Integrating family planning and reproductive health services in primary health care: the Rwandan model.

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1. Significance/background

Integration of services for sexual and reproductive health (SRH) is globally recognized as beneficial to both clients and health providers with improvements in quality and efficient use of resources. Yet even with the increasing attention to the experience of the client, decisions surrounding where and when to offer services as part of an integrated package have implications for health systems. Although there is a growing body of evidence, research is still needed to determine and demonstrate the value of SRH integration in different settings and situations. The Ministry of Health (MOH) Rwanda, in collaboration with its partners, continues to put in place different strategies to accelerate the reduction of maternal mortality and to improve the access to quality sexual reproductive health and rights. As part of these efforts, the MOH and RBC collaborated with Bixby Center of the University of California, Berkeley to design and implement a model for integrating FP into all SRH services. The resulting intervention relies on a client-centered approach to provide high quality, integrated, comprehensive SRH services which include abortion and post-abortion family planning (FP) services with emphasis on long acting reversible contraception (LARC).

2. Program intervention/activity tested

We utilized a client-centered approach to provide high quality, integrated comprehensive abortion and post-abortion family planning services with emphasis on long-acting methods. Using a collaborative process, the Bixby Center: i) assessed the needs for training, policies, guidelines, procedures, and related matters; ii) designed and implemented a replicable model of service integration in one district; and iii) designed and implemented strategies to increase uptake of post-abortion family planning, with special attention to long-acting methods. Specific objectives of the integration project were to: 1) develop and implement an integration package that includes relevant changes to policies and strategies, provider trainings, job aids, and information, education and communication (IEC) materials; 2) ensure that

appropriate supplies (i.e. commodities, drugs, equipment/kits) are available; and 3) establish indicators to measure integrated services, supportive supervision, reporting tools and HMIS changes.

3. Methodology (location, setting, data source, time frame, intended beneficiaries, participant size, evaluation approach)

The integration program trained providers and provided relevant supplies and materials to 33 total health facilities in the districts of Huye and Musanze; 15 public and 2 religious health centers in Huye, and 14 public and 2 religious health centers in Musanze. Providers were trained to offer counseling, testing, and treatment services for a multitude of SRH indicators to ensure clients received as many aspects of care as needed from one point of service. Family planning materials, including contraceptives and post-abortion care supplies, were provided to participating health facilities.

Data for this study come from ongoing data collection, in which providers complete an intake form that obtains information on client socio-demographics and services received. We collected data on age, sex, and reason for consultation, as well as whether the client received counseling or testing on SRH services and cancer screenings. These included FP method, PAC, GBV, HIV, STI, cervical screenings, and breast cancer. Information was collected on whether the client was referred to the center or service, and if they were referred out to another service. The provider also recorded his/her qualification level and whether he/she was trained on the integrated SRH program.

We used data from the first three months of the program, September through November 2016, to review the program and proceeded with implementation of relevant program improvements.

4. Results/key findings*

Preliminary results demonstrated that 7,444 female clients were seen across the 33 health facilities of Huye and Musanze over the three month time period. Among these women, 3,703 were not pregnant and not already using an FP method, indicating they were eligible to receive an FP method. Nearly half (46.1%) of these 3,703 women received a contraceptive method, with 44.5% of the 1,708 new users having obtained their method outside of FP services.

Nearly all (98.9%) clients who went to the FP service received a contraceptive method. Among those who went for post-natal care (PNC) services, 65.4% received a method, and 48.5% of those attending for HIV services received a contraceptive. Almost half (43.8%) of clients in the Youth Corners received an FP method. Only 23.6% of women in Maternity services obtained a method.

The method most commonly adopted was the implant, with 886 new users across all three months, and 223 new IUD users. These 1,109 LARC users accounted for 64.9% of all FP adopters, followed by the injectable at 17.9% of all new users.

We l continue to input data for 2017 to assess changes in FP uptake within these health facilities and assess the effectiveness of integration over time.

5. Program implications/lessons

SRH and sustainable development are inextricably linked. Health and development share common determinants and goals, such as delivering on the promise of health, gender equality and human rights for all. Integrating sexual and reproductive health services makes sense given the overlapping and interconnected behaviors and needs involved in the preventing and treating sexually transmitted infections (including STI and HIV), screening for and treating certain cancers and controlling fertility, through contraception or childbearing. However, the effect of structural integration on uptake of different FP methods, especially after abortion services has not been adequately addressed in the literature. Rigorous data and thoughful frameworks are cruical to expanding the evidence base. The review of this program demonstrated that integration of SRH services leads to family planning uptake, and particularly high LARC uptake, in different service delivery contexts. The integration program exposed clients to different types of SRH care that they might not otherwise have been offered, and led to mot of all eligible clients adopting a contraceptive method. These data indicate that integration has a positive impact on client SRH service utilization particularly those who would not have used a traditoinal FP clinic.