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Integration of Family Planning Services into HIV Care and Treatment Services inHealthcare Facilitiesin Abuja, Nigeria

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***Abstract**: Family planning (FP) analysis reports for Nigeria have emphasized the need to include FP services as part of an integrated package for HIV program. This study was conducted to assess the level of integration of FP services into HIV care and treatment services in Abuja healthcare facilities.It is a hospital-based retrospective chart review of both the HIV-infected women of reproductive age (15-48) enrolled in the HIV program within 48 months and the women attending FP clinics during the same period. Health providers were also interviewed to determine the challenges of FP-HIV integrated services in Abuja through structured questionnaires. The data were analysed using SPSS version 25.0.Of the 416 HIV client'sdata abstracted from HIV clinics, only 26.0% have received counselling on FP while only 22.8% were using any FP method at the time of the survey. The study found a poor uptake of FP among HIV clients across all healthcare facilities, except centre E with 82.1% of HIV infected using any FP methods. Only (17.9%) of 821 clients in FP clinics have been counseled on HIV in the same clinics.In FP clinics the major challenges include limited time (60.0%), 40% stated inadequate test kitswhilethe challenges in HIV clinics includeinsufficient space (30.0%), equipment (30.0%), supplies, and inadequate manpower. This study found very poor implementation of FP-HIV services integration in Abuja and recommend more training for both the healthcare service providers and the clients in order to successfully achieve the aim of the program.*

***Keywords:** Family planning, HIV, Service integration, Contraceptives, Antiretroviral Therapy*

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I. Introduction

Globally, women account for a greater proportion of people living with HIV, most of them are in their reproductive age [1]. The introduction of highly active antiretroviral has increased health outcomes of PLHIV, reducing HIV mortality but increased sexual activity with an increase in fertility rate this is collaborated by GBC Health, 2012 saying "In a number of African countries the rate of unintended pregnancy among women living with HIV range from 51 to 84%". Nigeria, the 2018 Nigeria HIV/AIDS Indicator and Impact Survey revealed that HIV is higher among women of reproductive age than men; 1.9% versus 0.9%. (Adamu *et al.*, 2019). This highlights the earnestness of addressing the unmet needs of HIV infected women through the use of family planning to stop unintended pregnancies and preventing new infections in children,

Policies have been recommended by governments, implementing partners, international organizations, funders and communities to explicitly support the integration of family planning and HIV service delivery and programs thus meeting contraceptive and other reproductive health needs of PLHIV. Integration of services is also a core component of key global health frameworks to eliminate new HIV infections among children. Counselling and provision of contraception can ensure unwanted pregnancy does not occur thereby reducing the number of infants exposed to HIV. Other studies have recorded integration to be associated with higher modern contraceptive prevalence and knowledge [3]. In another study, women living with HIV experience high rates of unmet need for family planning and unintended pregnancies as up to 35% of female clients on antiretroviral therapy (ART) in Nigeria had unmet contraceptive needs [4]

Family planning analysis reports for Nigeria have emphasized the need to include family planning services as part of an integrated package for HIV program. Nigeria national integration strategic plan stresses the need for integration of FP/RH approaches/services with HIV which has been demonstrated to be more cost-effective than using stand-alone approaches. Family planning for women living with HIV has the dual goals of preventing unintended pregnancies and prevention of new HIV infection.

II. Methodology

This study was a hospital-based retrospective chart review of both the HIV-infected women of reproductive age (15-48) who were enrolled in the HIV program within 48 months and the women attending family planning clinics for the same period in order to determine the level of integration of FP-into HIV services.The charts reviewed included the data of women living with HIV in HIV clinics and the data of clients attending family planning clinics in seven general hospitals in Abuja, the Federal Capital Territory (FCT) of Nigeria. Health providers were also interviewed to determine the challenges of FP-HIV integrated services in Abuja through structured questionnaires.The healthcare facilities involved in the study include Wuse General Hospital, Gwarinpa General Hospital, Dei- Dei Comprehensive Health Centre, Mpape health centre, Lugbe Primary health centre.

To ensure effective chart abstraction, a structured data abstraction instrument and guideline were designed to instruct the abstractors. The guideline was a reference document on how abstraction would be carried out from the health records. Fourteen (14) abstractors including supervisors who are experienced in retrospective research were selected and trained over two days on the objectives, required protocols to extract data, expectations and the guidelines. A pilot study was conducted at General Hospital Bwari, this provided the opportunity to evaluate the reliability of the data abstraction sheet. All trained abstractors were blind to the study. Data were collected using a structured chart abstraction tool. Ethical approval was obtained for this study from the Federal Ministry of Health (FMOH) in Abuja.The facilities were assured of data security and confidentiality.

The data abstracted from both FP and HIV clinics included information of women of childbearing age, whether HIV positive or HIV negative. The data were coded and entered into SPSS version 25.0 for analysis.

III. Results

The level of FP counselling in HIV clinics

Data were abstracted from HIV clinics of five (5) general hospitals that provide HIV services and seven hospitals that provide FP services in Abuja, and the names are represented by A, B, C, D, and E for HIV and A-G for FP. Based on the information of 416 HIV clients abstracted from HIV clinics across the five healthcare centres, this study found that only 26.0% have received counselling on FP while only 22.8% were using any FP method at the time of the survey (Figure 12). Healthcare centres C (39.8%) and E (37.0%) had the highest records of FP counselling for HIV clients while B and D did not record any counselling (Table 1).

Table 2 shows the poor uptake of FP among HIV clients across all healthcare centres in Abuja except centre E in which 82.1% of HIV infected women of reproductive ages were using any FP method. Centres A, B, and C did not have any of their HIV clients on FP at the time of this study.

Data were abstracted from FP clinics in seven centres in order to assess the integration. This study revealed that only 147 (17.9%) of 821 data reviewed in FP clinics have been personally counseled on HIV in the same clinics. The 17.9% that had been counseled on HIV were from two (D-27.2% and G-72.8%) of the seven centres (Table 3). Only 13.0% of all FP clients were HIV positive and all were on ART at the time of this study (Figure 1).

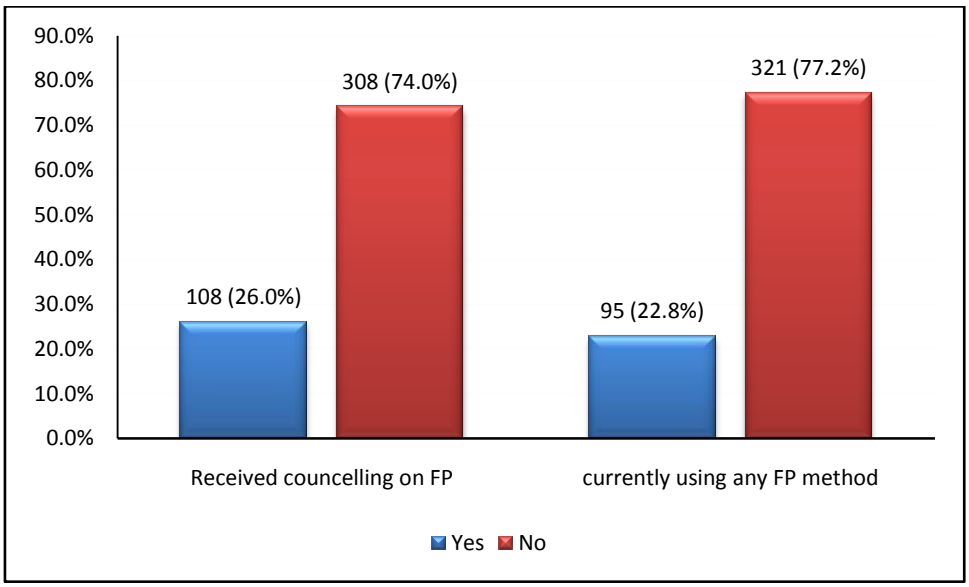

Figure 1: FP counselling received in HIV clinics

Table 1: FP counselling among HIV positive clients across all centres

Facility	Received FP Counselling in this facility		Total	X^2	P
	Yes	No			
A	25 (23.1%)	23 (7.5%)	48 (11.5%)		
B	0 (0.0%)	90 (29.2%)	90 (21.6%)		
C	43 (39.8%)	3 (1.0%)	46 (11.1%)	195.019	<0.001
D	0 (0.0%)	102 (33.1%)	102 (24.5%)		
E	40 (37.0%)	90 (29.2%)	130 (31.3%)		
Total	**108 (100.0%)**	**308 (100.0%)**	**416 (100.0%)**		

Table 2: FP uptake among HIV positive clients in HIV clinics across all centres

Facility	Currently using FP		Total	X^2	P
	Yes	No			
A	0 (0.0%)	48 (15.0%)	48 (11.5%)		
B	0 (0.0%)	90 (28.0%)	90 (21.6%)		
C	17 (17.9%)	29 (9.0%)	46 (11.1%)	178.123	<0.001
D	0 (0.0%)	102 (31.8%)	102 (24.5%)		
E	78 (82.1%)	52 (16.2%)	130 (31.3%)		
Total	**95 (100.0%)**	**321 (100.0%)**	**416 (100.0%)**		

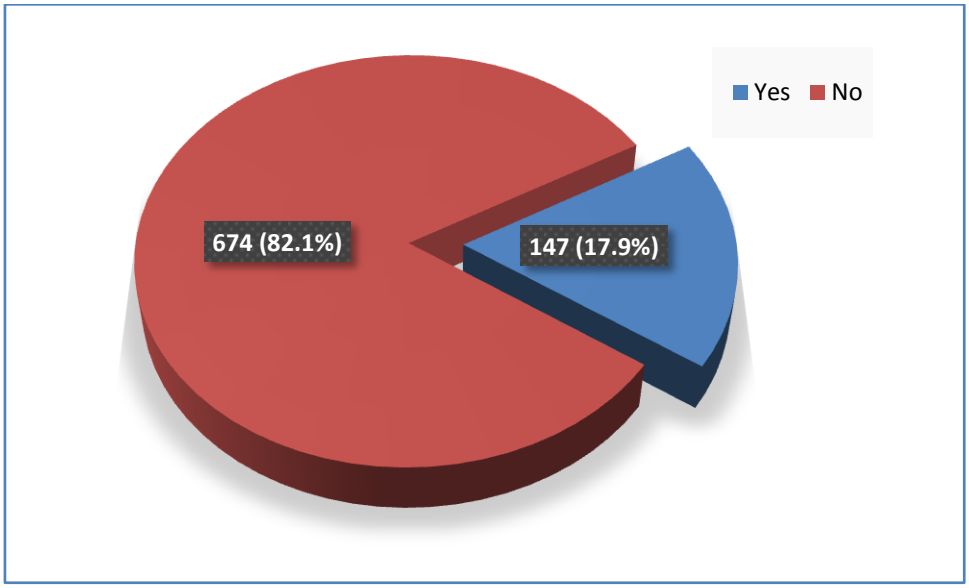

Figure 2: HIV counselling received in FP clinics

Table 3: Proportion of the FP clients who have received HIV counselling across all centres

Facility	Counseled on HIV? (%)		Total	X^2	P
	Yes	No			
A	0 (0.0%)	99 (14.7%)	99 (12.1%)		
B	0 (0.0%)	106 (15.7%)	106 (12.9%)		
C	0 (0.0%)	132 (19.6%)	132 (16.1%)		
D	40 (27.2%)	120 (17.8%)	160 (19.5%)	610.17	<0.001
E	0 (0.0%)	102 (15.1%)	102 (12.4%)		
F	0 (0.0%)	114 (16.9%)	114 (13.9%)		
G	107 (72.8%)	1 (0.1%)	108 (13.2%)		
Total	147 (100.0%)	674 (100.0%)	821 (100.0%)		

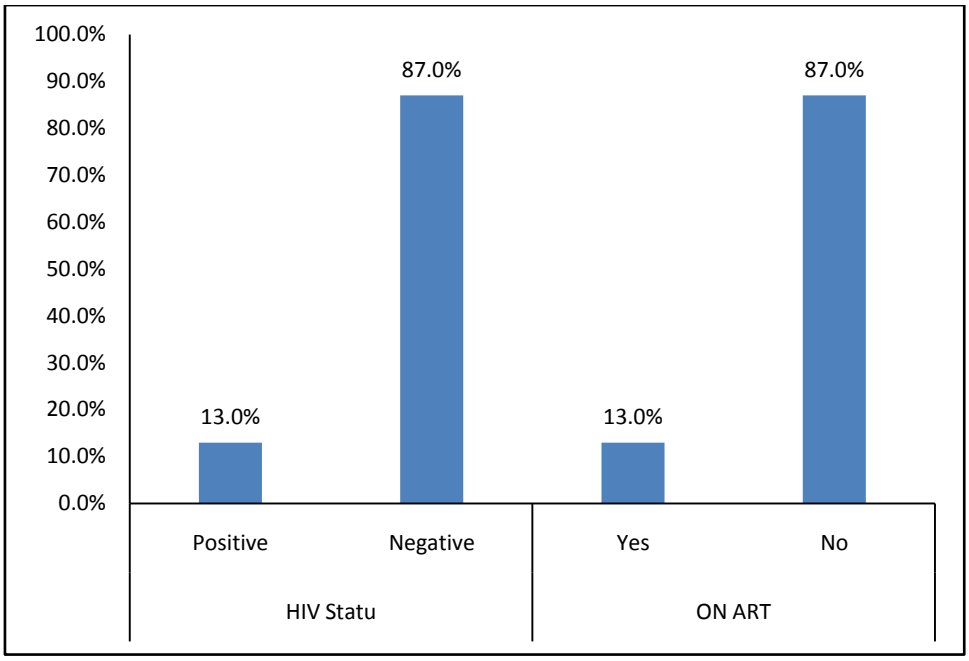

Figure 2: the proportion of HIV positive among FP women in Abuja

Challenges of HIV-FP services integration, the views of FP service providers

One FP service provider was interviewed from each of the seven clinics to determine the major challenges of FP-HIV services integration. This was done because there were limited number of staff in FP clinics across the healthcare facilities.

The major challenges indicated include limited time as indicated by 60.0% of the respondents, 40% stated inadequate testing supplies (test kits). In order to offer a full range of HIV services in their family planning centres, the participants stated that enough space (30.0%), equipment (30.0%), supplies, and adequate manpower are needed. They further stated the challenges that the provision of HIV services would pose to the quality of family planning services as inadequate manpower/burnout (40.0%), long waiting time, too many recording tools, and lack of secrecy (Table 4).

Seventeen HIV health service providers were interviewed from five healthcare facilities that offer HIV treatment and care services.The respondents mentioned insufficient referral forms (29.4%), long-distance between HTS unit and FP clinics (25.9%), poor advocacy (ignorance or poor education), and too much workload (15.9%) as the major challenges of referring clients for FP. Also, the challenges associated with offering family planning to HIV clients, according to the respondents include poor knowledge/skills of FP-HIV integrated services (52.9%), inadequate testing material (23.5%), and limited time to attend to many patients (17.6%), Table 5.

Table 4: Challenges of HIV-FP integration, the views of FP service providers

Variable	***Response***	***Percentage***
What are some of the challenges associated with offering HIV services to clients at this family planning centre?	Inadequate testing supplies/ test kits	40.0
	Not enough time,	60.0
What would be required in order to offer a full range of HIV services in this family planning centre?	Space	30.0
	Specific Equipment	30.0
	Staff	20.0
	Supplies	20.0
How do you think the provision of HIV services would affect the quality of family planning services provided?	Long Waiting time	20.0
	Too Many Tools	20.0
	Human Resource burn out	40.0
	Lack of Secrecy	20.0

Table 5: Challenges, and advantages associated with FP-HIV integration

Variable	*Response*	*Percentage*
What are the challenges of facility referral system?	No referral forms	29.4
	HTS unit far away from the FP clinic	25.9
	Low level of education on FP (poor advocacy)	15.9
	Not in my schedule of duty	5.9
	A verbal referral because all SDP is within the Hospital	7.0
	Workload won't allow that	15.9
What are some of the challenges associated with offering family planning to HIV clients at this centre?	Inadequate testing supplies	23.5
	Not enough time	17.6
	Inadequate knowledge/skills	52.9
	No challenge/Not the focus of the clinic	6.0
How do you think the provision of family planning services would affect the quality of HIV services provided?	Long Waiting time	44.2
	Human Resource burn out	26.4
	Too Many Tools	11.8
	Strengthening referral	17.6
In your opinion, when (if ever) is the most appropriate time to discuss FP services during ART visits?	Before HTS	17.6
	During the provision of HTS	47.1
	After ART provision	17.6
	After delivery	11.8
	During health talk	5.9
What do you see as the advantages of offering family planning services to HIV clients?	Maximised productive use of services	0.0
	Enhanced ability to prevent new HIV infections, especially among infants and youths	53.0
	Improved access to better-quality FP/SRH and HIV services	17.6
	tailored to meet the needs of people living with HIV	17.6
	Greater support for dual protection against unintended pregnancy and disease	5.9
	Reduced stigma and discrimination	
	Others	5.9

IV. Discussion

The level of FP counselling in HIV clinics

This study recorded a very low number of HIV clients who have received counselling on FP across all the healthcare centres, no evidence of FP counselling was seen in some of the facilities. Also, less than 30% were using any FP method. Lack of counselling could be responsible for the poor uptake of FP seen among HIV clients across all healthcare centres. Also, very few of FP clients were HIV positive and on ART. The findings of this study revealed that, while there are some levels of health integrated services in some healthcare facilities in Abuja, no integration was found in some facilities.

The low uptake of FP and counselling recorded in this study can also be attributed to the poor implementation of integrated HIV-FP services in many healthcare facilities in Abuja.

Narasimhan *et al.* reported similar findings in their systematic review of the integration of HIV testing services into family planning services. They reported that HIV test service (HTS) uptake was generally higher in integrated sites compared pre-integration sites, including in adjusted analyses, though they observed some differences in outcomes across studies [5]. They further reported that HIV counselling received increased significantly in facilities with interventions (integrated services) compared to those without intervention. [5]. Other studies that examined postnatal care settings, where integrated HIV and FP services into postnatal care were compared to standalone services found that the uptake of FP services was higher in the intervention facilities than the standalone ones [6].

Challenges being faced by healthcare service providers

This study also found that healthcare providers already had heavy workloads. For example, most healthcare providers in FP clinics would attend to or counsel at least 10 clients on each counsellingunit with each section lasting for about 30 minutes, and they hardly turn clients back. Poor documentation of referral was also seen among the healthcare providers. The majority of the HIV service providers, also counsel clients on FP with each service provider attending to at least 15 clients on average per day, andwould not turn clients away because of limited time. Apart from heavy workloads, other challenges facing healthcare providers include limited time, inadequate testing supplies (test kits), insufficient space, inadequate equipment, and inadequate manpower. In HIV clinics, insufficient referral forms, long-distance between HTS unit and FP clinics, poor advocacy, and poor knowledge/skills of FP-HIV integrated services were the additional challenges enumerated. They further stated that the full integration of health services might reduce the quality of healthcare services due to inadequate manpower would result in burnouts, long waiting time, too many recording tools, and may result in lack of secrecy on the part of the clients.

Previous studies have reported that service providers in facilities with no integration reported lack of FP supplies/commodities and inappropriate facility infrastructure for privacy and confidentiality as the main barriers to the provision of FP services [7] while some service providers in facilities with integrated services reported heavy workload as the main barrier to the provision of FP services [7]. Some authors have shown that providers may be reluctant to provide integrated services owing to personal biases and lack of information [8].

Some evaluations acknowledged challenges of integrated services as inadequately training of the health providers on delivering the intervention because of staff turnover or inadequate planning or budgeting to ensure that all key staff was trained [9]. In a review of the The impact of programs for prevention of mother-to-child transmission of HIV on health care services and systems in sub-Saharan Africa, the underlying health system challenges that affect both PMTCT and the health services with which PMTCT interacts, as identified by the authors include weak physical and human resource infrastructure, poor working conditions, and social and economic barriers to accessing health services [10].

The complaints about too many tools reported in this study have been documented by UNAIDS as major challenges facing the integration of HIV and FP services [11]. It has also been reported that the constraint in using M&E tools for integrated service provision and interlinking patient monitoring systems have negative effects on the standard, fullness, and accessibility of health data, adding to the burden of gathering and reporting additional measure of integrated service provision[12]. Farrel,in a study conducted in 2007 on a framework for integrating FP and ART services reported similar challenges found in this study as increased workload due to additional time to counsel clients, increased client waiting time especially when staffing levels are low, monitoring of quality or performance improvement may be more difficult, and overload the client with information they are not able to absorb, when FP is added to posttest counselling[13]. Other similar challenges documented in previous studiesinclude operational complexity, regulatory challenges, unclear financial attribution, and cultural inertia[14].

V. Conclusion

This study found very poor implementation of FP-HIV services integration in Abuja and recommend more training for both the healthcare service providers and the clients in order to successfully achieve the aim of the program as it is in some other African countries.

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