

A close-up, warm-toned portrait of a woman's face, looking slightly to the right. She is wearing a patterned headwrap. The background is a solid, warm orange color.

MAKING THE CASE FOR INTEGRATION

TIDES FOUNDATION'S AFRICA FAMILY
PLANNING AND HIV INTEGRATION FUND

MAY 2010

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IN the past several years government and philanthropic funders have led a dramatic increase in national, bilateral, and multilateral responses to combat the global HIV/AIDS epidemic. This increase in funding has led to a significant expansion in access to prevention, care, and treatment programs in high HIV-prevalence countries. However, much remains to be done to reach more populations in need and to provide an array of related health services on the platform of HIV/AIDS infrastructures. For example, throughout much of sub-Saharan Africa, reproductive health and HIV/AIDS prevention services have been offered separately. Separate funding mechanisms often prevent important linkages between HIV/AIDS services and reproductive health services.

Health ministries and health facilities are typically organized in parallel, and consequently, clients are required to visit a different provider for each of their health concerns. The unmet need for family planning services in general, coupled with the increasing demand for pregnancy planning by HIV-positive individuals, calls for a more holistic approach to providing reproductive health and HIV/AIDS services.

Large-scale HIV/AIDS programs can reach a broad range of individuals in need of family planning counseling and services for the dual purpose of planning for healthy pregnancies and avoiding unintended pregnancies. Benefits of an integrated approach include the provision of preconception counseling to optimize positive health outcomes for both mother and child; options for preventing unintended pregnancies for women and couples; and ensuring that the risk of HIV/AIDS is considered as part of informed family planning decisions.

MAKING THE CASE FOR INTEGRATION

THE TIDES AFRICA APPROACH

Each country faces its own epidemiological, institutional, and social contexts that shape its response to sexual and reproductive health needs. Nevertheless, a stronger linkage between HIV/AIDS and family planning services has the potential to draw on the strengths and resources of both fields in order to help women and men in regions highly affected by HIV/AIDS to make better-informed reproductive and health decisions. Increasingly, program planners and health policymakers have begun to recognize the opportunities missed and efficiencies lost in the parallel approach. This is a timely moment to examine models of integrating family planning counseling and services into HIV/AIDS programs and document the impact of this kind of comprehensive care for clients and programs.

The Africa Family Planning and HIV Integration Fund (Tides Africa) was conceptualized with the Hewlett Foundation in August 2007 to leverage HIV/AIDS funding to support the family planning and reproductive health fields in sub-Saharan Africa that are serving the same populations as the HIV/AIDS providers. The goal of the fund is to identify, enhance, and analyze both existing structures and outcomes of integrated program models as well as promising efforts in the region.

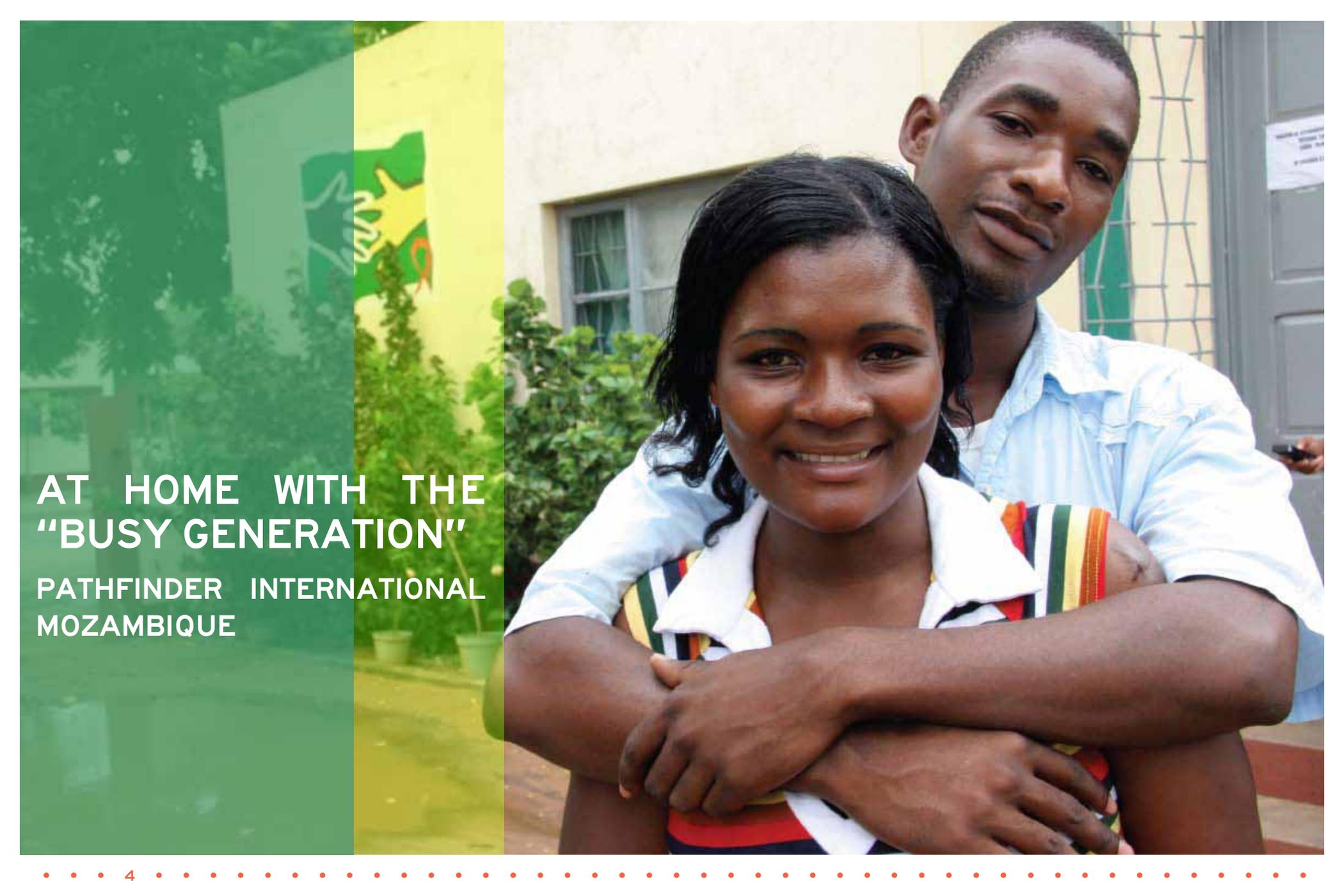
The purpose of the Tides Africa fund is to develop and administer an integrated grants program for non-governmental organizations

already providing HIV/AIDS prevention and treatment services in sub-Saharan Africa. In alignment with Tides Africa's evidence-based model, selected organizations were required to have a clinical practice on site as well as the ability to provide quantitative data on the benefits and constraints of the integrated model as delivered through their existing program.

During the first year of the project, the fund awarded grants totaling more than \$1.3 million to organizations providing services in Kenya, Mozambique, Rwanda, Tanzania, Uganda, and Zambia. With continued support from the Hewlett Foundation, Tides Africa is providing both transitional funding to the organizations for an additional year and facilitating the networking and convening necessary to generate a body of evidence on the outcomes and impacts of integrated programs on reproductive health and HIV services.

Ultimately, the Tides Africa fund was designed to enhance client access to comprehensive and voluntary family planning information and services within the context of HIV/AIDS programs to inform reproductive decision-making; and to meet the health and contraceptive needs of women and men in the region. Through integrating family planning services into HIV prevention and care, the fund seeks to increase access to contraceptive methods and enhance the public health impact of HIV programs.

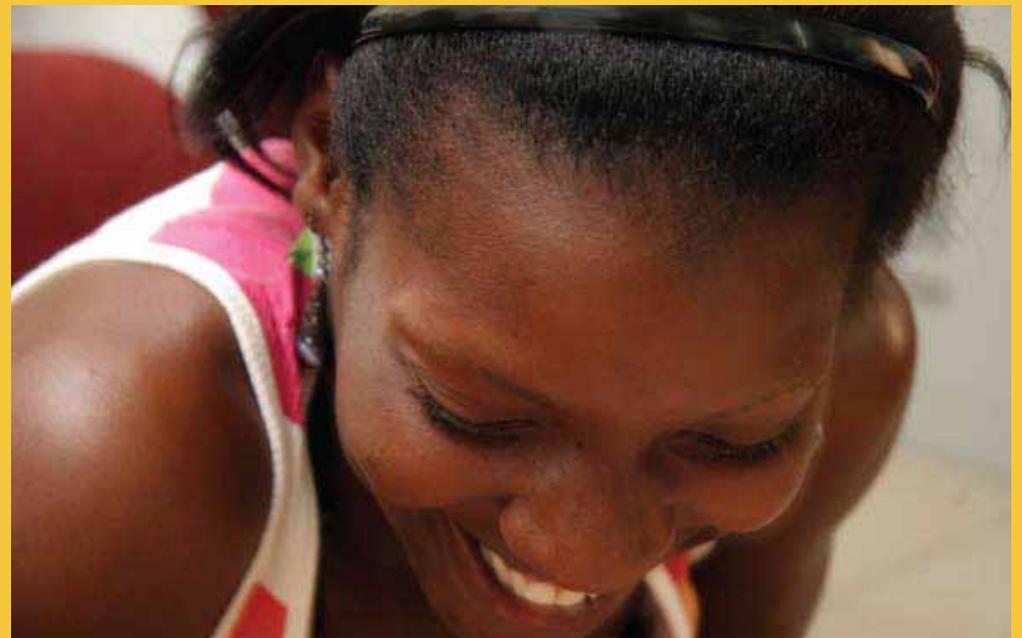
RENÉE JOSLYN,
SENIOR PHILANTHROPIC ADVISOR, TIDES AFRICA

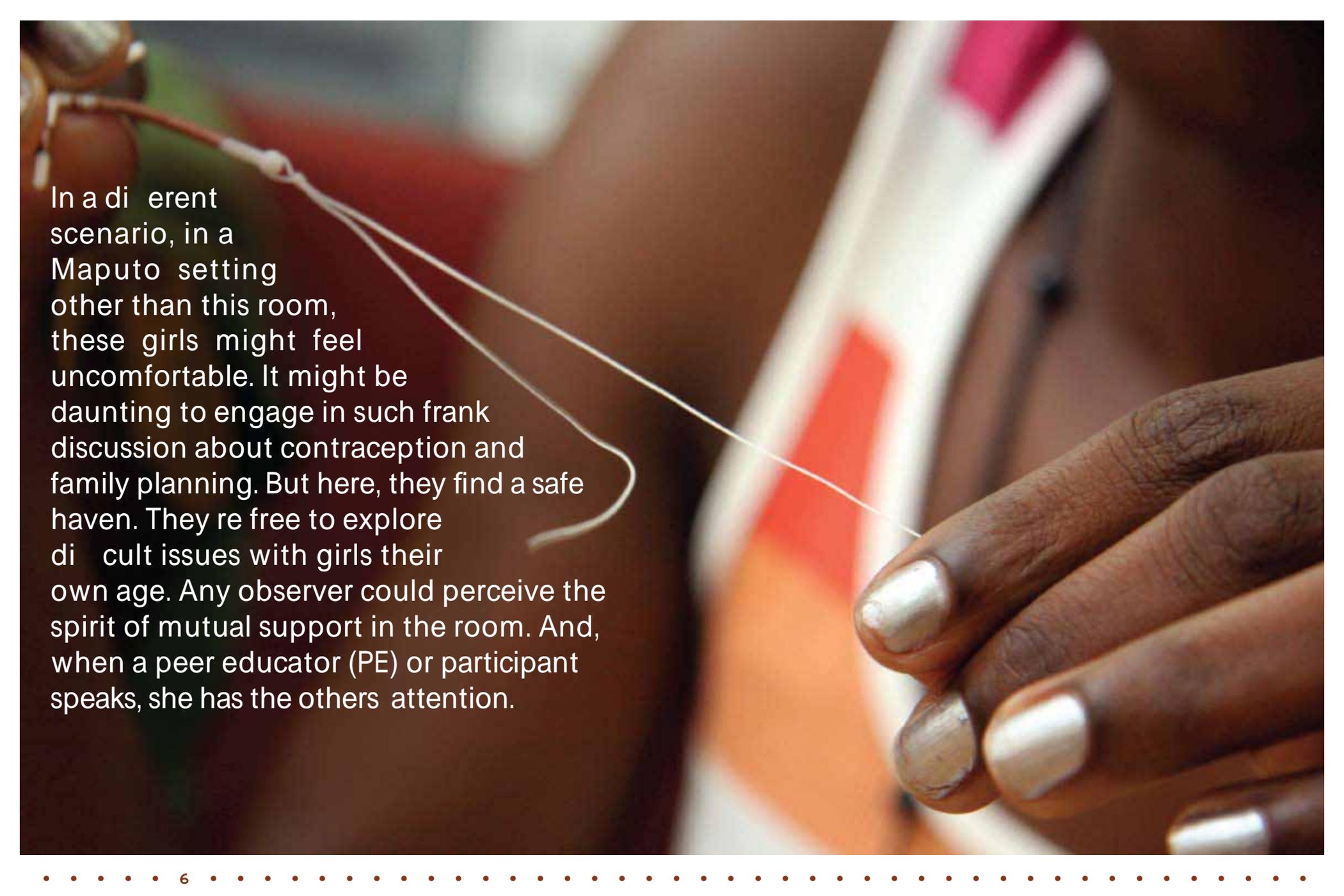
A young couple is shown in a close embrace outdoors. The woman in the foreground is smiling warmly at the camera, wearing a white polo shirt with a colorful striped pattern. The man behind her has his arms around her, looking slightly off-camera. They are standing in front of a light-colored building with a window and a door. A logo featuring two hands is visible on the wall behind them. The left side of the image is partially obscured by a green semi-transparent overlay containing text.

AT HOME WITH THE
"BUSY GENERATION"
PATHFINDER INTERNATIONAL
MOZAMBIQUE

TEN MOZAMBICAN YOUNG WOMEN GATHER IN A MEETING ROOM AT MAPUTO CENTRAL HOSPITAL, A YOUTH-FRIENDLY SERVICES SITE OF PATHFINDER INTERNATIONAL IN MOZAMBIQUE'S CAPITAL CITY.

Some of the individuals are HIV positive; some are negative. Maria Salouié, who is not much older than the rest of the group, leads a discussion about contraceptive methods. During a hands-on condom demonstration, a girl mishandles the device, eliciting giggles from the group. But the laughter is supportive; the mood is light.

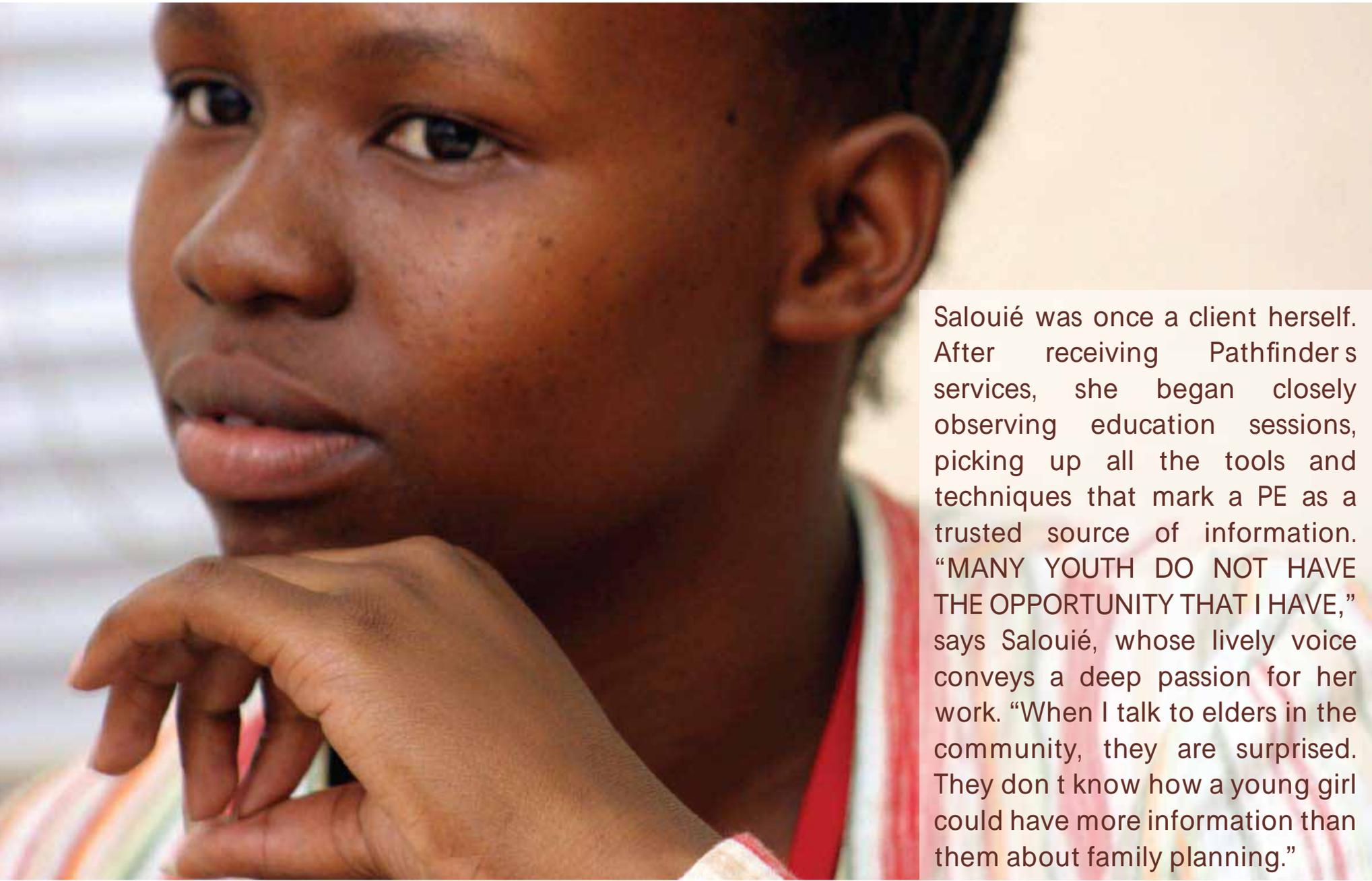




In a different scenario, in a Maputo setting other than this room, these girls might feel uncomfortable. It might be daunting to engage in such frank discussion about contraception and family planning. But here, they find a safe haven. They're free to explore difficult issues with girls their own age. Any observer could perceive the spirit of mutual support in the room. And, when a peer educator (PE) or participant speaks, she has the others' attention.



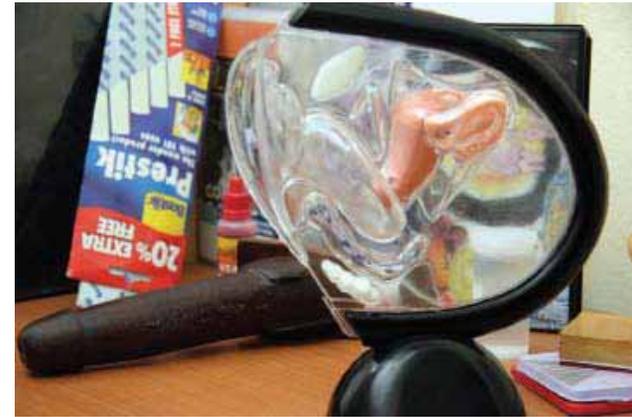
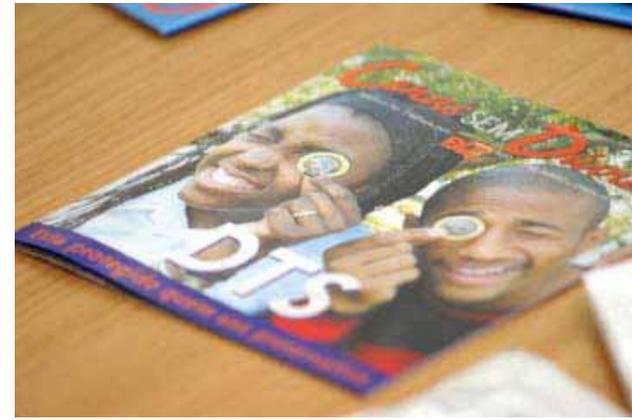
After the session ends and everyone leaves, chances are good that some or all of the girls will spread the word and invite peers to future sessions. They may even step up to join the ranks of the 232 PEs who spearhead Pathfinder International's integrated family planning project. This initiative, launched in late 2008 at two public health pilot sites in Maputo City and Gaza Province's capital, Xai-Xai, is a pivotal component of the ongoing Treatment Accelerated Program (TAP).



Salouié was once a client herself. After receiving Pathfinder's services, she began closely observing education sessions, picking up all the tools and techniques that mark a PE as a trusted source of information. "MANY YOUTH DO NOT HAVE THE OPPORTUNITY THAT I HAVE," says Salouié, whose lively voice conveys a deep passion for her work. "When I talk to elders in the community, they are surprised. They don't know how a young girl could have more information than them about family planning."

Many things are new about this TAP program – the explicit focus on explaining short-term and long-term FP methods; the distribution of oral contraceptives together with condoms; the referrals to facilities offering FP and sexual reproductive health services – but the sense of ownership displayed by Pathfinder's youth activists has been a constant since 1999. That year, Pathfinder launched the Geração Biz Program, a national, multisector program that has trained several thousand PEs. These volunteers initiated and sustained a broad campaign disseminating information about HIV/AIDS treatment and prevention. Through partnerships with local NGOs and youth associations, the PEs have devoted countless hours to canvassing, counseling, and educating, all the while recruiting more foot soldiers into their ranks.

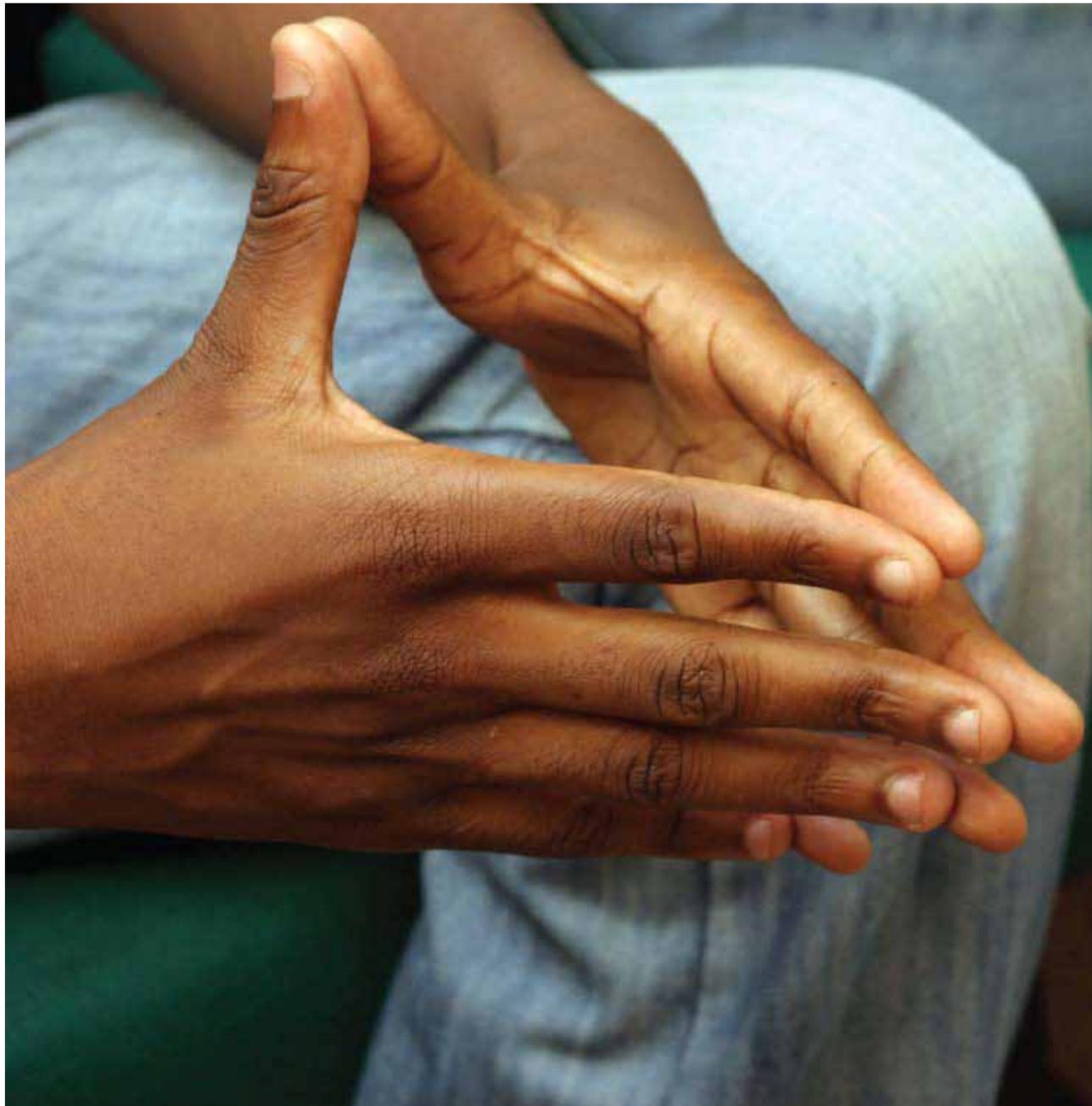
Pathfinder
INTERNATIONAL



Since the program's inception, the educators have expanded into a 5,000-strong legion. They have claimed the program as their own, coining the Geração Biz name ("busy generation"), which attests to their tireless efforts. As self-described "activists," they also embrace their role as social change leaders.



The need for youth-focused outreach is clear in Mozambique, a country with one of the world's highest HIV infection rates. Young people aged 15-24, a group making up one-third of the country's population, account for 60 percent of the country's new cases of HIV. Girls are particularly vulnerable, as infection rates among the 15-19 age group are much higher among young girls (16%) than among boys (9%).



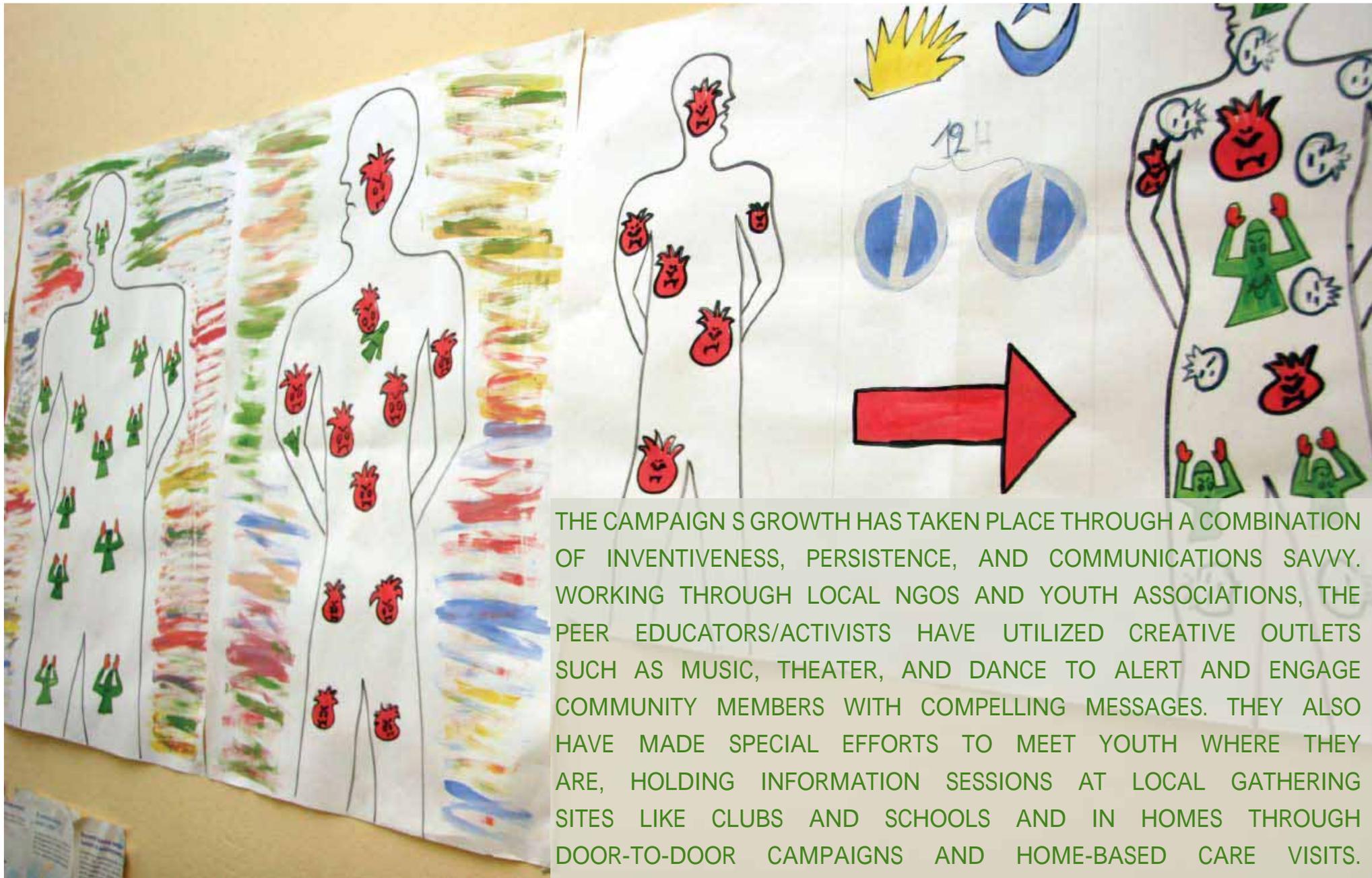
Pathfinder realized that the best way to respond to the profound health needs of Mozambique's youth was to use the proven approach of peer education. Founded in collaboration with the United Nations Population Fund, the Danish International Development Agency, and the Mozambique Ministries of Health, Education, and Youth and Sports, Geração Biz has earned distinction from the World Bank as a "Best Practice Model" and has helped preserve the legacy of Pathfinder International, a family planning and reproductive health organization that has impacted 25 countries since 1957.

Peer educators consistently show their colors as “the busy generation.” “EVERY YOUNG BOY OR GIRL I COME ACROSS, I TELL THEM ABOUT FAMILY PLANNING,” says Leonel, 26, a peer educator in Gaza Province who exudes a fatherly concern for peers. Unflagging commitment like Leonel’s has been key to the outreach efforts. PE responsibilities include handing out contraceptives, distributing FP-focused materials, and making referrals to clinics. The materials, developed using the direct input from youth, consisted of brochures and posters with information about contraceptive methods, and T-shirts and caps with dual protection messages. The clothing apparel made a particularly big splash and served the dual purpose of delivering accessible messages and identifying peer educators in the community.





Before the program began, Pathfinder set out a few target goals signaling increased demand for FP/SRH information and services all of which have been exceeded dramatically. Program coordinators and PEs originally wished to reach 18,000 young people in the first year; the final total was 55,000 community members reached in Maputo and 47,000 in Xai-Xai. In addition, PEs met and exceeded the target of 10,000 distributed materials in grand fashion, with a total of 22,750 additional materials reaching the youth population. “THE ENERGY TO RUN THE PROJECT IS HIGH,” says Samuel, a PE based in Xai-Xai. “ONE YEAR IS A SHORT AMOUNT OF TIME, BUT WE HAVE DONE A LOT MORE THAN WE IMAGINED.”



THE CAMPAIGN'S GROWTH HAS TAKEN PLACE THROUGH A COMBINATION OF INVENTIVENESS, PERSISTENCE, AND COMMUNICATIONS SAVVY. WORKING THROUGH LOCAL NGOS AND YOUTH ASSOCIATIONS, THE PEER EDUCATORS/ACTIVISTS HAVE UTILIZED CREATIVE OUTLETS SUCH AS MUSIC, THEATER, AND DANCE TO ALERT AND ENGAGE COMMUNITY MEMBERS WITH COMPELLING MESSAGES. THEY ALSO HAVE MADE SPECIAL EFFORTS TO MEET YOUTH WHERE THEY ARE, HOLDING INFORMATION SESSIONS AT LOCAL GATHERING SITES LIKE CLUBS AND SCHOOLS AND IN HOMES THROUGH DOOR-TO-DOOR CAMPAIGNS AND HOME-BASED CARE VISITS.



A key component of the campaign is its focus on holding support groups that meet regularly and specifically target HIV-negative youth, HIV-positive youth, and discordant couples. The intimacy of these meetings has fostered a hard-earned trust. “THIS IS THE RIGHT PLACE TO EXCHANGE EXPERIENCES,” said Leonor, an educational session attendee. “Everyone in here is interested and we are free to talk. Outside this building, it is different.” Support groups are particularly useful for HIV-positive participants who struggle to find a place where their right to have children isn’t put into question. They know they can rely on the information educators provide to make the right reproductive health decisions or take referrals to Pathfinder’s youth-friendly service sites.

Along with creating opportunities for trust, the face-to-face dynamic of the support groups has encouraged participants to engage in thoughtful discussion. Program coordinators realized that deep dialogue helps educators reach beyond the facts and figures and impact people’s underlying perceptions about family planning. When they are prompted to ask the right questions, participants can begin dispelling some of the more persistent myths about certain FP methods and their side effects, particularly the long-acting methods.



All of the work of the PEs/activists is bolstered by a Pathfinder leadership model of employing forward-looking tactics that build capacity and ultimately increase demand for services. In addition to training PEs, Pathfinder also trained 41 facility-based health providers, using an updated curriculum incorporating FP/HIV integration. These trainings dispelled myths about family planning prevalent among providers as well as youth and authorized providers to offer injectable contraceptives and intrauterine devices to both youth and HIV-positive people. The end result is a renewed contingent of health providers more confident in their contraceptive counseling skills.

Pathfinder's success has also hinged on refining its strategy as it receives new information. For example, after rolling out the integrated FP program, Pathfinder learned that community members were not initially receptive to peer educators and their messages about family planning. This challenge prompted the mass production of T-shirts and caps, which not only identified PEs but also legitimized their role as health experts. Subsequently, the PEs experienced more contact with the community.



In the months ahead, Pathfinder will continue grounding its HIV/FP integration work in partnerships with Mozambique communities. Program managers are continually reminding peer educators of the pivotal work they do in HIV prevention, treatment, and care, stressing their important roles as educators and activists and offering support so these community leaders can sustain individual outreach efforts. They also work to ensure that Pathfinder's vision is understood and embraced at the grassroots level. "Communication is a big deal," says Jorge Matine, Provincial Manager for Gaza. "The channels of communication need to go through to the activists working in the communities."



From the beginning of this program, Pathfinder has engaged national leaders and important stakeholders with the aim of strengthening contraception services and FP integration beyond Maputo and Gaza Provinces. For a large segment of the HIV/AIDS field in Mozambique, family planning services has not made the leap from policy to practice, but Pathfinder can help bridge the gap. “GERAÇÃO BIZ IS A NATIONAL PROGRAM,” says Dr. Ivone Zilhão, Pathfinder’s Adolescent Sexual and Reproductive Health Advisor. “WE CAN TRY TO BRING TECHNICAL SUPPORT TO THE WHOLE COUNTRY. IF YOU’VE GOT THAT, IT CAN BE AN ISSUE THAT DRAWS ATTENTION AT THE POLICY LEVEL.”

(Dr. Ivone Zilhão, Adolescent Sexual and Reproductive Health Advisor)



SPACE

HIV/FP integration is a new field and its published literature reflects its relatively “young” stage of development. However, our review of over 30 pieces of available scholarly and public literature has revealed several important findings:

HIV-POSITIVE INDIVIDUALS HAVE REPRODUCTIVE DESIRES SIMILAR TO OTHERS IN THEIR COMMUNITIES

In general, HIV/AIDS research does not focus on fertility, and in some cases, makes glaring omissions in this area. For example, some studies fail to control for such seemingly obvious factors as existing family size when examining fertility desires. However, research that correctly controls for other mitigating factors has clearly demonstrated the parity of fertility desires between HIV-positive individuals and their seronegative counterparts. This is particularly true for individuals who are younger, have less children, and are on antiretroviral therapy (ART).

When comparing HIV-infected women to uninfected women, no evidence of association was found between fertility intention and HIV serostatus, adjusting for age, number of living children, and sexual activity in the past three months (Tsui, Alaii, & Liku, 2009; see also Nattabi, Li, Thompson, Orach, & Earnest, 2009).

HIV-POSITIVE INDIVIDUALS LACK ACCESS TO FAMILY PLANNING CARE

Despite the demonstrated desires of HIV-positive people to control their own fertility, they continue to lack access to family planning services. Limited access is due in part to structural factors such as the well-documented “no family planning” proviso in the first iteration of the President’s Emergency Plan for AIDS Relief (PEPFAR).

MAKING A SPACE FOR INTEGRATION

CENTRAL THEMES OF AN EMERGING FIELD

However, lack of FP access is also a consequence of the stigmas against sexual activity aimed at HIV-positive individuals. For many years, before the wider availability of ART, HIV-positive persons had a much shorter projected lifespan. Now, even as those once called “HIV victims” transition to those “living with the virus,” stigmas against perceived high-risk behaviors persist.

HIV positive [women] are normally ignored when it comes to getting family planning services. You see, when you are HIV positive, people don’t expect you to be having sex now. So people don’t really concentrate on them when it comes to family planning, they concentrate on giving them ARVs and that is it (Nattabi et al., 2009).

NEW PROMISING PRACTICES ARE EMERGING THAT COMBINE REPRODUCTIVE HEALTH AND HIV/AIDS CARE AND TREATMENT IN IMAGINATIVE WAYS

Just among the six Tides Africa grantees, models are emerging that utilize peer counselors as service extenders, that re-train health care workers beyond the walls of any individual facility, and that partner with government and other existing distribution networks to deliver both knowledge and consumables to a growing network of facilities. These and other innovative models point to the range of available options for leaders in the field of integration to build upon and refine.

THE LITERATURE STILL LACKS A ROBUST DISCUSSION OF CHALLENGES IN IMPLEMENTATION
Most of the research to date has been built around advocacy for integration strategies. While the fruits of this advocacy are now evident in a new U.S. policy, the literature has largely ignored the significant challenges of integration. Among the areas articulated by Tides Africa grantees, but largely overlooked in the literature:

- Explorations of the process of partnership building.
- The importance of attitude change among healthcare providers. What is needed for institutional cultural change?
- The nuances of patient/client behavior choices and worldviews.

HIV/FP INTEGRATION NEEDS TO MOVE BEYOND OPPOSITION TO INNOVATION

In general, the challenges facing the next iteration of research on HIV/FP integration are about moving from prior U.S. administration policies, where literature was focused on making the case for integration, to a relatively friendly political environment where the challenges of integration need to be confronted head-on. Some of those challenges are articulated in the following section.



THE PROFILES THAT APPEAR IN THIS REPORT OF TWO TIDES AFRICA GRANTEES, INFECTIOUS DISEASES INSTITUTE (IDI) AND PATHFINDER INTERNATIONAL MOZAMBIQUE, POINT TO THE PROMISE OF INTEGRATED APPROACHES TO CARRY OUT GROUND BREAKING WORK AND PROVIDE RESPONSIVE, TRANSFORMATIVE CARE. HOWEVER, THESE AND OTHER TIDES AFRICA GRANTEES ALSO HAVE BEEN QUICK TO ADMIT THE VERY REAL CHALLENGES THEY HAVE CONFRONTED IN IMPLEMENTING THEIR PROGRAMS. IN OUR INITIAL VISITS WITH GRANTEES, SEVERAL IMPORTANT THEMES EMERGED. WE HAVE PROVIDED THEM HERE AND HAVE INCLUDED DIRECT QUOTES FROM GRANTEES WHERE APPROPRIATE.

TRANSFORMING A PLACE THROUGH INTEGRATION

REAL SOLUTIONS TO REAL CHALLENGES

- **THE DEMANDS OF INTEGRATION** While they were generally supportive of the concept of integration and enthusiastic about its potential, grantees were largely overwhelmed about how to implement those strategies. As one in-country leader stated, “We have HIV money, and malaria money, and so on . . . this is the first time we are receiving integration money.” Several grantees communicated on our initial visits a feeling of being “in over [their] heads” in terms of implementing lasting institutional change in the course of a year.
- **LIMITED CAPACITY** The challenges in integration have to do with larger systemic challenges of institutional capacity. Hospitals and clinics are already struggling (and often failing) to keep up with demand for ART and other treatment. In some locations, clinic workers have limited medical training, and in all locations individuals have a tremendous number of demands. The idea of adding an additional responsibility presents serious problems. As another grantee leader stated, “I think it’s overly optimistic to believe that one provider can provide excellent care in all of these different services.”
- **“COMPLICATED” U.S.-AFRICA PARTNERSHIPS** A subtext to all of our meetings with grantees has been the challenge of working with U.S. partner institutions that require varying levels of financial resources, provide varying levels of support, and demand varying levels of control. Some grantees felt their U.S. partners provided needed technical support and institutional credibility. Others, however, pointed to money spent on flights for U.S. partners back-and-forth across the Atlantic as a drain on operational costs. Still others suggested that U.S. or U.S.-born leaders at times provided a block to the professional development of their African-born partners.
- **DRAINS ON HUMAN RESOURCES** Grantees talked about challenges in the ability of already overburdened health care workers to take on additional roles. They also pointed to the overall shortage of providers, and the need to train more service extenders.

“Maybe we have been overly optimistic about what the health care worker can provide. We really need to think about our expectations of this one person.”

“In most of our health facilities, the biggest problem is the shortage of health care staff. They’re simply not there.”

- **SUSTAINABILITY** Grantees expressed concerns over fundraising and institutional infrastructure to maintain the practice of integration through the shifting winds of funding trends.

“This is the first time we are receiving integration money. What about the second and third year? How does this [work] continue?”

“So far, what I m seeing is very temporary mechanisms, but when it comes to institutionalizing it it s a problem.”

- **BUILDING PARTNERSHIPS** Given the challenges of implementation and sustainability, grantees recognized that partnership with government and other NGOs is vital. They shared challenges and insights in developing strong local collaborations, noting the importance of compromise and of providing tangible benefits to potential partners.

“We cannot shake hands without providing TA, and without providing a vision and a plan for how to do it.”

“You can t always win. Sometimes, you have to be patient and willing to give up something.”

- **ADDRESSING HEALTH CARE PROVIDER ATTITUDES** The grantee leaders were transparent about continuing problems in uptake, and the sometimes hidden role played by provider biases against sexual activity for HIV-positive individuals. They recognized that health care providers are not immune to larger societal beliefs against sex of any kind for sero-positive people, and of significant gender-specific prohibitions.

“We are coming from a background where it was no sex [for sero-positive people] . . . now we are saying, you can have sex . . . we are struggling with how to undo what has been done in the past two decades.”

“When the providers talk to the men, it would be a very di erent conversation than they had with the women.”

“We cannot forget that the health providers are part of the culture.”

- **RESEARCH CHALLENGES** As institutional leaders, health care practitioners, and researchers, many grantee leaders wear a host of di erent “hats.” Their research has been informed by several pressing and unanswered research questions, and a desire to fill persistent gaps in the available best practice, operational research, and health outcomes literature.

“Given the direction that the global health community is going in . . . if we discuss about gaps in information, this is a gap we have: we don t have information on how integration impacts health systems. If we are able to demonstrate that, we can get this better institutionalized.”

- **BETTER ENGAGING MALES** Grantees also pointed to the need to engage males as an underserved and underutilized population in integration strategies.

“Getting the men on board, I don t know how to do that . . . the timing of our clinics does not fit with their time”

TRANSFORMING A PLACE
THROUGH INTEGRATION
REAL SOLUTIONS TO REAL CHALLENGES

INTERVIEW WITH ROSE WILCHER, FAMILY HEALTH INTERNATIONAL

1. How have you been involved in the field of FP integration? How did you come to this work? What are your core beliefs and assumptions that drive your engagement?

Family Health International started working in the area of family planning/HIV integration because of the compelling evidence that it benefits public health. On the one hand, increasing access to contraception among clients of HIV services will reduce unintended pregnancies and, consequently, improve maternal and infant mortality and morbidity – the same benefits that family planning offers to all women. But, for HIV-positive women who do not wish to get pregnant, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV treatment, care, and support. In other words, it contributes directly to HIV prevention goals.

Unfortunately, though, family planning has been an underutilized intervention for HIV prevention. The enormous opportunities being missed to address the contraceptive needs of clients of HIV services – and, consequently, improve their reproductive health, protect their rights to determine the timing and spacing of pregnancies, and enhance the impact of HIV programs – have driven us to do more in this area.

2. It appears that the last year has been a whirlwind of transition in terms of U.S. and international policy regarding integration. In what ways have you seen the field change?

Indeed, we currently have unprecedented levels of policy support for FP/HIV integration. International consensus exists that stronger linkages between the sexual and reproductive health and HIV/AIDS fields are essential for meeting the Millennium Development Goals. A number of policy statements have recently been issued calling for stronger linkages. One of the most important policy developments has been the Obama Administration's Global Health Initiative, which places prevention of unintended pregnancies next to HIV as a global health priority and makes integration and women-centered approaches cross-cutting principles.

We are also now seeing increased interest in integration by HIV donors, including both PEPFAR and the Global Fund. In striking contrast to earlier PEPFAR policy, new field guidance and the new five-year strategy from PEPFAR encourage the integration of family planning

in PEPFAR-supported programs. The Global Fund has recently established a track record of its willingness to support reproductive health components of HIV grants, including the procurement of contraceptive commodities; this is good news.

We're also seeing incredible momentum at the country level, in large part due to increased commitment and buy-in from policymakers in the Ministries of Health. In many countries, including Kenya, Tanzania, Nigeria, Rwanda, and Uganda, Ministry of Health-led task forces, co-chaired by representatives from reproductive health units and HIV/AIDS units, have been formed to strategically advance integration policy and practice in those countries. As a result, some of these countries have developed integration strategies or strengthened the family planning content of HIV policies. For example, in Tanzania, the National Standard Operating Procedures for HIV Care and Treatment were revised to include routine screening for risk of unintended pregnancies, family planning counseling, and referral to family planning services as a core component of care and treatment services.

3. As the field begins to develop a system of “best practice” guidelines and evaluation matrices, what do you think are the continuing gaps in terms of our knowledge about what makes integration work (or not work)?

We need a better understanding of the technical inputs that are required to achieve effective, scalable integrated FP/HIV services. FP/HIV integration efforts may include a range of interventions, such as advocacy with managers and policy-makers, training of providers, supportive supervision, changes to client intake and reporting forms, revisions to service delivery guidelines, and creation of referral mechanisms, among others. The relative importance of each of these inputs is not known. Knowledge of the essential elements for achieving integrated services and the resulting cost and impact of those inputs is important for guiding what FP/HIV integration strategies can and should be scaled-up.

We also need to know more about appropriate and effective strategies for FP/HIV integration in concentrated epidemics. Most FP/HIV integration efforts to date have been in sub-Saharan Africa in countries with a generalized epidemic. However, integrating family planning services into HIV prevention, care, and treatment programs is of critical importance in concentrated or low-level epidemics as well. Because most HIV programs in these settings target people living with HIV and most-at-risk populations, such as female sex workers and injection drug users, they provide a platform for reaching these groups with family planning information and services. Studies are increasingly documenting that these groups have substantial unmet need for family planning.

4. What are some of the critical challenges you and your colleagues in the research and thought leadership arenas need to confront over the coming months and years?

In the coming months and years, one of the key challenges is going to be translating the favorable policy environment for FP/HIV integration into widespread practice at the service delivery level. These efforts need to be bolstered and guided by more cost-effectiveness and impact data, specifically through more rigorous studies that compare outcomes between integrated and non-integrated programs.

In addition to more rigorous trials, we need better routine M&E of integrated services. Identifying and institutionalizing a core set of FP/HIV indicators would not only generate more data for the evidence base, but insofar as “what gets measured gets done,” it might also serve to make integrated services a more routine part of the care providers’ offer.

While we strive to figure out what works best at the service delivery level, however, we cannot forget about the constraints that many women face to accessing services in the first place. Even the best integrated service delivery interventions may never reach their full potential if they are not accompanied by efforts to address broader gender-related barriers to service access in general and contraceptive use in particular.

5. Given that the “big fish” like PEPFAR and USAID make most of the financial investment in HIV/AIDS work, how do you understand the role of private philanthropy in supporting a more robust HIV/FP integration field?

We are hopeful that the Global Health Initiative and new PEPFAR policy make it easier for family planning services to become part and parcel of the HIV services they support. However, private philanthropy has a critical role to play in guiding these efforts. Investments from private philanthropy are urgently needed to support rigorous studies that will expand the evidence-base of integration best practices, and to ensure the best available evidence is communicated to global audiences and translated into service delivery practice.





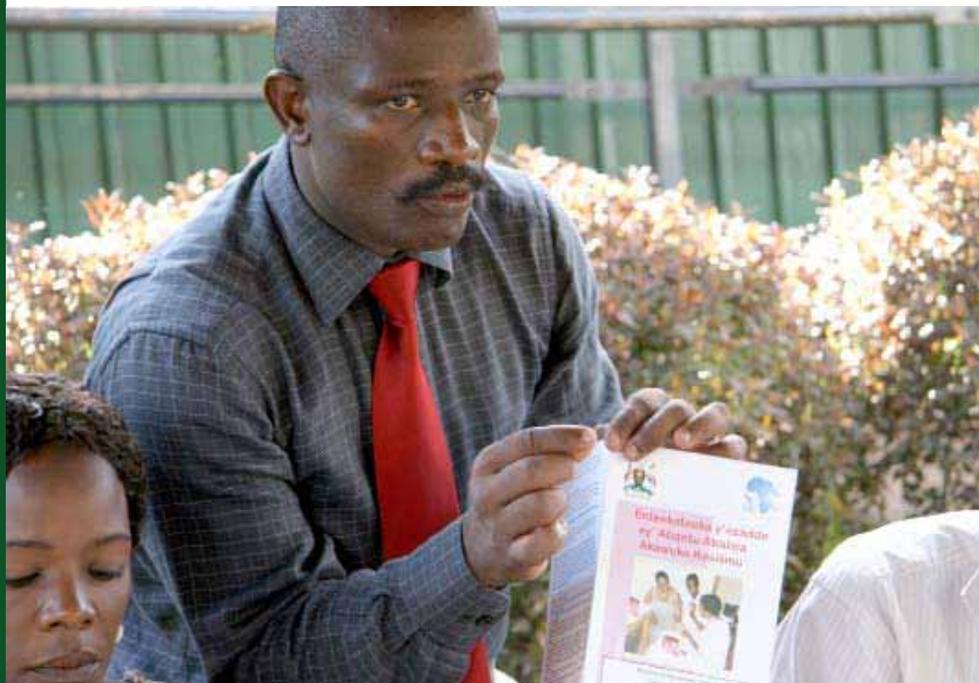
"EMPOWERING OUR FRIENDS"

**INFECTIOUS DISEASES INSTITUTE
UGANDA**

IN ANOTHER LIFE, BEFORE HE WAS DIAGNOSED WITH HIV, BENSON WAS A SOLDIER.

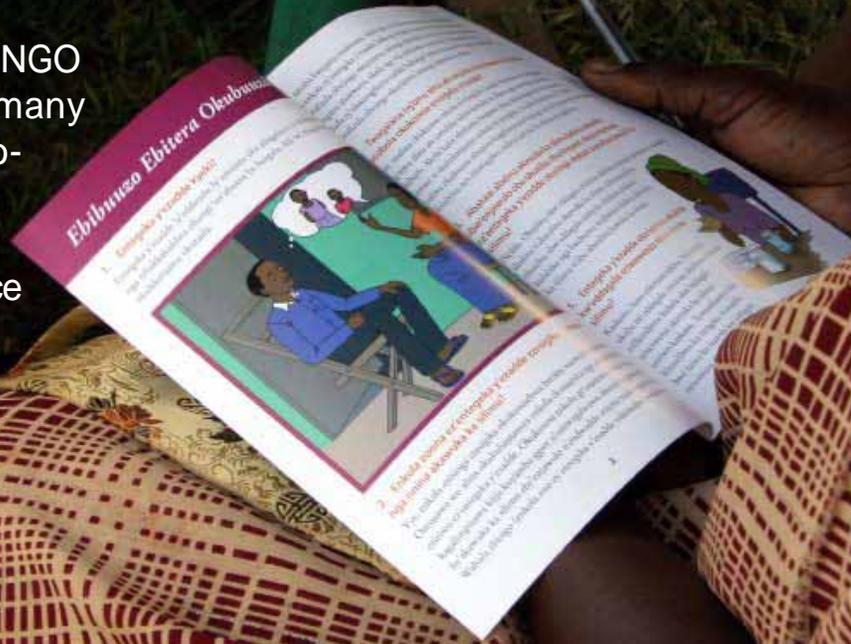
You can see it still in his firm posture and in his disciplined approach to the demands of his work as an advocate and organizer for patient rights. But Benson leads with his smile. He charms his peers and partners with a tireless passion and willingness to laugh at himself.

Benson is head of the Friends Council, a client-elected advisory board representing the 9,000-plus individuals who receive HIV testing, treatment, and reproductive health support at the Infectious Diseases Institute (IDI).

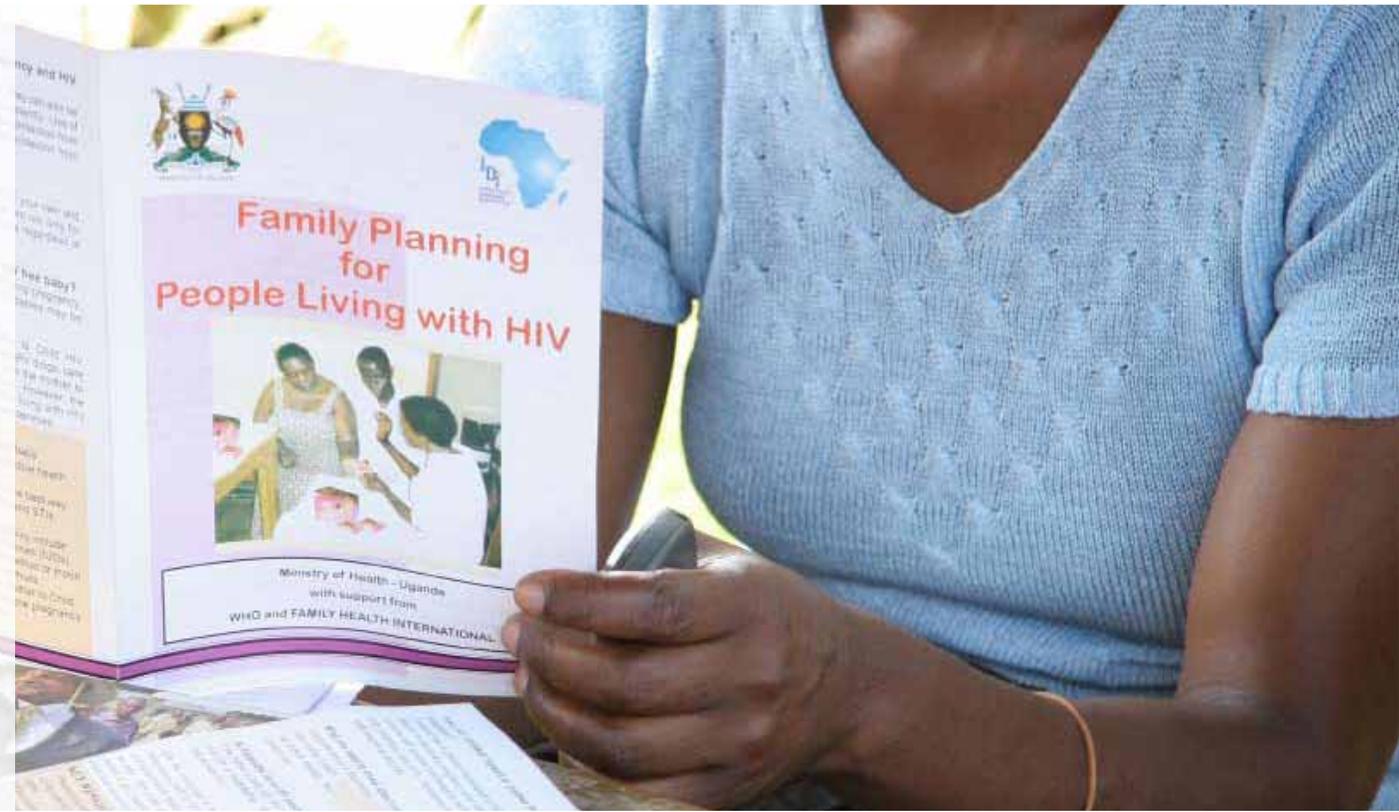


The contributions Benson and the other Friends Council members make through their service at IDI's clinics are too numerous to name: peer education through morning health education talks in the waiting room, games and arts & crafts for clients waiting for treatment or the pharmacy, peer counseling, and a bulwark of informal supports. Many of the critical issues addressed by the Friends Council focus on reproductive health. "Friends must understand that yes, they have the right to have sex, and to have children," Benson says. "But they must do it responsibly. We provide information so that they can do these things the right way."

A Makerere University-owned NGO located in Kampala, IDI fights many battles, but none is more important than the fight to eradicate the stigma around HIV. IDI leaders recognize the importance of ensuring that people do not feel shame about their HIV status, or experience ill-treatment at the hands of their health care providers.



In some cases, making people feel welcome is simply a matter of using the right words: beginning in 2007, IDI began referring to HIV-positive patients as “FRIENDS” (“a small change in language, a huge change in meaning,” reads the description of the new initiative). Emerging from this initiative was the Friends Council, which began directly overseeing the many crucial details that make up a positive client experience. “The environment within the clinic is not stigmatizing,” says Dr. Andrew Kambugu, Head of Prevention, Care and Treatment. “It’s empowering.”

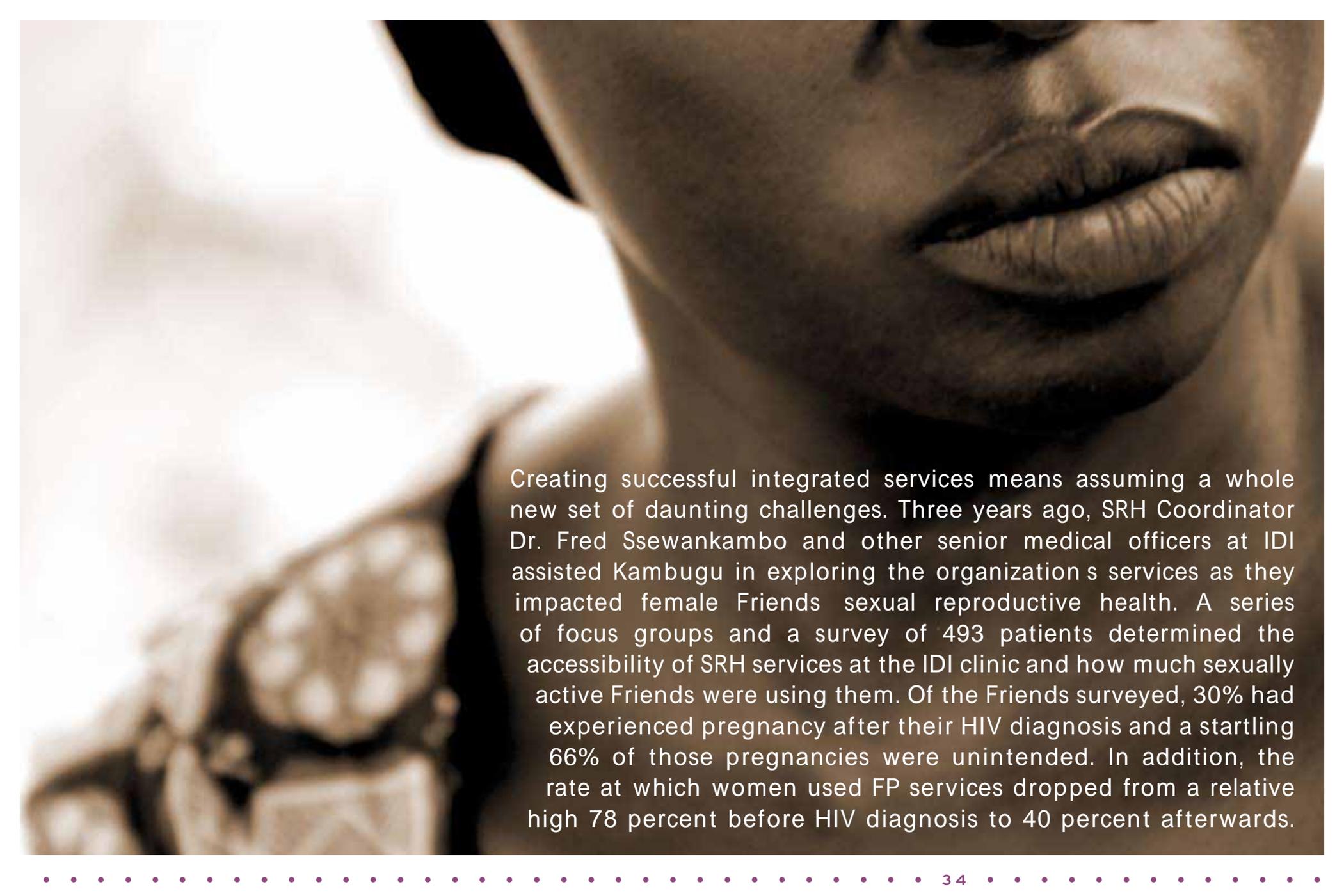


Fostering a sense of empowerment is essential, because in the HIV/AIDS field, challenges and obstacles for the infected are routine. And like its peers among the TAF cohort, IDI recognizes that the stigma around receiving family planning services sometimes can be as pervasive as the historical stigma surrounding HIV and AIDS.



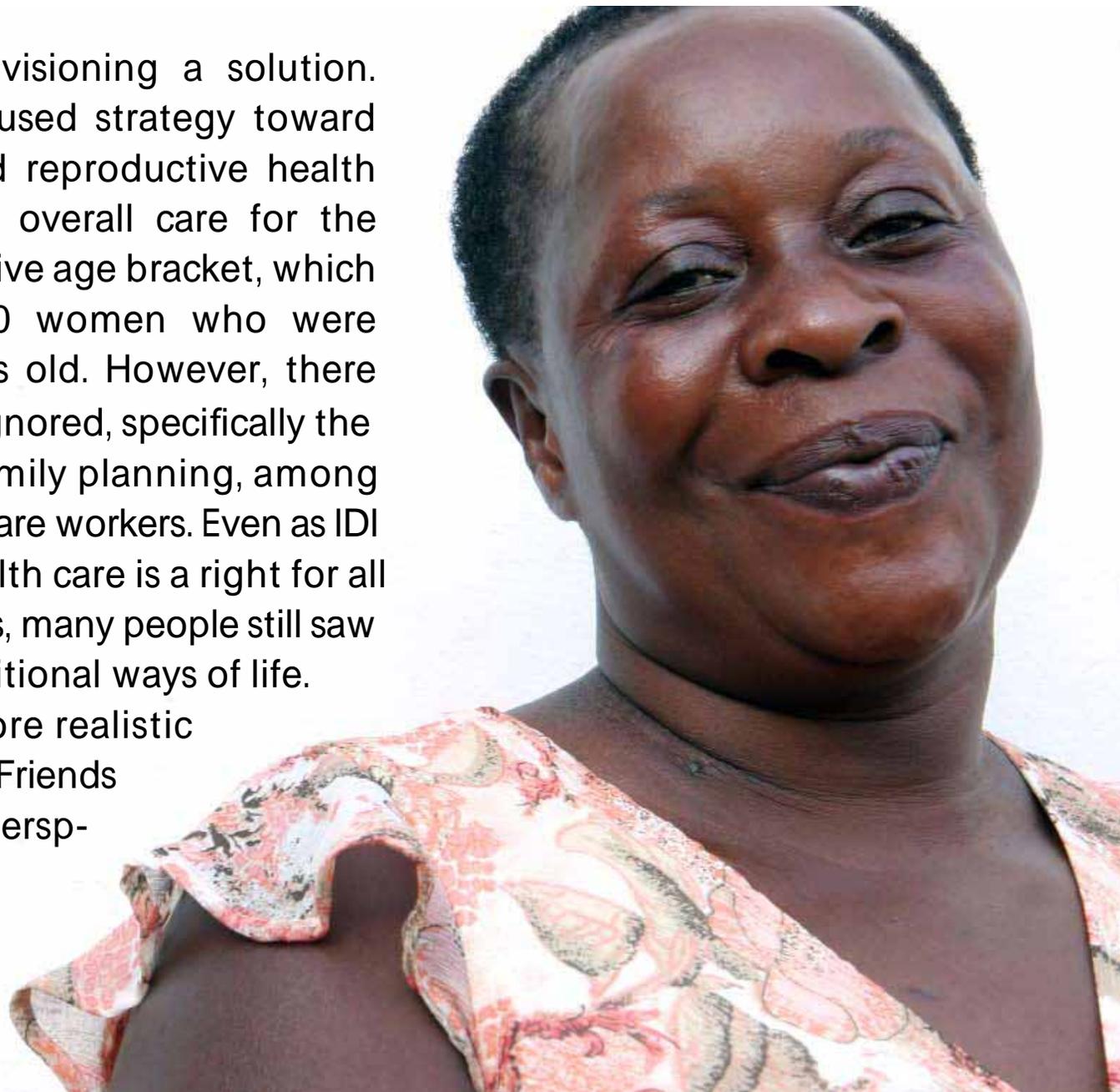


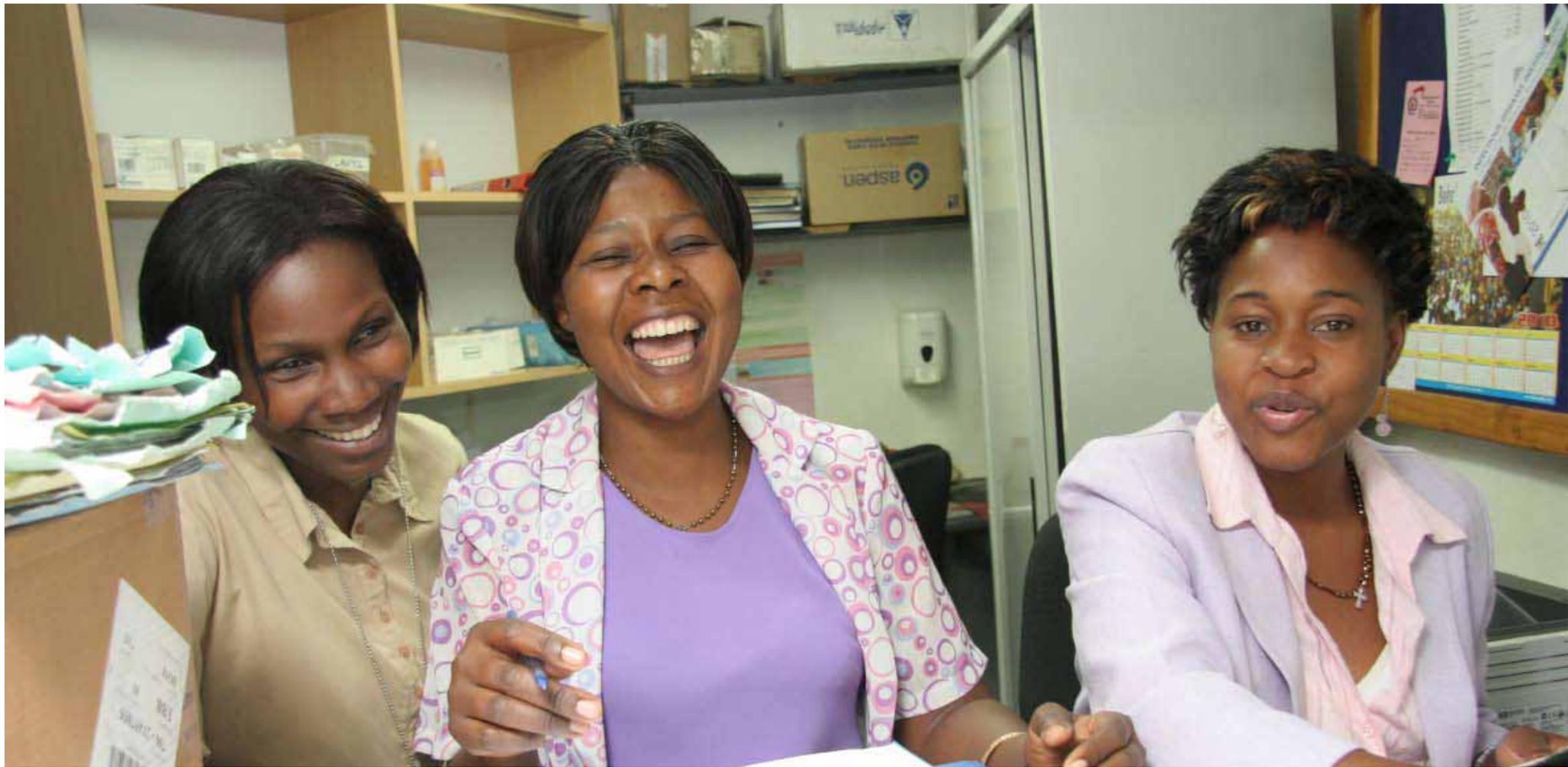
When clients are reluctant to receive FP services, and health care workers are reluctant to offer them, the soundest plans for FP integration cannot be realized. IDI leaders recognize the critical role that family planning and sexual reproductive health services plays in achieving more positive health outcomes, and through excellent services, training, and outreach, the organization is collectively committed to seeing more positive results in its own clinics and the larger community.



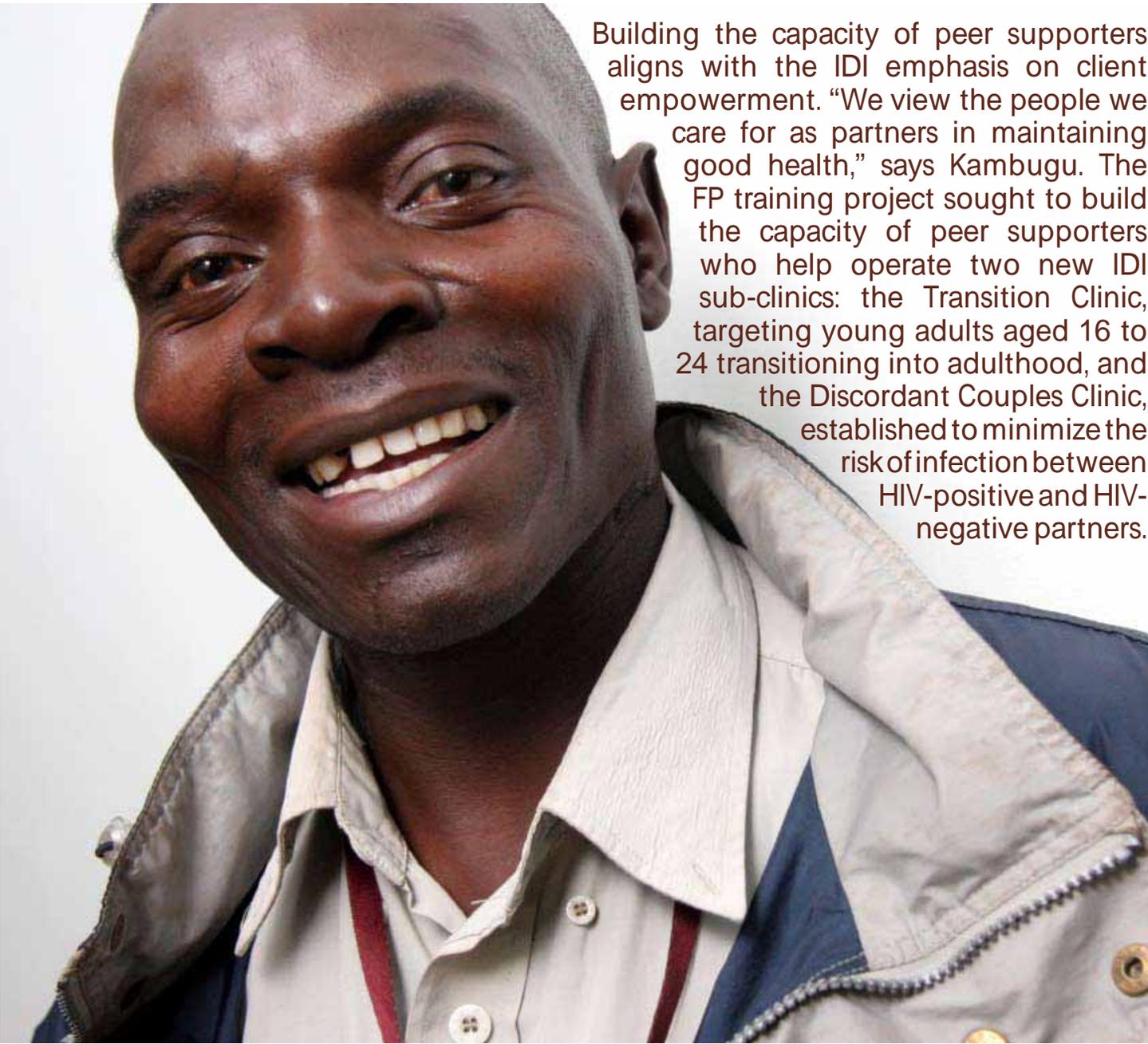
Creating successful integrated services means assuming a whole new set of daunting challenges. Three years ago, SRH Coordinator Dr. Fred Ssewankambo and other senior medical officers at IDI assisted Kambugu in exploring the organization's services as they impacted female Friends' sexual reproductive health. A series of focus groups and a survey of 493 patients determined the accessibility of SRH services at the IDI clinic and how much sexually active Friends were using them. Of the Friends surveyed, 30% had experienced pregnancy after their HIV diagnosis and a startling 66% of those pregnancies were unintended. In addition, the rate at which women used FP services dropped from a relative high 78 percent before HIV diagnosis to 40 percent afterwards.

Senior IDI leaders began envisioning a solution. They sought an effective, focused strategy toward increasing access to informed reproductive health decisions and improving the overall care for the female clients in the reproductive age bracket, which included approximately 1,500 women who were less than or equal to 30 years old. However, there were issues that could not be ignored, specifically the prevailing attitudes against family planning, among ordinary folks as well as health care workers. Even as IDI asserted that reproductive health care is a right for all people, regardless of their status, many people still saw FP provision as a threat to traditional ways of life. IDI was required to expect more realistic results as it persuaded staff and Friends to open their minds to a new perspective and new models of care. “Attitudes take a while to influence and change,” says Kambugu.





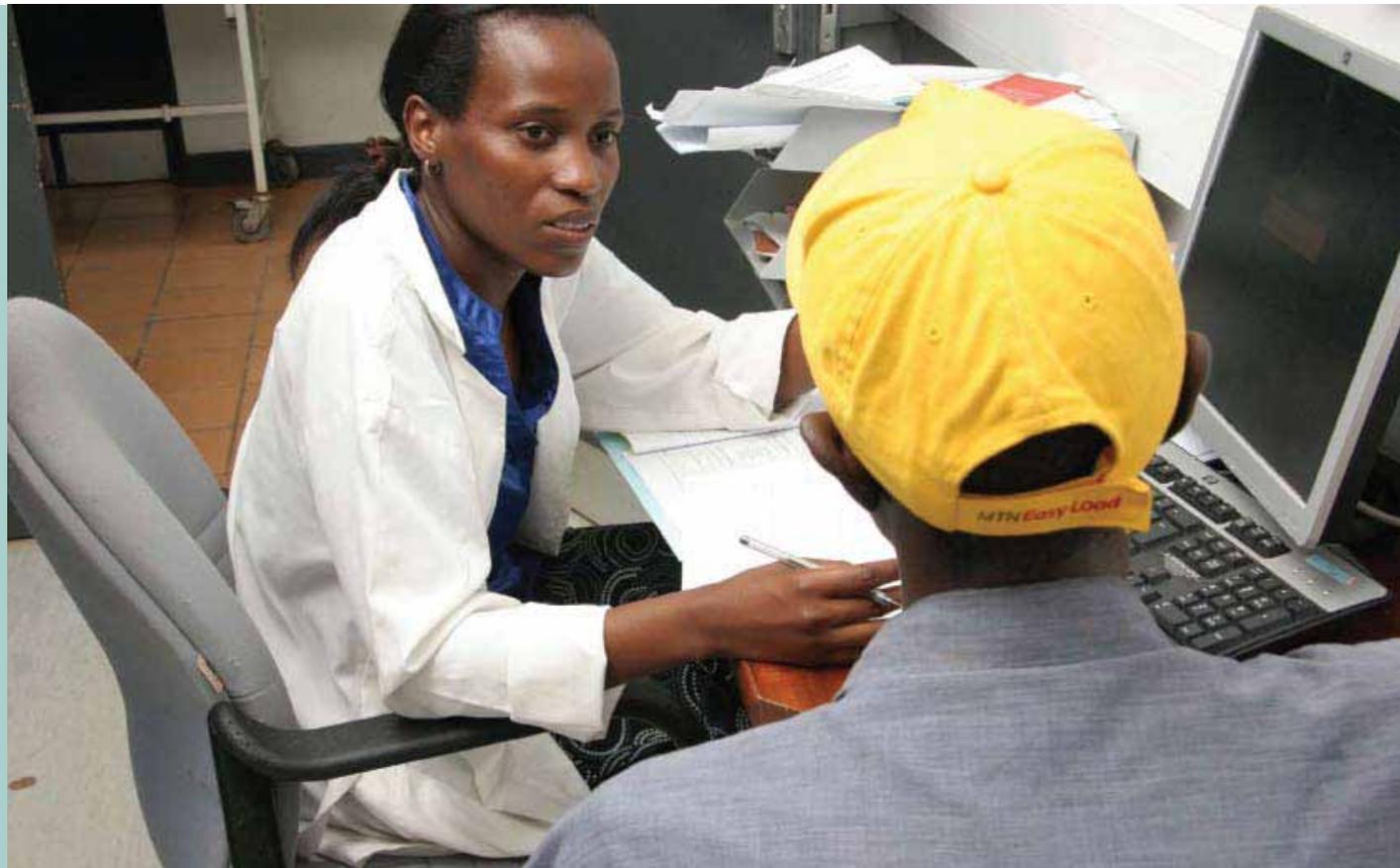
A total of 45 IDI staff members inaugurated the FP/HIV training program, completing classes in early 2009. The day-to-day implementation of the new initiative was entrusted to 12 leaders representing the departments of medical care, counseling, data entry, and outreach. A number of other IDI activities accompanied the training project, including obtaining accreditation to provide FP services by Uganda's Ministry of Health; developing Information, Education and Communication materials for broad dissemination; implementing FP standard operating procedures and efficient work flow models; and training 38 support group members to become fully conversant on FP and SRH issues.



Building the capacity of peer supporters aligns with the IDI emphasis on client empowerment. “We view the people we care for as partners in maintaining good health,” says Kambugu. The FP training project sought to build the capacity of peer supporters who help operate two new IDI sub-clinics: the Transition Clinic, targeting young adults aged 16 to 24 transitioning into adulthood, and the Discordant Couples Clinic, established to minimize the risk of infection between HIV-positive and HIV-negative partners.



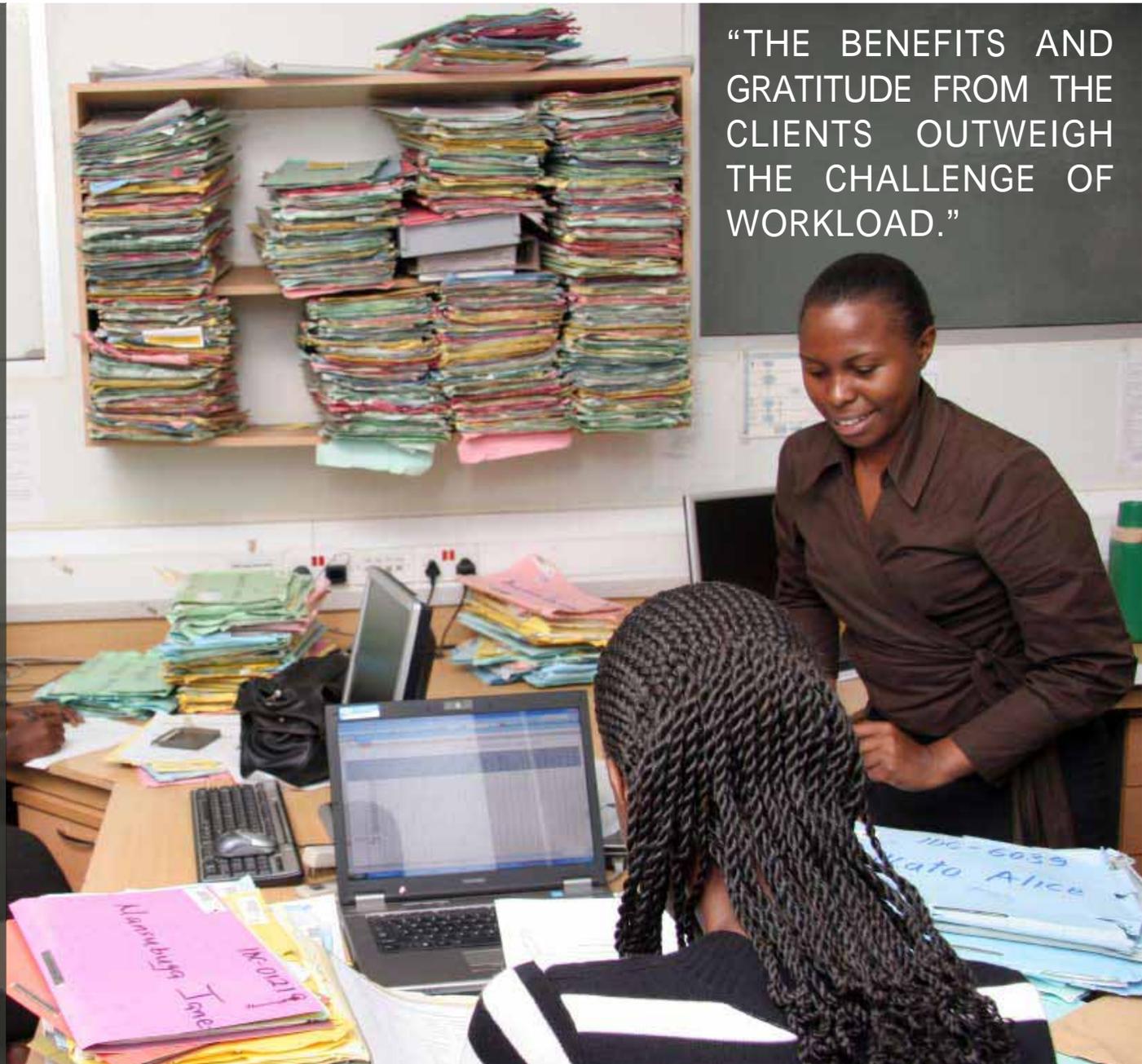
One Friend closely involved with the Discordant Couples Clinic spoke with Tides Africa about her experience as a close ally in the FP integration campaign. In addition to becoming well-versed in FP methods and issues, she and other Friends at the clinic have continued to develop the communications skills vital to promoting full disclosure among couples. “We’ve really helped those partners stay together,” she said. “FOR A NEGATIVE PERSON, WE TEACH THEM HOW NOT TO BE INFECTED; FOR A POSITIVE PERSON, HOW TO LIVE POSITIVELY.”



The ultimate goal of a FP/HIV integration initiative is to offer more comprehensive, holistic service a full SRH package. In the parlance of many staff members, this means being a “one-stop

shop” of services. It is an ambitious agenda that relies on significant contributions from individuals. Simon Wejuli, an SRH counselor, plays his part by fighting for his clients’ attention. “I get in the face of the clients as a service provider and get down to the grassroots,” he says. Betty Mbambu, a head nurse at IDI, recognizes that it’s not enough for people simply to show up for a health talk or counseling session. Providers are expected to oversee the presentation of all the facts. “We ensure that health workers see that the right information is passed to the Friends and they clearly understand the message,” she explains.

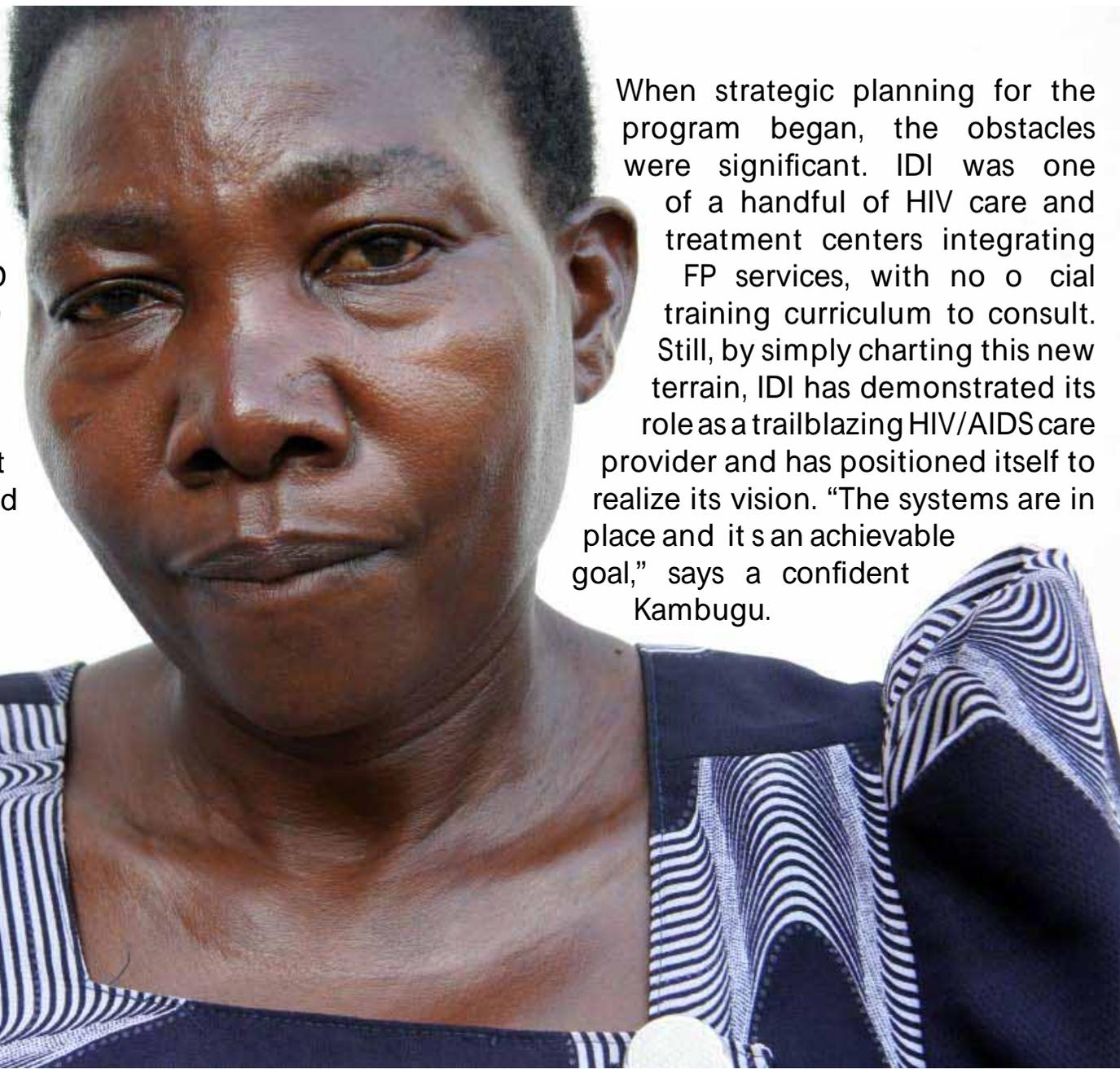
And in a clinic setting with 9,000-plus active clients, it is crucial to meet Friends health needs in a timely manner and to ensure that the delivery of new FH services does not sacrifice the quality of all other services. To anticipate this challenge, one new strategy is enlisting IDI nurses to offer a new treatment option called the nurse visit, which essentially addresses Friends less complex needs and thereby shifts some of the burden off doctors. Although a highly efficient model of care can only do so much to compensate for the additional demands on staff, “everybody is on board” and has embraced the new mission, reports Elizabeth Matovu. “The benefits and gratitude from the clients outweigh the challenge of workload.”



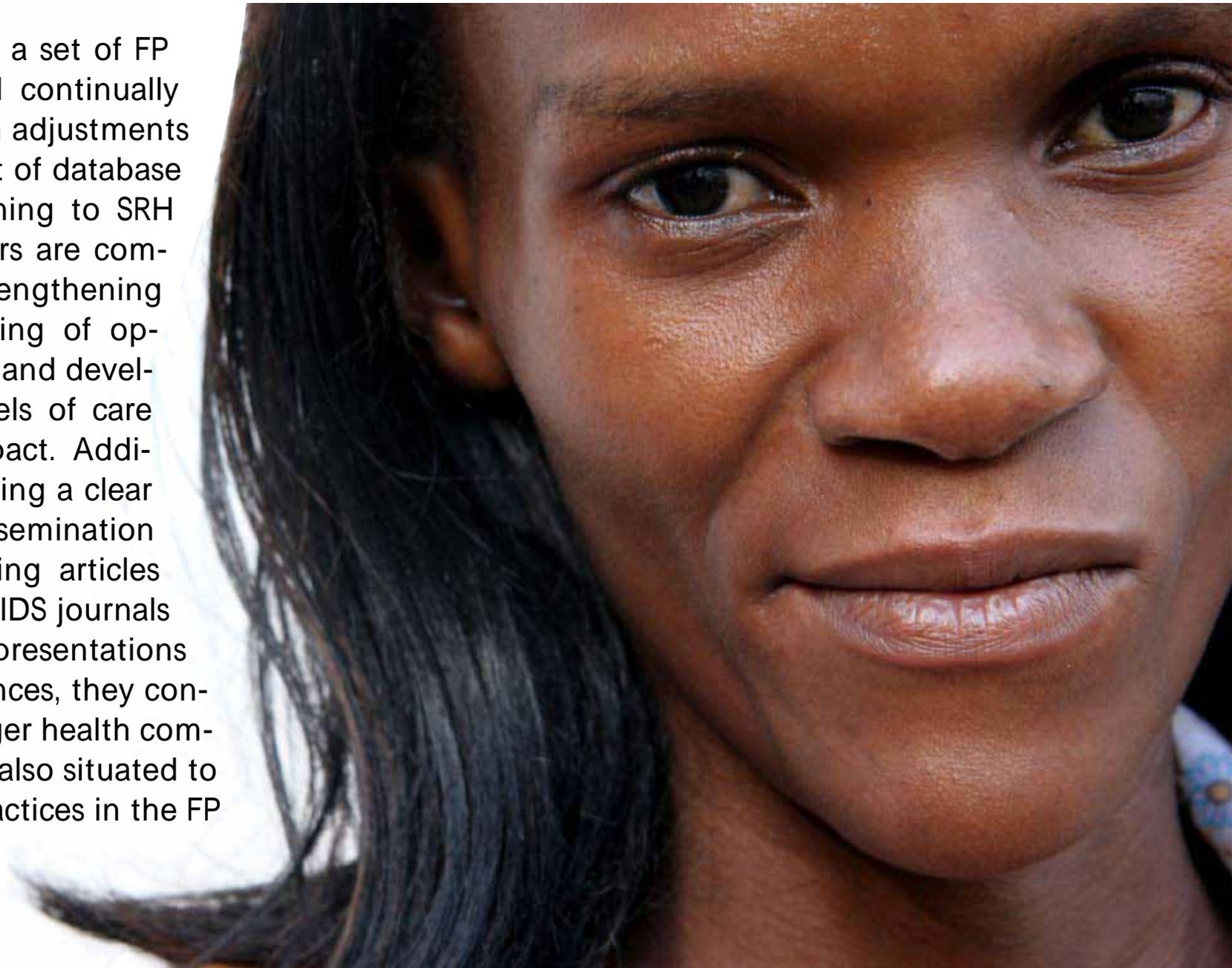
“THE BENEFITS AND GRATITUDE FROM THE CLIENTS OUTWEIGH THE CHALLENGE OF WORKLOAD.”

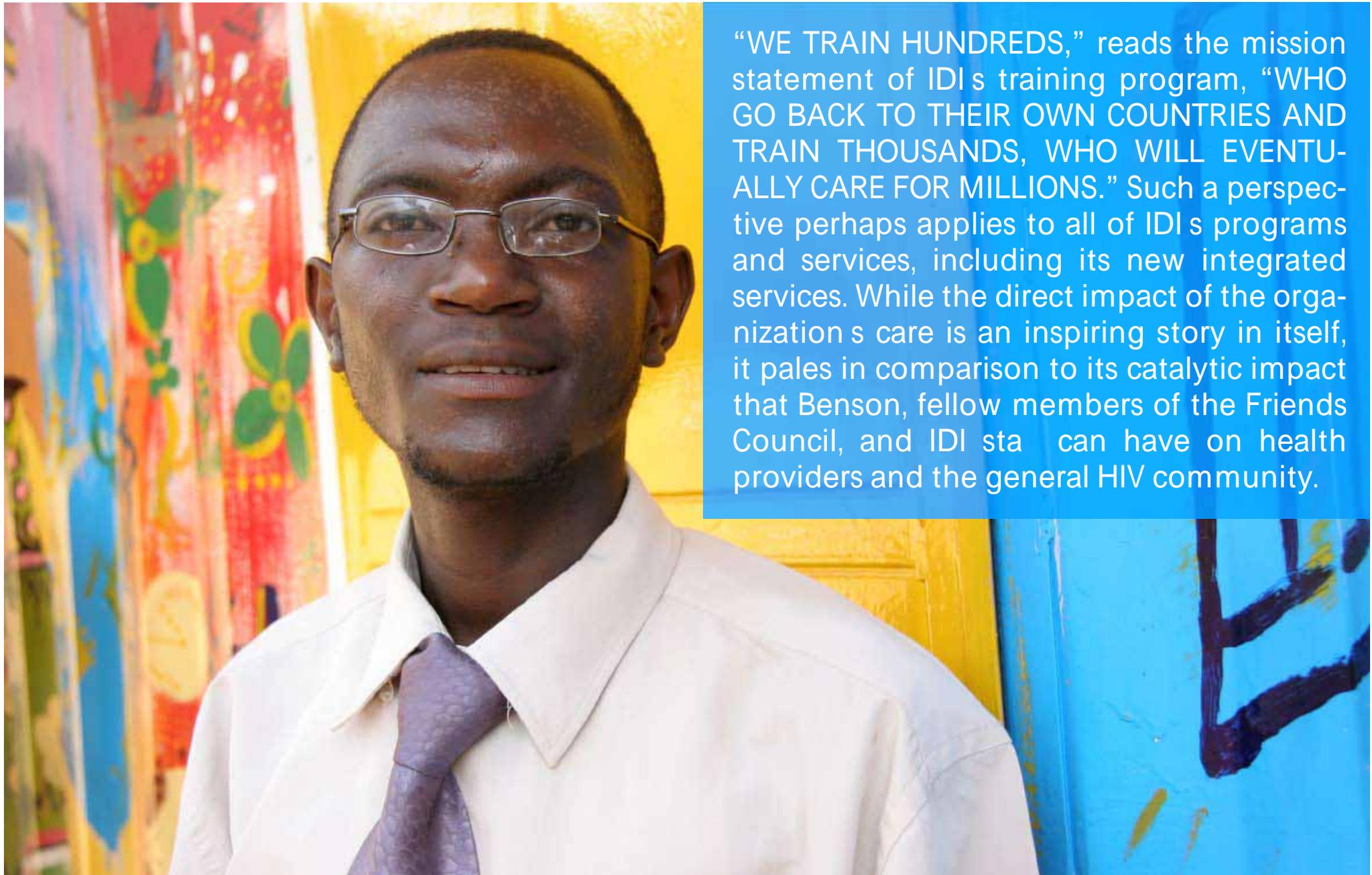
In IDI's assessment of its integration program's first year, Kambugu acknowledges that the clinics did not see the uptake in clients they expected, but they did see a 50 PERCENT REDUCTION IN THE RATE OF UNINTENDED PREGNANCIES BETWEEN MAY AND SEPTEMBER 2009. In addition, increases in the number of negative serostatus babies in cases of intended pregnancies show that the PMTCT program has minimized vertical transmission.

When strategic planning for the program began, the obstacles were significant. IDI was one of a handful of HIV care and treatment centers integrating FP services, with no official training curriculum to consult. Still, by simply charting this new terrain, IDI has demonstrated its role as a trailblazing HIV/AIDS care provider and has positioned itself to realize its vision. "The systems are in place and it's an achievable goal," says a confident Kambugu.



IDI has instituted a set of FP services that will continually improve, through adjustments informed by a set of database indicators pertaining to SRH outcomes. Leaders are committed to strengthening their understanding of operations research and developing new models of care for the best impact. Additionally, by pursuing a clear research and dissemination strategy, publishing articles in international AIDS journals and delivering presentations at major conferences, they contribute to the larger health community. They are also situated to learn the best practices in the FP integration field.





“WE TRAIN HUNDREDS,” reads the mission statement of IDI’s training program, “WHO GO BACK TO THEIR OWN COUNTRIES AND TRAIN THOUSANDS, WHO WILL EVENTUALLY CARE FOR MILLIONS.” Such a perspective perhaps applies to all of IDI’s programs and services, including its new integrated services. While the direct impact of the organization’s care is an inspiring story in itself, it pales in comparison to its catalytic impact that Benson, fellow members of the Friends Council, and IDI staff can have on health providers and the general HIV community.



BASE

INTERVIEWS *with several key in-country government officials who are focused on sub-Saharan Africa have informed the analysis of this report. To protect the anonymity of our sources, names and places have been omitted.*

A new administration and a forthright embracement of integrated strategies in funding have in some sense created a sea change in the climate surrounding FP/HIV integration. As one senior in-country leader speaking on the current state of the field in early 2010 put it, “Really, in the last year, we don’t have a lot of people telling us what we can’t do.”

On the surface, this represents a tremendous victory for longtime integration advocates. Yet, even with the new openness to integration, several structural barriers persist that make effective integration difficult. Of the two primary U.S. funders, USAID has dedicated funding for family planning services, while PEPFAR is explicitly focused on HIV/AIDS funding. While PEPFAR has rhetorically embraced integration as best practice, its evaluation matrices and impact-tracking statistics remain directly connected to testing, the delivery of antiretroviral therapy, and other related services. On the other hand, USAID funders do focus on family planning, but have much smaller pools of money, and are accountable for serving the entire national population rather than, for instance, in the case of the Tides Africa cohort, an average segment of infected people making up 8 percent of the population (United Nations).

As such, each agency, while philosophically supportive of integration, has serious barriers to sustained investment in integration strategies. In the words of one funder, potential collaborative efforts often become a conversation expressed as, “How much can we do for you [and the integration agenda] without chipping in any money?”

BUILDING A BASE FOR INTEGRATION

OPPORTUNITIES FOR STRATEGIC PARTNERSHIP

The current moment presents concrete opportunities for strategic philanthropic investment. Philanthropy can invest in continued innovative programming, targeted research, and applied analysis to develop a canon of best practices that can be transferred and scaled through clinics worldwide. Funders can also support increased connections and linkages between grantees that can add to the emerging community of practice. In the interest of solidifying the gains the field has made for integration over the last few years, philanthropy can support further advocacy and accountability that is designed to speed the transformation of PEPFAR’s evaluation matrices and tracking mechanisms. However, even as funders pioneer new efforts in this catalytic field, philanthropy must pursue partnership with government funders, rather than simply taking an adversarial stance. One official summed up the government approach to open partnership this way:

“We’ll be real, real candid about what we can do and what we can’t do, what we think is a good idea and what’s not a good idea. Pick up the phone. Where you’re looking at an award or something like that, say [to yourself], How does this fit? And what I would hope is that when you invest a couple hundred thousand dollars in something, it’s in an area where we can’t touch.”

Philanthropy, by filling gaps in funding where the larger government funders “can’t touch,” has already played a pivotal role in supporting broader integration of family planning into HIV/AIDS service delivery. In its readiness to “pick up the phone” and foster more healthy collaborative relationships with larger-scale efforts,

Tides Africa and its philanthropic peers can continue the transformation of integration from advocacy agenda to accepted best practice.

In sum, funders concerned with incorporating and advancing integrated care as a best practice in their work can pursue several of the available avenues:

- Participate in learning venues. Working in collaboration with other funders will help sharpen analyses, leverage funds, and mobilize for collective action.
- Engage in dialogue with the on-the-ground leadership of grantees, not just U.S.- or European-based senior leadership. The insights contained in this report were surfaced only through intensive collaboration with senior in-country, mostly African-born leaders who are often overlooked in the process of creating change.
- Actively pursue collegial relationships between government and institutional philanthropy. The USAID and PEPFAR officials contacted in the compilation of this report recognize the importance of strong relationships with their peers in the philanthropic sector. Regular conversations can only help strengthen the growing body of theory and practice around integration.
- Support advocacy to further refine the structure and accountability mechanism of U.S. programs. While the current climate around integration reflects the tireless advocacy of countless organizations, work remains in completing effective reform that makes PEPFAR and other programs accountable for delivering integrated care.

OVER A FEW SHORT YEARS, LEADERS IN THE FIELDS OF REPRODUCTIVE HEALTH AND HIV/AIDS TREATMENT HAVE MADE A CONVINCING CASE FOR INTEGRATED CARE. TIDES AFRICA GRANTEES AND THEIR PEERS AROUND THE WORLD HAVE PIONEERED INNOVATIVE APPROACHES AND LEARNED INVALUABLE LESSONS AS THEY HAVE SOUGHT TO SERVE THEIR PATIENTS, CLIENTS, AND “FRIENDS” BETTER. NOW, IN A NEW ERA OF INCREASED U.S. AND INTERNATIONAL RESPONSIVENESS TO THIS APPROACH, THE ONUS REMAINS TO DISTIL LESSONS LEARNED, TO ADVOCATE FOR MORE EFFECTIVE HEALTHCARE INFRASTRUCTURES, AND TO INVEST IN THE FUTURE OF HEALTHY FAMILIES.

MAKING THE CASE FOR INTEGRATION

TIDES FOUNDATION'S AFRICA FAMILY
PLANNING AND HIV INTEGRATION FUND