

Monitoring the Integration of Family Planning and HIV Services

Indicators Both to Measure Progress toward the 90-90-90 Targets and Ensure the Reproductive Rights of All Women

The HIV epidemic disproportionately affects women of reproductive age, especially in sub-Saharan Africa, where nearly 60 percent of people living with HIV are women. In support of the global 90-90-90 targets (see the box), the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommends reducing the number of unintended pregnancies among women living with HIV (WLHIV). Voluntary family planning (FP) services not only would reduce the number of children acquiring HIV but also reduce the risk for pregnancy-related complications and improve the health of WLHIV, by giving these women the means to space pregnancies (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014a; UNAIDS, 2014b). Improving the overall health of a woman will help her remain on HIV treatment and achieve viral suppression.



The challenge in sub-Saharan Africa is that 66 percent to 92 percent of WLHIV report not wanting another child (now or ever), but only 20 percent to 43 percent are using contraception. Moreover, some WLHIV desire more children but need information about how to increase the likelihood of safe conception and to reduce the chances of mother-to-child transmission of HIV when they do get pregnant (Baumgartner, et al., 2014; Kendall, et al., 2014). Integrating voluntary FP services in HIV care and treatment and safe conception and pregnancy services is a strategy used increasingly to meet the contraceptive needs of HIV-positive women and couples.

Women, including women living with HIV, should have a right to have the number of children they want and to space them to suit their own life's circumstances.

—The Gap Report, p. 234 (UNAIDS, 2014b)

UNAIDS has set the following HIV targets for 2020

- Diagnose 90 percent of all people living with HIV
- Provide treatment to 90 percent of those diagnosed HIV-positive
- Achieve viral suppression in 90 percent of those people receiving treatment by 2020.

—The Gap Report (UNAIDS, 2014b)

Successful integration of voluntary FP services in an HIV SDP necessarily involves multiple follow-up and revisit services, and is generally indicated when that SDP can also provide:

- FP screening
- Counseling for FP needs
- FP methods or referrals so clients can access FP methods not available same day or onsite (Medley, Bachanas, Grillo, Hasen, & Amanyiwe, 2015; United States President’s Emergency Plan for AIDS Relief [PEPFAR], 2013)

Yet, there is still discussion about how “integrated care” should be defined, and little agreement exists on how it should be measured—especially given the plethora of potentially applicable approaches for organizing integrated FP and HIV service delivery (FHI 360, 2013; World Health Organization [WHO], United States Agency for International Development [USAID], & FHI 360, 2009).

This brief, developed by the USAID-funded MEASURE Evaluation, outlines key elements of FP and HIV service integration as well as common challenges that limit their effectiveness. It is particularly useful to program managers and to technical and monitoring and evaluation (M&E) officers who are interested in determining whether integrated voluntary FP services being offered at HIV service delivery points (SDPs) are achieving their intended goals. The brief is a companion to a manual on this topic that MEASURE Evaluation also developed: *Monitoring the Integration of Family Planning and HIV Services: A Manual to Support the Use of Indicators to Measure Progress toward PEPFAR’s 990-90-90 Targets and Protect Women’s Reproductive Rights* (Freyder, Craig, & Kaji, 2016). The manual presents a set of indicators for monitoring the scope and outcomes of FP and HIV service integration. It is intended for use by USAID missions, but program managers elsewhere can benefit from it, as well.

A mathematical projection for Uganda showed that, while HIV services to prevent mother-to-child transmission averted an estimated 8.1 percent of vertical infections, family planning averted 19.7 percent. According to the model, unintended pregnancies accounted for 21.3 percent of new pediatric infections (Hladik, Stover, Esiru, Harper, & Tappero, 2009).

Integration Models

Modalities for integrating FP and HIV programs vary. Multiple approaches for organizing integrated service delivery are potentially applicable in the following situations, among others:

- A single HIV service provider offering FP counseling and contraception to a client
- An HIV client receiving FP services alongside her HIV services but from multiple providers
- Referrals, where HIV service providers encourage clients to seek FP counseling and methods at a separate clinic with separate providers

The mere coexistence of services in the same facility does not constitute integration. The application of a particular model depends on key components and in-country factors that, if limited, may pose challenges to successful integrated care (Adamchak, Okello, & Kabore, 2016; Baumgartner, et al., 2014; FHI 360, 2013; Hladik, et al., 2009; Medley, et al., 2015; PEPFAR, 2013; WHO, USAID, & FHI 360, 2009).

The appropriateness and feasibility of any particular integration approach is contingent on several factors: government leadership, through supportive laws, policies, and guidelines; available human resources; facility infrastructure, organizational structures, and funding streams; information management; provider time and capacity; functional supply chain and good commodity security; strong referral systems; and the nature of the HIV epidemic in an area (Adamchak, et al., 2016; Johnson, Varallyay, & Ametepi, 2012; Wilcher, Hoke, Adamchak, & Cates Jr, 2013).

PEPFAR has proposed the following technical platforms as most effective:

- Prevention of mother-to-child transmission of HIV
- DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe)
- Test and treat
- Key populations
- Community-based care and support
- Supply chain systems (PEPFAR, 2013)

Measurement of program effectiveness is essential to improve the integration of FP and HIV services, and standard indicators play an important role in assessing program performance. Using standard indicators makes it possible to monitor the results of integration efforts as well as the response to integration challenges commonly encountered (Adamchak, et al., 2016; Wilcher, et al., 2013).

Common Challenges

1. Integrated Service Delivery Information Systems

An integrated HIV-related SDP is one that provides FP screening, voluntary counseling for FP needs, and FP products or referral to its clients, in addition to HIV-related services. However, evidence suggests that neither FP screening nor the provision of voluntary FP counseling is well-recorded at the facility level. Poor documentation of FP services, and consequent failure to meet all three criteria for the integration of FP and HIV services, will result in underreporting and diminished capacity to capture FP/HIV integration at sites, regardless of actual service delivery (Adamchak, et al., 2016). Furthermore, challenges in adapting M&E tools for integrated service provision and interlinking patient monitoring systems have adverse effects on the quality, completeness, and availability of health data, adding to the burden of collecting and reporting additional indicators of integrated service provision (Johnson, et al., 2012).

Example of an Integrated Information System Challenge

Results from an FHI 360 pilot test of the feasibility of collecting data needed to calculate indicators of FP/HIV integration in five countries (Ethiopia, India, Rwanda, Tanzania, and Uganda) indicate that the weakness of referral systems and the poor documentation of completed referrals will likely bias the accuracy of indicators, such as “Percentage of HIV-related service delivery point clients who received a family planning method or referral after family planning counseling” (Adamchak et al., 2016). Investigators questioned whether referrals should be retained in the indicator, given that in many cases a referral is simply sending a woman down the hall to the FP room, where there is a high likelihood of completion. This could lead to an underestimation of the percentage of women whose FP needs are met through their contact with HIV services (Adamchak, et al., 2016).

Reference guides and tools (for example, job aids and information, education, and communication materials and checklists) can be used to support and improve providers' technical capacity and record-keeping. On-the-job training on data collection and reporting and supportive supervision for—and feedback sessions with—healthcare providers can also facilitate improvements in the quality of reporting by facilities (Achyut, et al., 2011; Interagency Task Team, World Health Organization, United Nations Children's Fund, & United Nations Population Fund, 2014).

2. Contraceptive Method Availability, Uptake, and Informed Choice

Improving the availability, accessibility, and acceptability of a range of contraceptive methods and minimizing provider bias are among the basic rights and principles of FP (FP2020 Rights and Empowerment Working Group, 2014; Newman, Fisher, Mayhew, & Stephenson, 2014). However, the range of FP methods offered depends on the resources of the clinic or facility and is constrained by vertical financing structures and procurement systems. Reporting on method-specific contraceptive use allows assessment of the effect of the integration intervention on the use of methods other than condoms (Johnson, et al., 2012; Wilcher, et al., 2013).

Coordinating mechanisms must be established and linkages between FP and HIV services must be strengthened in order to increase women's access to appropriate contraceptive care services and to support women in accepting a method or switching to a new one (Boonstra, 2011).

3. Training and Human Resources

Delivery of high-quality integrated services is often challenged by a lack of trained providers, who face heavy workloads with few incentives, and by a lack of refresher trainings in both FP and HIV services, which can perpetuate outdated practices (Johnson, et al., 2012; Johnston, et al., 2013). The point of training providers is so they can apply their skills and competencies correctly. This would be best assessed directly in the service delivery environment, but doing so, of course, is more challenging and resource-intensive (Church, et al., 2015). Strategies to address this are ensuring that providers have the necessary training and job supports, adding new staff positions, or task-shifting (Baumgartner, et al., 2014).

Countries that have high HIV prevalence and unmet need for FP services lack trained providers to deliver high-quality integrated services (Johnston, et al., 2013). Only 9.2 percent of healthcare workers in Tanzania and 25.4 percent of healthcare workers in Uganda were trained in both FP and any HIV services in the past three years (Johnson, et al., 2012).

4. Supportive Supervision and Healthcare Worker Accountability

Systems factors at the level of policy, infrastructure, and service delivery are lack of policy guidance on integrated care; limited physical space at SDPs, to ensure privacy and confidentiality and facilitate the physical co-location of services; poor oversight; inadequate monitoring systems; ambiguous service

delivery guidelines; and staff turnover, shortages, and overburdened healthcare workers. These factors often negatively influence the capacity and willingness of providers to deliver integrated services (Wilcher, et al., 2013). Routine checks and corrective support should be regularly performed and provided, and tailored job aids, patient records, and other forms should be used. In these ways, supervisors can identify client targets and determine if they are being met, thereby holding providers accountable for full implementation of an FP/HIV intervention (Baumgartner, et al., 2014).

The United States Government's legislative and policy requirements related to family planning targets must be considered when indicators to track FP outcomes are written and revised. The Tiarht Amendment provides that service providers and referral agents shall not implement or be subject to quotas or targets for the total number of births, number of FP acceptors, or the number of acceptors of a particular FP method (Gueye, Bayer, & Adina Hirsch, n.d.; USAID, 2015). For the purposes of this amendment, a target or quota is a predetermined number that a service provider or referral agent is assigned or required to affect or achieve. Although it is permissible to use quantitative estimators or indicators for planning and budgeting purposes, it is important to ensure that they do not translate into quotas or targets for individual service providers at service delivery points.

If you have questions or concerns about how to implement any of the indicators described in this brief and presented in detail in the accompanying manual while ensuring compliance with the Tiarht Amendment or other legislative or policy requirements, please contact your agency FP/HIV or FP compliance team or your legal advisor's office. Links to the USG FP policy and legislative compliance requirements are provided in the references section of this document (Gueye, et al., n.d.; USAID, 2015).

Indicators for Monitoring Progress

The table lists indicators from the MEASURE Evaluation manual that can be used to monitor the challenges described here and measure the progress of service integration.

The recommended indicators provide information on specific inputs and outputs and can be used together to provide an assessment of the overall FP/HIV integration situation. Data from these indicators can inform site-level preparedness to offer integrated FP services (the number of healthcare workers trained and the FP method supply); outputs of the service-delivery process (the number of services delivered; the number of new FP acceptors; and the duration of contraceptive protection); and, to a lesser extent, the quality of services provided (by assessing the range of FP methods available and the provision of supportive supervision).

FP/HIV Integration Indicators

Service delivery integration
<ul style="list-style-type: none"> • Percentage of HIV SDPs supported by PEPFAR that are providing integrated voluntary FP services (UNAIDS, 2014a)
<ul style="list-style-type: none"> • Percentage of (men and) women of reproductive age who receive FP counseling (including safe conception/safe pregnancy counseling) at a PEPFAR-supported HIV SDP
<ul style="list-style-type: none"> • Percentage of clients at PEPFAR-supported HIV SDPs who received a FP method
<ul style="list-style-type: none"> • Percentage of clients who received a referral from a PEPFAR-supported HIV SDP to an FP clinic
Contraceptive method availability, uptake, and informed choice
<ul style="list-style-type: none"> • Percentage of PEPFAR-supported HIV SDPs that offer at least three types of FP methods
<ul style="list-style-type: none"> • Number/type of contraceptive methods available at PEPFAR-supported HIV SDPs
<ul style="list-style-type: none"> • Number of FP clients who accept (for the first time in their lives) modern contraception at PEPFAR-supported HIV SDPs
<ul style="list-style-type: none"> • Couple-years of protection (CYP) in United States Government (USG)-supported PEPFAR programs
Training and human resources
<ul style="list-style-type: none"> ▪ Percentage of PEPFAR-supported healthcare workers who completed an FP training program
Supportive supervision and healthcare worker accountability
<ul style="list-style-type: none"> ▪ Percentage of PEPFAR-supported HIV SDPs offering at least three types of FP methods that have had documented routine supportive supervision of FP/HIV services within the past 12 months

Source: Freyder, Craig, & Kaji, 2016

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