

FAMILY HEALTH RESEARCH

Uganda



A forum for putting knowledge into practice



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WELCOME TO FAMILY HEALTH RESEARCH

This quarterly newsletter is designed to promote evidence-based practices in reproductive health programs.

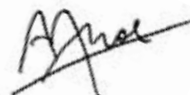
The theme of this debut issue is integration of services, particularly family planning and HIV services.

In Uganda the high prevalence of HIV infection among women has resulted in an increase in HIV infections among children, largely due to mother-to-child transmission of HIV during pregnancy, labor, and child-birth. In response, the Uganda Ministry of Health is scaling up small projects for the prevention of mother-to-child transmission (PMTCT) of HIV. Until recently, these projects

have been implemented in a vertical or fragmented manner in most settings.

Now, with the support of the World Health Organization's Regional Office for Africa, Uganda has been established as a learning site to promote a comprehensive and strategic PMTCT approach, in which HIV concerns become an integral part of the established family planning/reproductive health program.

We are pleased to be able to share details of this promising intervention on page 3. To help nurture and develop new ideas and initiatives, we invite readers to submit comments to our forum at familyhealthresearch@fhi.org.



Angela Akol
Project Director
Uganda office, FHI

KEYPOINTS

- Rigorous research is needed to evaluate impact and identify effective program models.
- Studies found substantial unmet need for family planning among HIV-infected women and couples.
- Service integration requires collaboration between family planning and HIV officials.

SERVICE INTEGRATION EXPANDING IN AFRICA

Research shows need for integrated services.

A growing number of health programs in sub-Saharan Africa are integrating some family planning and HIV services, and research suggests a pressing need for such services. Nevertheless, conclusive evidence that integrated services are effective is still lacking, agreed participants at a regional conference in Addis Ababa, Ethiopia, on October 9-10, 2006.

Organized by the Johns Hopkins Bloomberg School of Public Health and Addis Ababa University, the Linking Reproductive Health and Family Planning with HIV/AIDS Programs in Africa conference brought together more than 500 public health researchers, advocates, program managers, and policymakers from 20 countries to discuss 50 presentations.

One of several presentations about the impact of integrating services — on a randomized community trial conducted in Rakai, Uganda — found a small but statistically significant difference in hormonal contraceptive use between six intervention communities that received enhanced family planning services through an HIV surveillance program and six comparison communities (23 percent versus 20 percent contraceptive prevalence, respectively). Although no significant change in male condom use was observed in either the intervention or comparison communities, pregnancy rates were significantly lower in the intervention communities.¹

Other promising news came from studies in Kenya and South Africa, which concluded that integration did not compromise service quality (see articles, pages 4 and 5). Meanwhile, the possible cost benefits of integrating services were underscored in assessments conducted in South Africa (see article, page 5), Ethiopia, and the Ukraine. One study estimated that the HIV infections averted by integrating HIV prevention into maternal health programs would result in a savings of US\$34 per dollar spent in Ethiopia and US\$10 per dollar spent in the Ukraine.²

One rationale for integrating services — to address substantial unmet need for family planning services among all women, regardless of their HIV status — was bolstered by findings from studies among women and couples living with HIV, including those receiving antiretroviral therapy (ART).

- Contraceptive use decreased after HIV diagnosis among 460 Ethiopian ART clients, even though 55 percent of the women and 65 percent of the men said they did not want to have children.
- More than 60 percent of pregnancies among 235 women receiving HIV care and treatment in South Africa were unintended.

Most studies of integration, including those presented at the conference, have been

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FHI's Heidi Reynolds and Joel Rakwar confer between sessions at the Linking Reproductive Health and Family Planning with HIV/AIDS Programs in Africa conference in Addis Ababa, Ethiopia.

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inconclusive because they were cross-sectional or had methodological problems. Conference speakers called for more rigorous research to evaluate the impact of integrated services on both family planning and HIV services and to identify the best program models for various populations and situations.

Many speakers also pointed to the need for policies and organizational structures that support service integration. Several presentations highlighted changes in policies and guidelines to promote integrated services in Kenya that were achieved through close collaboration between the Ministry of Health's Department of Reproductive Health and the national AIDS program.³

Conference Web site:

www.jhsph.edu/gatesinstitute/CR/FP-HIV-Presentations

References

- 1 Lutalo T, Namukwaya Z, Kimera E, et al. A community randomized trial of enhanced family planning effort in a Ugandan HIV Surveillance Program.
- 2 Perchal P, Collins L, Assefa, B, et al. Cost-effectiveness of integrating HIV prevention into maternal health programmes in Ethiopia and the Ukraine.
- 3 Solomon M, Ayisi R. Integrating reproductive health with HIV/AIDS services in Kenya: A Ministry of Health perspective; Askew I, Mullick S, Liambila W, et al. From global intentions to local realities: Adapting international guidelines on FP/RH and HIV/AIDS integration to national programs in Kenya; Rakwar J, Wilcher R. Policy considerations for effective and sustainable integration of family planning and HIV services.

All references are to presentations from the *Linking Reproductive Health and Family Planning with HIV/AIDS Programs in Africa* conference in Addis Ababa, Ethiopia, October 9-10, 2006.



PROGRAM DISPATCH

INTEGRATING HIV INTO MCH SERVICES IN UGANDA

Integration planned for all levels of the health system.

Nine out of 10 pregnancies among HIV-positive women in a study in rural Uganda were unintended, according to researchers from the U.S. Centers for Disease Control and Prevention in Uganda.

These preliminary findings, based on 86 pregnancies among 618 women in Tororo, Uganda, highlight the need to integrate the country's family planning and HIV services. Providing such services can help HIV-positive women avoid unintended pregnancies and contribute to preventing mother-to-child transmission (PMTCT) of HIV.

The World Health Organization's (WHO's) Africa Regional Office is promoting such an integrated approach to PMTCT in

sub-Saharan Africa. In 2006 it named Uganda a learning site where different ways of providing comprehensive PMTCT services can be tested and evaluated.

"The Ministry of Health (MOH) began integrating family planning, maternal and child health, and HIV services in 2005," says Dr. Angela Akol, project director in FHI's Uganda office. "This technical support from WHO gives the ministry an opportunity to accelerate these efforts while strengthening the evidence base for integration."

A working group of reproductive health and HIV experts has laid the foundation for an integrated approach in Uganda. Its members incorporated information about how to provide and evaluate HIV services into family planning tools and guidelines. They also developed training materials and service delivery guidelines, which were used to train a central team of master trainers. Non-medical health workers will be trained to provide certain community-based services, including HIV testing and counseling.

THE INITIATIVE

- Strengthen the ability of health systems to deliver integrated services
- Document experiences and develop best practice materials
- Develop tools and guidelines
- Provide technical guidance on integration

FAMILY PLANNING- VCT INTEGRATION IN KENYA

After integration, quality of care is the same or better.

Family planning is a powerful and cost-effective HIV prevention approach, enabling HIV-infected women to prevent unintended pregnancies and thus transmission of HIV from mother to child. But is it feasible to offer family planning services to women accessing voluntary counseling and testing (VCT) services without detracting from those VCT services?

Research in Kenya by Family Health International and partners indicates it is. An intervention measuring the effect of integrating family planning services within 14 VCT centers there improved family

planning service provision without compromising VCT quality of care.

In the study, an estimated 8 percent of VCT clients were HIV-positive and at risk of unintended pregnancy (and thus possible HIV transmission from mother to child). Overall, nearly a third of VCT clients were found to be at risk of unintended pregnancy.

Thus, as service integration continues in Kenya, researchers say advocacy efforts should emphasize that many VCT clients — both HIV-infected and -uninfected — are at risk of unintended pregnancy. To determine whether new knowledge or awareness of family planning's benefits actually increases contraceptive uptake, such uptake should be monitored, along with the quality of VCT services.

Read or download the full study report at <http://www.fhi.org/en/RH/Pubs/booksReports/FPVCTKenya.htm>.

THE INTERVENTION . . .

- Development of a training curriculum approved by the Kenyan government.
- Advocacy and sensitization: By March 2006, over 450 people, including counselors, supervisors, and provincial and district health managers, had attended meetings raising awareness of the feasibility of adding family planning to VCT services and of contraception's benefits for VCT clients.
- Training of VCT providers: By May 2006, 38 trainers and 132 providers from 68 VCT centers had received family planning/VCT service integration training.



. . . AND ITS EFFECTS ON FAMILY PLANNING PROVISION

- Discussion of any family planning method increased 17 percent from baseline to follow-up.
- Compared with untrained providers, trained providers were more than twice as likely to discuss family planning use and desire for children, more than three times as likely to discuss contraceptive pills and injectables, and more than eight times as likely to discuss other forms of contraception.
- Almost all supervisors and providers, and more than half of clients, said the introduction of family planning either improved or did not negatively affect VCT quality.
- The number of clients leaving VCT centers with a contraceptive method did not increase significantly, and even at follow-up, 40 percent of clients said they had not received any family planning information.

FIELD RESEARCH REPORT

INTEGRATING VCT INTO FAMILY PLANNING IN SOUTH AFRICA

Study compares costs of integration models.

A recent assessment of the costs of two models for integrating HIV voluntary counseling and testing (VCT) into family planning clinics in South Africa's Northwest Province found that either model was likely to be less expensive than creating and staffing a stand-alone VCT center.

The cost assessment by Family Health International, which sought to identify ways to increase family planning clients' access to VCT, was part of a FRONTIERS (Population Council/South Africa) study implemented by the South African Ministry of Health. In that study, 18 clinics were assigned to one of the following models: full integration, partial integration, or the standard model of separate family planning and HIV services.

The study ultimately found that the two integration models were feasible, acceptable, and effective without compromising the quality of family planning services.¹ Based on the study results, an evaluation of a model for increasing VCT uptake, uptake of dual protection against unintended pregnancy and HIV infection, and improving quality of family planning services is under way in South Africa. A similar study is being conducted by the Ministry of Health in Kenya and will be evaluated by FRONTIERS.

For the cost assessment, both the start-up cost of training family planning providers and annual cost of delivering integrated services were assessed. The findings indicate that, compared to the cost of setting up additional free-standing VCT centers:

- Fully integrating services with family planning service delivery points could be more efficient if family planning providers have time to provide VCT to clients.

- Partial integration could be more efficient if family planning providers are too busy to offer VCT to clients and nearby testing centers are underutilized.

Reference

1 Mullick S, Askew I, Maluka T, et al. Integrating counseling and testing into family planning services: What happens to the existing quality of family planning when HIV services are integrated in South Africa? *Linking Reproductive Health and Family Planning with HIV/AIDS Programs in Africa*. Addis Ababa, Ethiopia, October 9-10, 2006.

THE MODELS

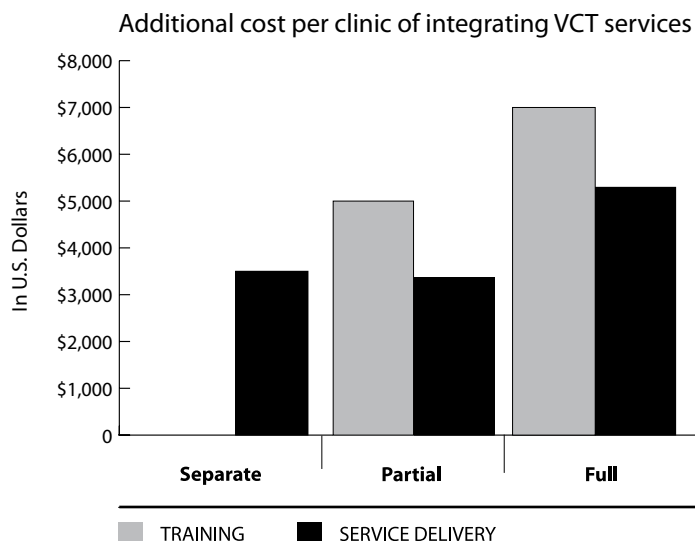
- **Full integration:** Providers trained to conduct pre- and post-test counseling and rapid HIV testing on site.
- **Partial integration:** Providers trained to offer pretest counseling and refer clients for HIV testing.
- **Separate services:** Family planning and VCT services remained separate.

RESULTS

The total cost of the full integration model was about US\$12,000 per clinic: \$6,900 for provider training and \$5,100 for service delivery.

The cost of the partial integration model was about US\$8,150 per clinic: \$4,900 for training and \$3,250 for service delivery.

Researchers caution, however, that these costs may vary in other contexts.



KEYPOINTS

- Integrating family planning and HIV services requires change at the national level.
- Training is essential because most providers do not know how to advise HIV-infected clients about family planning.
- Poverty and a shortage of trained providers pose formidable challenges to integration.

INTEGRATING FAMILY PLANNING AND HIV IN ZIMBABWE

Service integration begins with policy change and training.

In one sense, family planning and HIV services are integrated at the community level in Zimbabwe. In primary health care clinics throughout the country, a single health care provider is expected to offer not only basic services such as immunizations, but also family planning services and information about HIV prevention. Some may even be able to provide the antiretroviral drug nevirapine for prevention of mother to child transmission (PMTCT) of HIV.

At other levels of the country's health system, however, family planning and HIV services are separate, vertical programs. Providers countrywide are uncertain about how to advise HIV-positive women and couples about family planning, which is a primary strategy for reducing HIV-infected births. One example is the country's PMTCT program, which provides HIV counseling and testing to antenatal care clients and nevirapine for PMTCT to those who test HIV-positive at selected health centers and hospitals. Family planning services have not been well integrated into PMTCT and remain the program's "weak link," says Patricia Mbetu, country director for the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).

Despite a growing desire in Zimbabwe to better integrate family planning and HIV services, doing so requires change at the national level, says FHI's Gladys Dube, family planning and PMTCT advisor to the Zimbabwe HIV & AIDS Partnership Project.* To that end, the project is working with Zimbabwe's Ministry of Health and Child

* The project, led by Abt Associates in collaboration with Population Services International, Family Health International, and Banyan Global, is funded by the U.S. Agency for International Development (USAID).



HIV counselor Sylvia Madakadze, shown here using a model to demonstrate female condom use, now discusses a range of contraceptive options with her clients at the Genesis New Start Centre in Harare.

Welfare (MOHCW). And considerable progress has been made just in the last year.

Moving toward integration

The integration initiative began with an assessment of the family planning content of national HIV and reproductive health policies, guidelines, and training materials in June 2006. Eight of the 14 documents mentioned family planning, but none provided guidance on how to integrate services. By October 2006, the assessment's recommendations for strengthening or adding family planning content had been incorporated into the national strategy on PMTCT and pediatric HIV prevention, care, and treatment.

Contraception for Women and Couples with HIV, a training module developed by FHI and EngenderHealth, was adapted for inclusion in the national PMTCT training curriculum to strengthen providers' ability to provide family planning services. Dube and her colleagues at EGPAF, which supports MOHCW and nongovernmental organization PMTCT services nationwide, are using the curriculum to train 36 master trainers — three for each province — who in turn will train other PMTCT providers.

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The module also was used to train HIV counselors supported by the Partnership Project (see article, page 8). These efforts, and most other integration work in Zimbabwe, have introduced family planning into HIV services. Recently, however, the Zimbabwe National Family Planning Council (ZNFPC) asked the Partnership Project to do the opposite: to help train family planning counselors to advise HIV-infected clients. The project is including ZNFPC trainers in its sessions for PMTCT master trainers, where they will learn how to counsel HIV-positive clients about family planning and other “positive living” issues, such as diet, exercise, medical care, and psychological and social support.

ZNFPC trainers and service providers joined their counterparts from the country’s specialized HIV care clinics at a July 2006 training workshop on antiretroviral therapy, contraception, and managing opportunistic infections, which was organized by Zimbabwe’s HIV/AIDS Quality of Care Initiative (HAQOCI). HAQOCI used the FHI/EngenderHealth module for this workshop and has asked Dube to help revise national guidelines for HIV care, treatment, and support to ensure that providers are equipped to counsel patients about family planning.

Measuring progress

EGPAF and the Partnership Project worked with the MOHCW to develop a list of seven indicators of success in their service integration efforts. Two of those indicators measure progress in training providers in comprehensive PMTCT services that include family planning. Three indicators address how that training has affected whether clients actually receive enhanced family planning counseling. The final two indicators will assess impact, monitoring postpartum changes in reported use of contraception and in couple-years of protection among clients.

The project helped EGPAF’s partners and the New Start program (see article, page 8) adjust their reporting forms to incorporate the new indicators and began working with

MOHCW specialists to adapt its health and management information system to collect and analyze the information. “It doesn’t mean a lot of extra paperwork for them, just adding a few indicators to the forms they already have,” says EGPAF Program Officer Matthews Mariuzva.

Integration faces challenges

Encouraging national policymakers to integrate family planning and HIV is challenging, says Dube. In Zimbabwe, the dire economic situation exacerbates the usual competition for scarce resources between these programs. The country has an annual inflation rate of more than 1,700 percent, 80 percent unemployment, and chronic shortages of food, fuel, and medicines. Loss of trained health providers to other countries is also a serious problem.

Training Zimbabwe’s shrinking pool of health care providers to offer integrated services could be part of the solution to the country’s provider shortage, believes Dr. Owen Mugurungi, chief of the National Coordinating HIV/AIDS/TB Unit. “Severe resource constraints create motivation for integration,” he says. “We have to make sure services are integrated, because we cannot afford not to.”

HIV counselors Marvis Mudzana and Sylvia Madakadze point to a poster they use to counsel clients about different methods of contraception.



Resource on Integrated Services

Focus on ... *Integrating Family Planning and HIV/AIDS*

Services. A Digest of Key Resources.

Available at: www.infoforhealth.org/inforeports/.

To request a copy, please send an e-mail to:

orders@jhuccp.org or write to:

Orders, Center for Communication

Programs, Johns Hopkins

Bloomberg School of Public Health,

111 Market Place, Suite 310,

Baltimore, MD 21202, USA.

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ZIMBABWEAN HIV COUNSELORS OFFER FAMILY PLANNING ADVICE

During the client assessment at the beginning of each counseling session, HIV counselor Sylvia Madakadze asks about something she never used to talk much about: family planning. "Are you currently using a method?" she asks. "If so, which method?" She returns to the subject during post-test counseling, when she and her clients discuss how to avoid transmitting or acquiring HIV in the future.

"It is easy to blend it [family planning] in," says Madakadze, site manager at the Genesis New Start Centre in Harare. She was among the first 50 HIV counselors to receive training as part of a Zimbabwe HIV & AIDS Partnership Project initiative to strengthen HIV and family planning service integration in Zimbabwe (see article, page 6).

First established by Population Services International (PSI) in 1999, the USAID-funded New Start program provides HIV counseling and testing services to an average of 20,000 clients per month at 20 centers for a modest fee and through free outreach services. All 120 New Start counselors and the 22 counselors at the project's five post-test support centers were trained in family planning counseling in 2006.

To help counselors better understand their clients' family planning options, the FHI/EngenderHealth training module, *Contraception for Women and Couples with HIV*, was adapted for use in a two-and-a-half-hour session that is offered during New Start counselors' regular pre-service or refresher training. "Family planning was always part of the counseling, but some counselors were not doing it, and some were only talking about condoms," says Dr. Karin Hatzold, PSI's senior HIV/AIDS advisor in Zimbabwe.



The counselors particularly enjoyed the family planning component of their training "because the information was relatively new for them," she added. "The fact that family planning was an important part of PMTCT [prevention of mother-to-child transmission of HIV] was an eye-opener."

Five new questions on the centers' client intake forms remind counselors to discuss family planning with clients and help monitor whether those discussions take place. Counselors continue to advise consistent condom use for both the 30 percent of clients who test positive for HIV and those who test negative. Now they also discuss the limitations of condoms for contraception, provide information on other methods, and promote dual method use to prevent unintended pregnancies and sexually transmitted infections, including HIV.

New Start counselors offer clients condoms and refer them to nearby sources of family planning services for other methods. Counselors at the Genesis Centre say such services are accessible to their clients; outreach services in more remote areas are usually offered in local clinics that provide contraceptives. Family planning referrals have been added to the New Start referral tracking system, which can confirm successful referral of almost half of its clients.

Client response to family planning counseling has been positive, particularly among young people who have no other source for such information. "It seems that clients are more interested in our service because we are also offering family planning counseling," says Genesis counselor Marvis Mudzana.

Reference

1 Family Health International (FHI) and EngenderHealth. *Contraception for Women and Clients with HIV*. FHI and EngenderHealth, 2005. Available at: <http://www.fhi.org/en/RH/Training/trainmat/ARVmodule.htm>.