



Nigerian Urban Reproductive Health Initiative

**STRATEGY
FOR
INTEGRATING FAMILY PLANNING INTO
MATERNAL, NEWBORN CHILD HEALTH
AND HIV/AIDS SERVICES**



DEFINITION

Integration in the health sector has been defined as offering two or more services at the same facility during the same operating hour, with the provider of one service actively encouraging clients to consider using the other services during the same visit, in order to make those services more convenient and efficient. Integrated services should be offered at the same service delivery point but where that is not feasible, strong referral systems are required to ensure that clients receive the high quality service that they deserve(National Guidelines for the Integration of Reproductive Health and HIV Programmes in Nigeria (FMOH, 2008).

KEY AREAS FOR CONSIDERATION FOR INTEGRATION

Under the NURHI project, the focus will be on integration of Family Planning into the following services:

1. Maternal Newborn and Child Health Services
2. Post abortion care services
3. HIV/AIDS services

STRATEGY

The underlying objective for integrating FP into the above services is to increase FP uptake and thus raise CPR. To that effect, NURHI integration strategy will be implemented in a phased manner starting with high volume services that have potential for dramatic increase in FP service uptake. NURHI integration strategy will first be implemented in HVS, which have high volumes of births. The clinical areas which have potential to provide highest increase in FP uptake are listed in decreasing order:

1. Delivery
2. ANC
3. Immunization
4. Post Abortion Care (PAC)
5. PMTCT
6. ART
7. HCT

Under each of the above, specific integration approaches to be deployed will include any or all of the following:

1. Information, Education and Communication (IEC) materials
2. Referral information
3. FP counseling
4. FP service provision using specific approaches

TABLE I - SUMMARY OF INTEGRATION STRATEGY

S/NO	Service area	Integration Strategy
1	Delivery	<ul style="list-style-type: none"> - IEC - One –on – One Counseling - Couple Counseling - Immediate Post Partum IUD - Referral
2	ANC	<ul style="list-style-type: none"> - Group Counseling - One-on-One Counseling at 36 weeks - FP Method selection at 36weeks - Link to immediate post partum IUD(IPPIUD)–immediately following placental expulsion and up to 2 hours
3	Immunization	<ul style="list-style-type: none"> - IEC materials - Group Counseling - Referral to nearest FP clinic
4	Post Abortion Care	<ul style="list-style-type: none"> - IEC - FP counseling - FP service provision - Referral to FP clinic for methods not available
5	GOPD	<ul style="list-style-type: none"> - Group counseling - IEC - Referrals -
6	PMTCT	<ul style="list-style-type: none"> - IEC using existing PMTCT FP IEC materials - One-on –one counseling - Referral to FP clinic
7	HCT	<ul style="list-style-type: none"> - IEC - One –on –one Counseling - Referral to FP clinic
8	ART	<ul style="list-style-type: none"> - IEC - Group Counseling - Referral to FP clinic

BASIC REQUIREMENTS

The following are basic requirements for successful implementation of planned strategies:

A. Delivery/ Postpartum FP integration

1. IEC
Specific IEC materials on Immediate Postpartum IUD would have to be developed for women (1 – mode of action, possible side effects, benefits, follow up plans, 2 – IEC materials on other methods including lactational amenorrhea (LAM))
2. Counseling (One –on – Counseling & Couple Counseling)
This will be necessary especially in areas with high rates of unbooked women coming in to deliver. Such women would have had no contact with ANC or FP counseling. Similarly, some cases that may end up with emergency C/sections may desire BTL and therefore there is a need to counsel women before they sign the consent for surgery. Training on FP counseling is thus a mandatory requirement for all delivery suite staff.
3. Immediate Post partum IUD insertion within 2 hours of delivery. The basic requirement will include:
 - a. Training of Doctors and all Midwives taking deliveries per site on LTM and IPPIUD)
 - b. Record Keeping – Managing FP records for follow up in the FP clinic
 - c. IUD stock in the labour ward linked to the CLMS
 - d. Assuring availability of constant stock of elbow length sterile/high level disinfected (HLD) gloves and ring forceps at all delivery suites and labour rooms
4. Other methods:
 1. Referral link for BTL service when needed (Minilaparotomy – Puerperal and Interval BTL)¹
 2. Referral Link to the FP clinic in the Facility where needed

B. ANC

All sites that will have Post partum IUD program must be linked to an active integration segment at the ANC. Normally, Group Counseling is conducted in all ANCs. Limited One-on-One counseling is done at booking and in clinics offering PMTCT. This however is not detailed in FP and usually women are not counseled so that they can select a method during ANC visits.

For FP/ANC integration, which is an integral component of the IPPIUD, counseling is planned to be conducted as follows:

1. Group Counseling at ANC visits in pregnancy
2. One-on –One counseling at 36 weeks that culminates in method selection/acceptance or rejection
3. Linking counseled pregnant women to the delivery suite IPPIUD

¹Due to potentially low yield from permanent methods of contraception, NURHI will not actively invest in Tubal ligations. However, in view of the fact that most of the NURHI supported cities (Kaduna, Zaria, Ilorin) in the North, have high birth rates, the need for voluntary permanent method by couples need to be considered. Additionally, most of the High volume sites have the expertise and facilities to provide tubal ligations either as minilaparotomy under local anaesthesia or as elective surgery. Consequently, NURHI will support the collation and documentation of information about sites offering BTLs and vasectomies. Labour ward and gynaecology ward staff will be trained to proactively capture BTL and vasectomies in FP registers. Information on sites providing permanent methods will be shared with the FPPN members to facilitate referral.

4. May consider having video/educational sessions on PPIUD in the delivery suite or ANC for prospective clients to acquaint themselves with method - This is similar to the PMTCT videos being used by HIV/AIDS programs.

C. PMTCT

Sites offering PMTCT will have FP /PMTCT integration.

1. One-on –one counseling
2. Link to appropriate FP methods
3. IEC materials.
4. Training of PMTCT midwives on FP counseling

D. Immunization

Integration of FP into immunization services is one of the areas likely to provide high yield of FP uptake in view of the high volume records of immunization services. The strategy will involve:

1. IEC materials on all methods and integration of FP and LAM messages
2. Group Counseling.
3. Referral for prospective clients to the FP clinic

E. Post Abortion Care - PAC/FP

NURHI will integrate FP where PAC services exist. The strategy will include:

1. Provision of FP counseling (one –on –one) to all PAC clients
2. Provision of FP services
3. Referral to FP clinic for other FP methods not available at the PAC service point.

Note: 2 critical areas will have to be addressed in order for PAC/FP to be successfully deployed in selected high volume sites:

1. Logistics management of contraceptives. Contraceptives that will be made available to the PAC or MVA unit will be part of the general FP clinic commodity stock and should be managed as such.
2. FP clinic cards to be used for PAC or MVA clients over weekends and after FP clinic hours will be housed within the MVA unit but should be routinely transferred to the FP clinic for follow up. Ensuring numbers given to women receiving services in MVA/PAC units mustmatch with the overall FP clinic numbers.Follow up schedule can be challenging and must be adequately addressed.

F. HCT

Where stand-alone HCT centers exist, the strategy will include

1. IEC using IEC materials such as posters, handbills, cue cards etc. that provide information on all methods.
2. One-on-one Counseling as part of the HIV one-on-one pre and post test Counseling. Providers of HIV counseling will therefore need to be trained in FP counseling
3. Referral information and referral to FP clinic.

G. ART

In view of the fact that ART services have been fully integrated into medical clinics, the high client load of the ART clinics, numbering thousands in high volume sites, can be targeted for FP through the existing providers of ART services. To that effect, the following will be employed:

1. IEC availability at the Medical outpatient clinics where ART clients receive services.
2. IEC materials need to be developed for specific FP methods most suited for HIV clients.
3. Training of Doctors, Nurses and Pharmacists (who dispense ARVs) to HIV positive clients on FP counseling.
4. Referral to FP clinic.

H. Contraceptive logistics Management for integration points

The FP provider at the FP clinic will be responsible and accountable for all contraceptive stock at the integration points (Delivery suites and MVA/PAC sites). S/he conducts regular tracking and reconciliation of all stock and ensures there are no stock outs.

I. Record keeping for integration points

All integration points (Delivery suites, PAC sites, immunization units, HCT sites, ART sites and GOPD) will have FP registers that capture counseling and methods. The statistics will form part of the monthly service statistics at the FP clinic. Additionally, FP cards will be made available at the delivery suites and PAC/MVA rooms. These cards should be returned to the FP clinic immediately after the service is provided for further follow up.

J. Referrals

All integration points will have the comprehensive list of all FP clinics, FP providers and their contacts for the purpose of an effective 2-way referral. These will be pasted on the walls for ease.

Referral slips (in triplicate) will also be made available to all integration points

