%) | CT Clients N=112 N (%) |
|---|---|---|
| **In your opinion, would it be a good idea to have CT/FP services available here at the FP/CT centre?** | | |
| Yes | 109 (97) | 102 (91) |
| **Would you accept CT/an FP method if these services were provided at this centre?** | | |
| Yes | 105 (93) | 99 (88) |
| No | 5 (4) | 9 (8) |
| Already provided at the centre | 2 (2) | 2 (2) |
| Don't know | 1 (1) | 2 (2) |
| **Would you be comfortable accepting CT if the same provider that counseled you on FP services provided it?** | | |
| Yes | 107 (95) | 103 (92) |
| No | 5 (4) | 8 (7) |
| Don't know | 1 (1) | 1 (1) |

FP providers and managers thought that adding CT services in the FP clinic would be acceptable, although about a quarter of the respondents said it would be difficult but manageable to add this service. CT providers and managers also said it was acceptable to require them to provide FP services to their CT clients and appeared to be less likely to think the integration of the services would be difficult. There was nearly universal agreement among providers and managers interviewed that it is important to provide HIV counseling and testing to FP clients and to provide family planning services to CT clients.

**Table 23: Provider and Program Manager Reports on Acceptability of Integrating Family Planning and HIV Counseling and Testing Services**

| | FP Providers N=60 N (%) | CT Providers N=73 N (%) | FP Managers N=25 N (%) | CT Managers N=23 N |
|---|---|---|---|---|
| **Overall, what is your opinion about requiring FP providers in this facility to offer HIV counseling and testing services to their FP clients/CT providers in this facility to offer family planning services to their CT clients?** | | | | |
| Acceptable | 43 (73) | 60 (82) | 18 (72) | 19 |
| Difficult but manageable | 15 (25) | 11 (15) | 7 (28) | 4 |
| Not acceptable | 1 (2) | 0 | 0 | 0 |
| Other [(1)] | 0 | 2 (3) | 0 | 0 |
| *Missing values (N)* | *1* | - | - | - |
| **How important do you think it is to provide HIV counseling and testing services to family planning/child spacing clients?** | | | | |
| Not important | 1 (2) | 1 (1) | 0 | 0 |
| Somewhat important | 2 (3) | 2 (3) | 1 (4) | 1 |
| Very important | 57 (95) | 70 (96) | 24 (96) | 22 |

Note: Only N's are reported where sample size is fewer than 25
[(1)] Institutional or Religious belief

FP providers and managers were largely confident that FP service providers would have enough time to do more HIV-related counseling with FP clients. The providers were less convinced that

they would have enough time to provide actual pre and post-test counseling. Over 90% of program managers, on the other hand, thought that FP providers would have enough time for pre and post-test counseling. Both providers and managers were much less convinced that FP providers would have enough time to draw blood for the HIV test. (Table 24)

**Table 24: Family Planning Providers and Managers Readiness to Integrate Counseling and Testing Services**

| | FP Providers N=60 N (%) | FP Managers N=25 N (%) |
|---|---|---|
| **Considering all your responsibilities at this FP centre, do you feel you have enough time to provide the following HIV or STI related services to your FP clients? *** | | |
| Discuss with clients the benefits of knowing their HIV status | 56 (93) | n/a |
| Talk to clients about PMTCT | 55 (92) | n/a |
| Discuss about general HIV/STI prevention and risk reduction behaviors with clients | 53 (88) | 23 (92) |
| Refer clients to CT services | 52 (87) | 22 (88) |
| Help clients assess their risk of HIV infection | 51 (85) | 21 (84) |
| Educate the client on condom use by demonstrating condom use with a penile model or a pelvic model | 46 (77) | 18 (72) |
| Provide "pre-test counseling" | 44 (73) | 24 (96) |
| Provide "post-test counseling" | 39 (65) | 23 (92) |
| Take a blood sample for the HIV test | 27 (45) | 15 (60) |
| **STI related questions *** | | |
| Talk to client about how he/she and his/her partners can avoid STIs | 58 (97) | 23 (92) |
| Provide information on STIs by talking to the client | 58 (97) | 23 (92) |
| Refer clients to obtain STI screening | 54 (90) | 21 (84) |
| Give the client pamphlets about STIs | 51 (85) | 22 (88) |
| Provide drugs for syndromic management | 47 (78) | 21 (84) |

* More than one response possible

CT providers and managers also agreed that CT providers would have enough time to do counseling about family planning methods, but when asked if they had time to provide oral contraceptive pills, only 56% of CT providers responded affirmatively. (Table 25)

**Table 25: Counseling and Testing Providers and Managers Readiness to Integrate Family Planning Services**

| | CT Providers N=73 N (%) | CT Managers N=23 N |
|---|---|---|
| **Considering all your responsibilities at this CT centre, do you feel you have enough time to provide the following FP or STI related services to your CT clients? *** | | |
| Discuss with your female clients if and when they would like to become pregnant | 61 (86) | 19 |
| Talk to men about how their partners can avoid unintended pregnancy | 62 (87) | 19 |
| Provide information or education about FP methods by talking to the client | 54 (76) | 20 |
| Give the client pamphlets about FP or specific methods | 56 (79) | 22 |
| Educate the client on condom use by demonstrating condom use with a penile model or a pelvic model | 52 (73) | 17 |
| Provide oral contraceptive pills | 40 (56) | 18 |
| Refer clients to obtain other FP methods like the IUD, implants, or injectables | 62 (87) | 16 |
| *Missing values (N)* | *2* | *0* |
| **STI related services *** | | |
| Talk to client about how he/she and his/her partners can avoid STIs | 65 (92) | 22 |
| Provide information on STIs by talking to the client | 67 (94) | 23 |
| Give the client pamphlets about STIs | 68 (96) | 23 |
| Refer clients to obtain STI screening | 67 (94) | 21 |
| Provide drugs for syndromic management | 47 (66) | 18 |
| *Missing values (N)* | *2* | *0* |

Note: Only N's reported where sample size is fewer than 25
* More than one response possible

Both FP and CT providers and managers were very confident that they would have enough time to provide sexually transmitted infection (STI) services, like counseling and referrals, but they were less sure that there would be time to provide drugs for syndromic management for clients with symptoms of STI. Overall, CT providers and managers were most hesitant about providing syndromic management services to their clients, which could be a reflection of the numbers of CT providers who have non-clinical training (e.g. social workers, etc.).

Providers and managers of both service types were asked how they thought integration of services would affect various aspects of the quality of services they provide at their center. Family planning providers and managers generally agreed that while their workload and the waiting time for clients would become worse, other aspects of their services would improve in quality, notably the flow of counseling and the comprehensiveness of services. (Figure 3) CT providers and managers had nearly identical concerns about workload and waiting time and were equally optimistic about improvements in comprehensiveness and counseling flow. (Figure 4)

**Figure 3: Family Planning Provider's and Manager's Views on the Effect of Service Integration on Quality of Services Provided**

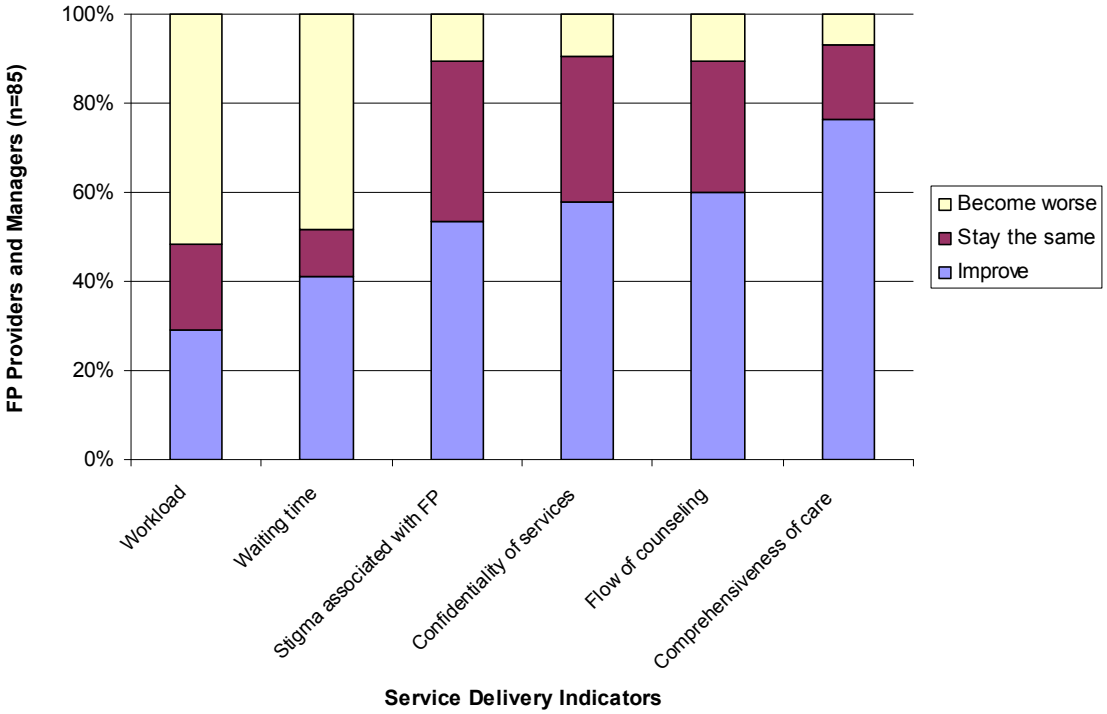
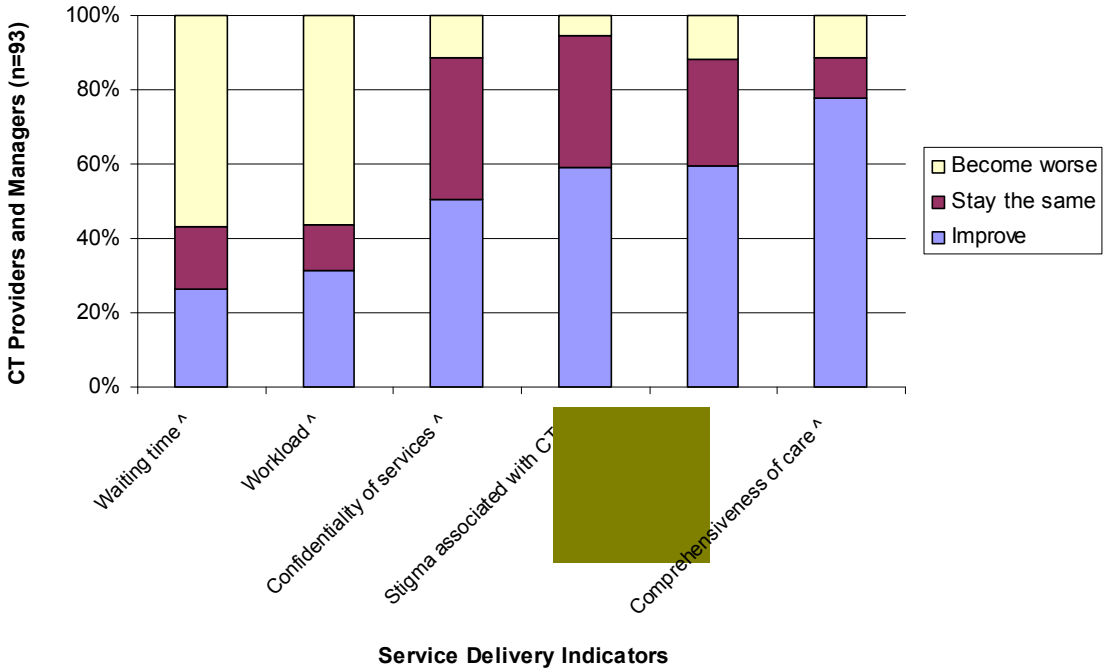



**Figure 4: Counseling and Testing Provider's and Manager's Views on the Effect of Service Integration on Quality of Services Provided**




^ 1 missing response; ⊥ 2 missing responses

Program managers only were asked what integrated services could be offered in their facility. (Table 26) Over 70% of FP managers thought that comprehensive HIV counseling and testing could be offered in FP services and 17/23 CT managers thought that contraceptive methods could be offered to CT clients in the CT center. Fewer managers thought only information could be provided (40% of FP managers and 15/23 CT managers). (Table 26)

**Table 26: Program Managers Opinions About What Services to Integrate**

| | **FP Managers N=25** N (%) |
|---|---|
| **Given the current set-up of your FP centre, in your opinion what type of CT services can be offered here, if any? *** | |
| Information only | 10 (40) |
| Counseling | 19 (76) |
| Referral | 18 (72) |
| Comprehensive counseling and testing | 18 (72) |
| | **CT Managers N=23** N |
| **Given the current set-up of your CT centre, in your opinion what type of FP services can be offered here, if any? *** | |
| Counseling | 22 |
| Contraceptive method choice | 17 |
| Referral | 16 |
| Provision of certain types of contraceptives (1) | 16 |
| Information only | 15 |
| Other (2) | 4 |

Note: Only N's reported where sample size is fewer than 25
* More than one response possible
(1) All types of contraceptives and barrier methods
(2) Billing method, Condoms, Pills, Injectables, IUD, we offer all services

The assessment asked clients, providers and managers when the best time would be to provide integrated services. FP clients largely agreed that it would be best to do HIV counseling before method provision. Few clients thought that integrating these services should require clients to come back for another visit to the facility. (Table 27)

**Table 27: Clients Reports on When Integrated Services Should be Offered**

| | FP Clients N=113 N (%) |
|---|---|
| **At what stage during the provision of FP services do you think it would be most appropriate to talk about CT? *** | |
| During counseling before method provision | 100 (89) |
| During counseling after method provision | 19 (17) |
| Another visit | 11 (10) |
| | **CT Clients N=112 N (%)** |
| **At what stage during the provision of CT do you think it would be most appropriate to talk about FP? *** | |
| During counseling before the HIV test | 67 (62) |
| During counseling after the HIV test | 51 (47) |
| Another visit | 18 (17) |
| *Missing values (N)* | *3* |

* More than one response possible

FP providers were much more likely to suggest integrating counseling and testing services into a client's first visit, than any other visit. This may be because the current practice is for providers to provide FP counseling on the first visit only. Subsequent visits to the FP clinic are very short with the primary aim being to resupply the client. One-third of FP providers and over a half of FP managers said that a separate visit would be a good time to provide CT services to FP clients, however this contradicts the wishes of clients. (Table 28)

**Table 28: Family Planning Providers and Managers Opinions on When to Integrate New Services**

| | FP Providers N=60 N (%) | FP Managers N=25 N (%) |
|---|---|---|
| **Based on your experience with FP clients, when during the visit would be an appropriate time to discuss CT services with them? *** | | |
| During their first FP visit | 54 (90) | 22 (88) |
| On a re-supply visit to the centre | 26 (43) | 20 (80) |
| On an unscheduled or follow-up visit when FP methods are not provided | 20 (33) | 13 (52) |
| Other [(1)] | 6 (10) | 1 (4) |

* More than one response possible

[(1)] All visits, at contact, routine screening appointment, when managing STI

Clients, providers and managers did not seem to have strong opinions about whether FP counseling would be better before or after the HIV test. Only (17%) of CT clients thought that another visit would be required to talk about FP. (Table 27)

**Table 29: Counseling and Testing Providers and Managers Opinions on When to Integrate New Services**

| | CT Providers N=73 N (%) | CT Managers N=23 N |
|---|---|---|
| **Based on your experience, when during a regular CT process would be an appropriate time to discuss FP services with clients? *** | | |
| Prior to pre-test counseling | 27 (37) | 9 |
| During pre-test counseling | 31 (43) | 12 |
| After HIV test is done | 22 (30) | 10 |
| During post-test counseling | 44 (60) | 14 |
| During another visit | 20 (27) | 12 |
| Other [(1)] | 2 (3) | 0 |

Note: Only N's reported where sample size is fewer than 25
* More than one response possible
[(1)] During pre-therapy counseling, when planning for pregnancy

## Anticipated challenges to integration

Providers and managers from both kinds of services were asked what the challenges would be to integrating services. The most common concern for both types of services was not having enough staff members, followed by inadequate knowledge and skills, and a lack of equipment. FP managers were nervous about CT stigmatizing their FP clinics, but some CT providers and managers were also concerned that integrating FP into their services would stigmatize the CT centers. The assessment was not able to probe further to learn more about these concerns, but they would need to be addressed in any integration project. (Table 30)

**Table 30: Provider's and Manager's Opinions on Challenges Associated with Integration**

| | FP Providers N=60 N (%) | FP Managers N=25 N (%) | CT Providers N=73 N (%) | CT Managers N=23 N |
|---|---|---|---|---|
| **In your opinion, what are some of the challenges associated with offering CT services to clients at this FP centre? *** | | | | |
| Not enough staff | 42 (70) | 16 (64) | 52 (72) ^ | 17 |
| Lack of equipment | 36 (60) | 18 (72) | 40 (56) ^ | 12 |
| Inadequate knowledge/skills | 33 (55) | 13 (52) | 49 (68) ^ | 17 |
| Not enough space | 28 (47) | 13 (52) | 29 (41) ⊥ | 8 |
| Not enough time | 25 (42) | 4 (16) | 32 (44) ^ | 12 |
| Inadequate testing [(FP: 1)] or contraceptive supplies [(CT: 1)] | 14 (23) | 6 (24) | 25 (35) ^ | 7 |
| Stigmatizes FP/CT center | 0 | 8 (32) | 12 (17) ^ | 7 |
| Other [(FP::2, CT: 2)] | 2 (3) | 2 (8) | 10 (14) ^ | 2 |

Note: Only N's reported where sample size is fewer than 25
* More than one response possible
^ One missing response; ⊥ Two missing responses
[(FP: 1)] HIV screening kits, Reagents, Test kits, Medical supplies
[(CT: 1)] All types of methods
[(FP: 2)] Convincing FP client, Impair privacy, IEC/BCC materials, Visual aids, Need to be patient
[(CT: 2)] Centre for staff, Difficulty in follow-up, Don't offer FP services, Finance, Increase client waiting time, Institutional/religious belief, More financial remuneration, Patient compliance, acceptability of FP methods, Doctor be carried along

Consistent with their perceived obstacles, program managers in both services reported that additional training would be required to integrate the services. FP managers requested HIV counseling skills, while CT managers requested reproductive health (RH) update training. In addition, however, some FP and CT managers noted that their staff members would benefit from re-training on their current scopes of work. For instance, 2 of 23 CT managers said their CT providers needed training on HIV counseling skills and 16% of FP managers said their FP providers needed RH update training. In addition to these technical areas, managers also very often requested training on management skills for themselves. (Table 31)

**Table 31: Program Managers Report on Changes Required to Facilitate Integration**

| | FP Managers N=25 N (%) | CT Managers N=23 N |
|---|---|---|
| **What changes would be required in order to offer additional CT/FP services in this FP/CT centre? *** | | |
| Additional training | 20 (80) | 19 |
| More staff | 19 (76) | 17 |
| Other specific equipment or supplies | 18 (72) | 14 |
| More space | 16 (64) | 11 |
| HIV testing supplies | 14 (56) | n/a |
| Contraceptive supplies | n/a | 15 |
| Other (FP: 1; CT: 2) | 5 (20) | 5 |
| **What skills or knowledge, if any, do you feel FP/CT providers need to acquire to adequately provide CT/FP services to their clients? *** | | |
| HIV counseling skills | 22 (88) | 2 |
| Interpersonal communication/counseling skills | 19 (76) | 1 |
| Reproductive health (RH) update training | 4 (16) | 22 |
| Other (FP: 3; CT: 4) | 6 (24) | 5 |
| None | 1 (4) | 0 |
| **What skills or knowledge, if any, do you feel would help you better manage the integration of CT into FP and FP into CT services? *** | | |
| Reproductive health (RH) update training | 5 (20) | 21 |
| Management skills | 22 (88) | 18 |
| Management information systems (MIS) | 1 (4) | 18 |
| HIV counseling skills | 17 (68) | n/a |
| Interpersonal communication/counseling skills | n/a | 12 |
| Other (FP: 5; CT: 6) | 4 (16) | 2 |
| None | 1 (4) | 1 |

Note: Only N's reported where sample size is fewer than 25

* More than one response possible

(FP: 1) ARV drugs, Financial backup, IEC materials, Specific policies and models

(CT: 2) Finance, Furniture for office, Integrate health services, Separate cupboard, Staff incentives

(FP: 3) ART/STI training, HIV test training, Policy orientation, Personal prevention skills

(CT: 4) Basic nursing/midwifery, FP providers training, Safe motherhood/PMTCT/ARV, Update on billings method

(FP: 5) Other skills and training, Literature, Financial incentives, Supervision

(CT: 6) Methods are available, Stress management

ANC, STI and youth reproductive health services

Key informant interviews took place in four of the six states (Anambra, Bauchi, FCT and Lagos) of the programmatic assessment. Of 18 facilities where key informant interviews about ANC, STI and youth reproductive health (RH) services were conducted, interviewers were able to interview the managers of 12 ANC clinics, 9 STI services, and 6 youth services. About half the ANC managers said they needed more staff, but nearly all ANC clinics were short on supplies, equipment and in some cases space. Managers thought these shortages would need to be addressed before implementing integrated services. Similarly, STI and youth reproductive health services reported staff shortages frequently and nearly all services reported needing more supplies and equipment if they were to integrate services. In addition, ANC, STI and youth RH services all requested more training for their staff members on FP and HIV topics.

## Conclusions

Strong support from providers, managers and clients for integration in both directions

The evidence from this programmatic assessment demonstrates strong support from providers, managers and clients for FP/HIV integration in both directions (i.e. FP into HIV and HIV into FP). All types of respondents generally thought it was a good idea to provide FP services in CT centers and to provide CT services in FP clinics. Providers and managers also agreed that it was important to provide integrated services to their clients, and they were positive about the effects integration would have on the comprehensiveness of care.

Clear evidence of need among both FP and CT clients

Approximately 40% of CT clients met a definition of unmet need for family planning, and of those CT clients not using FP, 37% said they were interested in using a family planning method. Clearly this is an important population in which to discuss family planning options. It should also be noted that in this assessment CT clients tended to be younger than FP clients. Younger clients may need different messages about FP than the messages typically used in FP services.

Given that 89% of FP clients say that they want an HIV test sometime in the future and that they find it highly acceptable to get an HIV test in the FP clinic, testing in the FP clinic would likely increase the total number of people receiving HIV counseling and testing. This could be an important increase in the total numbers of people who know their status in Nigeria in a time when the government is trying to enroll thousands of people on ART.

A surprising, and encouraging finding is that nearly half of FP clients reported ever having been tested for HIV in the past. We cannot, however, extend this finding to say that nearly half of Nigerians, or even half of women in Nigeria are accessing HIV testing. The women in this sample are women who are already actively participating in the health care system by using family planning, so they presumably would be more likely to access HIV-related services also. In addition, nearly 90% of FP clients said they would like to have an HIV test done sometime in the future – this establishes that there is need for HIV counseling and testing services within the population of FP users.

At the time that the assessment took place few CT providers were discussing family planning with their clients. It was more common for FP providers to discuss HIV testing with FP clients. There is a considerable amount of overlap in the types of responsibilities that FP and CT providers have in many facilities, which implies that both categories of providers would be well capable of offering integrated FP and CT services to their clients.

Need for update training for both categories of service providers

The most common need for introducing integrated services identified by both FP and CT managers is update training in FP and CT. When providers were asked whether their counterpart topic was included in their training, only about half of FP providers said that CT topics were included in their most recent training and approximately one-third (34%) of CT providers said that FP topics were included in their most recent CT training.

It is also interesting to note that around 70% of the FP providers, FP managers and CT managers that were interviewed said that they had ever used a modern method of contraception, but less than half of CT providers said they had ever used a modern form of contraception. It may be that CT providers are not as familiar and comfortable with FP methods as the other groups interviewed.

Referral systems need to be strengthened

In spite of the co-location of CT and FP services in most facilities assessed, referrals from one type of service to the other were relatively low. Record keeping on referral statistics was about average. Follow up on referral was poor. Since a majority of clients expressed a willingness to go for services when referred, efforts should be made to resuscitate the referral systems by reawakening the interest of all stakeholders in the referral system, initiating the development of guidelines for referral and designing a standardized tool for effecting FP/CT referrals (a 2-way referral form), strengthening the decision-making capacity of FT/CT providers for timely referral, and providing quality service delivery at all FP and CT centers.

Need to invest in a commodity support system, as well as equipment

About half of FP service providers and managers reported having a stock out of contraceptive supplies in the previous 6 months. Stock outs were much less common in the CT services (less than 20% of CT providers reported stock out of CT supplies). About half the ANC managers said they needed more staff, but nearly all ANC clinics were short on supplies, equipment and in some cases space. Managers thought these shortages would need to be addressed before implementing integrated services. Similarly, STI and youth reproductive health services reported staff shortages frequently and nearly all services reported needing more supplies and equipment if they were to integrate services.

There is a need to establish commodity and equipment support systems in order to ensure materials needed for services are available at all times; equipment and appliances are functional, and materials are replenished based on forecasting, stock level assessment and inventory. Logistics and supplies should be improved by strengthening institutional arrangements and procedures and processes for purchasing and distributing materials.

Condom counseling should be improved

Although 85% of FP providers said that they discuss general HIV/STI risk prevention and risk reduction behaviors with clients, only 51% of FP clients said that their provider had *ever* discussed how to prevent HIV. Although both types of providers said they talk to their clients about condom use, in most cases fewer than half the clients reported that their provider had discussion condom use in relation to preventing HIV, other STIs or pregnancy during their session with the provider on the day they were interviewed. Changing behaviors requires giving people repeated messages. Providers should take every opportunity to counsel clients about the protective effect of condoms.

Must find a way to support providers so they don't feel overwhelmed when asked to integrate

Providers and managers from both types of services expressed concerns that will arise as a result of integrating services. Such concerns include: shortage of staff, inadequate knowledge and skills, and lack of equipments and stigmatization in both directions. Expressed concerns would

need to be addressed before any integration of project. These will require provision of additional skilled manpower and training/re-training of existing manpower to provide integrated services. Managers and providers can review clinic flow and scheduling practices to identify ways to increase efficiencies and ease the time pressures on providers.

However, in view of the factors that need to be considered before integrating FP and CT services, decisions regarding the level of integration are best left to those organizations implementing these services. Whatever is eventually decided should be such that both providers and managers are not overwhelmed with excessive workload; clients are not unduly delayed during visits to the centers or required to make unnecessary visits.

Interestingly, CT service providers were nervous about FP stigmatizing their centers, and FP service providers were also nervous about CT stigmatizing their centers. Clearly these concerns would need to be addressed in any integration project.

**Recommendations for the implementation of integrated service delivery**

*Support for service integration in both directions*
Although providers, managers and clients at study sites demonstrated support for integration in both directions, this may not be reflected nationally. More concrete steps that facilities can take to enhance staff acceptance of and commitment to the integration of HIV services into family planning and vice versa include: initial sensitization of all stakeholders about the project, involving staff in the planning for these activities, building such activities into the organization's mission statement, job descriptions and service protocols, and seeking out training opportunities to enhance providers' level of comfort and skill in delivering HIV-related and FP services. Managers and providers can review clinic flow and scheduling practices to identify ways to increase efficiencies and ease the time pressures on providers.

*Intensive and Ongoing Needs for Training*
As a pre-requisite to starting service integration, there is need to provide training and/or re-training for both FP and CT providers in HIV and FP topics to equip staff with adequate knowledge and skills, which will enable them to effectively deliver quality, comprehensive reproductive care. To effectively deliver integrated FP/CT services, FP and CT providers must possess a considerable body of knowledge, and skills that is somewhat different from, although complementary to, that required for delivery of basic family planning or CT services. Ongoing training is essential to develop providers' knowledge, skills and comfort levels to address HIV and FP needs.

In the *knowledge* arena of HIV services, providers require up-to-date information on HIV and AIDS, modes of transmission, methods of prevention, STD and HIV linkages, substance abuse and HIV linkages, methods of testing for HIV infection, as well as basic information on available treatments for HIV. In addition, providers may need to increase their understanding of the stigma surrounding HIV which contributes to clients' and providers' reluctance to confront it.

In the *skills* arena, providers may need training in HIV risk assessment, evidence-based methods for risk reduction counseling, counseling related to the HIV testing decision, delivery of HIV test results to clients, and addressing HIV issues in a culturally sensitive manner.

In providing FP services, providers must be well equipped to provide family planning counseling, review of contraceptive methods, STI management, post abortion care (PAC), and also to give methods such as condoms and pills and refer clients to obtain other methods.

*Addressing need among FP and CT clients*
Advocacy and social mobilization will enlist the support of policy and decision makers, community members and organizations on FP and CT program and services. It will enhance male participation, particularly in FP services. Information, education and communication (IEC) materials in support FP and CT service need to be reviewed and developed. IEC materials to promote prevention of HIV and unintended pregnancies should also be developed.

An enhanced logistics support for service integration will promote clients' satisfaction. Logistical support for RH-HIV service integration includes ensuring materials needed for

services (particularly FP commodities, HIV test kits, drugs and supplies ) are available at all times; equipment and appliances are functional, and materials are replenished based on forecasting, stock level assessment and inventory. Logistics and supplies should be improved by strengthening institutional arrangements and procedures and processes for purchasing and distributing materials.

*Adoption of "Client-Centered Care" to facilitate Integration*

Client-centered care focuses on meeting the needs of the client and involves the client as an active partner in the development of a therapeutic plan. There is ample evidence that clients are better served when the content of clinical interactions is guided by the client's needs rather than a standardized "one size fits all" model. This has been demonstrated by research studies in both the family planning and HIV prevention fields.[4-6]

In the family planning arena, client-centered care is associated with more effective use of family planning methods, method continuation and greater satisfaction with care. Client-centered counseling may result in the selection of a method that best fits the client's life circumstances and abilities, contributing to better adherence, better outcomes and greater likelihood of remaining in care.

In the HIV prevention arena, client-centered care is associated with lower rates of sexually transmitted infections (STI), higher rates of return for test results and greater satisfaction with care. Research and experience confirm that clients are more likely to take risk reduction steps when they have self-identified the behavior that puts them at risk and participated in the development of a risk reduction plan, than when they are simply told what to do or not do.[7]

A client-centered approach to care may also help to ease some of the burdens of integration, including time constraints and provider overload. A study done in US showed that a client orientation enabled staff to individualize services to client's needs and to provide more appropriate HIV prevention messages.[7] Other benefits included: decreased client waiting times, increased staff morale, and improved client satisfaction. If client-centered care yields better outcomes in both family planning and HIV prevention counseling, and helps to decrease the burden on providers, a client-centered approach may be the "key ingredient" of successful efforts to integrate HIV and family planning services.

*Strengthening of referral systems*

A weak referral system reduces access to and quality of care. It also makes clients lose confidence in the efficiency of the health system. Although there is a well defined referral system, its implementation and monitoring is poor. Efforts at resuscitating the referral systems should be commenced by:

- Reawakening the interest of all stakeholders in the referral system.
- Producing and distributing national guidelines on referral and referral forms.
- supporting communities to participate in the process of referrals by sustaining availability of forms and establishing revolving funds to support the cost of referrals
- Strengthening the decision-making capacity of care providers for timely referral.
- Providing quality service delivery at all centers.

*Improvement on condom counseling*
Some core elements of CT services—condom use counseling, condom distribution, and referral to services—overlap with those of family planning. However, providers interviewed in this assessment appeared to inadequately address these areas. Counseling on how condoms prevent HIV transmission was adequate, but providers missed opportunities to counsel on how condoms prevent pregnancy. Further, condom distribution was low (only 41% of CT providers routinely distribute condoms to their clients). Providers and managers need to emphasize the dual protective effect of condom in preventing STIs and unintended pregnancy. FP and CT sites should also have regular supplies of condom to give to clients during visits.

In conclusion, integrating FP and CT services will no doubt improve quality and comprehensiveness of care and efficiency in health systems, however in view of the factors that need to be considered (as highlighted above) before integrating FP and CT services, the decision regarding the level of integration is best left to the organizations implementing these services.

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