

Adding Family Planning Services to HIV Counseling and Testing Centers in Kenya

Family Planning

HIV/AIDS

Key Points

- The full intervention increased the delivery of FP information to VCT clients, but it did not improve the provision of contraceptive methods other than condoms.
- Further refinements are needed to Kenya's FP/VCT integration approach—including improved training methods, better supervision, and potentially other systems-level interventions—if the uptake of non-condom contraceptive methods is to be increased in the VCT population.
- More research is needed to understand what intervention strategies are most effective at increasing access to and use of contraception in HIV service delivery settings.

The addition of family planning (FP) services to HIV services is recognized as a high priority in Kenya, but more robust strategies for integrating these services are needed. A recent study found that 29 percent of voluntary counseling and testing (VCT) clients had an unmet need for FP, but only 12 percent of those in need received a contraceptive method after an intervention.¹ There is clearly a need for FP among VCT clients, but evidence of effective approaches to integrated FP/VCT services is lacking.

In collaboration with Kenya's Ministry of Health, FHI revised the existing model of integration to strengthen the delivery of FP in VCT centers. The revised model incorporated several activities:

- A revised monitoring and evaluation (M&E) tool to track integration and remind providers to discuss FP with their clients
- Advocacy and sensitization to the integration
- Training on FP/VCT integration for providers, using a cascade model in which providers who receive formal, off-site training train others who have not attended the off-site training
- Supportive supervision

To determine whether these activities resulted in the successful provision of FP services, FHI conducted the activities in several locations in Kenya and examined the effects on clients and providers.

Evaluating Intervention Activities

The goal of the evaluation was to acquire data on the cost and effectiveness of integrating FP in VCT services to help the Ministry of Health determine whether and

how to expand integrated services to other parts of the country.

Study design. The evaluation used a cluster-randomized, post-test-only design. Of the clients who agreed to participate, 316 were women and 266 were men. All clients were 18 years of age or older.

Three “treatment” groups were created among 18 facilities in Kenya's Coast and Rift Valley provinces, where FHI collaborates with the AIDS, Population and Health Integrated Assistance (APHIA II) Project. A full-intervention group received all four interventions. A partial-intervention group received only the revised M&E tool plus advocacy and sensitization. A control group received none of the interventions. Nearly all facilities, however, had condoms, pills, and injectables available for distribution on site. (One facility in the control group had only condoms on site.) Specific objectives were to:

- Determine whether clients in the full-intervention group—particularly those in need of contraception—were more likely to receive FP information and methods than their counterparts in the other two groups
- Determine the costs of scaling up the full and partial interventions

The data were collected using interviews with clients and providers, observations of interactions between clients and providers, a revised M&E form, and cost data spreadsheets. Data collectors observed 542 client-provider interactions—130 in the control group, 207 in the partial-intervention group, and 205 in the full-intervention group. Exit interviews with 582 clients were conducted after the counseling

session (men and women who were counseled as a couple during the client-provider interaction were interviewed separately for the exit interview). M&E data were collected for all clients, except for those in the control group.

Results. The control group had the highest proportion of women (21 percent) with an unmet need for FP. The full-intervention group had 16 percent unmet need, and the partial-intervention group had 11 percent unmet need.

The provision of FP services to female clients varied among the three groups. In the full-intervention group, 15 percent of women received a contraceptive method (9 percent condoms, 6 percent hormonal methods). None of the women in the partial-intervention group received a method, and 10 percent of the women in the control group received a method, all of which were condoms. Women were referred for family planning services more frequently in the control group (12 percent) compared to the partial- or full-intervention groups (both 2 percent).

Counseling sessions with providers in the full-intervention group covered a greater number of family planning topics than did those in the other two groups. Nevertheless, providers in all groups discussed fewer topics than expected. Providers who had been formally trained in FP/VCT integration correctly answered questions about FP more frequently than did untrained and cascade-trained providers. But, the FP knowledge of formally trained providers was still lower than expected. Trained and untrained providers had similar attitudes about FP.

The cost of scaling up the full intervention at the provincial level was estimated to be US\$237,520, based on the assumption that each province has 6 districts, each district has 12 VCT centers, and each center is staffed with 3 providers. Training accounted for close to 90 percent of the cost of a full intervention. The partial intervention, which had no training component, was much less expensive.

Discussion and Recommendations

Few clients in any intervention group received a contraceptive method at the VCT centers. Of those who received a method, most received only condoms. Considering receipt of and referral for methods, the control group performed as well as the full-intervention group. Based on this outcome, none of the interventions was especially successful. However, formally trained providers were more likely to discuss FP with their clients.

Formally trained providers also outperformed untrained providers in contraceptive knowledge. However, their knowledge was far from complete. Providers who were trained by the cascade method performed no better than untrained providers. Thus, the overall training program needs to be improved. While the formal training of providers in the full-integration model improved FP counseling sessions compared to the partial intervention, the formal training was costly. The cascade training component, while inexpensive, was not effective.

Low provision of FP methods in this study may have also resulted from supply shortages and delayed supervision visits due to post-election violence. In order to improve and sustain integration activities, clinics must ensure that methods are readily available for the women who want them (whether in the facility or by referral), that supervision reinforces knowledge and practices gained through training, and that advocacy and sensitization occurs at all levels. In addition, the M&E intervention component, which consisted of adding FP indicators to the VCT M&E tool, could be improved by orienting providers to the indicators, correcting misinterpretations of them, and ensuring supervision of data collection. Strengthening and maintaining these support structures, will likely contribute to better outcomes for FP/HIV integration programs.

Reference

- 1 Reynolds HW, Beaton-Blaakman A, Burke H, Janowitz B, Nasution M, Reuben E, et al. Integrating family planning services into voluntary counseling and testing centers in Kenya: operations research results. Research Triangle Park (NC): Family Health International; 2006.

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FP/HIV-10-07E

Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709 USA
Tel: 1.919.544.7040
E-mail: publications@fhi.org
www.fhi.org