

ACQUIRE Evaluation and Research Studies

Evaluation of a Family Planning and Antiretroviral Therapy Integration Pilot in Mbale, Uganda

E & R Study #13 ♦ September 2008



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Authors:

The ACQUIRE Project Research International, Uganda and Kenya
Hannah Searing **Mary Randiki**
Betty Farrell **Mokeira Masita-Mwangi**
Sarah Gutin
Nalin Johri
Laura Subramanian
Henry Kakande
Grace Nagendi



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The ACQUIRE Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@acquireproject.org
www.acquireproject.org

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Acronyms

| | |
|--------|--|
| AIC | AIDS Information Center |
| ACET | AIDS Care, Education, and Training |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| COC | Combined Oral Contraceptives |
| COPE® | Client-Oriented, Provider-Efficient |
| DMPA | Depot Medroxyprogesterone Acetate |
| FGD | Focus Group Discussions |
| FP | Family Planning |
| HIV | Human Immunodeficiency Virus |
| IUD | Intrauterine Device |
| JCRC | Joint Clinical Research Center |
| KII | Key Informant Interview |
| MOH | Ministry of Health |
| OI | Opportunistic Infections |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| PNA | Performance Needs Assessment |
| PLHIV | People Living With HIV/AIDS |
| RI | Research International |
| RH | Reproductive Health |
| SRH | Sexual and Reproductive Health |
| TASO/M | The AIDS Support Organization/Mbale Branch |
| TFR | Total Fertility Rate |
| VCT | Voluntary Counseling and Testing |
| UDHS | Uganda Demographic and Health Survey |
| USAID | United States Agency for International Development |

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Executive Summary

In Uganda, there is an urgent need for quality, voluntary family planning (FP) services to help people living with HIV (PLHIV) achieve their fertility intentions and to reduce HIV incidence. Approximately 1 million Ugandans are living with HIV. Adult HIV prevalence (among those aged 15–49) is 6.7%, with the highest levels among women in urban areas (UNAIDS & WHO, 2007). Nearly 25% of all new HIV infections (132,500 each year) result from mother-to-child transmission (UAC, 2007). Although the mean ideal number of children is 5.3, the total fertility rate is 6.7 lifetime births per woman. Despite this gap between actual and desired fertility, only 18% of married women use a modern family planning method (UBOS & Macro International, Inc., 2007).

The AIDS Support Organization (TASO), one of the leading local nongovernmental organizations (NGOs) in Uganda providing HIV counseling, prevention, care, treatment, and support services to PLHIV, provides services in 11 centers and 15 minicenters. TASO Mbale (TASO/M)—located in the Mbale District in eastern Uganda—is one of the 11 centers and began providing antiretroviral therapy (ART) services in September 2004. Each month, TASO/M serves approximately 2,000 to 3,000 PLHIV and conducts 500 home-based visits.

TASO clinicians and administrators struggle to meet the FP needs of PLHIV who arrive at their clinics with unplanned pregnancies and/or incomplete abortions. Although TASO/M has provided limited FP services to ART clients on an ad hoc basis since 2004, it lacked a comprehensive FP program. With this in mind, the ACQUIRE Project¹—in collaboration with TASO/M and the Ugandan Ministry of Health (MOH) and with funding from the U.S. Agency for International Development (USAID)²—implemented an FP-ART integration pilot from March 2006 to April 2007 with the launching of FP services in September 2006.

The pilot was designed using ACQUIRE’s FP-ART integration framework, which outlines five levels of integrating FP into HIV services. Facilities can choose from the levels, and can add to them progressively, depending on their capabilities and resource (Farrell, 2007). TASO/M integrated to Level C. It provides four modern FP methods—condoms (already offered for HIV/STI prevention), oral contraceptives, injectables, and emergency contraceptive pills—along with referrals for long-acting and permanent methods (LAPMs) to the Mbale Regional Referral Hospital, located a few yards from TASO/M. It should be noted that this pilot was carried out in the private sector with a referral to a public-sector facility and, as such, the findings and recommendations are most relevant to a private institution with its own internal systems.

In November 2007, ACQUIRE conducted a retrospective evaluation using a case study methodology to assess its FP-ART integration pilot, including its effect on the program processes and FP method mix and uptake at TASO/M. Data collection occurred between November 26 and December 4, 2007, and included 105 client exit interviews, 30 provider-client observations, 37 self-administered provider questionnaires, six key informant interviews with program staff (from ACQUIRE, the MOH, and TASO/M), three group discussions with PLHIV, and three group

¹ The ACQUIRE Project (Access, Quality and Use in Reproductive Health) is a global leader with associate cooperative agreement of the U.S. Agency for International Development. It was awarded to EngenderHealth and its partners in 2003.

² Funding was provided by the FP/HIV Integration Global Leadership Priority (GLP) team in the Office of Population of USAID/Washington.

discussions with providers. This report presents the findings from this case study and provides recommendations for replication and scale-up.

ACQUIRE and TASO/M began the pilot with a performance needs assessment (PNA) to determine the FP knowledge and practices, the fertility desires and contraceptive knowledge and practices of community members, and the status of service-delivery systems (The ACQUIRE Project, 2007). The PNA resulted in an action plan to incorporate FP services as an integral component of the existing ART services.

Following the PNA, ACQUIRE supported supply, demand, and advocacy interventions from the action plan, with a strong focus on the supply side. The supply-side activities were implemented using ACQUIRE's FP-ART integration framework, with a systems lens that focused on supervision, logistics, referrals, and training. ACQUIRE oriented senior administrators to the FP needs of PLHIV. They developed an FP-ART integration training curriculum and adapted provider job aids and a client brochure designed by ACQUIRE in Ghana to support PLHIV (materials available on request). They trained TASO trainers in FP service provision and counseling and supported TASO trainers to use the new curriculum to train clinicians, counselors, community nurses, field officers, and PLHIV volunteers. ACQUIRE also modified a supervision checklist and trained supervisors and department heads in quality improvement processes and facilitative supervision. Finally, ACQUIRE helped analyze and improve TASO/M's data collection systems, as well as its mechanisms for FP referral to Mbale Regional Referral Hospital and other FP service sites.

On the demand side, ACQUIRE helped TASO integrate FP messages into health education activities, orient AIDS community workers to FP, and develop radio spots and awareness sessions on FP for community groups. Advocacy work included encouraging TASO management to allow field officers to provide FP services during community-outreach activities and facilitating consultation with TASO headquarters for future FP-ART scale-up and for incorporation of FP service delivery guidelines into ART protocols. The results and recommendations follow, organized by the study questions, with a focus on specific features of ACQUIRE's systems approach to FP-ART integration that may be used for replication and scale-up.

Results

The hallmark of an accomplished project is scale-up or replication. By this measure, ACQUIRE's partnership with TASO/M was successful: ACQUIRE's FP-ART model will be rolled out to all of TASO's 11 centers and 15 minicenters throughout Uganda over the next several years, as part of TASO's five-year strategic plan (2008–2012). It is ACQUIRE's hope that others both inside and outside of Uganda will consider the innovative and useful features of the FP-ART model when designing integration programs. Those who would like to replicate the ACQUIRE model should start with the five-step process (see Figure 1), the key feature of which is stakeholder participation to identify a realistic level of integration to aim for and to guide decisions about where, how, and when to integrate. Programmers should remember that the foundation for successful integration is supply, demand, and advocacy. Supply activities are at the core of the model and focus on strengthening the supervision, logistics, referral, and training systems to support the introduction of the new FP services. Also, it is critical to include demand activities in communities adjacent to sites, particularly those that address stigma against PLHIV. On the advocacy side, ACQUIRE found that it was important to garner management support for training and for deploying lower-level trained field officers to provide FP services in the community and to refer clients to the integration site; to lobby for funds to train new staff to compensate for staff turnover; and to incorporate FP service delivery guidelines into the HIV management protocols. In conclusion, integration requires a

holistic approach that addresses the interconnectedness of supply-demand-advocacy interventions, based on the facility's capacity to provide a level of integration that meets clients' needs without compromising existing services.

Experience in integrating FP into ART

- ◆ The level of integration was appropriate to the site.
- ◆ It was important to prepare the site for potential increases in workload.
- ◆ The PNA was an effective program planning tool.
- ◆ Stakeholders took ownership of the decision to integrate services.
- ◆ Adding FP services required space accommodations.
- ◆ Partner collaboration is essential.

Successes in program implementation

- ◆ Providers supplied FP counseling and services specified in the pilot.
- ◆ Providers demonstrated positive attitudes toward the reproductive health needs of PLHIV.
- ◆ Providers gained valuable skills through trainings in facilitative supervision and COPE[®], EngenderHealth's quality improvement process.
- ◆ Providers conducted FP education during outreach.
- ◆ Providers used ACQUIRE materials at the clinic.
- ◆ Providers were aware of the updated National Standards for FP Service Delivery.
- ◆ Field officers are providing FP methods during community outreach activities.
- ◆ Stigma against PLHIV lessened among providers and clients at TASO/M.

Community and client perspectives

- ◆ Clients reported hearing FP messages.
- ◆ Clients were well-informed about FP methods.
- ◆ Clients reported satisfaction with TASO/M FP services.
- ◆ FP myths and misconceptions persist in the community.
- ◆ Stigma against PLHIV remains in the communities adjacent to TASO/M.

Challenges in design and implementation

- ◆ Although some providers demonstrated correct knowledge of FP and of dual protection, more training is needed to reinforce new content.
- ◆ FP referral protocols were implemented, though referrals remain somewhat problematic.
- ◆ Although TASO/M shifted away from the open market to the MOH system to procure FP commodities and supplies, stock-outs continued.
- ◆ FP record-keeping was challenging due to lack of systematic protocols.
- ◆ FP services to men were limited.

Use of services

- ◆ Directly following sustained FP introduction in September 2006, the number of ART clients accessing FP showed a three-fold increase.
- ◆ Two-thirds of clients interviewed in exit surveys reported that they used condoms every time they had intercourse in the past six months. Of those receiving FP methods on the day of the survey, the majority reported getting injectables, condoms, and oral contraceptives.

Recommendations

Process

- ◆ Prior to integration, prepare on-site staff at all levels through orientation and discussion.
- ◆ Use participatory methods to engage stakeholders in identifying service gaps, defining what a successful program will look like, and selecting an appropriate level of integration.
- ◆ Carry out site preparations before initiation of service delivery training. Ensure that there is adequate, private space for FP services and counseling.
- ◆ Develop partnerships with referral sites; explore how partners can jointly share resources, develop staff capacity, and develop and implement referral protocols and systems.
- ◆ Garner technical support from the MOH; discuss and identify opportunities to strengthen supplies of FP commodities and equipment.
- ◆ Strengthen relationships between the public and private sectors to better coordinate district-wide FP-HIV integration efforts.
- ◆ Identify a variety of ways that international NGOs can check in with field progress.

Supply

- ◆ Train staff in FP service provision. Develop and maintain a continuing education/refresher mechanism to address staff performance.
- ◆ Train staff to provide effective FP counseling using FP-ART curricula, national guidelines, and World Health Organization (WHO) medical eligibility criteria.
- ◆ Train PLHIV volunteers to assist providers in client counseling and referrals; consider stationing volunteers at an on-site FP desk to interact with clients.
- ◆ Develop a unified system to record FP clients and commodities and institutionalize and train staff on use.
- ◆ Ensure steady supply of FP and HIV/ART commodities to meet rising demand for integrated services.
- ◆ Use facilitative supervision to improve supervisors' capacity to oversee the implementation of quality FP-integrated services.

Demand

- ◆ Develop creative ways to provide services to men beyond providing them condoms.
- ◆ Address stigmatization of PLHIV, as well as myths about FP at the community level, through targeted interventions. Consider partnering with existing groups already engaged in communications activities.
- ◆ Develop FP client materials in the local languages; disseminate them widely to clients and potential clients during client visits to sites and community outreach.
- ◆ Ensure that counselors cover the entire available range of FP methods, including those available at referral sites, so that clients are as informed as possible.

Advocacy

- ◆ Present study results to the MOH to discuss how this pilot might be applied to public-sector sites.
- ◆ Advocate for support to lower-level trained field officers to provide FP services in the community and for funds to train new staff, to compensate for staff turnover.

Background

In 2005, HIV prevalence in Uganda was 6.7%, which translates to approximately 1 million people living with HIV (PLHIV). The rates are higher among women (8%) than among men (5%) (UNAIDS & WHO, 2006). Currently, 24% of married women are using a family planning (FP) method, and 18% are using a modern FP method. The total fertility rate is 6.7 lifetime births per woman, and the mean ideal number of children is 5.3 (UBOS & Macro International, Inc., 2007). This implies that, on average, women are having two more children than their desired number. For PLHIV, this leads to a strain on scarce family resources and the potential for increase of mother-to-child transmission of HIV (MTCT).

Growing evidence suggests that HIV-positive women and men lack adequate access to reproductive health (RH) services, including FP and HIV services. At best, they are offered interventions for the prevention of mother-to-child transmission of HIV (PMTCT), without attention to their broader RH needs. However, because many PLHIV are sexually active, they are faced with the same issues as HIV-negative men and women regarding the numbers, timing, and spacing of their children and have the same need for comprehensive, safe, and quality FP services. Health workers generally lack the knowledge and skills to support PLHIV to make free and informed FP choices. And they are even less equipped to address the additional issues related to introducing FP to persons receiving antiretroviral therapy (ART). It is against this backdrop that the ACQUIRE Project, The AIDS Support Organization (TASO), and the Ugandan Ministry of Health (MOH) implemented an FP-ART integration pilot at the TASO Mbale Center (TASO/M) with funding from the U.S. Agency for International Development's (USAID's) FP/HIV Integration Global Leadership Priority team in the Office of Population (USAID/Washington). The pilot lasted from March 2006 to April 2007. FP services were introduced as a part of care and treatment services in September 2006.

In 2004, ACQUIRE pioneered a systematic and incremental framework (Farrell, 2006) for integrating FP and ART services (see Table 1, page 2). This framework implicitly recognizes the need to assess the facility's capacity (physical, human, financial, and technical) to add components of care to existing ART services. The addition of new components follows an identification of the level of integration that can realistically be achieved and the concomitant need for resources and changes to supervision, logistics (including client flow), and referral and training systems. To avoid overwhelming existing systems, ACQUIRE recommends a phased integrated approach.

In March 2006, with funding from USAID, ACQUIRE partnered with TASO/M to adapt and implement the framework for an FP/ART integration pilot in Uganda (Farrell, 2006). The process began with a performance needs assessment (PNA), an intensely participatory engagement with key stakeholders, which aimed to collaboratively identify the most feasible level of integration of FP services within TASO/M's existing ART program. This proved to be Level C in the framework: provision of FP counseling and of condoms, emergency contraceptive pills, oral contraceptives, and injectables, plus the strengthening of a referral mechanism with Mbale Regional Referral Hospital's FP Clinic—a public-sector facility located in close proximity to TASO/M—to provide long-acting and permanent methods of contraception (LAPMs). In an effort to address the gaps identified in the PNA, ACQUIRE implemented supply, demand, and advocacy interventions, with a strong focus on the supply-side, using a systems approach. FP service provision began in September 2006.

Table I. Levels of integrating FP into HIV services for on-site provision of contraceptive information, counseling, and method options

| Level A | Level B | Level C | Level D | Level E |
|--|---|---|--|--|
| <p>Provides all of the following functions:</p> <ul style="list-style-type: none"> • Provides family planning (FP) information to clients accessing antiretroviral therapy (ART), prevention of mother-to-child transmission of HIV (PMTCT), sexually transmitted infection (STI), voluntary counseling and testing (VCT), and tuberculosis services. • Performs risk/intention assessment for pregnancy or spacing. • Counsels on FP methods, on methods' ability to prevent STI and HIV infection, on method choices available and where to access them, on dual protection, and on potential drug interactions with hormonal methods. • Provides condoms, and instructs for and demonstrates correct use. • Provides emergency contraceptive pills.* • Refers for other methods not offered on-site. | <p>Provides all Level A functions plus:</p> <ul style="list-style-type: none"> • Provides oral contraceptives* with instructions for use. • Provides follow-up or refers for follow-up. • Counsels on potential drug interactions with oral contraceptives. | <p>Provides all Level B functions plus:</p> <ul style="list-style-type: none"> • Provides injectable hormonal contraceptives, with instructions for use and caution to return on schedule for reinjection without delay. • Provides follow-up or refers for follow-up. | <p>Provides all Level C functions plus:</p> <ul style="list-style-type: none"> • Provides intrauterine device (IUD), with instructions for use. • Provides hormonal implants, with instructions for use. • Provides follow-up or refers for follow-up. | <p>Provides all Level D functions plus:</p> <ul style="list-style-type: none"> • Provides surgical contraceptive methods, with instructions for self-care, and provides follow-up. |

* If facilities or programs providing Level A functions are not *immediately* prepared to provide oral contraceptives for ongoing use, they may provide emergency contraceptive pills with referrals for ongoing FP management. If the facility or program already provides oral contraceptives (Level B), it can also offer emergency contraceptive pills.

Key PNA findings

- ◆ Only 16% of HIV-positive women were counseled on their FP needs.
- ◆ Condoms were provided for HIV prevention but not as an FP method.
- ◆ HIV-positive men were excluded from FP activities.
- ◆ HIV community activities did not include FP.
- ◆ PLHIV preferred to receive FP services from their usual HIV service providers.
- ◆ TASO/M had a strong infrastructure and physical structure to accommodate FP services and strong management and supervision systems to support service delivery.
- ◆ FP messages focused primarily on women, excluding men.
- ◆ Rural communities did not value FP, and side effects of FP methods were a concern
- ◆ Only one TASO/M staffer had received FP training.
- ◆ Providers were concerned that FP integration would encourage HIV-positive clients to have sex.

ACQUIRE Interventions

ACQUIRE's FP-ART integration framework is based on a systems approach to build site capacity in training, referral, supervision, and logistics. To improve the training system, ACQUIRE began by developing the FP-integrated training curriculum. Selected sessions were modified and incorporated from the Ghana FP-HIV integration curriculum and the MOH FP-integrated PMTCT counselor training curriculum. With adjustments to the Ugandan and TASO/M context, the final version was reviewed and approved by the Ugandan MOH. Following the PNA, ACQUIRE then conducted a two-week training consisting of didactic and clinical practicum portions for 23 TASO trainers using the manual, and supported the newly trained trainers to train 15 service providers and counselors and field officers, as well as 12 community nurses and selected PLHIV volunteers. The training content included FP updates, counseling skills, FP method provision, and special considerations for women using ART. Training the PLHIV volunteers was particularly helpful, as they were able to counsel clients, direct them to the FP room, and provide follow-up visits, thereby relieving some of the workload on counselors and clinicians.

After the trainings, TASO/M staff fully integrated FP into existing ART services. This included giving FP health talks in the waiting area, providing FP methods on-site (oral contraceptives, emergency contraception, injectables, and condoms) and referring clients to the Mbale Regional Referral Hospital for LAPMs (implants, the intrauterine device [IUD], and sterilization). ACQUIRE bolstered the supervision system by providing training in facilitative supervision and COPE[®] (which stands for client-oriented, provider-efficient services) to on-site supervisors and department heads and by orienting these individuals to the special needs of clients in FP-ART service delivery. In addition, ACQUIRE helped adapt monitoring and supervision checklists to include FP services and promoted their use among supervisors. In the area of logistics and referral, ACQUIRE worked with TASO/M to analyze and improve its data collection systems and mechanisms for FP referral to Mbale Regional Referral Hospital.

ACQUIRE worked with TASO to develop and support a communications strategy to increase public awareness of and knowledge about FP within the communities adjacent to TASO/M. ACQUIRE helped TASO to integrate FP messages into health education activities, orient AIDS community workers to FP, and conduct awareness sessions on FP for community groups. The TASO staff appeared on local FM radio stations to talk about FP and respond to listeners' questions. To address myths, rumors, and fears about FP methods, community nurses were trained to counsel about and provide FP methods. Male involvement in RH/FP was promoted as a part of the overall communications effort. Advocacy work included integrating FP into TASO/M's ART protocol, encouraging TASO/M management to allow field officers to provide FP services during community outreach activities, and facilitating consultation with TASO/M headquarters for future FP-ART scale-up.

Methodology

In November 2007, ACQUIRE conducted a retrospective, multimethod evaluative case study of the pilot at TASO/M, with the assistance of Research International (RI), a local research organization. The purpose of the evaluation was to gather data on program implementation and effects to refine models and processes and to inform expansion and scale-up of pilot activities. The evaluation focused on clients receiving RH services, health providers, program administrators, and MOH staff.

Sampling was purposive and consisted of the following: 30 client observations; 105 client interviews, using a closed-ended exit-interview questionnaire; 37 provider interviews, using a closed-ended self-administered questionnaire; six key informant interviews (KIIs) with staff from the MOH, TASO/M, and ACQUIRE; and six focus group discussions (FGDs) with providers and PLHIV, using open-ended discussion guides (see Table 2; tools available on request).

Table 2. Evaluation sample

| | Provider Questionnaire | FGD/KII | Client Survey | Observation |
|------------------------------------|------------------------|---------------------------------------|---------------|-------------|
| Supervisors | 2 | | | |
| Doctors | 2 | | | |
| Medical/Clinical Officers | 6 | | | |
| Nurses/Midwives | 9 | | | |
| Counselors | 5 | 3 FGDs with providers* | | |
| Pharmacists | | | | |
| Laboratory Technicians/ Assistants | | | | |
| Field Officers | 12 | | | |
| ACQUIRE | | 6 KIIs; interviews with program staff | | |
| MOH/Mbale | | | | |
| TASO/Mbale | | | | |
| HIV Clients Counseled on FP | | 3 FGDs | 105 | 30 |
| Total | 37** | 12 | 105 | 30 |

* Providers were included in the FGDs if they did not complete the provider questionnaire.

**Includes one respondent who did not specify his/her position

The study team asked all available doctors, clinical officers, nurses/midwives, and field officers at TASO/M to complete the provider questionnaire. The majority of respondents were field officers and nurse-midwives (see Table 3).

Table 3. Provider type

| | Number | % |
|--------------------------|-----------|------------|
| Field officer | 12 | 33 |
| Nurse/midwife | 9 | 24 |
| Medical/clinical officer | 6 | 16 |
| Counselor | 5 | 14 |
| General physician | 2 | 5 |
| Supervisor | 2 | 5 |
| Not specified | 1 | 3 |
| Total | 37 | 100 |

Of the client interviews, the majority of respondents were 25–39 years of age and had attended primary school (see Table 4).

Table 4. Client characteristics

| Age | Number | Percent |
|------------------------|---------------|----------------|
| 15–24 | 13 | 12 |
| 25–29 | 23 | 22 |
| 30–34 | 26 | 25 |
| 35–39 | 21 | 20 |
| 40–44 | 11 | 10 |
| 45 and older | 8 | 8 |
| Missing | 3 | 3 |
| Religion | | |
| Protestant | 55 | 52 |
| Muslim | 28 | 27 |
| Catholic | 22 | 21 |
| Education level | | |
| Primary | 54 | 51 |
| Secondary | 27 | 26 |
| Higher | 7 | 7 |
| Never attended | 17 | 16 |
| Totals | 105 | 100 |

One field supervisor and two consultants from RI led the study team, which included 16 interviewers. They pretested the tools at the Mbale Regional Referral Hospital and collected the study data from November 26 to December 4, 2007. Data analysis included frequencies and proportions, content analysis of transcripts and reports, and trend analysis of service statistics. ACQUIRE staff from Uganda and New York jointly refined the study tools and protocols, monitored the training and implementation process, provided overall guidance for the evaluation, and revised and finalized the report. Study questions are shown below. Data are presented by study question, with the exception of the final question, which asks about features necessary for replication and scale-up. These features and key recommendations are presented in the discussion section of the report by intervention type (process, supply, demand, and advocacy).

1. What was the experience like of designing and integrating FP into an existing ART site?
2. In what ways was program implementation successful?
3. How did the community collaborate on integrating FP into ART sites? Did clients find that FP services were available?
4. What were the challenges of designing and implementing this pilot, and how were they addressed?
5. Was there an increase in the use of FP services by clients after integrating FP into ART services?
6. What specific features of ACQUIRE's systems approach to FP-ART integration could be replicated and/or scaled up?

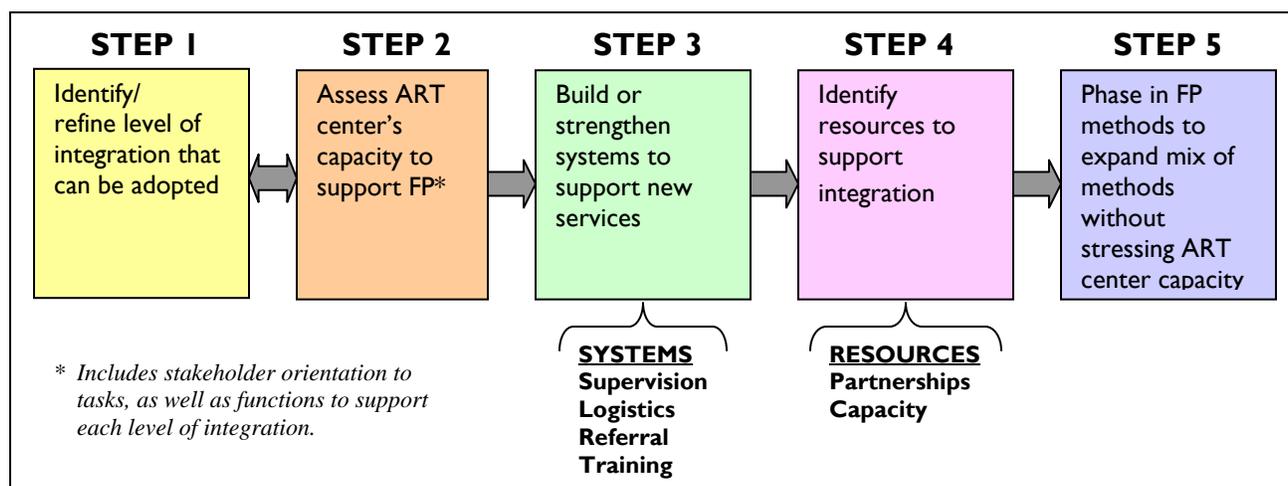
Study Limitations

ACQUIRE conducted FP trainings for trainers and supported those trainers to train counselors and providers during two time periods (September to November 2006 and April 2007). Training data from this case study remain problematic, for several reasons. First, the training questions in the provider questionnaire asked about training for the period November 2005 to November 2007. Therefore, it is unclear whether providers reported on training they received before or during this pilot. Second, due to poor logistics planning, researchers only interviewed 37 of the 47 providers at the site, because 10 others were on study leave or holiday. Finally, researchers could not access needed records from the site to identify the timing of provider trainings, due to the sudden and tragic death of Sister Tunde, the In-Charge at the FP clinic in Mbale Regional Referral Hospital. It should also be noted that the pilot interventions ended in April 2007, while the evaluation was conducted in November 2007, which may have compromised respondents' ability to recall. Finally, due to the sensitive nature of the study, some respondents were unwilling to answer all of the questions (e.g., those regarding the HIV status of partners).

I. Experience in Integrating FP into ART

ACQUIRE conceptualizes the process of FP/ART integration in five steps (see Figure 1). The first two steps may be iterative to identify a realistic level of integration of FP services for the proposed site, ideally through a PNA or another type of participatory assessment process. Once systems capacity is assessed, technical assistance interventions are tailored to build or strengthen systems to support new and existing services, to avoid destabilization of existing service delivery systems. Identified partnerships needing capacity building are supported to further contribute to the integration process. Finally, through monitoring of the service delivery performance, data can be used to determine the need for expanding the method mix or improving the current level of FP integration. Key process results are provided below.

Figure 1. The FP/ART integration process



The level of integration of FP into HIV services was appropriate to the site. A majority of providers (62%) reported in the survey that adding FP services did not adversely affect the provision of ART services. They stated that the level of integration was appropriate to the site, because clients were already receiving condoms for HIV prevention and were using FP from other sources. When asked about the perceived benefits of integration, the most frequent responses were: reducing unwanted pregnancy, improving the health of clients, reducing MTCT, and improving clients' willingness to talk openly about sex. Integration was also seen as cost-effective and as an opportunity to improve adherence to ART, due to the added follow-up from the FP activities. Major challenges cited were poor record-keeping, FP stock-outs, client misconceptions about FP side effects, and an increased workload for providers, especially in database management. In the exit surveys, clients were asked how the introduction of FP services affected their access to ART services. The largest proportion stated that they had experienced no change (41%) or that ART service provision had improved (35%).

It was important to prepare the site for potential increases in workload. In FGDs, providers revealed that site orientations and discussions prior to the initiation of the pilot were crucial to understanding and accommodating the extra workload resulting from the addition of FP services.

Key informant interviews with program staff further supported this notion with staff commenting that the process should proceed slowly to encourage discussion and buy-in. Examples from respondents included:

Before the integration of family planning services, the counselors were already prepared for it.

—FGD, Provider, TASO/M

Initially we held many meetings to help staff appreciate the added work, for instance on records. Others wanted family planning to be separated but we said no, because these are services we need to provide continuously.

—FGD, Provider, TASO/M

Yes it was clear, it kick-started the program. We signed a Memorandum of Understanding and [had] the stakeholders meetings and knew what we were going in for.

—KII, Program staff, TASO

The PNA was an effective program planning tool. The PNA conducted by ACQUIRE in March 2006 proved successful in informing program design and start-up. The initial FP-ART integration plan was modified based on the findings, which included identifying gaps in communications materials and the need to develop special services for pregnant mothers and infants. Changes were also made to the ART program as a result of the PNA process. For example, the center changed the seating arrangement of counselors and clients, removing a barrier (table between them) for more effective interaction and communication. Typical responses from program participants were:

It [PNA] also helped us to identify IEC [information, education, and communications] needs and get them developed.

—KII, Program staff, TASO/M

It [PNA] helped the TASO center to assess their capacity to handle and see the gaps in family planning service provision. Although we were giving condoms, they were for prevention of STIs [sexually transmitted infections], so even if someone was using FP, they needed a condom for dual protection.

—KII, Program staff, TASO/M

Group discussions with program participants revealed some challenges to implementing the action plan, including ignoring the backlog in laboratory tests. They also commented that the PNA process could have included more external participation, even though there was external input from TASO/M management at headquarters and Mbale's District Health Management Team.

Stakeholders took ownership of the decision to integrate services. Key informant interviews with program participants showed that TASO staff understood the need for integration, citing such reasons as: to bring services closer to clients; to reduce missed opportunities for providing FP services to clients; to reduce MTCT; and to reduce unintended pregnancies among PLHIV. Common reasons cited for the decision to integrate services within TASO/M were:

HIV-positive people get pregnant and go ahead to have abortions, yet this is something that could have been avoided.

—KII, Program staff, TASO/M

Some people have HIV but have never had children, hence they need to space their children.

—KII, staff, TASO/M

Adding FP services required space accommodations. The integration of FP services resulted in a need for space to privately conduct FP counseling and services and conduct record-keeping. As a result, TASO/M converted existing space, previously used for tuberculosis services, to accommodate both types of services.

Partner collaboration is essential. Interviews with program participants found that since TASO/M did not have the capacity to provide FP services alone, it was necessary to develop partnerships with the MOH, the district local government, the Mbale Regional Referral Hospital, the Family Planning Association of Uganda, and Marie Stopes International to aid in integration. For example, when TASO/M ran out of injectables, the Mbale Regional Referral Hospital supplied them.³ Additionally, respondents suggested that the partnership improved client services by allowing clients to attend appointments for different services in the two facilities on the same day, which in turn reduced their costs (e.g., for travel). The following are typical comments from administrators on the relationship between the TASO/M and the Referral Hospital.

We do not know it all, so we needed support. Previously, we at TASO offered FP on our own, but working together with other partners has helped us a lot.

—KII, Administrator, TASO/M

About collaboration, it has worked. For example, when they (TASO) run short of contraceptives like Depo Provera, then we supply it to them.

—KII, Administrator, Mbale Hospital

2. Successes in Program Implementation

Providers supplied FP counseling and services specified in the pilot. In the provider questionnaire, the majority of respondents said that they offered a range of services to clients. Most frequently reported was counseling for FP services (see Table 5). More than 90% reported that it was best to discuss FP methods with clients during HIV health-education sessions. The majority said they initiated these discussions by asking the client about her reproductive history (89%). All reported that they provided FP methods to men, the majority through the provision of condoms to women (68%). Just over half (57%) said that they also provided services to men in community outreach and when men accompanied women to the clinic. Client-provider observations revealed that most providers (93%) discussed sex and reproductive rights with their clients and that a majority (87%) asked them about their fertility desires. Most were responsive to the clients' questions and concerns about FP (93%), gave the clients accurate information about FP (97%), and corrected clients'

Table 5. Services provided (N=37, provider questionnaire)

| Service* | % Agree |
|---|---------|
| Counseling for FP services | 92 |
| Community outreach for HIV | 90 |
| Counseling for HIV | 87 |
| Provision of condoms, oral contraceptives, or injectables | 87 |
| ART | 81 |
| Administration | 19 |
| Provision of implants, IUDs, or sterilization | 8 |

*Multiple responses allowed

³ This finding is in contrast to provider perspectives presented below. Providers were more critical of the collaboration; citing issues with referral protocols and compliance (see section below, challenges in design and implementation).

misconceptions about FP (86%). Providers most commonly discussed condoms (93%), oral contraceptives (87%), and injectables (83%) with clients.

Providers demonstrated positive attitudes toward the RH needs of PLHIV. In the self-administered questionnaires, providers were asked about their attitudes towards PLHIV. Providers overwhelmingly supported the sexual and reproductive health needs of PLHIV, including their right to bear children and access FP methods (see Table 6). When asked what they would tell an HIV-positive woman who was considering pregnancy, the most common response was information about HIV transmission during pregnancy (97%). When asked what they would discuss with an HIV-positive woman who was not considering pregnancy, the majority (80%) said they would discuss FP methods with her, while the remainder said they would provide her with routine counseling and encourage abstinence (data not shown). Providers were less supportive of the needs of homosexuals and remained concerned about their own vulnerability to HIV infection through their work.

Table 6. Providers' attitudes toward PLHIV (N=37, provider questionnaire)

| Attitude | % Agree |
|---|---------|
| PLHIV have the right to another child if they want one. | 100 |
| This statement is untrue: Prior to starting ART, women should sign a statement that they will not get pregnant. | 100 |
| PLHIV have the same sexual and RH rights as those who are HIV-negative. | 97 |
| It is important to counsel every PLHIV about their RH and rights. | 97 |
| I am comfortable offering health services to PLHIV. | 97 |
| This statement is untrue: Women who are taking ART should avoid using injectables. | 97 |
| This statement is untrue: If a woman with an IUD becomes HIV-positive, she should have the IUD removed. | 92 |
| Telling PLHIV that certain behaviors put them at risk is generally sufficient to cause them to change their behavior. | 90 |
| This statement is untrue: The only FP methods that PLHIV should use are abstinence or condoms. | 89 |
| This statement is untrue: Pregnant HIV-positive woman should be advised to have a tubal ligation after they have delivered. | 89 |
| This statement is untrue: Providing FP services to HIV-positive women will encourage them to have sex and become pregnant. | 82 |
| People who have sex with members of the same sex have a right to access services in my facility. | 61 |
| I am at high risk of becoming infected with HIV while working in my clinic. | 49 |

Providers gained valuable skills on how to oversee quality FP services through facilitative supervision and COPE trainings. Group discussions with providers revealed that they especially valued trainings in facilitative supervision and COPE[®]. Informants felt these trainings in particular helped to develop their skills for providing staff feedback, conducting staff appraisals, and recognizing staff contributions to program implementation. Provider responses included the following:

The facilitative [supervision] training was one of the best trainings we had, well facilitated and very clear. We changed the methods of supervision we were using, including me.

—FGD, Service provider, TASO/M

I learned to distinguish between dealing with behavior and seeing how to help someone solve a problem.

—FGD, Service provider, TASO/M

The provider survey revealed that on-site supervisors were demonstrating skills gained in ACQUIRE trainings to oversee quality services. For example, respondents most frequently reported that their on-site supervisors reviewed client records, gave feedback on performance, and observed service delivery (see Table 7). Further, nearly three-quarters of providers reported that they received an external supervision visit in the past three months (data not shown).

Table 7. Tasks performed during on-site supervision (N=37, provider questionnaire)

| Task* | % Yes |
|---------------------------------------|-------|
| Reviews client records | 84 |
| Gives feedback on performance | 73 |
| Observes service delivery | 73 |
| Reviews service statistics | 68 |
| Checks supplies and equipment | 57 |
| Checks infection-prevention practices | 54 |
| Talks with clients | 51 |
| Provides skills training | 38 |
| Don't know | 5 |
| Nothing | 0 |

*Multiple responses allowed

Providers conducted FP education more than any other service during outreach. Once a month, TASO/M staff—usually community nurses—provide FP services at outreach sessions in rural areas adjacent to TASO/M. Each community has its own outreach day during the month. Table 8 lists the services provided during community outreach sessions. The service most frequently provided was discussion of FP methods. Nearly three-quarters of providers who conducted outreach services stated that they offered FP methods during outreach.

Table 8. Services provided during outreach (N=37, provider questionnaire)

| Service* | % Yes |
|--|-------|
| Discussion of FP methods | 95 |
| Health education about ART and adherence | 89 |
| General health education | 87 |
| Health education about HIV transmission | 78 |
| FP provision | 73 |
| ART provision | 62 |
| Publicity about services offered by clinic | 57 |

*Multiple responses allowed

Providers used ACQUIRE materials at the clinic. Client observations showed that providers used the communications materials adapted from ACQUIRE's FP-ART pilot in Ghana to counsel clients on FP methods: Seventy percent used the contraceptive reference chart, 50% used the counseling flow chart, and 37% used the FP-ART client booklet. It should be noted that one respondent from the key informant interviews pointed out that the materials would have been more useful had they been translated from English into local languages.

Providers were aware of the updated National RH Policy Guidelines and Service Standards for FP Service Delivery. The 2005 edition was revised and disseminated to health providers during the pilot project. In the self-administered questionnaires, the majority of providers (78%) stated that they were aware of the guidelines and virtually all (97%) said that their facility had the guidelines,

which were generally reported to be kept in the library or common area. A majority said that they got the information about the guidelines from their supervisors.

Field officers are providing FP methods during community outreach activities. Among 12 field officers who responded to the provider questionnaire, 80% said that they discussed FP and 40% said they currently provide FP methods during community outreach activities.

Stigma against PLHIV lessened among providers and clients at TASO/M. In separate group discussions, clients and counselors at the TASO Center reported that PLHIV have the right to engage in sex and have children, provided they practice safe sex and do not transmit HIV to their children. Most, but not all, counselors reported that HIV-positive mothers who want to have children should be directed to PMTCT services and given accurate information on the risks of MTCT with and without treatment. A few respondents did report that it was better for HIV-positive persons to refrain from having children. And, if they must, then they should do everything possible to avoid MTCT. One provider stated:

The client has the right to make the decision whether to have children or not, and counselors need to help them to go for PMTCT.

—FGD, TASO/M counselor

3. Community and Client Perspectives

Clients reported hearing FP messages. In group discussions, clients reported that they received FP information from radio, TV, posters, seminars, and health facilities. They most commonly reported hearing FP messages on condom use, the dangers of not using FP methods, and the use of FP to protect the HIV-negative partner in discordant couples. The FP benefits they mentioned were lessening the burden of raising many children, avoiding HIV/STI risk, increasing their ability to provide for their children, and ensuring that their children grow up in good health. Some PLHIV comments included the following:

I have enough children and why should I add more burden.

—FGD, Male-positive client

It has helped me to reduce the burden of raising many children because I can reduce on the number of children in my family because after my death, I know my people cannot manage to look after all of them.

—FGD, Female-positive client

For me, it is helping me to plan for my children before I die.

—FGD, Male-positive client

Clients were well-informed about FP methods. Clients were asked in the exit survey about their knowledge of FP methods. Table 9 shows that almost all clients knew about the pill, injectables, and condoms, but fewer knew about LAPMs. It is notable that approximately the same percentage of clients knew about the female condom as about the IUD and male sterilization. Other methods they mentioned were safe days, abstinence, and local methods.

Clients reported satisfaction with TASO/M FP services. In group discussions with PLHIV, respondents reported that they perceived health workers at TASO/M to be friendly, supportive, and caring. They stated that they appreciated the health workers and that the information the staff provided affected their decision to use FP methods.

Table 9. FP methods heard about by clients (N=105, client survey)

| Method* | % Yes |
|-------------------------------------|-------|
| Combined oral contraceptives | 94 |
| Injectables | 93 |
| Condoms | 87 |
| Implant | 65 |
| Female sterilization | 63 |
| Female condoms | 58 |
| IUD | 56 |
| Male sterilization | 52 |
| Withdrawal | 48 |
| Lactational amenorrhea method (LAM) | 37 |
| Rhythm method | 37 |
| Emergency contraception | 30 |

*Multiple responses allowed

In fact, some discordant couples stated that they would like T-shirts to show their discordant status to encourage other people to come to TASO/M. In contrast, prior to the start of the FP-ART integration program, respondents said that they were dissatisfied with FP services at TASO/M, citing inadequate information, high method costs, and expired methods. For example, respondents stated the following about the FP services at TASO/M prior to the pilot intervention:

We used to not get enough information because the health providers were not trained.

—FGD, Female-positive client

We used to have problems with the cost of the methods, and others gave expired or wrong methods.

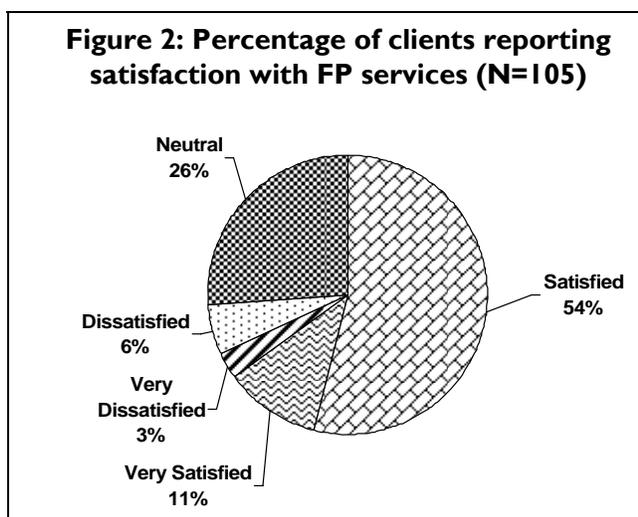
—FGD, Female-positive client

Figure 2 shows that in their exit interviews, two-thirds of the clients reported that they were satisfied or very satisfied with the availability of FP services. When those two-thirds were asked why they were satisfied, the most common responses were that the services were very effective and that it was easy to access the health provider.

FP myths and misconceptions persist in the community.

In group discussions, HIV-positive clients were asked to give their perceptions about what community members think. Their responses reflected persistent misin-

formation. Condoms were thought to cause stomach pains and itching and even to be contaminated with HIV. Oral contraceptives were thought to cause abnormalities in children, high blood pressure, infertility, and cancer. Injectables were believed to lead to heavy bleeding and high blood pressure. Finally, implants were thought to dissolve in the body, leading to weakness.



Stigma against PLHIV remains in the communities adjacent to TASO/M. PLHIV continue to be discriminated against in the community. In group discussions and interviews with PLHIV and with providers, respondents reported their perceptions about what community members think. For example, they stated that PLHIV are referred to as “dead living persons waiting to be buried.” Although respondents reported some community sympathy for PLHIV, in general, PLHIV were isolated. They said that community members disapproved of PLHIV having sex or bearing children and refused to allow their children to play with children of PLHIV, even if they are HIV-negative. Respondents speculated that this was because the majority of community members perceive that every child born to a PLHIV is HIV-positive. Some reported that TASO/M’s care and support services were actually perceived by community members as contributing to the spread of HIV and AIDS because PLHIV receiving the services look healthy. Some even stated that PLHIV receiving care from TASO/M were sometimes referred to as “murderers.” Typical responses from qualitative interviews were the following:

For me, after my wife tested and found that she was negative, those people advised her to leave me to die alone.

—FGD, Male-positive client

For me, because of the prolonged illness, they have nicknamed me ‘Omulwade’ (sickly one) and so they have forgotten my real name.

—FGD, Male-positive client

In case you happen to produce a girl and then she grows up, they discourage their sons from marrying her because they generally identify our homes with the disease.

—FGD, Female-positive client

4. Challenges in Design and Implementation

Although some providers demonstrated correct knowledge of FP and of dual protection, more training is needed.⁴ In the self-administered questionnaires, more than 80% of providers reported that they were trained on FP methods and ARV interaction and on the role of FP in HIV or dual protection. When asked how women are most often infected with HIV, nearly three-quarters of providers responded that it was through unprotected sex with their husband. Another 11% answered through early marriage; the remainder did not know. When asked about the single most effective way to reduce HIV and other sexually transmitted infections (STIs), 95% responded that the most effective way was through condom use. Few respondents correctly defined dual protection and dual method use: Fewer than 20% of providers correctly identified dual protection as simultaneous protection from both unintended pregnancy and HIV and other STIs, and less than 15% correctly defined dual method use as the use of a contraceptive method plus condoms.

Providers were well-informed about how to advise clients on methods they should use and about what the warning signs of possible side effects were, but they were less knowledgeable about the special considerations for the provision of FP methods to PLHIV (Table 10). For example, only slightly more than half reported that an HIV-positive woman on ART needs to be aware of the consequences of skipping oral contraceptive tablets. A little more than one-fifth did not know that ART may reduce the effect of the injectable close to date of reinjection. Just over 40% agreed with—or did not know the answer to—the statement that a woman should have her IUD removed if she develops clinical HIV; and just over 40% were unsure about or thought that IUDs cannot be used by nulliparous women without affecting their future fertility.

⁴ The data presented here should be interpreted with caution, since they are not necessarily representative of ACQUIRE training as a whole. (See the study limitations section for more information.)

Table 10. Selected measures of providers' FP knowledge (N=37, provider questionnaire)

| Method/Critical Knowledge | % Agree | % Disagree | % DK |
|--|----------------|-------------------|-------------|
| A. Combined Oral Contraceptives | | | |
| HIV-positive women on ARVs who are interested in combined oral contraceptives need to be aware of* | | | |
| ♦ Sticking to pill schedule | 76 | 24 | |
| ♦ Consequences of skipping tablet | 57 | 43 | |
| ♦ Drug interactions | 57 | 43 | |
| ♦ Possible need to take additional pills | 32 | 68 | |
| HIV-positive women with varicose vein can take combined oral contraceptives. | 5 | 52 | 43 |
| A woman can take her first packet of combined oral contraceptives any day that the provider is sure she is not pregnant. | 0 | 100 | |
| Combined oral contraceptives protect against STIs/HIV. | 3 | 89 | 8 |
| Warning signs of serious complications for oral contraceptive users are* | | | |
| ♦ Severe headache | 78 | 22 | |
| ♦ Intense abdominal pain | 57 | 43 | |
| ♦ Blurry vision | 38 | 62 | |
| ♦ Intense chest pain | 22 | 78 | |
| ♦ Intense pain in extremities | 30 | 70 | |
| B. Injectables (DMPA) | | | |
| ART may reduce the effect of DMPA close to the date of reinjection. | 78 | 22 | |
| DMPA offers protection against STIs/HIV. | 3 | 97 | |
| Warning signs of serious complications for DMPA users are* | | | |
| ♦ Severe headache | 70 | 30 | |
| ♦ Intense abdominal pain | 46 | 54 | |
| ♦ Prolonged heavy bleeding | 8 | 92 | |
| Women should return for DMPA reinjection in 12 weeks. | 65 | 13 | 22 |
| C. IUD | | | |
| Healthy HIV-positive women on ART can use IUDs. | 81 | 8 | 11 |
| Remove IUD if a woman develops clinical HIV. | 32 | 57 | 11 |
| IUDs can be used by childless women without affecting their future fertility. | 56 | 22 | 22 |
| IUDs offer protection against STIs/HIV. | 3 | 92 | 5 |
| Warning signs of serious complication for IUD users are* | | | |
| ♦ Intense abdominal pain | 70 | 30 | |
| ♦ Abnormal vaginal discharge | 65 | 35 | |
| ♦ IUD strings are absent, longer, or shorter | 38 | 62 | |
| ♦ Missed period | 27 | 73 | |
| ♦ Fever | 14 | 86 | |
| IUDs can remain in a woman's womb and prevent pregnancy for 12 years. | 22 | 49 | 29 |
| D. Implants | | | |
| HIV-positive women can use implants without restriction. | 57 | 24 | 19 |
| E. Surgical Contraception | | | |
| If PLHIV are sure they do not want any more children, they can use surgical contraception. | 86 | 3 | 11 |
| After vasectomy, a man is immediately sterile. | 32 | 65 | 3 |
| After tubectomy, a woman is immediately sterile. | 60 | 35 | 5 |
| If a man/woman has acute AIDS-related illness, surgical contraception can be delayed until his/her condition improves. | 89 | 3 | 8 |

*Multiple responses allowed

FP referral protocols were implemented, though referrals remain somewhat problematic. TASO/M is in close proximity to the FP clinic of the Mbale Regional Referral Hospital, theoretically allowing clients access to LAPM and other services on the same day. All providers stated that when a client wants a FP method not available at the facility, they refer the client to another facility. And the majority (89%) stated that during the next visit, they checked that the client followed the referral. However, interviews with providers revealed major challenges to the referral system. Providers stated that collaboration does not always take place, often because staff at both the TASO/M and the hospital believed that the other facility employed experts who could function well without assistance. Referrals were further compromised during hospital renovations, during which time clients who were referred from TASO/M could not access FP services at the hospital. Other reported challenges included clients' reluctance to go to referral centers, where (unlike at TASO/M) they might be charged for services, wait for a long time, or face stigma and discrimination.

Although TASO/M shifted away from the open market to the MOH system to procure FP commodities and supplies, stock-outs continued. Providers were asked about stock-outs of FP commodities and supplies in the self-administered questionnaires. More than three-quarters reported FP stock-outs in the six months prior to the survey. The method most commonly out of stock at TASO/M was injectables, while implants and equipment for male sterilization were most often absent from the Mbale Regional Referral Hospital. More than half of providers stated that the major reason for FP stock-outs was the failure to order methods on time. When asked what steps were taken to obtain supplies, nearly half reported ordering the supplies themselves, 40% informed their supervisors, and 25% obtained supplies from Mbale Regional Referral Hospital. When asked what they do when a client wants a method that is out of stock, the great majority said that they refer the client to another facility (92%). This issue was further explored in key informant interviews with program staff, who explained that ACQUIRE provided technical assistance to TASO to change their ordering practice from the open market to the National Medical Stores (NMS), which is the MOH division responsible for procurement. Common responses included the following:

Initially, we were getting from the district and hospital and we did not have the budget and yet there were stock-outs. Then headquarters contacted NMS and now we get supply.

—KII, Program staff, TASO/M

Stock-out periods [were] because it was difficult for TASO to get through the district health office, so TASO was advised to get through NMS directly.

—KII, ACQUIRE staff

FP record-keeping was challenging due to lack of systematic protocols. Prior to the pilot, providers recorded information on care and treatment for ART clients, but no information on FP services. With the introduction of the pilot, providers were asked to develop ways to capture this information. In the provider survey, 65% of respondents stated that they created separate registers for FP services, while 43% stated that they modified the existing care and treatment record to include FP. When asked where they actually record the information, the most common response was the client card (78%), followed by the client register (57%).

In-depth interviews with providers revealed that a shortage of client cards was exacerbated by the center's continued reliance on the District Health Service for the cards. When asked about data use, all providers in the survey said that they used the data to prepare progress reports and/or to inform requisition of supplies. Results from interviews with providers confirmed these findings. Informants reported that record-keeping was their biggest challenge, because there was no systematic approach

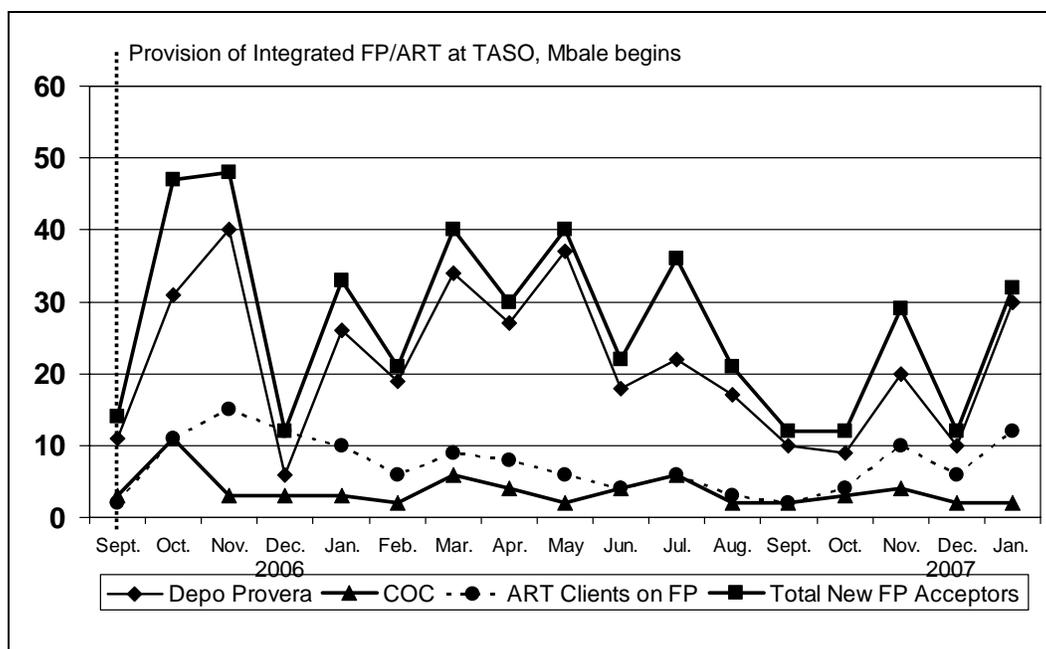
to doing it. Without this, they reasoned, there was no need for a computerized database or database training. They also reported that the staff person in charge of record-keeping left the organization for another job during the pilot, leaving counselors to complete and send forms for data entry.

Services to men were limited. In the provider survey, all respondents reported that they offered FP services to men. However, when questioned about specifics, data showed that providers defined this as providing condoms to women for their partners or when men accompanied their partners to the clinic. Only 5% of providers stated that they gave condoms directly to men, and only one provider reported referring a man for FP services.

5. Use of Services

Directly following sustained FP introduction in September 2006, the number of ART clients accessing FP increased three-fold. ART clients continued to access FP services at a rate of about 30 clients per month throughout the pilot, albeit with fluctuations in client acceptance due to seasonality and stock-outs (see Figure 3).

Figure 3. Number of family planning clients served at TASO Mbale Facility, by method/service



The majority of clients interviewed in exit surveys were 25–39 years of age (68%) and had previously visited the facility (90%). Almost half were receiving ART, and of these, slightly more than half had done so for a year or more. More than one-third were aware of their partner’s HIV status. Seven percent said that their partners were HIV-negative. More than half reported that they were currently using an FP method. Two-thirds reported that they used condoms every time they had intercourse in the past six months. Tables 11 and 12 provide data on the types of services clients reported receiving on the day of the survey. The largest proportion of clients reported receiving treatment for opportunistic infections, confirmation of HIV test results, and adherence counseling.

Those receiving FP methods most frequently reported getting injectables, condoms, and oral contraceptives.⁵

Table 11. Percentage of clients reporting RH services received (N=105, client exit survey)

| Service* | % Yes |
|---------------------------------------|--------------|
| Treatment of opportunistic infections | 42 |
| VCT | 39 |
| Adherence counseling | 37 |
| ARV follow-up | 30 |
| FP resupply | 27 |
| Follow-up (not ARV) | 22 |
| Starting FP | 11 |
| Starting ARV | 7 |
| PMTCT | 6 |

*Multiple responses allowed

Table 12. Percentage of clients reporting FP services received/referred (N=105, client exit survey)

| FP Service* | % Yes |
|----------------------|--------------|
| Rhythm | 1 |
| IUD | 1 |
| Withdrawal | 2 |
| Female sterilization | 6 |
| Abstinence | 8 |
| Oral contraceptives | 11 |
| Injectables | 36 |
| Condoms | 36 |
| Rhythm | 1 |

*Multiple responses allowed

⁵ These data are consistent with the findings from the latest Demographic and Health Survey in Uganda (UBOS and Macro International, Inc., 2007), which listed injectables, condoms, and oral contraceptives as the most frequently used methods among married women of reproductive age.

Discussion and Recommendations

This report is intended to give the reader information about experience from one FP-ART pilot, with a focus on the process of replication and scale-up. Convinced by the success of this pilot, TASO has already begun scale-up within Uganda. According to TASO staff, the ACQUIRE model will be rolled out to all TASO centers over the next several years as part of the TASO headquarters' new five-year strategic plan (2008–2012), with funding from the U.S. Centers for Disease Control and Prevention (CDC). The salient features of the pilot and major program recommendations for replication and scale-up are below.

Process

Programmers should start with the five-step process outlined in Figure 1:

1. Identify/refine appropriate integration level
2. Assess capacity
3. Strengthen systems
4. Identify resources
5. Phase in additional FP methods, as appropriate

This study found that participatory processes and orientations were particularly important to encourage stakeholders to discuss and take ownership of the process. When they did, they understood the need for integration and became champions of the process. Partnership is another salient feature of this pilot critical to replication. Programmers forged key partnerships between TASO/M and the Mbale Regional Referral Hospital for referrals and between TASO/M and the NMS of the MOH to ensure a steady supply of commodities and supplies. A final implicit partnership was between TASO/M and the ACQUIRE Project. Although not discussed in detail by the respondents, ACQUIRE staff later observed that follow-up by ACQUIRE to TASO/M was essential to fostering progress. A final notable step in the process was modifying physical structures—for instance, adding a new space for FP counseling and provision, and removing the table between providers and clients to facilitate communication. Major process recommendations for replication and scale up are the following:

- ◆ Prior to integration, prepare on-site staff at all levels through orientation and discussion.
- ◆ Use participatory methods, such as the PNA, to engage stakeholders in identifying service gaps, defining what a successful program will look like, and selecting an appropriate level of the framework for integration.
- ◆ Carry out site preparations before initiation of service-delivery training (e.g., training of supervisors, plans for reorganization of work, and modifications to service-delivery systems). Ensure that there is adequate private space for FP services and counseling.
- ◆ Develop partnerships with referral sites; explore how partners can jointly share resources, develop staff capacity, and develop and implement referral protocols and systems.
- ◆ Garner technical support from the MOH; discuss and identify opportunities to strengthen supplies of FP commodities and equipment.
- ◆ Strengthen relationships between the public and private sectors to better coordinate district-wide FP-HIV integration efforts.

- ◆ Identify a variety of ways that international NGOs providing technical assistance can check-in with field progress (e.g., through periodic phone check-ins, piggy-backing of follow-up visits by international staff going to a nearby vicinity, and/or field staff traveling to or through international NGO field or headquarters offices).

Supply

Successful replication and scale-up require the building or strengthening of supervision, logistics, referral, and training systems to support the introduction of the new FP services. A solid training program is critical to success and should include clinical and counseling components. Counseling should particularly focus on the RH/FP needs of PLHIV, including their right to the voluntary provision of FP methods. Training staff to interact with PLHIV and be more sensitive to their RH needs, implementing quality improvement processes like facilitative supervision and COPE, and developing and disseminating job aids and client materials were critical to enhancing staff skills and attitudes, thus improving the quality of service delivery. PLHIV volunteers participated in the pilot to support providers in FP counseling, referral, and follow-up, often sitting at the FP desk and answering clients' questions. Although not well-explored in the study, anecdotal evidence gathered during monitoring visits shows that these individuals were extremely dedicated and useful in informing and helping clients meet their FP needs.

Reviewing and improving referral systems was also necessary to ensure that clients are able to make informed choices about all available FP methods, including LAPMs. However, the pilot revealed that written referral protocols were ineffective for clients who cannot read. Equally important was discussing staff resistance or willingness to make referrals and to train staff to clearly communicate to clients information about charges, waiting times, and possible stigma at referral sites. The supply of FP commodities is crucial for service delivery. TASO/M addressed this by accessing commodities from the FP clinic at Mbale Regional Referral Hospital, by strengthening staff skills in the "pull system," and by purchasing commodities from the NMS. Many of the logistics challenges stemmed from confusion about where and how to record FP statistics. Major supply-side recommendations are as follows:

- ◆ Train staff in FP service provision, and develop and maintain a continuing education/refresher mechanism to address staff performance needs due to attrition and recruitment of new staff.
- ◆ Train staff to provide effective FP counseling using FP-ART curricula (such as the ACQUIRE manual), national guidelines, and WHO medical eligibility criteria; include direction to staff on when and how to introduce FP into the discussion; this program was successful in doing so in HIV health education sessions during the time when staff take the client's RH history.
- ◆ Train PLHIV volunteers to assist providers in client counseling and referrals; consider stationing volunteers at the FP desk on-site to interact with clients.
- ◆ Develop a unified system to record FP clients and commodities and institutionalize and train staff on FP use.
- ◆ Ensure steady supply of FP and HIV/ART commodities to meet the rising demand for integrated services, and include in-depth exploration of FP commodity supply options and what effect the use of those options might have on the budget and choice of level of FP integration in the PNA.
- ◆ Use facilitative supervision training to improve supervisors' capacity to oversee implementation of quality FP-integrated services

Demand

ACQUIRE's demand-side interventions included basic communications activities. This approach was certainly successful: Clients reported awareness of FP and satisfaction with TASO/M services. However, clients were less informed about LAPMs than about the short-acting methods (combined oral contraceptives, condoms, and injectables) available at TASO/M. It is important to note that stigma against PLHIV and myths about FP continue to be issues for the communities' clients and providers. One activity that may have made a difference, if implemented, was working through an existing drama group in TASO/M. Originally, ACQUIRE suggested working through this group to help disseminate FP messages and address stigma against PLHIV. Unfortunately, this group was disbanded in March 2007. Finally, although male involvement activities were integrated into the FP program, more could be done. Demand-side recommendations include the following:

- ◆ Develop creative ways to provide services to men beyond providing them with condoms, such as by introducing special days to counsel couples together about all FP options, including male centered methods (e.g., vasectomy), and by training male PLHIV volunteers.
- ◆ Address the stigmatization of PLHIV, as well as myths about FP at the community level, through targeted interventions (e.g., peer educators/champion development, community theater, radio messages, and/or health worker outreach and drama groups). Consider partnering with existing groups already engaged in behavior change communications activities.
- ◆ Develop FP client materials in the local languages; disseminate them widely to clients and potential clients during client visits to sites and community outreach.
- ◆ Ensure that counselors cover the entire available range of FP methods, tailored to the clients'/couples' fertility desires, including those methods available at referral sites, so that clients are as informed as possible. Develop wall charts that show all methods and identify where to get those methods not available on-site.

Advocacy

TASO/M successfully advocated for integration work throughout this pilot and beyond. TASO/M has a tested FP-ART protocol that is in use. TASO/M field officers are providing FP counseling services during outreach. Most impressively, TASO/M has included integration activities in their five-year strategic plan and has received CDC funding to support the process of scaling up the FP-ART pilot in TASO's 11 centers and 15 minicenters across Uganda. It is important to note that this pilot was conducted at one site in the private sector, one that is adjacent to a public-sector referral hospital. Recommendations for replication and scale-up within Uganda and beyond include the following:

- ◆ Present study results to the MOH to discuss how this pilot might be applied to public-sector sites, stressing that a pilot in the public sector should be conducted at a site that is already providing quality ART services and that has the human and financial resources to expand without compromising existing services, and that the site should either provide or have a functioning referral system for LAPMs.
- ◆ Advocate for support to lower-level trained field officers to provide FP services in the community, and for funds to train new staff, to compensate for staff turnover.

In conclusion, TASO/M successfully implemented the ACQUIRE FP-ART integration model. Although the model focused heavily on implementing supply-side activities through a systems approach, it was important to incorporate demand activities into the program, most especially to address stigma within adjacent communities in support of meeting the RH needs of PLHIV. Advocacy activities were also crucial, particularly those that assist sites to obtain FP commodities

and supplies and those that educate and encourage stakeholders about program successes, leading to the eventual scale-up and replication of successful programs. Effective integration requires a holistic approach that addresses the interconnectedness of supply-demand-advocacy interventions, based on the facility's capacity to provide a level of integration that meets clients' needs without compromising existing services.

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