Expanding integration of family planning into HIV care and treatment: lessons and best practices

Program Brief
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BACKGROUND

There is a very high rate of unintended pregnancy among HIV-infected women in sub-Saharan Africa.[1,2] Providing effective contraception to this group of women who want to delay or end childbearing would help them to plan their families, prevent mother-to-child transmission of HIV, and reduce maternal and newborn illness and death.

In the last few years, there has been a growing programmatic push in Kenya towards integrating family planning (FP) services into HIV care and treatment nationwide. The University of California, San Francisco (UCSF) and the Kenya Medical Research Institute (KEMRI) have played a critical role in the expansion of integrated services.

This Program Brief begins by reviewing the roles that UCSF and KEMRI have played in generating evidence of the effectiveness and cost-effectiveness of such integration, expanding services at the county level and nationwide, and supporting national and global leadership on integration. It then presents a set of lessons learned and best practices for scaling up FP/HIV integration.

THE FIRST RANDOMIZED CONTROLLED TRIAL OF FP/HIV INTEGRATION

UCSF and KEMRI conducted the first cluster randomized controlled trial (RCT) of FP/HIV integration. The study took place in the Nyanza Region of Kenya between 2009 and 2011.

In the trial, clinics were randomized to integrated FP/HIV services (the intervention) or non-integrated services (control). At integrated clinics, women with HIV who wanted contraception received it during routine HIV care—along the lines of a "one-stop shop." At the control sites, women who wanted contraception were referred to FP clinics at the same facility.

The researchers that found that integrating FP into HIV care and treatment was associated with a higher proportion of women using more effective contraception (hormonal methods, intrauterine device, or sterilization).[3] The study also found that integration was cost-efficient and cost-effective,[4] and that acceptability of integration was high among female and male patients and health care providers.[5–9] The trial results suggest that integration is a promising approach to increase the use of more effective contraception among HIV-positive women.

EXPANDING SERVICES AT THE COUNTY LEVEL

After completion of the study, the Kenyan Ministry of Health (MoH), with support from the Family AIDS Care & Education Services (FACES) technical team, a collaboration between UCSF and KEMRI,[10] successfully integrated 92% of the 140 FACES-supported health facilities in Kisumu, Homa Bay, and Migori Counties. This process of county level integration began in 2012.

Following integration of services, the use of more effective contraception increased program-wide. Between July 2012 and June 2014, the proportion of HIV-infected women who were using a more effective contraceptive increased from 42% to 60%.

ADVOCACY AND LEADERSHIP AT THE NATIONAL LEVEL

UCSF and KEMRI have worked with the Kenya Reproductive Health and HIV Integration Technical Working Groups to strengthen governmental systems for FP and HIV care and treatment service integration in Kenya.

This work included the development of the Minimum Package for Reproductive Health (RH) and HIV Integrated Services.[11] The minimum package is a set of recommendations to implementers or service providers on the minimum requirements (human

resources, infrastructure, training materials, etc.) for effective integrated service provision. The goal of the package is to operationalize Kenya's National RH-HIV Integration Strategy,[11] with four specific objectives:

- To outline a basic set of RH-HIV interventions/services to be integrated at various levels
- To provide guidance on basic service provision requirements for integrated RH-HIV services
- To standardize the provision of integrated RH-HIV services
- To increase access to and uptake of integrated RH-HIV services.

SHARING KENYAN LEADERSHIP GLOBALLY

At the international level, UCSF and KEMRI have shared their experiences through participation at key meetings, including hosting and presenting at the Integration for Impact Conference in Nairobi, Kenya in September 2012 (the agenda is at http://integrationforimpact.org/agenda). They also presented their findings at other international scientific meetings, including the International Conferences on Family Planning held in Dakar, Senegal in 2011, and Addis Ababa, Ethiopia in 2013.

UCSF, KEMRI, and the Kenyan MoH have developed information-sharing partnerships with Tanzania and Zambia. During meetings and site visits, best practices were shared including strategies to (i) sustain and scale up FP-HIV integration beyond model sites and research, (ii) implement monitoring and evaluation indicators, (ii) engage the community, and (iv) enhance coordination between government and partner organizations.

UCSF and KEMRI also developed and distributed a Policy Brief[a] to high level officials in the United States, including to members of the Sexual Reproductive Health (SRH)-HIV Interagency Working Group (IAWG). The IAWG is co-chaired by the United National Population Fund (UNFPA), the World Health Organization (WHO) and International Planned Parenthood Federation (IPPF) and has a membership of 23 organizations working in the field of SRH and HIV linkages.[b]

Finally, UCSF and KEMRI presented on a panel event entitled "Integration Works for Women" at the Elizabeth Glaser Pediatric AIDS Foundation in Washington, DC. The event was attended by about 25 representatives of government and advocacy organizations in both the HIV and reproductive health areas.

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a Available at http://globalhealthsciences.ucsf.edu/sites/default/files/content/ghg/e2pi-integrating-fp-into-hiv-services.pdf

b DfID, EngenderHealth, FHI360, Guttmacher, ICAP, ICS Support, ICW, Institute for Global Health, International HIV/AIDS Alliance, International Initiative for Impact Evaluation (3ie), IPPF, PATH, Population Council, Global Fund to Fight AIDS, TB and Malaria, GNP+, PEPFAR, UCSF, UNAIDS, UNDP, UNFPA, USAID, WHO and the World Bank

LESSONS LEARNED AND BEST PRACTICES

Based on the results of the RCT, and on experience scaling up integration of FP services into HIV care and treatment at county and national level, a number of lessons have been learned on the critical steps to achieving successful integration.

The following ten steps help facilitate the successful scale up of FP and HIV service integration, which in turn enhances clients' options for FP in terms of choice and ease of access.

TEN STEPS TO INTEGRATE FAMILY PLANNING AND HIV CARE SERVICES

1. **Form a multidisciplinary team**
   a. Engage the County Health Management Team, facility leaders, clinicians, pharmaceutical and laboratory technicians, community health workers, and community members living with HIV
   b. Assign roles and responsibilities

2. **Engage community**
   a. Identify key community health workers, teachers, religious leaders, chiefs, and other key community stakeholders
   b. Provide basic training on FP and HIV integration
   c. Encourage outreach activities

3. **Assess capacity of the facility to integrate**
   a. Conduct inventory of staffing, space, equipment, and supplies
   b. Measure level of skills, knowledge, and training needs of the health care workers

4. **Train all facility health care workers**
   a. FP counseling
   b. Overview of, and practical training on, short and long term FP methods
   c. Safer conception practices
   d. Inventory management
   e. Clinic logistics (flow of clinic, roles, and responsibilities)

5. **Provide logistical support**
   a. Determine contraceptive methods to integrate into HIV care (short-term, long-acting reversible contraception, and/or permanent contraception)
   b. Identify referral points
   c. Develop flow chart of clinic activities
   d. Rearrange facility to provide sufficient privacy, space, and equipment
   e. Provide necessary supplies, commodities, equipment, and tools for documentation
   f. Ensure sufficient staffing

6. **Educate and counsel clients**
   a. Deliver health talks by male and female clinicians, lay counselors, and clients
   b. Provide individual and couple counseling
   c. Distribute culturally appropriate information, education, and communication (IEC) materials

7. **Reinforce commodity security**
   a. Strengthen commodity delivery systems
   b. Document contraception usage
   c. Ensure timely reporting of consumption data and proper ordering, receipt, storage, and use of commodities

8. **Service provision**
   a. Provide a range of short, long-term, and permanent methods
   b. Schedule HIV care and FP follow-up visits on the same day
   c. Document contraception initiation and continuation on patient records as well as referrals

9. **Conduct monitoring and evaluation**
   a. Monitor rates of contraception initiation, switches and continuation
   b. Evaluate percent distribution of contraceptive users by family planning method

10. **Provide supportive supervision**
   a. Provide ongoing mentorship to achieve and maintain provider proficiency
   b. Conduct regular meetings with key community stakeholders and with patient advisory groups
   c. Revise IEC materials to address emerging concerns in the community

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AUTHORS

This program brief was written by Daniel Grossman, Craig Cohen, Rachel Steinfeld, and Gavin Yamey. Daniel Grossman is Vice President for Research at Ibis Reproductive Health, Oakland, California, USA, and is also Assistant Clinical Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at University of California, San Francisco (UCSF), USA. Craig Cohen is Professor In-Residence in the Department of Obstetrics, Gynecology & Reproductive Sciences at UCSF, the Director of Family AIDS Care and Education Services (FACES), and the Director of the UC Global Health Institute GloCal Health Fellowship and the UCSF Reproductive Infectious Disease Fellowship. Rachel Steinfeld is the FACES Reaearch Coordinator. Gavin Yamey leads the Evidence to Policy initiative in the Global Health Group at UCSF.