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FAMILY PLANNING/ HIV INTEGRATION

Technical Guidance for USAID-Supported Field Programs

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Dear Colleagues:

I am pleased to send you the new *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs.*

As we are all aware, the HIV/AIDS epidemic is continuing to expand, touching all corners of the world and impacting on the lives of countless individuals and communities. At the same time, demand for family planning (FP) is expanding, and unmet need continues to increase globally. At this point in time, it is more important than ever to emphasize and measure the added benefits and improved cost-effectiveness of integrated FP/HIV programming.

Building upon USAID's previously distributed publication, *Integration of Family Planning/MCH with HIV/STD Prevention: Programmatic Technical Guidance*, this guidance includes new suggestions and findings regarding effective integration approaches for both FP and HIV/AIDS program managers. The document includes technical insights regarding FP/HIV integration and should be used in conjunction with USAID's *Guidance on the Definition and Use of the Child Survival and Health Programs Fund* for information regarding appropriate use of USAID funds.

Best practices for the integration of FP and HIV/AIDS activities are constantly being updated as new information becomes available. This guidance provides us with the most recent thinking about integrated program design and implementation. Integration of FP and HIV/AIDS activities is an area of study that is relatively new and, therefore, one from which we can all learn and to which we can all contribute. To ensure the dissemination of state-of-the-art thinking, this guidance will be periodically updated and reviewed as new evidence is presented. I look forward to seeing additional innovations from USAID missions and other partners implementing activities in this exciting field.

Sincerely,

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ACRONYMS

ABC	abstain, be faithful, and/or use a condom correctly and consistently
ARV	antiretroviral
BV	bacterial vaginosis
CBD	community-based distribution
CPR	contraceptive prevalence rate
CSW	commercial sex worker
CT	chlamydia
DHS	Demographic and Health Survey
FBO	faith-based organization
FP	family planning
GC	gonorrhea
GPA	Global Programme on AIDS
HEART	Helping Each Other Act Responsibly Together
HIV	human immunodeficiency virus
IDU	injecting drug user
LAM	lactational amenorrhea method
MCH	maternal and child health
NGO	nongovernmental organization
PMCT	prevention of mother-to-child transmission
SDM	standard days method
STI	sexually transmitted infection
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization
ZNFPC	Zimbabwe Family Planning Association

EXECUTIVE SUMMARY

It has been over five years since USAID issued the *Integration of Family Planning/MCH with HIV/STD Prevention: Programmatic Technical Guidance.* Since then, there have been significant changes in the environment in which USAID works, including dramatic increases in HIV programming and funding.

In family planning (FP), there remains substantial unmet need for services, while funding streams have either been straight-lined or reduced. In many countries, country program managers and field missions wish to integrate FP and HIV programs in an effort to achieve program synergies and improve efficiency. In other areas, traditional vertical program approaches are the norm, which can sometimes mean missed opportunities to reach important populations with critical information and services.

The evidence concerning FP/HIV integration continues to unfold as we look at how to maximize efficiencies and achieve a broad health impact without sacrificing quality of services and care. Integration is not always the answer; the following points are intended to help program managers identify key technical approaches when considering program integration.

- **One size does not fit all.**

Programming for FP/HIV integrated approaches must be tailored to the specific country context. In countries with generalized epidemics, integration efforts may occur across a range of interventions, with FP integrated into HIV activities and HIV activities integrated into FP activities.

In more concentrated epidemics, integration efforts should be focused on ensuring access to HIV prevention information and FP services for higher-risk populations. Indeed, in environments where both contraceptive prevalence and HIV prevalence are low, integration activities may actually weaken results, and a more vertical approach to voluntary FP, coupled with focusing HIV activities on higher-risk populations, may be most effective.

- **"ABC" (abstain, be faithful, and/or use a condom correctly and consistently) behavior-change strategies are central to HIV prevention and are also relevant to family planning needs and practices.**

Abstinence (either delaying the age of sexual debut or abstaining from sex) prevents pregnancy, HIV, and sexually transmitted infections (STIs).

Reducing the number of sexual partners, as achieved through "be faithful" behavior-change messages, has been crucial to successes in reducing HIV transmission. The implications for pregnancy prevention are more complex, but mutually monogamous couples who use FP have dual protection against HIV and unintended pregnancy.

Condoms, if used correctly and consistently, are important to the prevention of HIV, STIs, and pregnancy. However, data indicate that most married couples prefer other FP methods. Thus, while important, condom use most often occurs with non-regular sexual partners, and in general condom programs should not replace efforts to ensure access to other effective FP methods.

- **Make programs for youth and young adults a priority.**

Delaying sexual debut, reducing the number of partners, and increasing correct and consistent condom use in this group has tremendous potential to alter disease transmission and prevent teen pregnancy. The common ground for HIV and pregnancy prevention among young people is the enhancement of self-esteem and decision-making skills, which leads to informed and responsible choices.

- **Include family planning in prevention of mother-to-child transmission (PMCT) efforts.**

USAID-supported PMCT interventions should follow the World Health Organization (WHO) definition of mother-to-child transmission, which includes the prevention of unintended pregnancies among HIV-infected women. Women participating in PMCT interventions should have access to FP counseling and services. Information about the benefits of birth spacing can help both HIV-positive and HIV-negative women plan for future pregnancies.

- **Include family planning services or referrals with voluntary counseling and testing (VCT) services.**

Unprotected sex may lead to STIs, HIV, and unintended pregnancies. During VCT, the possibility of pregnancy should also be discussed during pretest counseling. Referral to FP services and/or provision of non-clinical FP methods should be available for clients who desire an FP method. In high-prevalence countries, there may be instances where FP clinics can offer HIV counseling and either provide VCT or refer clients for testing services.

- **Prevention of unintended pregnancy and the prevention of HIV transmission can be achieved through several forms of dual protection.**

One of the most effective ways to achieve prevention of unintended pregnancy and HIV is for mutually monogamous, uninfected partners to practice effective contraception. Other dual protection methods are the practice of abstinence and/or the delay of sexual debut, correct and consistent condom use, and use of an effective FP method along with correct and consistent condom use.

- **Be cautious with STI treatment approaches.**

STIs are an important co-factor in the transmission of HIV and can also influence fertility. Programmatically, however, STI services pose several challenges, especially in relation to integration.

Syndromic management for vaginal discharge is **not** an effective approach for cervical STIs, such as gonorrhea (GC) and chlamydia (CT). Syndromic management is effective for treating genital ulcers in both men and women and urethral infections in men. Moreover, successful STI programs are heavily dependent on correct and consistent drug supply.

Prior to launching an STI initiative, information about prevalence and patterns of drug resistance is a critical and a mandatory planning component.

- **Promote sound policies for HIV and family planning issues.**

Policies can contribute to changing social norms on issues related to both HIV and FP. In addition, analysis of FP and HIV trends can assist political leaders and policy makers in determining the need for vertical or integrated approaches. Political leaders and effective policies can help to reinforce the benefits of voluntary FP in reducing maternal and child mortality and in contributing to HIV prevention.

- **Work with community-based organizations, including faith-based organizations (FBOs).**

Collaboration with these sectors is an important way to help reinforce behaviors to prevent both pregnancy and HIV/STIs. Community-based programs provide a key opportunity to change social norms and address issues such as stigma, ideal family size, and empowerment of women and youth.

- **FP/HIV integration should not happen for integration's sake.**

The focus should be on no missed *good* opportunities; program managers should look for synergies to maximize reach while paying close attention to the country context.

The field of FP/HIV integration is changing, and new evidence is slowly emerging. Documents like this one will change as new data become available.

FAMILY PLANNING / HIV INTEGRATION

Technical Guidance for USAID-Supported Field Programs

INTRODUCTION

This guidance is an update of USAID's *Integration of Family Planning/MCH with HIV/STD Prevention: Programmatic Technical Guidance* (1998).

The previous guidance focused on the limitations and appropriate uses of syndromic management of sexually transmitted infections (STIs), counseling approaches for behavior change, and reaching men as a key population for both pregnancy and HIV prevention. This guidance builds on those issues and is expanded to include new evidence about effective integration of family planning (FP) into HIV programs and integration of HIV counseling and services into FP programs.

Intended for USAID field officers, cooperating agencies, and other USAID partners, this guidance is a technical tool to help program managers make sound choices in integrating HIV/AIDS and FP programs. It does not address issues concerning earmarks and use of funds, which are fully outlined in the *Guidance on the Definition and Use of the Child Survival and Health Programs Fund, FY 2003 Update*.

It is important to note that FP/HIV integration is an area of thinking in which the evidence base is rapidly growing.[1] However, important knowledge gaps remain that need to be addressed. Thus, this guidance will be periodically reviewed and updated as new evidence emerges.

The process for developing these guidelines was undertaken in collaboration with USAID/Washington, field missions, and other donors and partners, with the intention that the concepts expressed will be supported by UNAIDS, UNFPA, the World Health Organization (WHO), and other multilateral and bilateral donors.

GUIDING PRINCIPLES

Synergy (1+1 = 3)

The central tenet of this guidance is to emphasize approaches that are most likely to have a broad health impact and to increase the efficiency and effectiveness of prevention.

This guidance does not preclude the need for separate programs and interventions, but rather, in appropriate settings, aims to ensure there are no missed good (value-added) opportunities for HIV prevention and FP promotion.[2]

Evidence-Based

Recognizing that development work is situation-specific, we draw on the best current programmatic evidence to determine priority interventions. For example, emerging epidemiological evidence suggests that a multipronged behavior-change approach (such as ABC, which stands for "abstain, be faithful [partner reduction], and/or use a condom correctly and consistently") is more effective for HIV prevention than is condom promotion alone.[3]

A multipronged behavior-change approach is more effective in generalized epidemics, especially for young people. All three of these behavior-change messages have potential applications to pregnancy prevention programs as well.

Program for Impact within Each Country Situation

This guidance underscores that "one size does not fit all," and there is an important need to use data to identify the areas where integrating FP and HIV programs and interventions makes the most sense. USAID missions and other partners will need to consider the specifics of their country situations to help determine whether vertical or integrated approaches will have greater impact. Issues of cost and sustainability are other factors that are important in identifying the most effective program approaches.

Other considerations include, but may not be limited to, the following:

- ***What is the epidemiology of HIV?***

Is the epidemic *low-level* (HIV prevalence has not consistently exceeded 5% in any defined at-risk sub-population); *concentrated* (HIV prevalence is consistently over 5% in at least one defined sub-population but below 1% in pregnant women nationwide); or *generalized* (HIV prevalence is consistently over 1% in pregnant women nationwide)?[4]

If the epidemic is still confined to high-risk groups, targeted HIV programming will have more impact. For example, in Cambodia, where the epidemic has been largely fueled by sex work, interventions focused on decreasing visits to commercial sex workers (CSWs) and promoting condom use in brothels have been successful in reducing the spread of HIV.[5]

In this context, investments to integrate HIV activities (such as treatment of STIs) in FP venues did not make sense. On the other hand, there may have been opportunities to consider integrating FP counseling or services into HIV activities (for example, in counseling CSWs).

When considering the status of the HIV epidemic relative to FP integration, it is important to understand that the epidemic is not static and evolves over time, affecting different populations.

- ***How mature is the family planning program?***

How significant is the unmet need for contraception, and where is the need greatest? For example, in Mali, HIV prevalence in the general population is 1.7%, while total fertility is 7%, and the use of modern methods of contraception is very low, at 5%.[6] Here the need for basic FP services for the general population remains critical. Thus, strengthening FP programs should be the priority intervention. The greatest impact on the spread of the HIV epidemic would be achieved through interventions targeted toward core transmitters and groups who move between core transmitters and the general population, such as married men who visit CSWs.

- ***What is the interplay between HIV and family planning programs, and does the overall program environment support or hinder integration?***

For example, in Zimbabwe, where HIV prevalence is very high and the existing FP infrastructure is strong, there are valuable opportunities for integration. A model is currently being tested in Zimbabwe using community-based distribution (CBD) agents for FP to provide HIV information and referral to HIV voluntary counseling and testing (VCT) services.*

*Advance Africa is currently integrating HIV prevention information into the Zimbabwe Family Planning Association (ZNFPC) CBD program. For more information, see www.advanceafrica.org.

- ***Does the family planning program address the needs of high-risk populations such as CSWs, transient and mobile populations, and injecting drug users (IDUs)?***

In general, these populations are not reached by pregnancy prevention programs, yet may have FP needs. HIV prevention and mitigation activities with these populations may offer opportunities for integration with FP.

Reaching the "Tipping Point"

A key concept in behavior change on a large scale can be referred to as the "tipping point,"[7] in which a diverse array of interventions collectively cause overall social norms to shift. Thus, it appears that success in HIV prevention in Uganda resulted from many forces working together, which induced a large shift in behavioral norms. These included frequent presidential pronouncements about HIV prevention, involvement of FBOs and other nongovernmental organizations (NGOs), basic care and support programs for people living with HIV/AIDS, increased correct and consistent condom use with non-regular sexual partners, delay in age of sexual debut, reduction in the number of sexual partners, and access to VCT services. Any single one of these forces in isolation may not have had as much of an effect as the multiple reinforcing messages using multiple channels.

Although HIV prevalence has declined significantly in Uganda, the country's fertility rate is still among the highest in the world. Clearly, this could create opportunities to better enhance HIV/AIDS programs' ability to link with FP efforts and prevent unintended pregnancies.

KEY TECHNICAL APPROACHES CONDUCIVE TO FAMILY PLANNING/HIV INTEGRATION

Note: The approaches outlined below are not necessarily presented in their order of priority.

1. ABC (Abstain, Be Faithful, and/or Use a Condom Correctly and Consistently)

The three key behavior-change messages that are at the core of successful HIV prevention efforts (abstain, be faithful, and/or use a condom correctly and consistently) are also relevant to FP needs and practices.

Abstinence (abstaining from sex and/or delaying the age of sexual debut) can reduce HIV/STI transmission and help prevent unintended pregnancies among

A = Abstain

B = Be Faithful

C = Use a Condom Correctly and Consistently

unmarried people. Declines in HIV prevalence in Uganda can be linked in part to dramatic increases in the number of 15- to 19-year-olds who report never having had sex. By the 2001 Demographic and Health Survey (DHS), this included 61% of males and 48% of females.[8]

Moreover, an increase in contraceptive use coupled with a delay in sexual debut contribute significantly to smaller, healthier families. Interventions to delay sexual debut provide common ground with non-clinical health partners, such as schools and FBOs. Postpartum abstinence, which is practiced widely in Africa, can also have a protective effect in reducing the risk of an additional pregnancy but may increase the risk for HIV/STIs if the male partner is not faithful during the postpartum period.

Being faithful through mutual monogamy or partner reduction is also important to HIV prevention. According to epidemiological data and modeling, a reduction in the average number of partners—including "concurrent" partners (which includes visits to CSWs) as well as "sequential" partners—is crucial to containing the spread of any STIs, including HIV.

In Uganda, for example, approximately 30% of respondents in a 1989 Global Programme on AIDS (GPA) survey reported having casual sex during the previous year. By 1995, this had decreased to about 10%.[9] Even for monogamous couples there is need for delaying, spacing, or limiting births, especially considering the known health benefits to women and children. Mutual monogamy coupled with use of an FP method can be an effective form of dual protection for preventing HIV and unintended pregnancy.

Condoms, if used correctly and consistently, are pivotal to prevention of HIV, some STIs, and pregnancy.[10] Consistent condom use is generally greater with non-primary sexual partners, as opposed to typical FP clients. In countries with low-level or concentrated HIV/AIDS epidemics, condom promotion in FP clinics may not be the most effective HIV prevention approach. However, FP clinics and community-based FP services may offer important venues for condom promotion and other HIV-prevention activities, particularly in high-prevalence, generalized epidemics.

Another behavior associated with increased HIV transmission is drug use. The transmission of HIV among IDUs is important, particularly in Eastern Europe

and parts of Asia and Latin America, where IDUs play a significant role in the spread of the epidemic. There is also evidence that recreational use of other drugs, including alcohol, reduces inhibitions and makes unsafe sex more probable.

IDUs, recreational drug users, and their partners are also at risk for unintended pregnancy. Program efforts targeted toward recreational drug users and IDUs, including behavior-change messages, can also provide opportunities to incorporate important pregnancy prevention information. (USAID is developing guidelines specifically to address HIV prevention strategies for IDUs.)

Prevention Is Central

ABC behavior-change messages should be a priority area for investment. Clearly, "A" (abstinence) and "C" (correct and consistent condom use) can have an impact on preventing both HIV and unintended pregnancy. The data increasingly demonstrate that "B" (be faithful [partner reduction]) contributes to reduction of HIV prevalence; however, the implications for fertility are much more complex. For example, uninfected monogamous couples who use FP are protected against HIV and unintended pregnancy.

For FP managers, a key message is that successful prevention programs require activities beyond the clinic setting. Services provided in FP or maternal and child health care (MCH) clinics often make only a small contribution to the behavior change that is all-important for HIV prevention. Thus, while ensuring that basic HIV prevention information is provided within clinics, priority should be given to activities beyond those settings, such as mass and community communication, social marketing, CBD, policy development, activities targeted to youth, and specific outreach to men.

Social Marketing

Social marketing (marketing approaches typically used to promote products) can be expanded to "sell" healthy behaviors, such as mutual monogamy and abstinence/delay of sexual debut, as well as values such as small family size and gender equity.

The concept of marketing healthy lifestyle decisions, linked to product promotion, has been implemented in several programs. In Zambia, the Helping Each Other Act Responsibly Together (HEART) campaign, developed by and for youth, promotes abstinence by encouraging young people to make healthy lifestyle decisions (such as staying in school) and promotes condoms for adolescents who are sexually active.[11]

Dual Protection

One of the most effective ways to achieve prevention of HIV **and** unintended pregnancy is for mutually monogamous, uninfected partners to practice effective contraception. Other "dual protection" methods are:

- Abstinence and/or delay of sexual debut
- Correct and consistent condom use
- Correct and consistent condom use along with another effective FP method ("dual method use")

In all FP and HIV programs, clients need counseling to help understand their risk for both unintended pregnancy and HIV/STIs in order to make choices that suit their individual circumstances. Condoms should be widely available, and both men and women should be counseled that correct and consistent use is needed in order to achieve the benefits of condoms in preventing HIV and pregnancy. At the same time, it is important to recognize that, particularly in terms of HIV prevention, condoms are most frequently used with non-regular partners, and increasing correct and consistent condom use to very high levels may be an unrealistic behavior-change outcome within the general population. Thus, promotion of condoms needs to be balanced with both "A" and "B" messages, as well as access to a variety of effective FP methods.

Caveats / Areas for Further Research:

- In order to ensure the appropriateness and relevance of behavior-change messages, pretesting message content and including evaluation are important in specifically understanding the cultural context in which the messages are being developed.
- What are the effects of "mixing" messages to include benefits of both FP and HIV prevention? Does a mixed approach detract or dilute either the promotion of FP or HIV prevention?
- More information is needed to help identify ways to effectively translate condom promotion into correct and consistent use, including addressing provider bias.
- Gender considerations are central to any behavior-change strategy and must be incorporated into evaluations of these interventions.

2. Integrated Interventions Should Be Targeted to Youth

The largest youth generation in history is entering its childbearing years, and about half of all new HIV infections in women occur among those between the ages of 15 and 24.

The common ground for preventing HIV and pregnancy in young people lies in decreasing their risk of exposure to unprotected sex. Tools to enhance communication and negotiation skills can lead to informed and responsible choices among youth.

Increasing the age of sexual debut, reducing the number of sexual partners, improving access to FP, and correct and consistent condom use have tremendous potential to alter disease transmission and avoid unintended pregnancy.

It is possible to influence youth to change their sexual behavior in positive ways, as is evidenced by successes achieved with this age group in Uganda and Zambia. In Uganda, there has been a decline in HIV prevalence among youth, which in part can be attributed to an increase in the age of sexual debut. In addition, empowerment of young females and women was a key component of the HIV prevention success in Uganda, and this may have improved their ability to abstain from sex or negotiate condom use.[9] However, despite these successes, fertility levels remain very high in Uganda. In Lusaka, Zambia, there also appears to have been a decline in HIV prevalence among youth during the 1990s (mainly due to a significant reduction in the number of partners), and recent national survey data indicate that the contraceptive prevalence rate (CPR) is rising significantly in Zambia.

Key to Successful Behavior Change

The key to successful behavior change in youth appears to be a multi-pronged approach recognizing that youth are a diverse group and that many factors influence young people's behaviors.

A variety of program approaches have had some modest success or appear promising in enhancing young people's knowledge, attitudes, perceptions, and skills relating to HIV and pregnancy prevention. However, experience suggests that multiple linked interventions may be the most effective in bringing about behavior change in youth.

At a minimum, programs need to address community norms and personal knowledge and skills, as well as to increase access to services. Ideally, behavior-

change messages should be reinforced through multiple channels. Some examples of these programs include:

- School and other curriculum-based programs that incorporate best practices in education and life skills
- Certain mass media campaigns targeted to youth, where messages are reinforced through various communication channels
- Community-level outreach through youth-serving and youth-development organizations, including FBOs
- Workplace programs[12]

Reducing Barriers to Access

"Youth-friendly" services may reduce barriers to access and increase quality and use of FP and HIV services. However, results have been mixed, reflecting the fact that clinics often fail to attract unmarried young people for reproductive health information and services.

In some cases, networks of service facilities have been "branded" as youth-friendly, and some success can be seen in Western Europe and, to some extent, in programs such as Mexfam in Mexico, Profamilia in Colombia, and the private Ghana Midwives Association. Non–clinic-based and private-sector services (including social marketing of condoms, contraceptives, and other behavior-change messages) may be better suited to meeting the needs of many young people.

Caveats / Areas for Further Research:

- Many existing programs tend to reach older youth, in many cases after sexual debut. What are the best approaches for reaching those in younger age groups before they are sexually active?
- What are effective and affordable approaches to provide FP and HIV/STI services to youth? What elements are essential to successful peer-education programs?
- What role do cultural or community norms play in supporting behavior change, such as delaying sexual debut and reducing cross-generational sexual activity? Are there cultural norms that could support the desired behavior change?

3. Family Planning and Prevention of Mother-to-Child Transmission (PMCT)

The WHO framework for prevention of mother-to-child transmission (PMCT) of HIV highlights the centrality of FP. The four-pronged framework includes:

1. Primary prevention of HIV in young women
2. Avoidance of unintended pregnancies among HIV-infected women
3. Provision of antiretrovirals (ARVs) targeted at preventing HIV transmission to HIV-infected women and their infants, safe delivery, counseling, and support for safer infant-feeding practices
4. Providing care and support for mothers and their families

HIV-positive mothers should have access to quality information and services in order to make their own decisions regarding future pregnancies and FP methods.

Women Should Have Access to Antenatal Care Based on WHO Evidence-Based Recommendations

In both concentrated and generalized epidemics, the PMCT package of services during antenatal care should also include promoting VCT, counseling for HIV-positive and HIV-negative women about the benefits of FP and birth spacing, availability of ARVs for PMCT, counseling on infant feeding options, and screening and treatment for syphilis. PMCT services should help to increase access to health care facilities where women can deliver with a skilled provider and receive the full package of services needed for PMCT and to promote safe birth practices.

The Postpartum Period

FP counseling and services during the postpartum period are critical for both HIV-positive and HIV-negative women. In some countries, there is an increased risk for HIV exposure after childbirth due to practices of postpartum abstinence concurrent with partner infidelity. While correct and consistent condom use is central to prevent HIV transmission and unintended pregnancy, especially among sero-discordant couples, longer-term methods still play a vitally important role for women, regardless of their HIV status. All contraceptive methods can be appropriate for HIV-positive women (including the IUD, based on FHI-supported research) and should be provided based on the women's choice.

Breastfeeding

The benefits of exclusive breastfeeding to child health and its contribution to child spacing are well documented. However, the risks associated with breast-

feeding and HIV transmission from mother to infant are also well understood. Due to the sensitivity around this issue, the range (or lack of) infant feeding options in different settings, and the changing evidence, program managers should refer to USAID's Breastfeeding Promotion Policy (ADS chapter 212).[13] All HIV-infected mothers should receive infant feeding counseling, including general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation.

Caveats / Areas for Further Research:

- A considerable number of HIV-positive pregnant women who receive pregnancy-related services and/or VCT may never receive appropriate counseling or may be lost to follow-up. Evidence from selected PMCT Call to Action sites of the Elizabeth Glaser Pediatric AIDS Foundation indicates that almost 50% of pregnant HIV-positive women and newborns who should have received both Nevirapine and other services—including FP—were lost to follow-up.[14] Further research is needed to reduce these losses, and community-based approaches may be a promising approach for doing so.
- Further research is needed on the safety and efficacy of exclusive breast-feeding and program models for alternatives if required.

4. Voluntary Counseling and Testing and Family Planning

Unprotected sex may lead to unintended pregnancy, STIs, and HIV infection. During VCT for HIV, the counselor explores the client's personal risk behaviors and then engages the client in a discussion about realistic and reasonable approaches to reducing HIV transmission risk. In addition, the counselor refers the client to care and support options, guided by the client's serostatus and related needs.

FP is a critical component of the continuum of care and support for VCT clients, regardless of their serostatus. The client-provider interaction during a VCT session can provide an opportunity to incorporate FP messages and contraceptive counseling guided by the needs and readiness of the client. During VCT, the importance of pregnancy prevention and its role in PMCT, as well as the benefits of birth spacing, can be discussed with both HIV-positive and HIV-negative clients. When FP counseling is provided during VCT, counselors need to address a range of options in accordance with principles of informed choice.

If Family Planning Services Are Not Available in VCT Settings, Family Planning Service Referrals Should Be Available

VCT counselors should inquire about contraceptive use during pretest counseling or intake and then make appropriate referrals for contraceptive services based on clients' needs. In addition, particularly in generalized epidemics, FP sites should provide HIV prevention counseling and referral for VCT. Evidence on effective contraceptive counseling in VCT and on VCT provision in FP settings remains limited, and further research is needed.

Couple and Premarital VCT

Couple and premarital VCT may be an ideal opportunity to assist both concordant and discordant couples in developing personalized plans regarding FP and HIV prevention.

A key lesson learned from FP programs includes the need to engage men in reproductive decision making. Assessing the need for FP should be an integral part of the counseling process for all couples. While counseling couples during pretest VCT may provide an ideal opportunity to discuss FP, as with any HIV counseling, there are challenges and risks associated with counseling couples, such as coping with a new HIV diagnosis and the potential for domestic violence and/or exclusion from family, especially for HIV-positive women in sero-discordant couples.[15]

Caveats / Areas for Further Research:

- There is considerable concern about overburdening already stretched VCT centers and FP clinics with additional services. Studies are under way to examine the most efficient and effective approaches to such integration and linkages.
- Information is needed to determine whether integrating these services increases the adoption of FP or the uptake of VCT. Efficacy and cost-effectiveness studies are needed.
- Questions remain regarding the best time to provide contraceptive counseling during VCT, how integrated and stand-alone VCT sites differ in terms of FP provision, and how FP clinics can best provide or refer clients for VCT.
- Research on the most effective approach for counseling couples is needed.
- Risk for HIV infection is not spread evenly across populations. Therefore, when choosing to introduce VCT into FP settings, it is important to assess the HIV risk of the specific population of those clinics.

5. STIs Are Important, But...

STIs are an important co-factor in the transmission of HIV and can also influence fertility. The introduction of STI screening into FP settings, often using a syndromic approach, has been a major area of program intervention. For a number of reasons, however, the results have been unimpressive and sometimes even deleterious.

STI diagnosis and treatment are often introduced without data on prevalence and types of STIs, resulting in the introduction of services in populations with low incidence and prevalence. In addition, syndromic management of vaginal discharge is not technically sound for the diagnosis of cervical STIs, such as gonorrhea (GC) and chlamydia (CT).

Unfortunately, there are currently no viable diagnostics for detecting these STIs among women in most developing countries. Syndromic management can be a very useful approach to detect genital ulcers and urethral discharge in men. All counseling and services related to STIs should also include information about HIV and unintended pregnancy, and clients should have access to condoms.

Information about STI Prevalence Is a Critical Investment

Information about STI prevalence is a critical investment for both HIV and FP program managers, and it is an essential step before considering major program interventions. Required information includes knowledge of the types of STIs and their prevalence in various populations, and information on drug availability and antimicrobial resistance.

Syndromic Management of Vaginal Discharge

Syndromic management of vaginal discharge is not effective for GC/CT in women in general service-delivery settings.

Vaginal discharge is indicative of vaginitis and is generally responsive to treatment. In particular, Metronidazole may provide relief to women with uncomfortable discharge. This medication is generally low-cost and widely available, and can be used against both bacterial vaginosis (BV) and trichomoniasis. Despite the disadvantage that there may be little lasting effect, especially if all male partners are not treated, this treatment should provide relief of symptoms and, as such, be perceived as a quality service.

Effective Forms of Syndromic Management

In contrast to syndromic management of vaginal discharge, other forms of syndromic management appear effective. This is particularly true for genital ulcers and urethral infections in men.

Some countries have adopted approaches to address this issue through private-sector pharmacies. Where appropriate, FP providers should include syndromic management of genital ulcers and services for men and should ensure access to condoms for clients and their partners. In addition, HIV outreach services and VCT sites should also make referrals for STI treatment if genital ulcers or urethral discharge is identified.

The Logistics and Costs of Drugs

The logistics and costs of drugs are a barrier to effective STI diagnosis and treatment programs and must be considered up front by program managers.

Although USAID funds can be used to procure STI drugs and reagents, these investments should be considered in light of other funding priorities. Prior to launching an STI initiative, information about prevalence and patterns of drug resistance are critical and mandatory planning components.

Caveats / Areas for Further Research:

- Better and less expensive diagnostic tests are needed to diagnose cervical infections and vaginal discharges in women.
- Partner treatment is essential to prevent immediate reinfection.
- Promising research is currently under way to identify microbicides that may be effective alone or in combination with female barrier methods in preventing transmission of HIV/STIs and pregnancy.
- More data are needed on the clinical and public health impact of social marketing of antibiotics for treating genital ulcers and urethral discharge in men through STI kits before such marketing is expanded.

6. Policies Built on Cultural Values Contribute to Changing Social Norms and Promoting Health Behaviors

Experience has demonstrated the powerful contribution of policy changes in reaching the "tipping point" and achieving success in both HIV and FP programs.

In Uganda, President Museveni promoted the concept of "zero grazing," which refers to maintaining monogamous relationships. The contribution of his open discussion and support is widely recognized. Despite Uganda's success in HIV reduction, women on average have seven pregnancies during their reproductive years, with significant negative consequences to themselves and their infants. However, recently contraceptive prevalence is starting to show steady increases,

and it is hoped that the remarkable policy-level success Uganda experienced in HIV prevention will be translated into this arena as well.[8]

Supportive Policy Environment for Youth

As youth are a vulnerable population, a supportive policy environment for youth programs is needed to ensure access to quality and appropriate information, support, and services for HIV and pregnancy prevention.

Funding and Priority Shifts

Funding and priority shifts can affect FP programs as limited host country health resources are fully engaged in combating the epidemic, particularly in high-prevalence countries.

The analysis of FP trends in Africa provides solid evidence of the diminished priority assigned to FP and pregnancy prevention.[16] In addition, in places where mortality from HIV or other causes is particularly high, a pronatalist stance may also result.

Birth Spacing Is Important in Reducing Maternal and Child Mortality, Even in Settings with High Prevalence of AIDS

It is important to consider the promotion of birth spacing as a means to saving many lives. This is particularly critical in the context of AIDS in order to ensure that every child be born as healthy as possible.

For countries with high fertility and HIV/AIDS prevalence above 1% in the general population, the overall well-being of families can be promoted through HIV and pregnancy prevention. In these environments, information concerning the positive effects of increasing birth intervals on maternal, infant, and child mortality can be an important tool for policy dialogue. Evidence shows that even in countries with high HIV prevalence, there is still a significant unmet need for FP.[16]

Caveats / Areas for Further Research:

- What are the cultural values to promote changing social norms or health behaviors that reinforce both the prevention of HIV and the use of FP?
- What role do community leaders play in reinforcing behavior-change approaches that support the prevention of both HIV and unintended pregnancy?
- How do integrated policies (for both FP and HIV) affect program implementation?

7. Community-Based Approaches Are Central to Success

Working with community organizations, including FBOs, is important to reinforce behaviors to prevent both unintended pregnancies and HIV/STIs and to facilitate access to services. Community-based programs provide a key opportunity to change social norms relating to issues such as stigma, ideal family size, and the empowerment of women and youth. In addition, many community and faith-based organizations are important service providers.

Community-Based Distribution (CBD) Programs

CBD programs can sometimes effectively integrate HIV prevention information. In higher HIV-prevalence communities, they can also provide referrals and links to VCT services through their community outreach efforts. The Zimbabwe national FP CBD program, which has a long history of being an effective program, is currently working to scale up this type of integrated approach nationwide.

Faith-Based Organizations (FBOs)

FBOs can and do play a critical role in many countries and have a tremendous influence over the lives and decisions of community members. In many instances, FBOs deliver health services, including FP. While some FBOs may not promote condoms or other forms of contraception, they can nonetheless play an important role in encouraging different aspects of behavior change, such as delay of sexual debut, partner reduction, and use of natural FP methods, such as the lactational amenorrhea method (LAM) or the standard days method (SDM). In these cases, programs should ensure that clients have access to information about all forms of prevention, including condoms and other contraceptive methods, through alternative channels. The effects of positive engagement by FBOs can be seen in countries such as Uganda, Indonesia, and Senegal.

Family Planning Information Can Be Integrated into Community Services Related to Home-Based Care

Home-based care agents in Kenya have received FP and reproductive health training and are able to provide these services within the home to both HIV-infected persons and other household members. While the need for FP may be slight when individuals are sick, these individuals may become sexually active if they begin to feel better after receiving care services.

Caregivers, who are frequently adolescent females, may also benefit from information concerning FP. Information about FP may also be welcome among those individuals concerned about orphans or engaged in orphan care.

Caveats / Areas for Further Research:

- What are the costs and potential sustainability of FP and HIV programs implemented through community-based organizations and FBOs?
- What is the capacity of CBD agents to effectively integrate HIV services into their existing programs? What is the appropriate level of skills training needed to enhance their work in prevention of both HIV and unintended pregnancy?
- What is the best strategy to engage FBOs in FP and HIV programs?

8. Commodities and Logistics Systems

Strengthening logistics systems is important to ensure the success of any program requiring a product. In the past, USAID has primarily supported vertical logistics systems for FP commodities. There are drawbacks to using parallel logistics systems, such as a country's capacity to handle procurement of drugs and reagents. In some cases, this has presented constraints for condom procurement and distribution systems, as managers work to make the product available for both FP and HIV programs.

Because of the long history of USAID population assistance, the strongest logistics managers in national health systems are often associated with FP programs. This can also present an opportunity, as strong logistics systems can be built upon to improve access to newer HIV commodities, particularly if the program is functioning in or moving toward a truly integrated system.

Where systems are weak, commodity needs of both programs should be a priority. A major effort needs to be made to prevent commodity stock-outs and consider the effects of health care reform and attempts to integrate vertical systems. Given these complexities, the pros and cons of dual commodity systems should be analyzed prior to fully integrating systems.

Without a Product, You May Not Have a Program

Managers need to consider both FP and HIV programs when undertaking projections for procurement and distribution of condoms and other FP methods. In addition, there are burgeoning needs related to commodities and drugs for HIV programs (for example, for VCT). In some environments, existing FP commodity procurement and distribution infrastructure may be effectively used for these products.

9. Promising Areas for the Future

Services Offering Male Circumcision

The evidence is increasingly compelling that male circumcision may reduce the risk for men of acquiring HIV by 60% or more.[17] As a consequence, it is reported that uncircumcised men are beginning to seek out this reproductive health service. Circumcision services could offer a promising opportunity for programs to increase male involvement and integrate broader messages about positive reproductive health behavior, including those related to FP and gender equity. USAID is supporting a pilot program to test this hypothesis in South Africa, and other studies are needed to address issues related to circumcision, such as safety, behavioral "disinhibition," and cultural issues regarding the introduction of services into a community that traditionally does not circumcise.

Family Planning Counseling and Links to Services Can Be Included in HIV Hotline Interventions

An individual's motivation to call an HIV hotline is often due to perceived risk exposure, which can also result in an unintended pregnancy. Thus, counseling and referral to FP services may be appropriate. HIV hotlines continue to expand globally, and they may present an important opportunity to use this communication vehicle to transmit correct information about FP. USAID is currently supporting such an effort in Nigeria, where the effects of adding contraceptive counseling and FP referral to the hotline will be evaluated to determine the efficacy of the integrated approach.

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