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INTEGRATING FAMILY PLANNING AND VCT SERVICES IN ETHIOPIA: EXPERIENCES OF HEALTH CARE PROVIDERS



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**Integrating Family Planning and VCT Services in Ethiopia:
Experiences of Health Care Providers**

P. Stanley Yoder
Macro International Inc.
Calverton, MD USA

Yared Amare
Consultant
Addis Ababa, Ethiopia

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Additional information about the MEASURE DHS project may be obtained from Macro International Inc., MEASURE DHS, 11785 Beltsville Drive, Calverton, MD 20705 USA; Telephone: 301-572-0200, Fax: 301-572-0999, Email: reports@macrointernational.com, Internet: <http://www.measuredhs.com>.

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ACRONYMS

| | |
|-------|--|
| ACIPH | Addis Continental Institute of Public Health |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| ART | Antiretroviral Therapy |
| C&T | Care and Treatment |
| FGAE | Family Guidance Association of Ethiopia |
| FHI | Family Health International |
| FP | Family Planning |
| HCP | Health Care Provider |
| HIV | Human Immunodeficiency Virus |
| IMCI | Integrated Management of Childhood Illness |
| MCH | Maternal and Child Health |
| MOH | Ministry of Health |
| MTCT | Mother-To-Child Transmission |
| OPD | Outpatient Department |
| PMTCT | Prevention of Mother-To-Child Transmission |
| SNNPR | Southern Nations, Nationalities and Peoples Region |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infections |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Testing |
| VICS | Voluntary HIV Counseling and Testing Integrated with Contraception Study |

EXECUTIVE SUMMARY

Objectives

Since at least the mid-1990s, there has been interest in many countries in integrating HIV/AIDS and family planning services to improve clients' access to both types of services, as well as to improve the efficiency and cost-effectiveness of services. In 2006, Pathfinder/Ethiopia began training health care providers in government hospitals and other health facilities in several regions of Ethiopia to offer family planning services within HIV voluntary counseling and testing (VCT) centers. It was thought that these health facilities would then begin implementing programs that integrated family planning services into VCT services.

This study was undertaken primarily to understand what effect the efforts to integrate family planning and VCT services in health facilities had on health care providers' work and service delivery practices in two regions of Ethiopia: Oromia and Amhara. A secondary objective of the study was to identify what factors facilitated the integration of family planning services into existing VCT services in participating health facilities in these regions.

Methods

To gain an understanding of health care providers' experiences with integrated HIV and family planning services, the research team conducted interviews with 25 health care providers and 16 supervisors in 18 health facilities in Amhara and Oromiya regions: 12 health care providers and 7 supervisors in Oromiya, and 13 health care providers and 9 supervisors in Amhara. The health care providers had attended a five-day workshop on integrating family planning services into VCT services offered by Pathfinder/Ethiopia.

The interviews with health care providers and supervisors were conducted by research assistants trained by the study directors. To get the health care providers to talk about their work, their training, and the services they provided in an open-ended way, the research assistants used a two-page conversational outline in Amharic that showed general introductory questions to be asked in the same way to everyone, as well as a list of related topics to be covered in any way appropriate. Conversations were tape recorded with permission, transcribed in Amharic, and then translated into English for analysis. After developing summaries for each respondent and reviewing the summaries and transcripts, the research team developed a draft outline to guide the writing of this report.

Work Experience

The health care providers interviewed were almost all nurses with several years of professional training. The majority of these nurses had worked in two or three health facilities in their careers. Changes in work sites often involved moves from rural health centers to urban hospitals. Having a nursing diploma made a transfer more likely. Many of the health care providers were also interested in acquiring further education, and their participation in courses and workshops led to periodic absences at their post. In their absence, integrated VCT/FP services would most often be suspended in the facilities where they worked.

Many of the respondents interviewed had been involved in a variety of training programs that had enhanced their knowledge, skills, and confidence, allowing them to provide services in various specialized areas. These health care providers greatly appreciated the additional knowledge and experience gained from their work and the various training programs in which they participated. At the same time, they were challenged by the large numbers of clients they served and the heavy workload. Sources of frustration expressed by health care providers included low pay, lack of per diem or compensation for off-site or night duty, shortage of medical supplies, lack of health insurance, and perceived mismanagement by their superiors.

Training in Family Planning Services

The training on family planning methods and service delivery offered by Pathfinder/Ethiopia took the form of a five-day workshop for selected hospital staff. The trainees learned how to provide counseling to HIV-positive and HIV-negative clients as well as how to distribute condoms and pills. Before the training, most VCT units would provide condoms to interested clients but usually without family planning counseling. Respondents' recollection of the content of the training was limited. Some participants mistakenly thought that the training was focused on the prevention of births in HIV-positive women. These shortcomings may have been caused by inadequate time allowed for the training and the conceptual emphasis given to the training.

Training participants were selected because their work related to family planning or HIV, or because Pathfinder/Ethiopia sought to distribute training opportunities to a wide range of staff. Trainees were selected not only from VCT units, but from other units within the facilities: ART, family planning, MCH, ANC and PMTCT. As a result, sometimes those who worked primarily in VCT units were not chosen for training in family planning methods. However, because most nurses rotated between posts such as VCT, ART, family planning, MCH, PMTCT, ANC, gynecology, and the outpatient department, it is unclear to what extent the selection process could have been modified to focus more on VCT staff.

Interaction of Health Care Providers with VCT Clients

Discussions with health care providers trained in integrated services provided a mixed picture of how they approached their VCT clients. Most of the health care providers targeted both HIV-positive and HIV-negative clients for family planning, although some offered family planning to HIV-positive clients only. HIV-positive women and men were counseled on the disadvantages of having children and informed about dual protection against HIV transmission and pregnancy. HIV-negative clients were counseled on spacing or preventing births. Clients were counseled on different family planning methods and their side effects, and allowed to choose a method that suited them. Still, many health care providers who participated in the integration workshop, as well as some supervisors, reported that they understood that family planning methods were to be offered mainly to VCT clients who test positive for HIV. They would tell HIV-positive women not to get pregnant again. They also focused family planning counseling on married individuals because they are the ones most likely to bear children. VCT clients over age 50, clients who were not sexually active and clients who were young or unmarried were not likely to be counseled about family planning methods.

VCT clients were generally quite receptive to family planning, although some, especially young clients, were interested only in HIV counseling and testing. VCT clients who tested HIV positive were often too absorbed with their test results to pay much attention to counseling on family planning, and might need further follow-up. Among the factors that concerned clients of the integrated services were irregular supplies of contraceptives, the side effects of contraceptives, and certain misconceptions they have about the methods. Individuals who were part of a discordant couple (i.e., one spouse/partner was HIV positive and one was HIV negative) did not always understand the implications of being discordant for condom use and sexual relations in general. VCT clients were sometimes unwilling to share their HIV-positive results with their spouses, so it was difficult for them to accept family planning services.

Integration of Family Planning and HIV Services

Health care providers were trained for one week in providing family planning counseling and methods so that services within VCT units would be integrated: VCT clients would be offered family planning services by the same person. However, not all services in the facilities concerned became integrated. The research team for this study found that only 10 of the 18 health facilities included in the study were offering integrated VCT/family planning services in their VCT unit; the other eight health facilities did not offer family planning in their VCT units at all.

Furthermore, the way in which the integrated VCT/family planning program was implemented by the 10 health facilities that did offer integrated services varied greatly. Family services were provided to VCT clients in these health facilities in one of two ways: 1) the VCT unit offered family planning and counseling services directly to VCT clients, or 2) the VCT unit offered family planning counseling to VCT clients and referred them to a separate family planning unit within the health facility for contraceptives. Only a few of the 10 health facilities that offered integrated VCT/family planning services in their VCT units offered both family planning counseling and family planning methods. The rest offered family planning counseling in their VCT units, but referred clients to family planning units for contraceptive methods.

Although referrals were less convenient and confidential for clients, they did provide reasonably good access to family planning. Many clients also preferred to go to family planning units for their subsequent contraceptive needs.

Several factors influenced the degree to which health facilities were able to achieve integration of family planning and HIV services: 1) the availability and use of human resources, 2) the system of staff rotation among service units, 3) the supply and mode of providing family planning methods, 4) the system of record keeping and reporting, and 5) the amount of follow-up and supervision by the integrated services program.

Factors that facilitated the integration of family planning and HIV services included: 1) the selection of VCT counselors for training in family planning methods and counseling, 2) a particularly effective training session, and 3) the sharing of skills from the training with colleagues in the health facilities. The integrated program was implemented in units other than VCT such as the ART, PMTCT and ANC units in cases where personnel from these units were trained, or where trainees shared their skills with colleagues. Counselors in family planning units

have advised their HIV-positive clients on dual protection, and their other family planning clients on HIV testing.

Factors that impeded the integration of family planning services in VCT units included 1) the selection of health care staff other than VCT counselors for the training, 2) the shifting of personnel from the VCT unit to other units because of staff shortages, 3) the large workloads of counselors, leading to the suspension of integrated services, 4) the lack of adequate and convenient workspace for counseling clients, and 5) the lack of supervision and follow-up by Pathfinder personnel. The lack of follow-up and supervision for the integrated program by Pathfinder/Ethiopia and heads of health care facilities was repeatedly mentioned as a problem by the trainees. More contact between Pathfinder/Ethiopia and heads of health care facilities would have helped facilities provide the oversight, human resources, reporting mechanisms, and moral support that were needed to maintain the continuity of the program.

Conclusions

The interest in integrating family planning HIV services on the part of the country's Ministry of Health, Pathfinder International, Family Health International, and many other groups is a most promising development in Ethiopia; integration may make services more accessible and more efficient. Through discussions with health care providers and their supervisors in two regions, the research team identified several suggestions for improving the process of integration in the future. Those suggestions generally fall into two main groups: 1) improving the content and follow-up of training in family planning, and 2) taking account of the local context of service delivery.

First, the health care providers reported that although the training gave them additional skills and motivation to serve clients, the workshop was too short and not sufficiently practical. They also said that they were disappointed that they were so rarely contacted by Pathfinder/Ethiopia after being trained. While those trained were told to expect supplies and supervisory visits, those supplies and visits did not materialize. In future rounds of training, supervisory visits should be part of the overall plan.

Second, it is important to consider how best to take advantage of the existing service environment in health facilities, and shape the trainee selection process and the training itself to fit the current conditions. Many facilities have a severe shortage of personnel, and staff may be assigned to any of the units at one time or another. Similarly, most of the staff rotate on a regular basis through the various service units. Thus, personnel trained in VCT services frequently work in other units of the facility (and vice versa). If family planning services are to be offered in VCT units over the long-term, training only one or two persons in the VCT unit to provide family planning along with VCT services will not suffice. Those who received the special training will often be working in units other than VCT and most of the other staff will at some time work in the VCT centers.

1. INTRODUCTION

This study was undertaken to understand the effect of the integration of family planning services into VCT facilities on the work and the practice of health care providers within health care facilities. A secondary objective of the study was to identify factors that facilitate the integration of family planning services into the existing VCT services. Since health care providers are the persons who actually deliver services, the study focused on their experiences in the provision of both family planning and HIV services. Although many other factors—including adequate funding, adequate staff training and supervision, consistent supplies of all contraceptives offered—are necessary to integrate VCT and family planning services, this research focused on the knowledge and experience of those who provide the services: their training, their skills, their sense of satisfaction, their perspectives on service delivery in general, their views of their clients, and their actual practice.

In the past few years, public health officials have advocated the integration of HIV/AIDS and sexual and reproductive health services, often referred to more simply as HIV and family planning services. The U.S. Agency for International Development has sponsored a web site entitled “HIV/AIDS & Sexual and Reproductive Health Integration” (www.hivandsrh.org) to promote discussion of service integration. Since family planning clients can benefit from HIV testing and counseling, and individuals who have been tested for HIV need advice on family planning methods, integration of services can satisfy both types of clients. The advantages of offering such services jointly include increasing client access to services and more effective use of financial and human resources (Bradley et al., 2008).

A number of countries have developed policies to integrate HIV and family planning services, yet the implementation of such policies has often lagged behind. The integration of family planning services into HIV testing contexts has most often been implemented in VCT centers, but even those efforts are fairly recent and have rarely been evaluated. One advantage of integrating family planning into VCT centers is that such services can potentially reach a diverse population of men, women, and youth. Largely for that reason, this study focused on the addition of family planning into VCT.

USAID Washington requested this study to obtain information about how policy that promotes integration is understood in health care facilities, and how HIV and family planning services have been integrated in practice. Macro International decided to conduct the study in Ethiopia because Pathfinder International had begun training health care providers to offer family planning services within VCT centers in several provinces several years ago.

The Family Guidance Association of Ethiopia (FGAE) began the integration of HIV services into reproductive health services in 2002, but service integration on a wider scale in Ethiopia really began in early 2005 following a meeting on Best Practices for Integration held in June 2004 in Entebbe, Uganda. A delegation of more than two dozen people from Ethiopia attended that meeting. By the end of 2004 a task force chaired by Pathfinder/Ethiopia had been formed to promote service integration: HIV services into reproductive health services, and family planning into VCT and PMTCT services. This task force or committee formulated plans to add family planning into VCT and PMTCT services in government facilities in four regions of

Ethiopia: Tigray, Amhara, Oromiya and the Southern Nations, Nationalities, and Peoples Region. Training of VCT counselors in family planning began in 2005 with a group of trainees from Tigray. Training for health care providers from Amhara and Oromiya regions took place in 2006 and 2007.

The present study was conducted in government health care facilities in two of the four regions where Pathfinder/Ethiopia is active: Amhara and Oromiya. The research assistants who conducted observations and directed interviews recruited into the study sample VCT supervisors, VCT counselors, and other health care providers who had been trained in family planning so they could offer family planning in hospital services. Supervisors were interviewed to determine to what extent they were familiar with a policy of integrating health services and the ways services had been integrated within their facility. VCT counselors and others trained by Pathfinder/Ethiopia in family planning were interviewed to learn about the family planning training they had, the services they offer, and the effect of the additional training on their work.

Making the work and experience of health care providers who provide integrated VCT and family planning services the focus of study offers several advantages over other options: they are the persons who actually provide the services, and it allows researchers to consider the context of service delivery in making integration work. Understanding the challenges faced by health care staff in offering family planning methods along with HIV testing and counseling to their clients suggests ways that services could be improved.

2. BACKGROUND OF STUDY

2.1 Rationale for Integrating Services

Since at least the mid-1990s, specialists in HIV/AIDS and reproductive health services have been discussing ways to integrate the standard services they offer. In a review about when and where it makes sense to integrate services, Karen Forheit and others write, “Integrated services are thought to expand access to and coverage of critical services and to improve their efficiency and cost-effectiveness by reducing duplication of service delivery functions and delivering more services per client contact” (Forheit et al., 2002:105). The authors suggest that health services should be considered as “integrated” when they are offered at the same facility at the same time, and when the same health care providers offer services directly or refer clients to another place for services during a single visit. If the integration of services improves client access to services in ways that are more efficient and cost effective, it can be deemed a success.

Integrating health services that have been offered separately in the past constitutes an ongoing challenge for all concerned: Ministry of Health officials who develop policy, donors who advise and/or provide funding, directors of health care facilities who direct implementation, and health care providers who actually deliver the services. Larger health facilities offer Maternal and Child Health services, Family Planning or sexual and reproductive health services, antenatal care and postnatal care, STI prevention and treatment services, and voluntary counseling and testing services. Some also offer PMTCT and antiretroviral therapy services. The most common formula for combined services in one facility is the integration of reproductive health services, including family planning, with MCH and ANC services. HIV and family planning services are usually provided in separate branches of one facility or in different facilities altogether.

Many models of the integration of HIV and family planning services have been formulated to guide service delivery. Some models add HIV testing and counseling to family planning centers, while others add family planning services to HIV testing centers. Some facilities offer basic family planning methods while others offer a full range of sexual and reproductive health services. Similarly, for HIV testing, one finds VCT services, PMTCT services, antiretroviral therapy services, and agencies that offer care and treatment for clients infected with HIV. The question is: Would clients of family planning programs also use HIV services, and would those who use HIV services also welcome family planning services if offered?

Various approaches have been recommended for determining when and how to integrate family planning services, STI services, and HIV testing and counseling services. Family planning services can be added to PMTCT, VCT, care and support services (CSS), and ART programs. Clients attending any of these services can benefit from the availability of family planning methods offered in conjunction with other services. High levels of unmet need for family planning among people with HIV/AIDS have been documented (Reynolds et al., 2005), and various programs that include integrated services are under way (Fleishman, 2006; Wilcher et al., 2008). The addition of HIV and/or STI services to reproductive health services has less obvious benefit to clients because many family planning clients are not at high risk for HIV

infection. Nevertheless, this form of service integration has been effective in some contexts (Fleishman, 2006).

Although the rationale for integration is strong, studies that provide insight into how to best implement integrated or linked services and whether these integrated models are effective at reasonable costs are lacking.¹ Two Family Health International studies have systematically evaluated an integrated program (Adamchak et al., 2007; Reynolds et al., 2006), and additional studies by other organizations are currently under way (Mullick et al., 2006; and Kidanu et al., 2006). In the Family Health International study of the effectiveness and costs of integrating family planning into VCT services, results were mixed (Reynolds et al., 2006). Although 29 percent of clients had unmet need for family planning, following the intervention, only 12 percent of clients had received a family planning method. Though providers had been trained to distribute pills and make referrals for other methods, they only distributed condoms. In an evaluation of an effort to train providers at two ART clinics in Ghana to include family planning counseling and services, only 10 percent of female clients reported that providers discussed family planning services with them, and only 10 percent of these women received contraceptives or referrals (Adamchak et al., 2007).

Little information is available about the specifics of how integrated programs should be set up and implemented, but the dual needs for both family planning and HIV services are clear. Several Family Health International studies have documented levels of unmet need² ranging from 14 to 67 percent among VCT clients (Reynolds, 2005), and from 9 to 14 percent among ART clients in Ghana (Adamchak et al., 2007). Moreover, levels of unintended pregnancies among HIV-positive women appear to be even higher: 51 to 99 percent of HIV-positive women had unintended pregnancies in studies in Côte d'Ivoire, South Africa, and Uganda (Desgrées-du-Loû et al., 2002; Rochat et al., 2006; Smart, 2006). In a study testing the feasibility and acceptability of adding HIV care and treatment services in family planning clinics, researchers found that family planning clients were at risk of HIV and other STIs (Bradley et al., 2008). Although 17 percent had multiple partners, only 30 percent knew their HIV status and 40 percent did not use a condom at last sexual intercourse. Only 23 percent of family planning clients believed themselves to be at high risk of HIV.

Some health programs have responded to such findings by integrating or linking HIV and family planning services without waiting for research results. Such efforts are frequently underfunded, uncoordinated, or undocumented. Program structures and functions vary. Furthermore, because there is no single accepted model of integrated or linked services, one integrated program may offer contraceptives, and another may offer only referrals for contraceptives. Family planning services may be added to HIV services such as HIV care and treatment, and ART programs,³ or HIV services such as care and treatment may be added to

¹ Some experts refer to linked programs as those that have a strong referral component, in contrast to integrated programs that offer comprehensive services that meet several needs simultaneously (Mbizvo, n.d.). For brevity, we will refer to both types of programs as “integrated” in this document. Integrated services may also be co-located, providing services through administratively separate entities that occupy the same site.

² The definition of “unmet need” used by these studies is modeled on the definition used by the Demographic and Health Surveys (Westoff, 2001). In general, a person is considered to have unmet need for family planning if s/he is sexually active, not using a contraceptive method, and does not want a pregnancy/baby for at least 2 years.

³ Usually programs that offer ART offer services both to clients who are clinically eligible for ART and clients who

family planning programs. Thus, integrated or linked models may include multiple combinations of HIV and family planning services.

Finally, an overarching objective of integrated or linked HIV/family planning services is to improve uptake of services. In fact, it is generally assumed that integrating HIV services into family planning services has the potential to increase uptake of HIV services among family planning clients, particularly care and treatment services. It also has the potential to create new contraceptive users if the availability of the HIV services attracts clients who do not typically access family planning services. Currently, there is no consensus regarding what family planning service components are necessary or sufficient to include in integrated programs in order to increase contraceptive use; there is also no consensus about what HIV components added to family planning services may increase uptake of HIV services, e.g., risk screening, family planning method counseling, method provision, counseling and testing, or linking components via a referral system. Depending on the model, hypothetically, integrated or linked services may improve uptake of either family planning or HIV services or both.

USAID/Washington has been promoting and funding the integration of family planning services in a wide array of countries over the past few years and has financed a five-country assessment of service integration. This assessment will involve in-depth interviews of key informants as well as survey questionnaires to collect data from program managers, health care providers, and clients. The assessment was designed by and is directed by Family Health International and involves a situation analysis conducted in late 2007 and early 2008 in five countries: in Ethiopia, Kenya, Rwanda, South Africa, and Uganda.

2.2 Models of Integration

The four major models of integrated HIV and family planning services are derived from combining services currently offered separately:

- family planning services brought into HIV care and treatment services (FP in ART)
- family planning brought into voluntary counseling and HIV testing (FP in VCT)
- family planning brought into PMTCT services (FP in PMTCT)
- HIV services brought into family planning (HIV in FP or SRH).

Although there may be numerous approaches to the design and implementation of family planning and HIV services, these four models have the potential to offer clients improved access to services by: 1) increasing uptake of contraception among women with HIV infection (FP in ART), 2) increasing access to family planning services for clients who do not use traditional family planning services (FP in VCT), 3) providing family planning guidance and counseling to pregnant women using ANC service, and 4) increasing access to HIV services such as HIV care and treatment among clients of reproductive age (HIV in FP). These models also respond to

are not yet eligible. Those services are broader than ART provision alone, and may include services such as treatment for opportunistic infections and nutrition counseling. For the sake of brevity, we refer to these types of programs as “ART programs.”

funding trends for HIV services that are increasingly focused on two services: HIV care and treatment, which results in a growing number of HIV-positive women receiving care, and counseling and HIV testing services, which ensure that a large number of people know their HIV status.

The model that has received the most attention to date is the “FP in PMTCT” model, partly because of the urgent need to avoid HIV transmission to newborns. According to a UNAIDS report published in 2004, more than two million children worldwide are infected with HIV, nearly all of them through mother-to-child-transmission (UNAIDS, 2004). The Glion Call to Action has called for closer linkages between family planning and PMTCT (WHO, 2004).

In their comprehensive review of the provision of family planning within PMTCT in 10 countries, Rutenberg and Baek noted that there are two divergent approaches to counseling HIV-positive women in PMTCT programs: 1) the public health approach, which suggests that HIV-positive women be told not to become pregnant again, and 2) a reproductive rights approach, which stresses the importance of maintaining women’s right to choose whether or not to have children (Rutenberg and Baek, 2005). Their review discusses the variations in the experiences of offering family planning services in PMTCT programs in countries in Africa, Asia, and Latin America.

The model with the greatest potential per woman reached to prevent HIV infection in infants is the “FP in ART” model, since all ART clients are HIV-positive. Moreover, because ART services require repeated contacts with clients, family planning in ART increases the likelihood that clients will decide to accept a contraceptive method, allows for method resupply, and may increase adherence to contraceptive methods. Although clients in care and treatment services may not yet be eligible for ART, this assessment considers both care and treatment clients on ART and those not yet eligible.

The model that adds family planning services to VCT (FP in VCT), on the other hand, will reach both HIV-negative and HIV-positive clients, and because of the relatively high coverage of VCT programs, this model will reach more potential contraceptive users. Although this model lacks ongoing contact with clients—and therefore the opportunity to reinforce messages and provide ongoing services—it may provide an opportunity to reach clients contemplating behavior change to bring them closer to actual change. Behavioral theories such as trans-theoretical and stages-of-change models describe how individuals cycle through different levels of readiness to change behavior before actually doing so (Prochaska et al., 1997). For clients contemplating preventing pregnancy, offering family planning counseling and methods during the VCT session may result in earlier uptake of contraception.

In all these models of integrated HIV and family planning services, knowing the client’s HIV status allows health care providers to tailor their contraceptive counseling to address any unique concerns the client’s HIV status may pose. Yet the addition of new elements to the base services in any of these models has the potential to degrade the quality of the original services, especially if the services are fundamentally weak (e.g., overcrowded, lacking in adequate supplies, experience contraceptive or drug stock outs, have insufficient or poorly trained staff) or are not strengthened prior to integration.

2.3 Integration of Health Services in Ethiopia

In the past few years, a number of programs have been created in Ethiopia to permit HIV and family planning services to be offered in the same health care facility by the same personnel. Interest in and commitment to integrated services received a major boost in 2004 when an Ethiopian delegation participated in an Implementing Best Practices (IBP) workshop on service integration (Entebbe, Uganda).

In 2007, Family Health International was asked by USAID to review information available in documents about the experiences of a number of African countries with models of integration of family planning and HIV services. Ethiopia was included in this review (FHI, 2007). A review of models of integration in Ethiopia conducted by Family Health International (FHI, 2006) found three models that had been operating for more than one year: 1) family planning added to PMTCT services, 2) VCT added to family planning services, and 3) family planning added to VCT services. Some projects involve Ethiopia's Ministry of Health and some do not. Some projects serve the general population whereas others serve only a specific targeted population such as pregnant women or youth.

Several projects in Ethiopia have begun to introduce family planning services into PMTCT services. Since 2004 IntraHealth has been working with the Ethiopian Ministry of Health to improve and expand family planning and other services offered by PMTCT centers in a project known as the Hareg Project (IntraHealth International, 2008). This is a three-year project funded by USAID. According to the IntraHealth International web site (<http://www.intrahealth.org>), assistance has been made available to 120 PMTCT centers and is expected to be made available to another 148 centers in all 10 regions of the country. The Family Health International review (FHI, 2007) also mentions a project in five centers supported by Abt Associates that promotes family planning, but it is unclear what activities have taken place. These projects were not included in the assessment because the decision was made for purposes of simplification to exclude family planning in PMTCT services from the study.

The Family Guidance Association of Ethiopia (FGAE) is one of the pioneers in introducing integrated HIV and family planning service in Ethiopia. Historically, FGAE is known for its family planning services provided over four decades sometimes under difficult conditions. In 2000, the FGAE started offering VCT services in one of its model clinics in Addis Ababa. FGAE was motivated to initiate VCT services because of the increase in the rate of HIV in the population and because most of FGAE's clients are women and youth, populations that are highly vulnerable to HIV. FGAE wanted to give its family planning clients access to VCT services. Initially, one family planning provider was trained in VCT and assigned to provide the services in a dedicated room. In 2002, UNICEF began assisting the FGAE in adding VCT to the reproductive health services offered in their facilities.

The Family Guidance Association of Ethiopia has used three approaches to the delivery of integrated family planning and VCT services, depending on the type of facility:

1. Family planning and VCT services are provided in separate rooms, and providers make referrals from one service to the other.

2. FGAE-operated family planning clinics provide clients counseling on VCT and refer them to the nearest public health facility for testing.
3. VCT and family planning services are provided in a single room with a single provider on the premises of FGAE facilities (FGAE, 2007).

FGAE's approach to delivering integrated family planning and VCT services created several challenges for clients and providers because stigma towards VCT service users was strong, the waiting time for clients utilizing both the VCT and family planning service was too long, and the VCT providers manifested burnout easily. To address these challenges, more providers were trained in VCT, and a rotation schedule was arranged so that every VCT trained provider could work in both family planning and VCT services. Service provision rooms were designated for specific services on a rotating basis. Thus, instead of there being a single room for VCT services, rooms were used for either family planning or VCT, with services rotating weekly. Finally, steps were taken to integrate family planning and VCT services within a single room. Thus a single provider is able to offer both family planning and VCT services according to the needs expressed by the client.⁴ Currently, 33 FGAE facilities out of 44 different types of clinics are providing integrated services (ACIPH, 2008).

In 2008, the most common model of service integration in Ethiopia was the integration of family planning services into VCT; three programs have adopted this strategy. One program is a project of the Addis Ababa University Department of Community Health. This program began in January 2005 and operates in only one site: the Butajira Hospital and Health Center. It was scheduled to end in February 2006 but may continue functioning. Since the assessment of integration by Family Health International excludes programs with fewer than three functioning sites, no data is being collected by FHI from supervisors, providers, or clients associated with this project.

A second project in Ethiopia that is integrating family planning and VCT services is a collaborative research partnership involving Pathfinder International, the Miz-Hasab Research Center, Johns Hopkins School of Public Health, and the Bill and Melinda Gates Institute for Population and Reproductive Health. The study, known as the Voluntary HIV Counseling and Testing Integrated with Contraceptive Services Study will evaluate the impact of adding family planning services to public sector VCT programs in Oromiya province. Through interviews with VCT clients conducted before and after an intervention, the research team seeks to determine to what extent such a program can respond to the needs and desires of VCT clients for family planning services. The study began with client interviews in eight public sector health facilities (six hospitals and two health centers) in Oromiya in July 2006. Training of personnel and other interventions were scheduled for July and August 2007. Because operations research is already scheduled for this intervention, the current assessment for Family Health International does not include any of these sites; however, the program and study directors are being sought for interviews as key informants.

A third program in Ethiopia for integrating family planning services into VCT services—the most comprehensive one in the country—was begun in 2004 under the direction of

⁴ Interview with FGAE HIV program officer

Pathfinder International and implemented by Pathfinder/Ethiopia and the Ministry of Health. Initially, Pathfinder/Ethiopia worked closely with the Ministry of Health and regional officials in Amhara region to introduce family planning services into VCT in 32 health care facilities, a total of 20 percent of such facilities in the region. The Ministry of Health selected the intervention sites and directed the training and mobilization activities related to service expansion. Overall, the program has provided materials and training in family planning for facilities in Tigray, Amhara, and Oromiya regions, and will soon start activities in the Southern Nations, Nationalities and Peoples Region. Because of its size, scope, and length of time in operation, this initiative is the most important VCT/family planning integration effort now operating in Ethiopia.

3. RESEARCH STRATEGY

3.1 General Research Question

The primary research question addressed in this study is the following: What effect did the Ethiopian government policy that government health facilities begin integrating family planning services into voluntary counseling and testing (VCT) services have on the service delivery practices of Ethiopian health care providers? A secondary objective of the study was to identify the factors that facilitated the integration of family planning services into existing VCT services in government health facilities.

Even though all government health facilities may have tried to follow the same Ministry of Health guidelines, the services actually delivered differ somewhat from one facility to the next. Therefore, the study first identified which services were offered in which ways in health facilities before contacting health care providers for an interview. Once the pattern of service delivery was established, the research team focused on the experience of health care providers in service delivery. Data about the practice and service delivery of health care providers were derived from the descriptions provided by health care providers about their training, their understanding of policy, and the services they had been providing.

Other approaches to the study of integrated services in Ethiopia were considered in designing this study. One approach would have been to examine in some detail the kinds of reproductive health services and VCT services that were offered in each facility, and then assess the challenges that would be faced in integrating the services in each facility. Another approach would have been to focus on the extent to which family planning and VCT services are correctly and efficiently provided in each health facility, thereby providing an evaluation of the quality of services provided. Still another approach might have been to examine clinic records before and after the integration of services to judge the impact of integration on client use of the services.

A 2004 Family Health International publication on integrating HIV and family planning services suggests still another approach: direct program evaluation (FHI, 2004). The report states: "Research is essential to demonstrate not only that integration will not overburden and thus compromise the quality of existing services, but also that it will actually improve reproductive health" (FHI, 2004:5). This publication mentions three results that an impact evaluation of integration might find: 1) a decrease in the quality of all services following integration; 2) health care providers who find that the addition of new services creates too much of a work load for them; 3) the improvement of reproductive health, however that may be defined.

These ways of describing program impact are important outcome measures. The options adopted by this study were more concrete and intermediate, focusing on: 1) the effect on numbers of clients using the services; 2) the usefulness of the basic training to health care providers; 3) the usefulness of the specialized training provided in family planning; 4) the understanding of government policy in the integration of HIV and reproductive health services.

In short, the research directors of the present study decided to focus on the experience of health care providers in offering services. This focus offers the opportunity to learn from those who actually provide services. It also allowed the study of the context of service delivery within health facilities. While this latter element is generally neglected in discussions of integration policy and program evaluation, a focus on the work experience of health care providers allows the research to consider the context of service delivery as one key element that affects service integration.

3.2 Specific Research Questions

Some of the specific questions considered in the process of designing and implementing the study are:

Services

- What are the standard family planning services offered in health care facilities?
- What are the standard services that have been offered in VCT facilities?
- What services are now being offered in facilities that offer integrated services?

Health care providers

- What do health care providers know about the policy of integration?
- What training/refresher in family planning and VCT did the health care providers receive? When? By whom?
- How do health care providers decide which clients should be told about family planning methods?
- What do health care providers think of efforts to integrate services?
- How has the integration of services affected the work load of health care providers?
- What do health care providers say about the response of their clients to the new services?
- How could the services offered be improved according to health care providers?
- How does the context of daily practice affect service delivery?

The research team paid particular attention to two aspects of the actions of VCT counselors and other health care providers who had been trained in family planning methods: 1) bringing up the subject of family planning methods to some of their clients but not to others, and 2) providing family planning methods to clients themselves or referring clients to another unit in the facility or to another facility. The research team assumed that health care providers trained to offer family planning services would offer those services to some clients and not to others, so it

became important to learn how counselors identify clients to whom they speak about family planning and others to whom they do not speak. Similarly, it was important to discover if health care providers offer family planning methods themselves or they refer clients who want family planning services to another unit.

The research team made a number of assumptions about the process of integrating family planning and VCT services from the viewpoint of health care providers. These included:

- Health care providers and their supervisors would be familiar with the Ethiopian Ministry of Health policy on integrating services.
- The health care providers trained in family planning methods in special workshops by Pathfinder/Ethiopia would be the VCT counselors.
- Once VCT counselors were trained to provide family planning methods, they would remain in the VCT unit to continue their service.
- Some health care providers would find that the addition of family planning services to VCT constitutes a burden to their regular practice.
- VCT counselors would welcome the opportunity to gain new training for their practice, this time training in counseling clients on family planning methods.

These assumptions were discussed during the training and the finalizing of the topic guide used in the interviews with health care providers. The study findings confirmed some but not all of the assumptions.

4. METHODOLOGY

4.1 Site Selection and Sampling

The Ethiopian government initiated a program of integrating family planning services into voluntary counseling and testing (VCT) services in three regions of the country—Oromia, Amhara, and Tigray. Selected health care providers from government health facilities in these regions participated in a five-day training workshop on family planning offered by Pathfinder/Ethiopia. For reasons of practicality, the research team for the study decided to limit the fieldwork to just two of these regions: Oromia and Amhara. Pathfinder/Ethiopia officials were more aware of the status of the integrated VCT/family planning programs in health facilities in these regions, and the health facilities in these regions were more accessible by ground transport than facilities in Tigray.

In Oromia, health care providers in 26 government health facilities participated in the family planning training offered by Pathfinder. The research team decided to exclude eight of these 26 facilities from the present study because they were already serving as sites for the Voluntary HIV Counseling and Testing Integrated with Contraception study where research on service integration had already begun. The research team also decided to limit the study to health facilities in western Oromia because health facilities in that part of the region were more accessible and up to 10 health facilities there were available for study. Excluding sites in which health care providers trained in the integrated program were absent, the research team selected nine health facilities in western Oromia as sites for the study: 1) Ijaji Health Center; 2) Tulubolo Health Center; 3) Sibu Sire Health Center; 4) Nekemt Hospital; 5) Shambu Health Center; 6) Agaro Health Center; 7) Jimma Health Center; 8) Jimma Higher Health Center; and 9) Hasendabo Health Center. Later when the team learned that the trainee from the Shambu Health Center was unavailable, it selected Batu Health Center in Ziway to replace the Shambu Health Center.

In Amhara, health care providers in 31 hospitals and health centers had initiated integrated health services in Western and Eastern Amhara Regions. The research team decided to limit the study to Western Amhara because it offered a greater number of trainees from a smaller number of facilities, a desirable attribute from a logistical standpoint. After excluding a few remote sites in this region, nine facilities were selected as study sites. These were 1) Debre Markos Hospital; 2) Fenote Selam Hospital; 3) Bure Health Center; 4) Adet Health Center; 5) Felege Hiwot Referral Hospital; 6) Wereta Health Center; 7) Debre Tabor Hospital; 8) Gondar Hospital; and 9) Gondar Health Center.

The research team's original plan was to interview three or four health care providers in each of the selected 18 health facilities who had participated in the five-day training workshop on family planning, along with one supervisor from each facility. When the team learned that one or more health providers who had participated in the training was absent at each facility, however, the goal became to interview at least 11 health care providers from Oromia and 13 health care providers from Amhara, plus 18 supervisors (one for each health facility in the study sample). As discussed below, the research team ultimately interviewed 25 health care providers and 16 supervisors from the 18 facilities in the two regions.

The 25 interviewed health care providers from the government health facilities came not only from VCT units of the facilities but also from other units, including the maternal and child health unit, the prevention of mother-to-child transmission of HIV (PMTCT) unit, the family planning unit, and the HIV antiretroviral therapy (ART) unit. The supervisors held positions such as medical director, head of health facility, and matron.

4.2 Training of Interviewers

To orient the five research assistants who would be conducting interviews, the Ethiopian research director conducted a four-day training workshop in Addis Ababa. The training included a presentation on the integration of family planning and VCT in Ethiopia; a review of the objectives, research questions and methodology of the study; a discussion of the principles of qualitative research; a discussion of the use of topic guides to guide conversations with health care providers. The topic guide used for interviews with health care providers is shown in Appendix A. Although all of the participants already had substantial experience with collecting qualitative data, they found the discussion of qualitative research to be a very useful orientation with highly unstructured, open-ended, interactive, and ‘subject-centered’ approaches.

The presentation on the integration of VCT and family planning services reviewed the nature of integration in general as well as its specific attributes with respect to family planning and VCT services. The rationale, benefits, and challenges for the integration of family planning and VCT services were discussed. The research assistants were able to express their own perspectives on the need for, and approach to, offering family planning within a VCT context. Also discussed was the experience with integration in Ethiopia, with special attention to Pathfinder’s program which has added family planning to previously functioning VCT services in government health facilities.

The topic guides that were to be used in the study (both the English and Amharic versions) were reviewed and discussed in relation to the objectives of the study. The research assistants suggested modifications to the topic guide and then practiced using the guide with colleagues in the workshop. The topic guides were pre-tested in two health care facilities in towns near Addis Ababa. Small adjustments to the guide were made after the pretest.

4.3 Organization of Fieldwork

Several weeks before beginning the fieldwork, Pathfinder wrote letters to the Oromia and Amhara regional health bureaus requesting their approval and support for the study. Both health bureaus wrote letters of support to the Zonal Health Departments under which the 18 selected health facilities operated. In Amhara Region, the letter was sent down the hierarchy from the Zonal Health Departments to Woreda Health Departments that informed the health facilities. The research team for Oromia Region carried the letters of support for the study to submit to the various Zonal Health Departments.

In addition to helping the research project gain official approval, Pathfinder staff at headquarters in Addis Ababa and regional levels contacted the heads of the selected health facilities a week or two before the fieldwork started in order to inform them about the study and request their cooperation. All of the health facility heads responded positively to this request. As

a result, the research teams were welcomed in the 18 health facilities they visited and managed to easily arrange discussions with facility heads and staff.

4.4 Data Collection

Data collection in Amhara and Oromiya regions was completed over a two week period in December 2007 by two teams of research assistants. Each team allocated a single workday for each facility on average, attempting to interview one or two counselors trained in integrated service provision and one person in a supervisory position (a nurse matron, the head of a unit, or the head of a health facility).

The two teams of research assistants were generally successful in finding eligible individuals to interview. The Amhara team found that health workers in four health facilities were absent during their visit. Fortunately, they were able to arrange meetings with three of them after completing their work in the rest of the health facilities. Overall, the team in Western Oromia conversed with 12 trained health care providers and seven supervisors. The team in Amhara region held conversations with 13 trained health care providers and nine supervisors.

Both research teams found the managers of the health facilities and the health care providers cooperative and willing to participate in the study. A few health care providers expressed reservation or anxiety about participating, but they gradually relaxed as the discussion progressed. Previous notification by regional Pathfinder staff and letters of support from the Regional Health Bureaus probably helped encourage involvement in the conversations. On visiting a health facility, the research assistants introduced themselves and the study and scheduled meetings with the appropriate health workers. Conversations often took place in the afternoon, when there are fewer clients in most health facilities.

Every guided conversation between a respondent and a research assistant was individual and private. Respondents were informed that the conversation was part of a research study aimed at recording their experiences with the integrated VCT/family planning program and not an evaluation or assessment. They were assured that the conversation would be kept private and confidential and were asked to give informed consent either verbally or in writing. The conversations were conducted in Amharic and tape recorded (with permission) for subsequent transcription. One person refused the tape recording, so only notes were taken during the interview.

The research assistants' conversations with the health care providers dealt with their daily activities, their training and work experience; special training programs concerning VCT and family planning in which they had participated; the administration system of the health facility they worked in; their perspectives on the principles of integrated VCT and family planning service provision; their service provision practices; and their overall assessment of the implementation of the integrated service in their institution. The research assistants found that most of the health workers were quite responsive in the guided conversations and freely shared their ideas.

Most of the respondents who were supervisors at the health facilities knew very little about the program for integrating services, and therefore could not say much about it. Even some

health care providers trained in family planning by Pathfinder had little to say about the program of integration per se. Their lack of knowledge can be attributed in part to the relatively short time period of the program (more than one year in Oromia and 4-5 months in Amhara). It is also attributable to the practice of rotating health workers among the different units of a health facility. Some health workers had spent very little time providing integrated services and were thus unable to draw on much experience in speaking about the program. In addition, the varying availability of family planning methods and the practice of referring some VCT clients to family planning units within the same health facility also limited the extent to which VCT counselors could offer family planning methods to their clients.

4.5 Data Analysis

After completing the interviews with health care providers and supervisors, the research assistants transcribed the taped discussions in Amharic script and then translated the Amharic transcripts into English. The transcripts in English were subsequently typed up in Microsoft Word for easy accessibility. The whole process was completed in about two months. The process of transcribing and translating the recordings allowed the researchers to gain familiarity with the data and a preliminary sense of some significant findings related to the initial research questions. This process led the research team into the first phase of data analysis in which responses relating to major concerns of the study were summarized for each respondent. Having summaries of information related to the main questions of the study for each respondent made it possible to examine individual responses in the light of their own circumstances and work experience.

The items under which some of these findings were summarized included the aspects of the educational and professional background of an individual respondent; special training programs undertaken; awareness of the principles of the integrated service; the process of conducting integrated counseling; how the counselors reorient counseling sessions to fit different types of clients, as well as client concerns and responses to integrated counseling; the impact of organizational aspects of each facility on the integrated service; strengths and weaknesses of the service; and provider recommendations about ways of improving the integrated service.

A subsequent review by the research team of the summaries for each respondent, along with the transcripts, allowed the listing of relevant themes and subthemes falling under each of the topics mentioned above. After repeated reading of the translations and the summaries, the research team developed a draft outline to guide the writing process. Using this outline, the researchers synthesized the information in the summaries and transcripts falling under each theme to write up sections of the report. Respondents' statements thought to be especially illuminating with regard to critical features and experiences of the integrated program are quoted verbatim in the text of this report.

5. PROFESSIONAL BACKGROUND OF HEALTH CARE PROVIDERS

5.1 Professional Training and Experience

Most of the health care providers interviewed who were trained in the integrated program were working as nurses after having completed two or three years of training. However, a small number had risen to become nurses after working for years as health assistants, a position that requires about one and half years of training and involves activities such as injections, dressing wounds, and vaccinations. Further education in their profession was a widely held goal for almost all of the health care providers who participated in the study.

The health care providers who participated in the study had between two and 27 years of professional experience. Because so many had an extended tenure as a health assistant before becoming a nurse, or had recently graduated from nursing school, most had worked as a nurse for only a few years. The majority had worked in two or three health facilities in their careers, often moving from rural health centers to urban hospitals. Transfers from one health facility to another usually followed a request by the health workers. Having a nursing diploma made a transfer more likely.

The health workers had experience providing care in various units of the government facilities in which they worked and usually did not specialize in one component of health care. They talked of rotating regularly among the main units of the facility: outpatient department, the delivery room, ANC, MCH, family planning, and VCT units. This rotation among different units arose from the need to adjust for staff shortages faced by health institutions as well as to provide health care providers with a wider set of experiences.

5.2 Duties and Responsibilities

The health care providers interviewed were called to serve in different units of their health care facilities, including VCT, ART, family planning, MCH, PMTCT, ANC, maternal ward, and the outpatient department. They commonly served as heads of such units, although they were sometimes one of only two people in the unit. As unit heads, they oversaw the work in their unit, represented the unit in facility meetings, and took care of the unit logistic and reporting requirements.

Some of the health care providers often worked in two or more units of their health care facility at the same time, spending part of the day in each of the units. For example PMTCT/“under-five care”; VCT/family planning; VCT/ART; ANC/family planning; gynecology/PMTCT/family planning, and gynecology/VCT units. The different posts occupied by a health worker are often closely related to each other, as in the case of VCT/ART, ANC/family planning and PMTCT/under-fives. A health worker’s participation in units such as PMTCT, family planning, ART and VCT was usually the result of participation in specialized training.

Health care providers were expected to rotate among the various units in a health facility every several months. This was a common practice aimed at sharing and varying workloads and broadening the skills of health workers. For instance, one health care provider mentioned

rotating among the family planning, ANC, “under-fives,” and outpatient units. In addition, staff shortages meant that most health workers regularly switched units to fill in. They were also required to take up night shifts in the outpatient department, but such service also brought financial compensation.

In addition to performing regular clinical work, some health care providers participated in various administrative committees such as HIV/AIDS, management, and disciplinary committees. A number of health care providers also reported engaging in various outreach endeavors related to educational activities on VCT, PMTCT, family planning and malaria, as well as EPI campaigns. Their outreach activities often required engagement with various community workers such as community-based reproductive health agents, home-based care workers, malaria agents, and various community leaders.

Almost every health care provider who participated in this study expressed positive sentiments about serving in their chosen profession. They reported gaining tremendous satisfaction from providing health care ranging from treating their patients, delivering healthy babies, preventing miscarriages, providing access to family planning, and counseling people on HIV or ART. In this regard, a 45-year-old female nurse who was working in a hospital in Oromia Region said the following:

I am happy when clients voluntarily come to VCT, get a blood test, and come to know their HIV status. I am glad when those clients whom I have counseled turn out to be HIV negative. I find it satisfying to advise them on how to protect themselves from factors that expose them to HIV and to advise reactive clients to use ART treatment and extend their lives.

Another nurse, a 41-year-old woman who worked in Amhara Region also described experiences which were sources of satisfaction for her:

Some HIV-positive clients come here very thin and unable to walk without support. Now after starting ART treatment they became well. So when they meet me in the streets, they greet me and say, “Sister you may have forgotten us, but we have not so because you are our life.” But I can never remember them because they have changed so much.

Health care providers also appreciated gaining experience and knowledge from their work and the various training programs that they undertook. At the same time, they were challenged by the large numbers of clients and the heavy workload. Sources of frustration for health care providers included their low pay, lack of per diems or compensation for fieldwork or night duty, shortage of medical supplies, lack of health insurance, and perceived mismanagement by their superiors.

5.3 Specialized Training

Ethiopian nurses with a nursing degree are eligible for participation in specialized training workshops offered by various agencies, including Family Health International (FHI), Pathfinder/Ethiopia, the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), the Ethiopian Orthodox Church, and the Organization for Social Services on

AIDS. The specialized training workshops last from three days to two weeks and provide training in topics such as VCT, Provider Initiated Counseling and Testing, family planning, PMTCT, Integrated Management of Childhood Illness, ART, management of opportunistic infections, tuberculosis, tuberculosis and HIV, and nutrition. These workshops add to the knowledge and skills of health care providers on particular areas of their work and enable them to offer special services to their clients. Most of the health care providers interviewed had participated in one or two of the workshops in addition to a workshop on family planning.

Many of the specialized training workshops for nurses had a practical component in addition to discussions of theoretical aspects. The health care providers believed that their knowledge and outlook were enhanced by these training programs. A 26-year-old female nurse working in a hospital in Amhara Region made this observation:

The trainings are like refreshments, meaning that they give us additional knowledge on PMTCT and VCT. They make you more responsible and confident in giving these services to benefit mothers.

Because the particular areas of work that the health care providers are currently engaged in are related to some of the specialized training they have received, such as VCT, family planning, ART or PMTCT, the health care providers have been able to apply the medical and counseling skills they have gained to their daily practice.

5.4 Training on Integration of Family Planning and VCT

The five-day training workshops organized by Pathfinder/Ethiopia on integrating family planning services into VCT took place in November 2006 in Oromia Region and in June 2007 in Amhara Region. The workshops typically involved one health care provider from health centers and two health care providers from hospitals. Twenty-seven health care providers from 14 health centers and 4 hospitals participated from Oromia Region, whereas 37 health care providers from 21 health centers and 11 hospitals participated from Amhara region. In Western Amhara, where the study was conducted, Pathfinder/Ethiopia trained 17 health care providers from 13 health care facilities.

Although the Pathfinder/Ethiopia workshop on the integration of family planning services into VCT services was intended mainly for health care providers in VCT units, particularly VCT counselors, workshop participants actually came from other units: ART, family planning, maternal and child health, ANC, and PMTCT. In some health facilities, the providers of VCT services were not offered the training. Although the training was still relevant to their work, its central focus on the inclusion of family planning into VCT services did not closely coincide with the operational concerns of health care providers in some of these other units. In many instances, the recruitment of trainees for the workshop was less than ideal.

Judging from the trainees actually recruited, the research team concluded that health care providers were chosen for participation in the workshop either because their jobs had some relationship to VCT and family planning or because of a desire to spread out opportunities for training among staff in a health facility. Both reasons are understandable in a broad sense, but the selection process meant that the trainees were not necessarily the persons working in VCT units,

as had been originally expected. Several health care providers alleged that favoritism might have been involved in the selection of staff for training.

Reports from participant in the five-day workshop of the content of the training program on integrated service varied widely. Some reported that the training was about offering family planning to VCT clients or integrating family planning into VCT, PMTCT, and ART services, and mentioned the advantages of providing VCT and family planning in a single unit. Many of those interviewed said the training offered instruction about the advantages of birth spacing and the different types of family planning methods. Any attention given to HIV counseling was mentioned less often.

Generally, the research team was surprised by the fragmented nature of the recollections of the content of the training workshop, for the workshops all followed the same curriculum. The variation in recollection could be related to a limited conceptual understanding of the objectives of the integrated program on the part of participants. Many thought that the training was about encouraging HIV-positive women not to have children. For some, this entailed informing HIV-positive women about the disadvantages of giving birth and the probability of compromising their immune status or having their children become orphans. A few trainees recalled the emphasis given during the workshop to the importance of encouraging couples with discordant HIV status to use dual protection.

The trainees generally believed the training gave them an adequate understanding of family planning and its integration with VCT, but they also recognized that they were not being trained in long-term family planning methods. Some also felt that the training enhanced their confidence, motivation, and a sense of responsibility regarding the integration service. On the other hand, trainees felt that the training was too short and lacked a practical component. The provision of a substantial amount of reading material did help, although it was often difficult to find the time to read.

The knowledge and motivation gained from the five-day training workshop enabled health care providers who worked in VCT units to integrate family planning in their counseling practices and at least refer clients to family planning units for contraception. A few health care providers were actually able to offer family planning methods in the VCT unit. Some health care providers who came from other units such as PMTCT, MCH and family planning also started to integrate family planning or HIV counseling into their activities.

6. INTERACTIONS WITH VCT CLIENTS

6.1 Counseling Practices

The integrated counseling services of the Ethiopian Ministry of Health did not offer a policy framework to guide government health facilities in implementing programs that integrated family planning services and HIV voluntary counseling and testing services. The health care providers who participated in Pathfinder/Ethiopia's five-day training workshop and were interviewed for this study gave quite varied descriptions of the objectives of an integrated VCT/family planning program. Quite a few of the 25 trainees and 16 supervisors who were interviewed associated the program with the provision of family planning to women and men who were HIV positive. They believed it was aimed at preventing HIV-positive women from having children, reducing transmission of HIV to children, and combating the loss of immunity caused by HIV infection. A few trainees and supervisors mentioned that the program was meant to offer family planning to VCT clients generally, to promote dual protection against HIV infection and pregnancy, or to provide multiple services at the same location thereby reducing the workload of health care providers. In contrast, one respondent reported that they were told that it was acceptable to refer VCT clients to family planning units as well.

VCT counselors who were trained in the integrated program incorporated family planning into their counseling sessions on HIV testing. They often counseled their clients on family planning in the posttest counseling session, although some discussed it in the pretest session as well. Many of the VCT counselors believed that the integration of family planning into VCT was meant mainly for clients who were found HIV positive, but quite a few reported that they also provided family planning counseling to those who tested negative for HIV, a practice that conformed with the integration program's goal of expanding access to family planning regardless of HIV status.

Health care providers working in VCT units usually start a counseling episode by explaining the nature and modes of transmission of HIV and then move onto an assessment of the client's risk for HIV. After the HIV test, they provide additional counseling regarding HIV and how to live with HIV infection. Most often at this point the counselors would introduce the topic of family planning. Clients who test negative for HIV would be counseled on preventing future exposure to HIV, and they would also be encouraged to start using birth control methods in order to delay or space births. HIV-positive women and men would be counseled about how to live with HIV and the potential risks of giving birth, including the transmission of HIV to the baby, decline in the health status of the mother, difficulties in breastfeeding the baby, and the probability of the child becoming an orphan. Counselors also explain the benefits of dual protection to clients (preventing both HIV transmission and conception). Attempts might be made to involve the partners of clients, and to advise them on the benefits of dual protection whether they were HIV positive or negative.

A 35-year-old female nurse described how she integrated family planning in her counseling on HIV testing:

When they first arrive for the service, I greet them and introduce myself. I then tell them how HIV is transmitted and the advantage of having a blood test in a detailed manner. After they have the blood test, I tell them how to live a positive life. Then I will ask them the conditions which have exposed them to HIV. For instance, I try to find out what addiction they may have and talk to them about how they could overcome the addiction. After they understand what they have to do in the future, including how to get proper treatment, then I talk about the advantages of family planning. If they say I want to have a child we cannot forbid them. The choice is theirs. However, I discuss with them the problem HIV people would face, if they had a child. I raise questions like: are you economically fit to raise a child? Or could you feed your child if you cannot breastfeed? In such a manner, we allow them to understand that they can have a better life by using family planning. We conduct the discussion based on their own ideas.

The counseling on family planning methods involves advising clients about the nature of these methods, their use, and their potential side effects. On the basis of this information, clients are allowed to choose a method that suits them. A 42-year-old male nurse working in a VCT unit of a health center in Oromia Region explained how he offered family planning choices to his clients in the following manner:

We counsel them about family planning methods and the different choices available to them. The selection is up to the client. For example, if I present them with three options, I will tell him the side effects of each. Then they will select what is better for them. There is no condition in which we create pressure upon rural women. We do try to address certain misconceptions about family planning that are common in rural areas. For example, there are rumors claiming that “pills accumulate in the womb and if taken for long time, cause a serious problem in the womb,” or that “there will be no more births after one takes injections.” Since the community around us is Muslim, we don’t mention condoms in meetings. This is because religious elders believe that condoms push youth towards bad habits.

Most counselors in VCT units adapted their family planning counseling according to the characteristics and needs of the clients. Many counselors did not raise the subject of family planning with clients who were older than 50, menopausal, not sexually active, or who had come for a pre-marriage HIV test. They were also less likely to stress family planning methods for youth, students, and unmarried men and women. When they did discuss family planning methods with these groups, they discussed only condoms and injectables for young women. Married clients were more likely than unmarried clients to receive a full discussion of family planning methods. Depending on their economic status or the number of children they had, married clients were encouraged to adopt short- or long-term family planning methods.

The client’s level of knowledge about family planning methods also affected the content of the conversation. Counselors held more complete discussions with clients that were less knowledgeable about family planning methods. Some clients, especially those in rural areas, were very reserved and therefore needed more probing and encouragement to identify their needs and preferences for family planning methods.

The HIV status of clients was another factor influencing the nature of the discussion between counselor and client. As noted above, some counselors thought that they were expected to counsel mainly HIV-positive clients on family planning. One went as far as to examine the physical status of his clients before deciding whether to counsel them. Another counselor offered family planning methods only to HIV-positive clients, referring all other clients to the family planning unit. The emotional state of HIV-positive VCT clients after being informed of their sero-status affected the extent to which counselors could engage them in a discussion of family planning. A 36-year-old female VCT counselor working in a health center in Oromia Region said:

Some of them are not willing to listen to you. They may say they do not want family planning methods or that they may not be interested in relationships any longer. In such cases, I will take more time to talk to them or make another appointment to counsel them. Others may argue with you. You may need much more time to convince them and bring about behavioral change, while others are quicker to accept what you tell them.

Some VCT clients who test positive for HIV may want to have children in the future, whereas others may not. While those who do not want to have any more children may be counseled to accept long-term family planning methods, those who do want more children are given somewhat different advice. A 25-year-old male nurse working in the VCT unit of a health center in Oromia Region explained what he would do in such a case:

If she is ready and willing to have a child and if her status and economic condition allow her to, the counseling session would be a little different. I may say that "It would be better if you use condoms temporarily." If your health improves after a while, you could look for a way to have a child. Also, there is a drug that can be taken to prevent transmission of the virus to the child.

The receptivity of VCT clients to family planning counseling affects the operation of an integrated VCT/family planning program. Most providers of the integrated services said that VCT clients were very receptive to family planning. As a result, the uptake of family planning methods increased substantially among clients who tested positive for HIV. Quite a few clients preferred to obtain family planning methods in the VCT unit rather than in the family planning unit.

A large proportion of VCT clients, particularly young clients, were interested only in the HIV test and related counseling, not in family planning methods. Men and women who wanted to have children were also less interested in family planning methods. Many VCT clients were too preoccupied with the results of their HIV test to pay much attention to discussions of family planning. They are more likely to be amenable to such discussions in subsequent visits, as they follow up on ART. Some VCT clients that were unwilling to share their test results with their partners also found it difficult to accept condoms and family planning methods. Female clients were sometimes unable to adopt a family planning method without getting the permission of their husbands. Thus, although the demand for integrated services was quite strong, some VCT clients did not readily accept family planning methods without additional support and follow-up.

6.2 Provision of Family Planning Methods

Standard integrated health services programs involve the provision of family planning methods within VCT units to clients who chose to accept them. VCT units had condoms available but did not necessarily provide much counseling about condom use. However, less than one-third of the health facilities actually offered family planning counseling and methods such as condoms, pills, or injectables in the VCT units. Some health facilities suspended the direct provision of these methods in VCT units after initially offering them. The reasons given for this action included: low demand, high client flow, and the transfer of trained personnel to other units or facilities.

A substantial number of health facilities that offered integrated VCT/family planning counseling adopted another approach: they had VCT counselors refer their clients to family planning units within the facility rather than provide family planning methods themselves. Such referrals were made either orally or using a written form. Some VCT counselors actually walked their clients over to the family planning unit and gave them priority in getting the services. These referral practices deviated from the program's stated aim of integrating the provision of family planning counseling and methods into VCT services. A number of reasons were given for utilizing the referral system: 1) established reporting and logistical mechanisms for providing family planning services were based in the family planning unit, 2) there was insufficient space in the VCT unit to provide family planning services, and 3) the heavy workload in the VCT unit was compounded by the addition of family planning services. Furthermore, the referral system suited many clients who preferred to go to the family planning unit on subsequent visits.

6.3 Client Concerns

Health care providers offering integrated services reported that their clients frequently expressed concern regarding the nature and use of family planning methods. Family planning methods were generally not available in the VCT units themselves. Moreover, the availability of methods such as Norplant, the IUD, and injectables was sometimes irregular in the family planning units. Some health facilities were not able to offer emergency contraception or more than a single type of contraceptive pill.

Many female VCT clients expressed concerns about the side effects of contraceptive methods during counseling sessions. The side effects ranged for headaches, hypertension, weight gain, and menstrual irregularities they thought were caused by injectables, to the burning sensation they thought resulted from the use of contraceptive pills. Some female clients found condoms and IUDs uncomfortable. Others, including commercial sex workers, were concerned about the defects in condoms. A substantial number of clients had misconceptions about family planning methods that the health care providers tried to allay. Examples of such misconceptions are the belief that birth control pills accumulate in the womb and increase the quantity of blood in the body, or that injectable contraceptives cause sterilization.

Client reactions to the HIV test results often affected the nature of the integrated counseling session in VCT units. Many clients were very apprehensive about their HIV test and reacted very emotionally when the test result was positive. A 45-year-old female nurse, who was

working in a hospital in Oromia Region described the responses of some VCT clients to a positive HIV test result in the following manner:

When their results turn out positive, some clients become angry, cry, wail, or fall down. Others deny that the result is theirs. It is very tough to work in a VCT unit. Let alone the clients, it makes me worried, stressed, and exhausted. After they hear their test results, many clients feel desperate, believing that they cannot live and work.

VCT clients who are upset by their HIV test results may not be concerned about reproductive outcomes right away, so a follow-up visit may be necessary to counsel them on family planning. The need to refer clients to other facilities for ART services may complicate efforts to provide them with family planning. And some clients, especially young people, are unwilling to pursue ART, and therefore miss not only the opportunity to receive ART services but family planning services as well.

VCT clients who test positive for HIV are often reluctant or unwilling to tell their spouse or partners about their HIV status. Women may be afraid that they will be accused of bringing HIV into the household. Both women and men may be afraid that their marriage will dissolve if they disclose their status to their partners. A female nurse working in the ART unit of a hospital in Amhara Region talked about some of the responses of these types of clients.

For example, there are people who know their status but do not want to tell their spouses. There are husbands who hide their status from their wives. Wives also do the same thing. Because of cultural factors, women are afraid to tell their husbands about their result. A woman can be afraid that her husband would hit her or send her out of the house. There are also patients who take ART drugs but do not tell their wives. When we inform some of them that they need to tell their wives, they say, "I told her but she is not willing to test. So she can come when she becomes sick." But they probably have not told their wives.

The reluctance on the part of clients who tested positive for HIV to inform their partners constrains their ability to encourage their partners to get tested for HIV. These clients, who would find it difficult to introduce condoms or other family planning methods into the relationship, are not likely to accept such preventive methods during a counseling session.

7. INTEGRATION OF FAMILY PLANNING AND HIV SERVICES IN HEALTH CARE FACILITIES

7.1 Implementation of Integrated Services

The expected result of Pathfinder/Ethiopia's integration program and training workshop for integrating family planning services into voluntary counseling and testing services was that VCT units in participating health facilities in Ethiopia would integrate family planning services with VCT services, offering clients integrated VCT/family planning services. This expectation was not borne out.

The research team for this study found that only 10 of the 18 health facilities included in the study were offering integrated VCT/family planning services in their VCT unit; the other eight health facilities did not offer family planning in their VCT units at all. The proportion of health facilities offering family planning services in VCT units was greater in Oromia (six out of nine facilities) than in Amhara (four out of nine facilities). Of the 10 health facilities that did offer integrated VCT/family planning services in their VCT units, only a few offered both family planning counseling and family planning methods in their VCT units. The rest offered family planning counseling in their VCT units but referred clients to the family planning units for contraceptive methods.

Several factors influenced whether and to what degree health facilities were able to achieve integration of HIV and family planning services: 1) the availability and use of human resources and work space, 2) the system of rotating staff among service units in health care facilities, 3) the supply and mode of providing family planning methods, 4) reporting arrangements, and 5) the amount of follow-up and supervision of the integrated services. These factors and their impact on the integrated program are discussed below.

Human Resources

The integrated program never got off the ground in some VCT units of health facilities because the health care personnel working in those units were never trained. As mentioned earlier, health workers from other units such as ART, PMTCT, ANC and family planning were selected for training. Some of them managed to attain some form of integration in their work by adding family planning services to their other activities, as noted below. Because some of them had not had any training in VCT however, they lacked the skills and motivation to engage extensively in counseling.

In some health facilities, when staff members undergo specialized training, they brief their colleagues on the training objectives and content. In the case of the integration program, this practice allowed some of the trainees, who were recruited from, or transferred to, units other than the VCT unit, to help initiate the integrated VCT/family planning program in the VCT unit. In one health facility, health care providers who had participated in the Pathfinder/Ethiopia workshop were able to persuade counselors in the VCT unit to counsel clients on family planning and then refer them to the family planning unit. In another health facility, they were

able to orient community counselors to provide family planning counseling and methods in the VCT unit itself. Unfortunately, post-training briefings did not occur in all facilities.

Most of the 18 health facilities included in this study faced severe human resource shortages, which are a widespread feature of the Ethiopian health care system in general. This problem has strongly influenced the implementation of integrated VCT/family planning services. The shortages of staff in many of the health facilities have required the shifting of health workers to units where manpower deficits are most severe. As a result, counselors working in VCT units may be moved to the outpatient department, ART, or the delivery room. This practice sometimes deprives VCT units of counselors trained in the integrated program, ultimately leading to the program's suspension in the health facility.

The reduced staff levels in VCT units are also likely to increase the workload of the counselors who remain. The workloads of VCT counselors are often excessive because of high client flow, work quotas, and reporting requirements. Such workloads place a huge burden on counselors, often leaving them exhausted. Heavy workloads also limit the amount of time counselors can devote to each client, making it difficult to delve into family planning issues during the counseling session. A 34-year-old male nurse, working in the ART unit of a health center in Amhara Region described the situation in the following manner:

Pre- and post-test counseling takes 25 to 30 minutes per client. If we counsel a client on family planning methods, it may take 5 minutes. This means each client may take 30 minutes. We are now given a quota of 900 clients a month in our work plan. To achieve our plan, we have to offer VCT service to 30 clients per day. A counselor therefore said that she could not provide services to 30 clients if family planning was added. I raised this issued during the training. Other professionals in the training also said that the integrated service was not practical.

Other counselors found that the integrated services increased their workload in ways they found burdensome. According to a counselor posted in a health center in Oromia Region, "When family planning is added onto VCT, it takes a very long time, which is very tiresome for counselors." Reductions in the personnel available to VCT units, pre-existing excessive workloads, and the resultant burden on counselors have therefore weakened the provision of integrated counseling in a number of health facilities.

An important factor behind the dwindling manpower in the health facilities is the high number of health workers who are pursuing educational opportunities, usually with the aim of getting a Health Officer degree. This has meant that quite a few health care providers who were trained in integrated services have either left their posts or were filling in for health care providers who worked in other units. Both outcomes end up compromising the integrated program.

A strategy recently adopted to combat the shortage of manpower in VCT units has been to involve community counselors in VCT units. Community counselors are volunteers who receive minimal training in HIV services. Quite a few community counselors were already engaged in providing VCT services in the 18 health facilities in this study. Although they could

offer an adequate level of HIV counseling, their lack of training in family planning and their rudimentary professional experience, meant that these community counselors were not able to participate in the integrated program. In a few instances, community counselors' involvement in VCT services actually led to the termination of the integrated program. In one institution in Amhara Region, however, they were able to counsel VCT clients on family planning after being oriented by health workers trained in the integrated program.

Another factor that significantly influenced the implementation of the integrated program in the participating health care facilities was the widespread practice of rotating staff on a regular basis between various units in a health facility. Staff members were rotated for periods ranging from one week to three months. As noted above, this practice was meant to distribute the workload and provide opportunities for staff to gain experience in different areas of health care. Unfortunately, however, this practice often led to the transfer of health care providers trained in integrated care from VCT to other units, thereby undermining the provision of integrated services.

Shortage of Work Space

Because many health facilities have a shortage of work space in which to interview clients and store supplies, VCT units were sometimes limited to a single room, restricting the number of counselors who could work there and thus the number of clients who could be served. Some rooms that were available to VCT units were very small, uncomfortably hot, or lacked adequate lighting. These conditions created an environment unfavorable for proper counseling. Indeed, lack of storage space was one of the reasons given for not keeping and offering family planning methods in VCT units.

Another spatial factor that emerged in this study was the physical distance between the VCT unit and the family planning unit within a health facility. It was suggested that this physical distance, combined with clients' concerns about confidentiality, could adversely affect access to family planning methods for some VCT clients who are referred to the family planning unit. In one hospital, a counselor trained in the integrated program managed to bring a family planning unit closer to the VCT unit after consulting with the matron. This case illustrates the importance of administrative support in creating favorable conditions for integrated services.

Management of the Supply of Contraceptive Methods

The provision of family planning methods is an important component of the integrated program. As noted above, integration of this component took two forms in health facilities involved in the program. A few facilities were able to fully implement the integrated program by offering both family planning counseling and family planning methods in the VCT unit. The second approach, which was adopted by a substantial number of health facilities, was to provide family planning counseling in the VCT unit, but referred interested clients to the family planning unit to receive contraceptive methods.

The convenience of the existing (established) logistical system in which family planning methods were distributed in the family planning unit appears to be an important reason for the second approach to the integration program. The existing arrangement was likely to continue

unless the trained health care providers and facility managers took the initiative to offer family planning methods in the VCT unit as well. The second approach was reinforced by the reporting system on family planning maintained by health facilities. Data on the number of family planning clients and the types and quantities of contraceptive methods provided to clients were regularly reported by the family planning units to the management of the health facility and Woreda (district) health bureaus. The fact that units other than the VCT unit (PMTCT and ART) did not report on family planning and did not have the reporting formats that would allow them to do so, was cited as one of the factors that militated against the provision of family planning methods in VCT units.

Other factors behind adoption of the second approach to the integration program were mentioned in section 6.2 on the provision of family planning methods. They include lack of storage space for family planning methods in VCT units, lack of time on the part of VCT providers, and client preference to receive family planning methods in the family planning unit rather than in the VCT unit, for their continuing contraceptive needs.

Regardless of which approach to the integration of family planning and VCT services was adopted, a factor that could significantly affect the success of the integrated program was the reliability of contraceptive supplies in health facilities. In most of the health facilities visited, the supply of contraceptive methods was adequate; however, a few facilities reported varying supplies of methods such as injectables. Some health facilities had to rely on external agencies for assistance, or had to refer clients elsewhere for long-term or permanent methods. Also, facilities often ran out of emergency contraceptives.

Follow-up and Supervision

The lack of follow-up and supervision of the integrated program by health facility management and Pathfinder/Ethiopia was repeatedly mentioned by the health care providers as factors behind the failure to maintain continuity and full integration of the program. Many of the supervisors who were in a position to oversee the program in a health care facility were not aware of its existence, possibly because there was no effort to orient them to the program, or because they were unable to recall its initiation. This situation obviously precluded the support they could give to the integration program in terms of ensuring the availability of trained personnel, materials, and space. A male nurse who had participated in the training workshop on the integrated program but was now being transferred to another facility in Amhara Region, underlined the problem as follows:

These kinds of programs are sensitive. For example, the officials in the Woreda health bureau do not know about the training I recently had on the integration program. There is only one health professional who works in PMTCT room who has had the integration training. When she has a day off or has night duty, there will be no one to give the service. The service will discontinue.

7.2 Integrated Services in Health Care Units Other than VCT

Although the integrated services program was primarily intended to link family planning and VCT services, it appears that in practice the program has expanded beyond the VCT units.

This unintended benefit probably came about as a result of the involvement of health care providers from ART, PMTCT, ANC, and family planning units in the training workshops. These health care providers were able to apply the integration principles and practices they had learned to the units in which they worked.

Health care providers from ART units in a number of health facilities who participated in the integrated program returned to their units with the understanding that their clients should be using family planning. In addition to providing ART drugs and counseling to their clients, they began to counsel them on family planning. These health care providers had previously encouraged ART clients to use condoms. They now advised them to adopt additional family planning methods for dual protection against HIV transmission and pregnancy. In a few health facilities, family planning methods were offered in ART units, while in others, clients were referred to family planning units for contraceptives. There were also instances in which female ART clients were encouraged to take a pregnancy test. Clients who tested negative for pregnancy were counseled to adopt family planning; those who were pregnant, on the other hand, were referred to PMTCT units.

ART clients had a range of responses to the family planning counseling. Many were glad to adopt family planning methods after a counseling session. Some ART clients, especially married women, had not disclosed their HIV status to their spouses, fearing eviction or dissolution of their marriage. Because it was difficult for such clients to utilize condoms and other family planning methods, they were often not receptive to counseling on family planning. Other ART clients were mainly interested in getting ART counseling and drug regimens and less interested in family planning methods. They often came to accept family planning as they continued to be counseled during their subsequent visits for ART.

Quite a few health care providers who had participated in the integration workshop came from maternal and child health units, including both ANC and PMTCT. These two units serve the same type of clientele, namely, pregnant women. After they received the training, the health care providers from such units started to counsel women on family planning as they moved through these services. Typically, women would first be enrolled in an antenatal care unit where they would be tested for pregnancy. According to some of the health care providers who were trained in the integrated program, women in the antenatal care unit who tested negative for pregnancy would be counseled to adopt family planning; those who were pregnant would be counseled to be tested for HIV and, if found to be HIV positive, would be referred to the PMTCT unit. There, either during or after their pregnancy, PMTCT staff who were trained in the integration program counseled the women to adopt family planning after giving birth. A young male nurse working in the PMTCT unit of a health center in Amhara Region explained how this was done:

If there is a positive result, you have to talk about other issues like breastfeeding options and the importance of delivering in health faculties. If her pregnancy is over 36 weeks and she does not plan to come to a health facility for delivery, you have to give her Niverapine. But we strongly counsel her to come to a health facility for delivery. After telling her all this, I advise her to use family planning services during the postnatal period. I tell her not to get pregnant in the future...

After delivery as well, she will be told to use family planning after 45 days, whether she is HIV positive or not.

Another category of women who received such counseling in the maternal and child health unit were those who had just undergone an abortion. Health care providers from family planning units who were trained in integrated services were sometimes able to find out that some of their clients were sent to them from VCT units after testing positive for HIV. In the case of married couples, they were then able to counsel them on dual protection. These health care providers appeared to be implementing integration in the reverse direction. They were using their increased awareness of the need to integrate HIV services with family planning by counseling their family planning clients to be tested for HIV. They could do this in the preliminary group sessions they conducted for these clients as well as in individual sessions. Those who were willing to be tested for HIV were then referred to VCT units.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

This study was conducted to examine the effects of integrating family planning services into voluntary counseling and testing (VCT) units in health facilities on the work of health care providers in two regions of Ethiopia: Amhara and Oromiya. The objectives were to discover how training health care providers in family planning counseling and methods has affected the service delivery practices of these persons and to identify factors that facilitated the integration of family planning services into existing VCT services. The study focused on understanding the experiences of health care providers in 18 health facilities who had participated in a training workshop on family planning. Research assistants trained by the study directors interviewed health care providers about their job, their training, and the services they provide.

The health care providers who were interviewed were almost all nurses with several years of professional training. The majority of these nurses had worked in two or three health facilities in their careers. Changes in work sites often involved moves from rural health centers to urban hospitals. Having a nursing diploma made a transfer more likely. Many of the health care providers interviewed were interested in acquiring further education, and their participation in courses and workshops led to periodic absences from their post. In their absence, integrated VCT/family planning services would most often be suspended. It is unlikely that a program for integrating services from Ethiopia's Ministry of Health or elsewhere would be effective in altering these aspects of the work environment of health care providers. Thus, any plan for training and supervision of providers of integrated services would need to take into consideration the movement of trained providers between facilities as well as between service units.

Many of the health care providers had been involved in a variety of training programs that had enhanced their knowledge, skills, and confidence, allowing them to provide services in specialized areas. Although health care providers greatly appreciated gaining experience and knowledge from their work and participating in various training programs, they were often challenged by large numbers of clients and heavy workload. Health care facilities typically have a schedule of rotation that moves providers from one unit to another. This policy has the effect, whether planned or not, of evening out the client load.

Conversations with health care providers indicated that individuals were selected to participate in the training workshops partly because their work had something to do with family planning or HIV, and partly because Pathfinder/Ethiopia wanted to distribute training opportunities to a wide range of staff. Trainees were selected from various units in hospitals: VCT, ART, family planning, MCH, ANC, and PMTCT units. Individuals who worked primarily in VCT units were not always chosen for training in family planning methods.

The study research team had expected that the personnel selected for training would mainly be those designated to provide VCT services. This expectation was not borne out because that criterion was not followed in the selection process. Many of trainees selected were from units other than VCT; they included ART, MCH, PMTCT, ANC, family planning, gynecology, and the outpatient department. Additionally, most nurses rotate through the units rather than

staying in specific units. It is unclear how the selection process could have been modified to focus more on VCT staff. A plan for future training would benefit from verifying rotation plans and assessing the number of persons that should be trained, to ensure regular and consistent delivery of integrated services.

The expected result of the collaboration between the Ministry of Health and Pathfinder to train health care providers in integrating family planning services into VCT services was that VCT units in participating health facilities in Ethiopia would be able to offer clients integrated VCT/family planning services. The research team for the study found, however, that only 10 of the 18 health facilities included in the study were offering integrated VCT/family planning services in their VCT unit; the other eight health facilities did not offer family planning in their VCT units.

The way in which the integrated program was implemented by the 10 health facilities that did offer integrated services varied greatly. Family planning services were provided to VCT clients in these facilities in one of two ways: 1) the VCT unit offered family planning counseling and family planning methods directly to VCT clients, or 2) the VCT unit offered family planning counseling to VCT clients, and then referred them to a separate family planning unit in the facility to obtain contraceptive methods.

Less than one-third of the 10 health facilities that offered integrated VCT/family planning services in their VCT units offered both family planning counseling and methods. The rest offered family planning counseling in their VCT units but referred clients to family planning units to obtain contraceptive methods. Although referrals for contraceptives were less convenient and confidential for clients, they did provide reasonably good access to family planning. Many clients also preferred to go to the family planning unit for subsequent contraceptive needs.

A variety of factors influenced the degree to which health facilities were able to achieve integration of HIV and family planning services. These factors include the following:

- the availability and use of human resources to implement the program,
- the system of rotating staff among service units in health care facilities,
- the supply and mode of providing family planning methods,
- reporting arrangements, and
- the amount of follow-up and supervision accorded to the integrated services.

Factors that facilitated the integration of family planning and HIV services include the following:

- the selection of VCT counselors for training in family planning methods and counseling,
- a particularly effective training session, and

- the sharing of skills from the training with colleagues in the health facilities.

The integrated program was implemented in units other than VCT, such as ART, PMTCT, and ANC in cases where personnel from these units were trained, or where trainees shared their skills with colleagues. Counselors in family planning units advised their HIV-positive clients on dual protection, and their other family planning clients on HIV testing.

Factors that impeded the integration of family planning services into VCT units included the following:

- the selection of health care providers other than VCT counselors for the training workshop,
- shifting of personnel from the VCT unit to other units because of staff shortages,
- the heavy workloads of counselors leading to the suspension of the integrated service program,
- the lack of adequate and convenient work space for counseling clients, and
- the lack of supervision and follow-up by Pathfinder personnel.

The lack of follow-up and supervision of the integrated program by Pathfinder/Ethiopia and heads of facilities was repeatedly mentioned as a problem by the trainees. This had a negative impact on their ability to provide the necessary oversight, human resources, system of reporting, work space, and moral support needed to maintain the continuity of the program.

Interest in the integration of family planning and HIV services on the part of the Ethiopian Ministry of Health, Pathfinder/Ethiopia, Family Health International, and other groups is a promising development in Ethiopia; integration may make services more efficient and more accessible to clients. Through discussions with health care providers and their supervisors, the research team identified several suggestions for improving the integration process in the future.

First, the health care providers reported that although the five-day training gave them additional skills and motivation to serve clients, the workshop was too short and not sufficiently practical. They also said that they were disappointed that they were rarely contacted by Pathfinder/Ethiopia after being trained. Although trainees were told to expect supplies and supervisory visits, the supervisory visits did not occur. In the next round of training, follow-up visits should be part of the overall plan.

Second, it is important to consider ways to take advantage of the existing service provision structure in health facilities and to shape the training to take into account this structure. In Ethiopia, many health facilities have a severe shortage of personnel, so everyone works in nearly all the units from time to time. Also, most of the personnel rotate regularly through the various service units, so if family planning services are to be offered in VCT units, several individuals in each health facility must be trained in the integrated program. With only one or two persons trained in both VCT and family planning a health care facility will be unable to sustain the provision of integrated VCT/family planning services over time. Program and

training directors would benefit from understanding the pattern of internal rotation within facilities, using this information to inform the process of trainee selection.

Finally, the mobility of staff, both within and between facilities, suggests that the image of service integration according to models based on service type (VCT, ART, PMTCT, care and treatment, etc.) does not adequately reflect the situation in Ethiopia. In the facilities visited, some personnel trained in family planning methods used their skills in units other than VCT. A model with more permeable boundaries between service units would fit the situation better.

8.2 Recommendations

The research team's recommendations regarding the integrated VCT/family planning program are based on this study of health care providers' experiences with the integration of VCT and family planning services and their own suggestions on how to improve the program.

- It is always useful to reflect on improving the quality of training programs. For training related to the integration of VCT and family planning, attention should be given to enhancing its conceptual aspects, practical components, the time allocated for the workshop, and the overall instruction methods used. The importance of counseling all VCT clients on family planning, both HIV-positive and HIV-negative clients, should be emphasized.
- Recruitment for training on VCT/FP integration should target health care providers who are likely to make the most use of the skills acquired—first those in VCT units, and then those in ART and PMTCT units of health facilities. Consultation between trainers and health facilities on the selection of trainees can help ensure the involvement of the most appropriate staff.
- The ongoing human resource shortages, frequent departures of staff to pursue educational opportunities, and staff rotation practices—all common in health facilities—should be considerations in planning for future training in the integration of services. Expanded and continuing training of more health care providers in the integrated program is needed to ensure the availability of trained staff needed for its continuity.
- The high volume of clients in VCT units and the substantial demands placed on counselors will have a major impact on the continuity and quality of integrated services. Sustained support should be provided to health facilities for training in VCT, including its integration with family planning. Serious attention should be given to equipping community counselors with the skills to counsel clients on family planning, possibly through instruction by health care providers trained in the integrated program. However, the need for the continued involvement of health care providers in the actual provision of family planning methods in VCT units must not be forgotten.
- Many of the health care providers who participated in the training workshop reported that the attention and support given to them by their supervisors and Pathfinder/Ethiopia was insufficient. Stronger efforts should be made to orient facility

heads on the objectives and content of the integrated program to secure their support for ensuring adequate human resources, workspace, materials, and other conditions for its proper implementation. They should be encouraged to maintain staff in posts in which they can continue to apply their training in the integrated program.

- Pathfinder/Ethiopia should strengthen its follow-up of the integrated VCT/family planning program through continuing consultations with trained staff on issues related to implementation, supplies of reporting materials and family planning methods, and enhanced monitoring and evaluation. Steps should be taken to address ongoing variability in supplies of family planning methods and increased demand for them because of the success of integrated services. The supply of injectables, emergency contraceptives, and long-term methods such as Norplant need special attention.
- Health facilities should be engaged with community outreach activities related to HIV to raise awareness and utilization of integrated services and to support VCT clients who will face difficulties discussing their HIV status and family planning with their spouse/partners. Many facilities are already doing so.

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APPENDIX A

Topic Guide for Interviews with Health Care Providers

Macro International, in association with Pathfinder/Ethiopia, is conducting this study on the experiences of health care providers with the integration of family planning with VCT service provision in health facilities. The study will help identify what factors facilitate the integration program and allow us to improve it. This interview prioritizes your experiences and perspectives in providing integrated family planning and VCT services. Therefore, please feel free to expand on everything that you think is relevant to you and the program. The questions we put to you are only guides to our discussion and should not restrict your responses in any way. Your responses to this interview will remain confidential and anonymous.

Thank you for your participation in the interview. Let us now start our discussion.

Personal information: Name; Gender; Age; Education; Position; Years of experience; Name and address of health facility; Name of facilitator.

I. Current work and responsibilities

(Please tell me about the work you do here from day to day)

- Activities of a typical day
- Specific responsibilities
- Contact with patients
- Types of patients they see
- Contacts with outreach units
- Relative satisfaction in working here

II. History of past work experience

(Please tell me about your background and preparation for working in health care)

- Education completed
- General training programs completed
- Past work experience
- Aspects of past work that were/were not satisfactory
- How they came to work in this facility
- How they see their professional future

III. Special training programs followed

(Please tell me about any special training you have had in HIV and family planning service provision)

- Training in HIV services: counseling and testing
- Training in family planning services
- Training in integrated HIV and family planning services

- Relative effectiveness of training
 - How they now use their training in their practice
- IV. The health care practitioner within the health care system
(Please tell me about the health care administration at the facility. You can describe it in terms of how it relates to your work)
- System of providing directions for practice
 - System of supervision
 - Record keeping requirements
 - Referrals provided
 - Any training provided by the facility?
 - Role and activities of community volunteers
 - Suggestions for improvement
- V. Current principles of integrated service delivery
(Please tell me about the principles for providing integrated family planning and HIV services here)
- Schedule and indicators for reporting on service delivery
 - What they would like to change about the principles of service delivery
- VI. The practice of offering family planning services to VCT clients
(Please tell me about how you go about offering family planning to VCT clients)
- how discussion is initiated and proceeds
 - variations by type of client
 - times in which they do not mention family planning. Reasons.
 - identification of what method is suitable
 - family planning family planning methods supply and referral
 - common concerns of clients
 - problems encountered
 - how clients respond to suggestions for using family planning
 - assessment of own capacity for counseling
- VII. Overall assessment of the policy and practice of integrated service delivery
(Please tell me about how you see the integrated family planning and HIV services in this facility)
- strengths of the service delivery
 - weaknesses of the service delivery
 - responses of clients to services offered
 - what others in the facility say about providing integrated services
 - ways to improve services

Thank you for taking the time to give us this valuable information. If you would like to add to anything to what we have discussed, please do so.