

# Integration of HIV prevention and testing into FP services: lessons learnt from Kenya

Dr Saiqa Mullick (Senior Associate), Dr Ian Askew (Director)

Population Council (FRONTIERS)



# Acknowledgements

- Mr Wilson Liambila
- Ms Charlotte Warren
- Dr Josephine Kibaru
- Dr Robert Ayisi
- Dr Marsden Solomon
- PHMT, DHMT, PASCO and DASCOS in Central Province
- Participants

# Funding

- The study presented was supported by the President's Emergency Plan for AIDS Relief through the U.S. Agency for International Development's Kenya Mission

# Overview

- Context in Kenya
- Rationale for integration
- Key results
- Lessons learnt
- Challenges

# Context

- High HIV prevalence (6.7%)
- Higher HIV prevalence amongst women
- Roll out of vertical HIV related services (PMTCT, VCT, ART) but uptake needs to improve (VCT uptake 13%)
- Women less likely to have heard of VCT (48%) than men
- Women less likely to have used a condom in last high risk sex encounter than men (24%)
- VCT offered during pregnancy through PMTCT programs or stand alone

# Context

- Relatively high contraceptive prevalence rate (40%)
- High utilization of public sector FP services
- FP services relatively well established
- High proportion of women who obtain contraceptives from public sector (58%)
- Majority on hormonal contraception and therefore not protected against STI/HIV
- High proportion of women reporting unwanted pregnancy (20%)

# There is a rationale for integration of HIV prevention and testing into FP services

- STIs and HIV are common in FP clients, yet FP providers miss opportunities to integrate information about other services
- FP services in these countries offer an opportunity to reach a large number of sexually active women
- Repeated visits offer the opportunity for follow up
- Reduction of unwanted pregnancies in HIV positive women a key PMTCT strategy

# Policy Context

- Policy environment conducive
- National Reproductive Health Strategy (1997-2010)
- National Health Sector Strategic Plan (NHSSP II 2005-2010)
- “Draft Strategy for integration of VCT services and FP services” defines integration as *“the incorporation of some or all of the components of FP services into existing VCT services and vice versa”* (MOH 2005)

# Objectives

- To assess the feasibility, acceptability, effect and cost of integrating HIV prevention, VCT information and services into FP services
  - To develop and implement a model of integration that educates FP clients about VCT and offers them C&T within the routine visit by an FP provider
  - To develop and implement a model that educates FP clients about VCT and refers interested clients for testing to vertical services
  - To describe the feasibility and acceptability of implementing each of the two models and provider perspectives
  - To assess the effect on integration on quality of FP services received

# Objectives

- To assess effectiveness in terms of increasing VCT uptake
- To assess the incremental costs of implementing the integrated models

# Methodology

Pre-post intervention design without control group

Participants were FP clients and FP providers

Central province: Nyeri (low VCT availability) and Thika (high VCT availability)

- Clinics which:

- Provide family planning services
- Have a high volume of family planning clients ( $\geq 100$  per month)
- Have more than one professional nurse
- Conduct HIV testing
- Provide treatment for sexually transmitted infections

# Description of Interventions

In both interventions:

- Family planning services were standardized and strengthened through training providers in the “Balanced Counseling Strategy” (BCS) approach to family planning
- HIV/STI prevention, dual protection and VCT awareness information was integrated into FP services

# Balanced Counseling Strategy

- Algorithm for family planning and a supporting set of job aids.
- The job aids consist of a set of palm-sized cards, one per contraceptive method, designed for providers to use and to facilitate discussions with clients.
- Each card is dedicated to one method and their use begins with laying out a set of choices of methods and eliminating unsuitable methods as the consultation proceeds.

# Balanced Counseling Strategy

- In the end the client is provided with information and a choice on the narrowed down set of appropriate methods.
- The information is also given to the client in the form of a pamphlet to take home.
- Cards on STI/HIV risk and dual protection were also used during the session to ensure that STI risk information is provided during all consultations (“BCS plus”).

# Intervention Description (cont)

Two integration models:

- High level integration (Nyeri): FP  
Providers trained to conduct routine offer of C&T and conduct testing if required – 9 day training
- Low level integration (Thika): FP  
Providers trained to conduct routine offer of C&T but refer to vertical service for testing – 5 day training

# Implementation Steps

- Sensitization of the National, Provincial and District teams
- Reviewing and developing a training strategy, training materials and job aides in collaboration with DOH
- Strengthening routine data collection in FP and VCT services
- Provide supervision and support for providers
- Strengthening basic supplies and commodities
- Training of health providers (75 – May 06)



# Evaluation Tools

- Pre and post intervention FGDs with clients and providers
- Facility assessments
- Pre and post intervention client –provider observations and exit interviews
- Routinely collected data

# FP Clients are at Risk of HIV and STIs

- 51% do not know their HIV status
- 24% say their partner has had a test
- 37% plan to have more children
- 4% used a condom in the last month
- 24% ever used a condom
- 96% are using hormonal contraception
- 2% using a condom with their hormonal method

## QUALITY OF CARE INDICATORS

	Testing Model (Nyeri)			Referral Model			P-value
	Baseline Mean	End-line Mean	P-value	Baseline Mean	End-line Mean	P-value	
Scores:							
STI prevention counseling (0-7)		1.40	1.79	0.054	1.11	2.86	0.000*
Dual protection counseling( 0-7)		0.92	1.83	0.000*	0.64	2.99	0.000*
<b>VCT counseling</b>		<b>1.11</b>	<b>3.64</b>	<b>0.000*</b>	<b>0.96</b>	<b>3.48</b>	<b>0.000*</b>
FP method counseling(0-6)		2.85	3.96	0.000*	3.48	6.29	0.000*
Client – provider rapport(0-9)		5.25	6.14	0.000*	5.53	5.95	0.000*
Client behavior change(0-8)		1.08	1.99	0.000*	1.09	1.60	0.000*

Overall scores improved significantly

Greatest increase in score was seen for VCT counseling

# STI Prevention Quality of Care Improved

- Discussion of STI/HIV and AIDS improved from 48% to 84% in the testing model and 30% to 70% in the referral model
- Discussion of STI/HIV risk factors improved from 40% to 52% in the testing model and 22% to 69% in the referral model

# Dual Protection and Condom Use

- Explanation that condoms protect against STI/HIV and pregnancy improved from 22% to 33% in the testing model and 11% to 57% in the referral model
- Encouraging the use of condoms with contraceptive method improved from 32% to 50% in the testing model and 12% to 71% in the referral model
- Significant improvements on information on how to use a condom and emphasizing correct and consistent condom use

# VCT Quality of Care Improved

- Discussion of sero-status improved from 30% to 77% in testing and 20% to 83% in referral model
- Mention of VCT improved from 42% to 82% in the testing model and 37% to 92% in the referral model
- Offer of VCT improved from 2% to 59% in the testing and 0% to 28% in the referral model
- Explanation of the window period and what the test is able to tell also improved significantly

# Evidence of Some Behavior Change, but Levels Still Low

- Self reported condom use at last sex improved from 4% to 6% (not significant) in testing model and 1% to 6% in referral model (significant)
- Condom use in last month improved from 4% to 14% in testing and 5% to 11% in referral model
- Using condom with contraceptive method improved from 2% to 5% in testing and 1% to 6% in referral model

# Improvement in proportion of repeat clients having tested for HIV

District	Purpose of visit	Exposure to an HIV test				P- Value
		Baseline		End line		
Thika		No. of Clients	Yes %	No. of Clients	Yes %	
	New FP Clients	63	66.7%	51	68.6%	0.824
	Old FP Clients	261	41.0%	259	57.5%	<0.000
	Combined FP Clients	324	46%	310	59.4%	0.001
Nyeri		No. of Clients	Yes %	No. of Clients	Yes %	
	New FP Clients	29	65.5%	27	70.4%	0.698
	Old FP Clients	185	45.9%	183	81.4%	<0.000
	Combined FP Clients	214	48.6%	210	80%	<0.000

No evidence of decline in quality  
of care for FP and for client  
provider rapport

# Conclusions

- Integration of HIV prevention and provider initiated testing is acceptable to both clients and providers and is feasible even in contexts of staff shortage.
- Use of the BCS plus tools facilitated integration
- Client provider rapport and information on counseling and testing improved significantly
- Quality of existing FP did not decline in either setting

# Conclusions

- The government departments involved have shown an interest and requested assistance in scaling up these interventions
- Integration models will evolve and will need to be more nuanced to address status specific needs of clients
- Interventions to improve VCT uptake need to be coupled with effective post test care or referral

# Lessons learnt

- One size doesn't fit all: same strategy may be implemented differently in different clinics and even on different days
- Need flexibility around implementation but providers should be prepared to respond to a range of clients RH and HIV care needs.
- Improved quality of care means clients rights to receive appropriate care is being addressed
- Although FP services are considered well established there are still a number of issues to be addressed in strengthening these services – investment needs to be made in RH services if they are to serve as the foundation for integrated

# Lessons learnt

- Investments need to be made in in-service training as providers pre-service training does not adequately prepare them to provide integrated services.
- Needs to be investment in OR to implement and evaluate models as needs evolve.
- There is a need for more research including monitoring impact of such interventions on HIV positive and negative health status.

# Challenges

- Reduction of unwanted pregnancies in HIV positive women has received little attention as an effective PMTCT strategy even in contexts where both rates of unwanted pregnancy and HIV prevalence are high
- Limited PEPFAR resources available for interventions based in FP services even though there is a potential to reach a large number of women
- Annual cycle of funding limits research that can document behavior change

# Challenges

- Staff shortages remain an issue
- Routine data collection and collation systems need strengthening to be able to monitor interventions
- Vertical programs require special efforts to be made for joint implementation, supervision, training etc