Family Planning–Integrated HIV Services: A Framework for Integrating Family Planning and Antiretroviral Therapy Services

June 2007

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This publication was made possible by the generous support of the American people through the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID or of the United States government.

The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a collaborative project funded by USAID and managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA). The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based and clinical care.

Printed in the United States of America. Printed on recycled paper.

Suggested citation: Farrell, B. L. 2007. *Family planning–integrated HIV services: A framework for integrating family planning and antiretroviral therapy services.* New York: EngenderHealth/The ACQUIRE Project.

Contents

Abbreviations/Acronyms

ART	antiretroviral therapy
ARV	antiretroviral
BCC	behavior change communications
CDC	Centers for Disease Control and Prevention
CPI	client-provider interaction
DMU	Dual method use
FP	family planning
IEC	information, education, and communication
IUD	intrauterine device
LAM	Lactational Amenorrhea Method
LAPM	long-acting and permanent method
MTCT	mother-to-child transmission of HIV
OI	opportunistic infection
PLHIV	persons living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
RH	reproductive health
SDG	service-delivery guidelines
SDM	Standard Days Method
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing

Acknowledgments

The principal writer of this document was Betty L. Farrell, with support from contributing writers Alyson Smith and Laura Subramanian.

Special thanks are extended to the EngenderHealth and ACQUIRE Project staff who so generously contributed their time, talent, and expertise in the reviews of this document. The authors would also like to thank Mary Ann Abeyta-Behnke, Senior RH/FP and HIV/AIDS Integration Advisor at the U.S. Agency for International Development (USAID), and Carolyn Curtis, the ACQUIRE Project's cognizant technical officer at USAID, for their valuable feedback on this document.

Michael Klitsch provided editorial management, along with comments on earlier versions. Elkin Konuk formatted the final publication.

Publication of this document was made possible through financial support provided by the American people through USAID.

Foreword: Family Planning–Integrated HIV Services

This document was developed for three main purposes: a) to stimulate critical thinking regarding programmatic gaps related to the reproductive health needs of women and couples living with HIV; b) to examine the HIV assessment, prevention, and referral needs of family planning (FP) clients; and c) to assist community and facility-based reproductive health (RH) providers and supervisors in tailoring services to reflect the integration needs of the communities they serve. Based on demand from the field, this document is the first in a planned series regarding the integration of FP into a range of RH services. This first segment of the series focuses on the integration of FP services with HIV services, specifically antiretroviral therapy (ART). The ACQUIRE Project plans to field-test this document among program colleagues interested in integration in Bolivia, Ghana, and Uganda.

Based on a literature review and on lessons learned from worldwide programmatic efforts to integrate services, this document aims to maximize the synergies between HIV and FP services through the prevention of unintended pregnancies as well as the achievement of desired pregnancies with optimal outcomes. This approach is consistent with a rights-based approach for informed decision making. The programmatic considerations offered within this document are consistent with and link FP with the United Nations' four elements for preventing mother-to-child transmission:

- Prevention of HIV, especially among young people and pregnant women
- Prevention of unintended pregnancies among HIV-positive women
- Prevention of HIV transmission from HIV-positive women to their infants
- Provision of treatment, care, and support to HIV-positive women and their families

This document focuses on FP integration with HIV services, more specifically with HIV care and treatment services. It encourages supervisors or planners, service providers, and community-based personnel to consider opportunities for operationalizing client-responsive integration of FP and HIV services. The document is divided into three sections: background; systems considerations; and integration in action. As such, the document can be used to develop an understanding of the concept of integration, to identify and address policy and systems considerations for integration, and to begin thinking about ways to assess capacity for and approach FP integration within ART services.

This document is primarily for:

- ❑ Ministry of Health planners, and policy makers
- ❑ District- or site-level program managers, supervisors, and trainers
- ❑ International and local nongovernmental organizations
- ❑ U.S. Agency for International Development (USAID) colleagues in Washington and in country missions
- ❑ EngenderHealth field staff providing technical assistance for FP and HIV programs

Secondary audiences for this document would include:

- ❑ Service providers (facility- and community-based)

Section I: Background

Before undertaking integration of family planning (FP) and HIV services, it is necessary to develop an understanding of the background, rationale, and relevant considerations for integration. This section provides an introduction to the concept of integration; a summary of the relevant literature regarding integrated FP and HIV services; a description of features, benefits, and challenges of FP– integrated HIV services; a guide for thinking about service-entry points for integration; and a description of various levels of FP integration that can be adopted at service sites.

Introduction

For more than a decade, attempts have been made to integrate FP with a variety of services—e.g., with the management of sexually transmitted infections (STIs), and currently with HIV services (prevention and risk reduction counseling; voluntary counseling and testing [VCT]; prevention of mother-to-child transmission [PMTCT], and antiretroviral therapy [ART]). International attention to HIV has overshadowed attention to FP, especially in Africa, where the HIV epidemic is most acute (Strachan et al., 2004). The key role that FP plays in HIV prevention has been only minimally acknowledged until recently.

There are approximately 20 million women of childbearing age living with HIV for whom FP plays an important role in limiting the epidemic. As the availability of ART increases and their quality of health and life improves, their need for contraception will become more pressing. The persistent "unmet need" for FP in general, with the increasing demand for FP by HIV-positive individuals living longer, requires that FP information and services be provided within HIV services—from voluntary counseling to testing to care and treatment. In a recent study in Uganda by the Centers for Disease Control and Prevention (CDC), pregnancies were occurring among ART users who did not want any more children (97%), among women who were not planning to have more children at the time (99%), and among women who said that their partners did not want more children either (79%) (Smart, 2006).

The stigma that HIV-positive individuals face frequently affects their decision-making process when it comes to accessing HIV and FP services. For example, individuals may not access VCT or HIV services because they fear negative social consequences. A client's concern about being stigmatized or judged by a provider can cause her/him to refrain from discussing certain issues (such as reproductive intentions) or to withhold her/his HIV status. Personal bias on the part of a provider may act as a barrier to providing either FP methods to persons living with HIV (PLHIV) or HIV counseling and services to FP clients. In some settings, providers have been known to coerce PLHIV by threatening to withhold treatment unless they agree to use a provider-dependent FP method (e.g., surgical contraception). Discussing sexual behavior is another obstacle for both providers and clients, especially when trust is limited and discussion of sexual matters is not the cultural norm.

Gender relations and community attitudes play a significant role in influencing an individual's decision-making process regarding contraceptive use with HIV. Decisions to use FP or dual protection may cause a spouse or partner to become suspicious; this can often lead to negative or violent outcomes within a relationship. Negative associations with condom use can impact the negotiating power of an

HIV-positive individual with her/his partner. Stigma reduction and couples communication are therefore vital programmatic considerations for initiating and sustaining behavior change.

How best to provide FP and HIV services in an efficient, client-responsive way continues to be challenging. There is concern among health care decision makers for providing effective services without diluting the goal of each of these two components of health care. This challenge becomes more acute in resource-constrained settings.

The ACQUIRE Project is committed to integrating FP within reproductive health (RH) services, by strengthening the existing FP component, by revitalizing the FP element within a care package (e.g., postabortion care), and by introducing FP linkage where it has not been previously operationalized, as in HIV services. Integration of FP within HIV services is just one aspect of the larger model of integration that the ACQUIRE Project is addressing. ACQUIRE's approach focuses on the multiple facets that contribute to successful program design, including service-delivery systems, providers, clients, and tailored decision making based on a given context. This approach is embedded into the integration framework, which is built upon ACQUIRE's Fundamentals of Care (i.e., informed choice, clinical safety, and an ongoing mechanism for quality improvement) (The ACQUIRE Project, 2005). The ACQUIRE programming process uses current data for decision making, assesses the context in which services will be provided, and provides support to facility- and community-based service-delivery systems for the provision of client-responsive, quality services.

Summary of the Literature

The international health community is increasingly taking steps to address the integration of FP within HIV services (and vice versa). Due to this increased consideration for integration, the body of evidence that explicitly speaks to integrated FP and HIV programming is growing. Much of the current literature consists of research studies focusing on the attitudes and behaviors of HIV-positive individuals, research studies concerning the medical effects of contraceptive use by HIV-positive individuals, and documentation of pilot projects. A rights-based framework often provides the foundational starting point for much of the literature concerning HIV-positive individuals.

Key themes emerging from the literature include:

- The stigma of HIV/AIDS plays a significant role both in client-provider interactions and in community dynamics.
- Clients have the right to make informed decisions and access complete, accurate information.
- Providers may be hesitant to provide integrated services due to their own biases and lack of information.
- An increase in ART use tends to lead to an increase in sexual activity.
- Many HIV-positive women (and men) would like to have children or to have more children.
- FP offers the benefit of delaying pregnancy to optimize maternal health.
- The parallel funding mechanisms for HIV/AIDS and FP often cause obstacles for integration.
- FP use by HIV-positive individuals can prevent both unintended pregnancy and mother-to-child transmission of HIV.
- Women often carry the burden of knowing their HIV status as a proxy for men's status and frequently hold the responsibility for a couple's FP needs.

Gender relations and the cultural/community context play a role in HIV-positive individuals' disclosure of HIV status and in their uptake of FP or their use of dual protection.

People living with HIV/AIDS must be consulted and involved throughout the program cycle.

Integrating HIV into FP programming presents an opportunity for providing information to HIV-negative individuals on how to stay that way and allows for HIV messages to reach married women, who are frequently less exposed to them.

These key themes play a vital role in the creation of holistic programming for integrated FP and HIV services; thus, consideration of all of these issues is woven into this document.

An existing gap in the literature is the dearth of programmatic documentation and evidence necessary to contribute to the larger body of advocacy and research material. As more organizations prioritize integrated programming, further data and evidence will emerge to reduce this gap; additional programmatic documentation and findings on lessons learned will also facilitate the creation of a standardized menu of best practices.

A joint EngenderHealth/United Nations Population Fund (UNFPA) project literature review—*Sexual and Reproductive Health for HIV-Positive Women: Literature Review/Annotated Bibliography*—was completed in December 2004, and Info Reports "Focus on…Integrated Family Planning and HIV/AIDS Services", July 2006, Issue No. 6, can be referenced for more extensive information. A list of references/ bibliography is also included here, in Appendix E.

Integrated Services: Features, Benefits, and Challenges

Integration is an approach in which health care providers use opportunities to engage the client in addressing broader health and social needs than those prompting the health encounter. Integration provides anticipatory assessment and plans and evaluates services relevant to the clients' desires, needs, and/or risks.

When the integration approach is applied to FP and HIV services, the goal is to provide comprehensive HIV prevention, counseling and testing, and treatment in which FP is an integral component of care. Consequently, the FP component of care will reflect the unique needs of HIV-positive individuals to improve sexual and reproductive health (SRH) outcomes (e.g., fertility decision making, contraceptive options in relation to HIV status, and use of antiretroviral drugs or drugs to treat opportunistic infections [OIs]). The FP component of care will address the needs of HIV-negative individuals to prevent infection while achieving their desired fertility goals. The integration approach also incorporates HIV client risk assessment, counseling, and referral for HIV services as an integral component of FP services.

Very often, integrated services create an image of a facility where a client could have all of her/his health needs met during one encounter; this may not necessarily be feasible or appropriate, however, depending on the service's capacity. FP-integrated HIV services may be offered at the same facility or location during the same operating hours. FP-integrated HIV services may also be offered by the same provider in one visit, or "the provider of one service would actively encourage the client to consider using the other service during that same visit," if the needed services are beyond the capacity of the facility or the skills set of the attending provider (Foreit et al., 2002). However, for integration to be

effective as described, an effective referral system *must* be in place to provide accessible and affordable coordinated care.

Below is a list of basic features characterizing FP-integrated HIV services.

Features of FP-Integrated HIV Services

FP-integrated HIV services are characterized by a range of client-provider interactions that incorporate fertility management within the context of HIV services. These would include:

- ☞ Provision of FP information, counseling, risk assessment, and behavior change communications (BCC) for informed decision making
- ☞ Health monitoring (history-taking, fertility desire/pregnancy risk assessment, physical assessment, including essential laboratory services when indicated)
- ☞ Treatment procedures that may include referral and provision of medications and/or FP commodities

Benefits and Challenges of FP-Integrated HIV Service Delivery

The *benefits* of incorporating FP into existing HIV services include that such an approach:

- ☑ Offers contraception as an integral part of comprehensive, client-centered HIV services, particularly during posttest counseling or over time, depending on the client's receptivity.
- ☑ Offers options for preventing unintended pregnancies to HIV-positive clients (using/not using ART), and as a part of PMTCT services.
- ☑ Provides preconception counseling, to optimize positive health outcomes
- ☑ Increases the pool of people who might not normally be reached through traditional FP clinics—e.g., youth (single and married), men, commercial sex workers, men who have sex with men but who also have female partners, and injecting drug users.
- ☑ Expands providers' skills set to improve their performance of required tasks.
- ☑ Can diminish the referral barriers to accessing FP information and methods, especially where a trusting rapport has already been established. (Where referral is the integration modality, it can strengthen the coordination between two units to increase access to FP information and services.)
- ☑ Can increase staff's job satisfaction because they are comprehensively addressing their clients' needs.
- ☑ Where ART is available, supports women's access to a wider variety of treatment options without the fear of pregnancy and potential fetal damage.
- ☑ Can help clients use condoms more consistently and effectively with both regular and casual partners.
- ☑ Can provide information about dual protection by offering counseling, instructions for the dual methods chosen, and provision of both methods in one setting or during one client-provider encounter.
- ☑ Makes it convenient for clients to initiate dual method use.
- ☑ Ensures that the risk of HIV and AIDS is considered as part of making informed FP decisions.

The *challenges* of incorporating FP into existing HIV services include that such an approach:

- ☒ Adds time to counseling encounters, can increase workload, and can increase client waiting time, particularly when staffing levels are low.
- ☒ Requires health personnel who provide HIV services to acquire knowledge and develop new skills.
- ☒ Requires facilities to incorporate FP into their record keeping, activity reporting, commodities logistics, and management of services consistent with the types of methods provided.
- ☒ May make monitoring of quality or performance improvement more difficult (depending on the approach to service delivery).
- ☒ Requires buy-in on the part of providers and minimization of any existing provider bias prior to integration.
- ☒ Requires establishment of new provider partnerships (e.g., FP providers will need to consult with HIV care providers, and case management will demand consultation between nurses, physicians, and PLHIV).
- ☒ Requires adequate assessment of male and female community members' and PLHIV networks' attitudes regarding FP in general, specific FP methods, and their use in the presence of HIV.
- ☒ Requires creating FP messages and materials that address the needs of an HIV-positive population.
- ☒ May overload the client with information they are not able to absorb, when FP is added to posttest counseling.

"Thinking Integration": Service Entry Points

In terms of integration, potential points at which client-tailored information and services can be provided or recommended emerge along a continuum of care. As mentioned earlier, an integrated approach engages the client in addressing her/his broader health and or social needs besides those that prompted the health encounter. The chart that follows identifies points at which the individual's contact with the health system can facilitate access to FP and HIV information and services.

To use this chart:

- ▸ Read across the shaded top row to view the range of integrated FP and HIV information and services that can be performed.
- ▸ Read down the colored left-hand column to identify a potential point at which the client may enter the health care system.
- ▸ Then read along the entry point to see the range of FP and HIV information and services that can be provided, depending on the client's needs.

For example, a client entering antenatal care could be offered FP information; HIV information; sexuality information (particularly if she is young); FP counseling, including her partner if she is interested in postnatal FP; HIV prevention and/or risk-reduction counseling; counseling and negotiations skills-building for use of condoms; referral for VCT as part of PMTCT; provision of ARV medications, if indicated; and referral for other FP/RH health services for which a need has been identified.

"Here Where I Enter"
Points of Entry for FP- Integrated HIV Information and Services

	Provide FP-related IEC/BCC	Provide HIV-related IEC/BCC	Provide sexuality education	Assess for risk of unintended pregnancy and for HIV	Provide FP counseling (couples counseling, where feasible)	Provide FP methods, including dual protection	Provide HIV prevention/risk reduction counseling (couples counseling, where feasible)	Provide counseling for condom use (condom negotiation skills)	Refer to VCT service	Accept referrals for VCT	Provide FP as part of ART	Refer to FP or other RH services
Community public health sector services	✓	✓	✓	✓	✓	✓ Condoms, combined oral contraceptives, injectables	✓	✓	✓			✓
Community services (traditional practitioners, faith-based organizations)	✓	✓	✓	✓	✓	✓ as above, plus Standard Days Method (SDM)	✓	✓	✓			✓
Primary level of health care (mobile, static)												
Antenatal care	✓	✓	✓		✓		✓	✓	✓		✓ PMTCT	✓
Postnatal care	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Postabortion care	✓	✓	✓	✓	✓	✓	✓ *(second visit)*	✓	✓			✓
FP	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Syndromic STI management	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Child health, Immunization, nutrition	✓	✓		✓	✓	✓	✓	✓	✓		✓ as part of PMTCT	✓
Malaria prevention and management	✓	✓		✓	✓	✓	✓	✓	✓			✓
Management of minor ailments	✓	✓		✓	✓	✓	✓	✓	✓			✓
Secondary level of health care												
Reproductive tract infection management (etiologic)	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓

	Provide FP-related IEC/BCC	Provide HIV-related IEC/BCC	Provide sexuality education	Assess for risk of unintended pregnancy and for HIV	Provide FP counseling (couples counseling, where feasible)	Provide FP methods, including dual protection	Provide HIV prevention/risk reduction counseling (couples counseling, where feasible)	Provide counseling for condom use (condom negotiation skills)	Refer to VCT service	Accept referrals for VCT	Provide FP as part of ART	Refer to FP or other RH services
HIV testing services	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓
Labor/delivery						✓ Postpartum IUD; postpartum voluntary sterilization with prior informed consent	✓	✓	✓			✓
Obstetric emergencies												✓
Postnatal ward	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Permanent methods	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Fistula prevention and repair	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Medical services (e.g.,	✓	✓		✓	✓	✓	✓	✓	✓			✓
—Tubercu-losis: Diagnosis, treatment, monitoring	✓	✓		✓	✓	✓	✓	✓	✓		✓ or as part of tuberculosis treatment	✓
—ART: Lifestyle and life planning/ health counseling, laboratory monitoring, drug provision	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Orphans and vulnerable children	✓	✓	✓ and support delay of sexual debut	✓ and for sexual abuse or exploitation	✓ if in a relationship	✓ if already sexually active	✓ if already sexually active	✓ if already sexually active	✓			✓

Levels of Integration for Facility-Based Services

To make the process of integration manageable and practical, we can examine the range of levels for integrating FP into HIV services. FP-integrated HIV care and treatment services need to be appropriate to the setting and resources. Facilities/programs can aim for a progressive range of integrated services, depending on their capabilities and resources.

On the next page is a program model chart of five possible levels for integrating FP with HIV services. Though the ACQUIRE Project's focus is on strengthening facility-based services, these levels of integrated services can be offered through mobile service mechanisms; Levels A through C can be offered by community- and/or home-based personnel (see Appendix A for detailed descriptions of service cadres and tasks for each integration level).

Levels of Integrating FP into HIV Services for Onsite Provision of Contraceptive Information, Counseling, and Methods Options

Level A	Level B	Level C	Level D	Level E
Provides all of the following functions: Provides FP information to clients accessing ART, PMTCT, STI, VCT, and tuberculosis services. Performs risk/intention assessment for pregnancy or spacing. Counsels on FP methods, methods' ability to prevent STI and HIV infection, method choices available and where to access, dual protection, and potential drug interactions with hormonal methods. Provides condoms, instructs for and demonstrates correct use. Provides emergency contraceptive pills.* Refers for other methods not offered onsite.	***Provides all Level A functions plus:*** Provides oral contraceptives* with instructions for use. Provides follow-up or refers for follow-up. Counsels on potential drug interactions with oral contraceptives.	***Provides all Level B functions plus:*** Provides injectable contraception, with instructions for use, and with caution to return on schedule for reinjection without delay. Provides follow-up or refers for follow-up.	***Provides all Level C functions plus:*** Provides intrauterine device (IUD), with instructions for use. Provides implant, with instructions for use. Provides follow-up or refers for follow-up.	***Provides all Level D functions plus:*** Provides surgical contraceptive methods, with instructions for self-care, and provides follow-up.

* If facilities or programs providing Level A functions are not *immediately* prepared to provide oral contraceptives for ongoing uses, they may provide emergency contraceptive pills with referral for ongoing FP management. If the facility or program already provides oral contraceptives (Level B), it can also offer emergency contraceptive pills.

Section II: Systems Considerations for Integration

With an understanding of the concept of integration in relation to FP and HIV services, we now move to a description of systems considerations for FP-integrated HIV services. This section provides an overview of policy, service-delivery, and community requirements for operationalizing integration, as well as a description of selected systems to support FP-integrated HIV services.

Looking Broadly at Support for Operationalizing Integration

Operationalizing integration requires support on at least four levels:

1. *Integration at the Policy Level:* The FP or HIV services would coordinate and jointly plan service-delivery guidance to achieve integration of FP and HIV services throughout the health structure.
2. *Integration at the Program Level*: The FP or HIV services would be incorporated into existing activities at the central, regional, and district levels of planning for management of services, human resource management, and finances.
3. *Integration at the Service Site Level:* The FP or HIV service providers would be trained to incorporate the following skills: risk assessment, counseling, provision of contraceptives, and management of side effects and complications; referral for contraceptives not provided at the HIV services site; preconception counseling and consultation with client's HIV care provider; and/or referral for HIV service components not provided at the FP site.
4. *Integration at the Client and Community Level:* The FP or HIV services would reflect responsiveness to clients' and communities' needs for integrating fertility management and HIV prevention, detection, and treatment activities.

Now that we have looked at these key levels of FP integration with HIV services and the operational levels at which integration needs to take place, we will focus on the policy/programmatic, service-delivery, and community-level considerations that are necessary for integration planning. In this section, we pose questions to provoke thought for deciding the appropriateness and feasibility of integration. These questions do not represent an exhaustive list of points for consideration; you will most likely generate additional questions related to your setting.

Policy and Programmatic Support for Integration

For FP-integrated HIV services to function effectively and efficiently, policies must provide guidance to the administrative and service-delivery levels of the health care system. An illustrative list of policy and programming requirements appears at the top of page 12.

Questions for consideration at the policy level might include:

What policies and protocols (programmatic, financial, and management) need to be modified to facilitate integration and maximize clients' access to integrated services, particularly for youth, for low-income individuals, and for unmarried persons.

Where would the overall responsibility lie for support of integrated services, with FP or HIV?

What roles do the existing gender norms play in contributing to low uptake of FP or HIV services? What policy statement can be created to address these dynamics?

How best do we integrate services for men?

In areas where the main mode of HIV transmission is through injecting drug use, what policies are needed to facilitate FP-integration into HIV services?

Illustrative Policy and Programming Requirements for Integrating FP and HIV Services

Policy and programming requirements might include the following:

- ☑ Articulation of the standard of care to give technical guidance for:
  - staff performance and staff training;
  - standards of FP-integrated services to be offered at each level of service delivery, including partner notification, where operational or feasible;
  - service record keeping;
  - availability of essential drugs, commodities, and supplies.
- ☑ Articulation of the standard for engaging gender considerations of male and female clients within service delivery and in the creation of IEC/BCC materials.
- ☑ Articulation of the FP-integrated HIV service tasks for each cadre of health personnel and nonhealth personnel, facility- and community-based.
- ☑ Articulation of the standard of FP-integrated HIV content for preservice training of health personnel.
- ☑ Establishment of the standard for supervision and management of integrated services (reflected in assessment and monitoring tools).
- ☑ Establishment of budgetary allocations to support integrated services.

Adapted from: Foreit et al., 2002, p. 74.

Requirements for Delivering Integrated Services

Requirements for quality FP-integrated HIV services should be met in static, home-based, and mobile delivery mechanisms. The ACQUIRE model for quality is the Fundamentals of Care, which are composed of three elements:

I. ***Ensuring informed and voluntary decision making.*** This is the process by which an individual arrives at a decision about health care based on knowledge of the available options and on access to and understanding of complete, up-to-date information. To make an informed choice about reproductive health, a client must have access to service options and receive and understand the information relevant to making a decision, as well as the consequences of the actions being considered. Through effective client-provider interaction and appropriate counseling and referral, providers enable a voluntary decision-making process.

II. ***Assuring safety for clinical techniques and procedures.*** Clinical safety is a critical issue for both clients and providers and refers to the procedures that are conducted and the clinical environment in which they are carried out. Clinical techniques and procedures are considered safe when skilled providers practice in accordance with updated, evidence-based standards, guidelines, and infection prevention protocols, within a physical structure appropriate for managing clinical services.

III. ***Institutionalizing a mechanism for ongoing quality improvement and assurance***.

Ensuring high-quality services is a continuous process requiring strong management, quality assurance, and supervision systems that create an enabling and supportive environment. Quality improvement/performance improvement/participatory learning and action tools can guide the establishment of such mechanisms and their implementation. Providers, managers, supervisors, communities, and clients all have essential roles to play in effective quality assurance processes.

More details on the Fundamentals of Care can be accessed on the ACQUIRE Project website at www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/ACQUIRE_Knowledge_FOC_final.pdf.

Illustrative FP-Integrated HIV Service-Delivery Requirements

- ☑ Service-delivery guidelines for management, supervision, and service provider functions that are informed by policies.
- ☑ Staff trained in FP as part of HIV counseling, STI management, and maternal and child health services, as well as oriented to the scope of integrated services for their setting.
- ☑ IEC/BCC materials that include dual protection messages.
- ☑ Expanded and/or strengthened referral systems to facilitate clients' access to FP methods not provided onsite, to other health services, and to social and legal support services, with a built-in feedback mechanism to the referring provider/facility, when appropriate.
- ☑ Supervisory tools reflecting standards for FP-integrated HIV services.
- ☑ Service-delivery statistical reporting forms reflecting activities for FP-integrated HIV services.
- ☑ Commodities acquisition and storage guidelines consistent with the chosen level of FP-HIV integration.
- ☑ Essential drug list reflecting FP-HIV integration (FP methods, instruments, and supplies; HIV screening supplies; antiretroviral medications; medications for the prevention and treatment of OIs; and laboratory agents and supplies).
- ☑ Facility physical structure conducive to privacy, client flow, and the accommodation of additional equipment and supplies, or facility structure with the capacity to be modified to achieve these ends.

Note: In some settings, ongoing ART services are supported by periodic mobile medication delivery and follow-up. During these encounters, clients' health and psychosocial well-being are assessed between facility-based visits for laboratory monitoring and medical management. In this service-delivery approach, FP may also be incorporated in the existing counseling, as well as provision of FP methods, depending on the cadre of staff; the equipment, drugs, and supplies available; the space available (room, privacy); and the client volume per mobile visit period. Mobile services would also make referrals to FP sites for methods that they or the ART sites are not able to provide.

Questions for consideration at the service-delivery level may include:

What needs to be done at the facility-based service-delivery level to establish and maintain user-friendly integrated services for women/men/couples/youth?

What might be done within integrated services to help streamline commodity logistics management?

How would the organization of work need to be changed to accommodate FP counseling and method provision?

Community and Community-Based Integrated Services

The ACQUIRE integration model builds on community collaboration to inform the design of facility-based services. The community plays a crucial role in the dissemination of information by influencing behavior, including the use or nonuse of facility-based services. Where they exist, networks of PLHIV are one of the key community resources. These networks bring realistic considerations of the needs of PLHIV to ensure that plans for services will achieve the intended goal. It is through ongoing dialogue with the community, including PLHIV networks, that health care decision makers, health service managers, supervisors, and facility and community-based providers can tailor service delivery to meet the expressed needs for integrated services.

Community-based personnel may include individuals who have been identified by their communities and trained to provide psychosocial support to persons using HIV services. They may also be community-based workers who have formal or informal links with ministries (e.g., health, labor, gender) and who have been trained to include HIV prevention messages and some level of risk assessment for referral to VCT or PMTCT services. Community-based workers have long been involved in providing FP services beyond the confines of clinics and health centers. Community health workers may or may not receive salaries or stipends, but facility-based staff or the relevant ministry personnel to whom they have an operational link usually provide some supervision.

A component of the community that cannot be ignored is men. Gender roles impact women's decision making and their ability to act on their decisions. Partner engagement and support is desirable for women to successfully exercise their fertility intentions, including their preference for FP method(s). Engaging men in FP-integrated HIV services is critical for ensuring the well-being of both women and men, in supporting effective communication between partners, in minimizing risk of disease transmission, and for planning and supporting sustained behavior change for healthy living. For men to benefit from FP-integrated HIV services, programming must include male representation through PLHIV networks and community outreach and must gather perspectives on ways to help men gain access to information, counseling, and services in a manner that promotes a caring and protective role for themselves and their families. Actively engaging men can inform approaches to where, how, and when information and services would be most convenient to access (e.g., via men's health clubs, peer outreach, employee services, and evening or weekend clinics). While traditional health centers may be constrained by public-sector regulations concerning days and time of services, linkages between public-sector facilities and nongovernmental or community-based male-oriented services could fill this gap.

An illustrative list of tasks for efficiently working with community resources for FP and HIV integration is presented on page 15.

Community-Based Integrated Service Tasks

Protect clients' rights to informed decision making in support of fertility desires, regardless of HIV status.

Provide FP information and counseling, including dual protection, to clients accessing ART, PMTCT, STI, and VCT services.

Facilitate FP referrals for clients accessing ART, PMTCT, STI, and VCT services, where FP services are not available onsite.

Provide condoms and other selected FP methods (methods they have been trained to provide) to clients accessing ART, PMTCT, STI, and VCT services.

Support clients accessing ART, PMTCT, STI, and VCT services to use their chosen method(s) successfully.

Conduct awareness-creation activities with men to promote their access to and use of FP-integrated HIV services.

Conduct community activities to create awareness of FP-integrated HIV services for increased use, through inclusion of PLHIV networks.

Questions for consideration at the community-based service-delivery level may include:

What additional resources (e.g., time, personnel, materials, and funds) would be needed to help community-based personnel perform the listed tasks?

What would be necessary for community-based integrated service to maintain the privacy and confidentiality of clients' HIV status and family planning practices?

How could male-focused awareness-creation activities be most effectively planned and implemented?

How would the existing supply acquisition and distribution system need to be modified for community-based HIV personnel to provide oral contraceptives? Injectable contraception, where feasible?

Service Systems Considerations for Integration

ACQUIRE's model for strengthening health systems in support of facilities-based FP/RH services can be applied to integration. The ACQUIRE Project focuses on a systems approach to enable health facilities and their staff to effectively respond to the needs of their clients. This section will address considerations for supervision, training, logistics, referral, and record keeping systems.

The systems approach helps public-, private-, and NGO-sector officials to strengthen their capacity to:

Supervise facilities and providers, to ensure that the fundamentals of care are appropriately implemented

Plan and administer provider training to ensure that they have up-to-date knowledge and skills in FP-integrated HIV services

Secure and distribute supplies, equipment, and commodities

Refer clients for family planning services that are not available at a given site

Accurately record service statistics for family planning within HIV services

Supervision

Supervisors play an important role in supporting staff to successfully adopt new behaviors (e.g., FP activities within HIV care and treatment services). Facilitating change is one of the most challenging functions of supervisors. The concept of facilitative supervision, which is based on widely accepted quality management principles, "is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised" (EngenderHealth, 1999). Using facilitative supervision can offer supervisors and their staff a mechanism that eases the change process, enables team-building, and promotes participatory problem-solving.

Incorporating *COPE for Antiretroviral Therapy Services*[*] and *COPE for Services to Prevent Mother-to-Child Transmission of HIV*, for example, builds on facilitative supervision to empower staff to effectively identify and solve integration problems that may emerge; help supervisors and staff communicate more effectively; and help supervisors leverage resources (materials, staff, commodities, funds) from higher administrative levels by describing what is needed to maintain an ongoing mechanism for monitoring the quality of integrated services.

Training

Training is a valuable tool for quality improvement, by preparing staff and investing in them to competently perform new functions or improve or expand their skills. Integrating FP into HIV service requires a demanding training effort that must address attitudes as well as knowledge and skills. Provider bias is a tremendous barrier to the ability of PLHIV to access RH information in order to make informed decisions and manage their fertility. As ARVs become increasingly available, the health of PLHIV begins to improve. Individuals begin to feeling better, their appetite increases, their libido returns, and they become more interested in the future. This raises questions about the risks and possibilities of childbearing and of achieving their desired family size. HIV providers who have focused almost exclusively on counseling for the prevention of STI, HIV, and pregnancy are now challenged to shift their thinking and counseling to explore with individuals their future and reproductive desires and goals.

While training is necessary for performance improvement, it is not sufficient to bring about integration. Attitudes take time to change, and expecting a one-time FP training to bring about the desired change is unrealistic. If the staff who are being trained do not have a health background, it may also take time for them to grasp the necessary technical knowledge. Therefore, training plans may need to include a progressive series of on-site training events to build on previous sessions.

Depending on the level of integration a site might adapt, staff may be on a steep learning curve related to FP counseling for informed choice and to details of FP methods, such as their mode of action, instructions for users, and management of side effects. Job aids to help the newly trained provider or counselor function competently and effectively and to master the content more quickly should be an integral part of the FP training. Posttraining follow-up is crucial to supporting the new FP practices within the HIV care and treatment services. Follow-up can be provided by the trainers or by similarly trained supervisors, either alone or in coordinated visits.

Training content that supports integration of FP issues into HIV care and treatment services must be consistent with agreed-to or approved posttraining functions and must include practical application of knowledge, attitudes, and skills learning and of demonstration of competence before staff can

[*] A COPE toolbook for ART services is currently being field-tested by EngenderHealth.

independently serve clients (see Appendix A: Cadres and Tasks in FP-Integrated HIV Services, pp. 27–28). Service site supervisors and senior levels of management will need to determine whether central or on-the-job approaches to training will be the most time- and cost-efficient and the least disruptive to services.

Logistics

Another vital component to the success of integration is the functionality of the logistics system. This system is most vulnerable to flaws in vertical programs' attempts to integrate. HIV and FP logistics systems have historically been completely separate; this division is further reinforced by donors and by Ministry of Health systems. Consequently, for integration to be successful at the service-site level, attention must be given to how the division between donors and ministry systems can be reconciled to eliminate administrative barriers. When donors and higher administrative levels are in harmony, dialogue between FP and HIV logistics managers and service supervisors will be needed if they are to examine how best to coordinate acquisition, distribution, and inventory recording processes to ensure reliable supplies of FP commodities to satisfy demand.

Referral

Few FP or HIV services are able to provide a complete range of services onsite. Consequently, it is crucial that FP and HIV services explore the resources available to complement the scope of their integrated services. When resources are identified, it is then necessary to develop, modify, or strengthen a referral mechanism to ensure that clients receive the indicated or requested services without being lost to follow-up. Where FP and HIV service sites have a predominantly female client pool, efforts to encourage partner participation may require modifying the referral system to facilitate male participation (e.g., by having hours for male services and/or by hiring staff for male client-provider interactions). Settings with skilled providers for couple counseling may also need to be identified if that capacity cannot be developed within the integrated services.

The referral system to support FP-integrated HIV services should provide the following information for the client:

- Location
- Hours
- Fees
- Contact person(s)

This basic information should be available to clients in written or graphic form, including clear instructions for how to reach the site. Information related to the type of referral (e.g., VCT) should include anticipated duration of the visit and of the waiting time for results or services.

Additional support for effective referral might include:

- Use of service-delivery guidelines for referral, where these exist
- A monitoring mechanism for the referral system
- An easily retrievable/accessible list of referral sites, locations, and contact persons for each site (a list that is periodically updated)
- Institutionalized values for confidentiality, such as joint orientation of staff and community to the value of confidentiality and how to protect it as the foundation for helping the referral system work

A functioning communication/feedback system between the referring facility and the site accepting the referral (form, phone, other), to support timely information-sharing and continuity of care

Mechanism for client follow-up (including assessment of how well the follow-up mechanism is functioning)

Transport subsidies for clients who cannot afford the cost of traveling to the referral site

Adapted from: PATH, 2001.

Record Keeping

Since most health service programs focus on single components of care (e.g., FP, HIV, antenatal care), data collection tools, recording, and reporting tend to have a singular focus. When integrating FP with HIV services, tools need to be modified to capture the FP activities contributing to a more comprehensive set of service performance statistics. In government health systems, altering management information system forms can be a complex and lengthy process. Service sites have used a variety of approaches to track the agreed-to service data:

Creating additional areas for FP data on the HIV recording and reporting forms

Adding FP forms to the HIV forms

Redesigning the daily log book to include the FP data, and tallying the combined data on standardized forms by using additional plain sheets of paper to show the FP data

Developing an interim system to have HIV clinic staff report FP service statistics to appropriate departments (even within the same institution)

Most of these are interim solutions, to be used as decision makers in the health care system explore what works and what does not before making an investment in altering the information management system.

Section III: Integration in Action

With an understanding of the specific systems requirements involved in integration, we can move to approaches for integrating FP and HIV services. This section provides a detailed guide for assessing capacity to integrate services; a description of concrete approaches for service integration; and considerations for the sustainability of integrated services. Conclusions and next steps are also discussed.

Assessing Capacity to Integrate Services

To begin the process of integrating FP and HIV services, decision makers and/or managers, providers, and potential users of the services should generate a common vision of what integrated services will look like. When the service model is clear, existing services should be assessed to identify any gaps and to determine both needs and the interventions to overcome these needs and achieve integration.

The box below offers an example of what quality FP-integrated HIV services might look like. (Such services would include prevention and risk assessment, prevention and risk-reduction counseling, VCT, PMTCT, and care and treatment.)

Vision of FP-Integrated HIV Services

Staff are welcoming, nonjudgmental, respectful, and caring (reducing stigma and discrimination).

Clients are informed of their risk of unintended pregnancy and their risk of HIV and STI infection.

Providers skilled in FP counseling are available.

Reliable and high-quality FP services are both available and accessible.

A functional referral system exists to follow up clients taking ARV medications and using FP.

A functional referral system exists to follow up clients in antenatal, labor and delivery, postnatal, and postabortion care services.

A functional referral network is linked with other medical, social, and legal support services.

There is training capacity and supervision to sustain a supply of trained providers and to maintain desired provider performance.

Assessing the Capacity of Your Facility/Program to Provide Integrated Services

The level of FP-integrated HIV services will depend on the facility's capacity to:

Be involved in community outreach, including reaching out to men

Make referrals efficiently

Provide VCT services

Offer treatment (ART, including OI services)

Provide follow-up.

To accomplish all of this requires maintaining a reliable supply of equipment and commodities for providing contraceptives as an integral component of HIV services. You can assess the capacity of your facility to achieve the desired level of integration by answering the questions in the next section, which offer systematic considerations for planning FP-integrated HIV services.

The box below offers a summary of questions for managers of HIV services, their supervisors, and their facility- and/or community-based staff to explore. Initially, local HIV and FP data should be analyzed to guide discussions about the appropriate level of integration. The level of FP-integration of HIV services that can be successfully sustained should be determined at the policy, community, facility, and systems levels. For more detailed questions and their implications, see **Appendix B**.

POLICY AND COSTS
Are policies in place that delineate health personnel tasks for delivery of FP- integrated HIV services? Are there service delivery guidelines for FP to be included in VCT? in ART? Has a budget line for FP commodities, instruments, equipment, and supplies and for HIV treatment drugs been established within the HIV sector? Does/will the health system's financing mechanism cover FP-integrated HIV services?
IEC/BCC
Does the facility have posters that visibly disseminate messages about FP-HIV integration? Does the facility have client brochures that reflect FP-HIV integration?
COUNSELING
Do providers protect the client's right to privacy during service delivery (through counseling and procedures)? Are providers knowledgeable about and comfortable with providing FP-integrated HIV counseling?
REFERRAL
Is there an effective referral mechanism between FP and HIV (VCT, ART, OI) services? (*"Effective" means that the client gets from her/his point of origin to the referral site, with communication occurring between the sites to ensure continuity of care.)* Are there referral sites for other FP/RH- and/or HIV-related needs within a reachable distance (e.g., within 5 km) of this facility?
PHYSICAL STRUCTURE
Does the structure have space to accommodate the potentially increased client volume? Does the physical structure allow for privacy (auditory and visual) and confidentiality of client records? Do the structure, time, and staff of the facility welcome the engagement of men? Services to youth?
STAFFING
Are staff available to provide FP counseling and method provision throughout the continuum of HIV services (e.g., VCT, ART)? Are VCT or ART staff trained in FP counseling, method provision, and procurement of FP commodities, instruments, and supplies? Do staff demonstrate respect for the rights of HIV-positive women and couples to make decisions about their fertility?
MANAGEMENT AND SUPERVISION
Do supervisory tools reflect staff performance for FP-integrated HIV services? For monitoring of service systems? Do service statistics reflect FP-integrated HIV service activities?
LOGISTICS
Is there a mechanism for maintaining a reliable supply of FP and HIV service needs?
COMMUNITY PARTNERSHIPS AND RESOURCES
Are there organizations of PLHIV with which collaboration could promote access to and use of FP-integrated HIV services? Are there ongoing community outreach activities into which integration awareness activities can be incorporated? Are there influential persons who can be allies in promoting behavior change?
LEVEL OF INTEGRATION
Can existing services adopt their chosen level of integration without compromising service quality (e.g., without increasing client waiting times or staff workload)?

Examples of FP-Integrated HIV Services

If we pull together all of the information presented, images of FP-integrated HIV services might look like these. Also see **Appendix C** for broader examples of FP integration.

- A community-based organization of PLHIV opted to add FP to their center's Health Talks, provide FP counseling, and provide combined oral contraceptives and injectable hormones (DMPA) to their existing offering of condoms for prevention of new infections. The organization began offering ARVs the previous year. The staff supported the plan, based on opinions sought from users of the center. Community officers who provide home-based care (e.g., ART monitoring, ARV resupply, general/psychosocial monitoring of the patient's well-being, and coping skills of the families) agreed to include FP counseling and provision/resupply of condoms, oral contraceptives, and DMPA. Other methods would be provided by the regional hospital, which is a very short walk from the center within the same compound. One PLHIV group suggested that the ART center create a dedicated space with its own staff to provide FP as a way of minimizing waiting. Managers are reserving this option after seeing how generalized integration works out. (Mbale, Uganda)

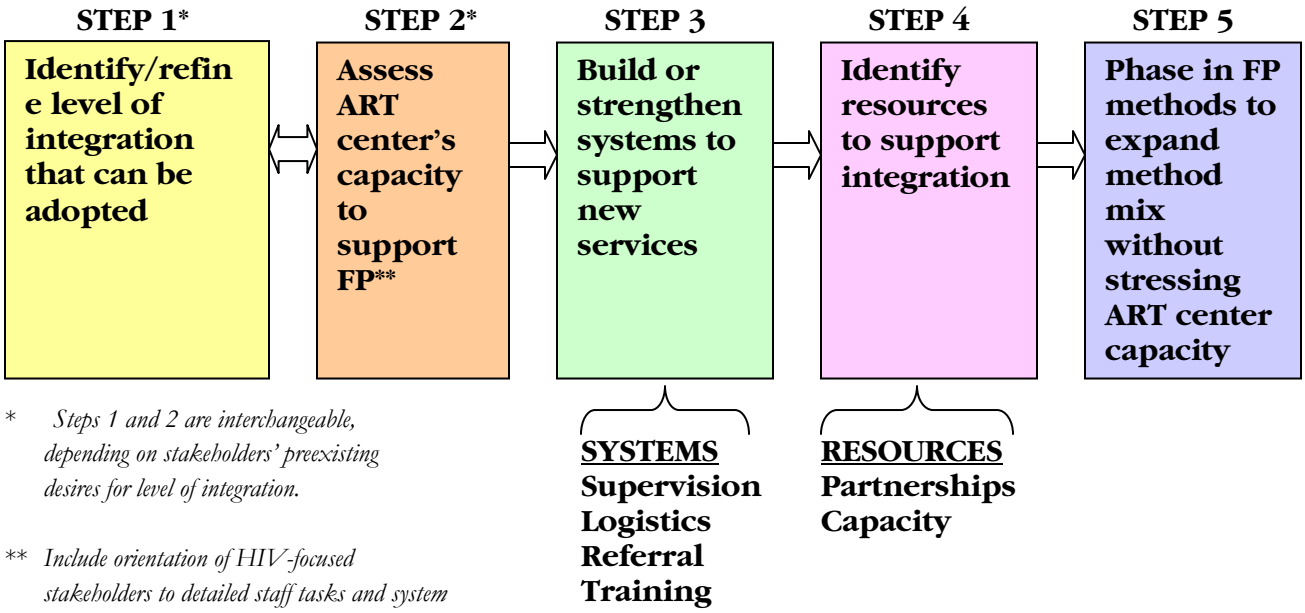
- An HIV treatment center with mobile service opted to initially provide condoms and oral contraceptives along with their mobile resupply of ARVs. Based on patients' responses to mobile availability of FP, the treatment center planned to assess their ability to offer short-acting methods and refer only people seeking long-acting and permanent methods (LAPMs) to the district hospital's FP clinic next to their compound. (Rakai, Uganda)

- A district hospital's PMTCT program integrated FP counseling for postpartum FP to be accessible before discharge or during the initial postnatal and child health monitoring visits. The district's FP service offerings are being expanded to provide LAPMs along with condoms, combined oral contraceptives, and DMPA. One of the district health center's services are being modified to be a PLHIV-friendly referral point for the area's ART center. (Sembabule, Uganda)

Approaching Integration of FP with HIV Services

Where the policy and program environment are supportive of integration, facility managers are better able to plan and implement integrated services. Key to the success of integration will be creating a relationship of respect and trust between the staff, client, and community. Where and when feasible, the physical structure (facility), all staff, and service hours should accommodate service users.

The following steps may help continue the process of integrating FP with HIV services:



* *Steps 1 and 2 are interchangeable, depending on stakeholders' preexisting desires for level of integration.*

** *Include orientation of HIV-focused stakeholders to detailed staff tasks and system functions to support each level of integration.*

STEPS 1 and 2

- Form a group/team of key staff from departments that will be needed to achieve integration. Such a team would include clinicians, supervisor, manager, counselor, stores manager, pharmacy, reception, community outreach, home-based care providers, and housekeeping. Include male and female community members and PLHIV network representatives, to be called upon as needed; this will ensure maintaining a client focus within the assessment process. These team members will participate in information gathering to assess the feasibility of FP-integrated HIV services.
- Assess the prevailing attitudes and biases of community members regarding FP and HIV. Ensure that the opinions, suggestions, and concerns of male and female community members and PLHIV networks are heard.
- Determine with the local community's input what level of integration may be most appropriate.
- Map existing FP and HIV services in the immediate area and the location of accessible referral sites.
- Check in with the community and with PLHIV network representatives being served regarding the value to them of FP-integrated HIV services, how they would envision using the services, and how they would like to see the services organized.
- Based on community input, define the scope of integration needed.

STEPS 3 and 4

- Assess the facility's service-delivery systems and build or strengthen systems for supervision (standards and guidelines), logistics (commodity supply system for FP), referral (for methods the ART center does not provide), and training (improve provider knowledge, skills and attitudes).

- Identify resources needed to design, implement, monitor, and evaluate integrated services, assess requirements for sustaining integrated services, build in what is needed, as feasible, and identify (list) tools[†] to support integration.
- Analyze costs to start up and sustain[‡] integrated services compared with vertical side-by-side services.
- Cultivate complementary partnerships with and strengthen capacity of PLHIV networks, community groups, and facilities that can provide LAPM.
- Develop a plan for implementing FP-integrated HIV services over an agreed-to period of time and monitoring them using identified benchmarks, including input from the community, from PLHIV network representatives, and from clients. See **Illustrative Indicators**, **Appendix D**, page 35.

STEP 5:

- Based on the assessment, agree on the additional FP methods (including selected LAPMs) that might be provided onsite without stressing the ART center's capacity to provide quality services.
- Identify the period of time needed to assess and prepare the site to include additional FP method(s) and their corresponding staff tasks.

Sustainability Considerations

Consideration must be given to how FP-integrated HIV services can be sustained beyond the initial investment of resources. Areas of consideration for planning sustainable integrated services are listed in the box on page 24.

Conclusion

The justification for FP-integrated HIV services is compelling for several reasons. FP offers PLHIV and health personnel opportunities to safely plan desired pregnancies, and offers clients protection against unintended pregnancies—thereby contributing to a reduction in the number of orphans, preventing mother-to-child transmission of HIV, and preventing potential fetal damage when certain ARV drugs are used. Most importantly, all women and couples, regardless of their HIV status, have a right to access contraception to achieve their fertility desires.

Addressing the sexuality and RH needs of individuals who are HIV-positive can have far-reaching effects on the health and well-being of current and future generations, as well as on the economic stability of families, communities, and countries. FP-integrated HIV services require coordinated efforts among donors, administrative and service-delivery systems, and personnel who may have not had to interface before. Integrating FP and HIV services adds complexity to service management, but this can be minimized when sites assess their ability to sustain a level of integration that is consistent with the capacity of their services and resources.

Integration of FP with HIV services is just one aspect of the larger model of integration that the ACQUIRE Project is addressing. The ACQUIRE approach focuses on strengthening service-delivery systems through the fundamentals of care. It is our aim that this document will assist you in thinking through a successful and efficient plan for service integration.

[†] See **Illustrative FP-Integrated HIV Service-Delivery Requirements**, page 13.
[‡] See **Sustainability Considerations for FP-HIV Integrated Services**, page 24.

Sustainability Considerations for FP-HIV Integrated Services

Policy

Sustainability thrives with **Advocacy** for:

- Community support of the program
- Policies that support the maintenance of integrated services
- Removal of service barriers
- Male engagement and male-oriented services
- Youth-oriented education and services
- Women's reproductive health rights (e.g., violence against women, female genital cutting, and coerced abortion or coerced sterilization for the HIV-positive)

Program

Sustainability succeeds when **Facility-Based Services** have:

- Training capacity that is established and maintained
- A mechanism to ensure facilitative supervision and ongoing quality improvement
- Funding and a clear demarcation of responsibility for accountability

Community

Key to sustainability is identifying and collaborating with preexisting community networks and/or community-based services. Sustainability flourishes when collaborating with the community results in:

- Stimulating demand for and use of integrated services
- Enabling clients to objectively assess their behavior and the extent to which it may place them at risk of HIV infection and/or unintended pregnancy
- Reaching out to men, youth, and couples
- Fostering a caring and supportive community environment for and with PLHIV
- Partnering to develop action plans for sustaining and/or expanding integrated services and/or increasing their use

Sustainability can be supported when **Social Marketing**

- Designs strategies to promote the marketing of condoms (female as well as male) and an expanded range of contraceptives, dual protection, and information about and referrals for VCT and other HIV and RH services.

Adapted from: Pathfinder International, 2000, p. 17.

Appendixes

APPENDIX A
Cadres and Tasks in FP-Integrated HIV Services

Level of Integration	Cadre	Provider Tasks by Cadre
A	Community outreach personnel Communications personnel—messages and information dissemination Service providers	Conduct FP "health education" sessions in service settings offering ART, PMTCT, STI, VCT and tuberculosis services. Conduct pregnancy risk/intention assessment. Provide basic information on each available FP method, including each method's ability to protect against HIV and STIs. Include dual protection information during counseling. Provide condoms and instructions for correct use, including demonstration/return demonstration. Provide emergency contraception, as indicated. Refer the client for their selected methods not offered onsite. Document services given.
B	Community outreach personnel Communications Personnel—messages and information dissemination Service providers	**Tasks of "A" plus:** Conduct counseling on available FP methods, including potential drug interactions with oral contraceptives. Include information regarding oral contraceptives' inability to protect against HIV and STIs; counsel for dual method use (DMU) Screen, counsel, and provide oral contraceptives. Provide instructions for correct use of oral contraceptives; for HIV-positive, give tailored instructions for use of pill if taking ARVs. Document services given.
C	Community outreach personnel, including referral to service site Communications personnel—messages and information dissemination Service providers	**Tasks of "B" plus:** Conduct counseling on available FP methods, including potential drug interactions with injectables. Include information regarding injectables' inability to protect against HIV and STIs; counsel for DMU. Screen, counsel, and provide injectables. Provide instructions for use of injectables; for HIV-positive, give tailored instructions for use of injectables if taking ARVs. Carry out infection prevention and safe injection practices. Document services given.

Level of Integration	Cadre	Provider Tasks by Cadre
D	Community outreach personnel, including referral to service site Communications personnel—messages and information dissemination Service providers (midwives, physicians, clinical officers, nurses) at facility and/or community outreach services	**Tasks of "C", plus:** Conduct counseling on available FP methods, including the IUD's and/or implant's inability to protect against HIV and STIs; counsel for DMU. Screen, counsel, and provide the IUD or implant. Carry out infection prevention practices for IUD or implant insertion and removal. Provide instructions for use of the IUD or implant, including recommended date of removal. Document services given.
E	Community outreach personnel—referral to service site Communications personnel—messages and information Service providers (physicians for procedure; nurses and midwives for pre-/postprocedure counseling, instructions, and client support during procedure [if it is minilaparotomy under local anesthesia], and postoperative client monitoring)	**Tasks of "D", plus:** Conduct counseling on available FP methods. Inform client of voluntary sterilization's inability to protect against HIV and STIs; counsel for DMU. Conduct counseling for informed decision making and obtain informed consent for permanent methods. Provide voluntary sterilization. Provide postoperative client monitoring. Provide pre-/postprocedure self-care instructions. Provide instructions to men regarding the need to rely on condoms and/or another contraceptive during the first three months following the procedure.

APPENDIX B

Assessing the Capacity of Your Facility/Program to Provide Integrated Services: Questions and Implications

For most of the questions listed, there are suggested implications to consider and discuss, based on your setting and infrastructure. Answering these questions can help determine what would be involved in achieving and sustaining the desired level of integration. These questions can be streamlined to create a rapid assessment tool.

Goal: To facilitate changes within the health care system to support FP-integrated HIV services.

Questions	Yes/Implications	No/Implications
Policy		
Are policies in place that delineate health personnel tasks for FP-integrated HIV service delivery? **(See "Task/Cadres" chart, Appendix A.)**	Disseminate widely and orient managers, supervisors, service providers, and community to the integrated standard of care.	Requires identifying health system and community stakeholders to contribute to the development of policies that support integrated services.
Are there service-delivery guidelines (SDGs) for FP to be included in ART (or VCT)?	Disseminate widely; review periodically to maintain currency with rapidly changing scientific recommendations; orient staff to using SDGs.	Requires identifying health system stakeholders to develop SDGs for integrated services, and to develop a dissemination and orientation plan within the health sector and in the communities being served.
Are there any policy barriers to integrating services (e.g., that unmarried youth cannot access FP)?	Identify partners to advocate for change using emerging evidence-based and cost-benefit approaches.	Requires that staff continue to keep abreast of policy changes that may impact integration of services.
Are donors receptive to supporting integration?	Maintain a dialogue with donors for strategic and appropriate investment of resources for integrated services.	Requires advocacy to help donors see what is entailed in integration and the emerging evidence-based and cost-benefits of integration.
Has a budget line for FP commodities, instruments, and ARV drugs, equipment, and supplies been established within the HIV sector?	Disseminate budget guidelines within the health care system; review periodically against cost assessment reviews to ensure adequate funding to support integrated services.	Requires facilitating the development of a budget based on cost assessment evidence, if feasible.
Cost		
Does/will the health system's financing mechanism cover FP-integrated HIV services?		Requires policy-level advocacy and interventions for health financing coverage.
IEC/BCC		
Do client brochures reflect messages integrating FP and HIV services?	Include materials in service delivery, information sharing, and community outreach.	Requires identifying material development resources to incorporate messages about FP-HIV integration.
Do the facility's posters visibly reflect FP-integration HIV messages?	Periodically update and rearrange to attract clients' attention.	Requires determining effective placement of posters in service delivery; for use during information sharing and

Questions	Yes/Implications	No/Implications
		community outreach.
Counseling		
Do providers protect the client's right to privacy during service delivery (counseling, procedures)?	Periodically assess effectiveness of privacy measures.	Requires determining ways to protect client privacy—auditory and visual.
Are providers knowledgeable and comfortable providing FP-integrated HIV counseling?	Assess periodically through supervision using standardized FP-integrated HIV service-performance tool.	Requires assessing learning needs and determining most cost-effective and learning-efficient mode for performance improvement.
Do existing ART (VCT) services provide counseling on fertility decision making and FP, including FP method provision?	Assess periodically through supervision using standardized FP-integrated HIV service performance tool.	Requires identifying points on HIV continuum of services for integrating FP counseling, method provision, and monitoring of method use.
Referral		
Is there an effective referral mechanism between FP and HIV (VCT, ART, OI) services? "Effective" means that the client gets from her point of origin to the referral site, with communication between the sites to ensure continuity of care.	Assess periodically for efficiency and effectiveness.	Requires identifying resources for FP method provision (e.g., LAPMs) and for establishing a referral link with these sites. Feedback mechanism may be needed or may need to be strengthened.
Are there referral sites for other FP/RH and/or HIV-related needs within a reachable distance (e.g., within 5 km) of this facility?	Document and update periodically; and share with staff for use with clients.	Requires identifying resources for FP method provision (e.g., LAPMs) and for establishing a referral link with these sites.
Physical Structure		
Does the structure have space to accommodate increased client volume?	Periodically assess for optimal use of space.	May require considering rearranging existing space, if possible, or using an alternative site or a different model of integration.
Does the physical structure allow for privacy (auditory, visual) and confidentiality of client records?	Periodically assess adequacy of privacy and confidentiality measures.	Requires assessing resources for making equipment and structural changes beyond the site's ability to rearrange the space.
Do the structure, time, and staff welcome men? Youth?	Periodically survey clients (male, youth) for information on their satisfaction with space and services.	Requires determining reasons for "no," deciding what is possible, and identifying resources for male and youth services.
Staffing		
Is staffing available to provide FP counseling and method provision throughout the continuum of HIV services (e.g., VCT, ART)?	Assess the need to reorganize work to accommodate additional tasks.	May limit the variety of methods provided and increase reliance on referral.
Are ART (VCT) staff trained in FP counseling and method provision?	Conduct periodic updates to maintain currency with rapidly changing science.	Training needs consideration should include when, where, how, and by whom training will be provided, as well as the cost and training approach that will

Questions	Yes/Implications	No/Implications
		be used.
Are ART (or VCT) staff trained in the system for maintaining a supply of FP commodities, instruments, and supplies?	Assess periodically for adequacy of stock.	Requires orientation of staff and supervisors to use the system effectively to maintain adequate supplies for integrated service delivery. May require facilitating access to FP commodity logistics system.
Would staff attitudes facilitate FP-HIV integration?	Monitor and support positive attitudes.	Would require interventions to foster positive attitudes about FP-integrated HIV services.
Do service providers/counselors demonstrate respect for the rights of HIV-positive women and couples to make decisions about their fertility?	Monitor and support desired behavior.	Would require orientation of staff to the rights of the client to make independent fertility decisions, regardless of HIV status.
Are service providers/counselors aware of the current guidelines for contraceptive use by women who are HIV-positive and by women taking ARV therapy?	Monitor and conduct updates, as indicated.	Requires conducting updates for staff to new guidelines and dissemination of new guidelines.
Are ART providers aware of the current information on ARV and OI drug interactions with hormonal contraceptives?	Monitor and conduct updates, as indicated.	Requires conducting updates for staff to new guidelines and dissemination of new guidelines.
Are HIV and FP staff performing infection prevention procedures to standard?	Monitor and conduct refreshers, as indicated	Requires conducting refresher and supervisory monitoring of infection prevention practices.
Drugs, Equipment, Supplies (Should reflect local standard) List the drugs, equipment, and supplies required for FP services, ART services (and VCT service) separately for facility-level or community-level activities.		
Management and Supervision		
Have supervisors been trained in the integration skills that they are expected to support?		Requires orientating supervisors to facilitate integration and maintenance of quality services.
Do supervisory tools reflect FP-HIV integrated performance of staff? For monitoring of service systems?		Requires modifying tools to reflect the level of integrated services.
Do service statistics reflect FP-HIV integrated service activities?	Requires monitoring for maintenance of completeness and accuracy of documentation.	Requires modifying management information system forms consistent with the level of integrated services.
Do supervisors review client records and service statistics when monitoring integrated services?		Requires supervisor to be knowledgable about the standards for documenting integrated services in client records and services statistics.
Do managers/supervisors have a written plan for monitoring the proposed integrated services?		Requires developing monitoring plans consistent with the level of integration.
Logistics		
Have FP commodities, instruments, and supplies been added to the HIV services standardized list?	Monitor periodically for consistency with recommended standards of care.	Requires review of standardized equipment, supplies, and drug list to provide the determined FP-integrated HIV services.

Questions	Yes/Implications	No/Implications
Is there a mechanism for maintaining a reliable supply of FP and HIV service needs?		May require accessing supplies from alternative sources *or* not providing services for which supplies cannot be reliably obtained.
Community Partnerships and Resources		
The community's feeling about FP-integrated HIV services: Does the community believe in or understand the benefits of integrated services?	Engage the community in planning and monitoring integrated services.	Requires creating awareness regarding FP-integrated HIV services and the benefits and challenges of these, and engaging the community in deciding the scope of integrated services.
Are there organizations of PLHIV?	Include representatives of PLHIV to contribute their perspective in planning and monitoring integrated services.	Requires exploring the feasibility of PLHIV networks helping to develop a community-based group in the area.
Are there organizations providing FP or HIV (VCT, care and treatment services)?	Explore possibilities for coordinating services to support referral linkages.	
Are there ongoing community outreach activities into which FP-HIV integration awareness activities can be incorporated?	Collaborate with the community outreach programs to incorporate awareness-creation activities and to develop a referral mechanism.	Requires collaborating with community resources to develop a mechanism for creating awareness of integrated services and to create referral linkages.
Are there influential persons who can be allies in promoting behavior change?	Sensitize influential individuals as a resource to endorse health-promoting sexual and reproductive behavior and to promote use of integrated services.	Requires finding potentially supportive influential or popular figures and grooming them for promoting behavior change and use of integrated services.
Level of Integration		
Instructions: Insert desired level of Integration Will the existing services be able to adopt Level ___ service integration without compromising the quality of the services currently being offered (e.g., without increasing client waiting time or staff workload)? See **Appendix A** for Tasks and Inputs for each level of integration.		

APPENDIX C
Examples of FP Integration with RH Services

During any and every client encounter, consider the client's risk for unintended pregnancy, STI, HIV, and other preventable infections and problems that negatively impact maternal and child health
HIV services (e.g., VCT, ART)
Include assessment of client's fertility desires in VCT activities.
Provide information about FP and its role in protecting against sexual transmission of HIV, against mother-to-child transmission of HIV, and in supporting effective ART.
Promote dual protection.
Provide information on locations for FP services.
Provide FP methods to the capacity of the sites.
Facilitate referrals for FP services (e.g., LAPMs).
Assess FP use/continuation during ART.
Counsel clients on ways to ensure contraceptive effectiveness in the presence of possible drug interactions.
Inform clients on the option and availability of emergency contraception.
Management of OIs
Include assessment of FP method use for developing the treatment plan for OIs.
Counsel clients on ways to ensure contraceptive effectiveness in the presence of possible drug interactions.
Provide referral or FP counseling and method if client does not desire a pregnancy.
Postabortion Care
Establish staff presence, skill, and availability to provide FP counseling, method provision, and/or referral *before* discharge from postabortion care.
Include dual-protection counseling in client counseling.
Explore client's risk for STIs and HIV during FP counseling, to appropriately refer for VCT as a preventive measure against HIV infection and to prevent MTCT in the subsequent pregnancy.
Antenatal Care (e.g., PMTCT, malaria prevention and management)
Promote VCT to plan for positive maternal and child health outcomes in the presence of HIV infection, in the context of informed choice.
Promote VCT to develop strategies for HIV-negative women to remain uninfected.
Promote benefits of spacing pregnancies for maternal and child health.
Counsel on methods available immediately postpartum (Lactational Amenorrhea Method [LAM], IUD, condoms, voluntary sterilization).
Maintain follow-up through FP or child health services for women to continue with their postpartum method or access another ongoing method (e.g., transition from LAM to another FP method).
Teach newly delivered women correct techniques of breastfeeding to maintain intact nipples (and thus prevent HIV transmission through broken skin and blood) and stimulate an adequate supply of breastmilk.
Provide condoms for use during the antenatal and postnatal period.
Provide informed consent counseling for immediate postpartum tubal occlusion and postpartum IUD, where available.
Assess risk of malaria and counsel about risks during pregnancy with or without HIV; counsel to develop prevention strategies and treat aggressively to prevent anemia.
Postnatal Services (e.g., immediately, at 2 weeks, and at 4–6 weeks)
Provide postnatal FP counseling and provision of methods that support exclusive breastfeeding.
Provide immediate postpartum tubal ligation.
Provide immediate postpartum IUD.
Provide postnatal FP counseling and methods that do not compound anemia and do not inhibit lactation.
Monitor client success with FP methods during the immediate postnatal period and assess client's risk for STIs and HIV.
Promote VCT for health and fertility management planning.

During any and every client encounter, consider the client's risk for unintended pregnancy, STI, HIV, and other preventable infections and problems that negatively impact maternal and child health
Include dual-protection information during client counseling.
Fistula Services
Include assessment of client's fertility desires in postoperative fistula repair counseling , as well as at discharge and during follow-up.
Provide FP counseling to assist client/couple to achieve her/their fertility desires, including dual-protection information and information on the necessity to abstain from sexual intercourse for three months postoperatively.
Provide the client's chosen method, including condoms, where appropriate and accepted (or facilitate referrals for FP methods not available at fistula repair site).
Monitor clients' success with FP methods during the fistula rehabilitation period.
Facilitate referrals for FP methods not available at fistula repair sites.
Incorporate FP information during fistula prevention outreach activities, including referral to FP services sites (public, private) and community-based providers.
Include information to clients on emergency contraception during fistula prevention outreach activities.
Child Health Services (e.g., nutrition, immunization, prevention and management of childhood infections)
Assess the client's exclusive breastfeeding practices.
Assess the client's risk of HIV infection to prevent MTCT.
Assess the client's fertility desires (spacing, limiting, ending).
Include dual-protection information during FP assessment and counseling.
Assess the client's needs to transition to another method of FP when the criteria for use of LAM no longer exist or when indicated by the client's desire.
Provide FP counseling and methods or referral for FP methods during client encounters for child health services.

APPENDIX D
Indicators of FP-HIV Integration

Below are illustrative indicators for monitoring and evaluating FP-integrated HIV services.

Sample District FP-Integrated HIV Program Indicators

Program Goal: To provide FP-integrated HIV care and treatment services

Objective 1: To ensure district policies and protocols supporting FP-integrated HIV services
Illustrative Indicators 1.1 HIV services are mandated by district authorities to provide FP counseling to all clients attending HIV services 1.2 District budgets allow for supplies of FP commodities to HIV clinics 1.3 District budgets support the training of HIV staff in FP counseling 1.4 District management team has system in place for HIV clinics to report on FP activities 1.5 District HIV and FP supervisory structures work together for FP-integrated HIV services by having meetings at least quarterly
Objective 2: To ensure that HIV clinics are able to provide FP counseling and services
Illustrative Indicators 2.1 Number of HIV clinics with at least one staff person trained in FP counseling 2.2 Number of HIV clinics with all needed equipment (defined) to provide FP counseling 2.3 Number of HIV clinic providers trained in FP counseling 2.4 Number of HIV clinics with emergency contraception available 2.5 Number of HIV clinics with at least three methods of short-acting FP methods 2.6 Number of HIV clinics with established referral system for clients to access FP methods not available onsite
Objective 3: To ensure that FP counseling in HIV clinics is of good quality
Illustrative Indicators 3.1 % of client-provider interactions (CPIs) in HIV clinics where FP is discussed *(special CPI study)* 3.2 % of CPIs in HIV clinics where provider explore client's reproductive concerns/questions 3.3 % of CPIs in HIV clinics where provider present risks and considerations of pregnancy with HIV and use of ARVs 3.4 % of CPIs in HIV clinics where provider present the special instructions for use of hormonal FP methods with women on ARVs 3.5 % of CPIs in HIV clinics where providers ensure client's privacy (auditory, visual) 3.6 % of CPIs in HIV clinics where provider use IEC materials to support counseling 3.7 % of HIV clinic clients reporting having received FP information *(special exit study)* 3.8 % of HIV clinic clients reporting satisfaction that FP/RH needs have been met (*special exit study)*
Objective 4: To ensure that community activities support FP-integrated HIV services
Illustrative Indicators 4.1 Number of community members(peer educators, PHLIV, or women's groups) trained in FP-integrated HIV messaging, counseling, selected method provision, and referral 4.2 System in place for referral of clients to HIV clinic for FP services 4.3 Number of community events where FP and HIV is discussed
Objective 5: To increase use of FP by clients attending HIV clinics
Illustrative Indicators 5.1 Number of new FP users 5.2 Number of continuing FP users 5.3 Number of HIV clients using dual protection 5.4 Number of referrals from community to clinic 5.5 Number of referrals from HIV clinic to FP clinic for methods not provided on site 5.6 Number of clients in HIV clinics reporting unwanted pregnancies *(special study)*

APPENDIX E
References and Resources

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