



Country Assessment: Kenya

Family Planning Needs in the Context of the HIV/AIDS Epidemic

October 2004



In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.

Acknowledgments

On behalf of the assessment steering committee, Family Health International (FHI) would like to thank the United States Agency for International Development (USAID) for its financial support of this project.

We also owe a large debt of gratitude to the Kenyan Ministry of Health for its leadership and support during this assessment, and to the following members of the steering committee, whose valuable input throughout the project, collaboration during the fieldwork, and interpretation of the findings made this initiative a success:

Dr. Ominde Achola, Commonwealth Regional Health Community Secretariat
Dr. Beatrice Aluvaala, Christian Health Association of Kenya
Ms. Margaret Gitau, National AIDS and STD Control Program
Dr. Maina Kahindo, Family Health International
Dr. Paul Kizito, National Council for Population and Development
Mrs. Rose Mutua, National Nurses Association of Kenya
Dr. Olakhi Odongo, Kenya Medical Association
Dr. Josephine Ojiambo, Kenya Medical Women's Association
Dr. Omondi-Ogotu, Kenya Obstetrical and Gynaecological Society
Dr. Marsden Solomon, Ministry of Health/Division of Reproductive Health
Dr. Njoroge Waithaka, Kenya Medical Association

We would like to acknowledge FHI staff members Dr. Ndugga Maggwa, Dr. Pierre Ngom, Maureen Kuyoh, and Rose Wilcher for their conceptualization and technical oversight of the assessment process, and Dr. Joshua Kimani, Dorcas Kungu, and Ruth Gathu for their assistance with project implementation.

Finally, FHI would like to extend its appreciation to Prof. Japheth Mati for the technical leadership and logistical support he contributed to the project, including the preparation of this report, and to Kathleen Henry Shears for editing the report.

Table of Contents

Abbreviations	iv
Key Findings.....	1
Introduction.....	1
Family Planning in Kenya.....	2
HIV/AIDS in Kenya.....	3
Policies, Strategies and Guidelines	4
Policy Gaps	5
Resources for Family Planning and HIV/AIDS Programs	5
Current Status of Family Planning and HIV/AIDS Services	6
Family Planning Services	6
HIV/AIDS Services	7
Family Planning in the Era of HIV/AIDS	8
Impact of HIV/AIDS on Family Planning Practice	8
Family Planning Needs of HIV-positive Individuals and Couples.....	9
Linkage of HIV/AIDS and Family Planning Services.....	9
Integration Opportunities	10
Recommendations	11

Abbreviations

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral therapy
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
CYP	Couple-years of protection
DMPA	Depot-medroxyprogesterone acetate
FHI	Family Health International
GOK	Government of Kenya
HBC	Home-based care
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IUCD	Intrauterine contraceptive device
KDHS	Kenya Demographic and Health Survey
NASCOP	National AIDS and STI Control Program
NGO	Non-governmental organization
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive Health
TFR	Total fertility rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Key Findings

- **A dramatic shift in priorities and resources to HIV/AIDS programs threatens to reverse the historic gains made over the past two decades by Kenya's once-strong family planning program.**
 - **A deteriorating health care system limits access to family planning and HIV/AIDS services and compromises the quality of both services.**
 - **Integrating family planning and HIV/AIDS services offers an opportunity to make the best use of available financial and human resources to provide comprehensive, convenient health care.**
-

Introduction

Family planning services can prevent mother-to-child transmission of HIV by helping HIV-infected women avoid unwanted pregnancies. Contraceptive barrier methods, such as male and female condoms, protect against sexual transmission of the virus. Yet, despite the potential contribution of family planning to preventing HIV/AIDS, most HIV/AIDS prevention and care efforts are evolving as separate, vertical programs that do not provide traditional reproductive health services.

Responding to concerns that HIV/AIDS programs are diverting attention and resources from comprehensive reproductive health services, the U.S. Agency for International Development (USAID) asked Family Health International (FHI) to assess how the epidemic has affected family planning needs and services in three African countries: Kenya, South Africa, and Zimbabwe.

In all three countries, FHI, in collaboration with the Commonwealth Regional Health Community Secretariat, reviewed published and unpublished literature on family planning and HIV/AIDS epidemiology, policies, and programs and assembled a team of experts to conduct a field assessment. FHI formed a local steering committee in each country to provide technical oversight and ensure the assessment produced information that was locally relevant. The steering committees were composed of representatives from in-country governmental and nongovernmental institutions working in family planning and HIV/AIDS.

In Kenya, the Ministry of Health was a key collaborative partner on the assessment, with representatives from the Division of Reproductive Health and the National AIDS and STI Control Program (NAS COP) serving as co-chairs of the steering committee. The field assessment was conducted in Nairobi and nine districts in five different provinces in

March 2004. Assessment team members interviewed 280 policy-makers, donor representatives, program managers and implementers, service providers, and opinion leaders from the public and private sectors, including nongovernmental and faith-based organizations. A summary of findings from the desk review and field assessment in Kenya is presented here. A more detailed report is available from FHI.

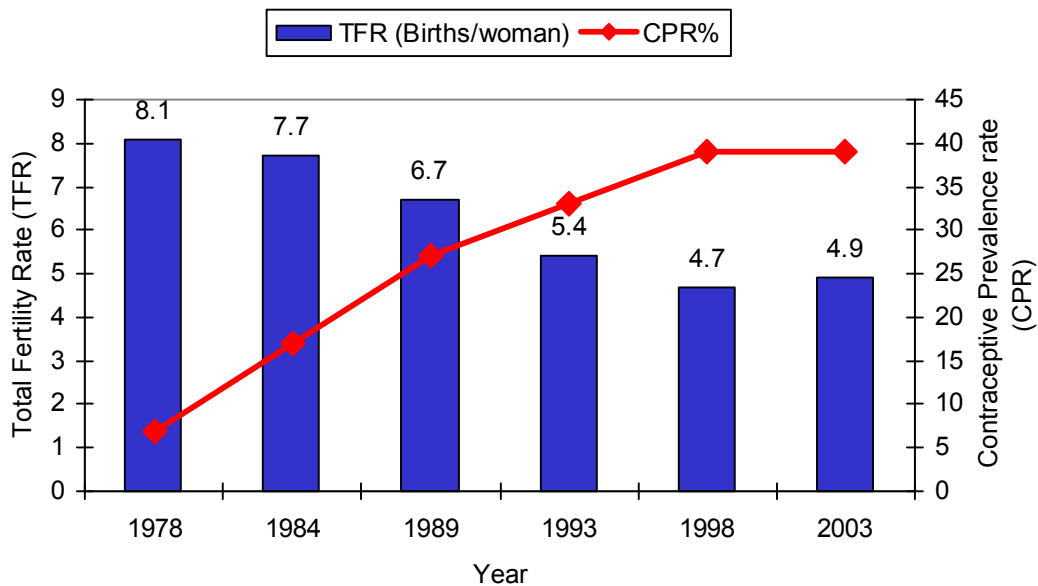
Family Planning in Kenya

Contraceptive practice increased steadily in Kenya during the 1980s and 1990s. By 1998, the contraceptive prevalence rate (CPR) had reached 32 percent for modern methods and 39 percent for all methods. Widespread use of modern methods is considered the principal cause of Kenya’s historic fertility decline and reductions in its annual population growth rate. From the mid-1970s to 1998, the total fertility rate (TFR), or average number of births per woman, dropped from 8.1 to 4.7 -- a decrease of 42 percent in 20 years.

Between 1993 and 1998, however, the annual rate of increase in the CPR dropped from nearly 2 percent to 1 percent. The most recent data, from the 2003 Kenya Demographic and Health Survey (KDHS), show that the CPR appears to have reached a plateau at approximately 38 percent.

The results of the 2003 KDHS also suggest that the declining fertility trend of the past two decades has stalled. TFR is reported as 4.9, compared with 4.7 in the 1998 KDHS. The steepest drop in TFR occurred during the late 1980s and early 1990s, and its descent slowed during the mid-1990s (Figure 1).

Figure 1: Trends in CPR and TFR in Kenya: 1978-2003



The 1998 KDHS reported an unmet need for family planning of 24 percent. This estimate, combined with the percentage of women already using a contraceptive method, shows a demand for family planning services among two-thirds of married women in Kenya.

Depot-medroxyprogesterone acetate (DMPA) is the preferred family planning method in Kenya, contributing to more than half of couple-years of protection (CYP) from pregnancy, followed by pills and condoms. Data on contraceptives distributed in Kenya in 2002 indicate that condom use was responsible for 11 percent of CYP, but in the 2003 KDHS, less than 2 percent of married and sexually active unmarried women reported using condoms as a contraceptive method. The difference in the relative importance of condoms reflected in these statistics suggests that condoms are used more often for protection against HIV and other sexually transmitted infections than for contraception.

The use of oral contraceptives decreased from 11 percent in 1993 to 8.5 percent in 2003. The 2003 KDHS also shows a decline in female sterilization and the use of intrauterine contraceptive devices (IUCDs) -- both methods that require greater clinical attention, and are therefore more likely to suffer where the health system is not efficient.

Young people, ages 10 to 25, make up more than one-third of Kenya's population. About 21 percent of all teenage women -- and 45 percent of 19-year-olds -- included in the 1998 KDHS were either mothers or were pregnant at the time of survey.

HIV/AIDS in Kenya

Kenya has the fourth highest number of HIV-infected people among countries worldwide, and ranks seventh in proportion of population infected. By the end of 2001, about 2.5 million Kenyans were living with HIV, and 1 million had died of AIDS.

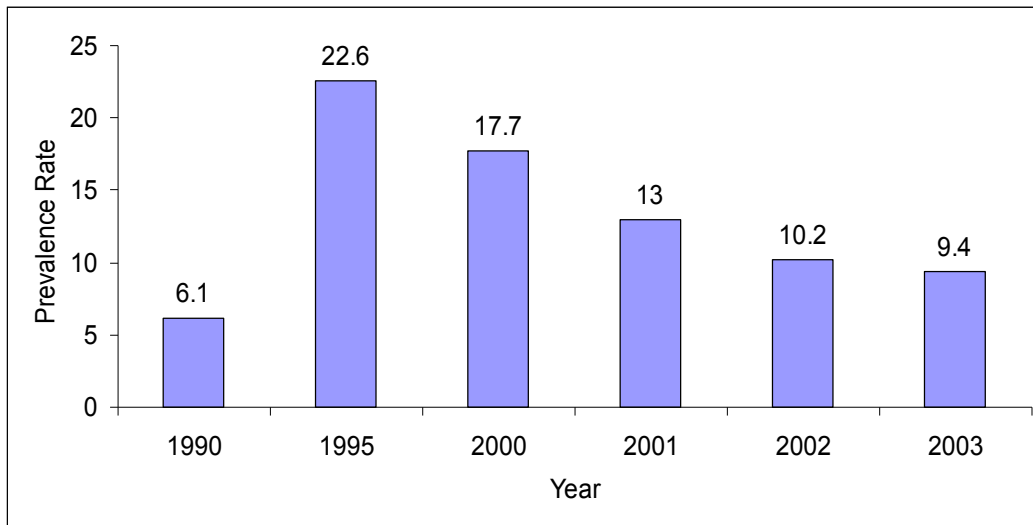
According to Ministry of Health sentinel surveillance data for women seeking antenatal services in Kenya, HIV prevalence rates rose steadily during the 1990s, reaching a high of 22.6 percent in 1995. Since then, sentinel surveillance data indicate that HIV prevalence rates have been declining, reaching 9.4 percent in 2003 (Figure 2). The 2003 KDHS estimated that 6.7 percent of the adult population was infected with HIV. Despite these encouraging signs, HIV/AIDS continues to pose a serious threat to public health and to all sectors of the Kenyan economy.

In Kenya, as in most of sub-Saharan Africa, HIV is a gender issue. Approximately 1.4 million women are living with HIV, and between 1999 and 2001, the ratio of infected women to men increased from 1.2 to 1.5 to 1. Among girls ages 15 to 19, HIV prevalence is 3.5 percent -- seven times higher than the rate (0.5) for teenage boys.

HIV/AIDS is the leading cause of orphaned children in Kenya. UNICEF projects that the number of orphans in the country, currently estimated at 1.3 million, will reach 2.1 million by 2010. Orphans and other children made vulnerable by AIDS face many

challenges, including the risk of exposure to HIV infection, sexual abuse, and teenage pregnancy.

Figure 2: Trends in HIV prevalence rates in Kenya: 1990-2003



Source: NASCOP, Ministry of Health, 2003

Policies, Strategies and Guidelines

There is no apparent conflict between Kenya's HIV/AIDS and family planning policies. Some policies specifically recognize the family planning needs of HIV-affected people. Several policies and strategies -- particularly those addressing reproductive health -- mention the links between family planning and HIV/AIDS. Kenya's national HIV/AIDS policy states that voluntary HIV counseling and testing (VCT) among people of reproductive age provides information that can enhance decisions regarding fertility. The country's VCT guidelines currently present family planning as a major component of VCT services.

However, neither family planning nor HIV/AIDS policies are disseminated to or implemented by service providers at all levels. Stakeholders such as provincial and district health officials and members of key professional bodies said that they were not adequately engaged in forming policy, a process they perceived as coming from the top down.

Key informants agreed that dissemination of policies to the grassroots was hampered by high turnover among health professionals, poor communication and supervision, and reduced training opportunities for service providers. Weak delivery systems and a lack of demonstrated political will, particularly in support of unpopular actions such as providing condoms and family planning services to youth, were identified as significant barriers to implementing effective policies. Key informants also thought poor monitoring and evaluation policies made it difficult to allocate resources efficiently.

Policy Gaps

Although Kenya has no shortage of policies and strategies that address family planning and HIV/AIDS, an analysis of those documents and interviews with key informants revealed several critical gaps:

Comprehensive RH policy: Kenya has a reproductive health strategy and family planning guidelines, but no actual policy on comprehensive reproductive health.

Setting priorities: The government has not clearly stated the priority status of family planning. In addition, the absence of a Health Master Plan with clear priorities and identified needs leaves donors to set health service priorities, leading to an over-concentration of resources in some interventions and geographical areas.

Integration: Most policies that require implementation at the district level are vertical, leaving little room for the integration of family planning and HIV/AIDS services.

Monitoring and evaluation: A monitoring and evaluation policy that is poorly implemented and lacks clear indicators makes it difficult to measure outcomes and gain support for evidence-based interventions.

Private sector role: Policies and guidelines do not clearly address private and public sector partnerships and the policies are not disseminated within the private sector. Along with charitable bodies and faith-based organizations, the private sector is the source of health services for about half of all Kenyans seeking care.

Resources for Family Planning and HIV/AIDS Programs

“Family planning is now dying as HIV comes up. – District Health Management Team member

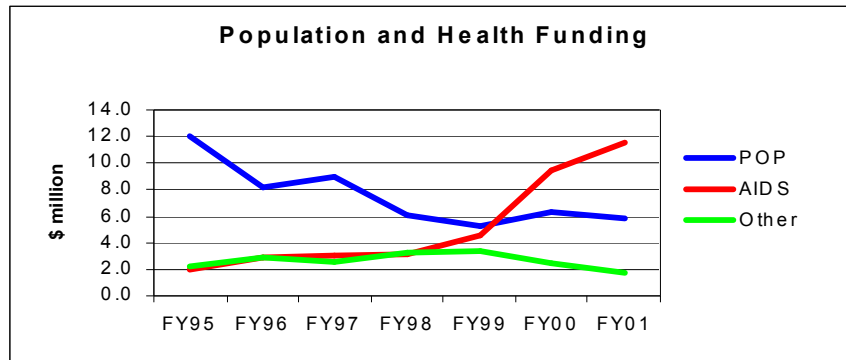
The proportion of the Government of Kenya (GOK) budget allocated to health decreased steadily from an estimated 10 percent in 1980 to 4 percent in 1999. User fees were established in the late 1980s and that cost-sharing revenue has helped offset the full impact of the decline in government funding. It is not known, however, whether any cost-sharing funds support family planning or HIV/AIDS activities.

International donors play a major role in supporting family planning and HIV/AIDS programs in Kenya. From 1995 to 1997, for example, they funded 77 percent of the annual government family planning expenditure of about US\$20.8 million; the rest came from the GOK, with the assistance of a World Bank loan. International donors have also been the sole suppliers of contraceptive commodities.

Over the past decade, funding for family planning has plummeted, while HIV/AIDS allocations have soared. For example, USAID/Kenya -- the leading donor to the Kenyan population program -- cut its support for family planning by one-third from 1995 to 2002,

while increasing its funding for HIV/AIDS programs six-fold (Figure 3). In 2004, USAID budgeted US\$35 million for HIV/AIDS and US\$6 million for family planning in Kenya.

Figure 3
Trends in USAID Funding – 1995/2001



Source: USAID/Kenya

In the past few years, the main donors have channeled more funds through the Treasury than to NGOs, reversing the funding trend during most of the 1990s. As a result, many reproductive health and family planning programs and services operated by NGOs have been discontinued or severely curtailed.

Current Status of Family Planning and HIV/AIDS Services

Family Planning Services

Key informants said that most private and nongovernmental organizations have switched to HIV/AIDS activities “where the money is” and therefore, the public sector has become the main option for those seeking family planning services. Key informants rated the following components of these services as poor: government support and commitment, supervision, incentives to staff, availability of supplies, transportation, and accessibility of services to youth and men. International support and commitment, staff skills, record keeping, service accessibility to women, and quality of care were considered average. Similar components of HIV/AIDS services received average ratings.

Challenges in providing family planning

All five provinces included in the assessment suffer from a shortage of trained staff, due mainly to an embargo on hiring within the civil service. Training funds have also been reduced, limiting the availability and quality of training. Many providers said that their knowledge of family planning methods was not up-to-date and that they lacked the skills needed to serve HIV-positive clients.

Lack of funding also hampers efforts to educate and create demand for family planning. Key informants reported that IEC, a once strong information and communication program, was moribund. Most health facilities had no materials promoting family planning, and overburdened providers had little time to provide education and counseling to clients. The community-based distribution program -- considered one of the major contributors to the rapid uptake of family planning in Kenya and formerly the source of supply for 11 percent of Pill users -- has been discontinued in most parts of the country as a result of donor funding cutbacks.

Supply of family planning commodities is erratic, limiting method choice and encouraging method discontinuation. At clinics and other service delivery points in all provinces, most family planning commodities were out of stock for the better part of 2003.

Other challenges to providing high-quality family planning services include widespread poverty, lack of support among men and some religious leaders, and opposition -- even among service providers -- to reproductive health services for young people.

HIV/AIDS Services

Access to HIV/AIDS services in Kenya varies widely from one district to the next. The services provided depend on the type of health facility, ranging from HIV risk assessment, dual method use counseling, and VCT at the primary level to prevention of mother-to-child transmission (PMTCT) of HIV and antiretroviral (ARV) therapy at secondary and tertiary levels. Many community-based organizations and some community-based distributors and traditional birth attendants provide home-based care (HBC) for people living with HIV/AIDS.

Key informants reported that HIV testing was becoming an acceptable routine test in antenatal care. Available data show that the majority of pregnant women accept VCT, although only 25 to 60 percent who test HIV positive receive antiretroviral treatment for PMTCT.

By May 2004, Kenya had 346 VCT sites, including 260 in public health facilities. A total of 350 VCT sites will be established within public health facilities by 2007. Up to 1.5 million Kenyans could be tested per year in the scaled-up VCT program.

The government also plans to expand access to ARV therapy, which currently reaches only about 4 percent of those in need. The goal is to deliver effective ARV therapy to 50 percent of those in need of treatment -- or 250,000 people -- by 2008. The main providers of ARV therapy include the private sector, NGOs, and faith-based organizations. The public sector started providing ARV therapy in national and some provincial hospitals in 2002.

Challenges to providing HIV/AIDS services

HIV/AIDS programs face many of the same challenges that confront family planning programs. Most HIV/AIDS services are provided through existing health services, and thus suffer from challenges such as lack of staff, infrastructure, and reliable supplies. Both services must contend with opposition to condom use from some religious leaders and with inadequate attention to the needs of young people.

Family Planning in the Era of HIV/AIDS

Impact of HIV/AIDS on Family Planning Practice

HIV/AIDS influences family planning practice and demand. The greater focus on HIV/AIDS programs affects both the financial and human resources available for family planning services and women affected by HIV/AIDS face a range of social pressures that influence their reproductive health decisions.

Behavior change

In the absence of empirical evidence, key informants were divided over whether HIV/AIDS had significantly affected sexual behavior. Some believed the change was minimal. Others cited increased condom use or reports of reduced business by sex workers as evidence that fear of HIV/AIDS was leading Kenyans to change their sexual behavior. Most service providers offered anecdotal reports of increased condom use, although the number of clients actually practicing dual protection is unknown.

Demand for family planning

In Kenya, as in most African countries, the individual desire for offspring is bolstered by strong societal and family pressure on women to bear children. HIV-infected women are not exempt from these pressures. Key informants reported that although some infected couples decide not to have children because of their “precarious future,” others may want more children to help support them. Informants also noted that having children can help HIV-infected women hide their status.

A desire to “replenish the population” in response to AIDS-related deaths and high infant mortality may explain the trend in fertility preferences shown in the 2003 KDHS. From 1993 to 2003, the proportion of women who said they wanted to have children within the next two or more years increased from 38 percent to 45 percent.

Questions about possible interactions between hormonal contraceptive methods and HIV/AIDS may also affect use of family planning methods. Certain ARVs reduce the efficacy of hormonal contraceptives, and studies are examining the possible impact of hormonal contraceptives on HIV acquisition, transmission, and disease progression. A few service providers expressed concern about prescribing the pill to HIV-infected clients who are vomiting, which renders the method ineffective, and also to patients on certain anti-TB treatments because of possible drug interactions. Most providers said that they

would not give an IUCD to an HIV-positive woman because they feared increased risk of pelvic inflammatory disease. But all available evidence shows that IUCD use is safe for HIV-infected women. The World Health Organization now recommends IUCDs as an option for women living with HIV unless they have developed AIDS and do not have access to or are not responding to antiretroviral treatment.

Decline in service quality

Constant shifting of program management and service delivery personnel to HIV/AIDS services has resulted in a lack of effective communication and supervisory support for family planning. Space previously used for family planning services is now shared with HIV/AIDS services, which can compromise privacy and quality of care. Poor quality of family planning services, in turn, leads to a diminished demand for those services.

Family Planning Needs of HIV-infected Individuals and Couples

Key informants in every district consistently stressed that "with or without AIDS, family planning has a place." Most informants agreed that HIV-infected people have family planning needs just as non-infected people do, and that services geared to these different populations relate mainly to the method mix.

Family planning and HIV/AIDS service providers estimated that about 70 percent of HIV clients need family planning services, while all family planning clients need HIV prevention services. Many providers also said that people living with HIV have a high unmet need for family planning services, partly because negative attitudes among providers make potential patients reluctant to visit family planning clinics. A considerable proportion of service providers said that pregnancy ought to be prevented at all cost in HIV-infected women. They rarely discuss the relative risk of infection to the baby and how PMTCT interventions can reduce that risk.

Few HIV/AIDS services include routine family planning, although the Ministry of Health recently developed a national strategy for integrating family planning services into VCT programs. According to field interviews, dual protection counseling appeared to occur only in facilities offering family planning and PMTCT services.

Service providers expressed concern about the lack of guidelines for HIV-infected women on the use of family planning methods. Updated guidelines that reflect currently accepted practices in the era of HIV/AIDS are urgently needed.

Linkage of HIV/AIDS and Family Planning Services

Most respondents saw integration as the logical way forward for providing high-quality family planning and HIV/AIDS prevention and care services. The same personnel implement multiple programs in the districts, and provincial and district health management teams said the lack of integration compromises efficiency. Instead, they suggested, family planning and HIV/AIDS services could complement one another, reducing cost and time for clients and services while improving client follow-up. Table 1

shows the potential areas of synergy for both family planning and HIV/AIDS programs identified by key informants.

Table 1: Confluence of interest for RH/FP and HIV/AIDS programs

<i>Type of Service</i>	<i>Concerns for HIV/AIDS programming</i>	<i>Concerns for RH/FP programming</i>
Antenatal care services	Channel for information and services or referral to VCT, PMTCT, HBC	Antenatal care; FP information and counseling
Maternity services	VCT and PMTCT services	Delivery services; FP services or referral
Postnatal care services	VCT, ARV information, service, or referral	Postnatal care, breastfeeding, neonatal care FP services – all methods
FP services	FP needs of HIV+ and discordant couples; interactions between FP methods and HIV; ARV and TB therapy and hormonal methods	All FP; interactions of ARVs and anti-TB drugs with hormonal methods
Barrier methods	Protection against HIV and sexually transmitted infections; promotion of dual protection	Contraception; promotion of dual protection
CBD services	Demand creation for VCT, PMTCT, ARV therapy, HBC; referral	Demand creation for FP; provision of selected contraceptive methods
PMTCT services	VCT; prophylaxis against MTCT	Contraceptives to prevent future pregnancy
VCT services	All VCT services; risk reduction counseling	FP counseling, services, and referral Access to men, youth, and adolescents
ARV therapy services	All services	FP information, services, referral; access to men, youth, and adolescents
HBC services	All services	FP services for HIV-infected and -affected people

RH=reproductive health; FP=family planning; VCT=voluntary counseling and testing; PMTCT=prevention of mother-to-child transmission; HBC=home-based care; ARV=antiretroviral

Integration Opportunities

Key informants offered several advantages to integrating family planning and HIV/AIDS services, and noted conditions that would facilitate integration:

- A positive policy environment: most of the existing strategies and guidelines support linkages between family planning and HIV/AIDS programs.
- Interventions for HIV/AIDS and family planning both target sexually active individuals and promote use of barrier methods.
- Integrated services are a good approach to accessing those who are hard to reach, including men and youth.
- Existing logistical and supply systems can be used to procure supplies and commodities for both services, while existing infrastructure, with minor or no modifications, can be used for integrated services.
- Existing staff can be trained to offer integrated services, e.g., incorporating family planning into the VCT training curriculum.

- Complementary strengths: Family planning facilities tend to be more family-oriented and welcoming to couples, while HIV/AIDS facilities may be the best entry point for youth, men, or sexually active individuals who are not planning families.
- Expansion of HIV/AIDS services such as PMTCT, VCT, ARV therapy, and HBC offers opportunities to satisfy the unmet need for family planning among their clients.
- Providing integrated services under one roof can help overcome challenges posed by the stigma often associated with attending stand-alone HIV/AIDS services.

Despite these opportunities, key informants also identified challenges to integration including the need to:

- train, motivate, and support multi-skilled workers,
- avoid overburdening staff at a time of severe staff shortages,
- mobilize resources to renovate or expand overcrowded health facilities, and
- gain the support of some program managers who are ambivalent toward integration.

Recommendations

Political commitment: The GOK should affirm its commitment to existing policies on population and development by recognizing family planning as a crucial strategy for attaining development goals, allocating sufficient funds for family planning, and establishing a line item for family planning in the national budget.

Advocacy: Stakeholders should raise awareness among government officials and donors about the erosion of Kenya's progress in reproductive health and build support for resource mobilization and other measures to reverse this trend, as follows:

Policy development, dissemination, and implementation

- Involve stakeholders in developing policies to ensure effective implementation and to make policies more responsive to the diverse needs of Kenyan communities.
- Strengthen mechanisms for distributing and disseminating policies and guidelines to ensure they reach implementers at all levels.
- Encourage the full participation of the private sector in policy development, strategic planning, and implementation. Include the private sector in the Ministry of Health's supervision, monitoring, and evaluation network.

Supervision, monitoring, and evaluation

- Include in strategic plans provisions for supervision, monitoring, and evaluation of all service delivery points, including private providers.

- Establish an effective mechanism to coordinate the activities of various service providers, including the many community-based organizations involved in HIV/AIDS activities.
- Strengthen management by adequately preparing and remunerating managers, from the district ministries of health to those in charge of health centers and dispensaries.
- Improve Ministry of Health staff morale and motivation through measures such as appreciation, recognition, better wages, and improved training opportunities.

Service delivery

- Establish mechanisms for integrating components of family planning services into all HIV/AIDS programs, particularly those providing VCT, PMTCT, ARV therapy, anti-TB therapy, and HBC services.
- Integrate elements of HIV/AIDS prevention and care into family planning programs where appropriate and strengthen the capacity of family planning providers to address the reproductive health needs of HIV-infected women.
- Improve efficiency of service delivery through appropriate deployment of service providers in areas where their skills are most needed.
- Consider reviving the CBD program. In addition to promoting family planning and providing methods such as condoms and pills, community-based distributors could also help increase demand for HIV/AIDS services such as VCT, PMTCT, and ARV therapy and could play an active role in HBC programs. HBC community health workers can also assess the reproductive health needs of their clients and provide basic reproductive health services and referral.
- Strengthen mechanisms for commodity procurement and distribution to ensure contraceptive security.
- Develop strategies to make family planning and HIV/AIDS services more “youth-friendly” and to promote involvement of men in reproductive health and HIV/AIDS prevention and care.

Research to practice

- Review and update existing family planning guidelines so they reflect currently accepted practices in the era of HIV/AIDS and address service providers’ concerns about the use of family planning methods by people living with HIV.
- Integrate family planning into training curricula for HIV/AIDS programs to produce service providers capable of performing multiple roles and reduce the impact of staff shortages.

Research needs

- Conduct research to improve our understanding of the effects of HIV/AIDS on family planning practice, behavior change, increased or reduced demand for family planning, and access to family planning services.
- Rigorously evaluate efforts to integrate family planning and HIV/AIDS services to identify effective integrated service delivery models and understand their impact on contraceptive use.