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**AIDS TECHNICAL SUPPORT PROJECT (ATSP)
LESSONS LEARNED: INTEGRATION OF
HIV/AIDS PROGRAMS WITH OTHER SERVICES**

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Acronyms

AIDS	Acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
ATSP	AIDS Technical Support Project
CS	Child survival
CSSP	USAID's Child Survival Support Program
HIV	Human immunodeficiency virus
IPPF	International Planned Parenthood Federation
MCH	Maternal and child health
NCIH	National Council for International Health
NGO	Nongovernmental organization
PVO	Private voluntary organization
PLWA	People living with HIV/AIDS
STI	Sexually transmitted infection
UNFP	United Nations Population Fund
USAID	U S Agency for International Development

Introduction

The worldwide AIDS epidemic continues to challenge the traditional roles of health and development program planners and project staff members. Their challenge is not only to implement AIDS and HIV prevention programming at the grassroots level, but also to do so in ways that are effective, sustainable, and ensure the optimal use of human and financial resources.

Integrating HIV/AIDS programs into other health projects has been explored as one promising approach. Integration of HIV/AIDS interventions is seen as a way to help ensure comprehensive health care delivery and allow for cost-effective partnering of resource-constrained health and development programs.

Multiple examples of this type of integration were explored by cooperating agencies as part of USAID's AIDS Technical Support Project (ATSP). This paper analyzes two examples to outline the benefits, barriers, and disadvantages to such integrated services: the integration of programs to prevent sexually transmitted infections (STIs) and HIV with programs to deliver family planning services, and integration of HIV prevention into child survival programs. This paper also presents an argument for integrating HIV prevention into care and support programs for people living with HIV/AIDS (PLWA).

This paper was compiled using articles by Dr. Elaine Murphy, the Senior Program Advisor at the Program for Appropriate Technology in Health (PATH), and Ms. Sudha Sivaram, a student intern at Johns Hopkins School of Hygiene and Public Health, and Ron MacInnis, director of the Global AIDS Program at the National Council for International Health (NCIH).

I. Integrating STI/HIV Prevention into Family Planning Services

Women now comprise the fastest-growing population of new cases of HIV. In fact, efforts to reach the traditional “risk behavior groups” — sex workers, their clients, members of the military, and long-distance truck drivers with multiple partners — have been successful in reducing the number of new HIV cases among these groups. At the same time, spouses and sexual partners of already infected men constitute a growing proportion of those infected with HIV. The question is how best to reach these women at risk. Integrating STI/HIV prevention into family planning (FP) programs may be one effective approach.

Half the women in the world use modern methods of contraception that require at least some interaction with health care providers. Since contraceptive use is increasing in developing countries, even more women will be interacting with FP programs in the future, and this has heightened interest in integrating STI/HIV prevention activities into these programs. Unfortunately, many FP programs do not now include activities geared toward prevention of STIs including HIV or care for medically treatable STIs.

To better coordinate these activities, many organizations are looking at strategies for reaching women who were not previously targeted for HIV/AIDS prevention programs: monogamous spouses or partners. For a growing number of these women, the only risk factor for HIV infection is being married to men who have multiple sexual partners or who are intravenous drug users.

Research in many countries shows that even men who use condoms with sex workers or casual sex partners seldom do so with their wives and girlfriends.

Moreover, men tend to stop using condoms when a casual sex partner becomes a steady girlfriend. Counteracting this tendency has been the goal of several communication efforts, including the Jamaica Ministry of Health's "Keep On Keeping It On" campaign.

Some monogamous women can be reached at work sites, in educational settings, in markets, or in village gathering places. In general, however, because women in this category are diverse and dispersed throughout the population, they are not easy to target. Mass media can be effective in raising awareness and desensitizing the issue of STIs and HIV/AIDS, but many women in monogamous relationships pay little attention to safe sex messages because they consider them irrelevant. Other women worry about their partners' infidelity but feel unable to discuss the matter with their husbands or boyfriends, let alone persuade them to use condoms. Many of these women need interpersonal means — peer education or talking with a respected counselor — to personalize the risk.

As the prevalence of STI/HIV infections spread and awareness rises, risk-assessment and STI/HIV prevention messages are increasingly being integrated with FP counseling. A decade ago there was considerable resistance to such integration, in part because of fears that the respectability of family planning programs — themselves often controversial — could be compromised by including STIs. Most family planning professionals now agree, however, that at a minimum, all clients should be informed whether their family planning method protects them against STI/HIV.

Women also need information on how STIs and HIV are transmitted and that abstinence or the consistent use of condoms are the most effective means of protection. Providers should help clients assess their level of STI/HIV risk and explain that the behavior of one's partner can also put them at risk. Male condoms and, where available, female condoms should be offered as a primary contraceptive method and as an additional protection against STI/HIV.

There is some evidence that women who use a long-term and permanent contraceptive method (e.g., sterilization, IUDs, and implants) may be less likely to use condoms for protection, and these women may need careful counseling. For some, pregnancy prevention is a higher priority. Others do not want the inconvenience and cost of using more than one method. Still others who use long-term methods may not use condoms because they do not perceive themselves to be at risk for either pregnancy or STIs/HIV.

Some women — especially young adults or teens — incorrectly believe that all contraceptives protect against STI/HIV. One study of female adolescents found

that only 25 percent knew that oral contraceptives did not offer STI/HIV prevention

Monogamous women at high risk need special encouragement, skills, and support to use condoms in addition to any other method selected. Counseling both members of the couple, rather than just the woman, is often the most effective approach. If this is not possible, helping women build skills in condom negotiating and in communicating with their partners about sex is an effective addition to prevention messages.

Although integrating STI/HIV prevention and treatment into FP services is a positive way to reach many women at risk, it is not always easy. Some technical proficiency may be sacrificed as a vertical program integrates new services. Unless current staff members are trained in the new interventions and additional, trained staff members are available, FP workers may be overwhelmed by the number of tasks associated with each visit.

Data collection may also suffer if health workers cannot keep up with extra reporting requirements. Diagnostics and antibiotics must be made available if STI treatment services are offered (in addition to counseling). Clearly, these and other challenges to the integration of STI/HIV prevention into FP services point to the need for feasibility studies and careful planning.

The Population Council and local researchers analyzed efforts to integrate STI services into FP and maternal and child health (MCH) programs in Botswana. These findings spurred government officials to draft plans to improve the integration of services and influenced the next five-year plan of the United Nations Population Fund (UNFP) for Botswana.

International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) cites specific advantages to integrating family planning and STI/HIV prevention. In a report based on IPPF's program experiences in Honduras, Brazil, and Jamaica, Julie Becker writes:

We felt that integration in family planning could be an important new strategy for HIV prevention because family planning programs offered a number of advantages, including:

- They reach large numbers of sexually active people, especially women, with information/orientation and services,
- They are often the only contact women in developing countries have with organized health programs,
- Staff have considerable experience in providing education and counseling on reproduction,

- Family Planning Programs can develop interventions that will be cost-effective because services and infrastructure already exist,
- They have experience in promoting and distributing condoms

II. Integrating HIV Prevention into Child Survival Programs

With the advent of the AIDS epidemic, many U S –based, private voluntary organizations (PVOs) have begun to integrate preventive reproductive health services into existing child survival (CS) programs. Integrating these program activities can be an extremely beneficial and sometimes represent an obvious solution to problems related to the delivery of a number of health services. Organizations involved agree that the CS programs may also offer a unique opportunity to deliver integrated HIV/AIDS interventions. This is because CS interventions generally involve community participation, work closely with the local governments and nongovernmental organizations (NGOs), and most important, are designed to be sustainable over the long term with little or no outside support.

Many USAID–funded CS projects incorporate critical interventions that contribute directly to the reduction of maternal and child morbidity and mortality. These community-based interventions include childhood and maternal immunization, antenatal care, prevention of illnesses that account for a large proportion of child deaths, including diarrheal diseases, malaria, tuberculosis, and respiratory conditions, and promoting better nutrition, including through increasing the availability of foods fortified with key vitamins and minerals, such as vitamin A, iodine, and iron.

CS project staff members may be already providing health education services, and many are trained in HIV/AIDS and reproductive health issues in addition to their CS training. Therefore, they can fairly easily include HIV/AIDS prevention as part of their routine activities. For example, CS projects that include street theater

as part of their educational activities could develop a skit addressing HIV/AIDS prevention to be included in their current repertoires

In addition, many CS projects already incorporate interventions outside the traditional health sector such as environmental management, water and sanitation, micro-credit programs, and watershed development. Many projects also involve the local government and Ministry of Health in prevention and training programs run at the grassroots level and for community health workers, government health workers, and private health care providers. These activities can be used to train these health workers to incorporate HIV/AIDS prevention into their other health and development activities.

For example, a child survival program implemented by World Vision in Cambodia that trained hospital workers in child survival and safe motherhood interventions added training in HIV prevention education in response to the growing problem of HIV infection in the region. Today, the hospital serves as a referral center not only for maternal and child health care services, but also for pediatric AIDS cases.

Of course, there are obstacles to successful integration of HIV/AIDS prevention into CS programs. Dr. Dory Storms, director of the USAID's Child Survival Support Program (CSSP), cites two main barriers:

- Different target groups for HIV/AIDS prevention and CS programs. In CS programs, the beneficiaries are children under age 5, and the primary focus is on those under age 2. HIV/AIDS programs generally target men, young people, and other specialized groups. This inherently requires two different baseline studies to measure the effectiveness and success of integrated programs. It also raises the possibility that, in trying to reach these disparate target groups, a project may become overstretched. CS projects may be unable to reach those people who are at greatest risk of HIV infection — namely migratory males. “Essentially,” said Dr. Storms, “in HIV prevention you want to target the population that has control over condom usage, and that population is not generally in attendance at CS or at village health meetings.” In fact, many CS projects are almost exclusively rural.
- Different staff skills and expertise. CS educators and counselors who work well with women and children may not necessarily be comfortable approaching the sensitive sexual issues involved in HIV prevention and education. Sometimes, two separate staffs may be required.

Dr Storms does not consider these obstacles reason enough to exclude AIDS prevention interventions from CS programs — on the contrary, she considers CS activities a necessary tool for community awareness and education about HIV/AIDS. She warns, however, against relying on this integrated approach as a comprehensive response to HIV/AIDS to the exclusion of AIDS-specific programming.

Many African countries now face a growing problem of AIDS orphans, a natural result of the growing numbers of adults succumbing to the epidemic. Organizations that implement CS projects in these countries often include AIDS orphans in their program activities, providing them with education materials, facilitating their participation in schools, and helping them and their caretakers gain better access to health care.

As organizations plan future CS projects in partnership with the communities they serve, they must give careful consideration to the recommendations of various international donor agencies for addressing AIDS worldwide. This will help them optimize their resources to address the felt needs of the communities. For example, USAID will not fund CS programs that propose to purchase pharmaceuticals or conduct HIV testing, only those that focus on providing prevention education services.

Many PVOs consider both child survival and AIDS education services not only to be essential but also to be a right of communities. Many admit that integrating HIV/AIDS prevention into child survival projects is just a beginning. With time, they foresee a need for more and more AIDS education and services, which will consume a greater proportion of their staff time and resources.

The experience of PLAN International in Africa is instructive for the future. According to Karla Steele, director of Program Development for PLAN International, many programs in countries such as Uganda, Zimbabwe, and Kenya now focus on providing care for families and individuals who are living with HIV and AIDS.

In many PLAN projects in Africa, we are moving to the second stage of AIDS interventions — from education and information dissemination to providing counseling and care for individuals and families living with HIV/AIDS — therefore addressing the growing needs of the community.

For many organizations, providing prevention education services is only the first step in a natural and progressive continuum of prevention and care, which requires increased provision of counseling and care services. Because some donors will not fund caregiving services, equipment, and pharmaceuticals, a

number of these organizations are supplementing donors' contributions in order to provide these services on their own.

Over all, delivering high-quality, integrated services of this type requires an organization that can combine innovation, a well-trained staff, and sound management. Ensuring that these building blocks are in place will be an important focus of efforts to integrate AIDS prevention services into any ongoing program.

III. The Prevention-to-Care Continuum

Caring for and supporting people infected with the HIV virus is a crucial element of preventing its spread. People living with HIV/AIDS (PLWA) can take measures to protect their own health and can learn to change their behavior to protect their sexual partners. In addition, they are often the strongest voices in promoting prevention in their community.

Increasing the diagnostic and counseling services available to communities and families affected by HIV/AIDS can improve the cost-effectiveness and life-sustaining impact of care and treatment provided for opportunistic infections. It is well-documented that preventing such opportunistic infections is less expensive than providing tertiary care for end-stage AIDS patients. Also, as evidenced in countries hard-hit by AIDS such as Uganda, only when communities truly experience the impact of HIV by acknowledging and participating in the care of those infected, do they embrace the problem and begin to effectively act to prevent its spread.

Preventive education efforts have been successful in promoting awareness about HIV and AIDS among certain key segments of the population in some countries, including Mali in West Africa. A 1996 survey in Mali indicated that 77 percent of women and 96 percent of men had heard about HIV/AIDS, an encouraging finding given that awareness is an important first step in controlling an epidemic. However, there were only three sites in Mali, a country of 9 million, where men and women could be tested for HIV infection. The advantages of taking the test were unclear even to those fortunate enough to have access to it — those who tested positive had few options for care, and those who tested negative still needed motivation and support to follow safe sexual behaviors to stay that way.

Within the HIV/AIDS prevention-to-care continuum, the care element has several interrelated components, many of which are provided by other health and development programs

- **Medical care** providing appropriate diagnostic services and rational treatment for opportunistic infections, providing assistance to patients planning their follow-up care, treating STDs to prevent easier spread of HIV, and providing direct educational opportunities between caregivers and patients.
- **Traditional care** promoting proven and accepted local healing practices and alternative and complementary therapies that can benefit people living with HIV/AIDS, as well as allowing for spiritual support and participation of spiritual leaders
- **Nursing care** providing health care and health maintenance services, promoting hygiene and nutrition, counseling and educating family members on prevention and caring for afflicted family members
- **Counseling** facilitating informed decision-making (e.g., whether to get tested), providing post-test counseling, and promoting positive living and planning for the future
- **Social support services** providing information, developing support groups, and helping those with HIV/AIDS gain access to existing community services

Many of these services now available in various forms in many countries in Asia, Latin America, and Africa, depending on national commitments and international donor interests. The challenge is to use the limited resources available to develop innovative programs that meet these varying, but interrelated needs

USAID is currently examining appropriate ways to launch HIV/AIDS programs using the prevention-to-care continuum as a model. USAID's global HIV/AIDS program will include care strategies as a formal objective beginning this year. Many cooperating agencies that have worked USAID are beginning to consider AIDS as a development issue and, slowly, are adapting their responses accordingly.

These and other agencies seeking to implement such programs need to take into consideration the target communities' ability to provide these services on their

own For example, using PLWA as peer educators in the community is effective in providing information, supporting PLWA, and de-stigmatizing HIV and AIDS

Our experience so far with the HIV/AIDS pandemic has proven that concentrating on a single method of response is neither cost-effective nor successful The option of providing care and support services to those infected with HIV should not be considered as a trade off to be weighed against funding and implementing prevention efforts Instead, it should be seen as a necessary component to strengthening the prevention efforts now directed at halting the spread of HIV/AIDS

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