Photo: Eric Bond/EGPAF, 2020

Elizabeth Glaser Pediatric AIDS Foundation
Fighting for an AIDS-free generation

Assessing the Integration of Family Planning into Differentiated ART Service Delivery Models

The global scale-up of differentiated ART service delivery (DSD) models and transition to multi-month ART dispensing has raised concerns about the potential constraints on the ability of women living with HIV (WLHIV) to access family planning commodities, as they are often accompanied by less frequent clinical interactions and fewer visits to health facilities. To better understand this issue, EGPAF conducted a rapid assessment of the integration of family planning into DSD models in 12 health facilities supported by EGPAF in Kenya and Tanzania.

Key Questions

- To what extent are WLHIV utilizing modern contraceptive methods, including use of long-acting reversible contraception (LARC)?
- How is contraceptive care integrated into existing DSD models following the building blocks of service delivery?
- What are the successes and current barriers to integration of family planning (FP) into DSD models?

Methodology

- Rapid assessment included an excel-based facility assessment tool, including client flow mapping for each DSD model.
- 12 EGPAF supported facilities: dispensaries, health centres, and hospitals in Homa Bay County Kenya (6 sites) and the Kilimanjaro region of Tanzania (6 sites)
- Sites purposefully selected to reflect different levels of the health systems, rural/urban contexts, and demographic aspects within each country
- On-site data collection occurred between 26 October - 6 November 2020

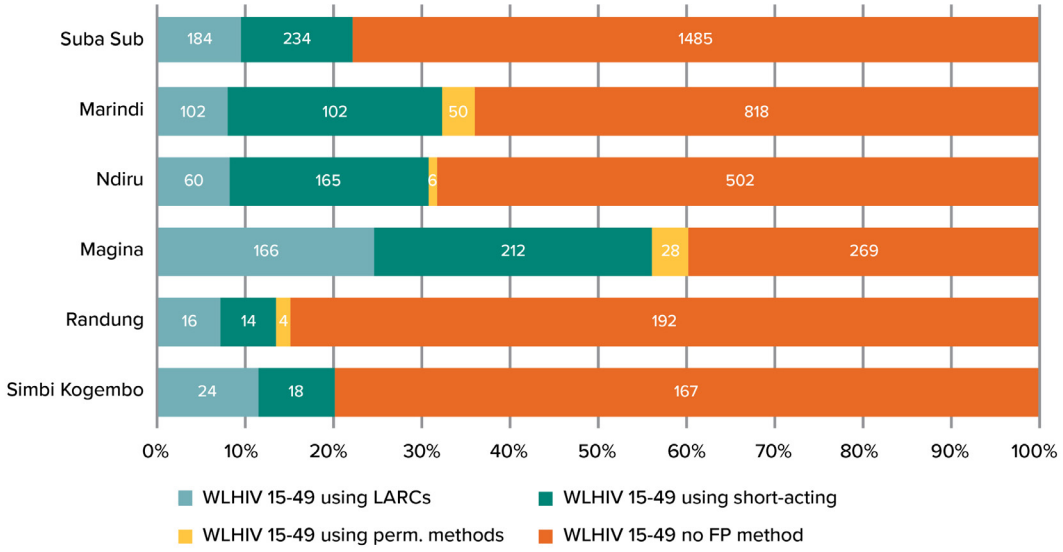
What We Learned

- Overall in Kenya and Tanzania only about one-third of women used contraception (32% in Kenya, 31% in Tanzania). The use of LARCs varied significantly between facilities (34% Kenya, 43% Tanzania), and IUD use was extremely limited in both settings.
- Contraceptive care was not integrated into the comprehensive care clinic (CCC) in Kenya, but required referral to the MCH unit. Similarly, women arriving for ART refill visits in Kenya were assessed for contraceptive need then referred to the MCH unit. In Tanzania contraceptive care was provided at the care and treatment clinic (CTC), but in a different room and by a different healthcare provider as for ART refills.
- The one-stop model (single provider, single room, single visit) was only available at small, lower-level facilities.
- A lack of integration of data sources (i.e. registers) and supply chain challenges hindered alignment of ART and FP visits and refills.

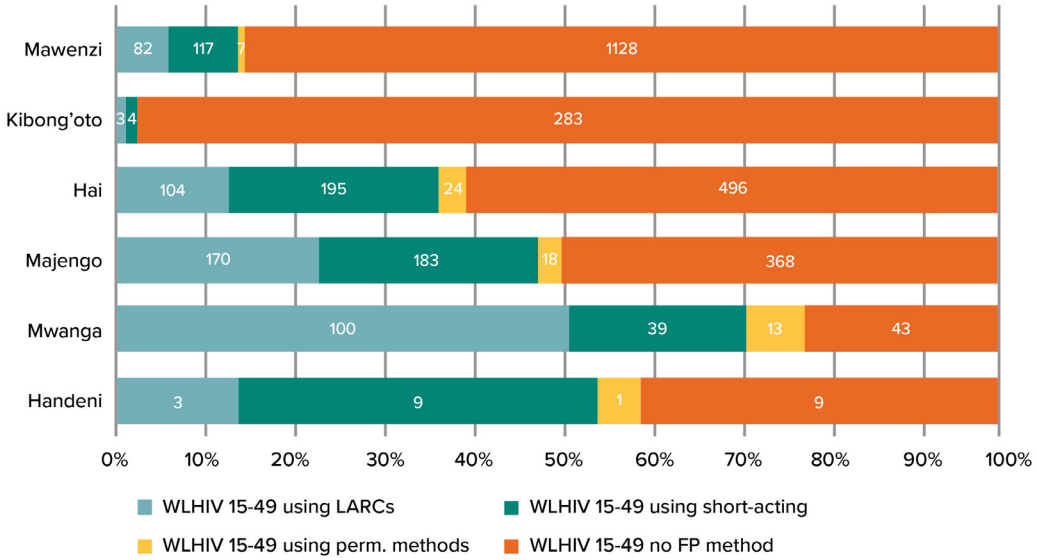
What We Still Need to Learn

- What are the perspectives of WLHIV on integrating family planning services into differentiated ART delivery?
- How are these perspectives influenced by the various models, especially community-based models?

Contraceptive uptake among women 15-49 years living with HIV on ART, Kenya



Contraceptive uptake among women 15-49 years living with HIV on ART, Tanzania



WLHIV were enrolled in a variety of DSD models, including fast-track ART refill, ART in MCH, family-centered groups, mother support groups, and adolescent groups. Community-based models were only offered at the Kenya sites. Generally, women who met the criteria to be considered "established or stable in ART" were eligible for a reduced frequency of clinical visits (every 6 months), with three-month ART dispensing between clinical visits. The clinical visit in both Kenya and Tanzania offered comprehensive clinical ART services including a clinical consultation, laboratory sample collection, adherence counselling, and ART prescription/refill.

The level of integration of FP into differentiated ART delivery varied between countries, by facility level, and by visit type (clinical vs. ART refill visit).

KENYA

HIV care takes place in the comprehensive care center (CCC) and family planning occurs separately in the MCH unit. Contraceptive needs are assessed at the CCC and women receive (escorted) referral from CCC to MCH.

No FP services are integrated into ART refill visits, either in facility or community.

ART and FP refills and visits are not formally aligned; visits may align if client requests coordination.

Operational guidance supports providing FP through DSD models, but this is not implemented in an integrated manner. Pre-packed ARVs for distribution in facility or community models do not include contraceptive commodities.

TANZANIA

Strong integration of FP and ART, particularly during the clinical ART visit. Women in DSD models have access to a full range of contraception options – ART and FP are both offered within the Care and Treatment Centers (CTC).

FP needs assessed at triage at ART refill visit. Contraceptive refills aligned with ART refills (i.e. 3 months oral pills for those who receive 3 month ART refills) and can be collected along with ART. Women may need to queue for certain methods.

Pathway and level of integration varied based on the available space in the CTC. Two lower-level sites offered a one-stop shop approach, while in higher level hospitals, FP services were offered by a different provider in a different room than ART.

Barriers identified for integration of FP services into differentiated ART delivery

- **Insecure supply of a variety of contraceptive methods.** Stockouts were frequently reported, which hinder the alignment of ART and FP refills and impact a client's choice.
- **Lack of staff trained** to provide FP and ART.
- **Poor documentation and follow-up of external referrals.** In Kenya, this included informal referrals from community-based group models.
- Collection of data on FP uptake among WLHIV on ART proved in particular in Tanzania challenging due to **lack of integrated M&E tools.**

Recommendations

- Implement **One-Stop model** for HIV and FP services, including by same provider where possible
- **Align provision** of oral pills and ARVs, particularly as MMD is extended to MMD6. *Must address supply issues*
- **Improve forecasting** of FP commodities to adequately include the needs of WLHIV, particularly as MMD expands
- Increase capacity for provision and **promote access to LARCs**. Ensure women are counseled on benefits of LARCs when enrolled in MMD3/6 (for WLHIV who do not wish to become pregnant)
- **Include oral contraception into prepacked ARVs** for distribution in facility and community ARV refills.
- Leverage **adoption and roll-out of self-injectable contraception** — can be prepackaged with ARVs for distribution in facility-based and community-based DSD models
- FP integration needs to be designed not only for the clinical visit but also for the refill visit as part of the DSD model. Support implementation of existing policies with operational guidance and capacity building. **Strengthen monitoring** of contraceptive uptake among women living with HIV in DSD models, including adapting ART monitoring tools to include integrated reporting of FP service delivery and reinforcing the need for documentation among service providers.

Building blocks for the integration of family planning services into differentiated ART delivery[1]

WHEN

- At the same time as ART
- At entry into a DSD model
- At every clinical interaction
- At every ART refill

WHERE

- At the same location as ART
- HIV clinic/hospital
- Other clinic
- Community

WHO

- By the same clinicians as ART doctor
- Nurse/midwife
- Community health worker
- Client/peer/family member

WHAT

- Full range of contraceptive methods
- Encourage use of LARCs
- Information, counselling, provision, and follow-up care

1 https://differentiatedservicedelivery.org/Portals/0/adam/Content/F0-QJsS3LUGbReUhgv_qmA/File/DSD_%20FP_Supplement.pdf