

Integrating family planning and HIV services

Research from Africa leads the way

Key points

- Integrating family planning (FP) and HIV services is an important strategy for addressing the reproductive health rights and needs of people living with and at risk of HIV infection.
- Support for stronger linkages between FP and HIV programmes is growing, and field-based integration efforts are expanding.
- Recent research from five African countries is influencing recommendations on how healthcare providers can deliver high-quality integrated services.
- As the momentum behind integration builds, more evidence on effective strategies for delivering these services is needed.

Because people seeking HIV services often share common needs and concerns with those who seek family planning (FP) services, integrating these two types of services enables healthcare providers to serve their patients more efficiently and comprehensively. As momentum builds behind integration efforts in Africa, evidence-based practices are beginning to emerge that will help providers to offer high-quality integrated services.

Models of integration

There is broad international consensus that linking FP and HIV services is essential for meeting international development goals and targets, including the United Nations Millennium Development Goals. The current political administration in the United States has placed FP next to HIV as a global health priority, and initiatives such as the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria are increasingly supportive of activities that link HIV programmes with FP services.

This increased interest in FP/HIV service integration has generated an expansion of field-based efforts to integrate these services. Although stakeholders are pursuing several approaches to integration, the most popular ideas involve integrating FP into existing HIV services. For example, adding FP services to HIV counselling and testing can reach populations who do not typically attend FP clinics, such as men, sexually active young and unmarried people, and those who are at high risk of HIV, such as sex workers.

Incorporating FP services into programmes for preventing mother-to-child transmission (PMTCT) of HIV has additional advantages. For women with HIV who want to become pregnant, use of antiretroviral prophylaxis during pregnancy can reduce the risk of mother-to-child transmission. For women with HIV who do not wish to become pregnant, preventing unintended pregnancies through voluntary use of contraception

is a proven, cost-effective strategy for preventing vertical transmission of HIV and reducing the number of children needing HIV treatment, care, and support (see 'Contraception to prevent HIV'). In addition, FP



This advertisement in a local Angola newspaper highlights the importance of HIV testing in pregnancy. For pregnant women with HIV, use of antiretroviral prophylaxis can prevent mother-to-child transmission. For all pregnant women, use of family planning services after delivery can promote healthy timing and spacing of future births.

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In July 2011, FHI became FHI 360.



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services that promote healthy timing and spacing of pregnancies help to reduce the risk of adverse pregnancy outcomes such as low birth weight, preterm birth, and infant mortality.

Integrating FP into HIV care and treatment can also facilitate the voluntary uptake of contraception by HIV-positive individuals, which can help them to maintain their health, plan safer pregnancies, and prevent mother-to-child transmission of HIV. On the other hand, it is also beneficial to integrate HIV services into existing FP programmes, because adding HIV services – particularly counselling and testing – to FP programmes can facilitate earlier diagnosis of HIV and referral for care and treatment.

Evaluating recent efforts

Despite the potential benefits of FP/HIV service integration, integration efforts have been slow to take root. Rates of unintended pregnancies remain alarmingly high among women with HIV, and FP interventions have been underutilised in HIV prevention, care, and treatment programmes. Until recently, integration efforts have also been hampered by a lack of evidence of effective approaches.

Four recent studies by scientists at Family Health International (FHI) are among those contributing to the growing evidence base on integration. In 2009, FHI and many local partners completed a five-country study presenting a ‘snapshot’ of early integration efforts in Ethiopia, Kenya, Rwanda, South Africa, and Uganda. The scientists used interviews of more than 2000 people and observations of staff at more than 100 clinics to determine unmet need for contraception, the readiness of clinics and providers to meet that need, the extent of integrated services being provided, and the availability of data to monitor the progress of integration. All

Contraception to prevent HIV

The potential contribution of contraception in preventing HIV-positive births is well established. One study conducted in eight African countries found that even modest decreases in the number of pregnancies to HIV-infected women – ranging from 6% to 35% – could avert HIV-positive births at the same rate as the use of antiretroviral drugs for PMTCT.¹ Another analysis conducted with data from Uganda estimated that in 2007, FP was responsible for preventing 6100 HIV-positive births, while antiretroviral prophylaxis prevented about 2200 HIV infections. However, an estimated 5300 infant infections still occurred as a result of unwanted fertility.²

Current levels of contraceptive use in sub-Saharan Africa already prevent an estimated 173 000 HIV-positive births annually, even though contraception is not widely available in the region.³ An additional 160 000 HIV-positive births could be averted every year if all women in the region who did not wish to become pregnant used contraception. An analysis of the focus countries of the US President’s Emergency Plan for AIDS Relief (PEPFAR) also found that contraception prevents a wide range of HIV-positive births every year – from 178 in Guyana to 120 256 in South Africa.⁴

References

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A man leaves the Naguru Health Centre in Kampala, Uganda. The centre offers integrated services including family planning, HIV counselling and testing, adolescent health, and antenatal and postnatal care, among others.

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programmes included in the analysis were integrating FP into HIV counselling and testing, FP into HIV care and treatment, or HIV services into FP.¹

Between 2007 and 2009, FHI also undertook three separate studies of PMTCT services in Kenya,² Rwanda,³ and South Africa.⁴ The scientists interviewed HIV-positive patients, their male partners, healthcare providers, and programme managers from 46 facilities offering antenatal care, postnatal care, or child welfare services. They analysed the data to determine whether FP services could reach HIV-positive pregnant and recently postpartum women with unmet contraceptive need. They also assessed the providers' readiness to offer such services.

Common themes

Although the FHI studies were conducted in diverse settings using varied methodologies, their findings were strikingly consistent across countries. Many of the findings have important implications for healthcare providers who may be offering or plan to offer integrated services.

All four studies documented an unmet need for FP services. Among clients of HIV counselling and testing in the five-country study, unmet need varied from a high of 46% in South Africa to a low of 17% in Ethiopia. Unmet need was lower among women receiving HIV care and treatment (about 20%), likely because a higher percentage of these women were in stable relationships and were already using contraception (most often condoms). In the three studies of PMTCT services, at least one-half of the women interviewed said either that they did not want their most recent pregnancy or that their most recent pregnancy was mistimed or unplanned.

Despite the clear demonstration of unmet need for contraception, the research also showed that many patients are not being systematically screened for unmet need. While most providers said that FP was part of the package of care they offer their patients, few of the patients actually received contraceptive methods other than condoms.

The results of the studies also suggest that insufficient training of providers is a major obstacle to the provision of FP. For instance, the five-country study found that about one-half of the providers in the study did not have the job aids and supportive supervision needed to facilitate service delivery. The PMTCT study in Rwanda found that more than one-half of the providers of HIV services had been trained in FP, but only about one-fourth had been trained in FP services specifically for HIV-positive women.

Misconceptions and general lack of knowledge about contraceptive options for women with HIV were also common among providers. Many providers in the five-country study were unaware of recently updated World Health Organization (WHO) medical eligibility criteria regarding contraceptive use by HIV-positive women. Providers in all three PMTCT studies had widespread misconceptions about the safety of contraception for women living with HIV, and many did not recognise that preventing an unintended pregnancy through the use of FP could prevent an HIV-positive birth.

Developing guidance

Because a provider's understanding of integration is essential for strengthening FP interventions within HIV programmes, FHI has used the findings from these studies to develop evidence-based recommendations that healthcare providers can use to deliver high-quality integrated services (see 'Ten essential steps for strengthening integrated services'). A broad array of additional tools and resources for providers also exists (see 'Tools for providers'). However, as implementers work to establish and enhance the ties between the fields of

Tools for providers

www.k4health.org/toolkits/fphivintegration

Family Planning and HIV Services Integration Toolkit (Family Health International/Knowledge for Health Project)

www.who.int/reproductivehealth/publications/family_planning/9241595132/en/index.html

Reproductive Choices and Family Planning for People Living with HIV: Counselling Tool (World Health Organization)

www.acquireproject.org/archive/files/10.0_training_curricula_and_materials/10.2_resources/FP-Integrated%20ART.pdf

Family Planning–Integrated Antiretroviral Therapy: A Curriculum (The ACQUIRE Project/EngenderHealth)

www.pathfinder.org/site/DocServer/Final_Pathfinder_FP-VCT_Counseling_Tool_12-07.pdf?docID=11661

Family Planning Discussion Topics for Voluntary Counseling and Testing (Pathfinder International)

www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm

HIV Counseling and Testing for Youth: A Manual for Providers (Family Health International)

www.fhi.org/en/RH/Training/trainmat/ARV-module.htm

Increasing Access to Contraception for Clients with HIV: A Toolkit (Family Health International/EngenderHealth)

www.who.int/reproductivehealth/publications/family_planning/9241593229/index/en.html

Decision-Making Tool for Family Planning Clients and Providers (World Health Organization)

www.fhi.org/en/RH/Pubs/booksReports/FP-HIV_Strategic_Considerations.htm

Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services (World Health Organization/U.S. Agency for International Development/Family Health International)

Ten essential steps for strengthening integrated services

1. Generate demand for integrated services. Advertise to your patients using posters, brochures, and leaflets. Encourage community health workers, volunteers, and local support groups to tell others about the services you provide.

2. Organise services. Learn how your patients move through the facility. Draw a diagram of the available space and reduce costs by offering multiple services in the same location, modifying waiting areas, or rearranging moveable fixtures to reduce bottlenecks and help triage patients. Also determine how services can be changed to reduce waiting times and patient costs.

3. Ensure commodity security. Register your facility with the appropriate authorities to receive contraceptives and HIV supplies. Develop a plan for a reliable supply system within the local network and within the facility.

4. Train healthcare providers. Assess the informational needs of all levels of providers and develop a plan to update their knowledge and skills. For example, provide information and basic counselling skills to lower-level cadres and community health workers. Learn WHO's medical eligibility criteria for contraceptive use by people living with HIV. Access free training materials from the Internet, organise in-house study groups, and use peer-to-peer support.

5. Screen all patients for an unmet need for contraception. All women of childbearing age and all men should be asked about their sexual activity, desire for pregnancy in the near future, and current contraceptive use. Screen patients at regular intervals and update information in their patient records.

6. Foster dual protection and dual-method use.

Develop counselling strategies to encourage male and female patients to use condoms correctly and consistently, and to use condoms with another contraceptive method. Stress the importance of preventing both pregnancy and sexually transmitted infections.

7. Challenge provider bias. Address the tendency to emphasise condom use and neglect other contraceptive methods. Correct the false belief that some contraceptive methods are inappropriate for people living with HIV. Support the right of people living with HIV to enjoy healthy sexual relationships and to become pregnant if desired.

8. Reinforce referral systems. Map all available sources of contraceptive methods not provided on-site, including public facilities, private facilities, and nongovernmental organizations. Develop a contact list with phone numbers and e-mail addresses. Institute a monthly follow-up system to track completed referrals.

9. Strengthen skills for supportive supervision. Update documents—supervision protocols, monitoring forms, provider job descriptions, and checklists—to reflect the provision of integrated services. Include elements that address contraception, challenges in promoting dual protection, and dual-method use.

10. Monitor and evaluate performance. Determine whether the FP service or the HIV service is responsible for reporting the delivery of integrated services. Collect relevant service data within an appropriate time frame, using standard indicators and reporting systems. Review the data as a team and use them to improve the services you provide.

FP and HIV, research to develop more evidence-based practices must continue.

As mentioned earlier, no single approach to integrating FP and HIV services exists, and reports from the field suggest that different levels of integration may be appropriate for different healthcare facilities or programmes. For instance, provision of FP methods at HIV service facilities may increase initial contraceptive uptake more than referrals do. However, not all HIV service facilities will be able to make contraceptive methods available on-site.

Some service delivery settings may better use their resources by equipping HIV service providers to screen patients for risk of unintended pregnancy and provide same-day referrals to a FP clinic. An evaluation of a referral-based model of FP/HIV integration in Nigeria found that integration can facilitate major improvements in FP clinic attendance and contraceptive uptake.⁵

No matter which approach is taken, it is evident that properly implemented FP/HIV service integration has the potential to produce tangible gains against the HIV epidemic and improve the overall health of mothers and their children.

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