



**INTRAHEALTH
HIV/AIDS CLINICAL SERVICES PROGRAM (HCSP)
Gasabo, Gicumbi, Nyagatare and Rulindo Districts**

Rwanda



Mildmay International



University of North Carolina

**Assessing the gap for optimal FP and HIV services integration at
selected HCSP Intrahealth supported clinical sites in four districts
in Rwanda**

**Final Report
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October/2008**

**USAID/Rwanda
Cooperative Agreement No. 696-A-00-07-00112-00**

1. Purpose of the baseline survey

To assess the current FP practices in the IntraHealth HCSP-supported health facilities and integration with HIV/AIDS services

2. Background and context

The IntraHealth HIV/AIDS Clinical Services Program (HCSP) is a five-year program funded by the U.S. Agency for International Development (USAID) that will reinforce Rwanda's health care system and expand access to HIV/AIDS clinical services focusing on the four Rwanda districts of Gasabo, Gicumbi, Nyagatare, and Rulindo.

The HCSP IntraHealth-led team is collaborating with Rwanda's Ministry of Health to increase the availability and accessibility of needed HIV/AIDS treatment, care and prevention services, including prevention of mother-to-child-transmission of HIV.

According to the 2005 Rwanda DHS, there remains a 38% unmet need for contraception among couples. Integrating FP and HIV/AIDS services maximizes the use of resources for achieving national goals in reducing HIV transmission and increasing contraceptive prevalence.

In the interest of integrating HIV services and family planning services, a group of USG-supported HIV and FP implementing partners have worked to define a service delivery model and implementation activities that would improve access to and quality of family planning, particularly for PLWHA. During their regular meetings, a set of challenges and issues to be addressed were identified: support FP as a Rwandan government priority for both HIV infected and HIV-negative people, frequent unintended pregnancies among known HIV+ women, frequent modern method contraceptive failures among HIV+ women, typically due to interruption in FP use, obvious access barriers, such as limited availability of FP services to certain days or cost, FP issues unique to HIV+ persons, such as the need for dual contraception, FP as one pillar of PMTCT and the need to actively monitor and support family planning as part of routine HIV care.

As of early May 2008, the proposed model of integration agreed on by the FP-HIV group and endorsed by TRAC Plus/CIDC was submitted to the MOH Unit of Planning, Policy and Capacity Building for official approval. The FP-HIV group agreed to keep moving forward: each individual HIV partner consented to implement the following activities in their respective sites:

- Baseline survey
- Meet with FP partners for each district to outline training timeline
- Meet with each site to discuss model of FP-HIV integration, logistics and expanded practice
- Plan mini-training of sites

In this context and in the continuity of other USG collaborating agencies, the IntraHealth HIV/AIDS Clinical Services Program is fully aware of the fact that integrating FP and

HIV/AIDS services maximizes the use of resources for achieving national goals in reducing HIV transmission and increasing contraceptive prevalence.

The IntraHealth HIV/AIDS Clinical Services Program will continue to support the Government of Rwanda and district partners to reverse the burden of the pandemic HIV/AIDS disease by promoting all preventive interventions and programs envisioning to mitigating the spread of the infection.

Though integrated STD/HIV services are fairly recent, integration itself is not new to health programs. Family planning has been integrated into maternal and child health services- and for many of the same reasons people now propose for integrating STD/HIV/AIDS services. One of thought out steps required to launch services integration is the baseline survey to assess the feasibility and the real-life and current service delivery. The information gained will be invaluable in the design of the service delivery system.

3. Process

A simple questionnaire developed by the FP/HIV Integration Group was used.

Interviewed were facility staff working in FP and HIV/AIDS services and available on the day of the visit. And the manager of health center or their deputy or their delegate were also included in the interview group especially on general information of the health facility, human resources, FP funding sources.

The following topics were covered: general information, family planning counseling and referrals, family planning services and methods, integration of HIV into FP, PMTCT, VCT and ART services.

4. Main findings

We visited 22 health facilities.

District	Number
Gasabo	4
Rulindo	7
Gicumbi	10
Nyagatare	1
Total	22

Following are their characteristics:

➤ Type

Type	Number	%
Public	16	72.73%
FBO	6	27.27%

➤ **Number of staff trained in FP**

	Health Facility	Tot Staff	Trained FP	%	Trained VCT/PMTC	%	Trained ART	%
Gasabo	Jali	13	12	92	13	100	4	31
	Gikomero	7	6	86	7	100	3	43
	Kayanga	5	5	100	1	20	1	20
	Rubungo	14	1	7	9	64	4	29
Rulindo	Rwahi	6	1	17	4	67	4	67
	Rukozo	7	2	29	7	100	7	100
	Murambi	8	4	50	0	0	0	0
	Remera-Mbogo	7	7	100	7	100	0	0
	Kinihira	10	10	100	10	100	5	50
	Kajevuba	7	7	100	7	100	3	43
	Kiyanza	8	7	88	8	100	3	38
Gicumbi	Tanda	7	7	100	7	100	2	29
	Rwesero	9	1	11	8	89	6	67
	Rutare	8	5	63	5	63	4	50
	Munyinya	10	1	10	8	80	5	50
	Byumba	12	9	75	12	100	1	8
	Bushara	8	3	38	0	0	0	0
	Mukono	10	9	90	9	90	4	40
	Giti	9	2	22	7	78	1	11
	Rushaki	12	2	17	6	50	5	42
	Kigogo	9	7	78	6	67	2	22
Nyagatare		8	4	50	8	100	5	63
	TOTAL	194	112	58	149	77	69	36

➤ **Referrals and family planning counseling**

Considering internal and external referral, health facilities can be categorized into the following:

- Sites where there is no specific room for FP counseling and services: no need of referral, the “one stop shopping”: Mukono, Rutare, Munyinya, Kinihira to some extent and Kigogo.
- Sites with specific rooms:
 - o Public and protestant FBO: A client is just provided with FP counseling and methods in general then oriented to the FP ward where they can be offered FP methods
 - o FBO (catholic): only NFP methods are available at these sites. Other modern FP methods are provided at health posts nearby. No referral system exists for clients tracking and follow up.

Concerning FP counseling techniques are used in these health facilities at some degrees depending on whether they are public or religious. Group counseling sessions are all given, the clients are directed in other services like ANC-PMTCT, VCT, ART, immunization, follow up of exposed children, IMCI where available. These serve as entry points for most of health services where there still exists specific room for FP services.

The pharmacy seems not to be integrated in this services delivery.

Key messages addressed during counseling sessions include the national policy on FP, benefits of birth spacing, effectiveness and safety of FP methods, transmission of HIV in pregnancy and the impact of HIV on pregnancy.

Tools and training material used are available but limited to some extent especially in health posts: FP flyers, brochures, billboards, condoms, and commodities (pills, implants, IUD, injectables).

➤ **FP services and methods**

Short term methods (pills, depo, and cycle beads) are available and utilized in all HF visited except in catholic FOSA where only cycle beads and other NFP are the only methods accepted.

Long term methods available include Jadelle (implants). Some IUDs are available for education sessions.

In Gicumbi district, an outreach strategy allows doing vasectomies at HF level (Mukono, Munyinya and Rutare).

Male condoms are available in all health facilities visited.

There is generally no cost associated with FP services (initial consultation (where it exists), FP commodity, and follow up).

However an additional amount of RWF 1000 or 200 is paid for Jadelle insertion (Kiyanza, Kajevuba, Murambi, Jali and Nyagatare).

The following MOH tools are used to document FP: registry, client chart and card (carte de liaison). These tools were not applicable in catholic health facilities (Rwesero, Rubungo and Rushaki).

HIV status is noted in registries in the observations column. Some health facilities (Mukono, Jali, Munyinya...) have self initiated a register for HIV patients taking ARV. Where specific FP room and services are still separated from other HF services, entry points for FP are maternity, postpartum consultation, VCT, HIV care, ANC-PMTCT (in the same local), curative consultation, immunization, growth follow up for exposed infants, IMCI (where available).

Most health facilities do not integrate surgical cases except for Tanda.

Information, counseling and education on FP are provided by trained nurses and social workers.

Where all the staff is not trained on formal FP, some health facility leaders have informally trained their staff on the site (Munyinya). Jadelle is only inserted by the FP-trained provider.

➤ **Integration of HIV into FP**

18 out of 22 health facilities have all their FP staff trained in VCT and PMTCT. In VCT clinic for FP clients, HIV risk is assessed depending on individual appreciation, and VCT not systematically recommended for at risk women enrolling in FP.

Concerning the physical organization of FP service delivery: FP samples, depliants, registers are transported to different rooms to support FP services if needed outside of the FP services: 10/22, 9/22 have a room specific and organized for FP services and in 10/22, they adopted a way to document a woman's HIV status on existing FP client by noting the HIV serostatus in the registry.

➤ **PMTCT Services**

There are operational in 19 out of 22 HF. PMTCT services are offered one day per week in 14 HC, 2 days per week in 4 HF and 3 days a week in one health facility.

Our assessment revealed that FP counseling, education, information and services are provided to PMTCT clients as a part of the program in the ANC, maternity, during postnatal care, exposed infant follow up and immunization but with some extent.

And follow up on the FP method chosen by clients is done by client card, PMTCT register, and community health workers assist in tracking them.

In 14 out of 22 health facilities, all PMTCT staff is formally trained in providing FP services.

The training was funded and organized by Prime II and Capacity in Gicumbi and Rulindo and by IntraHealth Twubakane in Gasabo.

FP status is documented in PMTCT registers.

➤ **VCT services**

They exist in 19 out of 22 health facilities.

And services are offered a day per week in 4 HF, two days in 3 HF and 3 days or more per week in 12 health facilities.

On the inquiry on whether VCT clients receive routinely FP counseling and services as a part of the VCT activities, only clients that turn out HIV positive are provided with FP counseling and education during the post test counseling. However these FP activities are not documented because VCT files/registries have no space to record them. FP services in VCT activities where applicable are provided by nurses and are not all trained in FP though some were oriented by their peer colleagues at the site (Munyinya).

VCT registers/files are designed in the way that does not allow to document FP activities. And even when the VCT client tests HIV+, and chooses a FP method, they are referred to FP services or not at all followed up closely. There are many missed opportunities of FP in VCT clients due to the lack of tools and of an efficient referral system in all health facilities.

➤ ART Services

ART services are available in the following health facilities: Jali, Rubungo, Rwesero, Rukoza, Kinihira, Rutare, Munyinya, Mukono, and Rushaki and open every day even in the weekend to provide clients with ARV drugs and follow up.

Women and couples on ART receive FP services as part of ART services in Munyinya, Mukono, Rutare, Jali, and Kinihira.

FP services are provided by both nurses and doctors in 3 HF, by nurses 5 HF, not provided in one HF.

Only in 5 health facilities, providers at the ART clinic are trained in FP.

The existing ART registers do not allow to document FP counseling and service utilization. Some health facilities have self initiated registers where patients on ART and their FP methods are recorded: Jali, Kinihira, Rutare, Munyinya and Mukono.

In one catholic ART site, no FP information is recorded but following a number of pregnancies notified in women taking ARV, the head is strongly willing to strengthen collaboration with the local leaders, community health workers and the nearest health post to ensure all referrals are effectively followed up on taking FP methods and documented (Rushaki). The HC provides male condoms to couples when one of partners is taking ARV.

For other ART sites, the challenge is on existing ART registers where there is no space to document FP activities.

5. Conclusion and recommendations

The goal of the integration of FP into HIV and vice versa is to meet the needs of the clients in the most efficient manner. Clients' needs include the need for specific services whenever they come to the facility, such as information, referrals, privacy, and brief waiting time. This means that many different services should be available at the site whenever it is open, so that clients will not need to make several visits to receive the health services they need. Integrated health and family planning services offer managers the possibility of providing *more convenient and comprehensive services to the client and more streamlined and cost-effective systems at the service site.*

In comparison to HIV services, there is low FP-trained staff in visited health facilities and all health care providers are not technically competent to offer FP counseling and services. This report has revealed that family planning services are not open every day, which results in missing out many opportunities for clients coming to visit them at any time. Management information systems for family planning services, for PMTCT, for VCT and for ART are not really integration-friendly and do not allow the providers to document all integration related activities done in either service

Successful integration of family planning services with other health services provided in the health facilities will depend to a great degree on the leadership capabilities of the heads of health centers. So a special program for developing their leadership capabilities is needed.

When integrating services, focusing on the client's needs provides a convenient starting place for considering ways of developing or improving integrated services. There is need to develop systems in which staff can work together to assess client needs and use this assessment as the basis for developing better integration.

An inter and intra facility referral system is essential for effective integration of services. HF managers should work with their staff to develop a system for both identifying needs of clients that come to the facility, and for referring them for other services within the facility as soon as these needs have been identified.

To have the program of integrated services succeeded, there is need to have staffs that are technically competent in the entire range of services provided by the facility.

Training family planning service providers in HIV/AIDS and HIV/AIDS providers in family planning may eventually achieve greater integration. In addition, it may help provide back-up coverage for vacation or illness for either HIV/AIDS or family planning service delivery, and thus prevent disruption of facility services.

6. Next steps

- Advocacy and partnership to MOH MCH and Integration of HIV in the health system Task Forces and other partners the following actions: policy guidance (norms and standards), development of tools, guidelines and protocols, coordinated supervision, organization and management of health services and HR and health information system.
- Meet with FP and HIV partners for each district to outline training timeline (Capacity, Twubakane, UNFPA);
- Meet with each site to discuss model of FP-HIV integration, logistics and expanded practice
- Continue advocacy and partnering with FBO leaders to increase their understanding of the role of FBOs in HIV prevention and family planning, and to design plans for partnering with FBOs to halt the spread of the virus.
- Discuss with health facility staff on the reorganisation of services, delivery of the integrated package of services, health information system and management of drugs, diagnostics and supplies.
- Organize Clinical FP trainings for all health care providers in HCSP-supported sites
- Organize coaching sessions on the use of this gap assessment exercise for the sites themselves especially in Nyagatare (knowledge transfer)
- Meet with FP and HIV partners for each district to outline training timeline (Capacity, Twubakane, UNFPA);
- Meet with each site to discuss model of FP-HIV integration, logistics and expanded practice