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The Integrated Family Health Program (IFHP) is a five-year, USAID-funded program to support FP and maternal, newborn, and child health (MNCH). IFHP is implemented by Pathfinder International and John Snow International, Inc., in collaboration with the Ethiopian Consortium of Reproductive Health Associations. With the overall goal of improved family health, IFHP strengthens the capacity of the health system to deliver key health services and commodities.

Integrating Family Planning and HIV in Ethiopia: An Analysis of Pathfinder's Approach and Scale-Up

Pathfinder International Ethiopia has extensive experience implementing family planning (FP)/HIV integration through public health centers (HCs) and community networks. This brief describes our approach and its evolution and scale-up over time. It presents our experience in relation to the recommendations of World Health Organization (WHO) guidelines on FP/HIV integration and also outlines next steps and recommendations.

Background

FAMILY PLANNING/HIV INTEGRATION

Many stakeholders agree that integrating FP services and HIV prevention, care, and treatment services provides valuable opportunities to: increase access to contraception among clients of HIV services who do not wish to become pregnant; ensure a safe, healthy pregnancy and birth for clients who do wish to have a child; and provide valuable HIV prevention and support

services to FP clients. Notably, the first of these opportunities contributes to preventing unintended pregnancy among women with HIV, which is one of the four cornerstones of a comprehensive approach to preventing vertical transmission of HIV.

Depending on local needs and health facility capacity, the extent to which FP and HIV can be integrated differs, particularly when introducing FP in HIV services. All HIV services that integrate FP should offer: screening for unmet need for



FIGURE 1: IFHP OPERATIONAL WOREDAS, 2011

contraception; promotion of dual method use; provision of condoms and other contraceptives according to training and availability; accurate information about all contraceptive methods; counseling for women or couples with HIV who desire a safer pregnancy; and referrals for contraceptive methods that the provider is not able to directly offer.

INTEGRATED FAMILY HEALTH PROGRAM

Pathfinder International has supported FP in Ethiopia since the 1960s through the establishment of the Family Guidance Association of Ethiopia, a pioneer in FP programming. Pathfinder Ethiopia has implemented large-scale FP and reproductive health (RH) programs for almost 16 years since opening a country office in Ethiopia in 1995 and works with stakeholders at all levels of the community and the health system. Through IFHP, Pathfinder and our partners promote an integrated model for strengthening MNCH, RH, and FP services for rural and hard-to-reach populations in 290 districts of six regions of Ethiopia (Oromiya, Tigray, Southern Nations, Nationalities, and Peoples [SNNP], Amhara, and parts of Benishangul-Gumuz

and Somali, as shown in the map). The total population of these districts is 33 million—40 percent of the national population. IFHP is currently the mechanism through which Pathfinder is pursuing FP/HIV integration scale-up. Given its expansive coverage and broad mandate, IFHP constitutes a valuable foundation on which to improve and expand FP/HIV integration, particularly because the program is responsible for supporting contraceptive services (commodities and training) and for developing strategic integration systems. Moreover, IFHP is able to leverage Pathfinder’s many years of FP/HIV integration learning.

PATHFINDER’S CONTRIBUTION TO FP/HIV INTEGRATION IMPLEMENTATION IN ETHIOPIA

Pathfinder began to build its experience in FP/HIV integration in 1999. The evolution of our approach and our involvement in FP/HIV integration in Ethiopia are presented in Figure 3.

Over the course of 1999–2006, Pathfinder Ethiopia: added basic HIV prevention messages to community FP/RH programs, standardized HIV/STI messages and training, included VCT referrals and condom distribution, and collaborated with policymakers. In 2006, we added CBD of FP to our CHBC program funded by the Swedish International Development Agency and contributed to research on FP/HIV integration. VICS’s results (published in 2009)¹ showed that FP/HIV integration benefits from ensuring FP counseling and services are provided to a more targeted audience than general VCT and from providing FP services where clients can go for repeat visits. Widespread availability of antiretroviral therapy (ART) and scale-up of HIV care and treatment services provided the opportunity for us to apply these recommendations through FP integration with HIV care and treatment. Between 2006 and 2010 Ethiopia achieved a tenfold increase in number of clients receiving care and ART, and the number of ART service sites grew from 72 to 435.² In the past few years, Pathfinder has worked closely with ART sites, where clients come regularly for medication and/or follow-up and to discuss and receive FP services from a known health care provider.

Through IFHP, Pathfinder continues to integrate HIV/STI prevention into all community RH service delivery and to support FP counseling and service delivery in facility-based HIV care, treatment, and VCT services. In January 2011, we conducted a data review of 68 of the 223 HCs we support for FP/HIV integration. This review revealed impressive achievements—in 2010, 285,000 VCT clients and 28,000 ART clients received integrated FP/HIV services.* Among ART clients, 28 percent accepted a hormonal method (see details on method mix in Figure 2). Among VCT clients, 23 percent of those found to be HIV positive and 9 percent of those found to be HIV negative accepted a hormonal method. (It is standard protocol for all VCT clients to be offered condoms.)

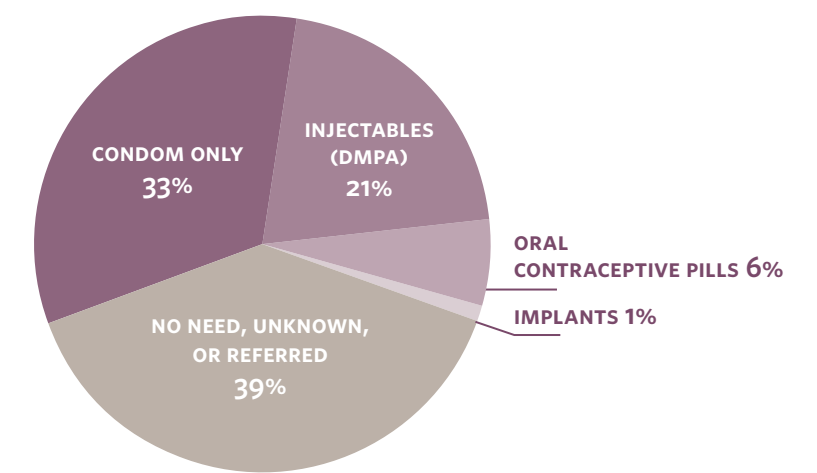
Implementation Analysis

Following a technical consultation that Pathfinder contributed to, WHO published “Strategic Considerations for Strengthening the Linkages between FP and HIV/AIDS Policies, Programs, and Services”³ (referred to as the “SC guide”) in 2009 to guide global integration efforts. The following analyzes Pathfinder Ethiopia’s experience with FP/HIV integration implementation according to the SC guide recommended policy and programmatic actions.

POLICIES AND GUIDANCE

The SC guide recommends: forming a joint FP/RH and HIV task force in the Ministry of Health (MOH); involving target audiences in policy and program

FIGURE 2: CONTRACEPTIVE METHOD MIX AMONG FEMALE CLIENTS ON ART



design; developing an advocacy strategy; revising national HIV policies to include FP services; and reviewing and revising existing HIV and FP/RH services as needed to accommodate task-shifting.

Following the 2004 IBP meeting, the Federal MOH and Federal HIV/AIDS Program Coordination Office (FHAPCO) established an FP/HIV Integration Technical Working Group (TWG), and requested that Pathfinder Ethiopia lead it. The TWG was mandated to develop and implement an FP/HIV Integration Plan of Action. This plan of action identified the following key objectives: increase access to FP information and services in VCT and PMTCT settings to prevent lost opportunities to meet clients’ needs; expand FP services to HIV-positive couples to prevent unintended

FIGURE 3: PROGRESSION OF PATHFINDER’S CONTRIBUTION TO FP/HIV INTEGRATION IN ETHIOPIA

1999–2001	2002–2008	2004	2007–2008	2006–2010	2008–2013
Expansion and Improvement of FP/RH Program	FP/RH Program	Implementing Best Practices (IBP) Meeting	VCT Integrated with Contraceptives Study (VICS)	Community Home-Based Care (CHBC)	IFHP
Added HIV prevention messages to community FP/RH services	Standardized HIV and sexually transmitted infection (STI) prevention messages, including condom promotion and voluntary counseling and testing (VCT) referrals, for community-level FP/RH training and tools	Engaged policymakers on integration of FP into VCT and prevention of mother-to-child transmission (PMTCT) at the launch meeting of USAID/WHO/UNFPA’s IBP Initiative in Uganda	Conducted training on FP/VCT integration for VCT providers from 8 HCs as part of VICS	Integrated community-based distribution (CBD) of FP in CHBC program providing care and support to HIV-affected households	Supports FP/HIV integration in 223 HCs to date, including providing training and ongoing onsite support

* ART is only available at 40 of the 68 sites, so ART clients are from 40 sites only.



HIV Care and Treatment Provider.

PHOTO: Alden Nouga

pregnancy and vertical transmission; reduce stigma and discrimination; and identify, select, and promote best practices in integration. The TWG contributed to guiding early FP/HIV integration by identifying pilot regions and holding a national orientation workshop. It also successfully brought together the FMOH and FHAPCO and solidified policy support for FP/HIV integration, which is clearly expressed in the Sexual and RH Strategy, as well as in national guidelines on HIV testing and counseling, PMTCT, and ART.

After the HAPCO health program unit merged with FMOH and FP/HIV integration became an established practice, it fell under the purview of the PMTCT/MNCH TWG.

Ethiopia pioneered strong collaboration between FP and HIV stakeholders, and early achievements and rapid scale-up were possible because of its TWG and its clear guidance through strategies and guidelines. The process was generally inclusive of a diversity of government, civil society, and international implementing partners; however, target populations were not directly included. As an advocacy strategy, the TWG held regional sensitization workshops to engage stakeholders.

CAPACITY TRAINING AND TASK-SHIFTING

The SC guide recommends curricula reform and task-shifting where appropriate. It also suggests key topics for training such as increasing sensitivity to the RH needs of people living with HIV, assessing fertility intentions, dual method use counseling, condom promotion, and referring clients to FP or safer pregnancy services.

Technical training in FP/HIV integration was an important step in introducing FP service delivery in HIV settings. Pathfinder Ethiopia developed a three-day interactive in-service training package that was pre-tested twice, revised following VICS results, peer reviewed by leading international and Ethiopian experts, and finalized at the outset of IFHP in 2010.⁴ Training topics include: FP counseling principles and skills, FP options in FP/HIV integration (including a presentation

of specific considerations for women with HIV and of drug contraindications), initiation of clients on contraceptive pills and injectables, recordkeeping, and referrals. The curriculum emphasizes regular assessment of FP need, dual method use, condom promotion, ethical practices with regard to voluntary FP use, safer pregnancy counseling, and referrals. Further, the latest WHO guidelines on Medical Eligibility for Contraceptive Use and on PMTCT are included. The training package consists of a trainer's guide, a participant's handbook, and a job aid. IFHP has trained over 1,110 providers from 250 HCs using this curriculum.

In our community work since 2002, we have trained community-based RH agents (CBRHAs) in basic HIV/STI prevention and in referrals for VCT in the context of a national FP/RH program (we trained 10,000 CBRHAs). (CBRHAs were phased out after IFHP's first year following the FMOH's directive to use model families as volunteer community health workers [VCHWs] supervised by health extension workers [HEWs]). Under IFHP, over 8,500 HEWs are supported through training, supportive supervision, and follow-up to strengthen community-based integrated health services. As part of a smaller activity, IFHP trained 170 CHBC providers on FP/RH counseling, contraceptive service provision, and referral linkages. These CHBC providers were trained using the full curriculum for CBRHAs, received pills and condoms for community-based distribution, and were linked with HCs that were supplied with injectables and long-acting FP commodities.

We believe the SC guide places an important emphasis on the value of revising training materials to include both FP and HIV, as well as the particular topics that arise when the two are combined (e.g., sensitivity to the needs of women with HIV choosing FP or desiring a pregnancy and drug contraindications that might impact FP choices). The guide also takes a strong position vis-à-vis dual method use. We found that interactive adult learning techniques (e.g., role playing and values clarification) were valuable for providers who were unaccustomed to FP counseling.

FACILITY STAFF SENSITIZATION

The SC guide suggests preparing onsite staff for the addition of new services and training them on protecting privacy and confidentiality.

Under IFHP, HC management and district health officials attended technical trainings offered on FP/HIV integration. Trainings were followed by ongoing onsite supervision and mentoring. FP/HIV integration HCs will be followed up on and mentored on a quarterly basis. We found that engaging managers in open discussion about the challenges of integration and discussing planned actions during trainings and follow-up facilitated implementation.

SUPPORTIVE SUPERVISION

The SC guide recommends: assessing and strengthening supervisory skills to ensure oversight of integrated services; equipping managers and supervisors to monitor quality of facility services; and updating supervisory protocols, monitoring forms, and checklists.

Almost half of the HCs supported by IFHP have received at least semi-annual supervision visits since training began in 2010. A standardized data reporting form is used during monitoring and mentoring visits by IFHP's cluster and regional office level officers. The form covers clinical issues, quality of care, coordination, logistics and supplies, referral linkages, and the Health Management Information System (HMIS). Under IFHP's mandate in RH/FP/MNCH integration, the program builds the supervisory skills of managers in the FMOH system and supports joint integrated supportive supervision by the district health offices. We also support the supervision system for community services through training and ongoing follow-up to HEWs.

INFORMATION, EDUCATION, AND COMMUNICATION (IEC)

The SC guide recommends using consistent messages and providing IEC materials on FP and HIV for clients, community-based groups, and volunteers.

The FP/RH program and IFHP have supported the FMOH's community RH service program and provided a set of cue cards to these cadres. In the past three years, over 30,000 sets of cards have been distributed. Each set of cue cards contains five cards on HIV/STIs and has information on referrals for testing.

To ensure consistent messaging at HC level, we have developed brief job aids on key counseling messages. For the VICS activity we developed a FP/VCT tool,

and in our 2010 training package we provide FP/HIV integration essential principles, key messages, and drug contraindications.

SPACE

The SC guide recommends engaging community leaders and members in the reorganization of space, and allocating space to allow for separate and private counseling.

Typically, we have found that most VCT, PMTCT, and ART settings are arranged for privacy and acceptability. We feel that some facilities with space shortages could use minor renovations to maintain privacy and flow of clients in some of the facilities with space shortage.

RECORDKEEPING, INFORMATION SYSTEMS, AND M&E

The SC guide recommends: modifying client records, registers, and other monitoring and evaluation (M&E) systems; establishing systems to evaluate whether clients access the services they are referred to; conducting continuous M&E of integrated approaches; and including mechanisms for eliciting client perceptions.

Pathfinder has applied several strategies to track FP service use for HIV clients. Because the HIV HMIS does not address FP, during the VICS activity and RH/FP Program, we asked HIV providers to track FP

		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
1	NO OF PRE-ART CLIENTS	616	2,408	3,225	3,054										
2	NO OF ART CLIENTS	163	12,181	18,914	20,000										
3	NO OF PRE-ART CLIENTS THAT USE FP	25	26	1	3	24									
4	NO OF ART CLIENTS THAT USE FP	11	8	19	18	37	55	72							
5	NEW CLIENTS USE FP	21	20	19	2	18									
6	PERCENTAGE OF ART CLIENTS USE FP	15	20	30	27	49	58	65							
7	NO OF CLIENTS USE CONDOM ONLY	36	25	41	27	78	58	110							
8	NO OF CLIENTS THAT USE DUAL METHOD	65	39	104	27	101	43	164							
A	Condom Pills	0	0	0	0	0	0	0							
B	Condom Injection	0	0	0	0	0	0	0							
C	Condom Implant	0	0	0	0	0	0	0							
D	Condom IUD	0	0	0	0	0	0	0							
9	NO OF CLIENTS THAT USE PILL	0	0	0	0	0	0	0							
10	Abortion Care on PRE-ART	0	2	2	1	3	0	3							

FP/HIV Integration Data Collection at Kola Diba HC.

PHOTO: Alden Nouga

service use in the notes column of their HIV register. In 2011, we printed and distributed registers for over 100 HCs for use in VCT and ART to encourage full data collection on FP clients seen in HIV sites.

The FP register we produced allows HIV clients to be fully registered for their FP services, but it still does not offer a full picture of the FP and HIV services offered to an individual client. The HIV care form is intended to collect this information, but is not an effective means of aggregating and tracking FP uptake or method uptake. We believe a modification at the national level is required to include FP services in HIV data collection, much as provider-initiated counseling and testing is integrated into FP data collection mechanisms. We have begun advocating in the national TWG for revisions of these registers. Systems for monitoring referrals are not currently in place for inter-facility or intra-facility referrals. This is an area we would like to improve in our work, particularly given the importance of expanding method mix and eliminating barriers to access to long-acting methods.

LOGISTICS, COMMODITIES, SUPPLY CHAIN, AND SUPPLY CHAIN MAINTENANCE

The SC guide recommends that HIV services that provide contraceptives ensure a regular supply by linking or merging with supply chains and should establish a logistics monitoring system for all commodities.

IFHP supports the FMOH's management of contraceptive security, including logistics management, across its coverage area and fills gaps as needed. Pathfinder has played this role since IFHP's predecessor, which has been a considerable advantage in our involvement in FP/HIV integration because we can directly ensure the availability of methods at VCT and HIV care and treatment settings during quarterly HC visits.

REFERRALS

The SC guide recommends that, if FP or HIV services are not available on site, programs should identify where the services are available, establish collaborative

relationships, provide referrals, and find out if clients access the services.

Currently, referrals from the community are not tracked and referrals for some long-acting (e.g., intrauterine devices [IUDs]) and permanent methods, which may not be available at HC level, are weak. The SC guide specifically recommends assessing referral services for obstacles. However, this has not been systematically performed in our program and should be emphasized moving forward.

COMMUNITY-BASED ACTIVITIES

The SC guide recommends: actively engaging community groups as partners; engaging leaders in discussions about biases against childbearing for HIV-positive women and couples; equipping outreach workers to offer information on HIV prevention and FP, provide referrals to HIV testing, counsel on all methods of FP, and provide select methods; organizing activities to reach adolescents; and involving CHWs and outreach workers in community-based behavior change communication.

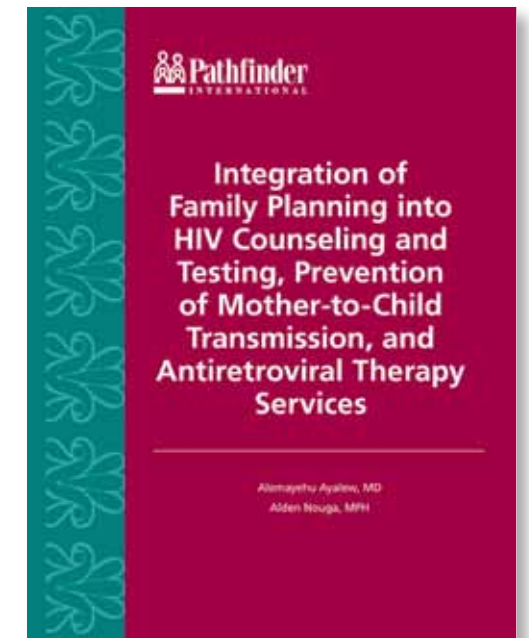
Since 2002, we have institutionalized basic HIV information provision, referral for VCT, and condom distribution as part of major community outreach work through CBRHAs, VCHWs, HEWs, and CHBC providers. Key messages were included in training materials and job aids (cue cards). We were also able to add community-based distribution of contraceptives to CHBC, though this was done at a smaller scale (170 community providers) than integration of HIV into community RH activities (over 10,000 community providers). Also, IFHP implements an adolescent RH intervention that supports in-school and out-of-school youth clubs, youth centers, and youth-friendly facility-level service, all of which include basic HIV information and linkages to all RH and HIV services.

Next Steps

The results of Pathfinder Ethiopia's FP/HIV integration activity are quite encouraging. Our work has included scaled-up service delivery at both community and facility levels. Furthermore, our approach has evolved over time, adapting to changing trends in HIV facility-based services and new evidence on FP/HIV integration.

To ensure that we continue to adapt our approach, in the coming year we intend to address some of our current implementation challenges and to conduct a thorough operations research to study the services provided and our impact. Specifically, we will seek to:

- Expand method mix:** In addressing FP/HIV integration we intended to support expanded method mix and long-acting method use, but our recent data review revealed that few long-acting methods are being provided and supervision visits suggest that there are barriers to referrals for implants and IUDs. We will work to improve referral systems (e.g., referral directories, confirmed referrals, and intra-facility linkages). We will also introduce referrals from HIV services to community FP providers, including providers in several districts who are being trained in community implant provision. Finally, we will explore the possibility of supporting implant provision in HIV care and treatment settings.
- Assess impact on unmet need:** Pathfinder Ethiopia is currently conducting a formal operations research that uses client and provider surveys to assess: 1) the ability of FP/HIV integration to address unmet need for contraception among people living with HIV; and 2) the ability of FP/HIV integration to improve access to the full range of contraceptive methods available in Ethiopia. Pathfinder expects the data analysis from this study to be available in mid-2012.
- Strengthen active sites:** One year of implementation has been completed since IFHP's roll-out of HC trainings and we have identified areas that require additional support. To address these areas we plan to provide intensive mentoring to address technical updates, staff transfers, and data quality audits.



Pathfinder's FP/HIV Integration Training Package includes a Facilitator Guide, Participant Handbook, and Job Aid.



The Kola Diba Health Center

The Kola Diba Health Center has fully adopted FP/HIV integration and represents a model for implementation. At this center, all ART clients (375 clients are seen regularly) have been counseled in FP since January 2011, the HC Director and HIV Care and Treatment Lead Provider demonstrate strong engagement, and the HIV Care and Treatment Lead Provider has developed a unique client tracking system for FP services in ART. Kola Diba's achievements are impressive—contraceptive methods other than condoms have been provided for 52 percent of the 323 women on ART; 72 percent of clients practice dual method use; 16 percent use hormonal methods only; and 8 percent use condom only as primary contraceptive method. The feedback below was elicited during a supervisory visit.

"Before, VCT clients could be counseled to use FP but they might not actually go [to the FP service room]. Now clients can feel assured that while they're at the VCT they will get FP."

—CLIENT OF FP/ART INTEGRATED SERVICES AND MOTHER SUPPORT GROUP LEADER

"Our multidisciplinary team meets every week—I use this time to discuss with ART, VCT, PMTCT, HIV, and FP department heads and to promote roles and responsibilities for linkages."

—HEALTH CENTER DIRECTOR

"Before integration started I was very much concerned about the unintended pregnancy rate among my clients and was thinking 'How can I address this issue?' It was a coincidence for me when I was called for integration training. I started implementing it right away. There are four pregnant ladies on ART—two have wanted pregnancies and two came referred from another PMTCT clinic, so there are no unintended pregnancies in this clinic."

—HIV CARE AND TREATMENT LEAD PROVIDER

"Because the HIV service provider knew the whole medical history of my husband and me, he could give us close counseling and support for FP—we trust him and prefer to talk to him about it. Dual method use even improves my relationship with my husband since we're both using FP."

—CLIENT OF FP/ART INTEGRATED SERVICES

HIV Care and Treatment Provider Describes FP Options.

PHOTO: Alden Nouga

- **Scale up further:** We want to ensure that more HCs integrate FP counseling and contraceptive services into HIV settings, so we anticipate continuing to scale up coverage. We will explore onsite training, using experienced practitioners as mentors, and pre-service training to reduce the cost and human resource burden of residential trainings. Although IFHP's target is to reach 250 HCs, by 2012 we plan to scale up from 223 to 300 HCs, which account for approximately one-third of the HCs in IFHP's catchment area.



A client discusses FP with her ART provider.

PHOTO: Alden Nougua

Recommendations

The following are recommendations applicable to the field of FP/HIV integration programming, in Ethiopia and beyond:

- **Establish and maintain close FP/RH and HIV collaboration:** We have found that a component of successful FP/HIV integration in Ethiopia at the national level, as at the HC level, is close collaboration between FP/RH and HIV partners to support linkages and synergies, including systems of supervision, mentorship, and multidisciplinary teams.
- **Integrate within integration:** We believe that our FP/HIV integration activities have been facilitated by the fact that they are not implemented as a standalone program. Rather, they exist within the context of a broader program that addresses integrated health services and supports health commodity availability, regular visits by supervisors, and ongoing support for data collection and referral systems. Future FP/HIV integration activities would benefit from being part of a comprehensive integration program like IFHP that has longstanding relationships with the health system and community partners.
- **Advocate for integrated HMIS:** Provider-initiated counseling and testing is standard protocol in FP services and has been incorporated into the FP register and logbook. However, the inability to track FP service use for HIV service clients in a direct way through the national HMIS is a persistent challenge. The national HMIS for HIV care and treatment and VCT services should be revised to incorporate FP counseling (including screening for FP need), contraceptive method provided, and FP referral services.
- **Ensure FP/HIV integration is covered in HIV in-service and pre-service training:** It would be good practice to include the concept of FP/HIV integration and relevant technical details in in-service trainings (e.g., comprehensive HIV care and treatment) and pre-service trainings of nurses and health officers.

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