

Integrating Family Planning into HIV Programs: Evidence-Based Practices

A favorable policy environment for family planning and HIV integration has emerged, the evidence base for the effective integration of services is growing, and a broad array of guidance documents and tools are available to support integrated programming.

What is family planning and HIV integration?

The integration of family planning (FP) and HIV services improves sexual and reproductive health outcomes by providing both services under one programmatic umbrella. This type of integration refers to the delivery of health services, and it is a subset of closely related but broader linkages between family planning and HIV policies, funding, programs, and advocacy.¹

Background

Historically, family planning services and HIV programs have had separate funding streams and independent operational structures. Over the last decade, however, the global health community has endorsed stronger linkages between family planning and HIV policies, programs, and services. These linkages are essential to meet the needs of women and their families and to achieve international development goals, such as an AIDS-free generation and greater access to reproductive health services.

The unmet need for family planning and the HIV epidemic are driven by similar root causes, including poverty, poor access to healthcare, gender inequality, and social marginalization of vulnerable populations (IAWG 2010). Clients seeking HIV services and those seeking reproductive health and family planning services also share many common needs and concerns. Indeed, countries with the greatest burden of HIV also have high levels of unmet need for family planning, and many women are simultaneously at risk for both unintended pregnancy and HIV acquisition. Nevertheless, the “widespread integration [of family planning and HIV] remains an unrealized goal” (Ringheim 2009).

Integrating family planning services into HIV programs can increase access to contraception among clients of HIV services who wish to delay, space, or limit their pregnancies. Integration can also help to ensure a safe and healthy pregnancy and delivery for those who wish to have a child. For women living with HIV who do not wish to become pregnant, family planning is an evidence-based, cost-effective strategy for preventing unintended pregnancies and for reducing new pediatric HIV infections (Reynolds 2008).

Family planning services can be integrated at several HIV service delivery points: HIV counseling and testing, prevention of mother-to-child transmission (PMTCT), and care

1. Adapted from definitions for “integration” and “linkages” in the *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services* (WHO, USAID, FHI 2009).



and treatment services. Different levels of integration might be appropriate for different health care facilities or programs, depending on the local context and available resources, capacity, and facility set-up (WHO 2009).

The integration of these services provides an opportunity for health systems to offer family planning information and services to those at risk of HIV and people living with HIV (Global Health Learning Center 2009). Integrated services enable providers to efficiently and comprehensively address an individual's sexual and reproductive health needs. By contrast, delivering these services in parallel represents a missed opportunity that may weaken the effectiveness or quality of programs and stall progress toward achieving key health outcomes.

A favorable policy environment for FP/HIV integration has emerged globally and at the national level in several countries. Moreover, the evidence base for the effective integration of services is growing, and a broad array of guidance documents and tools are available to support integrated FP/HIV programming. This document draws from research findings, program experiences in the field, and technical guidance to offer recommendations for institutionalizing and scaling up integrated family planning and HIV services.

Why is it important to integrate family planning and HIV services?

Like all women, men, and couples, people living with HIV have diverse fertility desires. Although one's desire for childbearing may change over time and even increase for some women after they start HIV treatment (Cooper 2009; Homsy 2009; Maier 2009; Myer 2007), recent data suggest that, on average, HIV-positive women tend to want fewer children than women without HIV (Landolt 2012; Beyeza-Kashesya 2011; Heys 2012; Hoffman 2008; Taalo 2009; Makumbi 2010). In one recent study, having an HIV-positive status was the strongest predictor of not wanting future children (Heys 2012).

Women living with HIV experience high rates of unmet need for family planning and unintended pregnancies.

Some studies suggest that the rates of contraceptive use among HIV-positive women are similar to or exceed that of women without HIV or women in the general population (Mbonye 2012; Crede 2012; Wanyenze 2011; Muyindike 2012; Polis 2011; Ngure 2012). However, condoms are reported as the method most often used for pregnancy prevention by women and couples with HIV (Sarnquist 2013; Brou 2008), and consistent condom use among HIV-positive women has been shown to be low (Kaida 2010; Johnson 2009; Heys 2009; Elul 2009; Andia 2009). Though a survey from Uganda reported fairly high dual-method use among women with HIV (Oliveras 2013), several other studies have reported very

low dual-method use (Beyeza-Kashesya 2011; Nattabi 2011; Wanyenze 2011; Chakrapani 2011; Chi 2012). Thus, many women with HIV have an unmet need for family planning and are at risk of unintended pregnancy.

Studies from Côte d'Ivoire, India, Rwanda, South Africa, and Uganda report high rates of unintended pregnancy (51% to 84%) among women living with HIV (Bangendanye 2007; Desgrees-Du-Lou 2002; Rochat 2006; Suryavanshi 2008; Schwartz 2012; Wanyenze 2011). A study in Uganda found that 75% of HIV-positive women had an unmet need for family planning, more than double the unmet need reported by HIV-uninfected women (34%) in the study (Jhangri 2012). A limited but growing body of evidence suggests that many women in Asia affected by HIV also lack access to family planning services and experience disproportionately high rates of unintended pregnancy and abortion (Petruney 2012).

Unintended pregnancy among women living with HIV carries significant risks for mothers and children.

A meta-analysis of 23 studies found that HIV-positive women have eight times the risk of a pregnancy-related death compared to women without HIV, and that an estimated one in four pregnancy-related deaths in sub-Saharan Africa are attributable to HIV (Calvert 2013). An analysis in Uganda estimates that even with a projected scale up of antiretroviral (ARV)-based PMTCT, unwanted pregnancies among women with HIV may account for almost a quarter of all HIV-positive infants and about a fifth of pediatric AIDS deaths (Hladik 2009).

Research also suggests that HIV-positive women are at greater risk of anemia and spontaneous abortion during pregnancy (Meda 1999), and possibly infection or hemorrhage after delivery. During pregnancy, malarial infections carry a greater risk for HIV-positive women than for HIV-uninfected women (Mount 2004). Babies born to HIV-positive women are at greater risk of being born preterm, stillborn, or at low birthweight (WHO/RHR 2007). HIV-positive women who seek induced abortion may be at greater risk of morbidity than HIV-uninfected women (de Bruyn 2003). And antiretroviral therapy (ART) may have a negative effect on birth outcomes, such as prematurity or low birthweight (Ekoveni 2008).

Integrating family planning and HIV services is desirable for many clients and has important potential benefits.

Global policy statements, national frameworks, and programmatic guidance and tools highlight the range of potential individual, program, and public health benefits gained from the integration of family planning and HIV services:

- Responds to the expressed preferences of clients who see integrated services as a convenient way to meet several important health needs at once.

- Prevents the need for clients to reveal their HIV status to multiple health care providers.
- Gives the client more control over his or her reproductive health and fertility.
- Reduces stigma and promotes a culture of rights-based health care.
- Improves access to family planning and reproductive health services for HIV-positive clients and high-risk populations.
- Promotes planning and spacing of pregnancy for all women.
- Allows for ongoing contraceptive management when clients come in for regular HIV-treatment services.
- Reduces unintended pregnancies, particularly among women at risk of and living with HIV.
- Minimizes additional health risks that unintended pregnancies pose to women with HIV.
- Enhances program effectiveness and quality of care. For example, providers can tailor contraceptive counseling to address questions and concerns that clients may have about the safety and effectiveness of different contraceptive methods for women living with HIV. Providers can also assist a woman in a serodiscordant couple to achieve pregnancy while minimizing the risk of sexual HIV transmission.
- Increases the promotion of dual-method use and dual protection.
- By increasing access to contraception and preventing unintended pregnancies, integration reduces new pediatric HIV infections, and the number of children needing HIV treatment, care, and support.

HIV/AIDS funders such as PEPFAR and The Global Fund increasingly encourage the integration of family planning into programs they support (Wilcher 2010). For example, recent PEPFAR guidance states that “The need for family planning for HIV-positive women who desire to space or limit births is an important component of the preventive care package of services for people living with HIV/AIDS and for women accessing PMTCT services...PEPFAR is a strong supporter of linkages between HIV/AIDS and voluntary family planning and [other] reproductive health programs” (PEPFAR Fiscal Year 2012 Country Operational Plan (COP) Guidance). Specific actions for facilitating the integration of family planning also feature prominently throughout the 2012 *PEPFAR Blueprint: Creating an AIDS-free Generation*.

At the country level, some government health leaders have established national coordination efforts between reproductive health and family planning departments and HIV departments, which, in turn, have led to measurable progress in policy and practice. For example, Kenya and Nigeria instituted national RH/HIV strategies in 2009 and 2008, respectively. At least 16 countries have implemented the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* to assess the current state of integration and develop action plans for strengthening efforts. In Tanzania, the government has proactively leveraged the PEPFAR platform to strengthen linkages between HIV programs and family planning services (Fleischman 2012).

[Sources: Integra Initiative; Elizabeth Glaser Pediatric AIDS Foundation 2011; IPPF, UCSF, UNAIDS, UNFPA, WHO 2009; Global Health Learning Center 2009; IAWG 2010; FHI 360 2010b]

Policy and financial support for integrating family planning and HIV services is robust and continues to grow.

For close to a decade, governments, normative bodies, funders, implementing partners, and communities have issued statements supporting the integration of family planning and HIV policies, programs, and services. As a result, meeting the contraceptive and other reproductive health needs of people living with HIV through the provision of integrated services is a core component of key global health frameworks, such as the UNAIDS *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive*. Major



KEY FACILITATORS OF SUCCESSFUL PROGRAMS

- Government leadership via supportive laws, policies, guidelines, frameworks, and technical working groups, but also through coordinated planning, budgeting, implementation and monitoring and evaluation (M & E) between the RH/FP and HIV departments of ministries of health
- Meaningful involvement of people living with HIV, national and local government staff, program managers, service providers, and community leaders in the design and rollout of integrated services
- Benefits of integration clearly articulated to policymakers, service providers, clients, and communities
- “Levels” of integrated services tailored to the local context and to the facility’s capacities
- Pre- and in-service capacity building on family planning counseling and service delivery for HIV providers and supervisors, and the use of peer mentoring or training-of-trainer approaches to help diffuse new knowledge or skills to all program staff
- Task shifting for the delivery of integrated services, such as using lower-level workers to offer group FP information sessions in HIV clinics and community-based settings
- Improved M & E that captures the additional services being provided through changes to health management information systems (HMIS) and reporting structures, and better use of data to strengthen services
- Strong referral systems, which should include “facilitated” referrals from HIV clinics to family planning services where feasible and appropriate, and referrals for long-acting and permanent methods, which often are not available at lower-level facilities where clients seek FP and HIV services
- Functional supply chains and good commodity security measures that ensure adequate family planning supplies within HIV programs
- Services designed to attract and include men and youth, including family planning messages and counseling
- Collaboration with local groups to facilitate community involvement and accountability for comprehensive, integrated family planning and HIV services, including high-risk groups such as female sex workers, discordant couples, and youth

[This list of key facilitators was compiled through a search of the peer-reviewed literature and a variety of programmatic resources by identifying common themes and data that were linked to program successes. Sources: IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives; Population Reference Bureau; Scholl 2011; FHI 2012c; Pathfinder International 2011a; Pathfinder International 2011; WHO 2009; Global Health Learning Center 2009; IntraHealth 2012; Gay 2012; Kennedy 2012; Mahumane 2011; Smit 2012.]

BARRIERS THAT REDUCE THE EFFECTIVENESS OF INTEGRATED FP/HIV PROGRAMS

- Political, religious, or community opposition to family planning, which can limit support for FP/HIV integration from key stakeholders in decision-making positions
- Lack of government support, national policies and guidelines, and coordination between RH/FP and HIV departments of the ministries of health
- Vertical funding mechanisms among donors and governments
- Insufficient involvement of people living with HIV (PLHIV) in the design and implementation of integrated strategies
- Human resource constraints, including staff turnover, re-assignments, and shortages; actual or perceived heavy workloads; and high client/staff ratios
- Limited space in HIV clinics for private contraceptive counseling or method provision, particularly for longer-acting or permanent methods
- Lack of supportive supervision and performance expectations for the provision of integrated services
- Provider biases and stigma toward the sexual and reproductive health of people living with HIV, including poor knowledge about reproductive rights and biased or coercive contraceptive counseling that focuses only on condom promotion, and not a full range of methods and dual-method use
- Lack of knowledge among providers of the range of contraceptive methods that are safe for use by women living with HIV
- Insufficient screening of FP needs among sexually active clients
- Provider and client fears or lack of information about potential interactions between family planning methods and antiretroviral (ARV) medications
- Insufficient training of providers on informed-choice counseling for family planning and method provision
- Weak referral systems between HIV and family planning service delivery points, particularly when a full range of FP methods is not feasible to provide at the HIV clinic
- Separate record forms, reporting mechanisms, and HMIS for HIV and family planning services
- Lengthy processes for adapting policies, guidelines, training curricula, information, education and communication (IEC) materials, and HMIS to promote and monitor integrated service provision
- Contraceptive stockouts
- Lack of youth-friendly services
- Lack of attention paid to community mobilization for reproductive rights and access to integrated services

[This list of barriers was compiled through a search of peer-reviewed literature and a variety of programmatic resources by identifying common themes and data that were linked to program challenges. Sources: IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives; Gay 2012; FHI 360 2012a; Okundi 2009; Population Action International 2012b; IntraHealth 2012; Pathfinder International 2011a; Smit 2012.]

What is the impact of integrating family planning and HIV services?

Reviews of the evidence suggest that linking sexual and reproductive health or family planning with HIV services is beneficial and feasible (Kennedy 2010; Spaulding 2009; IPPF, UCSF, UNAIDS, UNFPA, WHO 2009); that clinical and rights-based benefits accrue from integration (IntraHealth 2012); and that the evidence base for effective integrated models is expanding (Wilcher 2013a). Although the overall rigor of FP/HIV integration studies is low, the evidence of the benefits and the public health impact of integration is encouraging. In particular, research findings suggest that integrating family planning and HIV services:

Meets client desires and demand. Most clients would rather receive contraceptive services at the same place where they access HIV services (Asiimwe 2005; Farrell 2007; Harrington 2012; Newmann 2013).

Increases access to and uptake of contraception by people living with HIV who wish to prevent pregnancy.

Three reviews report that the majority of studies evaluating interventions to deliver sexual and reproductive health services to women living with HIV have reported positive outcomes, including increases in voluntary contraceptive use or increases in completed referrals from HIV services to family planning clinics (Kennedy 2010, Wilcher 2013a; Lopez 2013).

Several studies suggest that both “one-stop-shop” models of integrated service delivery and referral-based approaches can improve family planning access and use (Mark 2007; Stephenson 2011; FHI 360 2012c; Wilcher 2013a; Baumgartner 2013; Grossman 2013). Additionally, programs in Zimbabwe, Kenya, Malawi, Tanzania, and Ethiopia found that community-based provision of integrated services contributed to large increases in new family planning clients (IntraHealth 2012; Daniel 2012).

Reduces unmet need. Results from a five-year research initiative that evaluated four different models of integrated SRH and HIV services in “real-world” settings in Kenya, Malawi, and Swaziland confirmed an existing unmet need for SRH services among women living with HIV (including family planning), and found that integrated services can help women realize their fertility intentions and meet their contraceptive needs (Integra Initiative 2013). A referral-based integrated intervention in Tanzania reduced unmet need of sexually active clients by 8% (Baumgartner 2013). In addition, two studies have documented decreases in the incidence of pregnancies following integration of family planning and HIV services (Ngure 2009; Wall 2013).

Improves HIV-related indicators. Research from Haiti found that integrating additional services (including family planning) within HIV programs increased the uptake of HIV testing by 62 times over a 15-year period (Peck 2003). The Extending Service Delivery Project in Zimbabwe reported that offering integrated services through community health workers not only contributed to increases in contraceptive use, but also in referrals to voluntary counseling and testing centers. It also led to improvements in client attitudes and knowledge about both family planning and HIV (IntraHealth 2012).

Strengthens male involvement in family planning. Several studies have demonstrated that the integration of FP into HIV services has the potential to engage men in family planning. At least four interventions that targeted couples with FP/HIV services have been successful in increasing non-condom contraceptive uptake or decreasing the incidence of pregnancies (Stephenson 2011; Ngure 2009; Khu 2012; Wall 2013). Moreover, HIV-positive men who were interviewed as part of an FP/HIV integration study in Kenya preferred to receive family planning information and services in HIV care settings rather than maternal and child health or family planning clinics, which are oriented primarily for mothers and babies (Steinfeld 2013).

Holds potential to reduce costs while enhancing impact. Integrating family planning and HIV programs can potentially reduce the costs of service provision by maximizing productive use of scarce health system resources. It can also reduce the costs for clients by avoiding the need to seek services through multiple appointments. A literature review focusing on the cost-effectiveness of integrating HIV services with other health services notes that the integration of family planning was highly cost-effective or cost-saving compared to non-integration models. However, none of those studies directly compared the costs of offering integrated programs versus stand-alone services, nor did they examine the comparative costs of different integration models (Sweeney 2012). Since that review, two studies have offered additional information. Results from a five-year research initiative in three countries indicated that integration has the potential to facilitate efficiency gains in some contexts, for example by optimizing provider workload in the provision of HIV counseling and testing (Integra Initiative 2013). And, a cluster randomized trial evaluating costs associated with the integration of family planning into HIV care and treatment services in Kenya found that integration was feasible, inexpensive to implement, and cost-efficient in the Kenyan setting (Shade 2013).

What measures can be taken to advance family planning and HIV integration?

World Health Organization guidelines call for primary HIV-care providers to address family planning and reproductive health with every woman in chronic HIV care. The following steps can help standardize family planning as part of routine services in HIV settings:

Be strategic, and pursue “smart,” context-specific integration. Initial decisions necessary for developing a tailored integration strategy include determining whether integration is needed, which specific family planning and HIV services will be integrated and to what extent, when and where to integrate them, and the steps and information required for achieving and documenting success. Important contextual considerations include the scale of the HIV epidemic and unmet need for family planning, the strength of existing vertical family planning programs, and the capacity of the facilities that offer the base HIV services intended for the integration of family planning. Program planners can conduct rapid needs or facility assessments to help determine the best

entry points for family planning and HIV integrated services, and to determine the appropriate level of service integration in a given setting.

Models of Integration

Various models can be used to integrate services, including the provision of family planning within HIV testing, care, or treatment sites, within PMTCT services, or within peer-outreach and community-based and home-based programs. The levels of integration may vary per setting and offer some or all of the following: group education on family planning, client screening for family planning needs, counseling on the full range of contraceptive options and dual-method use, provision of some or all contraceptive methods, and referrals for those methods not available at the site. For example, a voluntary testing and counseling site may choose to screen clients for family planning needs, and (if necessary) offer counseling and referrals, whereas an HIV-treatment clinic may be equipped to offer screening, information, counseling, and a contraceptive method. The table below provides some examples of different levels of integration (Farrell 2007).

TABLE 1: LEVELS OF INTEGRATING FP INTO HIV SERVICES FOR ONSITE PROVISION OF CONTRACEPTIVE INFORMATION, COUNSELING, AND METHODS OPTIONS*

Level A	Level B	Level C	Level D	Level E
<p>Provides all of the following functions:</p> <ul style="list-style-type: none"> Provides FP information to clients accessing ART, PMTCT, STI, VCT, and tuberculosis services. Performs risk/intention assessment for pregnancy or spacing. Counsels on FP methods, methods' ability to prevent STI and HIV infection, method choices available and where to access, dual protection, and potential drug interactions with hormonal methods. Provides condoms, instructs for and demonstrates correct use. Provides emergency contraceptive pills.** Refers for other methods not offered onsite. 	<p>Provides all Level A functions plus:</p> <ul style="list-style-type: none"> Provides oral contraceptives** with instructions for use. Provides follow-up or refers for follow-up. Counsels on potential drug interactions with oral contraceptives. 	<p>Provides all Level B functions plus:</p> <ul style="list-style-type: none"> Provides injectable contraception, with instructions for use, and with caution to return on schedule for reinjection without delay. Provides follow-up or refers for follow-up. 	<p>Provides all Level C functions plus:</p> <ul style="list-style-type: none"> Provides intrauterine device (IUD), with instructions for use. Provides implant, with instructions for use. Provides follow-up or refers for follow-up. 	<p>Provides all Level D functions plus:</p> <ul style="list-style-type: none"> Provides surgical contraceptive methods, with instructions for self-care, and provides follow-up.

* From Farrell B, Rajani N. Integrating family planning with antiretroviral therapy services in Uganda. 2007.

** If facilities or programs providing Level A functions are not immediately prepared to provide oral contraceptives for ongoing uses, they may provide emergency contraceptive pills with referral for ongoing FP management. If the facility or program already provides oral contraceptives (Level B), it can also offer emergency contraceptive pills.

Address constraints and introduce reinforcements at multiple levels of the health system to effectively advance and sustain integrated FP/HIV services:

- **Government leadership, policy linkages, and coordinating bodies.** Countries that have successfully advanced the integration of FP/HIV services systematically pursued nationally coordinated efforts, creating an enabling environment to foster integration via policy, funding, and program linkages. Several countries (such as Tanzania and Kenya) have ministries of health that oversee technical working groups devoted to planning and coordinating integration efforts. These coordinating bodies can help harmonize parallel funding streams, policies, and program plans. For example, in Tanzania, members of the technical working group help ensure that FP/HIV integration is a priority within funds allocated from the Global Fund, PEPFAR, and other HIV programs. These groups can also offer programmatic guidance, endorse tools, and generate policy support for integration. In Kenya, the government and technical working group developed programmatic guidance — the National Minimum Package for Integrated RH/HIV Services. The South African government has included recommendations for strengthening the linkages between family planning and HIV in at least three of its national policies for reproductive health and HIV/AIDS.
- **Civil society and community engagement.** It is important to involve diverse groups of community leaders, youth, local organizations, people living with HIV, and healthcare workers in the design and implementation of the integrated services. A wide range of stakeholders in health service delivery recognize the value of integration. For example, many faith-based organizations that implement health services favor the integration of family planning into their HIV programs (Christian Connections for International Health 2009). In turn, civil society can help to raise awareness about the availability of integrated services at the community level, especially with key populations that may not be reached by mainstream programs or that are not well represented in national dialogues (Population Action International 2012).
- **Supply chain and commodity security.** Ensuring an adequate and consistent supply of contraceptives is imperative to the success of a newly integrated program. An understanding of the existing supply chain should reveal where changes or improvements are needed to serve the new program structure (Population Reference Bureau 2009). Preparations should include plans to meet the anticipated increased demand for family planning services as a result of integration (Population Action International 2012a). For example, the Cameroon Baptist Convention Health Board (CBCHB) leveraged complementary funding

available through USAID's AWARE/HIV and AWARE/ Reproductive Health programs for the integration of family planning into HIV services. As a result, the supply chain for HIV and family planning commodities was improved, leading to enhanced infection prevention, medical monitoring, and overall service quality (Elizabeth Glaser Pediatric AIDS Foundation 2011).

- **Training and other human resource considerations.** Over-burdened healthcare staff in many developing countries poses a challenge to decision-makers who are considering the integration of services. However, an assessment of facility readiness for integration in five sub-Saharan African countries suggests that up to two-thirds of providers had some “non-busy” time during the day, suggesting that their work loads do not preclude the addition of more services (FHI 360 2010c). The integration of FP/RH and HIV services may also reduce the issues associated with staff shortages by streamlining services through one healthcare facility and allowing health providers to treat and counsel clients in one location at one time (Population Action International 2012). However, it may be necessary to adjust client flow or work patterns (including task shifting), and make sure that staff members are adequately trained, supported, motivated, and given appropriate job aids and tools (Global Health Learning Center 2009).
- Providing ongoing training, supportive supervision, and user-friendly job aids and tools to front-line staff is necessary if providers have increased client loads and responsibilities (Population Reference Bureau 2009). In addition to on-the-job training or in-service supplemental training, family planning should be incorporated into pre-service primary training or HIV-training materials. Provider job aids will be needed to reinforce the knowledge that is gained during training. Two essential elements for training are 1) orienting providers to the sexual and reproductive health rights of people living with HIV and addressing provider biases (e.g., that people living with HIV should not bear children, are not sexually active, should only use condoms, or should be sterilized); and b) ensuring that providers are able to counsel on the range of safe and effective contraceptive methods for HIV-positive clients (e.g., providing the latest evidence and guidance about hormonal contraception and HIV or antiretroviral therapy).
- **Facility infrastructure.** Some service sites have limited physical space, which can create challenges for service expansion (Johnson 2012). Where possible, devise creative plans to allocate sufficient space to allow for separate and private counseling on FP and HIV and to ensure the clients' confidentiality. Counseling rooms should be neutrally identified (WHO 2009).

- **Communication and demand generation, including dual-method promotion.** Communication strategies for the clients and the community should be designed to increase awareness, demand, and support for integrated services and for dual-method use. In Zimbabwe, PSI's SALIN program successfully used national mass media to raise awareness and demand for dual protection and dual-method use. In Cambodia, FHI 360's SMARTgirl program delivered an innovative, creative, and stigma-free dual-method use campaign tailored specifically for female sex workers.
- **Male involvement.** Leverage the opportunities that are created by the integration of FP and HIV services to reach men with family planning information and services. For example, successful workplace interventions deployed in several countries by corporations to jointly address gender, HIV, and family planning increased the use of HIV services by men, increased the overall use of family planning, led to transformations in gender relations between male and female workers, and produced positive behavior and attitude changes among male peer health educators (Pathfinder International 2010). For men who are in contact with the healthcare system for HIV counseling and testing or for care and treatment, each visit is an opportunity for providers to assess the client's fertility intentions and family planning needs, to discuss family planning options, to encourage joint decision-making about pregnancy intentions and contraceptive use with female partners, and to facilitate access to family planning services for the couple (if appropriate).
- **Information systems and M & E.** Although programs are typically required to collect data and provide reports on many indicators — often for multiple stakeholders (e.g., separate funders or government departments) — capturing data on newly integrated services is essential for effective monitoring, evaluation, and improvement. Program planners must ensure that key indicators are collected and used to improve program design, delivery, and outcomes. This may require tracking indicators that are not requested by major HIV funders, and revising record forms and HMIS systems to accommodate information on integrated service provision.

In one example of aligning the M & E system with newly integrated family planning services, a large HIV program in Nigeria adapted clinic registers used in PMTCT and HIV testing and counseling (HTC) services to record family planning counseling and referrals, updated FP clinic registers to record referrals made from HIV sites, trained providers to use the revised forms, and engaged M & E focal persons to adapt relevant indicators and to report aggregated data from the service-delivery level up to state and national HMIS systems (Chabikuli 2009).

Capturing data on integrated services, however, may not always require new data collection. In a five-country analysis that examined whether available data could be used to calculate key indicators on integration (FHI 360 2010c), three of six tested indicators were considered feasible for most health systems to report:

- » The proportion of service delivery points that offer integrated FP/HIV services.
 - » The proportion of women accessing HIV services that receive an FP method.
 - » The proportion of women accessing FP services that are tested for HIV.
- Ongoing research. Most evidence of effective integrated programs has come from small-scale pilot programs. As these practices are replicated, well-designed implementation science studies will be critical to understanding the degree of impact (e.g., on FP uptake, unmet need, and unintended pregnancy), how to effectively implement and sustain integrated services at scale (including in concentrated versus generalized settings), and to generate data on the costs and cost savings of systematically integrated approaches.

[Sources: FHI 2010c; Global Health Learning Center 2009; WHO 2009; FHI 2010a; Population Reference Bureau 2009; Population Action International 2012a; Pathfinder International 2011b; IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives; Johnson 2012; Population Action International 2012c; PSI 2011; Scholl 2011; Wilcher 2013a; Wilcher 2013b; IntraHealth 2012; FHI 360 2012c; Elizabeth Glaser Pediatric AIDS Foundation 2011; FHI 360 2012a; K4Health Family Planning and HIV Services Integration Toolkit; Integra Initiative; FHI 360 2012b]

Key tools and resources

Family Planning and HIV Services Integration Toolkit.

This toolkit is a one-stop source for policymakers, program managers, service providers, and advocates. It provides links to guidelines, research, curricula, communication materials, job aids, case studies, and other tools to plan, manage, deliver, evaluate, and support integrated services. Available at: <http://www.k4health.org/toolkits/fphivintegration>

Preventing HIV and Unintended Pregnancies: Strategic

Framework 2011-2015. This framework was produced in support of the “Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.” It offers guidance for preventing HIV infections and unintended pregnancies — both essential strategies for improving maternal and child health, and eliminating new paediatric HIV infections. Available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/PreventingHIV_UnintendedPregnancies_SF2011_2015.pdf

Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services. This resource is based on a combination of expert opinions, recommendations in the published literature, and lessons learned from field experiences. It offers a range of activities for program planners to enhance new or existing linkages. Available at: <http://www.fhi360.org/resource/select-family-planning-and-hiv-integration-resources>

The PEPFAR Blueprint: Creating an AIDS-free Generation. Available at: (<http://www.pepfar.gov/documents/organization/201386.pdf>),

The PEPFAR Fiscal Year 2013 Country Operational Plan (COP) Guidance. Available at: (<http://www.pepfar.gov/documents/organization/198957.pdf>),

The PEPFAR Fiscal Year 2013 Technical Considerations. Available at: (<http://www.pepfar.gov/documents/organization/199147.pdf>).

These three PEPFAR documents support the implementation of a broad range of activities to ensure that women and couples living with HIV have access to rights-based contraceptive services they want and need.

The SRH & HIV Linkages Resource Pack. This website aims to build a common understanding of sexual and reproductive health and HIV linkages and provide an overview of the current status of SRH and HIV linkages among key partners. It contains useful resources for organizations that advocate for this issue. Available at: <http://srhhivlinkages.org/content/en/index.html>

Increasing Access to Contraception for Clients with HIV: A Toolkit. This toolkit is a performance-based training curriculum that includes all the resources needed for learning activities, with easy-to-use counseling tools, checklists, guides, and other job aids for providers and program managers. The full-text resources provide the most current guidance and technical information on the integration of FP and HIV services. Available at: <http://www.fhi360.org/sites/default/files/media/documents/increasing-access-contraception-clients-hiv-toolkit.pdf>



The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in a High HIV/STI Prevalence Setting. This toolkit uses an interactive, client-friendly approach to improve counseling on family planning and STI prevention, and the detection and treatment of sexually transmitted infections (STIs) including HIV. Available at: <http://www.k4health.org/toolkits/oral-contraceptives/balanced-counseling-strategy-plus-toolkit-family-planning-service>

Family Planning–Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services. This framework was developed to: a) to stimulate critical thinking regarding programmatic gaps related to the reproductive health needs of women and couples living with HIV; b) examine the HIV assessment, prevention, and referral needs of family planning clients; and c) assist community and facility-based reproductive health providers and supervisors in tailoring services to reflect the integration needs of the communities they serve. Available at: www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/FP-HIV-Integration_framework_final.pdf

Hormonal Contraception and HIV. This technical brief summarizes current epidemiological evidence on the use of hormonal contraception and HIV. Available at: <http://www.usaid.gov/sites/default/files/documents/1864/hormonal-contraception-and-HIV.pdf>

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