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Assessment of Integration of Family Planning into HIV/AIDS Care and Treatment Services in Health Facilities in Dire Dawa City Administration, Eastern Ethiopia

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January 2014
WP-14-140

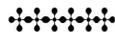


MEASURE Evaluation PRH is funded by the U.S. Agency for International Development (USAID) through cooperative agreement associate award number GPO-A-00-09-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group, Management Sciences for Health, and Tulane University. The opinions expressed are those of the authors and do not necessarily reflect the views of USAID or the U.S. government.

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Assessment of Integration of Family Planning into
HIV/AIDS Care and Treatment Services in Health
Facilities in Dire Dawa City Administration, Eastern
Ethiopia

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January 2014

Acronyms

ART	antiretroviral therapy
EDHS	Ethiopia Demographic and Health Survey
FP	family planning
IEC	information, education, and communication
IUD	intrauterine device
PLHIV	people living with HIV
PMTCT	preventing mother-to-child transmission
WHO	World Health Organization

Abstract

Background: In Ethiopia, approximately 38,401 pregnant women are living with HIV. Despite significant efforts to prevent mother to child transmission, there were an estimated 13,008 new pediatric infections in 2011. What proportion of these pregnancies were planned and what proportion were unplanned and could have been prevented with properly met family planning (FP) services is unknown. Making FP services accessible to people living with HIV (PLHIV) is one of the four key strategies that the World Health Organization (WHO) promotes in its comprehensive approach to prevent HIV infections in infants and young children.

Method: A cross-section study design was employed to assess the unmet need for FP and barriers to use among PLHIV in Dire Dawa Administration, Eastern Ethiopia. HIV-positive women of reproductive age (15-49 years) who were attending HIV/AIDS care and treatment services at three hospitals and eight health centers providing HIV/AIDS care and treatment services in Dire Dawa were interviewed as well as health care providers and program managers from those facilities, as well as two others. An inventory of services provided at the facilities was also conducted.

Result: A total of 438 PLHIV were interviewed. Among the 83% of the study subjects who had been pregnant at least once, only 32% desired more children. Nearly 89% of the participants had heard of at least one FP method. Seventy-nine percent had ever used an FP method in the past. Nearly 69% of the PLHIV were using an FP method during the data collection period, with male condoms being the most widely used. Seventy-two percent of the study subjects were counseled on FP methods. The unmet need for FP method was found to be 36%. A weak integration of FP services to chronic HIV care was noted.

Conclusion: There is high unmet need for FP among women living with HIV in Dire Dawa, Ethiopia. Addressing the unmet will improve the reproductive health of PLHIV and reduce the transmission of HIV to their babies. Integrating FP services into the HIV chronic care service is of paramount importance.

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Background

Ethiopia is among the countries worst affected by the HIV/AIDS pandemic. Among Ethiopia's total population of 82.1 million,¹ there are nearly 800,000 people living with HIV with an adult prevalence rate of 1.5%.² The population is unevenly affected by the disease with higher adult prevalence rates in urban versus rural areas (4.2% and 0.6%, respectively) and among females versus males (1.9% and 1.0%, respectively).³

In sub-Saharan Africa, an estimated 25% of all births are unintended with that percent increasing significantly among HIV-infected women.⁴ In Ethiopia, approximately 38,401 pregnant women are living with HIV. Despite significant efforts to prevent mother to child transmission, there were an estimated 13,008 new pediatric infections in 2011.⁵ Although it is unknown what proportion of these pregnancies were planned and what proportion were unplanned and could have been prevented with properly met family planning (FP) services, according to the 2011 Ethiopia Demographic and Health Survey (EDHS), unmet need for FP and unintended birth is high. Despite a significant decline in unmet need from a 2005 prevalence of 34%,⁶ it is still considerable at 25%.^{2,3}

Women who are HIV-infected remain vulnerable to unintended pregnancy, which contributes to the high incidence of maternal to child transmission of HIV.^{6,7} Access to effective and safe FP has the potential to avert more than 120,000 unwanted births annually in sub-Saharan Africa,⁷ thereby reducing the number of HIV positive children being born each year. Making FP services accessible to persons living with HIV (PLHIV) is one of the four key strategies that the World Health Organization (WHO) promotes in its comprehensive approach to prevent HIV infections in infants and young children.^{7,8} This strategy also increases the coverage and quality of FP services among a population that is commonly underserved and is at high risk of unplanned pregnancy. Expanded access to antiretroviral therapy (ART) in many developing countries has improved the life expectancies and health of many PLHIV who are resuming sexual activity and often need contraception.

Various studies have shown that women living with HIV have high unmet need for FP and the lack of integration between FP and HIV programs is an important factor that contributes to this.⁹ Integration refers to combining components of FP and HIV services that are currently separate, with the goal of maximizing coverage and health outcomes for the client and efficiently optimizing the use of scarce resources. Integrating services can take various forms: FP services can be integrated into HIV counseling and testing programs, into prevention of mother to-child transmission (PMTCT) services, or into care and treatment programs. HIV testing, prevention, and counseling can be added to existing FP, maternal-child, or primary health care services. FP and HIV services can be made available in the same location during the same visit and even by the same provider. Services can also be linked by referring a client from one service to another. Benefits of integrating FP and HIV services for programs and clients include:

- maximized productive use of scarce resources;
- enhanced ability to prevent new HIV infections, especially among infants and youth;
- improved access to and better-quality HIV/FP services tailored to meet the needs of PLHIV;

- greater support for dual protection against unintended pregnancy and disease;
- reduced stigma and discrimination;
- better coverage of key populations and areas of high HIV prevalence; and
- reduced care-seeking burden for individuals.¹⁰

There are several factors that hinder the integration of FP services into HIV/AIDS care and treatment programs. Poor organization of the services, lack of knowledge and training on the part of providers, poor attitude and practices toward FP, and lack of supply and mix of FP methods in health facilities are some barriers to integration. These bottlenecks can lead to missed opportunities and unintended pregnancies. Understanding the factors influencing the success of integration and the extent of unmet need for FP among women living with HIV is essential for designing an effective integration strategy that meets women's needs. This study was designed to assess the level of unmet need for FP among HIV-positive women and FP integration into HIV/AIDS care and treatment services in health facilities in Dire Dawa City Administration, Eastern Ethiopia.

Objectives

Studying both the clients' and health providers' perspectives, this research aimed to determine:

- the extent of unmet need for FP among HIV-positive women;
- the type and level of integration of FP into HIV/AIDS care and treatment services;
- readiness of health facilities and staff to provide integrated service to clients;
- barriers to integration of FP service into HIV/AIDS care and treatment; and
- number and type of FP services accepted by the clients.

Methods

Study Area

The study was conducted in Dire Dawa City Administration, one of the two city administrations in Ethiopia and one of the biggest towns in Ethiopia. Located 452 kilometers east of the capital, Addis Ababa, its total population is 377,000.¹ It is home to a diversity of people from different ethnic and cultural backgrounds, including many foreigners from neighboring Djibouti and Somalia. It has government institutions, colleges, factories, private enterprises, and well-developed social services. These factors, along with economic and social variables, are believed to increase the risk of HIV transmission. The HIV positivity rate is 4.9% which is among the highest in the country with females being more affected (5.8%) than males (3.9%). Every year, nearly 1,000 pregnancies occur among HIV positive women in the city administration.³

There are 11 health facilities in Dire Dawa that provide HIV/AIDS care and treatment services: eight health centers, one public hospital, and two private hospitals. All were included in this study.

Study Design

This was a facility-based, cross-sectional study. Quantitative data was collected from client exit interviews, self-administered questionnaires by health care providers, and inventories of services provided at the facilities.

Study Population

The study population included a sampled population of HIV positive women of reproductive age (15-49) who were attending HIV/AIDS care and treatment services in Dire Dawa during this study period and healthcare providers working at these service delivery points in the chronic HIV care units. The HIV positive women were selected from nine of the 11 facilities because there were virtually no clients at the HIV/AIDS care and treatment units in two of the smaller facilities, Gendgevada Health Center and Sabian Health Center, during the data collection period. Healthcare providers were from sampled from all 11 of the facilities.

Sampling Procedure

For the exit interviews, a single population proportion formula was used to estimate the sample size of clients to be interviewed [$n = (t)^2 \times p(1-p) / m^2$]. Due to lack of previous studies showing the unmet need for FP among women living with HIV in Ethiopia, the following assumption was made: unmet need for FP among HIV positive women as 50% ($p = 0.5$), level of significance to be 5%, $t =$ confidence level at 95% (standard value of 1.96) and absolute precision or margin of error to be 5% ($m = 0.05$). Computing with the above formula gave a total sample size of 384. Factoring in a 10% non-response rate increased the minimum sample size to 422. The calculated sample size was used to recruit study subjects from the selected service sites proportional to the facilities' case load. Based on the information obtained from each site, systematic random sampling was employed to identify study participants from each facility.

All the health facilities offering HIV/AIDS care and treatment were included for the inventory of services. Thirteen healthcare providers representing all 11 of the facilities completed the self-administered questionnaire.

Data Collection

The structured questionnaire used for the exit interview was prepared in English, translated to Amharic, and then translated back in to English to check for consistency. The topics included in the questionnaire were socio-demographic characteristics, discussions on FP with healthcare providers, contraceptive use and intentions, child desire information, sexual practices, and client satisfaction of the FP services. The self-administered structured questionnaire was prepared in English for HIV/AIDS care and treatment healthcare providers to assess their knowledge of and professional training on FP, attitude and practice towards FP, and integration of FP in the routine care they provide. The inventory of services provided at the health facilities was done using a checklist to systematically observe and document the organization of services, availability of contraceptives, equipment and materials for FP services, record keeping, and service statistics. An open-ended semi-structured interview guide was used for the in-depth interviews. The main

issues that were addressed were providers' perspectives of acceptability and feasibility of integration and readiness of providers and program managers for integrating FP services into HIV/AIDS care and treatment settings.

For the exit interviews, 15 female nurse data collectors (four for Dilchora Hospital, which provides the majority of HIV/AIDS care and treatment services in the administration, two for Legehare Health Center, and one for each of the other nine facilities) were recruited. Training was provided to data collectors for two days on the objective, relevance of the study, confidentiality of information, respondents' rights, informed consent, and interviewing techniques. The research team members supervised the activities and conducted interview role plays. The exit interviews with HIV positive women were conducted after the women had completed their visit to the facility. Before starting the interview, the patients were requested to participate in the study by the data collectors and gave their informed consent. The interviews were conducted in a separate, private room in the facility. No personal identifiers were gathered during data collection.

To avoid healthcare providers' bias and contamination of information, the providers were not informed about the specific purpose of the study.

Data quality was maintained by implementing the following measures:

- Questionnaires were translated to Amharic then back to English for consistency by two people.
- Three supervisors (the research team members) supervised the quantitative data collection process. The qualitative data collection was carried out by the investigators who were part of the research team.
- A comprehensive, two-day training was given for data collectors.
- Questionnaires were pre-tested in facilities outside the administration before the actual data collection. Based on the pretest, questions were revised and those found to be unclear or confusing were removed.
- Data completeness was checked daily by the supervisors.

Data Analysis

Quantitative data were entered, cleaned and analyzed using SPSS version 17.0 statistical software. Univariate analysis such as proportions, percentages, ratios, frequency distributions and appropriate graphic presentations besides measures of central tendency and measures of dispersion were used for describing data.

Ethics Approval

The Dire Dawa Administration Health Bureau reviewed the research proposal and granted ethical clearance to conduct the study.

Results

Female Clients

A total 438 PLHIV participated in the study (table 1). The majority of the women were from Dilchora Hospital. Of the total study participants, 78 (17.6%) were from public health centers.

Table 1: Source of Study Subjects

Facility Name	Frequency	Percent
Dilchora Public Hospital	348	79.5
Goro Health Center	2	.5
Bilal Private Hospital	7	1.6
Dire Dawa Health Center	2	.5
Mariam Work Private Hospital	6	1.4
Legehare Health Center	49	11.2
Addis Ketema Health Center	6	1.4
Gende Kore Health Center	13	3.0
Melka Gebdu Health Center	5	1.1
Total	438	100.0

More than 75% were aged 25-39 (table 2). Orthodox Christians (63%) dominated the study population. Half of them had only primary education. Nearly 45% were married or cohabiting and a third of the participants were divorced. A quarter of the participants were housewives, followed by daily laborers at about 20%.

Table 2: Socio-demographic Characteristics of the Study Participants

Variable	Frequency	Percent	
Age of participant	15-19	8	1.8
	20-24	54	12.3
	25-29	117	26.7
	30-34	108	24.7
	35-39	106	24.2
	40 +	45	10.3
Religion	Orthodox	279	63.7
	Catholic	4	.9
	Muslim	122	27.9
	Protestant	33	7.5
Educational level	Tertiary education (12+)	10	2.3
	High school (9 - 12)	94	21.5
	Primary education (1-8)	219	50.0
	Able to read and write without formal education	22	5.0
	Unable to read and write	93	21.2
Ethnicity	Oromo	140	32.0
	Amhara	234	53.4
	3-Somali	12	2.7
	Tigre	8	1.8
	Gurage	30	6.8
Current marital status	Married/cohabited	199	45.4
	Widowed	57	13.0
	Divorced	148	33.8
	Non married, not in a relationship	18	4.1
	Non married, in a relationship	15	3.4
	No response	1	.2
Occupation	Unemployed	74	16.9
	Student	8	1.8
	Housewife	113	25.8
	Housemaid	28	6.4
	Daily laborer	87	19.9
	Merchant	50	11.4
	Sex worker	12	2.7
	Government employee	23	5.3
	Private employee	34	7.8
Total	438	100.0	

Nearly 92% (407) of the participants had already started ART. Only 25 (5.7%) of the study subjects had not disclosed their HIV-positive status to their partners. The partners of the women were reported to be tested among 56% of the study subjects. Of those tested, 61 (24.5%) had a discordant result.

Table 3: Status Related to Sexual and Reproductive Health Services

Variable	Response	Frequency	Percent
Already started ART	Yes	407	92.9
	No	31	7.1
Disclosure status	Yes	250	57.1
	No	25	5.7
	Don't have a partner	156	35.2
Reason for non-disclosure	Fear of divorce	11	2.5
	Fear of abuse	9	2.1
	Other	4	.9
Partner tested	Yes	246	56.2
	No	46	10.5
	Don't know	109	24.9
Result of partner disclosure status	Negative	61	24.5
	Positive	183	73.5
	Don't know	5	2.0

Nearly 100% of the study subjects had engaged in sexual intercourse and 59% were currently sexually active. Fifty-six percent of the study participants reported always using a condom with less than 13% reporting that a condom was rarely used and about 16% reporting never use. Among the women reporting some condom use (i.e. always, most of the time, sometimes, and rarely), nearly 14% reported multiple sexual partners. More than 83% of the study subjects had been pregnant at least once and 77.8% had one or more living children. Among those, nearly 20% felt their last pregnancy was unwanted. Only 141 (32.2%) of the study participants reported their desire for additional children (table 4). Over 11% of the participants reported having one or more HIV-positive children.

Table 4: Fertility Desire of PLHIV in Dire Dawa City Administration

Fertility Desire	Response	Frequency	Percent
Like to have children or additional children	Yes	141	32.2
	No	272	62.1
	Don't know	20	4.6
Desired number of children want to have	1	46	10.5
	2	59	13.5
	3	17	3.9
	4	8	1.8
	5	0	0
	6	1	.2
	NA	7	1.6
Ever had unwanted pregnancy	Yes	90	22.2
	No	316	77.8
Ever had induced abortion	Yes	68	15.5
	No	28	6.4

Nearly 89% of the participants had heard of at least one FP method. Injectables (79.2%), pills (75.3%), and male condoms (72.6%) were the most commonly cited methods and tubal ligation (18.5%), the rhythm method (18.5%), and withdrawal (18.3%) were the least commonly cited.

Seventy-eight percent of the participants had used FP methods at least once in their lifetime. Of those who had responded to questions about current FP use, 64.4% reported they are currently using FP. The most commonly used method is condom (42.9%) followed by injectable and implants (figure 1). In the absence of complex data required to accurately measure unmet need, a proxy indicator was used to calculate unmet need for spacing and limiting by identifying those women of reproductive age who do not want children now or ever, or who do not want additional children, and are currently not practicing FP. With this crude estimate, the unmet need for FP was found to be 36.7%. Among those who had ever used an FP method, condoms and injectables were the most popular (with 35.4% and 33.3% ever use, respectively) with IUDs being the least popular (2.5%).

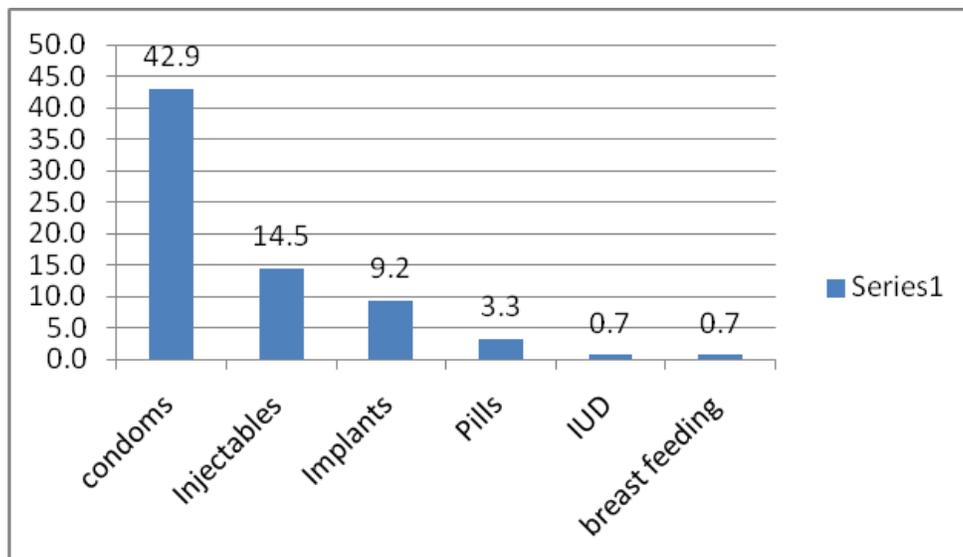


Figure 1: Methods used among current FP users (percent).

Over a quarter of ART clients (26%) reported not having been counseled on FP at an ART visit. Among the 72.8% who had, condoms were the most popular counseling topic (62.8%) and IUDs the least popular (36.1%).

FP Service Audit

Within each of the facilities there are separate, stand-alone service delivery points for FP and HIV/AIDS. The audit took place in the FP unit of each of the 11 health facilities (table 5), with the facility managers completing a written questionnaire. If a question was unanswered or the response was incomplete, the assumption was made that that service was unavailable. All facilities presumably provide referrals for FP, so this topic was not included in the questionnaire. All these health facilities provide at least one of the FP services, as shown in table 6. Ten facilities responded to questions regarding FP counseling, with all reporting that all clients are

receiving FP counseling, though this was not verified through observation. IUD insertion was available only in eight of the facilities. Tubal ligation service was provided in one of the health facilities.

Table 5: Health Facilities Included in the Facility Audit

Facility Name	
1. Yemariam Work Hospital	7. Gendgevada Health Center
2. Addis Ketema Health Center	8. Sabian Health Center
3. Goro Health Center	9. Melka Jebdu Health Center
4. Gendkore Health Center	10. Leghore Health Center
5. Dire Dawa Health Center	11. Bilal Hospital
6. Dilchora Hospital	

Seven of the health facilities had a poster advertising FP services (table 6). There was no place to show the working hours of the FP services in the facility.

Table 6: FP Services/Methods Available

Variable		Frequency	Percent
Posters advertising FP service	Yes	7	63.6
FP counseling provided	Yes	10	100
FP methods available	Male condom	9	81.8
	Oral contraceptives	9	81.8
	Injectable	9	81.8
	Implants	8	72.7
	IUDs	8	72.7
	Natural FP	3	27.2
	Tubal ligation	1	9.1

Only one health facility was not providing any HIV-related service in the FP clinic (table 7). Screening for sexually transmitted infections was done at the majority of the health facilities. PMTCT services were integrated with FP services in three of the facilities.

Table 6: HIV-related services provided by FP clinics

Variable		Frequency	Percent
Any HIV-related service provided	No	1	9.1
	Yes	10	90.9
Type of HIV service offered	General HIV information	10	90.9
	Screening for sexually transmitted infections	10	90.9
	Voluntary counseling and testing	8	72.7
	PMTCT	3	27.2

Vasectomies were not performed in any of the health facilities. Spermicide and female condoms were not available in the majority of them (table 8). Tubal ligation is also rare. The other FP methods were available in most of the health facilities.

Table 7: Status/Availability of FP Methods during Field Visits

Variable	Frequency	Percent
Combined oral contraceptive pills	10	90.9
Progestin only pills	8	72.7
Injectables	10	90.9
Implant	9	81.8
Male condom	10	90.9
Female condom	1	9.1
IUD	9	81.8
Spermicide	1	9.1
Tubal ligation	1	9.1
Total	11	100.0

HIV Clinics

Posters showing availability of ART services were visible in only one of the visited health facilities. There were no FP posters displayed in any of the HIV clinics. Most of the HIV-related services in the city are provided at these 11 HIV clinics. PMTCT service was available in only eight of the 11 health facilities.

Table 8: Available Services at the HIV Clinics

Variable		Frequency	Percent
Poster showing availability of ART services	No	10	90.9
	Yes	1	9.1
FP poster displayed in HIV clinic	Yes	0	0
HIV services available	HIV counseling and testing service	9	81.8
	PMTCT	8	72.7
	ART	11	100
	Ongoing counseling	11	100
	Treatment of opportunistic infections	9	81.8
	Regular follow-up for PLHIV	9	81.8
Provider(s) trained in FP at HIV clinic	Yes	0	0
HIV clinic provides FP services (other than male condoms)	No	4	36.4
	Yes	7	63.6
FP services and methods available in HIV clinic	FP counseling	5	45.5
	Male condoms	9	81.8
	Oral contraceptives	2	18.2
	Injectables	3	27.3

Limited FP services were available in the seven HIV clinics that reported providing FP services. Despite the fact that these were all HIV clinics, condoms were widely available in just nine of the facilities. There was a limited choice of FP methods and those that were available in the HIV clinics were not adequately stocked. No one had been trained in FP. Among the 64% of facilities providing FP services at the ART clinics, integration of services was poor.

Healthcare Providers

Thirteen health workers responded to the questions on availability and quality of services. Training in several areas of reproductive health was lacking; but most notable, none of them had received FP training (table 10). In most of the facilities, there were no systems that could be used to share knowledge and experiences of health workers, such as regular meetings, technical updates, etc.

Table 9: Providers' Responses about FP/HIV Integrated Services in the Respective Health Facilities

Variable		Frequency	Percent
Training received	Comprehensive abortion care	1	7.7
	PMTCT	1	7.7
	ART	7	53.8
	Management of opportunistic infections	1	7.7
	Infection prevention (in clinical setting)	1	7.7
	FP	0	0.0
	No training	4	30.8
Shared knowledge system	No	12	92.3
	Yes	1	7.7

The health providers' perception was that adolescents seem to use FP services more frequently than other groups, despite the fact that they comprised less than 2% of the study's sample size. Clients seem to make most of the decisions in choice of FP method (either themselves or with guidance from the provider), rather than the provider or client's partner (table 11).

Table 10: Characteristics of FP Clients as Perceived by Providers

Variable		Frequency	Percent
Providers' perception of type of clients receiving FP services	Pre ART	8	61.5
	PMTCT	3	23.1
	Adolescent (married or unmarried)	5	38.5
	Unmarried (adolescent or older)	3	23.1
Providers' perception of who makes FP decision*	Client only	5	38.5
	Client with provider guidance	4	30.8

* The responses were from nine providers.

Discussion

The need for FP among HIV-infected women is expected to be higher than the general population of women. The overall FP utilization found in this study was three times higher than the national average (64.3% compared to 28%). But with 20% of respondents reporting that their last pregnancy was unwanted and over 62% expressing a desire for no more children, unmet need for FP was found to be nearly 37%. Because a crude proxy indicator was used to estimate unmet need for spacing and limiting, we expect the actual unmet need to be higher since the other elements needed to measure this indicator were not incorporated.

Despite the data from the 2011 EDHS showing that knowledge of at least one FP method is nearly universal among both women and men,³ of the women questioned in this study, more than one in 10 had not heard of even one FP method. This finding is striking given the large disconnect from the national average and considering that this is a select population of women who interact regularly with healthcare providers, have already sought out sexual health services, and have a higher-than-average need for FP.

Nearly 25% of the study subjects were not counseled on FP methods. Limited orientation of health providers on FP in the HIV clinics could contribute to non-existent or inadequate FP counseling. This represents a significant missed opportunity that exists in the health system for improving unmet need for FP and reducing mother to child transmission of HIV.

Among those who had received FP counseling, they were not counseled on the full range of available FP methods, which limits informed choice. This could have been because providers lacked adequate knowledge of FP methods, did not have many different methods in stock, and/or were reluctant to refer elsewhere for the woman's preferred FP method. There seem to be limited channels of communication for health providers to inform HIV clients on the importance of FP. Programs should explore more channels of communication to improve this, such as using information, education, and communication (IEC) materials, health extension works, radio and television.

The integration of FP services into HIV care and treatment services was assessed using different parameters. The findings point to unsatisfactory integration in Dire Dawa despite the evidence showing improved FP use among HIV clients when the services are integrated with HIV care.¹¹

The potential for integrating FP into HIV clinics should be exploited to improve the existing unmet need for FP. The best option would be integration of FP services into HIV chronic care units. It requires training HIV service providers on FP methods and indications, providing IEC materials in these units, and availing required FP logistics. This entails having FP commodities located in the same room where HIV services are provided, and with the same provider. This will enable the HIV clinic service providers to provide appropriate and more holistic support to their client. Other studies on the perspectives of providers have also made consistent recommendations in this area.¹²

Availing this service can be considered as one-stop shopping, as the patients would not be expected to visit different units, which creates barriers with additional waiting time and

potentially a separate visit to the facility. Considering the stigma associated with HIV, people may wish to limit their interactions with health providers and may not be willing to visit other service outlets.

The other option is to have a strong referral system or linkage between the two service delivery points, which requires additional efforts on the part of both units to ensure referrals have reached their destinations. But again, there are key components that must be in place for an effective referral system, such as available and trained providers, a selection of contraceptives, and limited stockouts of FP commodities, to name a few.

Including facility audits and provider interviews improved the strength of this study. This made the review comprehensive and improved understanding of the existing situation from different perspectives. Focusing on clients who have been in chronic care may limit the generalizability of this study finding. As a result of the sensitive nature of some of the study questions, social desirability bias could have affected the conclusion and interpretation of this finding.

Conclusion and Recommendations

Despite FP use among the women receiving chronic HIV care services being higher than the national average, it lags in relation to the number of women reporting a desire to not be pregnant again. Thus, the high unmet need for FP among patients in chronic HIV care needs to be addressed.

Most of the health facilities were not providing FP services integrated with HIV care and among those that were, key components of integrated services were lacking. There was a shortage of necessary FP supplies in the HIV/AIDS care and treatment units and a serious lack of FP training among the providers in these units, resulting in missed opportunities for FP counseling.

Among many of the providers interviewed, there was a misconception that most of the clients were adolescents, perhaps not needing FP counseling or methods, when in reality the vast majority of the clients presenting at the HIV/AIDS care and treatment units in this study were married/cohabitating mothers over 24 years old. Furthermore, with slightly more than 10% of the PLHIV in this study having no knowledge of any FP method, this points to the fact that information about contraception and FP methods is largely absent in these facilities.

Based on these conclusions, we recommend improving the capacity of health workers in chronic HIV care clinic to provide FP services, including counseling. Appropriate IEC materials should be made available and distributed to improve the FP knowledge of clients. Lastly, an uninterrupted supply of FP commodities must be ensured to adequately respond to demand for FP services.

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