



Family Planning

HIV/AIDS

Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services

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For more information, or if you have questions or comments, please contact Mary Ann Abeyta-Behnke at: mabeyta-behnke@usaid.gov.

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	World Health Organization

Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
BCC	Behavior change communication
CBD	Community-based distribution
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community health worker
COPHIA	Community-based HIV/AIDS Care, Support, and Prevention Program
CPR	Contraceptive prevalence rate
CT	Counseling and testing
ESD	Extending Service Delivery Project
FP	Family planning
GNP+	Global Network of People Living with HIV/AIDS
HIV	Human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAM	Lactational amenorrhea method
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of health
MSM	Men who have sex with men
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
RH	Reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

Background

The importance of linking reproductive health (RH) and HIV/AIDS policies, programs, and services has been acknowledged by six major international agencies. These linkages are considered essential for meeting international development goals and targets, including the United Nations Millennium Development Goals.^{1,2,3,4,5,6,7}

Clients seeking HIV services and those seeking RH services share many common needs and concerns, and integrating services enables providers to efficiently and comprehensively address them. In addition, strong linkages help to ensure that the RH needs and aspirations of all people, including people living with HIV, are met.

Family planning (FP) is one aspect of RH where linkages with HIV programs are especially important. Integrating FP services into HIV prevention, treatment, and care services provides an opportunity to increase access to contraception among clients of HIV services who do not want to become pregnant, or to ensure a safe and healthy pregnancy and birth for those who wish to have a child. In countries where FP services are well used, integrating HIV services into the existing FP infrastructure is an opportunity to expand HIV prevention efforts and increase the use of care and treatment services. In both approaches, integration has the potential to draw on the strengths and resources of both programs in order to increase access to services, improve health outcomes for the mother and infant, and contribute to HIV and FP goals.

It is critical to pursue the integration of FP and HIV services in a strategic and systematic manner so as to maximize the public health impact of

these efforts. Program managers at the country level are increasingly requesting guidance on how to integrate services, yet few rigorous evaluations have been conducted to identify best practices. This document was developed in response to a growing call for strategic considerations on ways to strengthen the linkages between FP and HIV/AIDS policies, programs, and services.

Key Definitions

The terms *integration and linkages* are used throughout this document and are based upon the following definitions, which have been adapted from *Rapid Assessment Tool for Sexual and Reproductive Health Linkages: A Generic Guide*, developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, and Young Positives.

Linkages: The bidirectional synergies in policy, programs, services, and advocacy between RH and HIV.

Integration: Combining different kinds of RH and HIV services or operational programs to ensure and maximize collective outcomes. It would include referrals from one service to another and is based on the need to offer comprehensive services. Integration refers exclusively to health service provision and is therefore a subset of linkages.

A glossary of additional selected terms can be found at the end of the document.

Client Benefits of Integrating Family Planning and HIV/AIDS Services

Family planning can improve the health of women by delaying first births, lengthening intervals between births, reducing high-risk pregnancies, and reducing unintended pregnancies that could lead to unsafe abortions. In addition, use of male and female condoms can prevent sexually transmitted infections (STIs), including HIV.

Among women and men with HIV who are sexually active and do not wish a pregnancy, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV treatment, care, and support.^{8,9,10} Indeed, prevention of unintended pregnancies in HIV-positive women is one of the four cornerstones of a comprehensive approach to the prevention of mother-to-child transmission (PMTCT) of HIV. Nevertheless, unintended pregnancies among women with HIV remain unacceptably high.^{11,12,13}

For clients who are already accessing FP services, the addition of HIV counseling and testing provides an opportunity for this sexually active population to learn their HIV status, how to protect themselves from infection if they are HIV-negative, and how to prevent transmission to their sex partners and infants if they are HIV-positive. Strategies to help more people learn their status can also facilitate access to HIV treatment, care, and support. In many countries, family planning service settings can serve as a platform for provider-initiated testing and counseling (PITC).

For women and men with HIV who want to have children, linkages between RH and HIV programs are important to ensure access to services that will allow for a safe pregnancy and delivery. These services include, but are not limited to, preconception counseling and antiretroviral therapy (ART) to reduce vertical transmission risks. Closely spaced births and HIV/AIDS both increase risks of adverse pregnancy outcomes, such as low birth weight, preterm birth, and

infant mortality. Counseling on healthy timing and spacing of pregnancies is therefore especially important for women with HIV who want to have a child.^{14,15,16} Individuals in serodiscordant relationships might need information on minimizing the risk of infecting their partners along with assisted conception services.

What Is the Purpose of This Document and Who Should Use It?

A recent Cochrane review of the literature on RH and HIV linkages found that integrating FP and HIV services was feasible.¹⁷ Few studies, however, included rigorous evaluation designs that allowed for the identification of evidence-based recommendations on how to effectively integrate these services. Nevertheless, many ministries of health (MOHs) and implementing partners are pursuing and, in some cases, scaling up integrated FP/HIV services at the facility level and through community-based programs. They have based their efforts on best practices and lessons that they learned from implementing FP and HIV/AIDS programs separately.

Given the limited scientific evidence available to define a set of integrated best practices, this document aims to provide program planners, implementers, and managers (including MOH officials and other country-level stakeholders) with strategic considerations for implementing or strengthening integrated FP/HIV services. The document does not address other reproductive health issues that are also central to linked approaches, such as gender-based violence and STI management. (These and other RH issues will be discussed in future briefs.) Instead, the focus here is specifically on the intersection of FP and HIV, and thus should be used in the context of broader efforts to ensure universal access to RH services and HIV prevention, care, treatment, and support programs.

This document is based on a combination of expert opinions, recommendations in the published literature, and lessons learned from field

experience with integrating services to date. It offers a range of activities for program planners to consider implementing in order to enhance new or existing linkages. It also acknowledges, however, that integrating FP and HIV services might not be appropriate in every circumstance or country. Where integration is appropriate, this document is intended to help program planners identify action steps. It also provides links to existing resources, such as facility-assessment tools, training curricula, and job aids, that will support the implementation of action steps.

Most of the documented experience integrating FP and HIV services has been in African countries experiencing generalized HIV epidemics, but many of the lessons learned in these countries are applicable to other regions and countries as well. As implementers put these strategic considerations into practice, the evaluation and documentation of these efforts is imperative. More data are needed to refine our understanding of effective, integrated service delivery approaches and to prioritize intervention activities. As this information becomes available, this document will be updated to reflect the rapidly evolving state of knowledge about how and when to integrate FP and HIV services.

Expert Consultation

The strategic considerations presented here are drawn from experts in FP and HIV who represent more than 20 international development organizations and country-level program implementers. The experts participated on panels that reviewed the published and unpublished literature on three approaches to integration: FP/HIV counseling and testing, FP/PMTCT, and FP/HIV care and treatment. They determined

that, although the authors suggested ways to improve program integration, most of them did not present strong empirical evidence to support their claims directly. Nevertheless, the panel members identified common themes in the literature and drafted recommendations for strengthening field-based integration efforts. The recommendations were discussed at a workshop for technical experts that was held in October 2008. More than 100 researchers, program implementers, MOH representatives, international donors, technical assistance staff from institutions in Africa, and U.S. government officials who are involved in FP/HIV integration attended the workshop. This document emerged from that workshop.

Strategic Considerations for the Integration of Family Planning and HIV Services

Four key questions and corresponding activities are central to systematically and strategically pursuing stronger linkages between FP and HIV policies, programs, and services:

- 1. What type of service integration, if any, is needed?**
- 2. To what extent should services be integrated?**
- 3. What steps are needed to establish and sustain high-quality integrated services?**
- 4. What information is needed to measure program success and inform program or service delivery improvement, replication, or scale-up?**

Table 1 presents these questions and the key factors that planners need to consider. Each question and its key considerations are then described in greater detail in subsequent sections. We recommend that a joint task force between the RH/FP, maternal and child health (MCH), and HIV departments within a country's MOH be formed to lead the planning process. That process should begin with an analysis

of what type of service integration is needed. These government leaders should invite other stakeholders, including policymakers, donors, providers, clients, PLHIV, and community leaders to participate on the task force. Making informed decisions about the integration process could take time, but it should strengthen the overall quality and impact of health services.

Table 1: Strategic Framework for the Integration of Family Planning and HIV Services

Key question	Key activity	Key considerations
1. What type of service integration, if any, is needed?	Country- or regional-level situation analysis	<ul style="list-style-type: none"> ■ HIV prevalence and distribution ■ Contraceptive prevalence rate (CPR), unmet need for FP ■ Availability, strength, and organization of existing FP and HIV services ■ Potential demand for FP and HIV services ■ Available financial resources
2. To what extent should services be integrated?	Facility- or community-level assessment	<ul style="list-style-type: none"> ■ Human resource capacity ■ Physical set-up of facility ■ Strength and organization of existing services ■ Client flow and volume ■ Available financial resources ■ Community outreach
3. What steps are needed to establish and sustain high-quality integrated services?	Development and implementation of intervention package	<p>Needs and opportunities to improve:</p> <ul style="list-style-type: none"> ■ Policy environment ■ Technical capacity of providers, supervisors, and other health workers ■ Facility set-up and systems ■ Commodity supply ■ Community involvement
4. What information is needed to measure program success and inform program or service delivery improvement, replication, or scale-up?	Collection of strategic information	<ul style="list-style-type: none"> ■ Indicators for routine monitoring and evaluation ■ M&E systems ■ Opportunities for rigorous operations research studies

1. What type of service integration, if any, is needed?

HIV prevention, care, and treatment services are often integrated into the primary health care infrastructure, which includes FP services, with the goal of increasing access to HIV services. Similarly, FP services can be integrated at several HIV service delivery points: HIV counseling and testing (CT), PMTCT, and care and treatment services. The primary goal with this integration approach is to increase access to FP services among clients of HIV services. These linkages can occur through both facility- and community-based programs. Prior to pursuing a particular approach, program planners must weigh the potential benefits and challenges (as outlined in the text box on the next page) in the context of (1) the strength and structure of health services that are currently offered in the country and (2) local FP and HIV data. Such an analysis will help planners determine if it makes sense to integrate services and if certain approaches should be prioritized for particular regions or populations (for example, urban versus rural and groups at higher risk of HIV exposure).

One of the most important contextual factors to consider is the scale of the HIV epidemic.¹⁸ The integration of comprehensive HIV services into FP services might not be appropriate at a national level if an epidemic is concentrated or at a low level. If the majority of the FP clients are not at risk of HIV or not in need of most HIV services, targeted HIV programming would have more impact.

The scale of the epidemic has less bearing on decisions about whether or not to integrate FP services into HIV prevention, care, and treatment programs. Regardless of whether HIV services have been established to reach groups at higher risk in a country with a concentrated epidemic or for the population at large in a country with a generalized epidemic, these services offer an

opportunity to address the FP needs of their clients. Numerous studies suggest that clients of HIV services have a substantial unmet need for contraception in both concentrated and generalized epidemics.^{19,20}

National MOH planners must also consider the availability and strength of existing health service delivery programs and resources available to support implementation of integrated services. For example, in countries where contraceptive prevalence is low and the basic infrastructure for national FP services is weak, integration might have to be staged, starting with capitals and large provincial cities. If government leaders and other stakeholders are committed to improving the quality of health services and have sufficient resources and support from donor and multilateral sources, integration could actually strengthen the health system as a whole. A recent study in Rwanda showed that adding basic HIV services funded by the President's Emergency Plan for AIDS Relief (PEPFAR) to primary health centers contributed to an increase in the use of reproductive health and other services in those facilities.²¹

In countries where HIV prevalence is high and the existing FP infrastructure is relatively strong, integration provides a valuable opportunity to comprehensively address the risk of HIV infection, prevent unintended pregnancy, and promote healthy birth spacing and birth outcomes. In countries where HIV treatment services are available, the need to link them with reproductive health services is especially important. With antiretroviral therapy restoring health and fertility in PLHIV, links to services that enable women to realize their pregnancy intentions are essential.

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Benefits and Challenges of Different Types of Family Planning/HIV Service Integration

Integrating FP into HIV Counseling and Testing

Benefits

- This approach reaches men, youth, couples, and unmarried women who might not use traditional FP programs but who have unmet needs for contraception with FP information and services.
- The integration allows for holistic sexual health counseling.
- It serves hard-to-reach populations through various models of service delivery, such as mobile, outreach, and home-based counseling and testing.
- Family planning counseling provides an opportunity for both HIV-positive and HIV-negative clients to avoid initial or subsequent unintended pregnancy.
- Family planning counseling provides an opportunity to promote correct and consistent condom use for dual protection against STI/HIV acquisition or transmission and unintended pregnancy.

Challenges

- Counseling and testing is usually a one-time visit, and it seldom includes ongoing services or follow-up for clients.
- It generally requires referral systems, which often are inadequate, for resupply and follow-up for complications and side effects of FP methods.
- It is unclear if CT clients are more receptive to FP counseling during pre- or post-test counseling.
- Combining CT and FP counseling might place an undue time burden on the counselor, particularly in high-volume CT settings or in settings where clients are unfamiliar with HIV and FP and require full counseling on disease transmission and FP topics.
- Many CT counselors are basic-level health workers or lay counselors who might require substantial training, monitoring, and supervision to provide FP services.
- Providers need training on how to communicate with clients about dual method use and dual protection when discussing condoms.
- The feasibility of integrating FP services into PITC is unknown.

Integrating FP into PMTCT programs

Benefits

- Family planning information reaches women of reproductive age who were recently and might still be sexually active, have a high probability of future pregnancies, and are known to be HIV-positive.
- Postpartum women have high levels of unmet need for FP.
- Multiple provider contacts (during antenatal, intra-partum, and postpartum care, and with transition into pediatric care and care for the woman) are opportunities to repeat FP messages.
- Integration offers opportunities for linking with community outreach programs.
- Integration offers opportunities for counseling serodiscordant couples.

- Because providers have already been trained in FP, they can provide FP services with little additional training.

Challenges

- Most PMTCT clients are reached during antenatal care (ANC) when they are pregnant and the uptake of an FP method is not possible. All intentions to initiate an FP method require follow-up at delivery and/or postpartum.
- Many births do not take place at health facilities, which limits opportunities for postpartum FP counseling and uptake.
- It is difficult to reach men and youth in the maternal and child health (MCH) service delivery setting.

Integrating FP into HIV Care, Treatment, and Support Settings

Benefits

- This approach reaches only HIV-positive clients, thereby maximizing opportunities to prevent unintended pregnancies among clients who do not wish to become pregnant and reduce mother-to-child transmission.
- It provides opportunities to reach men with FP information and services.
- Regular repeat visits allow for reiterating FP messages, resupplying FP methods, following up for complications and side effects, and meeting changing fertility desires.
- Providers are familiar with clients' HIV status, health status, and treatment regimen, all of which they can take into account when providing FP counseling.
- HIV care, treatment, and support settings might be a less stigmatizing or discriminating environment for PLHIV to discuss fertility intentions, contraception, and sexuality.
- Established linkages between HIV treatment programs and community volunteer services for adherence support offer a natural fit for FP follow-up.
- Integration offers the opportunity for counseling serodiscordant couples.

Challenges

- Providers could feel too burdened with sick, complicated patients to take the time to discuss FP issues.
- Providers need training on how to communicate with clients about dual method use and dual protection when discussing condoms.
- This approach requires close coordination with FP providers for record keeping, supervision, monitoring, and receiving FP medical updates.

Integrating HIV Services into FP Clinics

Benefits

- Integrating HIV services provides an opportunity to promote correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy.

- The uptake of HIV services (particularly CT services) among FP clients might increase.
- Integrated services reduce the stigma associated with freestanding HIV clinics and might thereby increase the use of HIV services.
- The availability of HIV services could attract clients who do not typically access FP services and thereby foster new contraceptive users.
- Providers are able to tailor contraceptive counseling based on the client's HIV status.
- Integrated services offer opportunities for HIV prevention counseling among women of reproductive age, including married women who might underestimate their risk of HIV.
- The availability of more comprehensive services and support for FP clients might improve contraceptive adherence and continuation.

Challenges

- This integrated approach might not reach individuals at high risk of HIV infection and might not be the most efficient and effective way of reaching those individuals at most risk, such as men who have sex with men (MSM), sex workers, and injection-drug users.
- This approach is unlikely to be cost-effective in areas of low HIV prevalence or concentrated epidemics.
- Family planning providers might have no background in HIV services, thus requiring substantial training, monitoring, and supervision to provide HIV-related services.
- Providers need training on how to communicate with clients about dual method use and dual protection when discussing condoms.
- Adding complex HIV-related services could place an undue time burden on FP providers.

Integrating HIV Services into Community-based FP Programs

Benefits

- Integrating HIV services leverages existing community FP services (for example, community-based promoters and distributors) to add HIV counseling and referrals.
- Many community-based FP workers already provide some information on HIV, AIDS, and STIs.
- Integrating HIV services provides the opportunity to promote correct and consistent condom use for dual protection against HIV/STI infection and unintended pregnancy.
- Integrating services adds the opportunity for HIV prevention counseling for women of reproductive age, including married women who might underestimate their risk of HIV.
- Uptake of HIV services, particularly CT services, among FP clients might increase.

Challenges

- Community-based FP workers could have limited backgrounds in HIV services, thus requiring additional training, monitoring, and supervision to provide HIV counseling and communicate with clients about dual method use and dual protection when discussing condoms.
- Integrating services might add time to an already full schedule.

In addition to the challenges noted above, all efforts to integrate services will have to consider ways to address two, crosscutting challenges rooted in social context. The first is the bias that many health care providers and community members have against HIV-positive women bearing children. Helping women and men to realize their fertility intentions is a key goal of any integration effort. Given that infected women could be more vulnerable to rights abuses than uninfected individuals, extra attention must be paid to ensuring that HIV-positive women and couples are able to make informed reproductive decisions free of coercion. The second challenge is the need to consider how the potential impact of integrated FP/HIV programs might be mitigated by prevailing gender norms. For example, if integrating HIV counseling and testing into FP services helps more women learn their status, efforts should be made to ensure that these women are not at increased risk of gender-based violence for disclosing their status. Similarly, efforts to increase access to contraception through integration could have limited success if women do not feel empowered to initiate and use a method without their partners' consent.

2. To what extent should services be integrated?

A one-size-fits-all approach to FP/HIV linkages, and service integration in particular, does not exist. Even in countries with greater resources, it is often not feasible for every facility to offer all contraceptive- and HIV-related services in the same place at the same time by the same provider. Governments and private providers will have to make decisions about which specific FP and HIV services to integrate, when and where to integrate them, and the extent to which they should be integrated.

The MOH of Kenya led the integration of FP services into HIV voluntary counseling and testing (VCT) services there, and the USAID-supported ACQUIRE project integrated FP services into private-sector HIV care and treatment services

in Uganda. Their experiences suggest that different types of integration might be appropriate for different health care facilities or programs, depending on available resources, capacity, and facility set-up.^{22,23}

For example, some managers of facilities offering HIV care and treatment services could determine that it is feasible for their clinicians to incorporate FP counseling into their discussions with clients. They might also provide select methods (such as condoms, pills, and injectables), monitor ongoing use, and make referrals for all other methods.

Another facility might offer both HIV counseling and testing and FP services, but in separate rooms by separate providers. Managers in this case might determine that the best use of limited resources is to equip the facility's HIV counselors to screen their clients for risk of unintended pregnancy, offer basic information about FP, and provide a same-day referral to the FP room if needed. In this scenario, the FP provider would become responsible for providing appropriate follow-up care related to the client's FP use.

Similar recommendations emerged from the USAID-supported FRONTIERS project's experience integrating counseling and testing for HIV into FP services in Kenya and South Africa. The project explored two integrated approaches: a testing model, in which FP providers were trained to offer CT services and post-test counseling during the same visit; and a referral model, in which FP clients wanting CT services were referred to a specialized CT facility. Both models resulted in significant improvements in the quality of care and in HIV prevention behaviors at an affordable cost. Moreover, adding HIV services did not adversely affect the FP service. Both countries are expanding their implementation of the two approaches, allowing individual clinics to determine which approach is most feasible.^{24,25}

After decisions have been made at the national or regional level as to which type of integration to pursue, program planners, facility managers, and other stakeholders should assess their

physical, human, financial, and technical capacity to add new services at the facility or community levels. Based on this analysis, planners can determine the extent to which they can integrate new services without compromising the quality of existing services. The text box below offers examples of FP services that can be integrated into HIV services, and HIV services that can be integrated into FP services.

At the community level, networks of community-based organizations, support groups, and volunteers present a valuable opportunity to meet clients' interrelated FP and HIV needs and to provide appropriate links to facility-based integrated services. For example, Pathfinder International trained existing FP community-based distribution volunteers in Ethiopia to provide HIV prevention education and offer

referrals for testing. In Kenya, Pathfinder International leveraged its Community-based HIV/AIDS Care, Support, and Prevention Program (COPHIA) to address the need for FP among clients by training community health workers (CHWs) to offer FP counseling, adding condoms and pills to CHW home-based care kits, and strengthening linkages between COPHIA's community networks and local health facilities.

These pilot initiatives in community-based FP/HIV integration have demonstrated broadened access to HIV prevention education, increased demand for HIV testing, and expanded FP method use.²⁶ Involving community leaders and health outreach workers in integrated service design and delivery also promotes responsiveness to local needs and awareness of available services.

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Examples of Family Planning/HIV Integration for the Clinic and the Community

Examples of FP services that can be integrated into all HIV settings

- Assessment of the fertility intentions of male and female clients
- Referrals to FP services for clients at risk of unintended pregnancy
- Referrals to PMTCT services for HIV-positive clients desiring pregnancy
- Provision of male and female condoms and demonstration of correct use
- Promotion of condom use for dual protection
- Informed choice counseling on the full range of available FP methods and where to access them, including discussion of method effectiveness, side effects, and non-contraceptive benefits; potential drug interactions with hormonal contraceptives if the client is on ART; the capacity of FP methods to prevent STI/HIV infection; and dual method use
- Discussion of increased risk of miscarriage for women with advanced HIV infection
- Counseling on the effects of ART in improving the health of people living with HIV, including a return to fertility
- For HIV-positive clients desiring pregnancy, provision of information on the risk of transmission to their infants and uninfected partners; assessment of health status as it relates to pregnancy; and counseling on healthy timing and spacing of pregnancy, fertility return, the lactational amenorrhea method (LAM), and exclusive breastfeeding through six months or replacement feeding if it is acceptable, feasible, affordable, sustainable, and safe

- Provision of oral contraceptives, injectable hormonal contraceptives, intrauterine devices (IUD), or hormonal implants with instructions for use (great variability could exist among the service sites in their ability to provide contraceptives)
- Provision of method resupply and follow-up care, including management of side effects and complications as necessary
- Provision of tubal ligation and vasectomy (requires skilled providers and a higher-level health facility)
- Referral for methods not offered on site, preferably through same-day referral and uptake of method
- Where same-day FP provision is not feasible, provision of emergency contraceptive pills with condoms, depending on client circumstances

Note: If no reliable FP services exist in the area, the HIV facility and its provider should strive to provide at least condoms and preferably pills and injectables on site.

Examples of HIV services that can be integrated into FP service settings

If a client's HIV status is unknown:

- Assessment of whether the client knows his or her HIV status and counseling the client on the benefits of knowing one's status
- HIV/STI prevention education, including risk-reduction counseling, condom demonstration and provision, and counseling on dual protection and dual method use
- Referrals to CT services for clients at risk for HIV infection
- HIV counseling and testing (provider- or client-initiated)

If a client's HIV-positive status is known:

- Assessment of fertility intentions
- Counseling on reproductive choices and contraceptive options for women and couples with HIV
- Referrals to HIV care and treatment services
- For HIV-positive clients already pregnant or desiring pregnancy, referrals to PMTCT services
- Counseling on the possibility of ART improving the health of people living with HIV, including a return to fertility
- For HIV-positive clients desiring pregnancy, provision of information on the risk of transmission to their infants and uninfected partners; assessment of health status as it relates to pregnancy; and counseling on healthy timing and spacing of pregnancy, fertility return, LAM, and exclusive breastfeeding through six months or replacement feeding if it is acceptable, feasible, affordable, sustainable, and safe
- Couple or individual counseling on risk reduction for seroconcordant and serodiscordant couples
- Counseling on disclosure strategies for PLHIV and referrals for their partners for counseling and testing

- HIV care and treatment
- Treatment of opportunistic infections
- Specific HIV information and services for key populations, such as youth, MSM, sex workers, migrant workers, injection-drug users, and those in long-term, concurrent relationships
- Psychosocial support for PLHIV
- Adherence counseling
- Referrals to care and support programs for PLHIV
- Referrals to other HIV services not offered on site

Key Resources for Facility Assessments

The following assessment tools can be used to collect information at the facility level that will guide decision-makers in determining the preconditions necessary for integration, the level of integration that is feasible, and procedures for implementing and monitoring integrated approaches.

- Assessing Integration Methodology (Population Council)
http://www.popcouncil.org/frontiers/projects_pubs/topics/SLR/AIM_Manual.html
- Family Planning-Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services (EngenderHealth)
http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/FP-HIV-Integration_framework_final.pdf
- Integrating HIV Voluntary Counselling and Testing into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers, and Service Providers (IPPF, UNFPA)
http://www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf
- Quality of Care for Integrated Services: A Clinic Assessment Guide (Pathfinder International)
http://www.pathfind.org/site/DocServer/QOC_document_oct_6.pdf?docID=1581
- Rapid Assessment Tool for Sexual & Reproductive Health Linkages: A Generic Guide (IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives)
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/rapid_assesment_2009.pdf
- Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: A Manual for Trainers and Programme Managers (EngenderHealth, ICW)
http://www.engenderhealth.org/files/pubs/hiv-aids-stis/RH_for_HIV_Positive_Women_ English.pdf

3. What steps are needed to establish and sustain high-quality integrated services?

Once planners have conducted the situation analysis, made the facility- or community-level assessment, and determined the integration goal, they should begin to identify the necessary steps to achieve that goal. Ideally, efforts to integrate FP and PMTCT, HIV counseling and testing, and HIV care and treatment services should include a range of interventions across different levels of the health system. Experience to date suggests that there has been an over-reliance on training as the primary intervention activity, and that more comprehensive approaches are needed to address changes at policy, facility, provider, and community levels.²⁷

Table 2 outlines policy and programmatic actions that the literature and experts suggest will enhance FP/HIV integration approaches. Although the relative importance of each of these is not known, they all have the potential to contribute to high-quality, sustainable services.

Most countries attempting to integrate services have taken one or more of these actions. They are highlighted here to help policymakers and program planners consider all facets of a program before implementing or scaling up an integration intervention.

Even if policymakers and program planners are not able to implement all of the suggested activities, they should identify priority activities based on the needs and capacities of the facilities or programs targeted for integration, as well as the financial resources available. They should recognize that activities at different levels of the health system will be mutually reinforcing and should strive to implement comprehensive activities.

If time and resources allow, we recommend that country governments create an enabling policy environment before taking other action steps. In addition, efforts to reduce stigma and discrimination by providers and the community at large, particularly as they relate to childbearing in HIV-positive women, should be central to all intervention activities.

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Table 2: Policy and Programmatic Actions for Family Planning/HIV Integration

Policies and guidelines
Form a joint task force between the RH/FP and HIV departments in the MOH to help coordinate FP/HIV integration efforts and foster government commitment to and leadership on integration.
Involve target audiences, including district-level health managers, service providers, PLHIV, clients (including men and youth), policymakers, donors, multilaterals, and advocacy organizations for groups at higher risk of HIV exposure, in policy and program design.
Develop an advocacy strategy to mobilize engagement of and support for integrated services among policymakers, program managers, service providers, clients, PLHIV, and other key stakeholders.
Review and revise national HIV policies to include family planning services for healthy timing and spacing of pregnancies and prevention of unintended pregnancies as part of the standard of care for these services. Revise FP/RH policies to include HIV services as part of the standard of care for these services.
Review existing HIV and FP/RH policies and revise them as needed to expand the scope of integrated services that low-level health workers can provide—for example, allowing community health workers to provide select contraceptive methods and conduct HIV counseling and rapid testing.

Put into practice policies that support the integration of FP and HIV services by developing, approving, and allocating resources for national operational guidelines for all levels of the health care system, including standard operating procedures for health care facilities.

Capacity training and task shifting

Foster sensitivity to the RH needs of PLHIV, thereby reducing stigma and discrimination, in trainings for PMTCT, HIV counseling and testing, HIV care and treatment, and FP service providers, as well as community outreach workers and leaders. Engage all personnel in discussing potential biases against childbearing among HIV-positive women and couples.

Engage in curricula reform to introduce or enhance integrated FP/HIV content in national pre-service and in-service training curricula for HIV counseling and testing, PMTCT, HIV care and treatment, and FP.

Emphasize building the capacity to communicate with clients about dual protection and dual method use in all trainings for PMTCT, HIV counseling and testing, HIV care and treatment, and FP service providers.

At a minimum, build the capacity of PMTCT, HIV counseling and testing, and HIV care and treatment service providers to assess clients' fertility intentions, offer dual protection counseling and condom promotion, and refer clients to FP services or safe pregnancy services. Likewise, in a generalized epidemic, build the capacity of FP providers to assess whether a client knows his or her HIV status, provide HIV/STI risk-reduction education, offer dual protection counseling and condom promotion, counsel on reproductive choices and contraceptive options for women with HIV, refer clients of unknown status for HIV counseling and testing, refer clients with HIV to care and treatment services, and refer clients with HIV who want to become pregnant to PMTCT services.

Provide additional training for FP and HIV services providers as appropriate, depending on the extent to which they are expected to offer integrated care.

For referral-based models of integration, build the capacity and sensitivity of FP providers to address the contraceptive needs of women and couples who have been referred from HIV services.

Use retired nurses, lay counselors, peer educators, community outreach workers, or PLHIV to assist providers of both HIV and FP services. Activities by these assistants could include HIV prevention education, risk assessment, and counseling; and FP counseling, education, and screening.

Conduct group education in waiting rooms for FP and HIV services in order to increase client interest in and knowledge about available services and to reduce the time needed for individual counseling by providers.

Facility staff sensitization

Prepare on-site staff at all levels for the addition of new services through orientation and discussion.

Train on-site staff to maintain privacy during client counseling and to keep patient records confidential.

Supportive supervision

Assess and strengthen supervisory skills for on- and off-site supervisors to ensure effective oversight of integrated services and enable them to address provider concerns about workload, burnout, and other problems.

Equip facility managers and supervisors to monitor the quality of integrated services. Monitoring activities would include assessing adherence to service protocols, checking for contraceptive stock outs, and reviewing service statistics, such as the number of FP clients referred to HIV-related services or the number of HIV clients referred to FP services.

Update supervisory protocols, monitoring forms, service provider job descriptions, and checklists to reflect FP and HIV services and roles as they are added.
Information, education, and communication
Provide information, education, and communication (IEC) materials on FP and HIV for clients and community-based groups and volunteers in order to increase interest in, knowledge about, and the availability of integrated services.
Use consistent messages about FP and HIV at all health-facility entry points, in community outreach activities, in providers' messages to clients, and through the channels of mass media.
Space
Engage community leaders and members in the reorganization of facility space for integration to ensure acceptability.
Allocate space to allow for separate and private counseling on FP and HIV and to ensure confidentiality of clients. Counseling rooms should be neutrally identified.
Record-keeping, information systems, M&E
Modify client records, registers, and other M&E systems to account for the addition of FP or HIV services, including referrals, and train staff on the use of these modifications.
Establish systems to evaluate whether clients access services to which they are referred and to identify any obstacles to access.
Conduct continuous monitoring and output evaluations of integrated approaches and report findings to providers and managers on a regular basis to motivate providers and improve performance.
Include mechanisms for obtaining client perceptions on the quality of and satisfaction with the integrated services.
Circulate monthly or quarterly reports to all staff or departments in order to monitor performance.
Logistics
For HIV services that intend to provide FP contraceptives on site or through community health workers, ensure a regular and consistent supply by linking with or merging the appropriate supply chains. Likewise, for FP services intending to provide HIV services on site, ensure a regular and consistent supply of test kits, drugs, and other supplies as appropriate.
Establish a logistics monitoring system for all commodities.
Referrals
If FP or HIV services are not available on site, identify where the services are available, establish collaborative relationships and networks, provide appropriate referrals, and find out if clients access services to which they are referred.
Community-based activities
Actively engage community groups and representatives as partners in the integration process by identifying their needs for FP/HIV integrated services and soliciting their contributions to community program design and outreach efforts to meet those needs.
Engage outreach workers, community-based distribution (CBD) agents, and other community leaders in discussions about potential biases against childbearing among HIV-positive women and couples.

Equip outreach workers to offer information on HIV prevention, provide referrals to HIV-testing services, counsel on all methods of FP, and provide select methods.

Organize activities to reach and educate adolescents about FP/RH and HIV, and link counseling and testing to school programs and other appropriate programs for adolescents.

Community-based, behavior change communications activities should involve CHWs and outreach workers to maximize impact.

Link CHWs and all community outreach workers to the nearest health facility for supportive supervision, problem-solving, case management, supply distribution, and records management.

Key Resources for Technical Interventions

- Balanced Counseling Strategy Toolkit (Population Council)
http://www.popcouncil.org/frontiers/bestpractices/BCSPlus_102008.html
- Community Home-Based Care for People and Communities Affected by HIV/AIDS Training Curriculum (Pathfinder International)
http://www.pathfind.org/site/PageServer?pagename=Publications_Training_and_Capacity_Building_CHBC
- Increasing Access to Contraception for Clients with HIV: A Toolkit (Family Health International)
<http://www.fhi.org/en/RH/Training/trainmat/ARVmodule.htm>
- Family Planning Discussion Topics for Voluntary Counseling and Testing: A Reference Guide for FP Counseling of Individuals, Couples, and Special Groups by Trained VCT Counselors (Pathfinder International)
http://www.pathfind.org/site/DocServer/Final_Pathfinder_FP-VCT_Counseling_Tool_12-07.pdf?docID=11661
- Family Planning and Safer Pregnancy Counseling for People Living with HIV/AIDS: A Tool for Health Care Providers in HIV Care and Treatment Settings (CDC, Draft)
- HIV Counseling and Testing for Youth: A Manual for Providers (Family Health International)
http://www.fhi.org/NR/rdonlyres/eolxm36ulklpmcihmalj5ljyv5iqjf243ody56_rh55pqtu6_vjxam2koffrj_2wo723im6syphvna7dm/YouthVCTmanual.pdf
- Integrating HIV Voluntary Counseling and Testing into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers, and Service Providers (IPPF, UNFPA)
http://www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf
- Reproductive Choices and Family Planning for People Living with HIV—Counseling Tool (WHO)
http://www.who.int/reproductivehealth/topics/family_planning/9241595132/en/index.html
- Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls: A Manual for Trainers and Programme Managers (EngenderHealth, ICW)
http://www.engenderhealth.org/files/pubs/hiv-aids-stis/RH_for_HIV_Positive_Women_English.pdf

Programmatic Considerations Specific to FP/PMTCT Integration

The following recommendations provide additional strategic considerations for strengthening the linkages between FP and PMTCT services.

Entry points

- Consider the following services and locales as points of entry for identifying PMTCT clients and reaching them with FP information and services:
 - Premarital counseling (in those countries that require HIV testing prior to marriage)
 - ANC visits
 - Well-child services for children, such as immunizations
 - Newborn consultations
 - Maternity wards, waiting rooms, labor and delivery wards
 - Postpartum visits and well-baby checkups
 - Postabortion care services
 - CT services: pre- and post-test counseling
 - HIV care and treatment waiting rooms
 - Community outreach programs
- In policies and practice, support the provision of voluntary and informed-choice FP counseling and methods to women during the postpartum period (defined as 18 months for PMTCT clients).
- Provide FP services where PMTCT services are provided, ideally by the same providers or providers located at the site. Same-site services are preferable to referrals to another site.
- Involve CHWs who work with MCH services or traditional birth attendants to deliver messages about the benefits of ANC, facility delivery, healthy spacing of pregnancies, contraception to avoid an unintended pregnancy, and the availability of interventions to reduce MTCT for those women who are HIV-positive and pregnant or want to become pregnant.

Healthy timing and spacing of pregnancy for HIV-positive women who want to become pregnant

- Counsel women on healthy timing and spacing of pregnancy to reduce the risk of adverse pregnancy outcomes. Both close pregnancies and HIV/AIDS increase the risks of low birth weight, preterm birth, and infant mortality.
- Recommend birth spacing for all women:
 - After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal, and infant outcomes.
 - After a miscarriage or induced abortion, the recommended minimum interval before the next pregnancy is at least six months in order to reduce the risk of adverse maternal and perinatal outcomes.²⁸

- Counsel about the risks of unprotected sex and ways to minimize this risk by disclosing HIV status to sex partners; knowing partner's HIV serostatus; making sure HIV-negative, male sex partners are circumcised if appropriate; treating STIs; ensuring low viral load (or high CD4); and minimizing unprotected intercourse to the most fertile part of the month.

Breastfeeding and contraception for HIV-positive women

- Address infant feeding options with clients. If replacement feeding is not acceptable, feasible, affordable, sustainable, and safe, HIV-positive women are recommended to exclusively breastfeed for the first six months of their child's life.²⁹
- Reinforce messages about LAM but also counsel on condom use for protection against HIV transmission to sex partners.
- Provide guidance on transitioning from LAM and exclusive breastfeeding to other contraceptive methods at six months postpartum; this should be discussed during pregnancy or early in the postnatal period. In explaining methods, include their effect on breastfeeding. For women not breastfeeding, explain that return to fertility can occur as early as four weeks postpartum.
- If feasible, counsel on and offer postpartum IUD insertion as a contraceptive option for women who want to delay or end childbearing. IUDs do not have any effect on breastfeeding and can be safely used by HIV-positive women.

Key Resources on Healthy Timing and Spacing of Pregnancy

- HTSP 101: Everything You Want to Know about Healthy Timing and Spacing of Pregnancy (ESD)
http://www.esdproj.org/site/DocServer/HTSP_101_Brief_Final_corrected_4.9.08.pdf?docID=1761
- Healthy Timing and Spacing of Pregnancies: A Pocket Guide for Health Practitioners, Program Managers, and Community Leaders (ESD)
http://www.esdproj.org/site/DocServer/ESD_PG_spreads.pdf?docID=141
- HTSP Trainers' Reference Guide (ESD)
http://www.esdproj.org/site/DocServer/HTSP_TRG_COMPLETE_9-22-08-CORRECTED.pdf?docID=2221
- Postpartum Family Planning eLearning Course (USAID)
<http://www.globalhealthlearning.org/login.cfm>

4. What information is needed to measure program success and inform program or service delivery improvement, replication, or scale-up?

Evidence of strategies for effective, integrated service delivery is needed urgently to provide more definitive recommendations to program managers. The literature on research and program experience in FP/HIV integration contains few publications with rigorous study designs (for example, control sites or analysis of pre-intervention conditions), which limits the ability to draw conclusions about effectiveness. Future operations research studies should focus on two key areas: (1) answering questions about how to effectively integrate services, and (2) testing the impact of effective approaches on key health outcomes.

In addition to research, strong monitoring and evaluation components need to be applied to high-quality, replicable, and scalable integration programs in order to better document current efforts and help identify best practices. A universally agreed-upon set of integration-related indicators does not currently exist. However, many efforts are under way both globally and at the country level to identify and implement indicators for monitoring FP/HIV integration services.

The following key questions need to be investigated to advance the field of FP/HIV integration:

- Does integrating FP and PMTCT, HIV counseling and testing, and HIV care and treatment services (or community-based programs) result in improved health outcomes, such as fewer unintended pregnancies and fewer HIV infections, when compared to implementing these services and programs separately?
- Are the incremental costs of linking services equal to or less than the cost of providing services separately?
- How effective are referral-based models of FP/HIV integration for uptake of methods not immediately offered in the HIV service or for uptake of HIV services? And how effective are these referrals for the continuation of methods that were initiated within the HIV service?
- Does integrating FP and PMTCT, HIV counseling and testing, and HIV care and treatment services improve the quality of care clients receive without compromising the quality of existing systems?
- What are effective ways of communicating messages about dual protection and dual method use in integrated FP and HIV service settings?
- Is it feasible to integrate FP services into provider-initiated testing and counseling (PITC)? If so, what is the most promising PITC setting in which to reach the largest number of clients who need FP?
- What is the best timing for delivery of FP information to women in ANC who are identified as HIV-positive?
- With programming primarily limited to facility-based information and contraceptive supply, will integration result in long-term, widespread FP use? Few integration models include two activities that have formerly been key to sustained FP use—multimedia campaigns and community-based distributors.

Glossary of Selected Terms

Except where otherwise indicated, the following working definitions are adapted from *Rapid Assessment Tool for Sexual & Reproductive Health Linkages: A Generic Guide* and are intended to facilitate consistent understanding and interpretation of the terms used in this tool.³⁰

Dual method use: Using two methods of contraception, a barrier method for protection against sexually transmitted infections (STIs) and another method for protection against unintended pregnancy.* The contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended.

Dual protection: Using one method of contraception for protection against both unintended pregnancy and sexually transmitted infections (STIs), including HIV. Condoms used alone can prevent both STIs and pregnancy if they are used correctly and consistently. However, condoms used alone are associated with higher pregnancy rates than condoms used in conjunction with another contraceptive method.

Four-element strategy for preventing HIV infections in women and infants:

- Prevent primary HIV infection among girls and women
- Prevent unintended pregnancies among women living with HIV
- Reduce mother-to-child transmission of HIV through antiretroviral drug treatment or prophylaxis, safer deliveries, and infant-feeding counseling
- Provide care, treatment, and support to women living with HIV and their families

HIV testing and counseling: The gateway to HIV prevention, care, treatment, and support. All HIV testing of individuals must be confidential, conducted only with informed consent, and accompanied by counseling. Client-initiated counseling and testing, also called voluntary counseling and testing (VCT), refers to clients seeking an HIV test and counseling on HIV prevention and risk reduction. Provider-initiated testing and counseling (PITC) refers to HIV testing and counseling that is routinely recommended by providers to those attending health care facilities as a standard component of medical care, for example, to enable clinical decisions based on knowledge of the person's HIV status.**

Integration: Combining different kinds of RH and HIV services or operational programs to ensure and maximize collective outcomes. This would include referrals from one service to another. Integration is based on the need to offer comprehensive services.

Linkages: The bidirectional synergies in policy, programs, services, and advocacy between RH and HIV. The term linkages refers to a broader human rights-based approach, of which service integration is a subset.

* The definition for dual method use was adapted from: Cates W, Steiner MJ. Dual protection against unintended pregnancy and sexually transmitted infections: What is the best contraceptive approach? *Sex Transm Dis.* 2002;29(3):168-74.

** The definition for HIV counseling and testing was adapted from: World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS). *Guidance on provider-initiated HIV testing and counseling in health facilities.* Geneva: WHO and UNAIDS; 2007.

Selected Bibliography

Key resources used to inform the development of strategic considerations for strengthening the linkages between family planning and HIV/AIDS policies, programs, and services

Adamchak SE, Grey TE, Otterness C, Katz K, Janowitz B. Introducing family planning services into antiretroviral programs in Ghana: an evaluation of a pilot intervention. Research Triangle Park (NC): Family Health International; 2007.

Allen S, Seruflira A, Gruber V, Kegeles S, Van de Perre P, Carael M, et al. Pregnancy and contraception use among urban Rwandan women after HIV testing and counseling. *Am J Public Health.* 1993;83(5):705-10.

Aradhya KW. Uganda: integrating family planning into VCT. *Network.* 2004;23(3):16.

Asiimwe D, Kibombo R, Matsiko J, Hardee K. Study of the integration of family planning and VCT/PMTCT/ART programs in Uganda. Washington (DC): USAID Policy Project; 2005.

Askew I, Berer M. The contribution of sexual and reproductive health services to the fight against HIV/AIDS: a review. *Reprod Health Matters.* 2003;11(22):51-73.

Baek C, Rutenberg N. Addressing the family planning needs of HIV-positive PMTCT clients: baseline findings from an operations research study. *Horizons Research Update.* Washington (DC): Population Council; 2005.

Banda HN, Bradley S, Hardee K. Provision and use of family planning in the context of HIV/AIDS in Zambia: perspectives of providers, family planning and antenatal care clients, and HIV-positive women. Washington (DC): USAID Policy Project; 2004.

Bangendanye L. Pregnancy, pregnancy desires, and contraceptive use among HIV-infected women. Findings from a survey of women enrolled in PMTCT in Rwanda. 3rd Annual Pediatric Conference on Children Infected and Affected by HIV and AIDS; 2007 Dec; Kigali, Rwanda.

Berer M. HIV/AIDS, sexual and reproductive health: intersections and implications for national programmes. *Health Policy Plan.* 2004;19(Suppl 1):i62-70.

Best K. Averting HIV-infected births: integrating family planning services can help achieve goal. *Network.* 2004;23(3):21-8.

Best K. Family planning and the prevention of mother-to-child transmission of HIV: a review of the literature. Research Triangle Park (NC): Family Health International; 2004.

Bradley H, Bedada A, Tsui H, Brahmbhatt H, Gillespie D, Kidanu A. HIV and family planning service integration and voluntary HIV counseling and testing client composition in Ethiopia. *AIDS Care.* 2008;20(1):61-71.

Doupe A. Guidelines for integrating sexual and reproductive health into the HIV/AIDS component of country coordinated proposals to be submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 7 and beyond. Washington (DC): Global AIDS Alliance; 2007.

Farrell BL, Rajani N. Integrating family planning with antiretroviral therapy services in Uganda. *Acquiring knowledge*, no. 5. New York: EngenderHealth/ACQUIRE Project; 2007.

Farrell BL. Family planning-integrated HIV services: a framework for integrating family planning and antiretroviral therapy services. New York: EngenderHealth/ACQUIRE Project; 2007.

Hardee K, Shepherd C, Hamilton M. Policy reform: a neglected dimension in integration. Linking reproductive health, family planning and HIV/AIDS programs in Africa conference; 2006 Oct 9-10; Addis Ababa, Ethiopia.

International Planned Parenthood Federation/Western Hemisphere Region. Integrating HIV/AIDS treatment and care into reproductive health settings. Spotlight: HIV/AIDS/STIs. 2006;4(A Series).

Maharaj P, Cleland J. Integration of sexual and reproductive health services in Kwa-Zulu-Natal, South Africa. Health Policy Plan. 2005;20(5):310-8.

Mahendra VS, Mudoi R, Oinam A, Pakkela V, Sarna A, Panda S, et al. Continuum of care for HIV-positive women accessing programs to prevent parent-to-child transmission: findings from India. Washington (DC): Population Council; 2007.

Mark KE, Meinzen-Derr J, Stephenson R, Haworth A, Ahmed Y, Duncan D, et al. Contraception among HIV concordant and discordant couples in Zambia: a randomized controlled trial. J Womens Health. 2007;16(8):1200-10.

McCarragher D, Cuthbertson C, Johnson L. Integrating family planning and reproductive health into a home-based care (HBC) program through risk reduction communication: a post-intervention assessment. Research Triangle Park (NC): Family Health International; 2005.

Mitchell HS, Stephens E. Review: contraception choice for HIV-positive women. Sex Transm Infect. 2004;80(3):167-73.

Mphuru L, Barone M, Perchal P, et al. Integration of voluntary counseling and testing for HIV into family planning and reproductive and child health services in Tanzania. Linking Reproductive Health, Family Planning and HIV/AIDS Programs in Africa Conference; 2006 Oct 9-10; Addis Ababa, Ethiopia.

Mukaire J, Kalikwani F, Maggwa BN. Integration of STI and HIV/AIDS services with MCH-FP services. A case study of the Busoga Diocese Family Life Education Program, Uganda. Nairobi: Population Council; 1997.

Mullick S, Menziwa M, Mosery N, Khoza D, Maroga E. Feasibility, acceptability, effectiveness and cost of models of integrating HIV prevention and counseling and testing for HIV within family planning services in North West Province, South Africa. FRONTIERS final report. Washington (DC): Population Council; 2008.

Price J. Family planning and HIV service integration: early findings from a five-country assessment of activities and models. 4th National HIV and AIDS Research Conference; 2008 Jul; Kigali, Rwanda.

Quiterio G, Molina M, Miric M, Vernon R, Rivero-Fuentes M. Situation analysis of the integration of family planning services in postpartum, postabortion, and prevention of mother-to-child transmission programs in the Dominican Republic. FRONTIERS final report. Washington (DC): Population Council; 2008.

Rakwar J, Wilcher R. Policy considerations for effective and sustainable integration of family planning and HIV services. Linking Reproductive Health, Family Planning and HIV/AIDS Programs in Africa Conference; 2006 Oct 9-10; Addis Ababa, Ethiopia.

Ramkissoon A, Coovadia H, Coutsooudis A, Hlazo J, Mthembu P, Smit J. Options for HIV-positive women. *S Afr Health Rev.* 2006;19:315-32.

Reynolds HW, Liku J, Maggwa BN. Assessment of voluntary counseling and testing centers in Kenya. Potential demand, acceptability, readiness, and feasibility of integrating family planning services into VCT. Research Triangle Park (NC): Family Health International; 2003.

Reynolds HW, Kimani J, Cuthbertson C, Kuyoh M, Geary C. Assessment of services for adolescents in prevention of mother-to-child transmission programs. YouthNet research working paper no. 4. Research Triangle Park (NC): Family Health International; 2006.

Reynolds HW, Kimani J. Services for prevention of mother-to-child transmission (PMTCT). YouthNet research brief. Research Triangle Park (NC): Family Health International; 2006.

Richey C, Setty V. Family planning choices for women with HIV. *Popul Reports.* 2007; Series L(15).

Rutenberg N. Family planning and PMTCT services: examining interrelationships, strengthening linkages. Washington (DC): Population Council; 2003.

Rutenberg N, Baek C. Field experiences integrating family planning into programs to prevent mother-to-child transmission of HIV. *Stud Fam Plann.* 2005;36(3):235-45.

Searing H, Randiki M, Farrell B, Masita-Mwangi M, Gutin S, . Evaluation of a family planning and antiretroviral therapy integration pilot in Mbale, Uganda. Evaluation and research study no. 13. New York: EngenderHealth/ACQUIRE Project; 2008.

Stover J, Fuchs N, Halperin D, Gibbons A, Gillespie D. Costs and benefits of adding family planning to services to prevent mother-to-child transmission of HIV (PMTCT). Washington (DC): Futures Group; 2003.

Subramanian L, Russell N, Wickstrom J. Family planning for healthy living in Ghana: addressing the needs of people living with HIV. New York: EngenderHealth/ACQUIRE Project; 2008.

Vartapetova NV, Karpushkina AV. Prevention of mother-to-child transmission of HIV and family planning practices in HIV-infected women facility survey: report of main findings. Moscow: John Snow, Inc.; 2006.

Wilson L, Warren C, Mullick S. Feasibility, acceptability, effect, and cost of integrating counseling and testing for HIV within family planning services in Kenya. FRONTIERS final report. Washington (DC): Population Council; 2008.

World Health Organization (WHO). Technical consultation on the integration of HIV interventions into maternal, newborn and child health services; 2006 Apr 5-7; Geneva [Internet]. Geneva: WHO; 2006 [cited 2009 Jan 14]. Available from: http://whqlibdoc.who.int/hq/2008/WHO_MPS_08.05_eng.pdf.

References

- ¹ Interact Worldwide. Intimate links: a call to action on HIV/AIDS and sexual and reproductive health and rights [Internet]. London: Interact Worldwide; 2006 [cited 2008 Dec 10]. Available from: <http://www.interactworldwide.org/objs/563021320-intimatelinkspaper1.pdf>.
- ² World Health Organization (WHO). Glion consultation on strengthening the linkages between reproductive health and HIV/AIDS: family planning and HIV/AIDS in women and children [Internet]. Geneva: WHO; 2004 [cited 2008 Dec 10]. Available from: http://www.who.int/reproductive-health/stis/docs/glion_consultationsummary.pdf.
- ³ United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), Family Care International (FCI). The New York call to commitment: linking HIV/AIDS and sexual and reproductive health [Internet]. New York: UNFPA; 2004 [cited 2008 Dec 10]. Available from: http://www.unfpa.org/upload/lib_pub_file/321_file-name_New%20York%20Call%20to%20Commitment.pdf.
- ⁴ Joint United Nations Programme on HIV/AIDS (UNAIDS). Intensifying HIV prevention. UNAIDS policy position paper [Internet]. Geneva: UNAIDS; 2005 [cited 2008 Dec 10]. Available from: http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf.
- ⁵ United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Declaration of commitment on HIV/AIDS; 2001 Jun 25-27 [Internet]. New York: United Nations [cited 2008 Dec 10]. Available from: http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf.
- ⁶ African Union. Maputo plan of action for the operationalization of the continental policy framework for sexual and reproductive health and rights: 2007-2010. Special Session of the Africa Union Conference of Ministers of Health; 2006 Sep 18-22; Maputo, Mozambique [Internet]. Addis Ababa: African Union; 2006 [cited 2008 Dec 10]. Available from: http://www.africa-union.org/root/au/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/RHR_%20Plan_of_Action_2007_Final.pdf.
- ⁷ The Interagency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children. Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: towards universal access for women, infants and young children and eliminating HIV and AIDS among children [Internet]. New York: UNFPA; 2007 [cited 2008 Dec 10]. Available from: <http://www.unfpa.org/public/publications/pid/394>.
- ⁸ Reynolds HW, Janowitz B, Wilcher R, Cates W. Contraception to prevent HIV-positive births: current contribution and potential cost-savings in PEPFAR countries. *Sex Transm Infect*. 2008;84(Suppl II):ii49-53.
- ⁹ Sweat MD, O'Reilly KR, Schmid GP, Denison J, de Zoysa I. Cost-effectiveness of nevirapine to prevent mother-to-child HIV transmission in eight African countries. *AIDS*. 2004;18(12):1661-71.
- ¹⁰ Stover J, Fuchs N, Halperin D, Gibbons A, Gillespie D. Costs and benefits of adding family planning to services to prevent mother-to-child transmission of HIV (PMTCT). Washington (DC): Futures Group; 2003.
- ¹¹ Rochat TJ, Richter LM, Doll HA, Buthelezi NP, Tomkins A, Stein A. Depression among pregnant rural South African women undergoing HIV testing. *JAMA*. 2006;295(12):1376-8.
- ¹² Desgrées-du-Loû A, Msellati P, Viho I, Yao A, Yapi D, Kassi P, et al. Contraceptive use, protected sexual intercourse and incidence of pregnancies among African HIV-infected women. DITRAME ANRS 049 Project, Abidjan 1995-2000. *Int J STD AIDS*. 2002;13(7):462-8.
- ¹³ Homsy J, Bunnell R, Moore D, King R, Malamba S, Nakityo R, et al. Reproductive intentions and outcomes among women on antiretroviral therapy in rural Uganda: a prospective cohort study. *PLoS One*. 2009;4(1):e4149.

- ¹⁴ Martin R, Boyer P, Hammill H, Peavy H, Platzker A, Settlege R, et al. Incidence of premature birth and neonatal respiratory disease in infants of HIV-positive mothers. The Pediatric Pulmonary and Cardiovascular Complications of Vertically Transmitted Human Immunodeficiency Virus Infection Study Group. *J Pediatr*. 1997;131(6):851-6.
- ¹⁵ Brocklehurst P, French R. The association between maternal HIV infection and perinatal outcome: a systematic review of the literature and meta-analysis. *Br J Obstet Gynaecol*. 1998;105(8):836-48.
- ¹⁶ Abrams EJ, Matheson PB, Thomas PA, Thea DM, Krasinski K, Lambert G, et al. Neonatal predictors of infection status and early death among 332 infants at risk of HIV-1 infection monitored prospectively from birth. New York City Perinatal HIV Transmission Collaborative Study Group. *Pediatrics*. 1995;96(3 Pt 1):451-8.
- ¹⁷ World Health Organization (WHO), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF), Joint United Nations Programme on HIV/AIDS (UNAIDS), University of California San Francisco (UCSF). Sexual and reproductive health and HIV linkages: evidence review and recommendations. Geneva: WHO; 2008.
- ¹⁸ U.S. Agency for International Development (USAID). Family planning/HIV integration: technical guidance for USAID-supported field programs. Washington (DC): USAID; 2003.
- ¹⁹ Reynolds H, Wilcher R. Best kept secret in PMTCT: contraception to avert unintended pregnancies. *Global AIDSLink*. 2006;97.
- ²⁰ Population Council. Women living with HIV have unmet family planning needs. FRONTIERS operations research summary, no. 75 [Internet]. New York: Population Council; 2008 [cited 2008 Dec 12]. Available from: http://pdf.usaid.gov/pdf_docs/PNADL834.pdf.
- ²¹ Price JE, Leslie JA, Welsh M, Binagwaho A. Integrating HIV clinical services into primary health care in Rwanda: a measure of quantitative effects. *AIDS Care*. 2009;21(5):608-14.
- ²² Family Health International (FHI). Integrating family planning into HIV voluntary counseling and testing services in Kenya: progress to date and lessons learned [Internet]. Research Triangle Park (NC): FHI; 2006 [cited 2008 Dec 10]. Available from: <http://www.fhi.org/NR/rdonlyres/es5cvy4xltapklfigen2lj32zvkcvc2fpdv4ellln6c4viqjcjbpaamdhkcs-std3n25fixj6uhgomyuc/FPVCTintegrationKenyalessons.pdf>.
- ²³ Searing H, Randiki M, Farrell B, Masita-Mwangi M, Gutin S. Evaluation of a family planning and antiretroviral therapy integration pilot in Mbale, Uganda. Evaluation and research study #13. New York: EngenderHealth/ACQUIRE Project; 2008.
- ²⁴ Liambila W, Askew I, Aysi R, Gathitu M, Mwangi J, Homan R, et al. Feasibility, acceptability, effect, and cost of integrating counseling and testing for HIV within family planning services in Kenya. FRONTIERS final report. Washington (DC): Population Council; 2008.
- ²⁵ Mullick S, Menziwa M, Mosery N, Khoza D, Maroga E. Feasibility, acceptability, effectiveness and cost of models of integrating HIV prevention and counseling and testing for HIV within family planning services in North West Province, South Africa. FRONTIERS final report. Washington (DC): Population Council; 2008.
- ²⁶ Kane MM, Colton TC. Integrating SRH and HIV/AIDS services: Pathfinder International's experience synergizing health initiatives. Watertown (MA): Pathfinder International; 2005.
- ²⁷ Adamchak S, Reynolds H, Janowitz B, Grey T, Keyes E. Family planning and HIV/AIDS integration: findings from five countries. FP/HIV Integration Working Group Workshop; 2008 Oct.

- ²⁸ World Health Organization (WHO). Report of a WHO technical consultation on birth spacing [Internet]. Geneva: WHO; 2005 [cited 2009 Jan 26]. Available from: http://www.who.int/making_pregnancy_safer/documents/birth_spacing05/en/.
- ²⁹ World Health Organization (WHO), Joint United Nations Programme for HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA). HIV and infant feeding [Internet]. Geneva: WHO; 2006 [cited 2009 Jan 26]. Available from: http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf.
- ³⁰ International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA), World Health Organization (WHO), Joint United Nations Programme for HIV/AIDS (UNAIDS), Global Network of People Living with HIV/AIDS (GNP+), et al. Rapid assessment tool for sexual and reproductive health linkages: a generic guide [Internet]. Geneva: WHO; 2008 [cited 2008 Dec 15]. Available from: http://www.who.int/reproductive-health/hiv/linkages_rapid_assmnt_tool.pdf.



