

Integrating family planning into Ethiopian voluntary testing and counselling programmes

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Problem Governments and donors encourage the integration of family planning into voluntary testing and counselling (VCT) services. We aimed to determine if clients of VCT services have a need for and will accept quality family planning services.

Approach "Voluntary HIV counselling and testing integrated with contraceptive services" is a proof-of-concept study that interviewed 4019 VCT clients before the addition of family planning services and 4027 different clients after family planning services were introduced. Clients attended eight public VCT facilities in the Oromia region, Ethiopia. The intervention had four components: development of family planning counselling messages for VCT clients, VCT provider training, contraceptive supply provision and monitoring.

Local setting Ethiopia's population of 80 million is increasing rapidly at an annual rate of 2.5%. Contraceptive prevalence is only 15%. The estimated adult HIV prevalence rate is 2.1%, with more than 1.1 million people infected. The number of VCT facilities increased from 23 in 2001 to more than 1000 in 2007, and the number of HIV tests taken doubled from 1.7 million tests in 2007 to 3.5 million in 2008.

Relevant changes Clients interviewed after the introduction of family planning services received significantly more family planning counselling and accepted significantly more contraceptives than those clients served before the intervention. However, three-quarters of the clients were not sexually active. Of those clients who were sexually active, 70% were using contraceptives.

Lessons learned The study demonstrated that family planning can be integrated into VCT clinics. However, policy-makers and programme managers should carefully consider the characteristics and reproductive health needs of target populations when making decisions about service integration.

Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Introduction

Voluntary counselling and testing (VCT) is a core part of HIV/AIDS prevention and treatment programmes. Because both VCT and family planning programmes help clients avoid unwanted consequences of their sexual behaviour – HIV and unintended pregnancies – many policy-makers believe that integrating these two services will increase coverage and efficiency.

Ethiopia's population of 80 million is increasing rapidly at an annual rate of 2.5%, meaning it will double in 29 years.¹ Contraceptive prevalence is only 15%.² It is estimated that the adult HIV prevalence rate is 2.1%, with over 1.1 million people infected.³ Despite challenging circumstances, and with significant donor support, Ethiopia has dramatically increased its VCT coverage. The number of VCT facilities increased from just 23 in 2001 to more than 1000 in 2007, and the number of HIV tests taken doubled in just one year, from 1.7 million tests in 2007 to 3.5 million in 2008.⁴ With this significant increase in coverage, the large network of VCT clinics has the potential to greatly increase access to family planning information and services.

Ethiopian context

After attending a WHO-sponsored meeting on international

best practices in Uganda, Ethiopian government officials and representatives developed a plan to introduce family planning into VCT programmes. They developed a steering committee, which was led by Pathfinder International, Ethiopia. This committee aimed to train public sector VCT counsellors in family planning provision and to initiate integrated services in 20% of service sites for VCT and prevention-of-mother-to-child transmission of HIV in four focus regions. These sites were chosen based on available human resources, interest in participating and proximity to Pathfinder's local implementing partners.

Despite this initiative to integrate HIV and family planning services, there was no empirical evidence that Ethiopian VCT clients had an unmet need for family planning or that service integration would improve access or quality of care for clients. Pathfinder, the Miz-Hasab Research Center, an Ethiopian research firm and the Johns Hopkins Bloomberg School of Public Health joined forces to evaluate the integration programme in eight of Pathfinder's service sites. This research, the "Voluntary HIV Counselling and Testing Integrated with Contraceptive Services" Study, assessed the impact of adding quality family planning services into VCT facilities.

Between November 2006 and February 2008, Pathfinder introduced family planning services into semi-urban hospitals

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and health centres in Oromia region. First, administrative staff and health providers at all levels were sensitized about the importance of integrating family planning and HIV services, and then VCT service providers were trained in family planning. Pathfinder held five-day training courses on three separate occasions to account for frequent provider turnover. Training curriculum included basic information on the benefits of family planning, contraceptive options and side-effects.

Additionally, facilitators introduced counselling messages and protocols developed specifically for VCT clients, such as men, young people and HIV-positive individuals.

VCT counsellors were authorized to counsel clients on family planning and to offer condoms and contraceptive pills during VCT sessions. Nurse counsellors were also authorized to provide injectable contraceptives. Pathfinder provided a full-range of contraceptive supplies to both VCT and family planning units in all eight facilities. Monthly monitoring visits helped to ensure contraceptive availability within the facilities and resolve problems faced by the VCT counsellors. VCT providers' logbooks were modified to facilitate collection of information about family planning counselling and services, and these data were routinely assessed by Pathfinder, in addition to contraceptive stocks.

Before and after the family planning intervention was implemented, we conducted cross-sectional client interviews. In 2006, 4019 clients re-

Table 1. Characteristics of female clients after introduction of family planning in voluntary counselling and testing facilities

Characteristics	% (n = 2027)
15–24 years old	74.4
Never married	64.0
Secondary or higher education	62.5
Student	41.2
No children	71.0
Urban	86.3
Ever had sex	59.4
Had sex in past 30 days	27.7
HIV-positive	7.7
Women in current sexual unions (n = 677)	
Currently using contraceptive method	70.0
Unmet contraceptive need	17.0

ceiving standard-of-care VCT were interviewed about their contraceptive practices and needs. Approximately 18 months after introduction of family planning services, 4027 additional clients were interviewed using the same survey instrument.

Client characteristics

The VCT client profile had some unexpected characteristics. Table 1 outlines the characteristics of female clients who were interviewed at the second point in time, after family planning services were introduced. These VCT clients were young and well-educated. Their average age was 22 years, and more than 74% were younger than 25 years. Over 60% of women had a secondary or higher education and more than

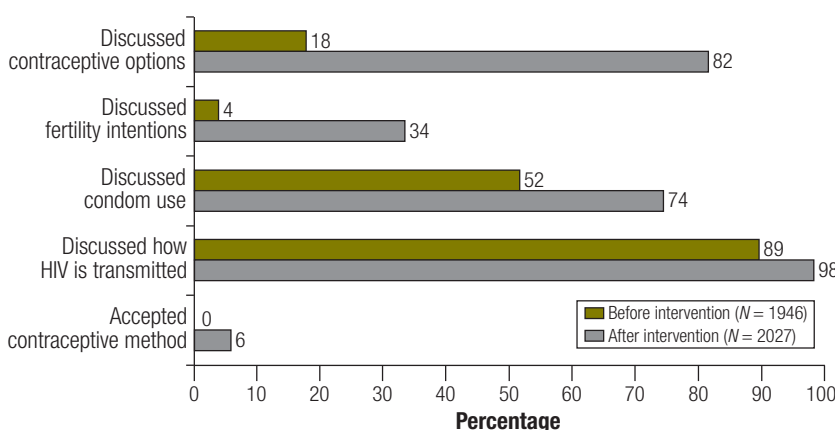
40% were still in school. Most women were single with no children; 64% of them had never married and 71% had no children. This is also a very urban population, with 86% living in urban areas.

The clients in this sample are quite different from the general Ethiopian population, but the most surprising client characteristic was the low level of sexual activity. More than 40% of these women had never had sex, and an additional 32% had not had sex during the last month. HIV prevalence was nearly 8%, which is considerably higher than in the general Ethiopian population, as expected among clients seeking HIV tests.

Not only were many clients sexually inactive, many of the sexually active clients were already using contraception. Among married and other sexually active women, 70% were using contraceptives. Of women in current sexual unions, 17% had unmet contraceptive need, meaning they did not want to have children soon but were having unprotected sex. This is about half of the unmet need that exists in the general Ethiopian population (34%).²

Despite the relatively low need for family planning services among study clients, there was an impressive increase in the provision of family planning information in VCT. Fig. 1 shows some of the family planning and HIV topics discussed before and after family planning services were introduced. Four times as many women received information on their contraceptive options

Fig. 1. Change in information provided and contraceptive use before and after introduction of family planning services to clients of voluntary counselling and testing



after the intervention and, importantly, this improvement in family planning counselling had no negative impact on HIV counselling. Indeed, significant improvements were also found in this area.

While overall contraceptive uptake was low, there were significant improvements in family planning distribution for women, as almost none of the VCT clients received contraceptive methods, including condoms, at baseline. The largely sexually inactive client population and the percentage of sexually active clients who were already using contraceptives are likely explanations for the low number of clients accepting contraceptive methods.

In-depth analysis was conducted to better understand the kinds of clients who received contraceptive counselling and methods, revealing that clients with higher risk for HIV and unintended pregnancy were much more likely to obtain family planning services. The benefits of integrating family planning and VCT services may thus be more pronounced among higher risk populations.

One of the most unexpected findings from this study was the low level of sexual activity among VCT clients. Based on our survey and in-depth interviews with clients, it seems many low-risk clients seek HIV tests because of their beliefs about modes of HIV transmission. Clients know HIV is transmitted by sexual activity, but they think that it is equally probable that HIV can be transmitted via other unlikely, or even impossible, means.

Limitations

The major limitation of the study is that its principal data sources are two cross-sectional surveys. Because clients are not followed up, we can say nothing

Box 1. Lessons learned

- Family planning can be integrated into voluntary counselling and testing clinics.
- The incremental cost of integrating family planning is modest.
- Policy-makers and programme managers should know and understand the characteristics and reproductive health needs of target populations when making decisions about service integration.

about attitudinal and behaviour changes over time. Additionally, the study's client population and service sites may not be representative of other parts of Ethiopia. While such representation is not necessary for a proof-of-concept study, it does mean that it is difficult to extrapolate from the surprising findings of high contraceptive use among the sexually active clients and the very high percentage of non-sexually active clients.

Conclusion

In conclusion, most of the surveyed clients were at relatively low risk for HIV and unintended pregnancy, either because they were not having sex or were already using contraceptives. Importantly, however, the quality of both HIV and family planning counselling improved dramatically, indicating, at the very least, that service integration is possible in the Ethiopian context. Because our facilities were not sampled using probability methods, they may have performed better or been different in terms of client catchment populations than other VCT facilities; therefore, one should exercise caution in generalizing the findings.

The incremental cost of integrating family planning is modest in the country's present funding environment. In 2008, Ethiopia received over US\$ 630 million for combating HIV/AIDS. More than half of this amount was from the President's Emergency Plan

for AIDS Relief (PEPFAR), which is the major source of funds for the country's VCT programme.⁵ The cost for family planning training was US\$ 325 per trainee. The only major recurring cost was the regular monitoring visits by Pathfinder, which had an annual cost of US\$ 1562 per facility. To have a comparable level of monitoring for all of the country's VCT facilities, the annual cost would be US\$ 1.5–2.0 million.

The most salient finding from this study, however, is that policy-makers and programme managers should know and understand the target client population before deciding whether service integration is likely to be efficacious or cost-effective. The reproductive health needs of the target population should be the single most important factor underlying decisions to scale up integrated services. This study suggests that an integrated VCT programme targeting populations at risk for HIV or unintended pregnancy may be an effective programmatic option (Box 1). ■

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Résumé

Intégration des services de planification familiale dans les programmes de conseil et de dépistage volontaire

Problématique Les Etats et les donateurs encouragent l'intégration des services de planification familiale à ceux de conseil et de dépistage volontaire (CDV). Nous nous sommes efforcés de déterminer si les clients des services de CDV avaient besoin de services de planification familiale de qualité et s'ils les accepteraient.

Démarche Le concept d'intégration des services de conseil et de

dépistage volontaire et des services de contraception a été soumis à une étude de validité, dans le cadre de laquelle on a interrogé 4019 clients de services de CDV avant l'adjonction des services de planification familiale et 4027 autres clients après l'introduction de ces services. Les clients avaient consulté huit centres publics de CDV de la région d'Oromia, en Ethiopie. L'intervention comprenait quatre composantes : mise au point de messages apportant des

conseils en matière de planification familiale aux clients des services de CDV, formation des prestataires de services de CDV, fourniture de moyens contraceptifs et surveillance.

Contexte local La population éthiopienne de 80 millions d'habitants augmente rapidement, avec un taux de croissance annuel de 2,5 %. La prévalence de la contraception n'est que de 15 %. Le taux de prévalence du VIH chez les adultes est estimé à 2,1 %, avec plus de 1,1 million de personnes infectées. Le nombre d'unités délivrant des services de CDV est passé de 23 en 2001 à plus de 1000 en 2007 et le nombre de tests de dépistage du VIH effectués a doublé entre 2007 et 2008, passant de 1,7 millions à 3,5 millions.

Modifications pertinentes Les clients interrogés après

l'introduction des services de planification familiale avaient reçu notablement plus de conseils de planification familiale et avaient accepté nettement plus de contraceptifs que ceux servis avant l'intervention. Cependant, les trois-quarts de ces clients n'étaient pas sexuellement actifs. Parmi les clients sexuellement actifs, 70 % utilisaient des moyens contraceptifs.

Enseignements tirés Cette étude a démontré que les services de planification familiale pouvaient être intégrés dans les dispensaires proposant des services de CDV. Néanmoins, les décideurs politiques et les gestionnaires de programmes devraient étudier soigneusement les caractéristiques et les besoins en matière de santé génésique des populations visées lors de la prise de décisions concernant l'intégration de ces services.

Resumen

Integración de la planificación familiar en los programas de asesoramiento y pruebas voluntarias del VIH de Etiopía

Problema Los gobiernos y los donantes promueven la integración de la planificación familiar en los servicios de asesoramiento y pruebas voluntarias (APV) del VIH. Decidimos determinar si los usuarios de los servicios de APV tienen necesidad de servicios de planificación familiar de calidad y si los aceptarían.

Enfoque «Integración del asesoramiento y pruebas voluntarias de detección del VIH con los servicios de anticoncepción» es un estudio demostrativo preliminar en el que se entrevistó a 4019 usuarios de APV antes de la inclusión de los servicios de planificación familiar, y a 4027 usuarios diferentes después de introducir dichos servicios. Se trata de usuarios que acudieron a ocho servicios públicos de APV de la región de Oromia, Etiopía. La intervención comprendía cuatro componentes: elaboración de consejos de planificación familiar para los usuarios de APV, capacitación de los proveedores de APV, suministro de anticonceptivos y seguimiento.

Contexto local La población de Etiopía asciende a 80 millones de habitantes y está aumentando rápidamente a un ritmo anual del 2,5%. La prevalencia de uso de anticonceptivos es sólo del 15%.

La prevalencia de la infección por VIH en adultos es del 2,1%, con más de 1,1 millones de personas infectadas. El número de servicios de APV aumentó de 23 en 2001 a más de 1000 en 2007, y el número de pruebas del VIH realizadas se duplicó, pasando de 1,7 millones en 2007 a 3,5 millones en 2008.

Cambios destacables Los usuarios entrevistados tras la introducción de los servicios de planificación familiar habían recibido significativamente más consejos de planificación familiar y aceptado significativamente más anticonceptivos que los atendidos antes de la intervención. Sin embargo, tres de cada cuatro usuarios no eran sexualmente activos. Entre los usuarios sexualmente activos, el 70% estaban utilizando anticonceptivos.

Enseñanzas extraídas El estudio demostró que es posible integrar la planificación familiar en los consultorios de APV. No obstante, los planificadores de políticas y los gestores de programas deberían analizar detenidamente las características y las necesidades de salud reproductiva de las poblaciones destinatarias en su toma de decisiones sobre la integración de los servicios.

ملخص

إدماج تنظيم الأسرة في برامج الالتماس الطوعي للاختبار والمشورة

المشكلة: إن الحكومات والجهات المانحة تشجع على إدماج خدمات تنظيم الأسرة وخدمات الالتماس الطوعي للاختبار والمشورة. ويهدف الباحثون هنا إلى تحديد ما إذا كان المستفيدون من خدمات الالتماس الطوعي للاختبار والمشورة يحتاجون إلى وسيقبلون خدمات تنظيم الأسرة عالية الجودة.

الأسلوب: يعتبر "التكامل بين خدمات الالتماس الطوعي للاختبار والمشورة لفيروس الإيدز وخدمات موانع الحمل" مفهوماً حاولت إثباته دراسة تضمنت إجراء مقابلة لـ 4019 مستفيداً من خدمات الالتماس الطوعي للاختبار والمشورة قبل إضافة خدمات تنظيم الأسرة إليها، ومقابلة لـ 4027 من مختلف المستفيدين بعد تقديم خدمات تنظيم الأسرة. وكان هؤلاء المستفيدون يراجعون ثمانية مرافق عامة تقدم خدمات الالتماس الطوعي للاختبار والمشورة في منطقة أوراميا في إثيوبيا. وكان للتدخل أربعة مكونات هي: إعداد رسائل المشورة الخاصة بتنظيم الأسرة للمستفيدين من الالتماس الطوعي للاختبار والمشورة، وتدريب مقدمي خدمات الالتماس الطوعي للاختبار والمشورة، وتقديم إمدادات موانع الحمل، والرصد.

الأوضاع المحلية: يبلغ تعداد سكان إثيوبيا 80 مليوناً وهم يتزايدون بسرعة بمعدل سنوي قدره 2.5%. بينما يبلغ معدل انتشار استخدام موانع الحمل

15% فقط. ويبلغ المعدل التقديري لانتشار فيروس الإيدز بين البالغين 2.1%. وهناك أكثر من 1.1 مليون مصاب به. وقد ازدادت أعداد مرافق تقديم خدمات الالتماس الطوعي للاختبار والمشورة من 23 مرفقاً في عام 2001 إلى أكثر من 1000 مرفق في 2007، وتضاعف عدد اختبارات فيروس الإيدز التي أجريت من 1.7 مليون اختبار في 2007 إلى 3.5 مليون اختبار في 2008.

التغيرات ذات الصلة: أُجريت مقابلة مع المستفيدين بعد إدخال خدمات تنظيم الأسرة وتبين أنهم تلقوا قدراً أكبر من المشورة حول تنظيم الأسرة وتقبلوا أكثر كثيراً موانع الحمل من المستفيدين الذين جرت خدمتهم قبل تنفيذ هذا التدخل. إلا أن ثلاثة أرباع هؤلاء المستفيدين لم يكونوا نشطين جنسياً، وكان 70% من النشطين جنسياً منهم يستخدمون وسائل لمنع الحمل. **الدروس المستفادة:** أظهرت الدراسة أنه يمكن إدماج خدمات تنظيم الأسرة في العيادات التي تقدم خدمات الالتماس الطوعي للاختبار والمشورة. لكن على راسمي السياسات ومديري البرامج الحرس في مراعاة سمات واحتياجات الصحة الإنجابية للسكان المستهدفين عند اتخاذ القرارات الخاصة بالتكامل بين الخدمات.

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