# Proceeding to the International Conference on Linking Reproductive Health, Family Planning and HIV/AIDS Programs in Africa, Addis Ababa, October 9-10, 2006

## Key Messages of the Conference

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In as much as the conference theme referred to *linking* RH and FP with HIV/AIDS programs in Africa, many of the research presentations, and thus meeting discussions, centered on "integration" features, such as adding one service into the other, cross-training providers in counseling, provision of dual protection methods, behavioral change communication with youth, and policy coordination. Without an operating definition for integration the conferees were not able to arrive at a clear consensus on whether integrating services for reproductive health and family planning with those for HIV/AIDS would be effective in addressing prevention of adverse pregnancy and sexual behavioral outcomes. However, these sentiments belie what was a rapidly expanding body of knowledge generated through study findings shared at the two-day conference. Many researchers were pleasantly surprised at the extent of parallel and intertwined threads of investigations being pursued by other colleagues in African and non-African countries. Although the structural aspects of integration, such as how services are organized, administered and physically located, needed to be distinguished from their policy and financial underpinnings, conferees quickly recognized the complexity of linking two major health program areas.

Some of the recurring issues arising across presentations and during breakout sessions are summarized here.

*1. Integration is a concept that needs deconstruction.*

The entry points for relating two service programs are many, varying by level (e.g., national and operational policies, health service infrastructure, and community education and outreach), by actors in the system (e.g., donors, government, health provider, private clinics, and clients), by health needs (e.g., prevention of adverse sexual or reproductive outcomes, severity of infection), by client attributes (e.g., gender, knowledge of prevention methods and preferred sources for services), and by available resources (e.g., provider capacity, donor assistance priorities, and rural-urban distribution of clinics, medications and equipment). Several studies noted that the provision of HIV and FP counseling by single providers has led to work overload and reduction in clients served. Others reported positive benefits of service integration at same sites, whether introducing either FP into VCT clinics or HIV counseling and screening into FP clinics, with greater exposure and more appropriate care extended to clients. Integration issues are not new or restricted to RH and HIV care, having been addressed by maternal and child health and tuberculosis treatment and management programs in the past. Nevertheless, differentiating between levels of and among points of services where integrated care can be delivered is seen to be a necessary first step in reducing the complexity behind the effort.

*2. Program linkage and integration requires political support and leadership.*

The country case study of Kenya shared at the meeting illustrated best the daunting challenges of integrating the implementation of two national policies with vertical operational arms. Nonetheless, the reported benefits were in addressing what otherwise might have been missed opportunities – VCT of women and youth, reproductive health counseling of men, reaching antenatal and postnatal clients with HIV and RH services. A number of factors, including common oversight of both programs by one health ministry department, service guidelines integrating both types of care and a common monitoring system, facilitated linkages and advanced integration. Government budgetary allocations to both RH and HIV commodities also meant better prospects for coordinated and sustainable support to both programs. Additionally, repeated throughout the conference discussions was the need for international donors to support country-level efforts at implementing integrated programs. All too often donors impose conditions on access to their funding that distract and disrupt government efforts to extend care to populations and locations of high need. Strong and informed national leadership—and their ownership of programs--was seen as necessary to direct and shape linked or integrated services. Health leadership at all levels is needed to facilitate dialogue to reconcile the various interests of different stakeholders.

*3. Behaviorally speaking, reproductive and sexual health are intimately linked.*

Conception and infection are both derived from unprotected sexual intercourse. Heterosexual sex is the primary pathway for STI and HIV transmission in Africa; consequently addressing risk behaviors and health needs of both men and women is an inevitable responsibility of governments, communities and individuals themselves. Conferees accepted the notion of a common target clientele for integrated care, further highlighting the high levels of unmet demand for family planning that co-exist with high HIV prevalence among reproductive aged women in many African countries. Despite this, there was also awareness that service approaches to disease prevention (as in HIV) were

intrinsically different than those for health protection (as in pre-conceptional planning). Some promising results from early intervention with youth through educational activities and youth-friendly services were shared simultaneously with findings on misperceptions and poor knowledge about sexual and reproductive health. Fertility and HIV status of women were not consistently correlated, although data from longitudinal studies in Uganda and Malawi suggest that intent to avoid pregnancy along with an increase in contraceptive use was higher among HIV infected than uninfected women. There was no research on how HIV infected women manage unwanted pregnancies. At the same time, the reproductive rights of PLWHAs to bear or not bear children were soundly recognized at the meeting.

*4. Many operational issues were identified from RH and HIV service integration.*
Many insightful comments were raised during the breakout sessions (detailed earlier). While it is not possible to cover all the notable findings from operations research on RH and HIV service linkage or integration, several are worth highlighting. One study found no deterioration in RH/FP service quality after integrating VCT services. On the other hand, the baseline quality was not outstanding, and the risk of provider burnout from a higher workload was present. Another study reported successfully introducing family planning counseling in clinics providing anti-retroviral therapy to HIV infected women. How HAART care will impact the reproductive intentions and behaviors of PLWHAs is yet to be demonstrated. More studies reported results from introducing contraceptives into VCT services than VCT into family planning clinics. This stimulated discussion about the resource implications of screening all family planning or antenatal clients for STIs or HIV as compared to responding to the reproductive health care entitlements of infected individuals. In low-resource settings, linking those diagnosed with STI and HIV infection immediately to comprehensive reproductive health services is arguably not only an appropriate constellation of care but also a client right.

A number of studies observed that VCT clinic-based contraceptive counseling for individuals diagnosed with HIV is largely limited to encouraging condom use. Awareness of other contraceptive options for HIV infected women is limited and epidemiologic research is still underway on the interactions between pregnancy, HIV acquisition and transmission and HAART.

Last, only two studies examined the cost and cost-effectiveness of integrated care and both do not allow for generalization beyond their specific contexts. Perhaps one of the biggest research challenges for integration is conducting standardized cost-effectiveness studies in different clinic settings to better appreciate the components driving costs against a common set of outputs.

*5. Does the HIV community care about integrating reproductive health care? Should it?*
The conference in some sense was a missed opportunity to engage the HIV research community more extensively. A limited number of HIV epidemiologists, prevention practitioners, and donors actively participated in the meeting. The momentum for this conference was clearly driven by reproductive health specialists studying how to link to HIV/AIDS services and programs. This raised the question of whether meeting reproductive health needs of at-risk individuals offers any compelling rationale for joint investments by the HIV sector. Additionally, many of the disease prevention outcomes of interest to HIV researchers were not addressed by conference studies. For example, do RH or FP services counsel clients to reduce sexual risk, such as reducing the number of concurrent sexual partners, or using condoms consistently, or preventing transmission to newborns? Will VCT services introduced into FP clinics reduce HIV transmission levels among women, and how do FP services reach out to men as sexual partners? Viewing the linkage question primarily through a lens focused on reproductive health outcomes may be inadequate to generate findings persuasive to an HIV audience.

*6. More and better research is needed, of course.*
A research conference would not be true to its character without a call for more and better scientific effort. The nature of science, however, is to continuously pursue the discovery of the unknown and answer the unanswered. While simultaneously expanding the corpus of knowledge on HIV and RH service linkages, a second major scientific benefit of this conference was to raise more questions to be addressed through future operations and behavioral research.

Several methodological issues were raised. For example, most studies relied on cross-sectional rather than longitudinal data, and where longitudinal, the follow-up intervals were short. Many studies were limited to a small number of clinics which prevented generalization and confidence for scaling up. Similarly, studies variously relied on self-reported and biologically measured health conditions. The prospects of launching a major multi-country longitudinal study of integration benefits were debated.

The knowledge benefits of the conference were particularly enhanced by just-in-time contributions from experienced program practitioners. A focused meeting to develop a research agenda for integration was recommended, and there was strong interest in repeating this type of action research meeting in future years.

The way forward
The context for HIV/AIDS prevention and promotion of reproductive health is constantly evolving. In Africa, the September 2006 adoption by the Ministers of Health of member states of the Africa Union of the Maputo Plan of Action for universal access to comprehensive sexual and reproductive health services gives priority to integrating these two areas of care. Programmatic momentum already exists in a number of countries, such as Kenya, Ghana, and Mozambique, and donor support appears to be growing, including at the Global Fund for HIV/AIDS, Tuberculosis and Malaria. Regional discussions of service integration issues are emerging; a February 2007 conference with a South Asia focus was held in Mumbai, India. Perhaps most important in the flux of activity will be the steady march of quality research to build the evidence base. In this regard, international donors can exercise their will to considerable gain by supporting quality research and evaluation of factors behind and consequences of healthy programs and outcomes that link STI, HIV, reproduction and family planning.

## Conference Background

Planning for this meeting began in January 2006 in a discussion between Addis Ababa University's Department of Community Health and the Gates Institute at Johns Hopkins Bloomberg School of Public Health. The vision blossomed into a much larger meeting by April 2006 and into an international conference by June. The conference was motivated by a commonly felt need to understand how reproductive health care and services related to the delivery of HIV/AIDS and sexually transmitted infection prevention efforts for the health of populations at risk. With half of infected adults being female, many in active reproductive ages, the real need for studying the linkages and their effects was indisputable.

A Call for Abstracts was issued in early June 2006 to solicit research presentations on service integration in Africa. The research could examine either linking or integrating HIV/AIDS care into RH programs or *vice versa*. Submissions could use qualitative and/or quantitative research design as long as they contained actual findings. Over 100 abstracts were submitted and peer reviewed with 50 accepted for oral presentation. Eight abstracts were presented as posters. The conference was organized by the Department of Community Health (DCH), Addis Ababa University and the Bill and Melinda Gates Institute for Pupulation and Reproductive Health (GI), Johns Hopkins Bloomberg School of Public Health and in collaboration with several national and international organizations.

The objective of the two-day conference held on October 9-10, 2006 in Addis Ababa Ethiopia was to determine the state of knowledge and practice through evidence-based research on linking or integrating reproductive health, family planning and HIV/AIDS programs in Africa. Over 500 international researchers, advocates, donors, policy makers and program administrators from over 40 countries convened for a conference on Linking Reproductive Health, Family Planning and HIV/AIDS Programs in Africa.

Research topics and related questions of special interest included:
***The Integration Process***: Operations research describing and analyzing the processes involved in linking RH and HIV/AIDS programs in terms of systemic, personnel, logistical, and budgetary elements. Examples of research questions: What efficiencies or inefficiencies are experienced in integrated programs? Do staffs reprioritize some elements of their work as a result of integration? Are more clients and/or different types of clients attracted to integrated programs?

***Impact of Integrated Programs***: Research examining the impact of service delivery, health communication, and social marketing programs on knowledge, behavior and health status in terms of RH and HIV/AIDS. Types of issues addressed: What is the cost-effectiveness of integrated programs? Do the RH and HIV/AIDS components of integrated programs complement each other? Are persons who reduce risk-taking behavior in RH (e.g., unwanted pregnancies) more or less likely to reduce risk-taking behavior associated with the acquisition of STD or HIV (e.g., reduction in sexual partners)?

***Reproductive Health Needs and Desires of Persons Living with HIV/AIDS (PLWHA)***: Research addressing the reproductive needs and desires of persons living with HIV/AIDS. Some examples of research questions: What factors are associated with HIV-positive men's and women's decisions to have children? What sources of support do HIV-

positive individuals receive in raising children and is such support effective for family and household wellbeing? What factors influence how discordant couples make RH related decisions?

***Policy Barriers to Integration***: While service integration can happen operationally at the field level, program administration and policy factors can influence implementation, particularly in terms of access to and extent of budgetary resources. What policy and program factors influence integration and how do devolution processes affect integration? Should governmental policy and program administration be organized differently to address cost efficiencies in resource allocations for HIV/RH integrated services? Do donor funding mechanisms discourage service integration?

***Behavioral and Epidemiological Linkages between HIV/AIDS and Reproductive Health Risks***: Sexual risk-taking behaviors may result in both adverse reproductive health outcomes (e.g. unintended pregnancy) and HIV infection. Do similarities and differences in client risk-taking behaviors influence the integration of HIV and reproductive health services?

At the opening of the conference, the audience heard number of opening remarks and keynote addresses from five distinguished guests:

*H.E. Bience Gawanas*, Commissioner for Social Affairs with the Africa Union, opened the conference by expressing full support and excitement especially as the conference followed so closely on the heels of the September Ministerial Meeting in Maputo. She felt this was extremely important as the conference theme addressed one of the six priorities of the Continental Policy Framework for Sexual and Reproductive Health and Rights Plan of Action.

The Ethiopian State Minister of Health, *Dr. Kebede Worku*, in his address strongly stated that, "Linkage, integration and mainstreaming of these services is beyond health specific issues. It is a question of clients' rights to have continuum of care…dual protection of pregnancy and sexually transmitted diseases, including HIV transmission, is one area for service integration."

It was important to hear the needs and desires of People Living with HIV/AIDS throughout the conference. *Mengistu Zemene*, President of Network of Ethiopians Living with HIV/AIDS (NEP+) gave voice to this constituency in his opening remarks.

*Monique Rakotomalala*, UNFPA Country Representative, and *Elizabeth Lule*, World Bank manager of AIDS Campaign Team for Africa, each gave keynote addresses on the rationale and opportunities for strengthening the linkages between reproductive health and HIV/AIDS programs, setting the stage for the remainder of the two-day conference. Ms. Lule's comments stressed the importance of working multi-sectorally, removing implementation barriers, and building on existing initiatives, and building up capacity and evidence.

At the close of the conference, organizers noted that translating the key findings of the conference will entail further dialogue between both HIV/AIDS and Reproductive Health sectors. Researchers will need to be continually engaged to define and expand the research agenda to encompass epidemiological aspects, operational and program issues. Finally and most important, is for both the reproductive health and HIV/AIDS communities to listen to and address the reproductive needs and desires of People Living with HIV/AIDS.

## Summary of Research Finding

Throughout the two-day conference, research was presented in 2 concurrent sessions held in the mornings and afternoons. There were a total of 10 sessions. The following is a summary of study presentations and discussion highlights presented in each session. (The first author's surname is given in parentheses.) All abstracts and presentations are available at http://www.jhsph.edu/gatesinstitute/CR/FP-HIV-Presentations.

**Session 1A: Integration (1) – When and Where?**

The study on integrating family planning services in VCT and PMTCT sites in Amhara Ethiopia revealed that integration of family planning services into VCT/PMTCT settings can reduce missed opportunities and increase contraceptive uptake. In Amhara, 30% of VCT clients accessing sites with integrated services have now adopted a family planning method. Investigators noted that the biggest barrier to overcome in integrating services in Amhara is the high burnout rates experienced by health professionals, in part due to heavy workloads. *(Asnake)*

A study looking at preferred facilities for family planning and HIV testing showed that clients do or will go to the same facility for different services. Using DHS survey data from Malawi and Kenya, investigators found statistically significant tendencies for clients to access pairs of services at the same facility, specifically family planning and childbirth services, family planning services and HIV testing, and childbirth services and HIV testing. Investigators cautioned, however, that the results are not generalizable and that between-country differences are to be anticipated. *(Pullum)*

A study in Rwanda revealed that family planning can successfully be integrated into PMTCT-VCT programs. In the study site, 90% of HIV-positive women attending PMTCT-VCT programs who were offered on-site family planning accepted a family planning method. Investigators stressed that in order for integration to be successful, family planning counseling must be conducted by trained health professionals at multiple service entry points including antenatal and postpartum services. *(Ngendahimana)*

Finally, results were presented from the first phase of a study assessing the impact of integrating HIV counseling and testing into existing family planning services in South Africa. Findings show no evidence of a decline in family planning service quality with the integration of HIV counseling and testing services. Unfortunately, findings also reveal that the quality of existing family planning services in South Africa is substandard. *(Mullick)*

**Discussion Highlights**
Two areas which participants felt needed further research:

- Contraceptive continuation rates for HIV service clients
- The potential of IUCDs to best meet contraceptive needs of women on ART

**Session 1B: Linking Family planning Services and VCT**
The study on integration of contraception into VCT services (VICS) in Ethiopia presented preliminary results of a baseline survey conducted in 8 public facilities around Ethiopia. The study found that HIV-negative individuals received less counseling compared to HIV-postive individuals, even though HIV-negative clients exhibit similar levels of risk behaviors. Clients who were aware that they were HIV-positive were less likely to desire more children; among those who desired more children, HIV-positive individuals were more likely to desire a child sooner (in the next 12-24 months). Neither female nor male VCT clients received contraceptive commodities during VCT counseling sessions and referrals were nonexistent. (*Kidanu)*

Operations research of family planning service integration into VCT in Kenya found that trained providers were more likely to have discussions on fertility preferences, family planning methods and usage. Providers were more likely to discuss family planning methods after the intervention, as reported by clients. However, clients were more likely to be given a family planning method than be given a choice of methods. Method mix was often limited to condoms. *(Reynolds)*

Two presentations shared successful integration experiences from Kenya. In Kenya, it was assumed from the beginning that failure to integrate would be a missed opportunity for several reasons: VCT counselors were already trained in counseling skills; integration offered convenience to clients; VCT clients may want to use condoms for pregnancy prevention; and VCT attracts clients who may want to access family planning services. A Ministry of Health representative discussed enabling factors for integration, which included a conducive MOH structure (both programs report to Department of Preventive and Promotive Health Services); inclusion of both HIV/AIDS and family planning components in the Kenya's reproductive health strategy; existence of a supportive policy environment; existence of service provision guidelines that require integrated VCT and PMTCT services with family planning and maternal health care; and inclusion of a single package with both HIV and reproductive health services offered in medical management of sexual violence. Integrated programs have seen encouraging improvement in indicators between 2002 and 2005: nearly all VCT clients of trained counselors were given information on family planning, VCT sites recorded an increase in the clients using condoms, and most VCT counselors had discussed family planning and HIV integration with their provider colleagues. Additionally, 92.9% of the clients who came for VCT reported that they were given information on family planning in the target sites after the training. In one VCT clinic, the demand for family planning outstripped the demand for VCT. *(Solomon, Koskei).*

**Discussion Highlights**

- Clarification on the functional definition of "integration"– is it a question of integrating programs, services or allocation of funds from one issue to the other, since each of these has unique problems (stigma, donor issues, etc)
- Clarity of any existing policy guidelines on reproductive rights for VCT clients
- More attention needed as to whether the quality of services will decline with integration, such as longer visit or wait times, or greater burden on the clinic
- Important to include the rights and desires of PLWHA.

**Session 2A: Integrating Reproductive Health and HIV Services for Youth**

Sexually active youth in many parts of the world are often poorly prepared to make decisions regarding their sexual and reproductive health, in part due to being inadequately served by the health system. A qualitative study by EngenderHealth and UNFPA in Brazil, Ethiopia and Ukraine found provider bias and misconceptions regarding the appropriateness of hormonal family planning methods and dual methods among HIV-positive women and adolescent girls. These results belie the importance of integrated sexual and reproductive health services for youth in varying socioeconomic contexts, while also acknowledging the inherent rights for both HIV-positive and HIV-negative youth. *(Dabash)*

A study conducted among youth living in camps for Internally Displaced Persons (IDP) in northern Uganda found that the mean age at first sex was 15.7 years and that 33.6% of female youth had their sexual debut as a result of rape. This population also exhibited high prevalence rates of HIV/AIDS, STIs and teenage pregnancy along with negative attitudes towards contraception. *(Adong)*

A study among Kampala urban poor school adolescents found average age at first sex to be even lower at just 13 years, and that students dealt with a host of sexual and reproductive health issues that negatively impacted their academic achievement, with extreme cases leading to school drop out. *(Kakooza)*

Integrated sexual and reproductive health services are most effective when they are youth friendly. In 2004, Straight Talk Foundation and UPHOLD started a youth friendly service center for IDP youth in northern Uganda and observed a high demand for services *(Adong)*. The Family Guidance Association of Ethiopia had a similar experience when they began integrating STI diagnosis and treatment with VCT into family planning services at selected youth centers with support from UNICEF in 2003 *(Kaba).* After the introduction of sexual and reproductive health programs in urban poor schools in Kampala, not only did students' knowledge and management of sexual and reproductive health issues improve, they also exhibited enhanced academic achievement and reduced failure rates *(Kakooza)*. In all three instances, services were rendered youth friendly through the use of peer education, infotainment (e.g. radio programs) and other recreational, capacity building and networking clubs and activities.

However, knowledge does not always translate into action. This was observed in a survey among rural youth in the Kassena-Nankana district of northern Ghana where although sexually active youth exhibited concerns about unwanted pregnancies and STIs, these were not matched with the adoption of preventive behaviors *(Debpuur)*. It is important, therefore, to support youth in building their capacity to take action. This cannot be achieved through clinic-oriented services due to the limited interface of youth with the health system. Rather, it can be achieved through institutions involved in youth formation such as schools.

**Discussion Highlights**

- Recognize the varying international and national definitions that exist for "youth"
- Programs should be targeted at sub-groups of youth as needs differ between the various adolescent stages
- Need to actively engage parents in the design and implementation of youth programs
- Best practices in youth friendly services should be disseminated

**Session 2B: Reproductive Intentions and HIV (1)**

Pregnancy intentions and desire for future children appear to be unaffected by HIV-positive status according to study presentations from Addis Ababa, Ethiopia, Cape Town, South Africa, and Ghana in this session.

A cross-sectional survey of men and women on ARV in Addis Ababa found that clients were more likely to want children if they were younger, married, had partners who desired children, and had no previous children *(Tamene)*. In Cape Town, a cross-sectional sample of HIV-positive adults found that women were significantly more likely to want children if they had no children or if their current partner was not biological father of any of her children *(Cooper)*.

And finally in Ghana, 64% of all women on ART wanted to have a child in the future, and 22% within 2 years *(Adamchak)*. These results further support what was found by a systematic literature review that in developing countries, community norms about childbearing and health have a greater effect on fertility intentions, and thus HIV-positive women often intend to continue to bear children *(Rutenberg)*.

Two studies show that high levels of unmet family planning needs exist among HIV-positive clients. In Cape Town, of the 19% of women who became pregnant since knowing their HIV-positive status, 61% were unplanned. A majority of women and men (both 90%) had never heard of Emergency Contraception (EC); however, 84% of women reported that they would be likely or very likely to use EC. In the cross-sectional survey of the rural Rakai cohort in Uganda,[1] half of ever pregnant HIV-positive women did not intend to get pregnant at the time they conceived, and 87% of ever pregnant HIV-positive women who did not intend to conceive were not using any modern family planning method at the time *(Matovu)*.

Furthermore, studies indicate that improved counseling sessions on family planning may be necessary to prevent vertical and heterosexual transmission of HIV and PMTCT, unplanned pregnancy, and to address fertility desires. Of the sexually active, condom users in the Addis Ababa study, 20.9% reported irregular use. Of the 19.3% who reported counseling sessions on fertility issues with ART providers, nearly 40% felt that the discussion did not sufficiently address fertility issues. In a random sample of female ART clients in the Ghana study, of the women who wished to discuss family planning with a provider, only 11% reported that family planning was discussed. The Ghanaian study found that women tend to risk MTCT: 30% believed all babies will be born with HIV, and 42% thought about half will be HIV-positive. Three-quarters thought it was extremely likely that HIV will be passed to an infant during breastfeeding. Although 66% were aware that a drug exists to reduce the chance of transmission, 67% still thought that the baby would be HIV-positive even with treatment.

**Discussion Highlights**

- Self-reporting of pregnancy outcomes has its limitations and therefore, a better method to measure outcomes should be implemented in future research study designs
- Counseling for discordant couples who intend to get pregnant is necessary

**Session 3A: Policy Considerations of Integrated Services**

Family Health International (FHI) designed, implemented and evaluated various integrated service delivery models in Kenya, Zimbabwe, South Africa and Nigeria. These experiences demonstrated that a supportive national policy environment is necessary but insufficient for integration to succeed. Integration requires dedicated funds and infrastructures at national, provincial, district and service delivery levels along with programmatic coordination between the family planning, reproductive health and HIV/AIDS units of Ministries of Health. Services have to become client centered, rather than product centered. Finally, in order to avoid turf issues between donor-driven vertical programs, the roles and responsibilities of partners must be agreed upon and articulated prior to beginning the integration process. *(Askew)*

After pre-field testing the WHO and partners' Guidelines for Essential Practice in Kenya, the Population Council found that the adaptation process should be strategic, phased and backed by sufficient resources. It is recommended that the process be participatory, inclusive and iterative by involving multiple stakeholders in the debate and revision of draft policies. The process should also involve minimal disruption of existing national policy frameworks. If possible, guidelines should be pilot tested before roll out. In order to ensure sustainability, it is imperative that integration begin at the national level and trickle down to programs. *(Rakwar)*

In order to facilitate the integration process, the USAID Health Policy Initiative developed a conceptual framework for policy reform that helps consider three key questions: Is integration addressed in national and operational policies? Are health systems structured for integration? Do people understand the complete policy process related to promoting and supporting integration? *(Hardee)*

Cutting edge research in HIV prevention promises to have important implications for integration policy. Randomized control trials in South Africa, Kenya and Uganda showed that male circumcision has a significant protective effect against HIV infection in men and their sexual partners. Scaling up safe adult male circumcision will require adequate training, equipment and supplies, specialized surgical centers, and discouragement of poorly trained traditional or

[1] The Rakai cohort was established in 1994 and consists of 43 communities and 12,000 individuals (15-49) who have been under continuous annual surveillance.

private practitioners. It will also require policy makers to consider provision of circumcision neonatally and prevention of behavioral disinhibition among circumcised men. *(Wawer).*

**Discussion Highlights**

- Need to differentiate between "linkage" and "integration," especially when considering human resource capacity and training levels required of staff
- Important to consider cost effectiveness of the intervention, especially for male circumcision
- Consider if offering both female sterilization and male circumcision procedures in the same clinics results in service delivery economies

**Session 3B: Integration (2) – When and Where?**

A study presented on the integration of sexual and reproductive health services in Kwa-Zulu Natal, South Africa showed that both providers and clients have positive attitudes towards integration. While interviews with 40 health providers and 300 clients in Kwa-Zulu Natal revealed these positive attitudes, they also uncovered several obstacles to successful sexual and reproductive health service integration. Findings indicate that in order for service integration to work, health staff must be committed and well trained, and general sexual and reproductive health information needs to be made readily available to clients. *(Maharaj)*

A second study on integration of VCT into family planning, reproductive, and child health services in Tanzania indicated that integration is not only possible, but with appropriate training and community support, integration in this setting also attracted more women than stand-alone VCT clinics. In addition, male involvement in family planning and reproductive health services increased, and overall existing services improved. Interestingly, after training and capacity building was provided to service providers, modern contraceptive uptake tripled in some areas. *(Mphuru)*

Baseline data presented from a study on repositioning postnatal care in Swaziland highlighted the need for improving the continuity of services and reducing missed opportunities in high-prevalence HIV settings. Observational data show that only 10% of providers gave information on family planning after delivery and that postnatal care visits were seen as missed opportunities for family planning service provision in Swaziland. *(Warren)*

A study in Ghana, which looked at the effects of integration of family planning counseling and services into HIV prevention and treatment, revealed that few HIV treatment providers view contraception as part of the scope of care for HIV-positive women on anti-retroviral treatment. However, with appropriate training and information, providers recognized the reproductive rights of PLWHAs and fertility needs have been incorporated into HIV counseling. The biggest challenge to service integration, however, is high staff turnover. *(Asare)*

Finally, an assessment of the linkages between VCT and reproductive health services in Ethiopia showed that formal linkages exist between ANC and VCT centers, but such linkages are weak to non-existent between VCT and family planning service centers. VCT centers do not offer clients family planning services nor do they provide family planning referrals. There is an urgent need to strengthen linkages to reduce missed opportunities. Additionally, results show that integrated IEC/BCC materials need to be developed, improved upon, and widely distributed. *(Mesganaw).*

**Discussion Highlights**

- Improved collaboration with stakeholders and expanded community involvement needed
- Improved counseling possible through improved health worker training
- Broader contraceptive options and audience (VCT clients receiving family planning counseling)

**Session 4A: Pregnancy and HIV/AIDS Prevention**

A recent survey found that women in Botswana continue to be at high risk for both HIV and unintended pregnancies. Younger, single women tend to be better protected from both HIV and pregnancy, while older women seemed less likely to protect themselves. The results for older women may reflect a desire to complete their families or a perception that they are in more stable relationships. These findings suggest that women require support and services to protect themselves from HIV and unintended pregnancies throughout their reproductive lives in order to ensure healthy families. *(Galavotti)*

The emergence of HIV/AIDS in Nigeria has led to the promotion of condom use through integrated health education programs. The National HIV/AIDS and Reproductive Health Survey 2005 found that there has been a significant increase in knowledge of using condoms for protection from HIV/AIDS, STIs and unwanted pregnancies. This has been matched by an increase in condom use by young adults and with non-marital sexual partners. These findings

present strong evidence in favor of integrating health education programs on HIV/AIDS, STIs, and family planning services. *(Bamgboye)*

PLWHAs require family planning and reproductive health services. While HIV reduces the likelihood of pregnancy and increases rates of spontaneous abortions, ART can increase fertility in HIV-positive women. Simulation studies also suggest that family planning can be as effective as nevirapine in preventing MTCT, and is in fact, part of WHO's strategy for prevention of MTCT. Furthermore, UNAIDS and UNICEF recommend HIV-positive women either not breastfeed children altogether, or wean at 4-6 months, both of which increase likelihood of postpartum fertility by ending amenorrhea. Despite these recommendations, HIV-positive women in sub-Saharan Africa have low family planning use resulting in many unwanted pregnancies. However, a significant proportion of PLWHAs may also desire children. *(Gray)*

The government of Tanzania is currently implementing a five-year National Care and Treatment Plan to HIV-positive residents, which emphasizes care across a continuum and includes family planning and reproductive health. Quantitative and qualitative research conducted by FHI found that half of patients are sexually active and with a third desiring more children. Over half of sexually active patients (52%) reported no condom use at last sexual encounter, largely because they desired a child (46%). Patients reported that they wanted family planning services in the "familiar environment" of the ART clinics rather than being referred to family planning clinics, yet counselors felt unprepared to address the family planning needs of their clients. *(Mpangile)* Therefore, family planning sessions should be established within ART clinics and counselors should be appropriately trained. The services should emphasize HIV prevention and dual protection. Family planning should also be promoted to improve the health of HIV-positive women and prevent MTCT.

**Discussion Highlights**

- Knowledge of serostatus should be the first step in planning a pregnancy
- Counseling HIV-positive women and men desiring children on how to prevent HIV transmission to partners and babies is needed

**Session 4B: Reproductive Intentions and HIV (2)**

HIV status did not appear to affect pregnancy rates, as determined by the METRO longitudinal study in Blantyre, Malawi and a qualitative study of HIV-positive women and men in South Africa. In the METRO study, pregnancy rates were the same for both HIV-positive and HIV-negative women after one year of study, but the percentage not wanting a pregnancy was always higher for HIV-positive women compared to HIV-negative women. *(Taha)* Conversely, findings from South Africa reveal that reproductive intentions are influenced more by individual desires and concerns, social expectations, provider expectations and medical interventions than by HIV status. *(Cooper)*

The results from the METRO study for pregnancy desires among HIV-positive women were similar to those found with longitudinal observation of newly detected cases in Lilongwe, Malawi. The desire to become pregnant decreased significantly among HIV-positive women over the one-year post-test period (from 33% to 14%). Differences between symptomatic women (CD4 <200) and asymptomatic women (CD4>200) became negligible, as even those who felt well significantly reduced their desire for pregnancy once HIV-positive status was known (pregnancy desire decreased 17% to 8% in CD4 <200 group and 42% to 16% in CD4 >200 group). *(Hoffman)*

The studies also revealed that PLWHAs have high unmet need for family planning, as evidenced by frequent unplanned pregnancies. In Lilongwe, 62.1% of the HIV-positive women who became pregnant over the study period reported that they did not intend to become pregnant. In Blantyre, 7.6% HIV-negative and 10.8% HIV-positive women experienced unwanted pregnancy during the study period.

A comprehensive study on the perspectives of HIV-positive women on their fertility in seven African countries[2] shows that many other challenges exist in addressing the fertility intentions of PLWHAs. For example, HIV-positive women who become pregnant experienced disapproval from community and health-care sector members. Information on contraception and HIV/AIDS is generally unavailable, and there is limited and highly variable access to EC. Pregnancy termination is often stigmatized and restricted, and there is a lack of knowledge of legal indications for abortion in many African countries. *(de Bruyn)*

[2] Botswana, Kenya, Lesotho, Namibia, Nigeria, South Africa and Swaziland.

Similar results were found in a qualitative study in South Africa, where procreation by HIV-positive men and women was also found to be highly stigmatized. Clients often did not discuss their fertility intentions with health care providers due to anticipated negative reactions. Investigators further explained that health care providers play an important role in addressing PLWHAs' fertility intentions, but the issue is often framed in ethical or medical terms, not in needs or rights terms for PLWHAs. Similarly, health care providers strongly promote condoms, which often cause internal conflict for the client between their desire for children and their desire for safe sex. Clearly fertility needs and rights of PLWHAs are not being addressed and any efforts to improve counseling are hindered by the current lack of service integration. *(van Dam)*

**Discussion Highlights**

- Need to address existing ethical issues surrounding HIV and pregnancy
- Need to convey that it's a woman's right to have children regardless of her HIV status
- Availability of ART and PMTCT treatment can affect pregnancy intentions

**Session 5A: Impact of Integrated Services and Programs**

Two studies showed a positive impact of integration on contraceptive uptake. In Rakai, Uganda, a community randomized trial of enhanced family planning effort in an HIV surveillance program resulted in statistically significantly higher use of hormonal contraceptives (23.2% vs. 19.9%) and lower pregnancy rates (12.4% vs. 15.7%) in the intervention arm as compared to the control arm. Investigators found that using trained volunteers and social marketing of contraceptives can improve contraceptive uptake among HIV-positive clients. *(Lutalo)* Similarly, initial results of integrating family planning into PMTCT settings in Ethiopia show promise. Now, six months after the initiation of the integration intervention, which included provider training and community mobilization campaigns, nearly half of all HIV-positive mothers have accepted a modern family planning method post-delivery. *(Asfaw).*

The other two studies also showed promising results of the impact of service integration on cost. However, investigators for both cautioned against generalizing results as cost studies are context specific. A study of the cost of introducing two different models of integrating VCT within family planning clinics in South Africa revealed that compared to the cost of setting up a stand-alone VCT center, it is more cost-effective to fully integrate services within an existing family planning setting given providers have time to provide VCT. However, partial integration may be more efficient if family planning providers are too busy to provide VCT and existing VCT centers are underutilized. (*Homan)* A second study analyzed the cost-effectiveness of integrating HIV prevention in maternal and child health programs in Ethiopia and Ukraine. The results show that integration generates cost savings. For example, in Ethiopia, integration saved an estimated $34 per every $1 spent. Integrating HIV prevention services into existing family planning and maternal and child health programs should therefore be strongly considered by policy makers and program planners. *(Perchal)*

**Discussion Highlights**

- Condoms often associated with HIV/STI prevention, but not with family planning
- Need for greater partner involvement in PMTCT
- More research on the effectiveness of different interventions, e.g., estimates of how much HIV is prevented by VCT is needed for the ability to better estimate overall cost effectiveness

**Session 5B: Reproductive Intentions and HIV (3)**

Risky sexual behavior remains a common practice among PLWHAs, as found by a qualitative study of fertility desire and sexual behavior of PLWHAs in Southwest Nigeria. Among ARV clients, 63.6% were sexually active, and of those, 51.2% did not use condoms regularly (though 90.5% had a single sex partner). *(Oyebola)*

PLWHAs, in general, desire more children. In Nigeria, 65.8% of those in the study desired more children. A qualitative study on reproductive health needs of PLWHAs receiving ART in Ethiopia also found that future fertility desires exist. *(Degu)* Interviews of ART clients on fertility intentions and family planning counseling and use Mombasa, Kenya, found that about 30% of clients want another child (men and women) and want the child soon (less than a year). *(Sarna)*

Reasons for desiring children are diverse. Open-ended questions of men and women receiving ART in South Africa found that reasons given for wanting children are *NOT* HIV related, while reasons for *NOT wanting* children *are* HIV related, such as negative health effects for HIV-infected people, possibility of orphaned children, and HIV-infection of the child. *(Myer)* Men and women have different reasons for desiring children as concluded by the study in Nigeria,

which found that most males want children to inherit property while most females felt pressure from family members and relatives to have more children.

Similar independent predictors of fertility desire existed across studies. In Nigeria, younger age and fewer numbers of living children were the strongest correlates of fertility desire *(Awolude)*. Similar predictors existed for women in South Africa, as well as shorter durations of relationships, and longer time on ART. In Ethiopia, unmarried and divorced PLWHAs were more likely to desire marriage and children.

Findings on the changes in pregnancy desire related to duration on ART are inconclusive. In South Africa, longer time on ART is a strong independent predictor of fertility for women, but not for men. In Kenya, however, no strong relationship existed between fertility preference and duration on HAART. Changes in sexual activity, however, are related to duration on HAART in Kenya; the percentage of people who are sexually active increases as the duration on HAART increases.

The content of counseling sessions on future fertility varies across studies. In South Africa, few clients communicated future fertility desires with their health-care providers. In Kenya, discussions with family planning providers were concentrated around one method, the condom, and centered on prevention of pregnancy, while discussion on how to meet one's reproductive goals and PMTCT was barely mentioned. *(Sarna)*.

**Discussion Highlights**

- How to adequately address discordant partners who engage in unsafe sex and are reluctant to partner disclosure
- PLWHAs who wish to become pregnant require counseling regarding ARVs, conception, antenatal care and childbirth
- Need more provider training on PLWHAs' fertility desires
- Fertility issues must be discussed with both sexes, with the recognition that issues may be different for men and women
- Increased access to ARV (and meeting the demand) is critical in light of high numbers of PLWHAs desiring future children

## Summary of Breakout sessions

At the end of each day, participants were encouraged to join one of the three breakout sessions for **policy**, **research** and **evaluation**, or **program** and **service delivery**. Following is a summary of the discussions from each session followed by suggested recommendations.

**Breakout Session: Policy Considerations**

Participants identified the following questions as important to the policy process for integration or linking of reproductive health, family planning and HIV/AIDS programs and services.

- Do donor funding mechanisms encourage or discourage integration?
- How do health systems, particularly weak ones, factor into integration?
- How can policymakers better identify gaps?
- What types of policies exist on integration?
- What are the barriers that prevent policy at service delivery side?
- Many of us at program level don't know existence of policy at national level. Does the policy at the national level facilitate the programs and service delivery level?
- What are the long term implications for family planning support if funding is shifted entirely to HIV?
- What about the integration of youth-friendly services, since clinic-oriented services are unlikely to meet young people's needs?
- What are we actually talking about in terms of integration? Is it just family planning or comprehensive reproductive health package?
- How current are existing policies in terms of reality? How fragmented are these policies?
- Should policies exist for prevention AND care and treatment options?

**Discussion Highlights**

- Important for national governments to respond to international donors with resolve and authority and to integrate available international donor funds into existing health systems and programs, instead of the other

way around. As an example, Mozambique's response to PEPFAR funding, where the government forced PEPFAR programs to assimilate into its own health system.

- Local governments need to take more control and responsibility of their programs. Governments need to take ownership, accountability and make a solid commitment towards integration for it to be successful. If governments are to graduate from donor funds, they must make a transition to funding their own projects, the process which is not yet known.
- The ability, or lack thereof, of countries to operationalize policy needs to be acknowledged. The time it takes for countries to implement policies must be considered when suggesting new ones. Most countries lack an overall omnibus policy that drives the health system. It may be necessary to restructure entire public health policies in certain countries.
- Several challenges to integration exist, including the monitoring of policy to ensure implementation, well-funded vertical programs that hinder integration, weak or unfavorable Ministry of Health structures, and weak national health systems.

**Recommendations**

*Immediate steps* which can happen without official policies in place

- Examine successful national policies for detailed information on planning, mechanisms and challenges to adapt for use in other countries
- Review existing policies in each country before developing new ones
- Do a SWOT (*s*trengths, *w*eaknesses, *o*pportunities, *t*hreats) analysis in countries where integrated activities already exist
- Document best practices at all levels of integration
- Introduce more pilot integration programs to be used as evidence for scaling-up
- Include excluded groups (e.g., PLWHAs) in planning, implementation, monitoring and evaluation of activities

*Further research* to be done in areas that will impact policy change

- Cost-effectiveness of integrated programs
- Differences in integration between high and low HIV prevalence countries
- Partial versus full integration

*Knowledge transfer* of related integration issues to policy makers

- Procurement of reproductive health commodities
- Situation analysis regarding effectiveness of integrated programs
- Systems analysis
- Identify gaps in integration of programs
- Information on integration regarding controversial issues, such as youth sexual and reproductive health and rights and abortion

*A "pie in the sky" research project*

- Large scale longitudinal, multi-country research undertaking

**Breakout session: Research and Evaluation**

Participants addressed the following questions related to research and evaluation of integrated or linked reproductive health, family planning and HIV/AIDS programs and services.

- Do reproductive health, family planning, and HIV/AIDS programs naturally complement each other?
- Is there research to show that integrated RH/FP/HIV/AIDS services have an impact in encouraging good reproductive health and sexual behaviors?
- What are some of the similarities and differences in reproductive health and HIV clients' risk-taking behaviors? How does understanding risk-taking behaviors facilitate effective or efficient of service integration?
- Are more clients and/or different types of clients attracted to integrated programs?
- Will integrated services adequately address the needs of all clients including PLWHAs, especially in terms of their fertility desires?
- What communication messages should be developed to encourage clients to seek integrated services while ensuring a stigma-free setting?

*Discussion Highlights*

- Reproductive health, family planning, and HIV/AIDS programs do naturally complement each other and therefore opportunities for integration should exist. However, currently, there is not enough evidence on offering integrated programs and services, including an understanding of types of clients who may seek such services to fully know the impact of integration. More prospective studies yielding empirical evidence are needed.

- Though HIV acquisition and reproductive health issues, in particular, pregnancy, share a common behavior—unprotected sexual intercourse—there are profound epidemiological differences which impact clients' risk of acquisition and similarly reveal differences in RH/HIV clients' risk-taking behaviors. It is therefore important to take life-cycle approaches to understanding people's risks, needs, and desires. Furthermore, effectiveness and efficiency of integration is highly dependent upon the local context, particularly whether the HIV epidemic is generalized or localized.

- It is clear that integrating family planning services into existing services offered to PLWHAs is necessary. However, the efficacy of integrating HIV services into existing reproductive health and family planning services is not clear and more research is needed. Clients are not "empty vessels to pour services into" as one participant noted. Services must be tailored to meet clients' needs; integration may be appropriate in some contexts but inappropriate in others. It is important is to ensure a stigma-free setting for all clients irrespective of HIV status.

*Recommendations*

*Research priorities*

- Prospective research looking at outcomes of integration
- Best models of service integration and the most appropriate contexts for service integration
- Case-control studies conducted in a wide variety of contexts
- Future research that is not conducted in a vacuum. Researchers and programmers should work together to build more effective programs

*Research questions*

- How can we best meet the family planning needs of PLWHAs?
- What are the costs/benefits of service integration?
- What is the demand for RH or HIV services?
- What is the acceptability of integration for clients? For providers?
- What is the practicability of "one-stop shopping?"
- With specific regard to HIV, need better understanding of repeat VCT testing and the quality of rapid HIV tests in field settings.

*Program considerations*

- Monitoring and evaluation measurements should be used as evidence of programmatic effectiveness
- Targets to measure effectiveness and/or efficiency must be carefully considered.

*Resources*

- Budgetary systems must support integration.
- With any additional monetary resources, more trained personnel are needed to alleviate high workloads experienced by current health workers.
- In health worker training, generalization and not specialization must be emphasized. Facilities must be upgraded to accommodate new services brought about by integration.

**Breakout Session: Programs and Service Delivery**

Participants tackled the various definitions and nuances associated with integration versus linking and discussed the levels of program and service delivery needs.

*Discussion Highlights*

Integration means that clients can access HIV/AIDS services at family planning/reproductive health clinics and vice versa. This has both policy and service delivery implications.

*Integration advantages*

- Integration, especially in resource poor settings, provides a cost-effective means to provide a broad range of services to clients.

- The ability to access HIV/AIDS services at family planning/reproductive health clinics means that clients can avoid the stigma associated with accessing VCT clinics.

- Hospitals already integrate a plethora of health services, which makes it intuitive to move toward an integrated model of family planning/reproductive health and HIV/AIDS service delivery.

*Integration impediments*

- Recognizing the limitations in providing full program and service delivery integration, a specific package of integrated services should therefore be offered. That package of services would be tailored to the capacity of particular health facilities and would also be the most cost effective and beneficial combination of services for clients.

- Donors tend to finance vertical programs with distinct indicators and reporting requirements. To overcome this, governments should formulate their own policies on integration and secure buy-in from donors to support integrated programs.

*Human resources and quality of services*

- Key to integration is in-service training of providers to extend the range of their competencies, for example, training midwives to provide counseling on HIV/AIDS. However, it is important to question the feasibility of this approach. Are we asking too much of our providers? Burn out is a valid concern for many health providers who are already over-stretched and not in a position to manage additional clients.

- Provision of incentives to provide additional services, is of course, critical to retaining health workers, and governments need to be supported in this effort.

- It is important to get buy-in from providers by addressing their attitudes towards integration. Providers need to recognize the benefits of integration from the perspective of clients. They must be assured that the increased demand for their services will be offset by increased number of providers who will be able to deliver the services.

- Integration may also reduce workload by consolidating distinct monitoring and evaluation and financial reporting requirements. Currently, these indictors are reported separately for each program, which can cause a strain on human resources at health facilities and consequently, weaken overall health systems.

**Recommendations**

*General considerations*

- Research is still required, but the current evidence base is sufficient to support integration of family planning, reproductive health and HIV/AIDS programs.
- Integration has already proven to be cost effective in terms of human and financial resources.
- Not to begin the integration process now, risks missing critical opportunities.

*Resource constraints*

- Define what type of integration is possible given varying combinations of providers, facilities and support systems.
- An institutionalized framework for integration must also be developed through streamlined policies and implementation guidelines which should be articulated as “doable” action points. This is important in order to flexibly channel funds from donors and governments to integrated programs at the facility level.
- Donors must re-examine their reporting requirements which may be unrealistic and may ultimately weaken the ability of health systems to perform their primary function of service delivery.
- While integration needs to be locally contextualized across Africa, whatever form it takes it will require training of sufficient numbers of providers as well as collaboration and coordination to succeed.
- Integration is ultimately an iterative and dynamic process dependent on funding and personnel that are in a constant state of flux. The path to integration at the facility level should begin with small feasible steps, such as integrated provision of information about family planning, reproductive health and HIV/AIDS in one session by one provider.

- Throughout the integration process it is important not to compromise quality from the client and provider perspectives.
- Demand creation for integrated services must also be considered.

*Research considerations*

- Need to know more about integration in situations with limited human and financial resources at the facility level as well as the role private providers can play in achieving integration.
- More evidence on the cost effectiveness would also be helpful in order to convince donors to invest in integration.
- Need to know how to retain existing human resources when integrating, how to harmonize existing indicators and what the barriers are to integrated service provision at the community level through community-based workers in terms of sustainability of programs.

*M&E indicators*

- In terms of possible indicators it is suggested that routine health management information systems be utilized to the extent possible. In order to achieve this, it is important to look at how existing indicators can be used so as not to overburden staff with having to report new indicators to measure integration. Cross cutting indicators, such as "how many PLWHAs access family planning," should therefore be determined. We have to reflect on how many people access services, what the workload for providers might entail, how clients respond, and how the health system responds. While some traditional indicators could work, others may not.
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