BRIEF REPORT

Strategies Used by Facilities in Uganda to Integrate Family Planning into HIV Care: What Works and What Doesn't

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Afr J Reprod Health 2010; 14[4]: 149-150

Introduction

Family planning (FP) often gets neglected in HIV care, but it is of immense importance in offering individuals and couples protection against unintended pregnancies. To help HIV care clinics improve FP provision for their clients, the Uganda Ministry of Health (UMOH) and the United States Agency for International Development (USAID) Health Care Improvement Project initiated the FP-HIV Collaborative for 15 sites in Uganda.

The UMOH Quality of Care Initiative in HIV Care identified the need to integrate FP to increase the pool of individuals who otherwise may not be reached through traditional FP clinics. The goal of this intervention was to offer FP services as an integral component of HIV prevention, care and treatment services for HIV-positive individuals, with core funding from Maximizing Access and Quality, USAID's SO1 group. This brief report presents a summary of the changes observed following the quality improvement intervention strategies that the site teams introduced.

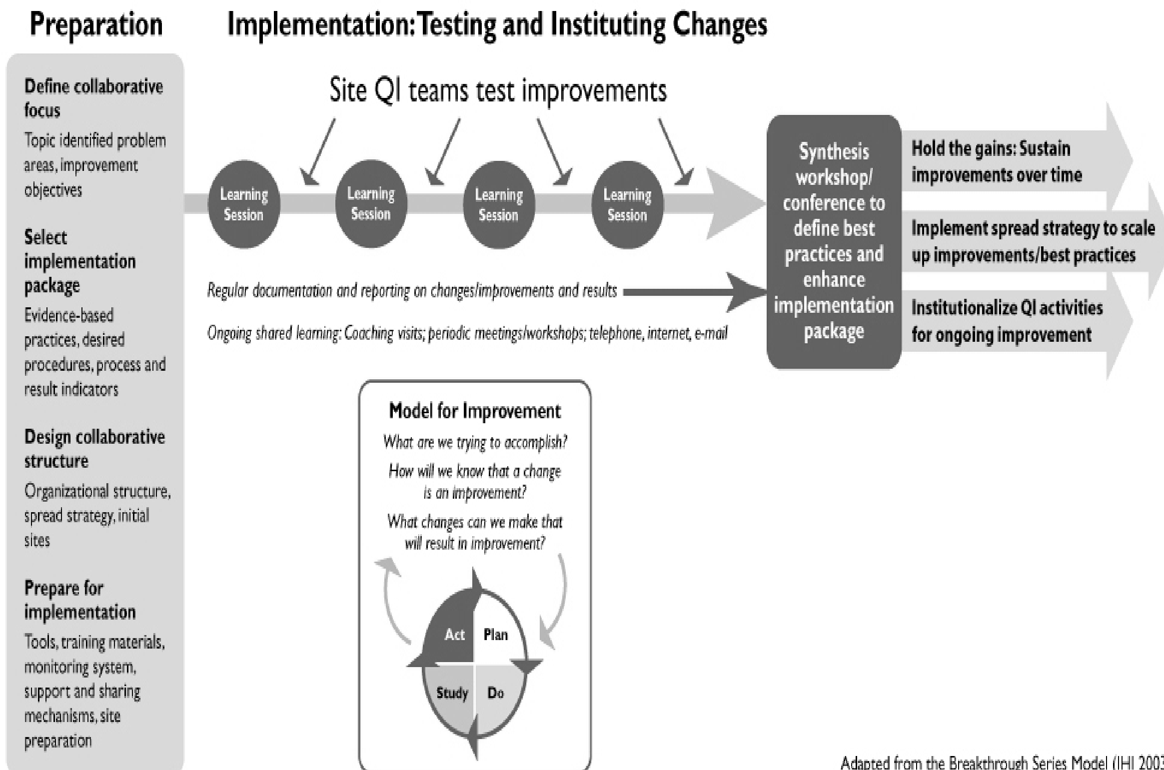
Intervention

A core team was formed consisting of a University Research Co. activity manager, a UMOH reproductive health specialist and several others, who worked closely with Engender Health and Family Health International. Following a situation analysis at baseline, objectives and related indicators for the FP-HIV care integration were formulated. In January 2007, of 30 HIV care collaborative sites, 15 self-selected to take on the challenge of integrating FP into their sites and collecting data on the FP-HIV care indicators (see flow chart). Providers from the 15 sites were trained and given the WHO counseling tools. With technical assistance and coaching from the core team, we integrated routine site/field operations.

The performance of each site was monitored using the three FP-HIV care integration indicators – proportion of HIV-positive patients of reproductive age who were: 1) counseled on FP methods at every clinic visit, 2) using at least one FP method, and 3) not yet on FP but were referred for FP services. This brief focuses on the first indicator and the quality improvement changes that were introduced, such as the self-motivated reorganization of the participating sites to bring about an improvement in client flow through optimal use of patients' HIV care cards and registers, as well as job aids, monthly coaching and phone conversations with the core team to address perturbing issues. FP services were integrated into HIV care/ART service clinics. Sites collected progress data from July 2006 until January 2008. Data were compiled monthly and later verified by external coaches during site coaching. Individual sites implemented changes to the standard of care starting in December 2006 and these were documented by site and external coaches. Data were analyzed using Stata version 10.

Results

Across all sites, adults who were counseled on family planning during clinic visits increased from 59% to 92% after just six months and this level of performance was maintained over the following 12-month period. Sites tried a variety of strategies to improve HIV counseling. All 15 sites (100%) provided additional on-site training in FP to all staff in the HIV clinic and used group counseling to inform patients about the importance of FP. Eight sites (61.5%) used peer counselors to share FP information with other patients. The sites that used this approach increased counseling by 46% compared to an increase of only 10% in the sites that did not use peer counselors (p=0.08). Eleven sites (84.6%) used job aids to remind staff to counsel on family planning and these sites had an increase of 38% compared to no increase in FP counseling in the two sites that did not use them. Although there were no significant differences when compared with sites that did not implement the other quality improvement changes, 10 sites (76.9%)



reviewed their records to ensure completeness of data, seven sites (53.8%) dispensed FP commodities in the ART clinic, and two sites (15.4%) conducted family planning training for men.

Lessons Learned/Future Directions

Results from the 15 sites showed sustained improvement in counseling on FP methods after a quality improvement intervention. Providers observed that integration of FP services and HIV care appeared to increase utilization of FP services and reduce stigma among their HIV clients. We also observed the usefulness of job aids in ensuring that correct information was delivered to clients. Limitations include the small sample size and the lack of external generalizability of the findings, but there appears to be borderline evidence that peer counselors are effective at increasing FP counseling in HIV clinics. We recommend that further studies be conducted into the effectiveness of this strategy in integrated FP-HIV care programs in order to improve reproductive health care for HIV-positive individuals.

Our future direction is to provide FP and HIV/AIDS services in an integrated manner in all our sites. These efforts will include the support of training for service providers, monitoring quality logistics and supplies, networking/referral mechanisms and facilitating continuous quality improvement activities. We anticipate challenges of funding and irregular supplies of FP commodities, which may negatively impact the quality of services rendered. However, with our field experience and willing collaborators, we believe we will be able to surmount these challenges to produce sustainable integrated FP-HIV care services in Uganda.

Acknowledgements

1. Maximizing Access and Quality, USAID's SO1 group for the funding.
2. The University Research Co. LLC Quality Assurance Project senior colleagues, in particular Dr. Stephen Kinoti, senior quality improvement advisor, and retired Ms. Peggy.
3. Reproductive Health Department, Ministry of Health.