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Title

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Permalink

<https://escholarship.org/uc/item/660326mq>

Journal

AIDS Care, 28(2)

ISSN

0954-0121

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Publication Date

2016-02-01

DOI

10.1080/09540121.2015.1080791

Peer reviewed



Published in final edited form as:

AIDS Care. 2016 ; 28(2): 209–213. doi:10.1080/09540121.2015.1080791.

Integrating family planning into HIV care in western Kenya: HIV care providers' perspectives and experiences one year following integration

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Abstract

With high rates of unintended pregnancy in sub-Saharan Africa, integration of family planning (FP) into HIV care is being explored as a strategy to reduce unmet need for contraception. Perspectives and experiences of healthcare providers are critical in order to create sustainable models of integrated care. This qualitative study offers insight into how HIV care providers view and experience the benefits and challenges of providing integrated FP/HIV services in Nyanza Province, Kenya. Sixteen individual interviews were conducted among healthcare workers at six public sector HIV care facilities one year after the implementation of integrated FP and HIV services. Data were transcribed and analyzed qualitatively using grounded theory methods and Atlas.ti. Providers reported a number of benefits of integrated services that they believed increased the uptake and continuation of contraceptive methods. They felt that integrated services enabled them to reach a larger number of female and male patients and in a more efficient way for patients compared to non-integrated services. Availability of FP services in the same place as HIV care also eliminated the need for most referrals, which many providers saw as a barrier for patients seeking FP. Providers reported many challenges to providing integrated services, including the lack of space, time, and sufficient staff, inadequate training, and commodity shortages. Despite these challenges, the vast majority of providers was supportive of FP/HIV integration and found integrated services to be beneficial to HIV-infected patients. Providers' concerns relating to staffing, infrastructure, and training need to be addressed in order to create sustainable, cost-effective FP/HIV integrated service models.

Keywords

HIV; family planning services; integrated; delivery of healthcare; healthcare provider; Kenya

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No conflicts of interest declared.

Introduction

Unmet need for contraception and unintended pregnancy rates are high among women living with HIV (Schwartz et al., 2012; Homsy et al., 2009). Prevention of unplanned pregnancies among HIV-positive women is considered essential to improving maternal and child health and eliminating pediatric HIV infections (UNFPA, 2012). Globally, interest has grown in integrating family planning (FP) services into HIV/AIDS care to increase contraceptive use among women and couples affected by HIV who don't desire pregnancy (Fleischman, 2006).

A growing body of evidence indicates that FP/HIV integration is feasible (Lindegren et al., 2012; Spaulding et al., 2009), cost-effective (Shade et al., 2013; Sweeney et al., 2012), regarded favorably by providers and patients (Baumgartner et al., 2013; Maharaj & Cleland, 2005; Church & Mayhew, 2009), and successful in increasing modern contraceptive use (Grossman et al., 2013; Kosgei et al., 2011; McCarraher, Vance, Gwarzo, Taylor, & Chabikuli, 2011). However, many integration efforts suffer from implementation challenges (Wilcher, Hoke, Adamchak, & Cates, 2013). The perspectives of healthcare workers can influence how integration efforts are implemented (Uebel, Guise, Georgeu, Colvin, & Lewin, 2013; Mayhew, 2000), yet few studies have offered an in-depth evaluation of the experiences of healthcare providers offering integrated HIV and reproductive health services (Mutemwa et al., 2013; Winestone et al., 2012; Maharaj, 2004). Our study interviews providers about their experiences within the context of the first randomized trial evaluating FP/HIV integration.

Methods

Study sites

This qualitative study was conducted between October and November 2011 one year after the implementation of FP/HIV integration as part of a cluster randomized controlled trial (RCT), which has been described elsewhere (Grossman et al., 2013).

Providers were recruited from six of 12 public sector HIV clinics randomized to FP/HIV integration in the Kisumu East, Nyatike, Rongo, and Suba Districts in Nyanza Province, Kenya. All facilities were supported by Family AIDS Care & Education Services (Lewis Kulzer et al., 2012) and provided HIV care including antiretrovirals and contraception (including pills, injections, subdermal implants, and intrauterine devices (IUDs)). Providers were trained in FP counseling and provision as part of the integration intervention. The Committee on Human Research at the University of California, San Francisco and the Ethical Review Committee at the Kenya Medical Research Institute approved this study.

Eligibility and sampling

Facilities were selected using random tables. Two or three HIV care providers per facility, including clinical officers, nurses, and clinic and community health assistants (CCHAs, lay health workers), who were working on the day of the interview and who had been working more than six months were selected via random number assignment and interviewed. Each participant provided informed consent and received approximately \$4.00 USD for remuneration.

Open-ended interviews

Providers were interviewed using a semi-structured interview guide that included open-ended questions exploring HIV providers' views on FP counseling and provision and their experiences providing integrated services. The interviews were conducted privately in English and were audio-recorded and transcribed.

Data analysis

Data were qualitatively analyzed in ATLAS-ti 6.2.23 (ATLAS-ti GmbH, Berlin, Germany) using a modified grounded theory approach (Charmaz, 2006). Transcripts were coded using *a priori* codes created from the interview guide and inductive codes based on emerging themes and concepts. Coding discrepancies were resolved through discussion and consensus.

Results

Demographic information can be found in Table 1.

Views Regarding Benefits of FP/HIV Integration

Improved Efficiency—Several providers referred to the integrated facility as a “one stop shop” where clients could get the services they need “under one roof.” Many believed that non-integrated settings introduce more travel and queuing for patients due to referrals, which could deter many patients from seeking FP services. A nurse observed,

“[A]fter integration, I think the uptake improved, because there are those who want a method but because they are being referred to another site for FP they could not opt for [it] because of that time wasting, waiting... But when it is given from one site...most of them take it.” (31 year-old male, health center)

Expanded FP Access—Some providers found that integration extended FP services to more people and facilitated male exposure to and involvement in FP. FP appointments could also be scheduled simultaneously with routine HIV care, which some providers felt improved adherence.

Strengthened Continuity of Care—Some providers felt the rapport and trust built with their patients during regular HIV visits put them in a better position to offer FP than a separate provider. A nurse said, “[I]t is me who created rapport with this client, this client is comfortable with me offering the [FP] services...” (28 year-old female, sub-district hospital)

Views Regarding Challenges of FP/HIV Integration

Staff Shortages—Many providers were concerned that new responsibilities increased their already overburdened workloads. Some felt staffing was not adequate to provide comprehensive services. A clinical officer said, “[W]e usually [offer] FP counseling once, only on Mondays, maybe if we could have enough staff then maybe we could do it every day.” (29 year-old male, district hospital)

Time Constraints—Time was a common source of strain. A nurse admitted that sometimes providers “may not explain everything because there are other clients waiting.” (35 year-old female, district hospital)

Lack of Space—Many providers noted that facilities lacked adequate space and privacy to address both FP and HIV needs for multiple clients at once. A CCHA observed,

“[A]t times the clinicians are two in a room and...maybe some clients feel that FP is something private and confidential...so if there is a man and there is a woman... the other person ends up not talking about it [and] then goes home not satisfied.” (39 year-old female, health center)

Insufficient Commodity Supplies—Several providers reported a shortage of contraceptive commodities. A CCHA said, “Sometimes the client will come and find that we don't have Jadelle [subdermal implant] so she will be told to go and come back again. Some go and they don't come back...” (30 year-old male, sub-district hospital) A nurse also noted that if a client can't get a method, at the next appointment she “might be pregnant.” (30 year-old male, health center)

Inadequate Family Planning Training—The most common challenge was the lack of sufficient FP training. While the intervention included training on FP counseling and methods, only nurses and clinical officers received training in FP provision. Several providers felt that women were sometimes denied a method because of providers' inability to provide subdermal implants and IUDs. A clinical officer said she believed “all the health providers, the doctors, the nurses, clinical officers” should provide FP services because “they get in contact with all the patients every day.” (28-year-old female, district hospital)

Discussion

Despite implementation challenges, the HIV providers in our study viewed FP/HIV integration favorably. Providers believed contraceptive use improved when patients could access FP and HIV services together, as confirmed by the RCT (Grossman et al., 2013). Other benefits include capitalizing on HIV providers' rapport with patients and reaching more patients with FP services, including men who are often not targeted with FP (Tao et al., 2015).

The implementation challenges described align with research about integrating HIV and reproductive health services in sub-Saharan Africa (SSA) (Baumgartner et al., 2013; Maharaj & Cleland, 2005; Mutemwa et al., 2013; Medley & Kennedy, 2010). The global HIV epidemic has significantly strained healthcare systems in SSA, and the difficulty of expanding patient care with limited resources was felt in our study. Given that providers were interviewed one year after FP/HIV integration began, the challenges associated with implementing new protocols may have been more acutely felt. Further research is needed to evaluate how to address obstacles like human resource shortages in order to capitalize on the service delivery efficiencies that can be produced by integration efforts (Topp et al., 2013; Deo et al., 2012) and that could be especially beneficial in resource-constrained settings.

Inadequate FP training was the most common problem for providers. While the study included baseline FP training and quarterly refresher trainings, staff turnover was high. Furthermore, only clinical officers and nurses provided FP methods while CCHAs offered FP education and counseling. Training lay healthcare workers to provide at least some contraceptive methods, such as pills and injections, has been found to be effective (Gallo et al., 2012; Malarcher et al., 2011) and could reduce pressure on other providers.

This study has several limitations. While providers were randomly selected from study sites, they may differ in important ways from providers in Kenyan clinics not supported by FACES and in other parts of SSA. Additionally, our sample includes CCHAs and may not reflect the workforce in clinics that do not employ lay health workers. Finally, providers' favorable responses could reflect a degree of social desirability bias.

Conclusion

To compliment research evaluating the feasibility and health impact of FP/HIV integration, our study explores healthcare providers' experiences with the implementation of FP/HIV integration. Based on our findings, future FP/HIV integration efforts may benefit from frequent clinical trainings for all healthcare workers, attention to commodity procurement and maintenance, renovations of facility space to accommodate the privacy required for FP services, and adequate staffing to provide comprehensive integrated care.

Acknowledgments

We acknowledge the important logistical support of the KEMRI-UCSF Collaborative Group and especially Family AIDS Care & Education Services (FACES). We gratefully acknowledge the Director of KEMRI, the Director of KEMRI's Centre for Microbiology Research, and the Nyanza Provincial Ministries of Health for their support in conducting this research. We thank the providers who generously gave their time to participate in this study and Sophie Otticha for her important contribution to this research.

Funding: The study was funded by the Bill & Melinda Gates Foundation. Dr. Newmann was supported by the National Center for Advancing Translational Sciences, National Institutes of Health, through UCSF-CTSI Grant Number KL2TR000143. The contents of the manuscript are solely the responsibility of the authors and do not necessarily represent the official views of the NIH.

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Table 1
Demographics and experience level among healthcare providers working at integrated facilities

	N	(%)
Sex	16	
Female	9	(56%)
Male	7	(44%)
Position		
Clinical Officer	4	(25%)
Nurse	6	(38%)
Community & Clinic Health Assistant	6	(38%)
Age		
Mean (SD)	29.4	(4.3)
Years working at HIV clinic		
Mean (SD)	2.6	(1.8)
1 year	6	(38%)
2-4 years	8	(50%)
5 years	2	(13%)
Years as healthcare provider		
Mean (SD)	4.3	(2.2)
2-4 years	9	(56%)
5 years	7	(44%)
Years working in HIV care		
Mean (SD)	3.5	(2.1)
1 year	2	(13%)
2-4 years	11	(69%)
5 years	3	(19%)