

# A Five-Country Study of Family Planning and HIV Integrated Services

Family Planning

HIV/AIDS

## Key Points

- The base service must be strong enough to absorb the new service. If it is not, decision makers must determine how to improve the base service before considering the needs and costs of the added service.
- Programs must improve training to ensure that providers can apply World Health Organization medical eligibility criteria for contraceptive methods to all clients, regardless of HIV status.
- Screening for unmet family planning needs must become a standard element of HIV services, and should be routinely updated in client records.
- In many settings FP services provide an excellent opportunity to discuss HIV risk assessment and to offer rapid, on-site testing for those in need.

A growing international dialogue on the feasibility and desirability of providing integrated family planning (FP) and HIV services prompted examination of existing programs and recommendations for integrated services. This study was undertaken to provide a “snapshot” of early efforts in five countries, in order to provide information that programs can use to improve integrated FP/HIV services.

The reasons for offering integrated services are many. Adding FP services to HIV counseling and testing might reach populations that do not typically attend FP clinics, such as youth, men, or sex workers. Adding FP services to HIV care and treatment might increase contraceptive use by HIV-positive individuals, helping to maintain health, plan safer pregnancies, and reduce the rate of mother-to-child transmission of HIV. Including HIV services in FP services could lead to earlier diagnosis and referral to treatment.

## Methodology

Following a review of literature and program reports, researchers selected five countries for the study: Ethiopia, Kenya, Rwanda, South Africa, and Uganda. Programs in the study followed one of three models of integrated services: family planning in HIV counseling and testing (FP-CT), family planning in HIV care and treatment services (FP-C&Tx), and HIV services (particularly counseling and testing) in family planning (HIV-FP).

Programs were included if they had:

- A deliberate strategy defining the implementation of integrated services
- Delivery of integrated services for a minimum of three months
- Three or more facilities delivering integrated services

More than 100 policymakers, stakeholders, donor agency staff, people living with HIV or AIDS, and public and private program managers participated in guided interviews. Managers, providers, and clients at 102 clinics completed structured questionnaires. A structured observation was conducted at each clinic. Family Health International was responsible for field activities in Kenya, Rwanda, South Africa, and Uganda. Macro International engaged a local field team in Ethiopia. Field work was carried out between August 2007 and June 2008.

Researchers examined these indicators:

- The percentage of women in need of FP or HIV services (client unmet need)
- The preparedness of programs to meet need (clinic readiness, provider preparation, provider attitudes)
- The level of integrated service provision (services delivered and received)
- The availability of data to monitor integration (monitoring and evaluation)

## Findings and Recommendations

**Client unmet need.** The unmet need for family planning services was higher for CT than for C&Tx clients because a higher percentage of CT than C&Tx clients are sexually active. For example, unmet need for FP in CT ranged from 17 percent in Ethiopia to 46 percent in South Africa while unmet need in C&Tx was less than 20 percent across all countries. More women attending both of these services used condoms than did the general population. However, condom use was sometimes reported as being inconsistent, and therefore the risk of unintended pregnancy remains high. There is no standard to assess risk of HIV infection and, therefore, unmet need for testing among FP clients. Need is low if the measure is restricted to those with multiple partners and no or inconsistent condom use but high if all women who do not use condoms are included.

*Some integration is taking place through necessity rather than through design.*

—Researcher, South Africa

*Integration is still novel. The national Department of Health is thinking integration is there, but ‘disintegration’ is still the norm.*

—Program manager, South Africa

*Clinic readiness, provider preparation, provider attitudes.* There were some weaknesses in the capacity to deliver the base service, including family planning commodity and HIV test kit stock outs in virtually all services during the prior six months and lack of informational materials. If the base service is not strong enough to absorb the new service, decision makers must determine the resources needed to improve the base service, including training, materials, infrastructure, and supervisory support.

Up to two-thirds of providers had some “non-busy” time during the day, indicating work loads do not preclude offering additional services.

Health officials could modify work patterns to more evenly distribute services and encourage clients to seek services throughout the day.

Among CT providers, up to two-thirds lacked the training needed to offer FP services and as many as 80 percent did not have the job aids and supportive supervision needed to facilitate integrated service delivery. Many providers were apparently unaware of recently updated World Health Organization (WHO) medical eligibility criteria regarding contraceptive use by HIV-positive women, and there was significant misunderstanding about their use of methods such as pills and intrauterine devices. While providers advocated condoms for HIV-positive women, with only one exception no more than 40 percent did so for HIV-negative women. Programs should calculate the cost of improving services and prioritize interventions for training, materials provision, and improved supervision. Pre-service and in-service training should ensure that providers (1) understand and accept WHO medical eligibility criteria, and (2) promote condoms both to reduce transmission from infected partners and to protect uninfected partners.

*Services delivered and received.* As many as 60 percent of CT clients and 30 percent of C&Tx clients were not being systematically screened for unmet need for FP. Providers in C&Tx were more likely than those in CT to discuss family planning. However, few clients in either CT or C&Tx received a method. Better mechanisms are needed to ensure that providers of HIV services screen for unmet need, counsel on a full range of contraceptive options for clients, and either offer methods on site or refer to a nearby FP clinic.

In FP facilities, the percentage of women who said that their provider discussed HIV topics was so low as to be of concern; no more than one-third discussed risk reduction or condom use. However, in three of four countries for which we had data, more than half the women had been tested prior to the current visit, possibly indicating that counseling on HIV testing is widespread from other sources. Nevertheless, FP providers should give a higher priority to discussing the risks of HIV and to promoting testing and safer sex. Clients not previously tested within a conventionally recognized time frame should be tested again to update their status.

*Monitoring and evaluation.* Most services routinely recorded client information, but most do not track integrated service data. No more than 45 percent of FP clinics recorded HIV test information, and only one-third of the CT sites in Ethiopia, Kenya and Rwanda recorded FP data. Without routine data collection, it is difficult to measure the successful implementation of integrated services and the effect on contraceptive uptake or increased HIV testing. Consensus must be reached on standard indicators of integration, and they should be added to health information systems.

## Conclusion

Much remains to be done to offer fully integrated family planning and HIV services and to develop effective, scaleable models. Findings from this study suggest that many opportunities are missed in integrated service delivery settings to address the dual family planning and HIV prevention needs of clients. As integration efforts continue to expand in the field, interventions must be strengthened and accompanied by evaluations that identify elements that are critical to achieving and sustaining integrated services.

As yet, little evidence exists to indicate that one model of FP/HIV integration offers strong advantages over another. In fact, the mode of service delivery most likely should be tailored to the individual clinic situation. Decision makers must consider the human and financial resources available and make rational decisions about the type and level of integration to pursue based on local data. The characteristics of clients and local availability of complementary health services should guide those decisions.



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publications@fhi.org.

Family Health International  
P.O. Box 13950  
Research Triangle Park, NC 27709 USA  
Tel: 1.919.544.7040  
E-mail: publications@fhi.org  
www.fhi.org

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