

Integrating Family Planning and HIV Services

Programs in Kenya and Ethiopia Lead the Way



Ed Scholl

A nurse in Meshualelia Health Center, in Addis Ababa, explains how to use the injectable contraceptive, Depo-Provera. The client will also be offered an HIV test as part of the Ministry of Health's efforts to integrate family planning and HIV services.

By Edward Scholl and Daniel Cothran

AIDSTAR-One

John Snow, Inc.
1616 North Ft. Myer Drive, 11th Floor
Arlington, VA 22209 USA
Tel.: +1 703-528-7474
Fax: +1 703-528-7480
www.aidstar-one.com

Alice arrives at a health center in Western Province, Kenya, with her nine-month-old baby girl, who has a recurrent fever. Alice suspects malaria, which is endemic in the area. Two hours later, she leaves with malaria medication and a free insecticide-treated bed net. To the casual observer, Alice got what she came for and had her health needs met. She even received a bed net she was not expecting.

But consider what Alice did not receive. Had her daughter been weighed, the nurse would have noticed that her growth was faltering because Alice is not yet supplementing her diet with nutritious weaning foods. Her daughter also missed the measles immunization for which she was due. Alice was not offered an HIV test for herself, which would have revealed that she is HIV-positive. Finally, no one asked Alice, who has six children and does not want to get pregnant again, if she is using a family planning (FP) method or if she would like information about contraceptives available at the health center. In short, Alice's immediate need was met, but multiple underlying health needs went undetected by the health center staff.

Alice's story is unremarkable. Similar scenes play out every day in health care settings around the world. In sub-Saharan Africa, where the burden of HIV, unintended pregnancies, and maternal and infant mortality are highest, missed opportunities to meet health care needs, such as those of Alice and her baby, can be deadly.

Fortunately, programs in Kenya and Ethiopia are leading the way in integrating FP, HIV, and maternal, neonatal, and child health (MNCH)

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services. To document how programs are actually implementing integrated services, AIDSTAR-One visited several programs in Kenya and Ethiopia and focused especially on the integration of FP and HIV services. FP/HIV integration has been the focus of much research and policy-level support, but documentation and evaluation of implementation experience are lacking.

Integration of FP/HIV services is gaining momentum, especially in regions of high fertility and high HIV prevalence. This effort is supported by many donors including the U.S. Government, funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development's (USAID's) Office of HIV/AIDS and Office of Population and Reproductive Health.

Launching Integrated Programs in East Africa

How did this shift toward greater FP/HIV integration come about? In Kenya, it started with research conducted by FHI in 2002 that tested the feasibility of integrating FP into HIV voluntary counseling and testing (VCT) centers. The results showed that integration was indeed feasible and that the potential demand was high (Reynolds et al. 2003). Within months of the release of the study findings, the Kenyan Ministry of Health (MOH) began developing a national strategy for integration. In addition, a national working group on reproductive health (RH)/HIV integration, co-chaired by representatives from the RH and HIV divisions of the MOH, was formed. The MOH released a VCT-focused strategy that has since evolved, and the new National Reproductive Health and HIV and AIDS Integration Strategy promotes the integration of all types of HIV and FP/RH services. Specifically, it calls for "restructuring and reorienting health systems to ensure the delivery of HIV and AIDS services within the same

Reproductive health and HIV services have similar characteristics, target populations, and desired outcomes. Clients seeking HIV services and those seeking reproductive health services share common needs and concerns, and integrating services will enable health care service providers to efficiently and comprehensively address them. Family planning programs are good entry points for most of the sexually transmitted infection and HIV and reproductive cancer services, and vice versa. Strong linkages will help to ensure that the reproductive health needs and aspirations of all people, including people living with HIV, are met.

—National Reproductive Health and HIV and AIDS Integration Strategy, Republic of Kenya, 2009

sexual and reproductive health (SRH) services or delivery of SRH services within HIV and AIDS services, during the same hours" (Republic of Kenya 2009, p. vi).

Ethiopia is another country at the forefront of FP/HIV integration, though the process began a few years after Kenya's. As in Kenya, integration began by training VCT counselors to provide FP counseling and methods. A pilot project funded by the Bill & Melinda Gates Foundation proved successful and paved the way for replication and

scale-up. Today, FP and HIV services are integrated at the national level, with support from PEPFAR, USAID/Ethiopia, the Bill & Melinda Gates and Packard foundations, the Dutch Government, and other donors.

Kenya and Ethiopia have made tremendous strides in integrating FP/HIV services over the past seven years and now serve as models for other countries in the region. A closer look at how integration is implemented in each country provides useful lessons for other countries and implementing organizations as they consider whether and how to integrate vertical programs or to scale-up and improve newly integrated programs. The programs described in this case study illustrate how integrated services are implemented, both by government and nongovernmental organization (NGO) providers. It is important to remember, however, that successful integration by service providers is preceded, and accompanied, by many other actions that facilitate integrated services. These include integration-friendly policies and guidelines, capacity training and task shifting, facility staff sensitization, supportive supervision, information systems, monitoring and evaluation, and commodity supplies.

Kenya

Kenya was a pioneer in efforts to integrate FP/HIV services, beginning with training VCT counselors to provide FP counseling and contraceptives. The 2009 National Reproductive Health and HIV and AIDS Integration Strategy goes beyond integrating FP and VCT services to integrate FP and HIV at all service delivery levels. While not explicitly outlined in the strategy document, integration of MNCH services with FP and HIV services is also occurring throughout the country in MOH facilities.

The largest U.S. Government project supporting the integration of FP/HIV/MNCH services in public and private facilities in Kenya is the AIDS, Population and Health Integrated Assistance (APHIA) Project. APHIA II, the name of the five-year project that ended in December 2010, has been replaced by a similar project: APHIA Plus. APHIA seeks to improve and expand facility-based HIV, tuberculosis, RH/FP, malaria, and maternal and child health (MCH) services, while also working to improve and expand civil society activities to increase healthy behaviors. USAID/Kenya's implementing partners for APHIA II and APHIA Plus include PATH, FHI, Pathfinder, JHPIEGO, and various subcontractors.

HIV AND FAMILY PLANNING IN KENYA

HIV prevalence in Kenya was estimated to be 6.3 percent of the adult population in 2009, with women more disproportionately infected (8.0 percent) than men (4.3 percent).

The total fertility rate in Kenya was 4.6 in 2009. Among married women of reproductive age, 45.5 percent were using contraceptives. Unmet need for FP was estimated to be 26 percent of women in reproductive age.

Source: Kenya National Bureau of Statistics and ICF Macro 2010

PRINCIPLE FEATURES OF FAMILY PLANNING/HIV INTEGRATION IN APHIA II/KENYA

- Government strategy on integration disseminated
- FP/HIV services integrated with MNCH
- Intrafacility referral predominant in hospitals
- Community outreach and follow-up through community health volunteers
- Task shifting and training on integrated service delivery
- Integrated services recorded in Mother & Child Health Booklet
- Principal indicator is number of facilities providing integrated services.

APHIA II Western: The Western Province of Kenya is part of the geographic area covered under the APHIA II Western project, which is implemented by PATH and its partners. One of the MOH facilities that has been strengthened under APHIA II Western is the Alupe Sub-district Hospital in the town of Busia, on the border with Uganda.

HIV services offered at this 130-bed hospital include provider-initiated testing and counseling, prevention of mother-to-child transmission (PMTCT), antiretroviral (ARV) treatment, care, and support. FP services offered include counseling and provision of contraceptive methods, including male and female condoms, combined and progestin-only pills, injectables (Depo-Provera), Jadelle implants, and male and female sterilization.

All women who visit the hospital are assessed for FP needs by being asked about their pregnancy status and current desire for another pregnancy. Women who are not pregnant or seeking to become pregnant are offered FP counseling and methods by a trained nurse or clinical officer. Hospital staff report that, in addition to being screened for FP needs, all patients at the hospital are offered HIV tests if they have not already had one, regardless of the reason for their visit. If the patient is a pregnant woman, she will be enrolled in prenatal care and, if living with HIV, in the PMTCT program.

These multiple FP/HIV/MNCH services are recorded in the Mother & Child Health Booklet, which the mother keeps and brings with her each time she visits the hospital. This allows health workers to scan the pages and note the patient's history, including when she took an HIV test (and its result), whether she is using an FP method, what immunizations the child has received, and so on.

Kakamega Provincial District Hospital is another MOH hospital in Western Province that further illustrates how FP/HIV integration is being implemented in Kenya. The 400-bed hospital

has a catchment population of 79,000. Kakamega also uses the Mother & Child Health Booklet to record MNCH/FP/HIV services provided to mothers and their children. The hospital offers a full array of these services, with patients moving from one room to another to access different services. The hospital also hosts a psychosocial support group that meets regularly to support people living with or affected by HIV. There is also a group of mentor-mothers who are living with HIV that meets with pregnant women or new mothers, who are also living with HIV, to counsel them and give them support. This program is run by mothers-2-mothers, a South African NGO.

Both the Kakamega and Alupe hospitals have a community outreach and follow-up component that uses community health volunteers. The volunteers make home visits for patient follow-up, refer family members to the hospital if they are sick, and provide counseling on a range of health topics. For people living with HIV, the volunteers also ensure that medications are being taken and will occasionally bring the medications to the home when it is difficult for their clients to reach the hospital. Their volunteer duties may also include counseling



Romana Campos

A mother in Kakamega Provincial Hospital with the Mother and Child Health Booklet, where all integrated services are recorded.

people living with HIV about nutrition, family gardens, and how to live with the virus. The volunteers offer counseling on FP and refer, but do not provide any contraceptive methods other than male condoms.

The type of FP/HIV integration seen at the Kakamega and Alupe hospitals can best be described as integrated services under one roof, on the same day, by different providers. This is sometimes referred to as integration with intrafacility referral. The FP/HIV integration practiced at these facilities also fully incorporates MNCH services. While Kakamega and Alupe represent only two hospitals in Western Province, discussions with USAID/Kenya, APHIA II Western staff, and other APHIA II grantees such as Pathfinder and FHI confirm that the type of FP/HIV integration seen at these two facilities is taking place nationwide in MOH facilities, from the hospital level to the dispensary level. At lower levels, such as at the dispensary, where there are far fewer providers, the integrated services may be offered by the same provider, or the client may be referred to a higher-level facility (e.g., for cesarean births or for female sterilization).

APHIA II integration results: The results of FP/HIV integration efforts under APHIA II can be only partially measured from program data collected by the APHIA II grantees and reported to USAID/Kenya. APHIA II grantees report many separate types of data on FP services (e.g., couple-years of protection) and HIV services, but these cannot be used to directly measure the level of integration in a facility. The one indicator that all grantees report on to USAID that directly measures FP/HIV integration results is the number of outlets providing integrated FP/HIV services.

APHIA II Western exceeded its integration target for FY 2010, as shown in the following table.

	Target	Achieved
<i>Number of outlets providing integrated FP/HIV services by the end of the year</i>	250	276

The extent to which FP/HIV integration has been successfully achieved was not formally evaluated under APHIA II, but USAID/Kenya and implementing partners are reviewing integration indicators and performance monitoring plans with an eye to be able to more thoroughly measure integration efforts under the new APHIA Plus Project.

Ethiopia

The integration of FP/HIV services in Ethiopia began a few years after Kenya, but has proceeded rapidly in recent years and is supported by the government, USAID/Ethiopia, and PEPFAR, as well as HIV and FP implementing agencies. The Government of Ethiopia's support for FP/HIV integration is expressed in their Sexual and Reproductive Health Strategy, as well as in national guidelines on HIV testing and counseling, PMTCT, and antiretroviral therapy (ART). The government's support of integration is also reflected in their health management information system; in the creation of the Rural and Urban Health Extension Programs, which procure contraceptives to ensure adequate supplies of FP methods; and, most of all, in the provision of FP and HIV services at all government facilities, often with services being delivered by the same provider.

At the MOH's Meshualekia Health Center in Addis Ababa, for example, every patient who comes for any service is offered an HIV test, regardless of the reason for the visit. The HIV rapid tests are found in every exam room in the antenatal, pediatric, FP, and outpatient departments. Similarly, all clients coming for antenatal care, postabortion care, and HIV testing, treatment, or care are offered FP counseling and methods, as needed. However, FP counseling



Daniel Cothran

A community health volunteer in Kakamega, Kenya, speaks with a community member about how backyard plots can be used for food security and income generation. Most women visiting health facilities have many health care needs that often go undetected. Integration can help identify and meet these needs.

is not offered to all health center patients (such as those visiting the outpatient department) because patient volume is reportedly too high for this to be feasible. Nonetheless, all clients seeking HIV services are assessed for FP needs; this information is recorded in the HIV Care/ART Follow-up Form. This form (used nationally by the MOH) has a column to be completed for each patient, showing pregnancy status and which FP method is being used, if any. In parallel fashion, the health center's Family Planning Register (also used nationwide in MOH facilities) has columns to indicate if an HIV test was offered, whether it was performed, and what the result was.

The MOH's Adama Hospital in Oromia Region has also thoroughly integrated FP and HIV services, even claiming that 100 percent of patients who come to the hospital are offered HIV testing and counseling as well as FP counseling and contraceptives. This hospital has 17,600 patients enrolled in its Antiretroviral Therapy Center (recently remodeled with PEPFAR funding), all of whom have records

showing whether they are using a contraceptive method.

These two facilities are not special model facilities that are pilot testing FP/HIV integration, but rather are part of the national health care system of hospitals, health centers, and health posts that are set up to provide integrated services under one roof, either through the same provider or through intrafacility referrals. Rural health posts, given their limited capabilities, are more likely to practice interfacility referrals—that is, referral to a nearby health center—for FP services that may not be available at the health post (such as female sterilization).

Government health extension programs:

Two other government-supported programs in Ethiopia that contribute to FP/HIV integration are the Rural Health Extension Program (RHEP) and the Urban Health Extension Program (UHEP). The former has been a fixture of rural health outreach by the MOH for several years.

RHEP employs rural health extension workers (RHEWs), all of whom are high school graduates, who work out of health posts and supervise community health volunteers. There are approximately 32,000 RHEWs in the country, and beyond their work in general health promotion, they play an important role in FP/HIV integration in rural areas. They are trained to provide several types of FP methods during home visits (condoms, pills, and injectables, and in some cases, the Implanon single-rod implant) and offer counseling on HIV. A few RHEWs also provide rapid HIV testing in the home, while others refer clients to the local health center for testing.

The MOH's UHEP, which began in 2009, uses nurses who serve as UHEP professionals. These nurses make home visits and provide a wide variety of services and education related to FP, hygiene and

environmental health, prevention and control of diseases (including HIV infection), mental health, and violence prevention. The nurses provide several FP methods during home visits (condoms, pills, and injectables) and refer for others.

USAID is seeking to strengthen UHEP's HIV-related activities with PEPFAR funding through a project implemented by John Snow, Inc. This project aims to support the implementation and monitoring of UHEP and improve access to and demand for health services, including HIV prevention, care, and support services. The program focuses on those most at risk for HIV in five regions and two city administrations, covering 19 towns and cities. In addition to providing HIV counseling and referrals for HIV testing, some UHEP nurses offer HIV rapid testing and counseling in the home. Another PEPFAR-funded implementing partner, IntraHealth International, is also supporting UHEP to increase access and demand for HIV testing and counseling among pregnant women.

The MOH's facilities and the community outreach activities of RHEP and UHEP support FP/HIV integration. Many nongovernmental programs are also providing integrated FP/HIV services, both through private clinics and home- and community-based care (HCBC) programs.

Home- and community-based care programs: FHI's HCBC program began in 2002 through USAID's IMPACT Project and has continued to the present, with funding from the Dutch Government. The HCBC program began with baseline assessments and discussions with community groups, all of which revealed strong interest in providing support for people living with HIV, many of whom were dying without treatment available. The program focused on providing palliative care, medications for opportunistic infections, nutrition education, and emotional and spiritual support to sick and dying patients and their families. With the advent of greater access to ARVs provided through PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), death rates due to AIDS started to fall in Ethiopia. The HCBC program increasingly observed people living with HIV rather than dying of AIDS. Many previously bedridden women living with HIV began to be sexually active again, and the rate of pregnancies, many of which were unintended, increased. In response, the HCBC program began integrating FP/HIV services.

Today, the HCBC program operates in 13 cities in four regions of the country: the Southern Nations, Nationalities, and People's Region; Oromia; Amhara; and Addis Ababa. The program has about 900 volunteer caregivers and 60 nurse supervisors. FHI has local partners at

HIV AND FAMILY PLANNING IN ETHIOPIA

HIV prevalence in Ethiopia was estimated to be between 1.4 and 2.8 percent of the adult population in 2009, with women disproportionately infected compared to men. Large urban/rural differences are present, with prevalence estimated to be 6 percent in urban areas and 1 percent in rural areas.

The total fertility rate in Ethiopia was 5.4 in 2005. Among married women of reproductive age, only 15 percent were using contraceptives, with injectable contraceptives accounting for two-thirds of all users. Unmet need for FP was estimated to be 34 percent of women in reproductive age.

Sources: Central Statistical Agency and ORC Macro 2006; Federal Democratic Republic of Ethiopia 2010

each of the 13 sites, including the Family Guidance Association of Ethiopia (FGAE), which implements the program in Adama and three other cities in the Oromia region.

In Adama, the program offers a model of FP/HIV integration at both the clinic and community levels. At the FGAE clinic, FP and RH services are the primary focus. In addition to a full array of FP services offered, the clinic provides HIV testing and counseling and care and support services for those affected by HIV, but does not provide PMTCT or ART services. HIV rapid tests (KHB followed by Stat Pak) are offered to every client in every examination room, and every provider is trained to provide the tests and counseling. Clients who test positive are referred to Adama Hospital or a nearby health center for either PMTCT or ART. However, in a departure from common referral practices in many countries, the provider does not just fill out a referral slip and hope for the best. The provider actually coordinates with the HCBC program to have a volunteer caregiver accompany the client to the hospital or health center and then follow-up at home.

In the community, the volunteer caregiver is expected to make regular visits to 25 households. Although the program began by providing palliative care to those sick with AIDS, the program has since broadened its focus to the health and well-being of everyone in the household, regardless of HIV status. The volunteer caregivers continue to encourage those who have not been tested for HIV to get tested, to monitor adherence to ARVs, and even to occasionally bring ARVs to patients who have difficulty reaching the clinic. They also distribute male condoms and oral contraceptives, and discuss other FP options with men and women in the home.

One unique characteristic of the HCBC program is its relationship with local *idirs*, which are traditional neighborhood-based social organizations that play a

very important role in each community. The HCBC program helped convince *idirs* to participate in providing mutual aid services to households affected by poverty and illness, including HIV. In all regions where the HCBC program operates, local *idirs* now recruit and help oversee the volunteer caregivers and use part of the funds they collect each month to help pay for medicines for opportunistic infections and food for those who are sick. In this way, the HCBC program has a vital link to the community, and its volunteer caregivers are accountable to the community and its representatives in each *idir*.

To enhance the sustainability of the HCBC program, FHI is working closely with the MOH to train professionals from UHEP to continue the work of the HCBC program under the auspices of UHEP; FHI is pilot testing this approach in Jimma, Gondar, and Nekemte. In these cities, FHI is not contracting with

In the beginning of the [HCBC] program, death rates were very high and family planning was not a priority. But as the program developed, people who had been at death's door rose up and became mobile and active again. We saw quite a lot of women getting pregnant, though these pregnancies were not always desired and were often unplanned. It became clear that there was a new need emerging for family planning and reproductive health services.

***– Francesca Stuer, Country Director,
FHI/Ethiopia***

a local implementing agency like FGAE, but rather folding the HCBC program into the UHEP structure, while also coordinating with the idirs, which will continue to recruit and oversee local volunteer caregivers. If the pilot program goes well, the work currently undertaken by the HCBC program will effectively become a permanent fixture of UHEP and local idirs.

The HCBC program provides a good example of FP/HIV integration at both the clinic and community levels. The program illustrates a model of integration that uses the same provider to offer FP and HIV services in the same examination room. It also shows how community-level workers can assist with facilitated referrals (e.g., to the nearby hospital for PMTCT and ART services not provided in the FGAE clinic) and how these same volunteers provide follow-up in the community, whether to ensure ARV compliance or to make sure a new FP client is happy with her contraceptive method. The program also provides a unique model of community involvement and accountability through its ties to local idirs. The integration of the program into UHEP may also prove to be a model of sustainability, though it is too soon to know the results of this pilot program.

Home- and community-based care integration results:

The two indicators used by FHI for measuring the success of FP/HIV integration efforts in the HCBC program are 1) the percentage of clients living with HIV who are counseled on RH and FP (target of 75 percent), and 2) percentage of clients living with HIV who adopt an FP method (target of 37.5 percent, or half of those who are counseled).

In 2009, the program exceeded all of its targets in all 13 cities. The percentage of FP users, for example, was 40 percent among all program beneficiaries. Overall, the HCBC program reaches about 20,000 beneficiaries who are living with HIV.

In 2009, FHI conducted research on the HCBC program to measure its impact on a range of indicators. The research design was quasi-experimental and included surveys of beneficiaries and non-beneficiaries. The findings, unpublished at the time of this writing, indicate statistically significant improvements in overall quality of life, reduction in stigma, increased social support, and more financial resources or savings among program beneficiaries than among non-beneficiaries. However, the study did not find statistically significant differences in health outcomes or FP use. This may be due to the fact that non-beneficiaries had good access to public health services and FP methods through nearby MOH facilities.

PRINCIPLE FEATURES OF FAMILY PLANNING/HIV INTEGRATION IN ETHIOPIA

- FP/HIV services integrated with MNCH
- Integrated services offered by same provider in many larger MOH facilities
- Intrafacility referrals also practiced
- UHEP and RHEP extend reach of integrated services
- HCBC program provides grants to local implementing partners
- Volunteer caregivers provide link between facilities/ community and help provide facilitated referrals
- Local neighborhood-based organizations (idirs) facilitate community involvement and accountability
- Task shifting and training on integrated service delivery.

What Worked Well

Facilitated referrals: Key to the success of any effort to integrate services such as FP and HIV is having a referral system in place that does not lose clients as they are referred from one service to another. This is very important, as it is rare for one provider to be able to provide all necessary services in the same place and at the same time. *Facilitated referrals* is the term often given to referrals that are accompanied by some action designed to increase likelihood of the client following through with the referral. For example, in the case of the HCBC program in Adama, this has been performed by voluntary caregivers escorting a client to the Adama Hospital for services not offered at the FGAE clinic. The caregiver provides follow-up during home visits.

Another example of a facilitated referral is the use of referral forms for community health workers (CHWs). In Kenya, the MOH provides each of its CHWs with a referral form to give to sick individuals or to others needing preventive care or FP services. The referral form, with its unique serial number, has a section where the CHW indicates the reason for the referral and completes a section for the action taken by the receiving officer. Use of this form undoubtedly provides a degree of status to the CHW in the eyes



Ed Scholl

Volunteer caregiver in the HCBC program during a home visit. Caregivers provide HIV care and support and counsel on FP methods, as well as provide pills and condoms.

of the community and makes the referral facility accountable for follow-up.

Health worker training: Also key to the success of integration efforts is the quality of health worker training. Training provides health care workers with the knowledge and skills to assess needs beyond the core discipline for which they initially received training, and then to either refer or provide the additional services needed by the client. The APHIA II Western project in Kenya sponsors a five-day workshop on FP/HIV integration for MOH clinical officers and nurses. These providers have a great deal of experience in HIV service delivery but are relatively new to FP service delivery. The workshops use two principal training resources published by the MOH, with technical input provided by FHI and JHPIEGO. The HCBC program in Ethiopia also provides five-day training on FP/HIV integration, primarily for nurse supervisors in the program, followed by yearly refresher training. All the neighborhood idirs participating in the program receive a separate one-day course on FP/HIV integration.

Linking clinic- and community-based services: The facilitated referrals that involve community volunteers have already been mentioned as an area of strength for programs in Kenya and Ethiopia. But the links between clinic- and community-based services go deeper than merely facilitating referrals and following up on patients returning to the community. RHEP and UHEP, Ethiopia's national programs, help to extend health care coverage in the country and provide a strong link between clinic- and community-based services.

The HCBC program provides another example of strong linkages between clinic- and community-based services. In particular, the involvement of the local idirs and the accountability of the volunteer caregivers to these neighborhood mutual aid societies provide a model for community involvement and ownership.

Government support: The strong government support for FP/HIV integration in Kenya and Ethiopia is another key to the success of integration efforts in both countries and has made integration the national norm rather than merely the model for small-scale pilot projects. In Kenya, government support is conveyed through the National Reproductive Health and HIV and AIDS Integration Strategy. In Ethiopia, government support is expressed through the Sexual and Reproductive Health Strategy and national guidelines. In both countries, MOH facilities practice intrafacility referrals for HIV and FP services, and they have incorporated record keeping forms that track the provision of integrated services (e.g., the Family Planning Register and the HIV Care/ART Follow-up Form).

Challenges

Overburdened health care workers: When providers and program managers in Kenya and Ethiopia are asked to name the challenges of FP/HIV integration, the first response is invariably along the lines of “There are too many patients and too few health care workers.” Indeed, this is a common challenge mentioned in the published literature on integration. Kenya’s MOH, supported by such programs as APHIA II, has tried to mitigate this through task shifting, whereby lower cadres of health care workers are given responsibilities that might have previously been reserved for physicians or clinical officers. For example, nurses now commonly provide ARVs and can insert intrauterine devices (IUDs) and contraceptive implants. Some clinical officers can now perform tubal ligations on women seeking to prevent future pregnancies, something that in the past only physicians performed.

In Ethiopia, the HCBC program, RHEP, and UHEP practice another type of task shifting, which allows nurses and health extension agents to provide Depo-Provera during home visits. These home-

and community-based programs also help alleviate crowding in the clinics and hospitals by providing some services outside of health facilities. In addition, and as part of the task-shifting strategy, trained nurses work in ART clinics. These nurses assess clients living with HIV, including for FP need, and are also allowed to prescribe ARVs and contraceptives to clients based on their needs and clinical eligibility.

While integration can be a challenge to implement for an already stretched health care work force, many health care workers see it as a worthy challenge. One provider working with the APHIA II Western project stated that integration brings her a high degree of satisfaction because she is now empowered to deliver services to patients she would have otherwise had to refer out, not knowing if the client would follow-up on the referral. Another provider on the same project even suggested that integration of services helps to reduce the volume of patients and burden on providers by addressing many health issues during a single visit and avoiding having the patient return multiple times.

Stockouts: Stockouts of contraceptives have proved to be a serious challenge to successful FP/HIV integration in Kenya. For example, Kakamega Provincial District Hospital in Western Kenya had been out of the injectable contraceptive Depo-Provera for over a month during the authors’ visit in December 2010. In a testament to the popularity of this method, a hospital provider said that clients continue to procure this contraceptive on their own

Key to the success of any effort to integrate services such as family planning and HIV is having a referral system in place that does not lose clients as they are referred from one service to another.

through private pharmacies. In Ethiopia, commodity stockouts have been relatively rare by comparison. Other commodities, such as drugs for treatment of opportunistic infections, also suffer stockouts, though the supply of ARVs has been reliable.

Inadequate monitoring and evaluation: One of the challenges in both Kenya and Ethiopia is how to measure the success of FP/HIV integration efforts. An oft-quoted adage is “What gets measured, gets done,” and it is an unfortunate reality that FP/HIV integration has not been routinely measured or evaluated. In fact, although PEPFAR supports integration efforts, PEPFAR implementers are not required to report on indicators for integration or even for FP. Even programs such as APHIA II Western—a project explicitly devoted to advancing the integration of HIV, FP, and MCH services—struggled to adequately measure integration results. The sole indicator used by all APHIA II grantees was the number of facilities providing integrated services.

It was noted previously that the APHIA II Western project exceeded its target by helping to achieve integrated services in 276 facilities. Yet this output indicator does not convey a sense of coverage (which would require a percentage figure rather than a number), nor does it measure client satisfaction or any kind of client action or health outcome. USAID/Kenya has acknowledged the weakness of APHIA II’s monitoring and evaluation of FP/HIV integration and plans to engage partners involved in APHIA Plus (the follow-on project) to develop new standardized reporting and common indicators to better measure integration progress and results. Exit interviews with clients are also envisioned as a possible measurement of client satisfaction with integrated services.

In Ethiopia, the indicators used by the HCBC program to measure the success of integration efforts are the percentage of clients living with HIV who are counseled on RH/FP and the percentage who adopt

an FP method. These indicators are more useful and client-focused than the APHIA II indicator. However, their focus is limited to whether clients living with HIV receive FP counseling and methods, which leaves out many other important aspects of FP/HIV service integration that should ideally be measured.

Recommendations

Based on the experiences of the APHIA II Western project in Kenya, the HCBC program in Ethiopia, and other programs, the following recommendations are offered to program implementers seeking to integrate FP/HIV services wherever the need for FP and HIV services is high.

Pursue “smart integration”: The U.S. Global Health Initiative (GHI) is a whole-of-government approach to global health launched in 2009. GHI provides a policy environment to support FP/HIV integration and emphasizes “smart integration”—not integration for integration’s sake, but integration that makes sense technically, economically, and in the context in which it is implemented. The need to be strategic about when and how to integrate services is particularly important as policy support and funding opportunities for integration increase. One of the most important contextual factors to consider is the scale of the HIV epidemic. Countries with concentrated, or low-level, HIV epidemics have a less compelling case to integrate HIV services into FP services, for example. When a decision is made to integrate FP and HIV services, program planners need to consider many factors in order to find the most appropriate, cost-effective approach. For example, should one provider offer both services, refer to other providers in the same facility, or refer to other facilities? One document that helps program managers at the country level ask these questions and provides guidance on how to integrate services is *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies*,

Programs, and Services (World Health Organization 2009). Other resources for integrating FP/HIV services are included at the end of this case study.

Expand monitoring and evaluation: As noted in the “Challenges” section, measuring the progress and results of FP/HIV integration has been a challenge for programs in Kenya and Ethiopia. Programs should carefully consider what is important and what is feasible to measure and not limit themselves to what they are required to report to PEPFAR. FHI is currently pilot testing FP/HIV integration indicators in Ethiopia, Rwanda, Tanzania, Uganda, and India, and plans to have results of the pilot test available in early 2011. The six indicators being tested, in ascending order of complexity, are the following:

- Proportion of HIV-related service delivery points (SDPs) with FP/HIV integrated services
- Proportion of HIV-related service clients screened for FP needs
- Proportion of HIV-related SDP clients who received an FP method or referral after FP counseling
- Proportion of female clients of reproductive age attending HIV-related SDPs with an unmet need for FP
- Proportion of repeat care and treatment clients reporting unintended pregnancy
- Proportion of FP clients who received HIV testing at the FP SDP or were referred for HIV testing.

Programs should consider using one or more of these indicators for measuring FP/HIV integration based on the results of the pilot test. Other indicators to consider that measure other inputs or outcomes related to FP/HIV integration include:

- Percent of clients who report receiving more than one service during their visit

- Percent of facilities with personnel trained in FP/HIV service integration
- Percent of facilities with no stockouts in the prior six months of FP methods, ARVs, HIV test kits, and drugs for opportunistic infections.

Implement task shifting: PEPFAR implementers have made tremendous advances in task shifting, and HIV services are increasingly being provided by lower cadres of workers. FP providers have long used non-medical personnel to provide contraceptives, including hormonal methods, in the community or during home visits. Programs seeking to further integrate services should consider how to delegate appropriate responsibilities to less specialized health workers to make services more available and lessen crowding at health facilities. To give just two examples, community-based extension agents could be trained to provide both condoms and hormonal FP methods, as well as provide rapid HIV testing and counseling. In health facilities, nurses can learn how to provide FP methods (including IUDs and implants) and most HIV services, including ARVs. Many resources, job aids, and training materials are available to help programs with task shifting and any required training (see the “Resources” section, as well as “Tools and Curricula” and “Additional Resources” at <http://ow.ly/3Gv5K>).

Provide home-based HIV testing and counseling (HBHTC): Related to the concept of task shifting is HBHTC. Providing HBHTC can greatly increase access to and demand for HIV testing and enhance FP/HIV integration efforts. Given the considerable home- and community-based programs in place in Kenya and Ethiopia, as well as the sizeable rural population in both countries (especially Ethiopia), it makes sense to have an HBHTC strategy and include test kits among the supplies given to trained nurses and rural extension agents who make home visits. HBHTC is already being used in Ethiopia’s UHEP (though not by all

nurses in the program) and could become a feature of other programs in those countries and in the region. AIDSTAR-One helped organize a regional technical consultation on HBHTC in 2009 (for the report of this meeting, see <http://ow.ly/3HTpr>).

Ensure commodity security: The slogan coined by the USAID | DELIVER PROJECT—“No product? No program!”—is apt. Clients should never leave a clinic empty handed because the product they need is out of stock. PEPFAR has devoted substantial resources to guaranteeing the supply of ARVs, HIV test kits, and drugs for opportunistic infections. USAID has long been a champion of contraceptive security. Nonetheless, with PEPFAR funds ineligible for contraceptive procurement and USAID population funds stagnant in real dollars over the past 30 years, contraceptive security is a major challenge.

In countries such as Kenya, USAID contraceptives meet part of the demand, but the MOH must procure most contraceptives. The frequency of reported stockouts of contraceptives in Kenya suggests the MOH is not procuring sufficient contraceptives to meet demand. Programs seeking to integrate FP and HIV services should do all they can to improve commodity security to provide products needed by clients. When stockouts do occur, alternative sources of products should be sought, such as private pharmacies or private providers that carry the missing products at subsidized prices.

Address male norms and behaviors: Although the contraceptive options for women are more numerous than for men, FP is the responsibility of both partners. When men do not support the use of FP, uptake among women may be low and inconsistent. Lack of support from male partners also influences many women to use non-visible methods of FP, such as Depo-Provera, which do not prevent HIV transmission and thus make dual

protection (e.g., use of condoms and another method of contraception) extremely challenging.

PEPFAR advocates for addressing male norms and behaviors in HIV prevention programs, which includes FP/HIV integration efforts (PEPFAR 2009). The best way to address male norms and behaviors will depend on the location of the project. In Kenya, the APHIA II Western project addressed this issue by, among other things, holding “Men’s Clinics” on weekends, where men were educated about PMTCT and other health issues and were given the option to be tested for HIV. In Mombasa, the APHIA II Coast project encouraged male involvement in PMTCT by having staff from an organization for people living with HIV conduct home visits to talk to male partners of clients who consented to be visited. In addition, women attending antenatal care visits with their partners were given priority and did not have to wait in line to be seen.

Future Programming

Opportunities for additional support for FP/HIV integration in sub-Saharan Africa appear strong. The U.S. Global Health Initiative, PEPFAR, and GFATM all support FP/HIV integration, and GFATM applicants may even include contraceptive procurement in their applications. USAID bilateral contracts and cooperative agreements are also increasingly focused on integrated service delivery rather than vertical programming, as evidenced by new programs such as USAID/Kenya’s APHIA Plus.

Many foundations are also supporting FP/HIV integration. Recently, the Bill & Melinda Gates Foundation provided a multimillion dollar grant to Population Action International to advocate for integration of RH and HIV services in Kenya, Ethiopia, Nigeria, Tanzania, and Zambia. In 2007, the Hewlett Foundation introduced the Africa Family Planning and HIV Integration Fund (Tides Africa) to leverage HIV funding to support FP/HIV integration.

Furthermore, organizations traditionally focused on FP service delivery, such as the U.N. Population Fund and the International Planned Parenthood Federation (IPPF), are also very committed to integrating HIV and FP/RH services. For example, IPPF, in collaboration with the London School of Hygiene and Tropical Medicine and the Population Council, is implementing a five-year research project gathering evidence to determine the costs and benefits of using different models for delivering integrated sexual health, RH, and HIV services.

Conclusion

In Kenya and Ethiopia, different models of FP/HIV integration are being employed. Some facilities provide both FP and HIV services by the same provider in the same examination room. Others provide one service by one provider, and then send the client to another exam room for other services. Still others refer clients to other facilities for services they do not provide, often accompanying the client and following up during a home visit to make sure the referred service was received.

Programs visited in both countries are actively screening for health care needs beyond the principal motivation for the health care visit. Clients coming for HIV-related services are being screened for FP needs and vice versa. In addition, most are being screened for needs other than HIV and FP, and offered preventive services including perinatal care, sexually transmitted infection and tuberculosis screening, Papanicolaou smears, childhood immunizations and nutritional surveillance, and insecticide-impregnated bed nets in malaria-endemic regions. Another characteristic common to the programs visited in both countries is the link between clinical services and home-based care. Integration does not just take place in the clinic, but is reinforced through home visits by community volunteers and peer support groups.

Though the integration models used in programs observed in Kenya and Ethiopia are different, what they have in common is a holistic understanding of an individual's health needs. This understanding is passed on to frontline workers who take the time to ask, listen, and act on a client's health needs, both expressed and observed.

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RESOURCES

Biomedical Interventions: Contraception to Prevent Unintended Pregnancies Among Women With HIV: <http://ow.ly/3Gv5K>

Evaluating the Integration of Family Planning and Voluntary Counseling and Testing in Kenya: http://www.fhi.org/en/RH/Pubs/Briefs/FPandHIV/FP_and_VCT_Kenya.htm

Making the Case for Integration: Tides Foundation's Africa Family Planning and HIV Integration Fund: <http://www.tides.org/fileadmin/user/pdf/Tides-Africa-Fund-HIV-Making-the-Case-for-Integration-Report.pdf>

The Case for Integrating Family Planning and HIV/AIDS Services: Evidence, Policy Support, and Programmatic Experience: http://www.fhi.org/en/RH/Pubs/servdelivery/FP_HIV_brief_package.htm

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