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Family planning needs in the context of the HIV/AIDS epidemic: Findings from a three-country assessment covering Kenya, South Africa and Zimbabwe.

Pierre Ngom[*], Rose Wilcher[*], Maureen Kuyoh[*], Hazel Dube[*], Sonja Martin[*], Joshua Kimani[*], Tara Nutley[*], Ndugga Maggwa[*]

Abstract

One of the key contours of the post-ICPD era is the broadening of family planning programs to encompass reproductive health needs and rights. In sub-Saharan Africa, such an agenda has been blurred by HIV/AIDS, the leading cause of death among women and men of reproductive ages. Family planning (FP) programs are key pillars to the reduction of maternal mortality and the prevention of HIV infections and unwanted pregnancies. However, we do not know much about how the HIV/AIDS epidemic is impacting on family planning needs, services, and policies. Family Health International, in collaboration with Ministries of Health in Kenya, South Africa and Zimbabwe, has recently conducted an assessment of how the HIV/AIDS epidemic is affecting family planning needs and services in these countries. This paper presents findings from this assessment, namely: the current status of FP and HIV/AIDS programs, needs and opportunities for FP programs and services, and possible strategies for strengthening FP programs and services in the context of the HIV/AIDS epidemic.

Background

IN 2004, an estimated 28 million adults and children were living with HIV/AIDS in sub-Saharan Africa, making it by far the region most affected by the epidemic. With only 10 percent of the world population, sub-Saharan Africa accounted for at least 75 percent of the estimated 3 million global AIDS deaths in 2004 (UNAIDS, 2004). To address the escalating HIV/AIDS burden, government health departments are reallocating health resources, shifting the training and deployment of health personnel, and changing the overall organization of the public health infrastructure. Consequently, the region has seen an expansion of HIV prevention and care programs and services, such as prevention of mother-to-child transmission (PMTCT) programs, Voluntary Counseling and Testing (VCT) centers, provision of anti-retroviral therapy (ART), and home-based care. However, these programs are evolving as vertical programs and lack the provision of the traditional reproductive health (RH) services. As a result, attention and resources are being diverted from efforts to provide comprehensive RH services, as recommended by international conventions such as the 1994 International Conference on Population and Development.

Family planning (FP) falls within the realm of traditional RH services and is an important strategy for preventing HIV infection. For HIV-positive women, the prevention of unwanted pregnancies is critical for preventing mother-to-child transmission of HIV. While prophylactic treatment during pregnancy greatly reduces risk of transmission from

[*] Family Health International

mother to child (Sweat et al., 2004), simulation models developed by Family Health International (FHI) and World Health Organization (WHO) suggest that strengthening the FP component within the PMTCT four-prong strategy may be a more cost-effective approach for averting HIV-positive births (Reynolds et al., 2004). This finding is corroborated by research carried out on 14 different countries (Stover et al., 2003) and is the key message emanating from the 2004 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children. Currently, WHO recommends pregnancy prevention among HIV-positive women as a major component of PMTCT programs.

Despite the potential contribution of FP to the prevention of HIV infection and transmission, contraceptive use in sub-Saharan Africa, including condom use, remains low. The most recent DHS data indicate that the percentage of married women aged 15-49 using any method of contraception range from 6% in Mozambique and 8% in Ethiopia to 54% in Zimbabwe and 56% in South Africa. In addition, unmet need for FP remains high, ranging from 13% in Zimbabwe to 36% in Ethiopia and Rwanda.

While FP is critical in mitigating the impact of the HIV/AIDS epidemic in sub-Saharan Africa, there is still a lot to be learned about how the epidemic has affected FP needs and services in the region. As suggested by recent country assessments (Yared et al., 2003; Aloo-Abunga, 2003, Syacumpi et al., 2003, Advance Africa, 2002) , it is likely that the epidemic has impacted FP programs and services on multiple levels, and many fear that those gains that have been made in narrowing the gap between FP use and unmet need will soon be lost. At a service delivery level, significant shifts in the allocation of financial and technical resources to address the HIV/AIDS epidemic and diminished political support for FP may compromise access to and the quality of FP services. At the provider level, FP clinicians now have the added responsibility, yet lack the skills, to respond to the unique contraceptive needs of clients who are at risk of HIV infection or are already known to be living with HIV/AIDS. Providers in HIV prevention and care settings, on the other hand, need to promote both condoms and hormonal or other effective and long-acting contraceptive methods in order to prevent unwanted pregnancies among HIV-positive and HIV-negative clients. With respect to clients, the expansion of VCT centers and knowledge of one's HIV status, may affect women's desire for children, use of FP, and sexual activity. Moreover, the impact of the HIV/AIDS epidemic is also believed to be having some negative ramifications on the visibility of the family planning movement worldwide (Blanc and Tsui, 2005).

Objectives, data Collection methodology and analysis

In 2003/04, Family Health International (FHI), in collaboration with the Commonwealth Regional Health Community Secretariat (CRHCS), the Regional Center for Quality of Health Care and in-country partners, carried out country assessments on the current status of FP and HIV/AIDS programs in Kenya, South Africa and Zimbabwe, the needs of and opportunities for FP programs and services, and possible strategies for strengthening FP programs and services in light of the increasing burden of the HIV/AIDS epidemic. This three-country assessment aimed to describe levels and trends in family planning and

HIV/AIDS indicators, synthesize existing FP and HIV/AIDS policies and strategies, assess shifts in attention and funding from FP to HIV/AIDS, identify existing policy gaps and challenges in providing FP services in the context of the HIV/AIDS epidemic. In each country, the assessment was also to yield information on the impact of HIV/AIDS on sexual behavior, family planning demand, the contraceptive needs of people living with HIV/AIDS (PLWHA) and opportunities/challenges for linking FP and HIV/AIDS services. To achieve these objectives, FHI collaborated with in-country partners so that the overall process was implemented within a Research to Practice approach. The information gathered during the assessment was intended to strengthen FP programs and services in the context of the HIV/AIDS epidemic.

At the beginning of the assessment process, a stakeholder team was formed in each country to provide guidance to the activities and ensure that the assessment produces locally relevant and programmatically useful information. Under the leadership of the local MoH, FHI and its partners then assembled an "Assessment Team" in each country that conducted a series of information gathering activities. The assessment team was typically composed of 6-8 members representing diverse areas of expertise, and compiled assessment data via such activities as a desk review of epidemiological, programmatic and policy documents, and in-depth interviews and focus group discussions with key informants and service providers.

Assessment teams analyzed the content of their notes at the end of each day of field work and wrote a report on the main findings, following outline templates designed by the project leaders. These outlines, as well as the interviewing guides, were designed to provide fairly uniform ways of collecting the data and reporting findings. At the end of their ten days in a province, team members used the suggested outline to summarize their findings and submitted a draft report to FHI. The project lead consultants then consolidated all the team reports into one fieldwork report. The final assessment activity was a working meeting with stakeholders to present the findings from the assessment, discuss key themes, build consensus regarding program gaps and opportunities, and formulate action plans to strengthen FP services and programs in the context of the HIV/AIDS epidemic.

Findings

Fertility, family planning and HIV/AIDS in Kenya, South Africa and Zimbabwe

The successful family planning services in Kenya, Zimbabwe and South Africa explain mainly the steep decline in fertility rates in these countries. Various surveys carried out in Kenya show that the total fertility rate (TFR) dropped sharply from 8.1 in 1978 to 4.9 in 2003. In the same period, the contraceptive prevalence rate (CPR) rose from 7 percent to 39 percent. During the 1982-1999 period, the TFR in Zimbabwe declined from 6.0 to 4.0, while the CPR increased from 27 percent to 50 percent. Current levels of TFR are relatively low for South Africa; the 2001 total fertility rate was 2.8, down from 5.8 in 1970, and the CPR increased from 35 percent in 1975/76 to 55 percent in 1998. Starting in the mid 1990s, there has been, however, a fertility stall, not just in Kenya, but also in South Africa and Zimbabwe. While in Kenya such a stall is also reflected in the trends in

the CPR, this is not the case in Zimbabwe and South Africa, two countries where HIV/AIDS prevalence rates are abnormally very high.

HIV/AIDS prevalence in Kenya has been declining since 1995 when it peaked at 23 percent to 9 percent in 2003, a level confirmed by the 2003 KDHS. In Zimbabwe, HIV/AIDS prevalence level increased from 17 percent in 1990 to 25 percent in 2002. The South Africa Department of Health estimate the HIV/AIDS prevalence at 16 percent in 2002, up from 2 percent in 1991. These national levels and trends data are from sentinel surveillance. Such data have often been blamed for underestimating HIV/AIDS prevalence, as they focus only on pregnant women attending antenatal clinics. Besides trends in HIV/AIDS surveillance data may be influenced by changes in data collection methodology and in the composition of the sentinel sites (Borgdorff et al. 1993).

Policies, strategies and guidelines

There is no shortage of family planning/reproductive health and HIV/AIDS policies in the three countries covered by this study. The desk reviews conducted during this study indicate clearly that there were no conflicts between existing HIV/AIDS and family planning policies (Mati, 2004; Moyo, 2004; Obi, 2004). Kenya's national HIV/AIDS policy states that voluntary HIV counseling and testing (VCT) among women and men of reproductive age can enhance decision-making about fertility, and the country's VCT guidelines present family planning as a major component of VCT services. The comprehensive national policy on HIV/AIDS in South Africa mentions family planning in the context of PMTCT in that it advocates *"improving family planning services to known HIV-positive women."* South Africa's VCT guidelines also mention family planning as part of providing comprehensive care for people with HIV/AIDS and as part of pretest counseling on *"safer sex strategies to reduce risk."* Family planning services are mentioned in the guidelines for feeding infants of HIV-positive mothers as part of the comprehensive care these mothers may need. The National Contraceptive Policy Guidelines highlight the dual role of barrier methods in protecting against pregnancy and sexually transmitted infections (STIs) including HIV/AIDS, and acknowledge HIV/AIDS as a specific reproductive health concern. In Zimbabwe, the national reproductive health policy and national family Planning Stragey documents call for the integration of family planning and sexually transmitted infection management. In addition, interviewees from the Zimbabwe National Family Planning Council (ZNFPC) indicated that the country's Family Planning Act of 1985 is being revised to integrate reproductive health programs and activities, including those focused on HIV/AIDS.

In the three countries, the major strategy for disseminating policies is through training workshops. Majority of the study respondents were aware of existing family planning and HIV/AIDS policies. However, stakeholders such as provincial and district health officials and members of key professional bodies said that they were not adequately engaged in policy formulation, which they perceived as a "top-down" process.

Key informants agreed that dissemination of policies to the grassroots was hampered by high turnover among health professionals, poor communication and supervision, and

reduced training opportunities for providers. Barriers to implementing policies included weak service delivery systems and a lack of demonstrated political will, particularly in supporting the provision of condoms and other family planning services to youth.

Policy gaps

Despite the availability of several policies and guidelines on family planning and HIV/AIDS, several gaps were identified by the study respondents, especially at implementation level. A recurrent concern from respondents was that most policies and programs were vertical, leaving little room for integration of family planning and HIV/AIDS services or for partnership with other public and private sectors. A program manager in South Africa remarked that, *"There is a lack of integrated interdepartmental policies at the national level. For instance, schools refuse promotion and distribution of condoms based on Department of Education Policies."*

Concrete measures to reach traditionally excluded groups such as youth and men were considered as a major hurdle to the full success of family planning services. Respondents were of the view that integration of FP services into HIV/AIDS services was a sound way of overcoming this problem while meeting the FP need of people living with HIV/AIDS.

The third area highlighted by respondents was monitoring and evaluation (M&E). Respondents felt that the M&E of implementation and utilization of policies and guidelines were often inadequate, not standardized and unfunded. This situation made it difficult to measure outcomes and disseminate related findings to gain support for translating research into practice and for implementing evidence-based interventions. In Zimbabwe, for instance, health professionals indicated that they would like to see a policy that will allow routine HIV testing on all pregnant women, and data from the national prevention of mother-to-child transmission (PMTCT) program suggests that this would be acceptable to the women. However, initiatives to determine the best ways to implement routine HIV testing and evaluate its impact are lacking.

There were, however, other key issues that were country-specific and that are worth mentioning. In Kenya, key informants felt that the absence of a Health Master Plan with clear priorities and identified needs leaves donors to set health service priorities, leading to an over-concentration of resources in some interventions and geographical areas. Key informants in Zimbabwe were of the view that FP and HIV/AIDS policies do not differentiate the needs of urban versus rural populations and are not simplified and translated into languages that can be well understood in rural areas. In South Africa, respondents commented that existing reproductive health and HIV/AIDS policies do not address critical cultural practices affecting HIV/AIDS prevention and care and family planning use. According to most respondents, these practices, which include circumcision, virginity testing, and tattooing, among others, were associated with high levels of morbidity and mortality in several ethnic groups in South Africa.

Shifts in resources for family planning programs

Except in South Africa, international donor funds are the major source that supports family planning programs in sub-Saharan Africa. Respondents in Kenya, South Africa and Zimbabwe were unanimous that family planning funding has plummeted, while HIV/AIDS allocations have soared.

In Kenya, one of the top donor agencies recognized that it has cut its support for family planning by one-third from 1995 to 2002, while increasing its funding for HIV/AIDS programs six-fold. A Kenya district team member lamented that *"Family planning is now dying as HIV comes up"*.

In South Africa, one representative of a top donor agency supported the view that family planning may be receiving little attention, highlighting the focus of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) fund: *"Due to the focus on the PEPFAR key areas of 2-7-10,[1] reproductive health and family planning is becoming less relevant…only projects that address the 2-7-10 agenda are being given attention at all levels."* However, key informants were mixed in their opinions of how the HIV/AIDS epidemic has affected family planning funding. Some speculated that family planning funding has remained stable, while others argued that family planning funds have been diverted to fight the HIV/AIDS epidemic.

Key informants in Zimbabwe were of the view that the HIV/AIDS pandemic has undermined the government's ability and capacity to fund all programs—including family planning programs—at both micro and macro levels. Overall, donor assistance to the Ministry of Health and Child Welfare (MOHCW) has decreased from US$71 million in 1997 to US$7 million in 2002. This decline has substantially affected family planning programs; 54 percent of resources required to run the Zimbabwe National Family Planning Council (ZNFPC) technical programs are provided by donors and 44 percent are provided from the sale of family planning products and services. Government officials reported that ZNFPC continues to receive government support at requested levels, but data show that government funding for ZNFPC—in real terms—decreased from Z$7.4 million in 1994 to Z$2.95 million in 2002. In contrast, HIV/AIDS programs have a much broader funding base, as donors that have pulled out of other sectors have continued to support HIV/AIDS programs. At least in some provinces, funding for these programs appears to be increasing. In 1999, an AIDS levy was introduced to supplement the MOHCW's budget for HIV/AIDS. The levy has already provided Z$23 billion to the government, and the National AIDS Council (NAC) has disbursed more than Z$5 billion to communities, sector ministries, and nongovernmental organizations providing HIV/AIDS prevention, care, and support.

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[1]treating 2 million people with AIDS, averting 7 million new HIV infections, and providing palliative care to 10 million people.

Challenges in providing family planning services in the context of HIV/AIDS

Findings from the assessment suggest strongly that more attention is being paid to HIV/AIDS programs than to family planning programs. As a result, only limited training and refresher courses are available, especially for new service providers with no formal training in family planning. Furthermore, high staff turnover has caused remaining staff to become demoralized and overburdened by high workloads, and many are moving elsewhere for better-paying jobs. Constant shifting of personnel at program management and service delivery levels to accommodate HIV/AIDS program needs has resulted in a lack of effective communication and supervisory support. Space previously used for family planning services is now shared with HIV/AIDS services, which sometimes compromises privacy and quality of care. Poor quality of family planning services, in turn, leads to low demand.

Shifts in funding from FP to HIV/AIDS also hamper efforts to create demand for family planning. In Kenya, key informants reported that the once strong information, education and communication (IEC) program was moribund: most health facilities had no materials for promoting family planning, and overburdened providers had little time to provide education and counseling to clients. The community-based distribution program -- considered one of the major contributors to the rapid uptake of family planning in Kenya and formerly the source of supply for 11 percent of Pill users -- has been discontinued in most parts of the country as a result of donor funding cutbacks. Supply of family planning commodities was found to be erratic, limiting method choice and encouraging method discontinuation. At clinics and other service delivery points in all Kenyan provinces, most family planning commodities were out of stock for the better part of 2003.

National-level program managers reported that the large numbers of people living with HIV presents a challenge because their emerging family planning needs must be addressed with limited resources. In addition, many service providers are not confident dealing with the contraceptive needs of HIV-positive clients. This was particularly mentioned in South Africa where many key informants believed that family planning service providers failed to actively promote dual protection, especially in rural areas. Instead, it was thought that there was too much reliance on injectable contraceptives and limited discussion of the need for barrier method use to protect against both pregnancy and HIV infection.

Family planning-related behavior within the context of HIV/AIDS

Sexual Behavior

Sexual behavior was the area where opinions from key informant differed most, both within and between countries. Kenyan key informants were divided over whether HIV/AIDS had significantly affected sexual behavior. Some said the changes were minimal. Others cited increased condom use or reports of reduced business by sex workers as evidence that fear of HIV/AIDS was leading Kenyans to change their sexual behavior. Most service providers offered anecdotal reports of increased condom use, although the extent of dual method use was unknown to them. In South Africa, most respondents felt that HIV/AIDS has not affected the

sexual and reproductive health behavior and choices of family planning users, particularly the younger users. In contrast, the majority of key informants in Zimbabwe pointed to the adoption of safer sexual habits. The primary behavior change cited was an increase in the uptake of condoms. This was paralleled by large increases in the number of condoms distributed through the public sector, from 14 million in 1997 to 40 million in 2003. Condom use was also reported to have increased among youth, though no data were available on consistency and correctness of such use.

Fertility desires

When asked about their perceived effects of the HIV/AIDS epidemic on fertility desires, respondents in Kenya and South Africa were of the view that the impact was both negative and positive. Key informants in Kenya reported that although some couples who perceive themselves at high risk of HIV/AIDS may decide not to have children because of the "precarious future" that may be caused by them contracting the disease; others argued that they may as well want more children to help support them when sick. They also noted that having children can help HIV-infected women hide their status. These mixed feelings should be contrasted with the findings from the 1993 and 2003 KDHS data. From 1993 to 2003, the percentage of women who said they wanted to have children within the next two or more years increased from 38 percent to 45 percent (Central Bureau of Statistics et al., 2004). Some key informants interviewed in Kenya explained these findings by a desire from society to "replenish the population" in response to AIDS-related deaths and the rising infant mortality over the past decade. In South Africa, reasons for positive/negative impact of HIV/AIDS on fertility desires were quite different to those evoked in Kenya. Some South African respondents believed that the desire to have children because of the availability of child-support grants might be overriding any concerns about contracting HIV/AIDS. As one key informant said, *"Married couples desire to have children regardless of their HIV status … they do it because they want the child grant."* Other respondents stated that the fear of HIV infection and leaving a trail of orphans might be diminishing the desire to have children. As one participant explained, *"Parents do not want to have children because they are scared to leave babies behind as orphans when they die."* Another observed, *"We are seeing a lower birth rate because of HIV and AIDS."*

Findings from Zimbabwe were unequivocal; the general consensus among respondents was that demand for family planning has increased in recent years, and representatives of both the MOHCW and ZNFPC believed that rates of contraceptive use could be as high as 60 percent by 2005. They argued that such increase underlies the introduction of depot holders to resupply contraceptives for continuing clients, the integration of family planning and HIV/AIDS services at some facilities and the renovation of farmhouses to clinics in two provinces so that family planning and other health services can be offered to more clients. Most respondents believed that HIV is the cause for the increase in family planning demand as couples seek contraception to limit childbearing, and avoid pregnancy and infection. Another common view among respondent was that people living with HIV/AIDS (including men) were using DMPA to gain weight.

Family planning needs of individuals and couples living with HIV/AIDS
Key informants in every country consistently emphasized that "with or without AIDS, family planning has a place." Most informants were of the view that HIV-infected people have family planning needs just as non-infected people do, and that differences relate mainly to the method mix hence the need for more counseling and support to PLWHA regarding their contraceptive method of choice. A common perception among service providers was that there was a high unmet need for family planning among PLWHA because stigma makes them reluctant to visit family planning clinics.

A few service providers expressed concern about the appropriateness of certain contraceptive methods for HIV-infected women. In all three countries, service providers raised concerns about administering an IUD to an HIV-infected woman because they thought it increased the risk of HIV/STI transmission and acquisition. But all available evidence shows that the IUD use is safe for HIV-infected women. In fact, the World Health Organization now recommends IUDs as an option for women living with HIV unless they have developed AIDS and do not have access to or are not responding to antiretroviral treatment (WHO, 2004). These concerns among providers may reflect a need for refresher trainings on contraception for HIV-infected women. In addition, a few service providers in Kenya expressed concerns about prescribing the pill to HIV-infected clients who are vomiting, which renders the method ineffective, and also to patients on certain anti-TB treatments because of possible drug interactions. In Zimbabwe, concerns were raised about the use of injectables and implants among HIV-positive clients and about possible interactions between ARV drugs and hormonal contraceptives. Because they were uncertain about the possible interactions between ARV drugs and hormonal contraceptives, many health professionals reported that they would instead encourage HIV-positive clients or those suspected to be HIV positive to use condoms. These concerns corroborate the programmatic relevance of recent studies that are examining the possible impact of hormonal contraceptives on HIV acquisition, transmission, and disease progression (Morisson and Best, 2004, Larveys et al., 2004, Wang et al., 2004.)

Linkages of HIV/AIDS and family planning services
Although most respondents rated efforts of linking HIV/AIDS and family planning services as weak in their respective countries, the vast majority saw integration as the logical way forward for providing high-quality family planning and HIV/AIDS prevention and care services. The same personnel implement multiple programs in the districts, and provincial and district health management teams said the lack of integration compromises efficiency. Key informants identified the following benefits of an integrated approach: Expanded access to and coverage of family planning, STI/HIV, and AIDS services, improved efficiency and cost-effectiveness, delivery of more services during each client contact, improved client satisfaction, increased acceptance of family planning services, changes in HIV-related high-risk behaviors, increased condom use by family planning clients, and reduced duplication of service-delivery functions.

Respondents were optimistic about the feasibility of linking HIV/AIDS and family planning services. Interventions for HIV/AIDS and family planning both target sexually active individuals and promote use of barrier methods. Respondents indicated that most

of the existing strategies and guidelines support linkages between family planning and HIV/AIDS programs. Integrated services were considered as a good approach to accessing those who are hard to reach, including men and youth. Also, the same staff could be trained to offer integrated services and existing logistical and supply systems can be used to procure supplies and commodities for both services, while existing infrastructure, with minor or no modifications, can be used for integrated services. Expansion of HIV/AIDS services such as PMTCT, VCT, ARV therapy, and HBC offers opportunities to satisfy the unmet need for family planning among their clients. Finally, respondents were of the view that providing integrated services under one roof could help overcome challenges posed by the stigma often associated with attending stand-alone HIV/AIDS services.

Another important area of inquiry was the type of outlet where integration can be implemented, and the types of family planning and HIV/AIDS services that can be integrated in such outlets. Table 1 shows the potential areas of synergy for both family planning and HIV/AIDS programs identified by key informants.

Table 1: Opportunities for integrating RH/FP and HIV/AIDS services

Main services/products provided by outlet	***Opportunities for HIV/AIDS programming***	***Opportunities for RH/FP programming***
Antenatal care	Channel for information and services or referral to VCT, PMTCT, HBC	Antenatal care; FP information and counseling
Maternity care	VCT and PMTCT services	Delivery services; FP services or referral
Postnatal care	VCT, ARV information, service, or referral	Postnatal care, breastfeeding, neonatal care FP services – all methods
Family planning	FP needs of HIV+ and discordant couples; interactions between FP methods and HIV; ARV and TB therapy and hormonal methods	All FP; interactions of ARVs and anti-TB drugs with hormonal methods
Barrier methods	Protection against HIV and sexually transmitted infections; promotion of dual protection	Contraception; promotion of dual protection
CBD	Demand creation for VCT, PMTCT, ARV therapy, HBC; referral	Demand creation for FP; provision of selected contraceptive methods
PMTCT	VCT; prophylaxis against MTCT	Contraceptives to prevent future pregnancy
VCT	All VCT services; risk reduction counseling	FP counseling, services, and referral Access to men, youth, and adolescents
ARV therapy	All services	FP information, services, referral; access to men, youth, and adolescents
HBC	All services	FP services for HIV-infected and -affected people

NB: CBD=community-based distribution; RH=reproductive health; FP=family planning; VCT=voluntary counseling and testing; PMTCT= prevention of mother-to-child transmission; HBC=home-based care; ARV=antiretroviral

Despite the solid grounds for integration of family planning and HIV/AIDS services, respondents pointed to key challenges, namely: gaining support of some policy makers, program managers, and service providers who are ambivalent toward integration; developing policies that specifically address integration; meeting the required training,

motivation and support of multi-skilled workers, avoiding overburdening staff at a time of severe shortage; and mobilizing resources to renovate or expand overcrowded health facilities. Moreover, these challenges should be addressed within the context of shifting interests towards HIV/AIDS programming and dwindling funding for family planning services.

The Way Forward

During the project workshops held in each country, stakeholders provided input to both the assessment process and outcome. As shown in the respective country appendix, stakeholders emphasized the following directions towards repositioning and/or strengthening family planning programs within the context of the HIV/AIDS epidemic: advocate for political commitment, develop and disseminate policies and guidelines for the integration of family planning and HIV/AIDS services, integrate family planning and HIV/AIDS services, carry out further research on ways of strengthening family planning programs in the context of the HIV/AIDS epidemic.

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APPENDIX:
Family planning needs in the context of the HIV/AIDS epidemic: Recommendations from family planning and HIV/AIDS stakeholders

1. KENYA

Political commitment

- The GOK should affirm its commitment to existing policies on population and development by recognizing family planning as a crucial strategy for attaining development goals, allocating sufficient funds for family planning, and establishing a line item for family planning in the national budget.
- Stakeholders should raise awareness among government officials and donors about the erosion of Kenya's progress in reproductive health and build support for resource mobilization and other measures to reverse this trend, as follows:

Policy development, dissemination, and implementation

- Involve stakeholders in developing policies to ensure effective implementation and to make policies more responsive to the diverse needs of Kenyan communities.
- Strengthen mechanisms for distributing and disseminating policies and guidelines to ensure they reach implementers at all levels.
- Encourage the full participation of the private sector in policy development, strategic planning, and implementation. Include the private sector in the Ministry of Health's supervision, monitoring, and evaluation network.

Supervision, monitoring, and evaluation

- Include in strategic plans provisions for facilitative supervision, monitoring, and evaluation that involve all service delivery points, including private providers.
- Establish an effective mechanism to coordinate the activities of various service providers, including the many community-based organizations involved in HIV/AIDS activities.
- Strengthen management capacity by adequately preparing and remunerating managers, from the district ministries of health to those in charge of health centers and dispensaries.
- Improve Ministry of Health staff morale and motivation through measures such as appreciation, recognition, better wages, and improved training opportunities.

Service delivery

- Establish mechanisms for integrating components of family planning services into all HIV/AIDS programs, particularly those providing VCT, PMTCT, ARV therapy, anti-TB therapy, and HBC services.
- Integrate elements of HIV/AIDS prevention and care into family planning programs where appropriate and strengthen the capacity of family planning providers to address the reproductive health needs of HIV-infected women.
- Improve efficiency of service delivery through appropriate deployment of service providers in areas where their skills are most needed.

- Consider reviving the CBD program. In addition to promoting family planning and providing methods such as condoms and pills, community-based distributors could also help increase demand for HIV/AIDS services such as VCT, PMTCT, and ARV therapy and could play an active role in HBC programs. HBC community health workers can also assess the reproductive health needs of their clients and provide basic reproductive health services and referral.
- Strengthen mechanisms for commodity procurement and distribution to ensure contraceptive security.
- Develop strategies to make family planning and HIV/AIDS services more "youth-friendly" and to promote involvement of men in reproductive health and HIV/AIDS prevention and care.

Research to practice

- Review and update the existing family planning guidelines to ensure they reflect currently accepted practices in the era of HIV/AIDS and address service providers' concerns about the use of family planning methods by people living with HIV.
- Integrate family planning into training curricula for HIV/AIDS programs. Integrated training could reduce the impact of staff shortages by producing service providers capable of performing multiple roles**.**

Research needs

- Conduct research to improve our understanding of the effects of HIV/AIDS on family planning practice, behavior change, increased or reduced demand for family planning, and access to family planning services.
- Rigorously evaluate efforts to integrate family planning and HIV/AIDS services to identify effective integrated service delivery models and understand their impact on contraceptive use.

2. SOUTH AFRICA

Policy

- Policies should be developed to improve access to and functioning of referral systems between family planning and HIV/AIDS services.
- Guidelines on the delivery of integrated services should be developed to support such programmatic efforts.
- Cultural perspectives should be considered in policy formulation.

Programs

- Reproductive health outreach programs for youth should be established through schools and youth groups.
- Family planning, VCT, and PMTCT services should address gender issues and increase male involvement through a renewed focus on couples counseling.
- Incentives such as increased salaries and allowances should be explored to halt the "brain drain" among health professionals.
- Integrated professional training should be established for family planning and HIV/AIDS staff. This training should emphasize dual-protection counseling and update trainees on the medical eligibility criteria for contraceptive use among HIV-infected women.
- The disbursement of social and HIV/AIDS grants should be strictly monitored and evaluated to minimize abuse.

Research

- A situational analysis should be performed in all provinces in South Africa to assess the readiness of clinics to provide integrated HIV/AIDS and family planning services. In addition, operations research should be conducted to determine effective models of integration.
- Given the conflicting opinions among key informants, rigorous behavioral research should be conducted with both HIV-infected and non-infected individuals to determine how the HIV/AIDS epidemic is affecting fertility desires and contraceptive practices.
- The factors contributing to the use and nonuse of different contraceptive methods should be studied, especially for condoms.
- The relationship between social grants and the spread of HIV/AIDS in South Africa should be examined.
- The socio-cultural issues surrounding dual-protection practice in South Africa should be elucidated.

3. ZIMBABWE

Stakeholder commitment

- All stakeholders need to be involved in decision-making about integration, and a coordinator of the integration process—perhaps a coordination body to monitor integration efforts and programs—should be established.
- Parliamentarians need to be well informed on family planning issues and policy needs if they are to mobilize political support and oversee programs once more policies are in place.
- Donors are encouraged to review the programs they are supporting and to fund integration so that all reproductive health programs are linked and no component lags behind.

Advocacy and education

- Renewed advocacy for family planning is needed at both national and provincial levels so that family planning will be viewed as a priority by all opinion leaders.
- Increased advocacy and community mobilization are needed to reduce stigma associated with HIV/AIDS and to inform people about VCT and PMTCT programs so they can make more informed choices about their reproductive health.

Policy issues

- No national family planning policy exists, so family planning sections from different policy documents should be consolidated into one document to facilitate standardization of service provision.
- Policies that infringe on reproductive health rights should be reviewed and revised as necessary. A need also exists to review and revise policies in an effort to reduce stigma and discrimination (e.g., to ensure that AIDS is treated like any other infection).
- To facilitate the integration of family planning and HIV services, guidelines for providing integrated services should be developed.
- Correct and updated information on what factors influence policy development needs to be made available to programmers, service providers, activists, and other family planning stakeholders to enhance the policy-development process.

Organizational restructuring

- The MOHCW should encourage interaction between reproductive health and HIV/AIDS departments and improve current human resource management to address salary issues for health workers.
- ZNFPC and the NAC should be working together because ZNFPC's strong programmatic capacity can complement the NAC's availability of resources.

Service delivery

- The concept of dual protection needs to be emphasized among both service providers and clients, as some providers are not fully conversant on the concept and there is low acceptance of condoms for dual protection among clients.

- Intense capacity building is needed to empower HIV/AIDS counselors to discuss and dispense contraceptives, and for family planning providers to discuss HIV-related issues.
- An effective referral system needs to be established so that clients can be referred to more specialized services when needed or when full integration of family planning and HIV/AIDS services is not possible.
- The ARV therapy program should be expanded so that affordable drugs are available to clients in more districts and that demand for VCT increases.
- ZNFPC's integrated community-based distribution program should be expanded to all districts.
- More mobile clinics should be established to reach underserved populations.
- A balance should be established for resource allocation between urban and rural areas so that service provision is comparable in all settings.

Training

- More demand is being placed on community-based distributors, so village workers and traditional birth attendants should be trained to complement their service provision.
- Nurses should receive more training on insertion of intrauterine devices and implantable contraceptives, and in the management of sexually transmitted infections.
- The post of medical officer of health services, who was responsible for training doctors and other health workers in both family planning and maternal and child health, should be revived and should include a responsibility to train these providers on HIV/AIDS as well.
- A training needs assessment should be conducted to reform training curricula for both family planning and HIV/AIDS. Family planning certificates should expire, and service providers who complete refresher courses should receive revised certificates.

Research to practice

- More operational research is needed in Zimbabwe to guide policy and help clients make more informed choices about their reproductive health. Specifically, more research is needed on interactions between HIV drugs and hormonal contraceptives, behavior change communication, gender issues, dual protection, safe and effective contraceptive methods for people living with HIV/AIDS, and operational issues surrounding the integration of family planning and HIV/AIDS services.
- More support should be given to research institutions within the MOHCW and ZNFPC to strengthen research to practice and to support integration efforts.