



Network

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Integrating
Services



The Family Planning/HIV
Collaborative Series



Volume 23 Number 3, 2004



Letter from the Editor

This issue of *Network* is the first of a series of publications dedicated to the topic of integrating family planning and HIV services. The collaborative effort — supported by the U.S. Agency for International Development (USAID) — aims to address the field's needs for information on service integration, taking advantage of the diverse knowledge, perspectives, and program experience of USAID-supported cooperating agencies.

Integrating family planning and HIV services, while not new, is a complex endeavor. Ideally, family planning/HIV integration maximizes the use of existing services and minimizes the number of people who do not obtain the health care they need. But much remains unknown about how best to integrate services and what impact such integration will have on reproductive health outcomes, such as preventing HIV infection and unplanned pregnancy. This issue of *Network* will present a general overview of current thinking about integration. But the publication series, as a whole, is intended to encourage health professionals — researchers, program

managers, policy-makers, and providers — to ask questions or share their experiences regarding the feasibility and effectiveness of efforts to integrate services.

With help from the Information and Knowledge for Optimal Health (INFO) Project at Johns Hopkins University and from FHI, the Health Information and Publications Network (HIPNet) will coordinate and oversee this participatory activity. HIPNet is a group of organizations working with USAID to encourage cooperation among organizations, eliminate duplication of publications, and promote dissemination and utilization of each organization's materials. For HIPNet's Web site, see <http://www.hopkinsmedicine.org/ccp/>. Readers are invited to contribute to this ongoing discussion by sending suggestions to Peggy D'Adamo, cochair of HIPNet, at mdadamo@jhucpp.org.

Kim Best
Managing Editor, *Network*

NewsBriefs

Contraceptive Use Criteria Updated

Based on the latest clinical and epidemiological data, updated summary tables of medical eligibility criteria for contraceptive use are available at http://www.who.int/reproductive-health/publications/RHR_00_2_medical_eligibility_criteria_3rd/index.htm. The tables, prepared to reflect recommendations made by an expert working group in October 2003, appear in the recently finalized third edition of the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use*.

Of note, review of the scientific evidence led to revised guidance on the use of the intrauterine device (IUD). In general, the revisions treat the IUD more favorably than before. Although IUD use should not be initiated in women with pelvic inflammatory disease or in women with current purulent cervicitis, chlamydial infection, or gonorrhea, such women who *already* have an IUD can continue to use the method, and infection can be treated with an IUD in place. Likewise, women can generally continue using the IUD if they are at increased risk of sexually transmitted infections (including

HIV), are HIV infected, or have AIDS. Initiation of IUD use is usually not recommended for women with AIDS who either are not receiving antiretroviral therapy or do not have clinical improvement while on such therapy.

Other noteworthy updates include the addition of a category entitled "known thrombogenic mutations" for which combined oral or injectable contraceptives should not be used. For another new category — "depressive disorders" — no restrictions exist for any contraceptive method, except for sterilization (for which caution is recommended). All hormonal contraceptives can generally be used or carry no restrictions for women with AIDS. Women using rifampicin and certain anti-convulsants can generally use combined injectable contraceptives now. Oral contraceptives and combined injectables can generally be used or carry no restrictions for women using griseofulvin. Finally, the tables have been updated to include three new contraceptive methods: patch, ring, and etonogestrel implants.

Injections Seldom Cause HIV Infection

Evidence indicates that sexual transmission — not unsafe injections — is the main way HIV spreads in sub-Saharan Africa, an international team has concluded.

In an article published in the February 2004 issue of *The Lancet*, the team reviewed and refuted assertions that unsafe injections given for medical reasons are a major mode of HIV transmission in the region. First, team members concluded that unsafe injections are not frequent enough to play a dominant role in such transmission. Transmission efficiency of HIV through injection in African health care settings is also far less than the 2.3 percent previously asserted, they estimated. This is, in part, because injections are usually intramuscular (rather than intravenous) and needles are likely to be cleaned before reuse.

Also, the team found that the asserted strong association between a history of

continued on page 11

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Ideally, integrating family planning and HIV services better enables both men and women to obtain the health care they need. The cover photo by David Reed of Panos Pictures depicts youth and adults from Cape Town, South Africa.

In This Issue

Integrating Services

Family Planning and HIV Service Integration	4
What Is Integration?	5
To Integrate or Not to Integrate	6
Potential Benefits and Challenges of Integration	8
HIV Services for Family Planning Clients	9

Integrating Family Planning into VCT Services	12
Challenges to Providing Family Planning Services	14

Case Studies	16
Uganda: Integrating Family Planning into VCT	16
Cambodia: Clients Find Everything They Need in One Place	17
Zimbabwe: 'I Have the Knowledge and Skills to Help'	18
Jamaica: System-Wide Integration of Services	19

Averting HIV-Infected Births	21
Preventing Pregnancy among HIV-Infected Women	22
Family Planning: Considerable Impact at Relatively Low Cost	25
Preventing HIV Infection among Pregnant Women	26

Involving Men	29
Integrating Services to Appeal to Men	30
Assessing Men's Attitudes about Gender Roles	31

Departments

News Briefs	2
Resources	32



Family Planning and HIV Service Integration

Potential synergies are recognized.

KEY POINTS

- Integration can enable family planning and HIV service providers to reach more people with a broader range of services.
- Many types of integration are being explored, but their impact on reproductive health is largely unknown.
- Research is needed to assess the feasibility and effectiveness of different models of integration.

In most settings throughout the world, family planning services and HIV services traditionally have been offered separately, with little or no integration. Family planning services primarily target married women of reproductive age. HIV prevention services primarily target individuals at high risk of HIV infection. But the potential benefits of integrating these services are increasingly apparent as ever more women of reproductive age become infected with HIV or are at risk of infection.

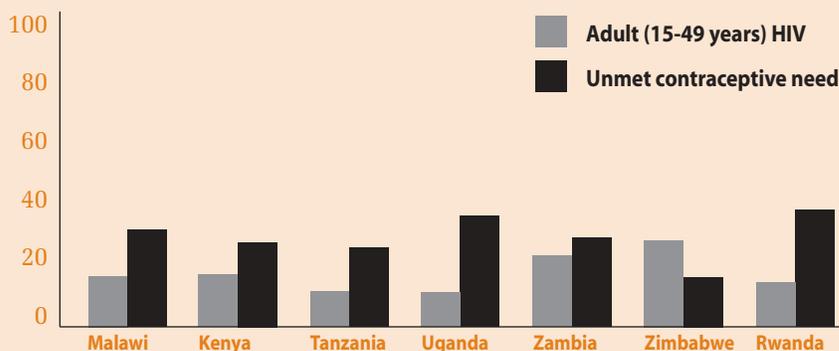
In developing countries, most HIV infection is sexually transmitted among men and women. About half of the 40 million people now living with HIV are women of reproductive age; percentages approach 60 percent in some African countries.¹ Many HIV-infected women likely need family planning services, but unmet need for these services is often greatest in countries with high HIV prevalence.² This need can be better met if family planning services are offered where such women access HIV or other services, in addition to being offered through family planning programs.

Meanwhile, clients accessing family planning services may well need HIV prevention, diagnosis, and treatment services. Many of these clients are married women,

who are usually considered at low risk for HIV infection. But evidence from several countries suggests that marriage may offer women little protection against HIV infection since, in some settings, even married women may have little or no power to negotiate safe sexual practices with their husbands. In Kisumu, Kenya, and Ndola, Zambia, teenage brides are becoming infected with HIV at higher rates than are single, sexually active young women of the same age.³ Forty percent of new HIV infections in Thailand occur between spouses, and 90 percent of those infections are transmitted from husband to wife.⁴

Service integration holds the potential for helping women and others — such as men, youth, and couples — prevent unintended pregnancy and HIV infection. Experience with integrating a variety of health services, such as maternal and child health and family planning or family planning and management of sexually transmitted infections (STIs), has been mixed. But the most successful experiences suggest that integration enables providers to offer more convenient, comprehensive services. Integration is also expected to expand access to services and make them more cost-effective.⁵

High Prevalence of Adult HIV and Unmet Contraceptive Need



Sources: United Nations, Population Division. *HIV/AIDS: Population Impact and Policies*, poster. New York, NY: United Nations Secretariat, 2001; Westhoff C. *Unmet Need at the End of the Century*. DHS Comparative Reports. Calverton, MD: ORC Macro, 2001.

Types of integration

Where services are currently integrated, some HIV services are usually provided through family planning programs⁶ (see article, page 9). These services may include diagnosis and treatment of STIs, sexual risk-reduction counseling, condom promotion, and HIV voluntary counseling and testing (VCT).

Integration is also starting to move in the opposite direction. Pilot efforts have begun to add family planning counseling and services to HIV services such as VCT and prevention of mother-to-child transmission (PMTCT). (See articles, pages 12 and 21, respectively.) Such integration aims to give all VCT and PMTCT clients, regardless of their HIV status, the opportunity to avoid unintended pregnancies and space the births of their children. For HIV-infected women, ready access to family planning can help avert unintended pregnancies and thus reduce numbers of HIV-infected infants.

Also being explored is the integration of family planning into care and support for people living with HIV. An FHI study is assessing integration of family planning promotion into the services provided by volunteer caregivers in a home-based care program for people living with HIV in South Africa, and results are expected by the end of 2004. Managers of a similar program in Kenya, the HIV/AIDS Care, Support, and Prevention (COPHIA) program carried out by U.S.-based Pathfinder International, decided that it was important to train community health workers in family planning services and HIV prevention so that they could respond to the reproductive health needs of clients and family members.

Questions unanswered

The reproductive health impact of integrating HIV services into family planning programs has not been rigorously evaluated. Even less is known about the feasibility and impact of integrating family planning into HIV services. Research is essential to demonstrate not only that integration will not overburden and thus compromise the quality of existing services, but also that it will actually improve reproductive health.

What Is Integration?

Integration in the health sector has been defined as offering two or more services at the same facility during the same operating hours, with the provider of one service actively encouraging clients to consider using the other services during the same visit, in order to make those services more convenient and efficient.¹ In practice, integrated services are not always offered under one roof, but when they are not, strong referral systems are required to ensure that clients receive the high-quality services that they deserve.²

Services or preventive health messages can also be integrated outside clinical settings through interventions such as behavior change communication, peer education, community outreach, youth programs, and social marketing.³ For example, in Nigeria's Lagos State, family planning counseling and referrals are now available through an HIV/AIDS telephone hot line established in 2001 by the Health Communication Partnership (HCP), which is funded by the U.S. Agency for International Development (USAID), and the Lagos-based Youth Empowerment Foundation. After training hot line counselors in family planning counseling and referral in February 2004, HCP began promoting the new service through radio advertisements, community rallies, and a USAID-sponsored family planning program.

Research has shown that community-based distribution (CBD) programs can successfully promote and deliver condoms to both men and women.⁴ The impact of integrating HIV prevention messages and voluntary counseling and testing referrals into a CBD program is being evaluated in Zimbabwe (see article, page 18). Meanwhile, condom social marketing programs, which use commercial sales outlets and marketing techniques to sell condoms at subsidized prices, have been more successful than other family planning programs in reaching men.⁵

■ Kathleen Henry Shears



▲ **At a community rally, a Youth Empowerment Foundation outreach worker promotes an HIV/family planning hot line available in Nigeria's Lagos State.**

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To Integrate or Not to Integrate

When does integrating family planning and HIV services make sense? New technical guidelines from the U.S. Agency for International Development (USAID) state that such integration is most appropriate in countries where the epidemic has moved beyond groups at

highest risk of infection and HIV prevalence has climbed above 1 percent among pregnant women receiving antenatal care. In these countries with “generalized” (see chart, this page) epidemics, the number of people who need both family planning and HIV services is likely to be high.¹

Family planning and HIV service needs intersect in a growing number of countries. In 2000, 55 countries had generalized epidemics, up from 25 countries in 1990.²

In contrast, in countries where the epidemic is “low level” or “concentrated” among people at highest risk of infection, HIV services specifically targeting those individuals are needed. Integrating services in such settings is unlikely to be cost-effective.³

An exception to these general rules is Mali, which has an epidemic that fits the definition of a generalized epidemic, with HIV prevalence estimated at 1.7 percent among pregnant women.⁴ But Malian women have an average of seven children, and only 8 percent of married women use any contraceptive method.⁵ In Mali and other countries where unintended pregnancies still represent a greater threat to health and survival than does HIV, strengthening the family planning program — rather than inte-

grating family planning and HIV services — should be the priority, USAID advises.⁶

Even in countries where HIV primarily affects high-risk groups, good opportunities may exist to reach people in need of HIV or family planning services through service integration. Some family planning programs, for example, may be able to tailor their services to reach those at highest risk, such as men, young people, and sex workers.⁷

Moreover, though a country’s epidemic is low level or concentrated nationally, it may be generalized in some geographic areas. “Epidemics in Asia are very local, so planning has to occur on that level,” says Steve Mills, associate director for technical support in FHI’s Asia and Pacific Division Office in Bangkok, Thailand. “What makes sense in one district may not make sense in another, since a high-prevalence area may be right next to a very low-prevalence area.”

■ Kathleen Henry Shears

Appropriate Services by Type of HIV Epidemic

HIV Epidemic Type

Service for Type of Population

Generalized: HIV prevalence above 1 percent among pregnant women

Integrated family planning (FP)/HIV for general population and high-risk populations

Concentrated: HIV prevalence above 5 percent in at least one at-risk subpopulation but below 1 percent among pregnant women

- FP for general population
- HIV (and possibly FP) for high-risk populations

Low level: HIV prevalence below 5 percent in at-risk subpopulations and below 1 percent among pregnant women

- FP for general population
- HIV for high-risk populations

Source: Adapted from U.S. Agency for International Development (USAID). *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs*. Washington, DC: USAID, 2003.

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Such research should assess the effects of different models of integration on service quality, adoption and continuation of family planning methods and HIV prevention strategies, acceptability and use of services, and cost-effectiveness.⁷ Pilot studies with experimental designs are urgently needed to generate evidence-based recommendations for programs since, in general, “little is known about how integrated services can best be configured, and what impact they have on prevention of infection and unwanted pregnancy,” caution the coauthors of an article about gaps in knowledge about STI service integration activities in sub-Saharan Africa.⁸ Even when successful models of integration are identified, their expansion will require changes in government and donor policies that currently encourage vertical programs.⁹

Before attempting to integrate services, program managers need to be aware of the challenges confronting them (see chart, page 8) and consider whether integration makes sense (see article, page 6). The likelihood that combining the two kinds of services will be cost-effective depends on clients’ needs, the prevalence of HIV in the area, and the strength of family planning programs.¹⁰ The appropriate level of integration depends on a program’s capacity and the costs and resources available to support and maintain integrated services, directly or through referrals.¹¹

Regardless of when, where, and how family planning and HIV services are integrated, family planning remains one of the most effective ways to enhance the well-being of women and their families. By enabling women to avoid unintended pregnancies and by reducing the risks associated with age at pregnancy, too many pregnancies, or pregnancies spaced too closely together, family planning prevents about 2.7 million infant deaths and 215,000 pregnancy-related deaths in the developing world each year.¹²

These benefits of family planning may be particularly important for HIV-infected women, whose health is already compromised, and for their children.

■ Kathleen Henry Shears



▲ Family planning enhances the well-being of women and their families. Here, a woman cares for children while selling food in a market in Dakar, Senegal.

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Potential Benefits and Challenges of Integration

Before deciding whether to integrate family planning or HIV services, program managers need to be aware of the potential benefits and challenges of doing so.

Type of Integration	Potential Benefits	Potential Challenges
FP → HIV or HIV → FP	<ul style="list-style-type: none"> • More people reached with needed services • Providers better able to meet clients' various needs • Cost savings through reduced duplication of service delivery functions • Fewer HIV infections and unintended pregnancies 	<ul style="list-style-type: none"> • High initial costs of establishing services and training staff • May overburden staff and weaken services, particularly if programs are poorly funded • FP and HIV services often implemented by different programs with different policies and sources of funds
HIV/STI prevention → FP (clinics or outreach), MCH , or ANC <i>increasingly common</i>	<ul style="list-style-type: none"> • Improved provider counseling skills and greater client satisfaction • Increased knowledge of HIV prevention strategies among women of reproductive age who are at HIV risk but might not otherwise receive HIV information and counseling • Many HIV-infected births averted by preventing HIV infection among women of reproductive age 	<ul style="list-style-type: none"> • May not reach those at high risk of HIV infection, particularly in concentrated or low-level epidemics • Inability of many female clients to act on prevention messages without a partner's support • Provider and client bias against condoms • Difficult for many FP programs to assume new tasks due to reduced funding and weak systems • Need to train providers to talk to clients about sexual behavior and relationships
VCT → FP or ANC <i>limited, but increasing</i>	<ul style="list-style-type: none"> • Increased access to and use of VCT services • Reduced stigma associated with HIV • Increased awareness of healthy sexual behavior • More targeted family planning counseling based on HIV serostatus • Many HIV-infected births averted by identifying infected women, then helping those who are not pregnant avoid unintended pregnancy or referring those who are pregnant for antiretroviral drug therapy 	<ul style="list-style-type: none"> • May not be cost-effective if most clients are not at risk of HIV • Possible provider reluctance to offer HIV services due to stigma associated with HIV and fears of occupational exposure to the virus • For VCT, special skills and equipment plus strong systems for supervision, monitoring, logistics management, and referrals for follow-up care needed
FP → VCT or ANC (usual site of PMTCT services) <i>limited, but increasing</i>	<ul style="list-style-type: none"> • Expanded access to FP for all VCT clients, including men and youth • Increased knowledge of dual protection strategies to prevent both unintended pregnancy and HIV infection • Greater opportunity for clients, regardless of HIV serostatus, to avoid initial or subsequent unintended pregnancy • Can greatly contribute to averting HIV-infected births among HIV-infected women 	<ul style="list-style-type: none"> • For FP, special provider skills, equipment, supplies, and space, as well as strong systems for supervision, monitoring, logistics management, and referrals for follow-up care needed • Unique contraceptive considerations for HIV-infected women
STI care → FP, MCH, or ANC <i>emphasis decreasing</i>	<ul style="list-style-type: none"> • Reduced risk of HIV infection through STI prevention, detection, and treatment • Fewer cases of secondary infertility, pelvic inflammatory disease, and negative pregnancy outcomes arising from untreated reproductive tract infections/STIs in women 	<ul style="list-style-type: none"> • Misdiagnosis more likely since FP clients may not be at high STI risk • Current lack of simple, effective technologies to diagnose and treat STIs in asymptomatic women or women with vaginal discharge • When diagnosis is uncertain, partner notification not feasible; women treated syndromically at risk of reinfection

Note: ANC = antenatal care; FP = family planning; MCH = maternal and child health; PMTCT = prevention of mother-to-child transmission; STI = sexually transmitted infection; VCT = voluntary counseling and testing

HIV Services for Family Planning Clients

When the HIV epidemic emerged in the 1980s, family planning organizations responded with some of the first HIV prevention projects in the developing world. Yet, a review of the contribution of sexual and reproductive health services to HIV prevention, conducted in 2003 for the World Health Organization (WHO), found that integrating HIV prevention into family planning services had not yet been implemented effectively, except in a few cases.¹

Still, it would be premature to conclude that integrating HIV prevention into family planning services does not work, says Dr. Ian Askew, the Population Council's representative in its office in Nairobi, Kenya, who helped conduct the review. Much has been learned, moreover, from implementing various strategies designed to achieve that goal. Such strategies include diagnosis and treatment of sexually transmitted infections (STIs) that increase the risk of acquiring HIV, sexual risk-reduction counseling, condom promotion, and voluntary counseling and testing (VCT) for HIV.

Diagnosis and treatment of STIs

STI service introduction at family planning and maternal and child health (MCH) clinics never received adequate financial support and was undertaken without strengthening the systems needed for effective service delivery. Moreover, the ability of providers in low-resource settings to detect and treat STIs in women is severely limited by the lack of simple, affordable diagnostic methods.² In such circumstances, WHO recommends syndromic management of STIs, which involves recognizing and treating STIs based on a group of clinical findings and patient symptoms.

But most women with STIs do not have symptoms, and the syndromic approach is not effective for determining how to treat women with vaginal discharge.³

Nevertheless, family planning and MCH providers still have a role to play in STI management, says Dr. Irina Yacobson, an associate medical director at FHI, who worked with colleagues at WHO and the Population Council to develop a guide for STI management in family planning and MCH settings. This draft publication incorporates WHO's current recommendations on STI management, which advise providers to treat a woman who has a vaginal discharge for vaginitis (bacterial vaginosis, trichomoniasis, and possibly candidiasis), which is often caused by infections that are not sexually transmitted. However, when a woman has clinical signs of cervical infection or there are reasons to believe that she was exposed to gonorrhea or chlamydia, treatment for cervicitis should be added.⁴

Family planning and antenatal care providers with the necessary skills and supplies can also use the syndromic approach to manage genital ulcer disease in women and can screen pregnant women for syphilis. All providers should at least educate their patients about the risks and consequences of untreated STIs, adds Dr. Yacobson.

Sexual risk-reduction counseling

Incorporating STI/HIV prevention messages into family planning services has been an appealing strategy because family planning programs attract clients who generally do not access HIV program services. Family planning staff can be trained to provide basic HIV prevention information, and family planning programs can offer an infrastructure of clinics and community-based programs for service delivery.⁵

But providing STI/HIV prevention services through family planning programs is problematic because these programs usually do not reach those at greatest risk of HIV infection, including men, youth, and single women.⁶ Even when married women are among those at highest risk of HIV, they often do not have the power to protect themselves by either abstaining from sex or insisting on fidelity or condom use by their husbands.

A comprehensive review commissioned by WHO found that efforts to integrate STI/HIV prevention activities with family planning and MCH services had improved providers' attitudes and counseling skills, increased user satisfaction, and, in some cases, increased condom distribution and the adoption of other contraceptive methods.⁷ Little evidence exists, however, that STI/HIV prevention activities among traditional family planning clients have reduced risky sexual behavior or increased condom use.⁸

Condom promotion

Male condoms — when used consistently and correctly — are an effective way to prevent HIV infection and unintended pregnancy.⁹ But promoting condom use through family planning may have limited impact because these services tend to target women, rather than the men who must agree to use condoms. Client and provider attitudes are another barrier to effective condom promotion. Condom use is rare in marriage and other steady relationships because it is often considered a sign of distrust.¹⁰ And many family planning providers are reluctant to promote condoms because they fear that greater use of a contraceptive method that is less effective than some methods will lead to more unintended pregnancies and abortions.

Little is known about the success of promoting the use of condoms plus another contraceptive method for dual protection against HIV and unintended pregnancy, although studies from South Africa¹¹ and Kenya¹² found that 13 percent to 16 percent of condom users also use another method. The addition of dual protection counseling and female condom promotion to family planning services in Ibadan, Nigeria, showed that integration of these activities is feasible but that interventions should also reach male partners to have a strong impact.¹³

In settings with high HIV prevalence, renewed emphasis on condom use alone for contraception among couples in long-term relationships might be a more effective way to encourage dual protection than is dual method use because it would allow couples to discuss condoms without accusations of infidelity.¹⁴

Voluntary counseling and testing

Providing VCT at family planning facilities enables providers to offer more targeted family planning counseling because clients know their HIV status, and it may motivate clients to adopt dual protection strategies.¹⁵ Moreover, anecdotal evidence from pilot projects conducted in India, Côte d'Ivoire, and Ethiopia suggests that integrating VCT into reproductive health services can reduce the stigma associated with HIV, increase awareness of healthy sexual behavior, increase access to and use of VCT services, and reduce the cost of establishing VCT services.¹⁶

None of these pilot projects has been rigorously evaluated. But the Rwandan family planning association, Association Rwandaise pour le Bien-Etre Familial (ARBEF), and FHI's Implementing AIDS Prevention and Care project are assessing the impact of VCT services on clients' sexual behavior at three ARBEF clinics as part of a broader evaluation of VCT programs

supported by FHI. Results are expected by the end of 2004. The Population Council's FRONTIERS in Reproductive Health program and the South African Department of Health are designing a study to compare quality of counseling, use of VCT services, sustained use of dual protection, and cost per client of direct provision of VCT with counseling and referral for HIV testing among family planning clients in South Africa's Northern Province.

Meanwhile, program managers need to consider whether providing VCT services or referrals in family planning settings is necessary, feasible, or cost-effective. Some family planning clinics in areas with high HIV prevalence may be able to provide VCT, while other clinics may only be able to offer counseling and refer clients for testing services.¹⁷ If neither option is possible, risk assessments offer a theoretical way to help clients assess whether they may be infected or at high risk of infection, and thus help them make appropriate reproductive and

contraceptive choices.¹⁸ However, such assessments may prove difficult, and their effectiveness for screening low-risk populations has not been demonstrated. More research is needed to improve these assessment tools.¹⁹

The way forward

Family planning program providers are often reluctant to offer HIV services. Many are concerned about the potential negative effects of new HIV responsibilities on workload, job security, allocation of scarce family planning resources, and overall quality of services. Others fear occupational exposure to HIV or worry that providing HIV services will discredit family planning programs.²⁰ And providers who are not trained to provide HIV services may not feel confident doing so.

Nevertheless, providers have an obligation to their clients to do what they can, says Dr. Ndugga Maggwa, regional director of FHI's Institute for Family Health in East and Southern Africa. "Wherever family planning services are offered, providers should be equipped to counsel clients about STIs and HIV and to refer them for services."

Dr. Maggwa and the Population Council's Dr. Askew advise family planning programs to reach out to men and youth, while reorienting routine consultations toward protection against both STIs/HIV and unintended pregnancies. "Strategies that seek to assess the woman's overall situation, counsel her on her risks and options, and respect her right to make the final decision concerning her behavior appear to be the most promising ways of helping her obtain the protection she needs," they recommend.²¹

■ Kathleen Henry Shears



ALPHONSE HATEGEKIMANA/FHI RWANDA

▲ *Condom promotion is one way that HIV prevention services can be integrated into family planning services. A provider from the Rwandan family planning association, Association Rwandaise pour le Bien-Etre Familial, counsels a client about condom use.*

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NewsBriefs

continued from page 2

injections and HIV infection did not adequately account for reverse causality. (Since HIV-infected individuals are more likely to be sick than are uninfected ones, they may be more likely to have received injections for treatment.) The asserted association also did not sufficiently account for confounding factors, particularly a history of sexually transmitted infections. The authors of the article also point out that there is no evidence that children receive fewer injections than do adolescents and adults, yet HIV infection (apart from mother-to-child transmission) is rare in children. Finally, the authors cite the HIV epidemic in South Africa, where unsafe injections are uncommon but HIV prevalence is very high: 26.5 percent in antenatal care clinics in 2002. On the other hand, substantial data indicate that unsafe sexual behaviors are the cause of the epidemic there.

In conclusion, the team found “no compelling evidence that unsafe injections are a dominant mode of HIV-1 transmission in sub-Saharan Africa. Conversely, though there is a clear need to eliminate all unsafe injections, epidemiological evidence indicates that sexual transmission continues to be by far the major mode of spread of HIV-1 in the region.”



Integrating Family Planning into VCT Services

The feasibility of integration is demonstrated in Africa and the Caribbean.

KEY POINTS

- HIV voluntary counseling and testing (VCT) centers serve people who may not normally visit a family planning clinic.
- Whether and how much to integrate family planning into VCT centers should be decided at the facility level.
- Government and other partner involvement in the outcome of integration activities can build consensus, ownership, and acceptance of the process.
- Research to provide evidence of the benefits of such integration is needed.

As efforts begin to shift toward integrating family planning into HIV/AIDS services, voluntary counseling and testing (VCT) centers are emerging as primary targets for integration. Research from Africa and the Caribbean shows that such integration is feasible and acceptable, and large-scale integration efforts are being launched and expanded there.

VCT services have become one of the most common means of preventing, detecting, and improving access to care and support for HIV/AIDS. And VCT services are likely to greatly expand with support from the five-year U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which focuses on fighting the HIV/AIDS epidemic in 15 resource-poor countries, mostly in Africa and the Caribbean.

In terms of family planning, VCT centers offer a rare opportunity to reach many people with contraceptive needs who may not normally visit a family planning clinic. Women are the primary clients of family planning clinics, but VCT centers attract large numbers of women, men, and couples. At the centers, provision of or referral for contraceptive services can help prevent pregnancies among uninfected women who wish to postpone or space childbirth. And among HIV-infected women or women who may be at risk of infection, pregnancy prevention can ultimately help in the prevention of mother-to-child transmission (PMTCT) of HIV (see article, page 21). For male clients and couples, especially those whose HIV serostatus is discordant, counseling and provision of condoms alone or in combination with other, more effective contraceptives can provide dual protection against unintended pregnancy and HIV transmission.

Implementing change

These potential benefits of integrating family planning services into VCT services are apparent, and international support for such integration is growing. A recent analysis of family planning content in 12 international VCT and PMTCT guidelines produced between 1997 and 2003 found that all but one explicitly address family planning, with the focus on providing information about contraceptives or referring clients to family planning services.¹

Despite this progress, the idea of such integration is still relatively new, and, generally, implementation is just beginning. The potential for its success is illustrated by the AIDS Information Centre in Uganda, which integrated family planning services into its VCT services in 1993 and now offers them at multiple sites throughout the country (see article, page 16). Now, other countries are exploring whether and how such integration will be effective in their particular settings. In Kenya, for example, a large collaborative effort to develop and implement a national strategy to integrate family planning into VCT services is well under way.

Kenya is a promising setting for integration because its Ministry of Health (MOH) already has an ambitious program to expand VCT services. Nearly 300 VCT centers have been registered, and Kenya is one of few countries to have developed country-specific VCT guidelines. The government also recognizes the benefits of family planning; Kenya was identified in the recent analysis as one of six countries to mention family planning in its VCT guidelines.²

"This governmental support has been a major first step toward integration," says Dr. Ndugga Maggwa, regional director of FHI's Institute for Family Health in East and Southern Africa, who is helping facilitate the integration process in Kenya. Progress continued, said Dr. Maggwa, with formative research to identify opportunities and challenges for integration. The Kenya MOH's National AIDS and STD Control Programme (NASCO) and Division of Reproductive Health, with technical assistance from FHI and partners, gathered information from 20 VCT centers throughout Kenya in June of 2002.³

Data from 20 VCT supervisors, 41 counselors, and 84 clients suggested that integration was acceptable but that only some of the centers were ready to implement it. Researchers noted that more counseling to describe the benefits of condoms, to increase the use of modern contraceptives, and to promote dual protection was needed. And though the majority of counselors had clinical training, an assessment of their contraceptive knowledge suggested that some were not prepared to provide contraceptive methods. Furthermore, only 10 percent of observed client-counselor

<http://www.fhi.org/NR/rdonlyres/ejivv3for7l7jqn72iryuasfxomv5kcfdikzh5v5bdqn7mt32lobzfmq5lokjksuiqpw27mvd6ctvl/VCTFPFinalReport.pdf>

Assessment of Voluntary Counseling and Testing Centers in Kenya: Potential Demand, Acceptability, Readiness, and Feasibility of Integrating Family Planning Services into VCT is the final report of a study by FHI on integrating family planning services into voluntary counseling and testing (VCT) centers in Kenya. The 23-page report describes findings from an assessment of 20 VCT centers. To read a two-page brief about the study, see <http://www.fhi.org/en/RH/Pubs/Briefs/KenyaVCT.htm>.

interactions included a referral for family planning services.

Overall, counselor training backgrounds, referral mechanisms, and contraceptive supply needs varied among VCT centers. The researchers concluded that decisions on whether and how much to integrate need to be made at the facility level, and this finding later became the basis of the national integration strategy.

To develop a strategy that would not compromise existing VCT services, NASCOP created a task force of diverse VCT and family planning experts. Together, these experts identified four potential levels of integration, each contingent on available resources at particular facilities (see chart, this page).

The national integration strategy recommends that all VCT centers achieve at least the first level, which — in addition to the traditional VCT services — includes the provision of basic pregnancy risk assessment and counseling services and the availability of contraceptive pills and condoms on-site. The fourth level, in which all contraceptive methods are available on-site, is viewed as a long-term goal since it would require enormous additional resources for most centers.⁴

The task force recently presented the strategy to a VCT committee within NASCOP, and the MOH gave its approval.

“I would recommend a similar process for other countries as well,” says Margaret Gitau, a program officer at NASCOP and chairman of the task force. “There is more ownership this way, and the final products are accepted by all, as all become involved in the whole process.”

On behalf of NASCOP and the MOH — and as task force facilitator — FHI is already working with task force members AMKENI (a national service delivery project led by EngenderHealth) and JHPIEGO (an international public health organization) to implement the first level of integration, as outlined in the strategy, into 20 proposed VCT centers in two provinces in Kenya. Results from operations research to determine the effectiveness and costs of implementation are expected in 2005.

Demonstrating impact

In general, whether integration of services has a measurable impact on improving reproductive health remains unknown, and research to generate clear evidence of

benefits is greatly needed. But the potential for positive impact of offering family planning services to VCT clients has been demonstrated in a VCT center in Port-au-Prince, Haiti.

The VCT center was established in 1985 by the Haitian Study Group for Kaposi’s Sarcoma and Opportunistic Infections (GHESKIO), a nongovernmental organization that works with the Haitian MOH to provide free HIV services in Port-au-Prince. The center gradually integrated other services, such as care for AIDS and tuberculosis patients and management of sexually transmitted infections (STIs). And, in 1993, it finally added family planning services.

In collaboration with researchers from Cornell University and Vanderbilt University, GHESKIO subsequently evaluated the experiences of the VCT center from 1985 to 2000.⁵ Data showed that demand for services, in general, increased more than 60-fold, from 142 clients in 1985 to 8,757 clients in 1999. The percentages of reproductive-age women, adolescents,

Adding Family Planning to VCT: Levels of Integration in Kenya

Level	Services Provided	Requirements
I	<ul style="list-style-type: none"> Assessment of pregnancy and STI risks Information and counseling on methods Provision of condoms and pills Referral for other methods 	<ul style="list-style-type: none"> Minimal training of counselors to provide services Availability of job aids, condoms, and pills Time and space to provide services
II	<ul style="list-style-type: none"> All services in level I Provision of injectables 	<ul style="list-style-type: none"> All requirements in level I Counselors trained to provide injectables Adequate infection-control procedures in place Additional equipment and supplies
III	<ul style="list-style-type: none"> All services in level II Provision of IUDs 	<ul style="list-style-type: none"> All requirements in level II Counselors trained to provide IUDs Additional equipment and supplies
IV	<ul style="list-style-type: none"> All services in level III Provision of full range of methods 	<ul style="list-style-type: none"> All requirements in level III Medical doctor to perform surgical procedures Additional equipment and supplies

Note: IUD = intrauterine device; STI = sexually transmitted infection; VCT = voluntary counseling and testing

Source: Kenya Ministry of Health. *Strategy for the Integration of HIV Voluntary Counseling and Testing Services and Family Planning Services*. Nairobi, Kenya: National AIDS and STD Control Program and Division of Reproductive Health, 2004.

Challenges to Providing Family Planning Services

Research suggests that decisions on whether to integrate family planning into voluntary counseling and testing (VCT) centers need to be made at the facility level. But even when a decision is made to integrate services, operational challenges can impede the process. Among the challenges that program managers and VCT providers may need to address are:¹

- shortages of staff time and space;
- shortages of supplies such as contraceptives, needles, syringes, and other clinical or surgical equipment;
- client-flow issues and weaknesses in infrastructure;
- training of VCT counselors to provide comprehensive family planning counseling and contraceptive methods;
- provider reluctance to assume more responsibilities;
- decisions on whether family planning counseling should be provided before or after HIV testing;
- implementation of infection-prevention procedures if injectables, intrauterine devices, or surgical sterilization are offered;
- development of educational materials for clients, training manuals for providers, and other operational procedures for integration; and
- establishment of effective referral links and follow-up systems.

If a full range of family planning services cannot be provided on-site, then referral to off-site family planning services is key. However, establishing well-functioning referral systems also presents challenges. VCT clients may not actually visit the family planning facilities to which they are referred. Also, family planning providers may need training about HIV-related counseling issues, may resist taking on complex HIV-related cases, and may need to learn to respect confidentiality of HIV status.²

■ **Kerry Wright Aradhya**

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symptom-free clients, and self-referred clients attending the center also increased after integration began.

Determining which services contributed most to this increase in client demand was not possible, but family planning services were well received. In 1999 alone, 19 percent of some 6,700 VCT clients began using contraceptives and then returned to the center for at least three family planning visits. Seventy percent of these new contraceptive users chose condoms alone, and the remaining 30 percent (all women) chose oral contraceptives, injectables, or vaginal sponges, either alone or with condoms for dual protection against both pregnancy and HIV infection.

A separate study conducted from March 1999 to November 2001 showed that after an additional intervention to introduce family planning services into the STI and HIV clinic within GHESKIO, 16 percent of some 3,000 HIV-infected women attending the clinic began using contraceptives.⁶

“When we screen women for HIV, we inevitably also find reproductive health needs, so it makes sense to provide these services on-site,” says Dr. Daniel Fitzgerald, an investigator of the original study and a Cornell University assistant professor who has assisted with service provision in Haiti. Further, “many women who initially come for reproductive health services end up being tested for HIV.

Women know they can receive a package of quality primary care services at the center, and they are willing to come.”

Integrating multiple services into VCT makes sense in Haiti, which has the highest prevalence of HIV outside of sub-Saharan Africa and is fighting a tuberculosis epidemic. HIV-positive Haitians have also faced intense social stigmatization in recent years. But “if thousands of people come for HIV testing, then they must believe the benefits of VCT and integrated services outweigh the risk of stigmatization,” report Dr. Fitzgerald and other authors of the original study.

As in Kenya, efforts to integrate services in Haiti have enjoyed the support of the government. Dr. Fitzgerald says that the

MOH is working with GHESKIO and partners to increase the number of sites that offer VCT and integrated services. With assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria and from PEPFAR, they established 20 new centers throughout Haiti in 2003 and plan to create 15 more by the end of 2004.

A similar effort to integrate multiple reproductive health services into VCT services is ongoing in Zimbabwe. In 2002, the *New Start* network — managed by U.S.-based Population Services International (PSI) on behalf of the Zimbabwean government and funded by the U.S. Agency for International Development (USAID) mission in Zimbabwe — began offering family planning and other reproductive health services (including STI screening and treatment) at its busiest stand-alone VCT center in the country. This new package of services, known as *New Start Plus*, is now available at four of 18 *New Start* VCT sites, and at least 10 percent of *New Start Plus* clients request and receive family planning services, says Shannon England, a VCT program development manager at PSI.

PSI is also working to integrate VCT into family planning services, as is the Kenyan government, but these efforts are not as well developed as those doing the reverse: integrating family planning into VCT.

“We need to be thinking about integrating both ways because each way presents different opportunities,” says Dr. Maggwa of Kenya. “But, it may be most prudent at this time to think about integrating family planning into VCT, especially since the infrastructure for VCT services is being developed and reinforced right now,” he says.

■ **Kerry Wright Aradhya**

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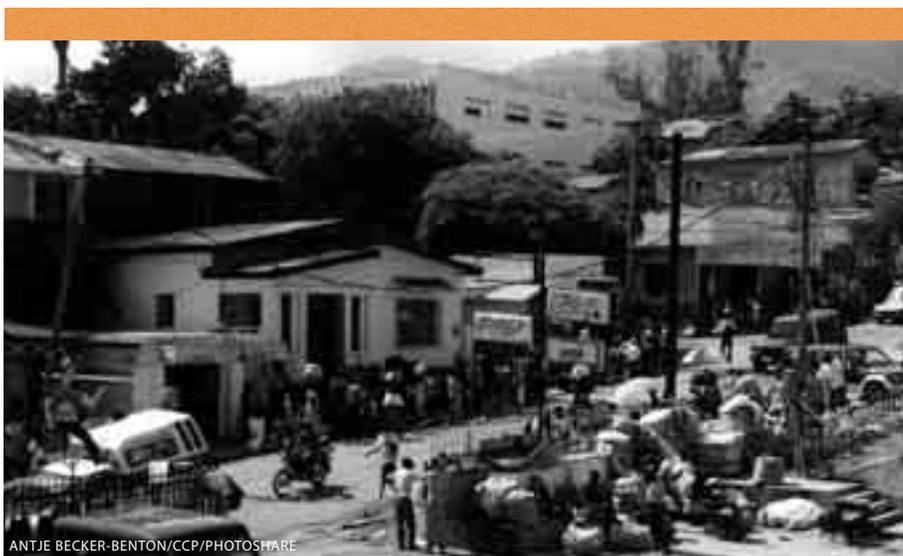
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<http://www.popcouncil.org/pdfs/horizons/vctyouthbaseline.pdf>

Most new cases of HIV infection in East and Southern Africa affect youth, making them an important target for voluntary counseling and testing (VCT). *HIV Voluntary Counseling and Testing Among Youth Ages 14 to 21* is a report on research conducted in Kenya and Uganda by the Population Council's Horizons program and partners to identify opportunities and challenges for providing VCT to this population. Findings highlight youth's strong interest in accessing VCT, the need for VCT providers to be trained on youth issues, and the value of counseling. Based on these results, the authors also provide recommendations on how to design high-quality VCT programs that offer youth-friendly services.

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▲ **In Port-au-Prince, Haiti (depicted here), an HIV voluntary counseling and testing center has integrated family planning and other health services. Similar centers throughout Haiti have been created.**

CaseStudies

Uganda: Integrating Family Planning into VCT

If you visit the impoverished neighborhood of Kisenyi in Kampala, Uganda, near the largest public transportation hub in the country and the biggest outdoor market in the city, you may be able to catch a glimpse of the new headquarters of the AIDS Information Centre (AIC). From the outside of the building, however, you will not be able to appreciate just how much the organization has evolved in recent years.

Opened in 1990 as a single site offering only HIV voluntary counseling and testing (VCT), the AIC now offers VCT integrated with multiple reproductive health services to thousands of clients each year at six main sites in Uganda. Receiving about 250 clients daily at these sites, the AIC is now one of the largest nongovernmental providers of VCT services in the country.

First provided at the main Kampala facility in 1993, family planning services have been offered at branches in the cities of Jinja, Mbarara, and Mbale since 1995. Jane Harriet Namwebya, a VCT technical officer at FHI, had the opportunity to observe the integration process. Having worked in various positions at the AIC from 1992 to 1998 and then as executive director until 2001, she recounts some of the obstacles to integration and how they were overcome.

“There was initial resistance from the VCT counselors regarding time constraints,” says Namwebya. “Many thought that by integrating services, including family planning, counseling sessions would become much longer. But this was addressed through training.” Reproductive

health volunteers also assist counselors to help ease the burden of providing multiple services.

For each client, a typical visit to the AIC includes pretest counseling, HIV testing, HIV prevention counseling, delivery of test results obtained on-site, and post-test counseling, all in a single visit lasting from 45 to 90 minutes. Counselors mention the AIC’s family planning services in both pretest and HIV prevention counseling, where they also demonstrate correct condom use. During post-test counseling, counselors offer free condoms and advice on how to negotiate condom use. The reproductive health volunteers are also in the waiting room throughout the day, providing family planning information, identifying particular family planning needs, and referring clients to counselors who can meet those needs.

Another barrier to integration — that many of the counselors did not have medical backgrounds — was resolved by creating an internal referral system. “Nonmedical counselors would assess the reproductive health needs of clients and then refer them to counselors who had medical backgrounds to provide further services,” says Namwebya. (All counselors at the AIC are trained to provide condoms, spermicides, and oral contraceptives. If clients request other methods, such as injectables or intrauterine devices, they are referred to counselors who are also nurses.)

The impact of integration on AIC clients’ reproductive health has not been assessed. But data from the AIC indicate that condoms are the most popular contraceptive method, with almost a third of family planning clients using condoms plus another, more effective method for dual protection against unintended pregnancy and HIV infection.¹ Demand for family planning has increased over time, and approximately 8 percent of clients at the four main sites offering family planning services accessed those services in 2002.² Other services that have been integrated into the AIC include syphilis testing, management of sexually transmitted infections, tuberculosis education, post-test support services for anyone who has



Web
Resource

<http://www.aicug.org>

Visit this Web site — the official site of the AIDS Information Centre (AIC) in Uganda — for more detailed information on how voluntary counseling and testing and integrated services are provided at the AIC. Also learn more about the history of the organization, access AIC publications and other educational material, and find contact information for all of the main AIC branches.

had an HIV test, services targeting youth, and community outreach activities.

Namwebya admits that, for convenience, health care services often have focused on only one aspect of a client’s health needs at a time. “But,” she says, “in reality, each individual’s health needs are truly interconnected. So health care services should be integrated to reflect this.”

■ **Kerry Wright Aradhya**

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Cambodia: Clients Find Everything They Need in One Place

The year was 1996. HIV incidence was clearly rising in Cambodia, but in Phnom Penh only one group — the Pasteur Institute — provided voluntary counseling and testing (VCT) for HIV. Incidence of HIV was mainly rising among people at high risk of infection. Yet, ominously, between 30 percent and 40 percent of clients (mainly married women) served at that time by the two-year-old Reproductive Health Association of Cambodia (RHAC) had reproductive tract infections (RTIs) or sexually transmitted infections (STIs). Such infections are, in themselves, risk factors for HIV infection. Furthermore, the same sexual behaviors that put people at risk for RTIs and STIs also put them at risk for HIV.

RHAC, an International Planned Parenthood Federation affiliate primarily supported by the U.S. Agency for International Development (USAID), was quick to act. That year, it sent staff to Thailand to learn to do HIV/AIDS counseling. It also began drawing blood samples for clients wanting to know their HIV status and sending samples to the Pasteur Institute for testing.

The following year, RHAC conducted a study of the feasibility of performing HIV testing at its own clinics. Staff reactions were mixed. “One-third of staff expressed doubts, but their professional expertise told them that the chances of serving AIDS patients would keep rising,” recalls Dr. Var Chivorn, associate executive director of RHAC. Client reactions were more favorable: Most welcomed the introduction of HIV services into a package of existing services that included family planning, diagnosis and treatment of RTIs/STIs, pregnancy care, and counseling about and treatment of minor gynecological problems.

Overall, the study suggested that RHAC clinics should provide HIV testing. But the cost per test — at that time limited to the ELISA technique — was simply too high for RHAC. Then, in 2002, a breakthrough occurred: Rapid test methods, suitable for clinics where the volume of testing was too low to efficiently use the ELISA machine, became available. RHAC then moved forward to introduce HIV counseling and testing services, supported by the United Nations Children’s Fund (UNICEF), into its six USAID-funded clinics.

VCT service guidelines for use by clinic staff and counselors were established. Informational materials were developed for staff use and for display in waiting rooms. HIV educational services via media and hot lines were created. More staff were added to busy clinics. Counselors were hired and trained. Nurses and midwives were trained to provide information about AIDS. Issues of HIV acquisition risks and post-exposure prophylaxis were addressed to reassure staff that they ran little risk of being infected. Alert systems in clinic rooms addressed provider fears that they might be in danger if clients became violent in reaction to a positive test. To better serve clients testing HIV-positive, links with home-based care teams, locations offering antiretroviral drug therapy, and the national tuberculosis center were established.

The next year, RHAC clinics provided VCT services to 13 percent (14,208) of their clients, of whom about 7 percent (some 995) were found to be HIV-infected. More than 100 infected clients needing additional services were referred either to home-based care teams or to tuberculosis centers.

Early concerns about the cost of providing HIV testing are no longer an issue. While a testing fee of U.S. \$1 can be waived if a client cannot pay, the RHAC has found that “most clients are happy

and able to pay this fee,” says Dr. Chivorn. “RHAC has proved that, regardless of the fee, clients come for testing because the service is of good quality.”

Similarly, fears that offering VCT services would be stigmatizing and scare away family planning and other clients were laid to rest. “We do not see any decline in family planning or other clients. In fact, clients in the clinics are increasing,” says Dr. Chivorn. About 13 percent of clients now are men, most of whom come for STI services. RHAC has also trained staff to serve adolescents.



PING CHUTEMA/RHAC

▲ **Counselors provide information about HIV/AIDS and HIV counseling and testing to all clients awaiting services at clinics of the Reproductive Health Association of Cambodia.**

“Overall, clients have been happy to find everything they need in one place,” says Dr. Chivorn. “This has strengthened RHAC’s resolve to further integrate services, which now also include early detection of cervical cancer, premarital counseling, and support to rape victims. And, this year, child health services are being added.”

■ **Kim Best**

Zimbabwe: 'I Have the Knowledge and Skills to Help'

In Zimbabwe, Hebron Gatora's workday officially ends at 4:30 p.m., but it is often later than 6:00 p.m. when he navigates his bicycle down the bumpy dirt road to his home in the community of Chihota. His dedication and pride as a community-based distributor (CBD) of contraceptives for the Zimbabwe National Family Planning Council (ZNFPC) is evident. Seemingly everywhere, people seek him out for advice.

Gatora has been a CBD worker for nearly a decade, taking family health services beyond clinic walls to the doorsteps of people in the community. But his job was recently expanded to include the

more holistic approach of providing information about HIV/AIDS, sexually transmitted infections (STIs), HIV voluntary counseling and testing (VCT), referrals to VCT services, access to prevention of mother-to-child transmission services, and much more.

"With my new role, I feel renewed," Gatora, 39, and a father of three, said in a recent interview with the Advance Africa project, supported by the U.S. Agency for International Development (USAID). "Now I can assist many people."

Advance Africa, a consortium of six organizations that includes FHI and seeks to increase family planning and reproductive health services in sub-Saharan Africa, began working with the ZNFPC in 2001 to integrate HIV/AIDS services into the jobs of CBD workers. The initiative followed an extensive ZNFPC review of the existing CBD program that considered ways of expanding CBD workers' roles to address the AIDS crisis in the country. Such expansion was natural since CBD workers were already reaching people of reproductive age. The expanded CBD program, which targeted adolescents, men, and low-parity women, was piloted in

eight districts and has since been expanded to 16 districts. USAID and Advance Africa continue to provide financial and technical support.

Initial districts were chosen based on proximity to VCT centers (so clients could make the trip within a day), availability of CBD workers, and proximity to ZNFPC provincial offices for support and supervision. VCT services in Zimbabwe are still largely urban based. CBD workers serve in rural areas, but few have problems making referrals because "clients are already asking them about HIV," says Premila Bartlett of FHI, who is country director for Advance Africa in Zimbabwe. The main challenges are the scarcity of VCT centers and travel difficulties that many clients face due to the country's economic decline.

Before CBD workers were trained for their expanded role, ZNFPC reviewed, streamlined, and revised CBD responsibilities and guidelines. Advance Africa provided technical assistance to ZNFPC to develop a curriculum. Subsequent training at headquarters and the provincial level targeted leaders of CBD groups, CBD workers, and volunteer depot holders (who work from home to provide information and resupply clients). To date, 19 CBD supervisors, 141 CBD workers, and 379 depot holders have been trained.

Although the project has not been evaluated, Advance Africa is working with ZNFPC to develop improved monitoring and evaluation systems and to assess the cost and cost-effectiveness of expanded service delivery, among other things.

Anecdotal evidence suggests that trained CBD workers and depot holders have embraced the provision of information beyond family planning. And initial analyses of the expanded program have been encouraging. Between 2001 and 2003, CBD referrals for VCT rose from 121 to 840, and referrals for STI and HIV/AIDS care rose from 202 to 499. The number of people receiving HIV/AIDS information and behavior change messages through group meetings rose 10-fold, from some 3,000 to more than 30,000. The impact of HIV/AIDS activities has also been measured in terms of the distribution of condoms: some 725,000 male and female condoms in 2003, compared to about 175,000 in 2001. Meanwhile, access to family planning has



R. GRINGLE/ADVANCE AFRICA

▲ *Depot holders and community-based distributors for the Zimbabwe National Family Planning Council, such as those pictured here, now provide HIV information and service referrals.*

increased and quality has improved, as providers have been retrained about contraceptive methods and now spend more time with clients. Distribution of oral contraceptives increased from about 53,000 in 2001 to more than 360,000 in 2003.

However, lack of funding has prohibited growth of the expanded program to a proposed 58 districts in Zimbabwe, says Bartlett. Similarly, economic factors have compromised the strength of Zimbabwe's well-respected CBD program as a whole. Since the 1980s, Zimbabwe's network of about 800 salaried male and female CBD

workers has shrunk to an estimated 550. Another concern is that CBD workers as a group are aging. Some find it difficult to ride a bike long distances and may not be "the most appropriate" people to reach youth, a goal of the expanded program, says Bartlett.

Nevertheless, "the CBDs are generally happy with their roles and find that they are now more relevant to the needs of their communities," she says.

Gotora continues to reach out with his expanded message anywhere he can — churches, businesses, agricultural shows,

clubs, and even roadside meetings in villages or at his own home. He says he considers his job nothing short of an honor.

"Now I can communicate and discuss with everyone, whereas in the past, we talked only about family planning and to women alone," Gotora said recently. "Women, men, and youth, many of them school-leavers, seek my services and advice on their different health and reproductive concerns. And I have the knowledge and skills to help."

■ Pamela Babcock

Jamaica: System-Wide Integration of Services

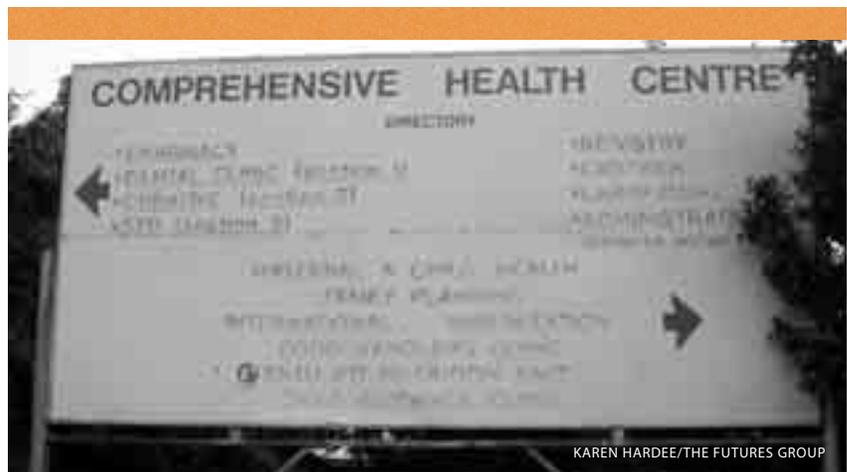
Most integrated delivery of family planning and HIV services is limited to pilot projects in one or a few health facilities. Little is known about how to integrate these services throughout a health care system.

But a study in Jamaica seeks to identify changes needed to make family planning and HIV service integration a reality system-wide. Conducted by the Jamaican Ministry of Health (MOH) and the Washington, DC-based POLICY Project of the Futures Group among 100 health care providers, program managers, policy-makers, and potential clients, the study will determine the feasibility and potential cost of integrating family planning and HIV services in the rural parish (district) of Portland and the urban area of St. Ann's Bay.

"We are asking, 'What policies, regulations, and guidelines need to change to actually institutionalize integration?'" explains Dr. Karen Hardee, research director for the POLICY Project.

The MOH has identified service integration as a priority to better meet the reproductive health needs of Jamaicans. Offering HIV prevention counseling and diagnosis and treatment of curable sexually transmitted infections (STIs) at family planning and maternal and child health facilities and through outreach is considered a good way to improve women's access to these services. It would also offer opportunities to provide comprehensive reproductive health services for youth and to attract male clients who could receive counseling about family planning and HIV/STI risk reduction, as well as STI treatment.¹

Reaching Jamaican women and youth is particularly important because they are at higher risk of infection with HIV and other STIs than are Jamaican men. HIV prevalence among Jamaican adults is relatively low, at 1.2 percent.² But rising levels of HIV infection among women have narrowed the ratio of male-to-female AIDS cases: In the 1980s, that ratio was 6 to 1; in 2001, it was 1.6 to 1. Women now account for 40 percent of all AIDS cases reported since the epidemic began, and girls ages 10 to 19 years are two and a half times more likely than teenage boys to be infected with HIV.³ In one study in the capital, Kingston, 27 percent of female



KAREN HARDEE/THE FUTURES GROUP

▲ In Jamaica, a study is under way to determine how to integrate HIV and family planning services, which now are offered separately.

family planning clients with no STI symptoms were found to have an STI.⁴ And half of reported cases of gonorrhea occur among Jamaican youth ages 15 to 19 years.⁵

The feasibility study began with workshops that brought together national, regional, and parish-level health officials; nongovernmental organization staff; and public and private health care providers to develop a plan for service integration in Portland and St. Ann's Bay. The plan outlines 20 possible strategies for combining family planning and HIV services and improving access to integrated services.

The proposed strategies address training, screening, access, referral, outreach, patient education, management information systems, and treatment. They range from training all providers in a more integrated approach to counseling and service delivery, to hiring additional staff at specific facilities.

Local research organizations carried out four feasibility studies of these strategies. They conducted interviews and focus group discussions with providers to assess their willingness and ability to provide integrated services. They gauged clients' reactions and perceptions of stigma through focus group discussions. Finally, they analyzed operational constraints to service integration and identified the cost per STI treated for each strategy in the proposed plan.

Data collection ended in April 2004. Once the data have been analyzed, the MOH and the POLICY Project will use the findings to plan how to remove operational barriers to family planning and HIV integration in Portland and St. Ann's Bay. The experience with integrated services in these parishes will, in turn, guide decisions about integrating services throughout the country.

■ Kathleen Henry Shears

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Resources

continued from page 32

http://www.usaid.gov/our_work/global_health/pop/publications/docs/fphiv.pdf

Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs (2003). New guidelines from the U.S. Agency for International Development (USAID) are designed to help USAID field officers and managers of USAID-supported programs decide when and how to integrate family planning and HIV services. This document discusses technical approaches for integrating family planning and HIV services and outlines guiding principles for effective integration.

http://www.ippfwhr.org/publications/publication_detail_e.asp?PubID=39

Have You Integrated STI/HIV Prevention Into Your Sexual and Reproductive Health Services? STI/HIV Integration Checklist (2002). Organizations can use this checklist, developed by the International Planned Parenthood Federation's Western Hemisphere Regional Office, to assess whether strategies

to prevent HIV and other sexually transmitted infections (STIs) have been integrated into their sexual and reproductive health programs, identify the training and resource requirements for such integration, and monitor integration efforts.

<http://www.popcouncil.org/pdfs/horizons/pmtctfp.pdf>

Family Planning and PMTCT Services: Examining Interrelationships, Strengthening Linkages (2003). This summary, based on findings from Population Council/Horizons studies, focuses on the degree to which VCT and PMTCT programs in Kenya and Zambia address family planning, and vice versa.

http://www.advanceafrica.org/publications_and_presentations/Technical_Papers/TP_FP_and_PMTCT.pdf

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need to strengthen efforts to prevent pregnancies among women who are HIV-infected, and explores operational and programmatic considerations related to improving such women's access to family planning.

<http://www.engenderhealth.org/res/offc/hiv/integration/>

Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual. Working draft (2002). EngenderHealth developed this manual for training health care workers to address HIV and other STIs in family planning counseling. The manual and handouts for participants feature participatory exercises on sexuality and gender, HIV/STI transmission and prevention, dual protection against HIV/STIs and unplanned pregnancy, and integrated counseling skills.



Averting HIV-Infected Births

Integrating family planning services can help achieve goal.

KEY POINTS

- Family planning services can greatly reduce HIV-infected births.
- Family planning providers will need considerable additional training, support, and motivation to serve HIV-infected women effectively.
- Opportunities to prevent pregnancies among HIV-infected women and to prevent infection among reproductive-age women are being missed, but progress is being made.

In the midst of an unrelenting AIDS epidemic, attention is increasingly being paid to the prevention of HIV infection among the world's most vulnerable individuals: its newborns.

In 2003, an alarming number of new HIV infections — about 700,000 — occurred among children, the vast majority of whom were infected by their mothers. Four main approaches to reducing such infections have been promoted by the World Health Organization (WHO) and its United Nations partners.¹

To date, funding for developing countries has primarily supported an approach of providing voluntary counseling and testing (VCT) for HIV during pregnancy and then a short course of antiretroviral (ARV) drug therapy to HIV-infected pregnant women and their newborns. This is to prevent HIV transmission from mother to infant during delivery. Another approach is to provide care and support to women, infants, and families infected and affected by HIV/AIDS. But minimizing HIV-infected births will likely be best achieved through a combination of approaches that includes preventing unintended pregnancies among HIV-infected women (see article, page 22) and preventing HIV infection among reproductive-age women (see article, page 26).²

Pursuing these latter two approaches requires new thinking about how various reproductive health and HIV services can be integrated in settings where women are likely to seek health care. Such integration can contribute to the prevention of mother-to-child transmission (PMTCT) of HIV in several ways:

- Integrating HIV counseling into *family planning services* helps prevent infection among women of reproductive age. Integrating VCT, as well, helps identify infected women who can then receive targeted family planning counseling and services.
- Integrating family planning services into *VCT services* and other HIV services helps those women who test positive prevent unintended pregnancy. It also helps those who test negative (but are sexually active, of reproductive age, and at risk of infection) avoid unintended pregnancy.

- Integrating HIV counseling and VCT into *antenatal care (ANC) services* (the usual site of PMTCT efforts) helps prevent infection among pregnant uninfected women. It can also identify pregnant women who are HIV infected. Integrating family planning services into ANC can help pregnant infected women avoid yet another at-risk pregnancy.

In all of these scenarios, family planning services can play an essential role in achieving PMTCT goals. Yet, employing family planning services to avert HIV-infected births — particularly, offering contraceptive services to infected women — requires more than simply combining services. It involves operational challenges that, as yet, have not been explored in depth. It also requires that providers be trained to understand the special reproductive and contraceptive needs of HIV-infected women. An infected woman's

continued on page 25



<http://www.fhi.org/en/RH/Pubs/bookReports/fppmtct.htm>

Family Planning and the Prevention of Mother-to-Child Transmission of HIV: A Review of the Literature is a 44-page report produced by FHI with support from the World Health Organization in preparation for the meeting, "Linkages between Reproductive Health and HIV/AIDS: Family Planning and Prevention of Mother-to-Child Transmission," held in Glion, Switzerland, May 3-5, 2004. The review explores how to integrate reproductive health services to prevent mother-to-child HIV transmission among women accessing family planning, HIV voluntary counseling and testing, or antenatal care services.

Preventing Pregnancy among HIV-Infected Women

Providing family planning counseling and services to HIV-infected women — to prevent initial or subsequent unintended pregnancy — is critical to the prevention of mother-to-child transmission (PMTCT) of HIV. Indeed, without such family planning services, achieving international goals to reduce the proportion of HIV-infected infants by 20 percent by 2005 and by 50 percent by 2010 may not be possible.¹

HIV-infected women must be carefully counseled about the risk of transmitting HIV to their infants during pregnancy and delivery. Those women who wish to either limit or space childbearing should have access to highly effective contraception.² And, because all women have the right to decide the number and timing of their children, anyone counseling an HIV-infected woman should support her family planning decisions.³

HIV-infected women who have not ruled out childbearing need to know that pregnancy does not appear to accelerate HIV disease progression.⁴ However, maternal HIV infection might affect infant health. A recent study found that miscarriage, abortion, ectopic pregnancy, and stillbirth rates among HIV-infected women — some of whom received antiretroviral (ARV) drug therapy — were no higher than those among uninfected women.⁵ However, in other studies, maternal infection has been associated with adverse neonatal and obstetrical outcomes, including premature birth, low birth weight, and postpartum hemorrhage.⁶

HIV-infected women using ARV drugs may want to use family planning until the effects of these drugs on maternal and child health are better understood. Clinical trials of the effects of zidovudine show no

increase in birth defects,⁷ but certain ARV drugs may be toxic for pregnant women and fetuses. The drug efavirenz (EFZ), for example, is believed to be a potent early teratogen, and recent World Health Organization (WHO) draft guidelines state that “EFZ should not be given to women of childbearing potential unless effective contraception can be assured.”⁸ Other concerns have been raised about whether a woman’s use of nucleoside reverse transcriptase inhibitors (such as zidovudine and lamivudine) could affect the mitochondrial or nuclear DNA of her child, potentially causing such side effects as lactic acidosis and anemia and increasing susceptibility to cancer.⁹

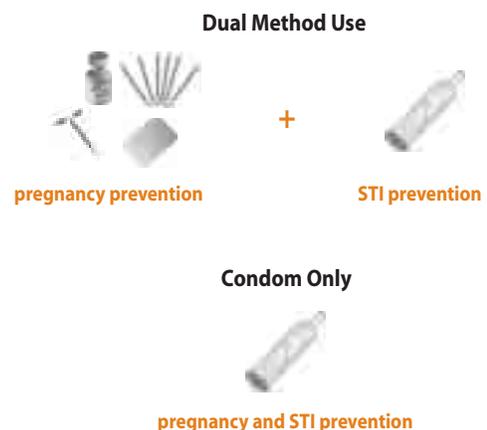
Contraceptive options for HIV-infected women

WHO also provides guidance as to the suitability of each major contraceptive method (including sterilization) for family planning clients in three HIV/AIDS categories: high risk of HIV, HIV-infected, and AIDS. Women in all categories are eligible for most major methods. Of note, based on the latest clinical and epidemiological data, recent revisions to the guidelines (see brief, page 2) have removed some barriers to intrauterine device (IUD) use. Initiation of IUD use is usually not recommended for a woman with AIDS who either is not receiving ARV therapy or has not clinically improved while on it. (This is because such a woman may have a suppressed immune system and thus be more vulnerable at the time of IUD insertion to infections, such as other sexually transmitted diseases [STIs] that could lead to pelvic inflammatory disease.) Otherwise, all other HIV-infected women, including those with AIDS, are now eligible to initiate or continue IUD use.¹⁰

Hormonal contraceptives may also be a good choice for many HIV-infected women.

For long-lasting contraception, the Norplant implant has been found to be safe, efficacious, and well tolerated in the immediate postpartum period among asymptomatic HIV-infected women.¹¹ However, there is some concern that nevirapine and EFZ can alter the metabolism of oral contraceptives, thus requiring an adjustment in contraceptive dosage or change to another contraceptive method.¹² Due to concerns about drug interactions, WHO guidelines state that the use of oral contraceptives and hormonal patches, rings, and implants is usually not recommended for women taking rifampicin, an antibiotic used to treat tuberculosis. Meanwhile, use of hormonal methods may be associated with increased risks of cervical HIV shedding (and thus HIV transmis-

Dual Protection Can Be Achieved in Two Ways



drawings by Salim Khalaf/FHI

sion),¹³ as well as HIV disease progression.¹⁴ More data on these possible associations will be forthcoming this year.

For HIV-infected women who have decided against childbearing, female sterilization is a good option. The procedure should be delayed, however, if a woman has an AIDS-related illness.¹⁵ The use of diaphragms (with spermicide) or cervical caps is usually not recommended for HIV-infected women and those with AIDS, according to WHO’s 2003 recommendations.

Finally, an HIV-infected woman should be counseled about dual method protection — using a condom for disease prevention (HIV transmission to her partner or the woman's reinfection with other HIV strains or STIs) and another, more effective method for contraception (see figure, page 22).

Family planning providers also should be aware that the contraceptive behavior of HIV-infected women may differ from that of uninfected women. Numerous studies suggest that contraceptive use by HIV-infected women can be surprisingly low. Many become pregnant. One reason is that infected women may very much want to have children, particularly in cultures that are pronatalist.¹⁶ The increasing availability of ARV drugs may also make pregnancy more appealing, since treatment offers hope for better health, better quality of life, and survival.¹⁷ Fears of the health effects of contraceptive use may also play a role. This suggests the need to provide ample information about contraceptive options and reliable follow-up to reduce method discontinuation related to side effects.¹⁸

Contraceptive needs of postpartum HIV-infected women are the same as those of nonpregnant infected women, with two exceptions. An infected woman's risk of transmitting HIV to her infant may grow with subsequent pregnancies, since the risk of such transmission increases as maternal infection progresses.¹⁹ Also, an infected woman may be less likely than an uninfected woman to breastfeed, since breastfeeding can transmit HIV to infants. But nonbreastfeeding women miss the contraceptive benefits of lactational amenorrhea.

As is the case for nonpregnant HIV-infected women, contraceptive uptake may be low for postpartum infected women.²⁰ Why this is so remains poorly understood. However, many infected women are reluctant to share their HIV status with their partners and thus are unable to argue for family planning. For example, in Zaire, a study of fertility rates among 238 HIV-infected women followed for three years postpartum found that the women's nearly uniform unwillingness to inform partners of their HIV status largely accounted for the "disappointingly high fertility rates in women who had been provided with a comprehensive program of HIV counseling and birth control."²¹ Thus, men's involvement

in family planning may be a key to preventing subsequent pregnancies among infected women.²²

■ Kim Best

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August 2004

continued from page 21

decisions are likely to be shaped by many factors, including her own health and that of her partner and existing children, access to long-term ARV drug therapy, whether she can disclose her HIV status, the possible impact of HIV infection and ARV use on contraceptive method options, and the possible impact of contraceptive method use on her health and infectivity.

However, policy guidelines indicate increasing support for the integration of family planning services to achieve PMTCT goals. More than three-quarters of international guidelines, national HIV/AIDS policies, and PMTCT and VCT policies reviewed in a recent analysis mention family planning.³ Three recent analyses suggest that family planning services can both have a marked impact on averting HIV-infected births and be cost-effective (see article, this page). And, in May 2004, some 70 health professionals, representatives from governmental and nongovernmental organizations, and donors met in Glion, Switzerland, to consider the contributions family planning could make to PMTCT. The meeting, supported by WHO, the United Nations Population Fund, the U.S. Agency for International Development (USAID), and private donors, resulted in a "Call to Action" to strengthen linkages between family planning and PMTCT. The declaration acknowledged that all four approaches recommended by WHO and its United Nations partners are necessary to meet PMTCT goals. It also recommended strengthening family planning and PMTCT links through advocacy, policy and program development, resource mobilization, monitoring and evaluation, and research.

Challenges for family planning, ANC providers

In many settings, family planning staff will need additional training, support, and motivation to effectively serve women at risk of HIV infection and women who are already infected. Staff must be prepared to provide HIV prevention counseling for women at risk. And, they are likely to need considerably more training to counsel and serve women whose HIV infection makes

Family Planning: Considerable Impact at Relatively Low Cost

Preventing pregnancy through family planning services has the potential to be an effective, economical contribution to the prevention of mother-to-child transmission (PMTCT) of HIV, as illustrated by three recent analyses:

- An analysis funded the U.S. Agency for International Development (USAID) of the costs and benefits of adding family planning services to PMTCT programs in 14 high-HIV-prevalence countries suggested that adding the services could double the impact of PMTCT programs in reducing HIV-infected births by 2007. Access to PMTCT services (i.e., voluntary counseling and testing and antiretroviral drug therapy) by half of pregnant women using antenatal care would avert 5 percent (39,000) of expected infections, at a cost of U.S. \$1,300 per HIV infection averted. The addition of family planning services to prevent future births to infected women would avert another 32,000 infections, at a cost of U.S. \$660 per HIV infection averted.¹
- An FHI modeling exercise found that, for the same costs, increasing contraceptive use to prevent unintended pregnancies in the general population averts more HIV-positive births than does increasing services that promote and provide nevirapine (antiretroviral drug therapy) in antenatal care programs. For example, spending U.S. \$45,000 to increase contraceptive services would avert 88 HIV-infected births. Spending the same amount to promote and provide nevirapine in antenatal care would avert 68 such births.²
- An analysis of the estimated impact of various PMTCT approaches in eight African countries with severe HIV epidemics (Botswana, Côte d'Ivoire, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe) indicated that preventing just 1,000 to 8,000 pregnancies among HIV-infected women or slightly decreasing adult HIV prevalence were both as effective in reducing HIV-infected births as was treating infected mothers with nevirapine.³

■ Kim Best

reproductive and contraceptive choices far more complex than those for uninfected women (see article, page 22). Staff will need to be able to explain issues related to mother-to-child transmission of HIV. Concerns that working with HIV-infected clients will stigmatize and discredit existing family planning services must be overcome. Training about universal infection-control precautions may be necessary to quell providers' fears of being infected by HIV-infected clients. Concerns that working with HIV-infected women will increase already heavy workloads and might compromise scarce family planning funds must also be addressed.⁴ Finally, unless they receive by referral women who have already been identified as HIV infected, family planning

services face the challenge of integrating VCT services to identify infected clients (see article, page 9).

Like family planning services, ANC services face the challenge of determining a woman's HIV status. The introduction of VCT provision into the antenatal setting has the potential to be quite effective.⁵ For example, in a pilot study of same-day VCT in six urban antenatal clinics in Lusaka, Zambia, 84 percent of pregnant women requested testing, and a quarter of those women tested positive.⁶ However, many pregnant women are reluctant to accept VCT. In a four-year study to examine the introduction of PMTCT services within maternal and child health programs in Kenya and Zambia, about two-thirds of

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Preventing HIV Infection among Pregnant Women

Antenatal care (ANC) services present excellent opportunities to help pregnant women who are uninfected or of unknown HIV status avoid infection that they could transmit to their fetuses. The risk that a woman will transmit HIV to her fetus during pregnancy is 5 percent to 10 percent.¹ This risk may be even greater if a woman becomes infected while pregnant, since her HIV virus level may be especially high immediately after infection.²

ANC services also present opportunities to help women protect themselves from infection postpartum and possible subsequent transmission to their infants during breastfeeding. Infection rates in the postpartum period are high in many countries. In Southern Africa, 5 percent to 10 percent of HIV-uninfected women become infected in the year after they give birth.³

Interventions to prevent HIV infection in pregnant women, as in nonpregnant women, focus on counseling about reducing potentially risky behaviors by the woman or her partner. Also, any pregnant woman who is unaware of her partner's HIV status or feels that she may be at risk of infection should encourage her partner to use condoms.⁴ A woman may have little control over her partner's behavior. But involving men in counseling, when possible, can be a key to raising awareness of the need to practice safe sex to prevent infection during pregnancy. In fact, to reflect men's role in transmitting HIV to children, the term "parent-to-child transmission" sometimes is preferred to the biologically precise term of "mother-to-child transmission."⁵

Although research is needed to demonstrate the impact of male involvement on reproductive health outcomes, efforts to reach out to partners of pregnant women at risk of HIV infection are proceeding.

In Rwanda, IntraHealth is attempting to involve men at its six sites that offer services for the prevention of mother-to-child transmission of HIV. There, women are encouraged to take home a letter inviting their partners to visit the centers for voluntary counseling and testing (VCT) and HIV prevention counseling. Results have been encouraging: Although acceptance rates vary among facilities, nearly 20 percent of some 7,400 male partners who were sent letters between March 2002 and February 2004 have accepted testing.

"This male involvement is vitally important," says Sosthene Bucyana, IntraHealth/Rwanda deputy director. "Not only does it reduce the perception that women are always the cause of HIV infection, but it helps increase awareness among men, regardless of their HIV status, of the need to practice safe sexual behaviors to prevent the acquisition or transmission of HIV."

■ Kim Best

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more than 22,000 women who sought antenatal care as new clients received pretest counseling. But fewer than one-third went on to have an HIV test.⁷ Reasons for disappointing VCT uptake at ANC/PMTCT sites throughout Africa may include logistical barriers (e.g., results are unavailable the same day or tests are expensive) and fears that test results will not remain confidential.⁸ Even when women are tested, a substantial number do not return for their results.⁹

ANC services that attempt to integrate family planning services must confront other operational issues. For example, in Africa, adding family planning services can burden government ANC services, which are "notoriously overcrowded, understaffed, and have limited physical space for group or individual counseling," says Elizabeth Preble, an international health consultant who specializes in HIV/AIDS and reproductive health and has studied operational barriers to integrating family planning and PMTCT services in Africa and Asia. "Adding family planning services requires additional skills, space, and staff capable of dispensing contraceptives. In the African context, many ANC staff have already expressed resentment at having to take on additional PMTCT responsibilities, let alone family planning demands as well."

Training issues require considerable attention. In Africa, "at present, PMTCT and VCT curricula do not always cover family planning issues in detail, especially as they might relate to HIV-infected women," Preble says. But, at a minimum, providers should be able to offer information about the importance of family planning as a PMTCT intervention, and to explain the basics of contraception. They also need to be able to offer contraceptive methods that can be adopted immediately postpartum, or be able to refer clients for postpartum family planning services and contraceptive methods.

Family planning referrals, in themselves, can be problematic. "While many PMTCT programs now pledge to follow women, test their babies, and refer them for family planning, ARV therapy, and other AIDS-related care, this is not universally happening in African PMTCT settings," Preble says. An evaluation of a PMTCT

pilot program in South Africa showed that clients referred to family planning services had poor access to health facilities. Distances were long and women lacked affordable transportation. Furthermore, poor patient records impeded continuity of care, and clients had to wait long times to be served.¹⁰

Another challenge is to ensure that PMTCT programs meet the family planning needs of their adolescent clients. Adolescents seen at antenatal clinics are more likely than older women to be pregnant for the first time. They may face strong social pressure to bear a child to prove their fertility and may continue childbearing — regardless of HIV status — if appropriate postpartum family planning counseling and services are unavailable to them. For this reason, FHI researchers are conducting a study in Kenya to identify and evaluate strategies for meeting adolescents' HIV and reproductive health needs within PMTCT programs.¹¹

Missed opportunities, but progress continues

In a recent evaluation of pilot PMTCT projects supported by the United Nations and initiated in 11 primarily African countries in 1999-2000, all national-level program managers reported that their PMTCT programs (centered within ANC and maternal and child health care) included family planning services. Most sites offered both family planning counseling and contraceptive methods, either in the same building or next to it, as part of clients' routine care. However, PMTCT programs had made relatively little progress in addressing the prevention of HIV infection in reproductive-age women and the prevention of unintended pregnancy in infected women.¹²

The extent to which pilot PMTCT programs address family planning (and vice versa) was also evaluated as part of a four-year intervention study conducted at two sites in Kenya and one in Zambia by Horizons, the Network of AIDS Researchers in East and Southern Africa (NARESA) in Kenya, the MTCT Working Group in Zambia, and the United Nations Children's Fund (UNICEF).¹³ Among its findings:

- Opportunities to counsel clients about family planning were missed. In Zambia, for example, slightly more than a third of PMTCT clients — regardless of HIV serostatus — received family planning counseling during their antenatal visit. At the two Kenyan sites, about a fifth of clients discussed family planning during their antenatal visit, and women rarely received postpartum family planning counseling. Although many women reported current use of a family planning method, they did not receive family planning counseling linked to PMTCT goals or the particular needs of HIV-infected women.
- PMTCT services did not appear to influence uptake of contraceptive methods (except for condoms) in settings of low contraceptive prevalence, scarce resources, and high HIV prevalence. Notably, in these settings, family planning and PMTCT services are generally parallel rather than integrated. In both

HIV-infected women were no more likely than uninfected women to be using a modern method of family planning.

- At two sites (one in Zambia and one in Kenya), 39 percent and 65 percent, respectively, of HIV-infected women reported that they had a regular sexual partner but were using no family planning method.

Further analysis by Population Council researchers of the integration of family planning and PMTCT services, reported in April of 2004 and based on field experiences in Cameroon, Kenya, Namibia, South Africa, Uganda, Brazil, the Dominican Republic, India, and Thailand,¹⁴ found that the availability of family planning services at PMTCT sites did not ensure integration of HIV and family planning messages. Family planning was usually provided in PMTCT training but was a low priority and was given little time. Human resources were not readily available in some settings to place



▲ *Integrating services can be difficult when existing services are overcrowded and understaffed. Here, one health worker prepares to immunize a large group of children at a maternal and child health clinic in Livingston, Zambia.*

Zambia and Kenya, for example, postpartum family planning prevalence among women who received ANC at a PMTCT site was comparable to contraceptive prevalence reported in recent demographic and health surveys. Also,

greater emphasis on family planning. At the national level, family planning and PMTCT services tended to be separate programs, often with separate funding. Finally, little monitoring and evaluation of family planning as a PMTCT service existed.

Of note, however, “we found strong positive views about the use of condoms by HIV-infected women for dual protection against unintended pregnancy and HIV transmission — either used alone or in combination with a more effective contraceptive method,” says Dr. Naomi Rutenberg, senior program associate with the Population Council and lead author of the report summarizing findings of the analysis. “Condoms were seen as safe, cheap, easily available, promoted by PMTCT providers, and preserving the women’s health by preventing infection with sexually transmitted infections and reinfection with HIV.”

The researchers recommended integrating family planning support and services targeted to the needs of HIV-infected women into PMTCT services. They suggested that providers build on positive attitudes toward condoms among HIV-infected women and involve men to promote dual protection. They also recommended improving mechanisms for postnatal follow-up and offering a continuum of care for HIV-positive women.

Despite the many identified barriers to integration, the researchers concluded that many pilot activities showed promise and that “national and international leadership to integrate family planning as an essential component of PMTCT programs is bearing fruit and should be continued.”

■ **Kim Best**

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Involving Men

Impact of integrated services depends on male cooperation.

KEY POINTS

- Men play a central role in reproductive health decisions.
- Programs are increasing efforts to involve men.
- Some of these programs address expectations about gender roles that compromise the health of women and men.
- Rigorous evaluation of the impact of these programs on reproductive health outcomes is needed.

Family planning programs that have integrated HIV prevention into their services have discovered that the full benefits of their efforts will not be realized if they overlook a group of people they may have been unaccustomed to serving: men.

Reproductive health experts have long recognized that involving men in family planning yields such benefits as client satisfaction and the adoption, continuation, and effectiveness of contraceptive use.¹ But it has also become clear that the cooperation of male partners is necessary for women to act on HIV prevention messages delivered through integrated services.²

Recognition of the central role that men play in most decisions about reducing HIV risks — from initiating sex to remaining faithful to one partner to using a condom — has accelerated efforts to involve them in protecting reproductive health.

Focus on gender

Since the mid 1990s, when the Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo called for efforts to “encourage and enable men to take responsibility for their sexual and reproductive behavior” — and linked these efforts to promoting gender equality³ — a growing number of programs have sought to increase male participation in reproductive health. Many of these programs involve men primarily so they will support partners’ use of contraceptives. Some offer reproductive health services specifically for men. Increasingly, programs that work with men also address threats to reproductive health that stem from underlying inequities between men and women, such as those that make it difficult for women to negotiate condom use.⁴

Studies in many countries have documented the connection between health and prevailing attitudes about what it means to be a man or a woman.⁵ Societal expectations about what it means to be a man, for example, may give men the power to influence or even determine women’s reproductive health choices,⁶ which may undermine women’s ability to protect themselves from unintended pregnancy or HIV infection. Such expectations also compromise men’s health when

“manliness” is associated with taking risks, using physical force, and having many sexual partners, while seeking health care or taking precautions to protect their health is considered a sign of weakness.⁷

Dr. Margaret Greene, senior associate at the George Washington University School of Public Health’s Center for Global Health, believes that programs promoting gender equity most closely reflect the spirit of ICPD. “What is needed is a clearer focus on how gender roles and inequities constrain health — not a simple shift in what services are offered,” she says.

From theory to practice

Staff working on EngenderHealth’s Men as Partners (MAP) program, which supports services and education for men to enable them to share responsibility for reproductive health, found that simply doing an exercise on gender and reproductive health during a training workshop had little impact. “As we realized how entrenched these gender issues are, they have become an increasing part of everything we do,” says Manisha Mehta, MAP program manager.

In MAP training programs for family planning providers, gender issues are raised as providers learn how to encourage men to support women’s reproductive health choices, rather than to make the decisions unilaterally. Trainers also help providers overcome gender-related biases that might affect the way they interact with men and women, such as judgmental attitudes toward unmarried, sexually active women or assumptions that men should speak for their wives when couples are counseled together. In South Africa, where MAP focuses on violence and HIV prevention, men participate in workshops where they are encouraged to question prevailing gender roles and practice new ways of interacting with women.⁸

Program H, designed by the Brazilian nongovernmental organizations Instituto PROMUNDO, Programa PAPAI, and Estudos e Comunicação em Sexualidade e Reprodução Humana (ECOS) and by the Mexico-based Salud y Género, takes a similar approach with young men in Latin American countries. The program encourages young men to consider the costs of

Integrating Services to Appeal to Men

Reaching men requires a holistic approach. Men's concerns about sexual and reproductive health issues that family planning programs rarely address — such as infertility and sexual dysfunction — “give the provider an opportunity to discuss issues related to reproductive health and sexually transmitted infections,” says Manisha Mehta, who manages EngenderHealth's Men as Partners program.

For the Mexico-based nongovernmental organization Salud y Género, appealing to men's pride in fatherhood has proved effective for opening dialogue with men who might feel threatened by topics such as violence, alcohol use, or sexuality.¹ In the Gambia, men agreed to participate in Stepping Stones workshops when the HIV prevention intervention was adapted to emphasize preventing infertility.² And in New York City, where the Young Men's Health Clinic attracts male clients by providing physical examinations required for participation in school, sports, or jobs, one out of four young men attending the clinic for a routine exam was also treated for a sexually transmitted infection.³

Some organizations reach men by incorporating reproductive health messages into other programs for men. The “Seizing the Day” project provides HIV prevention and reproductive health education as part of an adapted traditional circumcision rite for adolescent boys at Chogoria Hospital in Meru, Kenya.⁴ Another innovative integration initiative by the San Diego, California-based Project Concern International and the Institute for Reproductive Health at Georgetown University in Washington, DC, incorporated family planning services into a community-based water and sanitation project that had already gained the trust and participation of men in El Salvador.⁵

Programs that seek to address gender roles often involve more than one reproductive health issue. In South Africa, the EngenderHealth Men as Partners program's integration of HIV and violence prevention, reproductive health, parenting, and HIV care and support is a natural result of its emphasis on the connection between health and gender norms, says Dean Peacock, who manages EngenderHealth's programs in South Africa. Dr. Gary Barker, executive director of Instituto PROMUNDO in Brazil, notes that the topics of the manuals that PROMUNDO helped develop for Program H in Latin America⁶ — sexuality and reproductive health, fatherhood, violence, mental health issues, and HIV — are linked by the program's efforts to change societal expectations about what it means to be a man.

■ Kathleen Henry Shears

stereotypical definitions of masculinity, as well as the benefits of changing health-threatening behaviors. It also provides skills training, male role models, and support from peers — all factors associated with more equitable attitudes and behaviors in PROMUNDO's previous work with young men in Brazil.⁹

Evaluating projects

A review of reproductive health programs involving men, conducted for the U.S. Agency for International Development (USAID) by the Synergy project of Washington, DC-based TvT Global Health and Development Strategies, identified 14 evaluated projects specifically designed to influence gender norms. But only four of the evaluations — of the New Visions project in Egypt, MAP in South Africa, the Soul City television and radio series in South Africa, and Program H — had experimental designs. The reviewers concluded that strong data on the efficacy of most of the projects was lacking, and they called for more uniform, rigorous evaluation.¹⁰

An evaluation methodology (see article, page 31) developed as part of Program H is being tested in Brazil and India, and the first randomized controlled trial of an intervention to influence health-threatening gender norms is under way in South Africa, with results expected in 2006. Funded by the U.S. National Institute of Mental Health, the trial will assess the impact of Stepping Stones, a community-based HIV prevention intervention for men and women, on gender-related attitudes, HIV prevention behaviors, and new HIV infections.

Also in South Africa, a prospective study of MAP interventions will assess changes in the attitudes and behaviors of both community members and participants. Because MAP participants report that their efforts to change are not always well received, EngenderHealth and its partners have begun working with those who shape social norms in South African communities, including municipal government leaders, community leaders, and sports and entertainment stars.

“Whatever epiphanies men experience in a workshop, we have to realize that they go back into the communities that socialized them in the first place,” says Dean

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Peacock, who manages EngenderHealth's programs in South Africa. "If programs are not rooted in those communities, then they will just wither away."

■ Kathleen Henry Shears

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Assessing Men's Attitudes about Gender Roles

Use of a new tool to evaluate interventions that seek to change health-threatening attitudes about gender roles is helping to clarify whether more egalitarian gender attitudes are associated with behaviors that ultimately reduce reproductive health risks.

The evaluation tool, called the Gender-Equitable Males (GEM) Scale, was developed by the Washington, DC-based Horizons program of the Population Council and by the Brazilian nongovernmental organization Instituto PROMUNDO. The scale consists of 24 statements about attitudes regarding gender roles in domestic work and child care, sexuality and sexual relationships, reproductive health and disease prevention, and intimate partner violence, as well as attitudes toward homosexuality and close relationships with other men.

A test of the scale in a community-based survey among 749 men in three Rio de Janeiro neighborhoods revealed statistically significant associations between GEM Scale scores and behaviors such as partner violence and contraceptive use. Men ages 15 to 24 years who least supported egalitarian gender attitudes were most likely to report violence against a partner and least likely to report contraceptive use. Among men ages 25 to 59 years, support for more equitable gender norms was associated with condom use.¹

The scale is being used to evaluate the impact of group education and lifestyle social marketing interventions that promote gender equity among 750 young men in three low-income Rio de Janeiro communities.² Preliminary results showed that the interventions were associated with improved GEM scores. Preliminary analyses also revealed statistically significant associations between equitable gender attitudes and reduced reports of symptoms of sexually transmitted infections (STIs) among young men in the intervention communities. Those with higher GEM scores were four to eight times less likely to report STI symptoms during the previous three months. Final results of this two-year evaluation are expected in 2005.

■ Kathleen Henry Shears

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