

**Integrating Family Planning and
Voluntary Counseling and Testing Services in Ghana:
A Rapid Programmatic Assessment**

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Executive Summary

While the overall level of HIV infection in Ghana has remained relatively low, the national estimated prevalence is increasing, and half of the people living with HIV/AIDS are women of childbearing age. In addition to the expansion of HIV prevention and care programs, including voluntary counseling and testing (VCT), family planning has a critical role to play in curbing the HIV/AIDS epidemic in Ghana. Strengthening linkages between family planning and VCT services provides an opportunity to make efficient and effective use of available resources to holistically address clients' dual risks of unintended pregnancy and HIV infection.

Despite the potential benefits of integrating family planning and VCT services, little evidence exists to describe the current demand for and provision of integrated services. Also, potential facilitators of and obstacles to effectively integrating these two services are not well defined. In an effort to address these gaps in knowledge, this rapid programmatic assessment of family planning and VCT services in Ghana examines opportunities for and challenges to strengthening linkages between the two services. The specific objectives of the assessment were to:

- 1.) Document the extent to which family planning services and/or referrals are currently being provided by VCT service providers in Ghana;
- 2.) Document the extent to which VCT services and/or referrals are currently being provided by family planning service providers in Ghana;
- 3.) Identify opportunities for and challenges to integrating family planning into VCT services;
- 4.) Identify opportunities for and challenges to integrating VCT into family planning settings;
- 5.) Define programmatic options for strengthening linkages between family planning and VCT services.

The assessment consisted of a desk review of relevant epidemiological, programmatic, and policy documents and open-ended interviews with family planning and VCT program managers, services providers, clients, and policy-makers. The interviews with nearly 100 key informants explored themes such as attitudes toward integrating family planning and VCT services, readiness of staff and facilities to provide integrated services, and potential demand for family planning services in VCT settings and vice versa.

Overall, the majority of key informants expressed support for integrating family planning and VCT services, explaining that integration offers an opportunity to make the best use of available facilities, logistics, and personnel to provide comprehensive, convenient reproductive health care. The assessment revealed many existing factors that facilitate or hinder the integration of family planning and VCT services in Ghana. These factors related to the general acceptability of integration, human resource capacity, facilities and logistics, and quality of care. In addition, factors related to stigma and gender dynamics were described as potential challenges to integrating family planning and VCT services.

As the notion of integrating family planning and VCT service delivery in Ghana becomes more clearly defined, different levels of integration may be warranted at different facilities depending upon facility resources, logistics, and personnel. Several programmatic recommendations for strengthening linkages between family planning and VCT services in Ghana emerged from the assessment, including developing guidelines for different levels of integrated service delivery and enhancing provider training.

Acronyms

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
DHS	Demographic and Health Survey
FHI	Family Health International
FP	Family planning
GAC	Ghana AIDS Commission
GHS	Ghana Health Survey
GSS	Ghana Statistical Service
HIV	Human immuno-deficiency virus
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
MI	Macro International, Incorporated
NACP	National AIDS Control Program
PLWA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PPAG	Planned Parenthood Association of Ghana
RCH	Reproductive and Child Health
RH	Reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Background

In an era when 38 million adults and children are living with HIV/AIDS, and women of childbearing age account for nearly half of the infected population, family planning has a critical role to play in curbing the HIV/AIDS epidemic.¹ For HIV-positive women, the prevention of unintended pregnancies is essential for preventing mother-to-child transmission of HIV and reducing the number of children orphaned when parents die of AIDS-related illnesses. For both HIV-positive and HIV-negative individuals, contraceptive barrier methods such as the male and female condom provide dual protection against pregnancy and HIV transmission.

While the overall level of HIV infection in Ghana has remained relatively low, the national estimated prevalence obtained from antenatal clinic-based sentinel surveillance is on the rise, increasing from 2.3% in 2000 to 3.6% in 2003.² Also, preliminary data collected for the 2003 Ghana Demographic and Health Survey (DHS)³ provided the first national population-based estimate of HIV prevalence, an estimated 2.2%. In Ghana, HIV infection is spread primarily through heterosexual transmission, but mother-to-child transmission accounts for a full 15% of infections, and half of the people living with HIV/AIDS (PLWHA) in Ghana by 2001 were women.⁴

At the same time that the HIV/AIDS epidemic has been steadily increasing in Ghana, contraceptive use, including condom use, has remained low. According to the 1998 DHS in Ghana, only 22% of married women are currently using any method of contraception, and unmet need for family planning is high at 23%. Among married women using any modern method of contraception, hormonal methods (the pill and injectables) are most widely used, accounting for more than 50% of contraceptive use, while condoms account for approximately 20%.⁵

In response to the epidemic, the Government of Ghana's National Strategic Framework on HIV/AIDS for 2001-2005 supports the expansion of HIV prevention and care programs and services, including voluntary counseling and testing (VCT).⁴ As VCT programs expand, exploring opportunities to integrate VCT and family planning is warranted in an effort to create synergistic relationships between programs, reduce missed opportunities, and ultimately maximize the effectiveness and impact of services.

No single, universal definition of integrated family planning and HIV/AIDS services exists, and the conceptualization of integration can vary. The United Nations Population Fund (UNFPA) and International Planned Parenthood Federation (IPPF) describe integration as "incorporating aspects of two or more types of services as a single, coordinated and combined service" shaped by local context, existing referral networks, client and community needs, as well as an organization's mission and capacity.⁶ The United States Agency for International Development (USAID) also published technical guidance for integrating family planning and HIV/AIDS services. USAID explains how integrated services have the potential "to maximize efficiencies and achieve a broad health impact without sacrificing quality of services and care."⁷ However, it also acknowledges that best practices for integrated family planning and HIV programming are constantly being updated and evidence concerning integration is continuing to expand. While implementation of integration may vary from one setting or organization to another, a continuum of possibilities exists for linking family planning and HIV/AIDS services.

Given that most clients of VCT services are sexually active and of reproductive age, the integration of contraceptive services into VCT programs allows providers to holistically address clients' dual risks of HIV infection and unintended pregnancy. It also provides an opportunity to reach clients who might never seek traditional reproductive health services, such as men and youth, with critical family planning information. Furthermore, unlike prevention of mother-to-child transmission (PMTCT) programs, which are implemented primarily in antenatal care clinics, VCT services provide an opportunity to reach women and couples with family planning services before they become pregnant.

In addition to integrating family planning into VCT settings, incorporating HIV services into the structure of existing family planning programs also constitutes an important HIV prevention strategy and an opportunity to holistically address clients' reproductive health needs. By integrating VCT into family planning services and identifying clients who are infected, family planning providers can tailor contraceptive counseling based on an individual's HIV status. This personalized counseling may increase the salience of dual protection messages and enhance opportunities for averting HIV-positive births. Furthermore, the integration of VCT services into family planning programs provides an opportunity to increase access to HIV services among women of reproductive age, a population not easily reached by traditional HIV programs primarily targeting high-risk, core transmitter groups. Also, using family planning as an entry point for VCT services may increase use of HIV prevention and care services by reducing the stigma associated with vertical HIV programs.

Despite the potential benefits of integrating family planning and VCT services, insufficient information exists to describe the current demand for and provision of family planning in VCT settings. Possible obstacles hindering effective integration of family planning into VCT programs are also not clearly identified. As well, relatively little is known about the current demand for and provision of VCT services in family planning settings, and the obstacles that may exist to integrating VCT services into family planning programs. In an effort to address these gaps in knowledge and better understand the potential contribution of integrating VCT and family planning services, Family Health International (FHI), in collaboration with the Ghana Health Service (GHS) and USAID/Ghana, implemented a rapid programmatic assessment of family planning and VCT services in Ghana.

Assessment Objectives

This assessment set out to gather information that would inform the development and implementation of strategies for strengthening linkages between family planning and VCT services. The specific objectives of the assessment were to:

- 1.) Document the extent to which family planning services and/or referrals are currently being provided by VCT service providers in Ghana;
- 2.) Document the extent to which VCT services and/or referrals are currently being provided by family planning service providers in Ghana;
- 3.) Identify opportunities for and challenges to integrating family planning into VCT services;
- 4.) Identify opportunities for and challenges to integrating VCT into family planning settings;
- 5.) Define programmatic options for strengthening linkages between family planning and VCT services.

Process/Methodology

To achieve these objectives, FHI conducted a desk review and implemented a field assessment with key informants from both the family planning and HIV arenas in Ghana. For the desk review, FHI examined existing, relevant epidemiological, programmatic, and policy documents to understand the distribution of VCT and family planning services throughout the country, to document the policies and guidelines shaping delivery of these services, and to identify the key players involved in family planning and VCT services in Ghana. The field assessment consisted of open-ended interviews with 96 key informants from 11 different facilities that provide family planning and/or VCT services in Ghana. These key informants were family planning and VCT program managers, service providers, lab technicians, clients, and policy-makers. In addition, representatives from the National AIDS Control Program (NACP) and the Reproductive and Child Health (RCH) Unit of the GHS provided their perspectives. The 11 facilities included in the assessment were selected to represent a range of service delivery models, such as hospitals, polyclinics, and stand-alone VCT centers. A variety of operating authorities were also represented at these 11 sites including public, mission, and private facilities. All of these facilities were based in the Greater Accra and Eastern regions, and some had participated in the national joint VCT/PMTCT training program.

In order to tailor questions to an informant's experience and expertise, interview guides were developed for each group of key informants. The various themes explored during interviews with each audience, as well as the number of individuals interviewed, are outlined in Appendix A. To ensure accuracy and enhance the depth of the information gathered, the fieldwork team conducted interviews in pairs, and then synthesized and summarized interview findings for each facility shortly after completing the interviews. The final synthesis of assessment findings presented in this report is based on both the desk review and the key informant interviews.

Findings

Policies and Guidelines

In Ghana, reproductive health policies, programs, and services are shaped by the National Reproductive Health Service Policy and Standards. This document includes not only family planning, sexually transmitted infections (STIs) and post-abortion care among the "essential information for clients seeking reproductive health services," but also mentions HIV services such as PMTCT and VCT as well.⁸ Among the objectives of family planning services, dual protection against unwanted pregnancy and HIV transmission is identified specifically, and VCT is included in the listing of activities to be undertaken by contraceptive service providers.⁸

HIV/AIDS policies, programs, and strategies are guided generally by the Draft National HIV/AIDS/STI Policy and the National Strategic Framework on HIV/AIDS. These guidelines provide broad support for the expansion of HIV prevention and care programs, including counseling services and condom promotion.⁴ National policies regarding the delivery of VCT services specifically are delineated in Ghana's Draft National Guidelines for the Development and Implementation of HIV Voluntary Counseling and Testing.⁹

These VCT guidelines first explicitly mention the possibility for integrated family planning and VCT services when describing the physical set-up of VCT. They state that VCT can be carried out either in stand-alone sites or integrated sites or via mobile services. Integrated sites, or those

“sites that are part of existing health services,” may provide VCT services as a component of general or “specialist medical care” including family planning services.⁹

In addition to describing the integration of VCT into existing family planning services, the VCT guidelines discuss the provision of family planning within VCT sessions. Family planning (FP) is among a list of “services linked to VCT,” and the guidelines state that “basic family planning information should be incorporated into all VCT counseling sessions, both for HIV-positive and HIV-negative clients.” The guidelines add, “when possible, FP services should be provided at the VCT site” and “if this is not possible, HIV-positive VCT clients should be referred for FP services.”⁹

However, in the same document’s discussion of “guidelines on HIV test related counseling,” the topic of family planning is not specifically mentioned as a component of pre- or post-test counseling. Condom use, including condom demonstration, is listed as a component of pre-test counseling, although its dual purposes of protecting against disease transmission and pregnancy are not discussed. Also, “appropriate referrals to additional services” are recommended during post-test counseling, but family planning services are not mentioned explicitly.⁹

Ghana’s National VCT Guidelines state that “it is the responsibility of the counselor to know of and to mobilize additional services to meet client needs.”⁹ The guidelines add, under the section “special circumstances,” that counseling of couples is encouraged for those “who wish to make informed decisions about having children” and should include information about “selection of family planning methods.”⁹ While VCT training modules used to prepare VCT counselors mention that VCT services can “help clients make informed decisions about marriage, pregnancy and sexual relations,” and VCT can serve as an “entry point” for clients who need other services including family planning, specific instruction on family planning counseling is not included in any of the VCT training modules.¹⁰ Condoms are only discussed as a “protection method against HIV transmission,” and other family planning information is not included in the training modules.¹⁰

Location and Distribution of Family Planning and VCT Services

Approximately 25 facilities provide VCT services in Ghana, 15 of which are located in the Greater Accra Region. VCT services are largely integrated into existing health facilities, with only 4 of the 25 VCT sites existing as stand-alone VCT clinics.

Family planning services, on the other hand, are widely distributed throughout the country, and facilities providing temporary modern methods as well as permanent contraception can be found in each region of Ghana. Of Ghana’s more than 400 family planning facilities, the 2002 Ghana Service Provision Assessment Survey reports that 89% (approximately 382 facilities) provide temporary modern contraceptive methods.¹¹ Public health centers and clinics are overwhelmingly the most common types of facilities delivering these methods and other comprehensive contraceptive services.¹¹

Although the Ghana Service Provision Assessment does not explore the availability of HIV prevention or care programs at family planning facilities, the assessment does describe the availability of contraception and VCT at facilities offering HIV/AIDS services. According to

assessment reports, 91% of facilities offering HIV/AIDS services also offer temporary family planning methods. Public facilities are the most common provider of VCT services, and private religious facilities are the second most common.

Family Planning and VCT Services Currently Available

Nine of the 11 facilities included in this assessment provided comprehensive family planning services including information, education, counseling, and provision of a range of modern contraceptive methods. The two facilities without these services, a mobile VCT clinic and a private, church-operated hospital, both offered referrals to family planning services. Family planning providers at approximately half of the facilities reported that they included dual protection messages in their routine family planning counseling.

All of the 11 facilities assessed provided comprehensive VCT services. In addition to diagnostic and walk-in VCT services, the majority of these facilities also had prevention of mother-to-child transmission programs, which served as an entry point for VCT services. All VCT facilities provided condom counseling and/or distribution, and providers at approximately half of these facilities said they included dual protection messages when counseling VCT clients.

Demand for Family Planning and VCT Services

Demand for family planning and VCT services varied greatly between facilities; demand was generally higher for family planning than VCT. At family planning facilities, service providers reported an average client load of 2 patients per day at smaller facilities, more than 35 per day in the outpatient department of a regional hospital, and nearly 50 clients per day at a busy polyclinic. Also, routine records at some family planning facilities for 2003 revealed that a significantly greater number of clients received services than suggested by providers' reports of average client load.

Utilization of services also differed significantly among VCT facilities. Providers and program managers at some facilities reported seeing only a few VCT patients per month while others provided services for as many as 45 clients each week. Higher VCT client load was not limited to one type of facility; a mobile VCT clinic, a public polyclinic, and a private mission-operated hospital all reported an average VCT client load of more than 30 clients per week. This variation in service demand among facilities may reflect differences in client recruitment strategies, since some VCT facilities used community-based agents to increase both awareness and use of services. Also, the length of time VCT services had been available varied greatly among facilities, as did the availability of additional HIV/AIDS services such as antiretroviral (ARV) therapy and PMTCT programs.

Facilitators and Perceived Advantages of Integrating Services

Although referral between family planning and VCT services was common, family planning providers at only one facility offered comprehensive VCT services—including information, education, counseling, and testing—within their family planning counseling sessions. None of the facilities provided comprehensive family planning services within VCT settings. However, the overwhelming majority of VCT and family planning providers, clients, and policy-makers interviewed expressed support for the concept of integrated family planning and VCT service delivery. These key informants identified several advantages of integrating family planning and

VCT services and discussed existing conditions that would facilitate the integration of services. Factors that could ease integration included those related to the general acceptability of integration, human resource capacity, facilities and logistics, and quality of care.

Acceptability

Providers and program managers generally expressed support for increasing integration of family planning and VCT services. According to one family planning program manager, the integration of VCT and family planning was “*long overdue.*” At another facility, a VCT program manager asserted, “*We have already recognized the need for integration. We should initially refer, but later on train them to deliver the whole range of services. A talk was given on family planning to VCT providers at the last counselors’ meeting since we have already recognized the linkages.*” A service provider elaborated further by saying, “*integration is a good idea since they (family planning and VCT) are both counseling. If you have knowledge of all those services, you have to give it to that client.*”

Clients also indicated their support for integrating VCT and family planning services. One family planning client said, “*I think it is a good idea to introduce the HIV testing services. If you have multiple partners, then you would have the chance to do the test.*” Another family planning client agreed, “*Yes, integration will enable everyone who comes to family planning to get information and encouragement to test (for HIV). (Outpatient department) talks should include VCT and it should be given one-on-one as well.*”

Support for integration was also observed within the Ministry of Health. Officials from both the NACP and the RCH Unit expressed a desire to achieve integrated family planning and VCT service delivery, although they recognized that they were in the very early stages of working toward that goal. The NACP officials are largely focused on getting VCT services established, but reported that they eventually hope to see family planning integrated into VCT services as well as VCT integrated into family planning. An official from the RCH Unit expressed a similar desire, adding that integrated services would mean that the range of reproductive health (RH) and HIV services are available to clients “*regardless of their point of entry into the service delivery system.*”

Human resources

At several facilities, providers’ training, workload, and general perceptions about the ease of providing integrated counseling were identified as facilitators of integrating VCT and family planning. In many instances, family planning providers had already received training in VCT, and at a few facilities the same staff were responsible for both VCT and family planning services. Indeed, according to Ministry of Health officials, those providers most often selected to receive the joint VCT/PMTCT training were public health nurses and midwives, most of whom already have a background in family planning.

At facilities where separate providers delivered family planning and VCT services, integrated services were occasionally viewed as an opportunity to reduce duplication of effort and potentially decrease providers’ workload. Neither family planning nor VCT providers reported feeling threatened by others taking over some of their regular duties or

being trained to provide the same services. In addition, several key informants commented that the skills required for VCT counseling and family planning counseling were similar, thus facilitating dual training of providers. One VCT counselor observed, *“You know, counseling for family planning and counseling for HIV, they are not diverse. With just a bit of orientation, you’ll be okay.”*

Facilities and logistics

The layout and the location of family planning and VCT services at many facilities allow for greater integration of services. At all nine facilities offering comprehensive family planning services, VCT was also available within the same facility. In almost all of these facilities, provision of VCT services was *“just steps away”* from family planning services, and a referral link between the family planning and VCT units existed. This proximity of services was often mentioned by providers and program managers as facilitating integration of VCT and family planning. One key informant explained, *“The loss of clients who may refuse referrals would be minimized since the client would not have to leave the building.”* Such intra-facility referrals were not required in one instance where family planning providers actually delivered VCT services within contraceptive counseling visits. Although this degree of family planning and VCT integration was found at only one facility, program managers and providers from other family planning and VCT settings reported having adequate space and appropriate layout for more integrated service delivery. Policy-makers and program managers largely viewed integration of family planning and VCT services as a rational use of facilities and logistics in a resource-constrained environment.

Current record-keeping practices and information, education, and communication (IEC) materials also exist to facilitate integration of services at some facilities. For example, the MOH/GHS *Family Planning Record Book* used at multiple family planning facilities includes a field for recording clients’ HIV status, when it is known. In addition, the record book offers a provider checklist for education of family planning clients, and VCT is included on this list. Also, providers described how the flip chart used to counsel family planning clients at Planned Parenthood Association of Ghana (PPAG) included opportunities to discuss STI and HIV risk reduction and services.

Quality of care and access to services

Integration of family planning and VCT services was viewed by many key informants as a mechanism for increasing quality of care by providing more comprehensive services, enhancing providers’ relationships with clients, and expanding access to services. *“It will rather improve quality of care,”* stated one family planning provider, when *“we provide both services under the same roof.”* Integrated services allow clients to obtain more complete medical care, explained one VCT provider: *“The clients don’t have much access to health information. They confide in us. They ask a lot of questions. Some go and come back to us. They tell us any other problem they have such as STIs and then we refer them.”*

Key informants also discussed the opportunities that integrated services would provide for improved continuity of care and client-provider interactions. When providers know the HIV status of their clients, personalized counseling messages may be delivered and a client’s individual health concerns managed more effectively. Family planning staff believed that

providers could build on the rapport established with clients during contraceptive counseling to facilitate discussion of VCT services, and *“thus save time compared with when a new client has to be counseled afresh for VCT.”* Similarly, some VCT providers reported that *“the confidence of clients won over through VCT could easily (be) built upon for family planning counseling.”*

In addition, clients and providers expressed that integration of family planning and VCT services provided an opportunity to minimize *“missed opportunities”* while improving the efficiency of service delivery. One VCT provider clearly illustrated this increased efficiency by stating, *“you use one stone to kill two birds. She came for VCT and got another service provided.”* This sentiment was echoed by a family planning provider who said, *“It would rather help me and also help the client, and it would save time.”* A family planning client agreed that ultimately time was not a hindrance to integrating VCT into family planning services: *“Why rush away when you would spend more time accessing care and treating the illness if you contract it? It is better to waste time to hear about HIV/AIDS than to rush off and have to come back later when it is too late.”*

Providers often reported that integrating family planning and VCT into *“one-stop services”* would make services more convenient for clients. One service provider explained succinctly, *“if we have all-in-one services here, then the clients can leave and go home.”* A family planning provider further described this benefit to the client saying, *“She does not have to go to every corner before she leaves the polyclinic. It would prevent the client from having to come to the polyclinic at different times for a service you can provide at one sitting.”*

Integrated family planning and VCT services were also often reported as a mechanism for reducing the stigma associated with VCT while increasing overall demand for both VCT and contraceptive services. Clients and providers explained how integrated services could reduce stigma since *“one would not be able to tell which service a client came for.”* One family planning provider explained that *“including VCT into family planning, the stigma is reduced. There is more comprehensive care, patients can encourage each other, and clients who present with their spouses are better off.”* Also, an administrative nurse manager observed that integration of services could improve VCT coverage if HIV counseling and testing are routinely offered to all family planning clients.

Many key informants agreed that integrated VCT and family planning services would *“promote increased acceptance of family planning and VCT”* and *“increase patronization of both services.”* Family planning and VCT providers believed that *“integration ... could increase service uptake,”* and some providers noted that the integration of family planning into VCT could enhance acceptance and use of contraception among men.

Barriers and Challenges to Integrating Services

Although program managers, providers, clients, and policy-makers identified several factors that would facilitate integration of family planning and VCT services, key informant interviews also highlighted some of the barriers that exist and challenges that must be overcome in order to achieve integration. Some of these barriers and challenges may help explain why only one of the assessed facilities is currently providing the full range of VCT services within a family planning setting, and none of the facilities offer comprehensive family planning within their VCT

services. Some factors identified as facilitators were also described by respondents as barriers to integrating services. These factors related to the general acceptability of integration, human resource capacity, facilities and logistics, and quality of care. Additional obstacles related to stigma and gender dynamics were also reported.

Acceptability

Although the majority of key informants reported overwhelming support for integrating VCT and family planning services, a few providers and program managers expressed some reservations. The head of VCT services at one facility was reluctant to integrate family planning into VCT services, while at another facility provider sentiments were mixed. Although family planning staff described their support for providing one-stop integrated services “*under one roof*,” providers at the same facility’s VCT/PMTCT unit opposed integrating VCT and family planning services. One VCT provider explained, “*the clients will be exhausted if you do both VCT and family planning*.” Another staff member, who provides VCT through the facility’s PMTCT program, expressed reservations about integrating comprehensive contraceptive services and VCT, saying, “*I feel that family planning is on its own, you can’t fuse the two*.”

Another factor affecting the overall acceptability of integrated services was the perception that VCT and family planning services have different target populations. At one facility, a program manager reported that their VCT services largely targeted young unmarried people, while family planning services at the facility were most often accessed by married women. These women were perceived to be at such low risk of HIV that the provision of condoms was uncommon. The manager reported that family planning service providers only dispensed condoms to those clients who suspected that their partners were unfaithful, were single mothers, or directly requested them. Similarly, at a few other facilities, family planning providers described offering VCT services only to clients who they believed to be at high risk of HIV based on an individual’s reported sexual and social history. Also, some family planning clients confirmed that they did not perceive themselves to be at risk for HIV and, therefore, would likely decline VCT services. One woman explained, “*I am not disturbed that I could get HIV because I live with my husband. I don’t think anything bad about my husband*.” Another VCT provider did not think it would be appropriate to provide family planning services to older VCT clients.

Ministry of Health officials also acknowledged that family planning clients may not represent those at greatest risk of HIV and, consequently, those in greatest need of VCT services. However, all agreed that opportunities to educate individuals and couples about HIV and encourage testing should not be missed. According to one official, “*irrespective of where clients come from, the provider should talk to them about VCT and impress upon them the importance of knowing their status*.”

Human resources

While some informants reported that integrating services would decrease provider workloads by reducing duplication of effort and increasing efficiency, others felt that integration would actually increase workload and lead to staff burnout. At some facilities, family planning providers reported already experiencing heavy workloads and staff shortages. These providers were concerned that integration of services would worsen these existing challenges. Even at the one facility where family planning providers are already offering VCT, more staff and training

were reportedly needed in order for providers to counsel and follow-up with all clients. Additionally, some providers who were in favor of integrating services felt they would need to be compensated with extra remuneration for the expanded scope of services they would provide under integration, even if the total number of hours worked did not change.

VCT providers were a bit less worried about workload, although they also expressed some concerns. In a few of the busiest VCT facilities, several health workers received training in VCT/PMTCT, but only a few staff actively provided VCT while others remained occupied providing different services within the facility. At other facilities, however, several VCT providers, including a laboratory technician responsible for HIV tests, reported that they could currently accommodate an increased client load.

The need for additional training of service providers in order to offer integrated family planning and VCT services was a common theme throughout the assessment. This additional training was mentioned most often with respect to integrating family planning into VCT services. In facilities where the VCT providers did not already have a background in family planning, they reported having had little exposure to family planning issues. Therefore, they reported needing additional training if they were to provide one-stop services. In most of the facilities assessed, staff providing family planning services had also been trained to provide VCT, and in some facilities the same staff were responsible for both services. Nevertheless, a few family planning providers expressed some hesitation about providing VCT services because they felt inadequately prepared to offer post-test counseling for HIV-positive clients.

Facilities and logistics

A critical facility-level challenge to achieving integration was the lack of adequate space to ensure confidentiality. At a couple of facilities, the current family planning set-up does not provide the level of privacy/confidentiality needed for provision of VCT services. For example, at two different facilities, the family planning counseling rooms were separated by wooden partitions or plywood, which did not ensure complete auditory privacy to the client. Thus, these family planning providers reported needing to redesign their space to accord maximum privacy. For VCT settings, a facility-level obstacle encountered was that many VCT counseling rooms were not equipped for the provision of clinical family planning methods such as the IUD.

A shortage of VCT supplies was reported to be a chronic problem facing VCT programs. Almost all facilities reported shortages of HIV test kits and reagents, which in turn affected demand for VCT. Providers at one facility reported suspending VCT services when test kits were in short supply and, at another facility, the use of expired reagents led to false positive test results for some clients. Because these are concerns for VCT services in general, they clearly have implications for integrated services as well. A lack of contraceptive commodities was also mentioned by a few key informants as a challenge to any efforts to integrate family planning and VCT services.

To facilitate integration of services, respondents at many facilities reported needing IEC materials. Providers at one facility in particular suggested having an on-site banner that would alert clients to the availability of integrated family planning and VCT services. These same providers also said that a revised management information system including data collection

forms and registers would be needed should integrated services become routine. Additionally, a shortage of the new family planning client record book was reported at one busy family planning facility, while the national RH protocol manual and VCT guidelines were not available in a few other facilities.

Quality of care and access to services

Many key informants expressed concern that integrating VCT and family planning services would lead to increased client costs, and that this might hinder uptake of integrated services. Providers at one facility compared the costs of the two services, reporting that family planning services cost ₺10,000 - ₺15,000 per visit while VCT services cost ₺50,000 per test. Several providers thought that HIV testing needed to be more affordable, and a family planning client also reported concern about the high cost of an HIV test.

Several key informants suspected that integration would result in prolonged waiting time for clients and that this would limit uptake of services. Indeed, one provider was concerned that clients “*may go away altogether*” if service integration resulted in longer hours in the waiting room. Other family planning providers commented that their clients often seemed to be in a hurry, and that these clients would not be interested in receiving a full range of VCT beyond information on HIV and service availability.

Another concern was that counseling on family planning and HIV during the same visit may be “*information overload*” for the client. Some providers thought that this may cause clients to have difficulty retaining the information discussed, or that “*clients may mix the information on VCT and family planning.*” Some service providers reported that when they elicit feedback from clients to assess their knowledge after being counseled on family planning alone, information gaps exist. Thus, they raised concerns about how much information would be retained after counseling on both family planning and VCT.

Finally, many providers were not clear how follow-up care would be provided for clients who initiate a family planning method in the context of a VCT session. Skeptical that integrating family planning services into VCT settings would allow for such continuity of care, one provider remarked that “*alternative arrangements are needed for clients who may require more frequent care.*”

Stigma

While many informants thought that integrating family planning and VCT services would reduce the stigma attached to HIV testing, a few were concerned that the stigma attached to VCT might deter clients from accessing family planning services. One family planning provider remarked, “*Some clients may refuse to be tested or even attend the clinic because when they come here we talk to them about HIV as if they have AIDS.*” For this reason, the same provider preferred an arrangement where they provided information on HIV and the availability of VCT services, but referred the client for testing rather than providing the full range of VCT services in the family planning unit. Another service provider explained: “*I think VCT and family planning services, they go together. I don't think it should be a big problem putting the two together. The only problem I see is that when somebody comes for family planning, and then you propose HIV, they*

may think you are being judgmental. It's as if you think that they have HIV. The client may wonder, 'is the doctor seeing some signs in me to make him think I have HIV?'"

Key informants also acknowledged that achieving integrated service delivery would require concerted efforts by providers themselves to reduce the stigma attached to HIV services. Many health workers are unwilling to provide HIV services as part of their routine care, and VCT service providers admitted that the negative attitudes of health workers contributed to a prevailing stigma.

Gender Dynamics

Even if VCT and family planning service integration is achieved, VCT uptake may still be limited by gender-related issues. Many key informants indicated that women offered VCT in family planning settings may not feel empowered to accept testing without their husbands' approval. This sentiment was confirmed by PMTCT providers who said that some of their antenatal care clients refuse HIV testing because their husbands are not there to consent. One family planning client interviewed acknowledged that she was not sure if she would agree to VCT and felt that a positive HIV test would lead to serious problems if her husband found out. Another family planning client who had actually undergone VCT reported that her husband was angry when he learned she had taken an HIV test because it implied she suspected him of infidelity. He accused her of "*not thinking well*" of him and charged that an HIV test was "*not something to play with.*"

Other Themes

The timing and order of service provision was also discussed throughout the assessment. Key informants provided mixed views on when family planning counseling should be introduced during a VCT session and when HIV counseling should be discussed during a family planning visit. With respect to integrating family planning into VCT, providers were split over whether family planning counseling should be introduced during the pre-test or post-test counseling. Advocates of pre-test family planning counseling argued that clients would be too focused on their test results during post-test counseling to meaningfully absorb information on family planning. On the other hand, those in favor of post-test family planning counseling felt that clients would be able to make a more informed decision about a contraceptive method because they would know their HIV status. Some also felt that HIV-positive clients would be more likely to accept family planning.

However, some key informants suggested that family planning counseling during a post-test session may not be appropriate if the client tests positive. One Ministry of Health official explained that the focus of a post-test session for an HIV-positive client is on dealing with the diagnosis. Discussions about family planning would be more appropriate at a follow-up counseling session. A VCT client further explained that family planning counseling would be acceptable during a post-test session, but only if he was negative: "*For me, when I came, my mind was focused on the test. So, maybe after the test it will be alright to talk about family planning if the result is negative.*"

Opinions also varied across the interviews with respect to the timing for integrating VCT into a family planning session. Some program managers and providers believed that VCT should be

introduced early in the counseling session so that it could also factor into method selection, while others thought it should be introduced after a method had already been selected. Most clients were indifferent as to when VCT counseling took place, although one family planning client thought it would be acceptable to discuss VCT during a group session while waiting for individual family planning counseling.

Some policy-makers and program managers thought that the timing for introducing VCT or family planning should be left to the judgment and skill of the service providers. However, regardless of the direction of integration, most key informants agreed that the counseling session should first provide the service for which the client came to the clinic so that their primary motivation for accessing care could be satisfied.

Conclusion

A rapid assessment of family planning and VCT services in Ghana was conducted in order to explore the opportunities for and challenges to strengthening the linkages between these two services. For the most part, the policy-makers, program managers, service providers, and clients interviewed as part of this assessment thought that integrating family planning and VCT services offers an opportunity to make the best use of available facilities, logistics, and personnel to provide comprehensive, convenient reproductive health care. The assessment revealed a number of existing factors favorable to the integration of family planning and VCT services, including:

- Integrated service delivery is already taking place in some facilities, although the degree of integration varies considerably among facilities.
- Most of the existing strategies and guidelines in both areas support linkages between family planning and HIV/AIDS programs.
- The NACP and RCH Unit, the two government programs responsible for VCT and family planning services, respectively, have an established collaborative relationship.
- The overwhelming majority of key informants found the concept of integrated family planning and VCT service delivery acceptable.
- Many of the staff selected to participate in the national VCT/PMTCT training already have a background in family planning.
- Most VCT centers in Ghana are physically located in the same facilities where family planning services are offered.

Despite these favorable conditions, the following challenges were also identified:

- The impact of integrating VCT services into family planning programs may be limited if family planning clients do not represent those at high risk of HIV infection.

- While all VCT clients would benefit from family planning counseling and the opportunity to make informed choices about contraception, demand for VCT services is quite low.
- Even though VCT services are largely being established within existing health facilities, they are conceptualized as separate, distinct services and often are stigmatized.
- There is general disagreement among providers and program managers, and no guidance from policy-makers, on how to operationalize integrated service delivery.
- The national VCT/PMTCT training does not include information on family planning counseling and methods or details on how to integrate VCT and family planning services. VCT counselors with no background in family planning have had little exposure to family planning issues.

Recommendations

The notion of integrating family planning and VCT service delivery in Ghana has not been clearly defined, and different levels of integration may be warranted at different facilities depending upon facility resources, logistics, and personnel. Therefore, the following recommendations emerged from this assessment:

- Guidelines that outline different levels of integrated service delivery should be developed. For example, at a minimum level, providers of both family planning and VCT services should assess a client's risk of both HIV *and* pregnancy and then make referrals for additional family planning or VCT services. At the highest level of integration, family planning providers should offer the full range of VCT services during a family planning visit, and VCT providers should offer family planning counseling and administer the full range of contraceptives. An intermediate level of integration may be for VCT providers to counsel on family planning, provide pills and condoms, and refer for all other methods.
- A facility assessment tool should be developed to help program managers determine the most feasible and appropriate level and direction of integration for their facilities. Considerations should include infrastructure, supplies, financial and human resources, training, client population, demand for services, partnerships, and monitoring and evaluation.
- Trainings should be offered to update providers' knowledge and skills on integrated service delivery. However, the content of these trainings should be tailored depending on the level of integration that is feasible. To achieve the highest level of integration, an integrated family planning and VCT training curriculum should be developed and offered to both family planning and VCT providers. This training should cover how to operationalize integrated family planning and VCT service delivery and enable providers to deliver the full range of family planning and VCT services. When an integrated training is not feasible, VCT providers should, at a minimum, receive refresher training on assessing a client's risk of HIV and unintended pregnancy, providing dual protection counseling, and making referrals to family planning services. Similarly, family planning

providers should be trained to assess a client's risk of HIV and unintended pregnancy, deliver dual protection messages, and refer clients to HIV counseling and testing services.

- Operations research should be conducted to determine the most appropriate organization of services for different levels of integrated delivery; the effect of integrated service delivery on provider workload, client waiting time, client satisfaction, and quality of care; and the impact of integrated service delivery on VCT uptake and contraceptive initiation.
- Providers should be sensitized to conceptualize family planning and VCT as holistic, inter-related services, not as separate, distinct services.
- Community mobilization efforts designed to increase demand for VCT among women *and* men and to decrease stigmatization should be strengthened.
- The government and donors should commit the financial and material resources necessary to ensure contraceptive security and the availability of HIV testing supplies.
- National policy guidelines and standards shaping family planning and VCT service delivery should be available at all service delivery points.

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Appendix A

Key Informant	Number Interviewed	Illustrative Interview Themes: VCT Settings	Illustrative Interview Themes: Family Planning Settings
Service Providers	46	<ul style="list-style-type: none"> • Family planning (FP) services currently provided, including referrals and dual protection counseling; timing of FP provision during VCT session • Attitudes towards integrating FP into VCT (feasibility and acceptability) • Barriers to providing FP services during VCT sessions and possible solutions • Perceived readiness to address the FP needs of clients • Perceived training needs in FP 	<ul style="list-style-type: none"> • VCT services currently provided, including referrals and dual protection counseling; timing of VCT provision during FP session • Attitudes toward integrating VCT into FP (feasibility and acceptability) • Barriers to providing VCT services during FP sessions and possible solutions • Perceived readiness to address the HIV needs of clients • Perceived training needs in VCT
Program Managers	16	<ul style="list-style-type: none"> • Attitudes toward integrating FP into VCT (feasibility and acceptability) • Readiness of VCT staff and facility to provide FP • Effectiveness of current referral mechanisms for FP • Barriers to providing FP services during VCT sessions and possible solutions • Perceived staff and supervisor training needs in FP 	<ul style="list-style-type: none"> • Attitudes toward integrating VCT into FP (feasibility and acceptability) • Readiness of FP staff and facility to provide VCT • Effectiveness of current referral mechanisms for VCT • Barriers to providing VCT services during FP sessions and possible solutions • Perceived staff and supervisor training needs in VCT
Clients	25	<ul style="list-style-type: none"> • Potential demand for FP services in VCT setting • Attitudes toward receiving FP services in VCT setting (acceptability) 	<ul style="list-style-type: none"> • Potential demand for VCT services in FP setting • Attitudes toward receiving VCT services in FP setting (acceptability)
Policy-makers	9	<ul style="list-style-type: none"> • Attitudes toward integrating FP and VCT services • Gaps in current policies/guidelines with respect to FP/VCT integration • Future policy development plans to support FP/VCT integration 	