

ANNEX 4: SRH, HIV AND AIDS: APPROACHES, EXPERIENCES AND EFFECTIVENESS

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
Approach 1: Integration of HIV/AIDS into FP/SRH settings				
1.1 STI/HIV education/counselling/management				
Bangladesh Frontiers project + Bangladesh government 2-year feasibility study at 8 rural health centres + 4 control sites 2000	<p>Adding reproductive health services for men at rural Health and Family Welfare Centers (HFWCs), traditionally targeted only at women.</p> <p>Service providers and field workers received training on reproductive health, including the diagnosis and management of RTIs and STIs and men's reproductive health.</p> <p>Outreach and promotion of services.</p> <p>Following the intervention MoH has decided to scale up to further 100-150 HFWCs.</p>	<p>Targeted outreach strategy, particularly the group discussions, was instrumental in increasing both men's and women's use of RTI, STI, and general health services.</p>	<p>Integration of services was acceptable to both male and females.</p> <p>The addition of services for men resulted in significantly increased utilization of clinical services by both men and women.</p>	<p>Challenges: Drug stock outs and the implications of increased demand.</p> <p>Continuing stigma associated with STIs and RTIs and impact on service utilization.</p> <p>Source: Population Council website.</p>
Brazil, Bolivia (undated)	<p>Integrated counselling for sexual health supported by multisectoral efforts.</p> <p>i.e. NGO community advocacy (targeted at both men and women) to address underlying issues eg sexual rights, power relations between men and women.</p>	<p>Integration was more advanced where complemented by advocacy initiatives.</p>		<p>Quoted in WHO 2005 draft, p.33.</p>
Egypt	<p>Study of the acceptability of integrating sexual health/sexuality</p>	<p>Sexuality counselling was acceptable to FP clients despite</p>	<p>Increased counselling about the impact of chosen family planning</p>	<p>Insufficient training meant counsellors were still embarrassed</p>

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6 FP clinics 1999	issues counselling in FP counselling. Training on gender and sexuality, and contraceptive update.	conservative setting. sexuality training course had positive impact on providers' attitudes towards barrier methods.	method on sexual relations. Increase in sexuality-related discussions not related to family planning. Positive association between training providers on sexuality-related counseling and client acceptance of barrier methods.	to discuss sexual matters. Abdel-Tawab, 2000.
Ethiopia Community-based reproductive health care Pathfinder International Around 8000 CBRHAs are being trained in 4 regions	Provision of RH/FP and HIV/AIDS prevention to poor and remote traditional communities. Aims to bring modern health care to communities that rely on traditional methods such as healers, faith, birth attendants etc. and are resistant to FP. Delivered through community volunteers (Community-Based Reproductive Health Agents – CBRHAs) trained in FP, RH, MCH, AIDS prevention and care, and other common illnesses). CBRHAs are trained in counselling and addressing large groups to change beliefs and behaviours and harmful traditional practices. Encourage people to seek VCT, and follow up on those who test positive.	CBRHAs are respected as the primary health “experts” in many villages. They have gained support of local leaders (Woredas) and religious leaders - highly conservative religious organisations have become outspoken proponents of FP and opponents of Female Genital Cutting and other harmful practices. Program reaches the community beyond home visits – FP methods distributed in factories, markets etc., lessons at schools, mosques and churches.	In many villages resistance to FP has disappeared.	Pathfinder International 2005.
Haiti	Syphilis screening as part of antenatal services.	This is routine in many countries. Haiti experience shows that it is feasible in resource-poor settings	Rate of congenital syphilis in the intervention area decreased by 75% over three years.	Fitzgerald 2003. Quoted in WHO 2005 draft, p.35.

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Mexico Study of around 2000 clients of FP clinic	Information about family planning methods and STD risk factors and prevention, together with personal choice to patients with cervical infection. Study compared a group in which the provider selected the woman's contraceptive and group given information and choice of contraceptive.	with significant impact on health outcomes (in Haiti the testing was made possible by solar-powered batteries). Giving women sufficient information to make their own choices regarding contraceptive use, or to assess their own STI risk was found as effective as when based on physician judgement.	Women were more likely to choose condom if able to self-assess. The intervention increased the selection of condoms and reduced the selection of IUDs, especially among women with cervical infections, for whom IUD insertion is contraindicated.	Lazcano Ponce, 2000.
Nigeria Operations research study in 6 FP clinics	Counselling FP users on dual protection and female condom. Involved promoting female condom to new FP users and emphasising message of dual protection.	It was crucial to change providers' attitudes and values to incorporate the importance of HIV/AIDS prevention in counselling messages.	Condom acceptance (mostly female condom) increased from 2% to 9%. Client knowledge increased.	Male partners were found to be the major impediment to dual protection adoption emphasising need to target male partners of clients. Adekun 2002.
South Africa Study in 12 public health facilities 1998-1999	Study of dual method use among clinic clients (men and women) who had asked for condoms and FP, or STI patients who had obtained condoms from providers during their clinic visit.	Study has shown that promotion of dual method use is feasible during FP/STI counselling, also highlighting the gender-specific nature of contraceptive and prophylactic choice.	16% of respondents had used dual method after session with provider. It is unclear whether this strategy is effective in ensuring long term change.	Myer, 2002. rather than consensual choice, dual method use occurs when a man's aim of protecting himself from STIs coincides with his female partner's goal of preventing unwanted pregnancy.
Zambia 8 family planning clinics 1998	Study measured the readiness of FP clinics to provide STI prevention and diagnostic services Methods: observation of client-provider interactions and interviews.	Family planning clinics were not as well prepared to integrate STI diagnostic services as they were to add preventive services (lack of testing facilities or medicines).	Client knowledge increased about nonbarrier methods' inability to protect against STIs.	Both client and provider characteristics (cultural factors, education level) played a role in the transfer of this information: educational levels of providers and clients may be barriers to a successful transfer of STI

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Desk review of documented experiences 1998 Commissioned by WHO	Integration of STI management into FP services.	Quality of services, providers' attitudes and communication skills improved. Increased access and utilisation of services, due to expanded coverage and outreach to men, youth or other groups not previously the focus of FP. Integration has not driven away FP clients. Cultural barriers to discussion of sexuality and resistance of service providers to integration of new tasks have been overcome successfully.	Integration seems to have enhanced quality of FP. Not much evidence of impact on STI morbidity. No firm evidence of increased STI care utilisation.	prevention information. while communication with less-educated clients needed improvement, providers also overlooked to inform more educated clients and focused on those less educated. Source: Chikamata 2002 Dehne and Snow, 1999.
Zimbabwe Zimbabwe National Family Planning Council (ZNFPC) and Advance Africa Project (USAID funded) 2001-2003 Piloted in 8 districts and expanded to 16 districts	Integrating the provision of information about HIV/AIDS, STIs, VCT, and referrals to VCT, PMTCT services in the role of community-based distributors (CBDs) of contraceptives. Traditional door-to-door approach was expanded with new role of Depot Holders (to re-supply contraceptives and provide referrals to CBDs) and use of	Integration did not over burden the CBDs and produced improved results for both FP and HIV. It led to greater job satisfaction and commitment in reaching the communities, and increased performance in FP distribution. CBDs are respected and sought out for services. Community involvement and participation were crucial in successfully	End-line study showed significant improvements in all areas related to HIV/AIDS/STIs education, testing, and referrals. There was an increase in use of male and female condom. Male condom use increased from 175,100 to 1,041,958 and female condom use from 54,976 to 888,279. Referrals to VCT centres increased from less than 50 to	Advance Africa Project 2005. . FHI network 23(3) 2004.

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	“satellite points” (i.e. churches, schools) to reach sparsely populated areas on selected days.	<p>implementing this community-based programme and facilitated community partnership and ownership in managing the programme.</p> <p>The depot holder concept was a cost effective and sustainable FP/RH delivery system that provided accessible, available and acceptable services at the grassroots level.</p>	<p>more than 2000.</p> <p>Access to FP increased and quality improved (e.g. through provider re-training).</p>	
Approach 1: Integration of HIV/AIDS into FP/SRH settings				
1.2 VCT/PMTCT				
<p>Cambodia</p> <p>Reproductive Health Association of Cambodia (RHAC)</p> <p>Large scale (Six clinics)</p> <p>2002-2003</p>	<p>Integration of HIV counselling and testing services into existing package (FP, ANC, STIs/RTIs treatment).</p> <p>Strategies:</p> <ul style="list-style-type: none"> • VCT guidelines and informational materials. • Media campaign and hotline about HIV. • Counsellors hired and trained. • Existing staff trained. • Links with other services established. 	<p>Clients were happy to find everything in one place.</p> <p>Perception of service quality means that clients are happy to pay for testing fee (which can be waived). availability of rapid, cheap testing was key.</p> <p>Other services were not stigmatised away by introduction of VCT.</p>	<p>High uptake of VCT (13% of clients).</p> <p>No decline in FP and other clients.</p> <p>Overall increase in clients, 13% of which are male using STI services.</p>	<p>Due to success RHAC has decided to integrate further services).</p> <p>Source: FHI network 23(3) 2004 p 17.</p>
<p>Kenya</p> <p>Pathfinders International</p> <p>Public, private and mission-based</p>	<p>Integrating VCT, ART and PMTCT provision in RH and MCH services</p> <p>Key components:</p>	<p>PMTCT has become “the norm” for women, with related decrease in stigma.</p>	<p>Significant increase in new ANC clients and use of PMTCT services.</p>	<p>Colton 2005 (Pathfinders review)</p> <p>Challenges include: infrastructure and staffing.</p>

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<p>health facilities and community based services</p> <p>Large scale (PMTCT integrated into 198 facilities in three provinces)</p> <p>2002-2005</p>	<ul style="list-style-type: none"> Sensitization campaign (from national to health care providers to TBAs). Training service providers in PMTCT and AIDS counselling. Training of CHWs in PMTCT. Development of two-way referral systems (CHW-health facility and health facility-CHW). Upgrading facilities to ensure privacy. 	<p>Role of CHWs was crucial in referral system: strong linkages between community and facility services, through CHWs. CHWs also crucial in follow up, adherence and managing side effects.</p> <p>Improving basic ANC services and infrastructure benefits PMTCT services and uptake.</p> <p>To ensure integration Important to train all staff, not just ANC and maternity staff, with support and refresher training.</p> <p>Local ownership is critical for ensuring quality and supervision.</p>	<p>Significant increase in women accepting HIV counselling and testing.</p> <p>Increased Nevirapine uptake for mothers and babies.</p>	<p>Stock outs (testing kits, nevirapine, contraceptive etc).</p> <p>Follow ups of mother and babies. Confusion about feeding, cost of formula milk.</p> <p>Persistence of stigma, use of traditional healers.</p> <p>Poverty additional burden to CHWs.</p> <p>Providers experience problems with monitoring and data collection.</p>
<p>Zambia, Ndola district</p> <p>Ndola Demonstration Project</p> <p>6 DHMT health centres covering a periurban area of around 170,000</p> <p>2000-2002</p>	<p>Introducing VCT and PMTCT counselling and services into MCH and ANC settings.</p>	<p>Initial logistical problems with VCT set up were relatively easy to overcome.</p> <p>Modest overall success suggests need for more education on prevention methods and BCC on sexual risk reduction.</p> <p>Two-way community linkages were limited. referrals were only to major hospitals. continuity of care was limited.</p>	<p>Increased awareness of PMTCT modes (but still limited knowledge of prevention methods).</p> <p>Some improvement in discussion of IFC and PMTCT in counselling sessions.</p> <p>Increase in exclusive breastfeeding practices and improved complementary breastfeeding practices</p> <p>Infant feeding decisions improved</p> <p>Awareness of availability of VCT increased from 45% to 75%, but uptake remained low. VCT seen as</p>	<p>Challenges: improving facilities, supplies and staffing. logistics problems hampered planned strengthening of routine ANC/MCH services.</p> <p>Work on the demand side needed.</p> <p>Innovative ways to reach men are needed. partner behaviour more difficult to alter.</p> <p>Stigma and cost are barriers to acceptance of replacement feeding.</p> <p>Source: Horizons Program, 2002.</p>

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			<p>source of stress rather than way of reducing worry.</p> <p>Women reduced sexual partners, but not men.</p>	
Approach 1: Integration of HIV/AIDS into FP/SRH settings				
1.3 Antiretroviral treatment (ART)				
<p>Dominican Republic</p> <p>PROFAMILIA</p> <p>2004-05</p> <p>Pilot in 1 clinic, later expanded in second clinic.</p>	<p>Integration of HIV care and treatment into SRH services.</p>	<p>Good level of adherence to ART attributed to multidisciplinary team approach, availability of on-site counselling.</p> <p>High confidentiality and integration of HIV with general counselling means that PLWHA feel treated equally.</p> <p>Raising HIV/AIDS awareness among staff reduced stigma and discrimination among them.</p>		<p>A key lesson was that HIV/AIDS services should be just another service in the package of SRH services offered, rather than converting a clinic into an 'HIV/AIDS centre'.</p> <p>Source: IPPF 2005</p>
<p>Kenya</p> <p>Family Planning Association of Kenya (FPAK)</p> <p>Pilot in 4 FPAK clinics</p> <p>2005</p>	<p>Integration of HIV care and treatment into SRH services</p> <p>Aimed to increase access to and use of HIV/AIDS care and support services for PLWHA.</p> <p>Strategy was to increase capacity within FPAK to deliver HIV/AIDS service. delivery of expanded service. increase visibility of service and demand.</p>	<p>Has built on existing service facilities and contact opportunities</p>	<p>Successful in increasing access: 223 of 1,722 clients receiving VCT tested positive</p> <p>Out of 328 pregnant mothers receiving PMTCT counselling and having an HIV test, 20 tested HIV positive and received nevirapine-based treatment.</p> <p>25 eligible people started on ART.</p>	<p>Not always well received by specialist providers of HIV/AIDS service – FPAK seen as competition.</p> <p>Covering routine costs a continuous challenge.</p> <p>Source: IPPF 2005.</p>

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Rwanda Family Planning Association of Rwanda (ARBEF) 2004-05 one-year pilot in two clinics	Integrating HIV/AIDS care into existing SHR services (already including VCT). Project aimed at strengthening the capacity to deliver HIV/AIDS services including ART and OIs treatment. Clinics do not directly provide ART but refer to free Government health services.	Medical insurance support has enabled to keep most PLHAs on treatment for OIs, and enabled some to be introduced to ARVs. Programme built on existing experience and linkages with community distributors and PLWHA networks. Strengthening referral network and home-based care has reduced hospital admissions. Recruitment of staff and community volunteers. Improvements to facilities.	Number of clients accessing clinics doubled (reported as result of increased effectiveness of the programme). Increased demand for VCT and other services. Significantly scaled up the education, care and support activities.	Source: IPPF 2005.

Approach 2: Integrating FP/SRH into HIV/AIDS care, support and treatment programmes

2.1 FP/SRH

Haiti GHESKIO (NGO) VCT centre 1985-200	Integration of on-site primary care services into VCT at a stand-alone VCT centre. PHC services included HIV and TB care, treatment of STIs, and reproductive health.	Experience showed that VCT is a good entry point for people in need of services for communicable diseases and reproductive health. and, reciprocally, that services attract more people to VCT, including populations at high risk for HIV infection. "Women know they can receive a package of quality primary care services at the centre, and they are willing to come".	Increase in people seeking VCT. Rates of HIV transmission were lower than expected in the setting. Good uptake of other services: AIDS care provided to 17% of new VCT clients, TB treatment to 6%, STI management to 18%, and family planning to 19%. Increased demand for contraceptives.	Programme is now being duplicated elsewhere. Peck et al 2003 Quoted in FHI network 23(3) 2004 p 13-14. And WHO 2005 draft p. 38.
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Kenya	Integrating FP into VCT	Located in high prevalence/high stigma setting, but high attendance at centres was attributed to people "believing the benefits of VCT and integrated services outweigh the risk of stigmatization".	1999 16% of HIV infected women using contraceptives.	
Government	Based on feasibility study conducted in 2002.	No evaluation to date.		AMKENI and JHPIEGO implementing first level of integration.
Strategy approved in 2003. implementation under way	Development of strategy that identifies 4 levels of integration, with level 4 as long-term goal. Levels differ in the type of contraceptive methods provided on site.			Source: FHI 2004.
	Development of training tools.			
	Implementation will be phased.			
Uganda	Integrating FP in VCT, PMTCT, and ART settings.	Training helped to overcome resistance by counsellors who saw integration as extra burden.	AIC reported increased demand for FP over time. 8% of overall clients in 2002.	Concerns:
2004-2005 study assess feasibility of providing FP services in VCT, PMTCT, and ART settings	2 VCT sites: FP offered as integral component of service: - FP info given through general health counselling if requested by client. - FP information given during HIV/AIDS counseling. referral to RH Attendant for further info + contraceptives.	Positive attitudes towards integration: PLHAs participating in the study reported a need for family planning. desire for integrated HIV/AIDS and FP services, preferring to receive FP at the same places as HIV-related services and from providers who know them.	A third of FP clients using condom + other method for dual protection.	Limited resources (staff and supplies).
POLICY Project	PMTCT sites: FP information (+ non surgical contraceptives) routine component of AN/post natal services.	Clients spending the whole day in HIV/AIDS centres, have little time to go elsewhere to access		Concern that offering full scale FP services will lead to competition with FP providers.
Based on 4 services (2 in urban and 2 in rural sites) including the AIDS Information Centre (AIC), a large NGO provider of VCT	ART settings: counsellors report			Some providers (and PLHAs) fear that adding FP services will result in increased sexual activity and pregnancies among HIV-positive clients.
				formal referral systems and mechanisms are weak or

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	<p>giving FP counselling/condoms/referrals (but is not service they are expected to provide).</p> <p>AIC created internal referral system.</p>	<p>additional services. most women felt integration would assist them in changing the negative attitudes of their husbands toward FP since they could attend FP counseling sessions together.</p> <p>Successful factors in promoting FP in PMTCT settings include: the closer linking of FP services & counselling in space and time to PMTCT programmes. placing more emphasis on FP counselling for women with HIV/AIDS during the antenatal period rather than the postnatal period when contact is frequently lost.</p>		<p>nonexistent and coordination remains problematic because of the vertical management of FP/RH, VCT, and PMTCT programs.</p> <p>Asimwe and Hardee, 2005 and FHI network 23(3) 2004 p 16 for AIC.</p>
<p>Zimbabwe</p> <p><i>New Start Plus</i></p> <p>PSI</p> <p>2002</p>	<p>Integrating Family Planning into VCT</p> <p>Builds on well-established New Start centres offering high quality VCT at a number of locations.</p> <p>Available at 4 of 18 New Start Centres.</p> <p><i>New Start Plus</i> offers also FP and other RH, and STI screening and services.</p> <p>PSI/Z pays private physicians to provide services such as STI diagnosis and treatment.</p>	<p>Uptake of FP, STI and PMTCT services is low, with decline in numbers of clients.</p> <p>Approach is costly.</p> <p>Evaluation team recommended that centres are not expanded in remit or number and that New Start Plus centres focus on provision of counselling and referral services</p>	<p>Low uptake of FP services.</p> <p>Initial data suggested that 10% of clients requested and received FP services.</p> <p>No evidence to indicate that providing other services increases uptake of VCT.</p>	<p>Existing weakness of New Start Centres is availability of post-test services or referrals. there is little collaboration with other institutions.</p> <p>Source: FHI network 23(3) 2004 p 15. PSI Zimbabwe Assessment 2004.</p>
<p>Brazil, Cameroon, Dominican Republic, India, Kenya, Namibia, South Africa, Thailand, Uganda</p>	<p>Integration of FP into PMTCT settings.</p>			<p>Concerns: Possible overcrowding of integrated facilities.</p>

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Review of experiences conducted in 2004	At all sites FP is a standard component of PMTCT programs and is offered either within or adjacent to the same building as other PMTCT services. But: Availability of FP services at PMTCT sites did not ensure the reverse (integration of HIV into FP messages).			Quality of FP services. FP not considered priority in PMTCT training and allotted minimal time. Follow up difficult: not all mothers return for post-natal care Contraceptive stock-outs. Persisting fears about contraceptives (excl. condoms). Rutenberg and Baek 2004

Approach 2: Integrating FP/SRH into HIV/AIDS care, support and treatment programmes

2.2 HIV/STI prevention in VCT and treatment settings

Haiti Partners in Health From 1998 1 rural site expanded to 5 sites partnering with NGOs and MOH	Integration of free HIV care and treatment with prevention. Delivered as part of PHC effort with support from over 700 community health workers. Patients are routinely counseled to avoid risky behaviors. Both clinical and non-clinical staff participate in addressing non-medical impediments to adherence and health promotion.	Support from community health workers helps to reduce stigma, enhances interest in prevention, involves residents in health promotion. Situating testing and treatment in PHC eliminates stigma attached to freestanding AIDS clinic. Approach has improved PHC provision and increased PHC utilization rather than draining resources from it.	Mortality and OIs sharply reduced. Reduced hospitalisation. Sharp increase in detection of HIV cases and uptake of VCT . Sharp increase in visits for all services.	Sources: UN Millennium Project, HIV/AIDS Task Force, 2005 Nierengarten, 2003. Global HIV Prevention Working Group 2004.
Uganda Study of 926 HIV-infected people in rural setting	Integration of HIV treatment and prevention. Home-based ART programme that included prevention counselling	Integrating ART provision with prevention counseling, and partner VCT was associated with reduced sexual risk behavior and indicates that strategy may reduce HIV	Six months after initiating ART, risky sexual behaviour reduced by 70%. Estimated risk of HIV transmission	Bunnell, 2006

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2003-2004	and VCT for cohabitating partners, and condom provision.	transmission.	from cohort members declined by 98%.	
South Africa MSF with regional Dep. of Health Initially 3 clinics in Khayelitsha. From 2004 (expanded services)	Integrated HIV care, treatment and prevention. Provision of HIV/AIDS medical services in a primary care setting. Relies on generic medications and seeks to integrate HIV, TB and STD treatment services. Provides VCT, OIs management, ARV treatment. Prevention services include group services on risk reduction counseling and disclosure of HIV status to partners. Centre for rape survivors offers medical and psychosocial care, incl. post-exposure prophylaxis to prevent HIV transmission, and trauma counselling.		Impact on public attitudes: residents of Khayelitsha had greater awareness of HIV, more positive feelings toward voluntary HIV testing, and higher rates of condom use. By July 2004, 150 to 200 medical consultations per day and nearly 1,200 people on ARVs. by August 2005, 2,600 people on ARVs, and more than 8,000 medical consultations per month. High adherence rates.	Shows feasibility of approach in resource-poor setting. Sources: MSF website. Global HIV Prevention Working Group 2004.

Approach 3: Integrating FP/SRH and HIV/AIDS programmes for key groups

3.3 HIV/AIDS and youth SRH services

Cameroon Horizon Jeunes PSI	Social marketing techniques for promoting sexual and reproductive health among adolescents ages 12 to 24. Implemented within and integrated into a larger social marketing program (SMASH). Focus on	High exposure of youth to project activities. Significant youth involvement in design of messages and delivery of activities.	Significant increase knowledge on condoms and contraceptives. Increased awareness of STI and HIV/AIDS risk. Delayed initiation of sexual intercourse.	Alford et al 2005. SMASH project 2000.
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Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
Operations research study in one location 1996-1997	<p>delaying the initiation of sex <i>and</i> to use condoms to prevent HIV and STIs. promotion of modern contraceptive methods.</p> <p>Youth-developed and youth-targeted campaign messages. Peer education. Youth clubs Distribution of IEC products. Youth-targeted distribution of condoms and oral contraceptives. Training of health care providers in making services youth-friendly. Involvement of parents and community leaders. Integration within a nationwide social marketing program. Mass media advertising.</p>		<p>Increased abstinence among sexually experienced youth. Reduced number of sexual partners (males). Increased use of contraception (males). Increased use of condoms (females).</p>	
China Study in two towns in Shanghai suburb 2000-2002	<p>Comprehensive SRH education programme</p> <p>Designed both to delay sexual activity and to provide contraceptive knowledge and supplies.</p> <p>Components:</p> <p>Community-based sexual health counseling and contraceptive services at a youth health counseling center. Sex education through pamphlets and lectures, videos, group activities. Contraceptives and condoms made available free of charge. Training for family planning</p>	<p>Key result of study was a reduced incidence of sexual coercion – showing importance of comprehensive SRH education incl. negotiation and life skills.</p> <p>There was a significant increase in reported sexual activity consistent with target group (unmarried 15-24 year olds) showing importance of contraceptive education and promotion.</p>	<p>Increased use of contraception. Increased use of condoms. No effect on delaying sexual activity. Reduced incidence of sexual coercion.</p>	<p>Advocates for Youth, 2005. Wang 2005.</p>

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
	providers in provision of youth-friendly services. Meetings of community leaders and parents.			
Ghana Youth Friendly Services (component of AYA Programme) Implemented through mix of public and NGO partners. 2001 -	Provision of a package of youth-friendly SHR services (including HIV counselling and referral for testing and care). Strategy: Integration of YFS within existing reproductive health services offered at static facilities. Outreach by Peer Service Providers (PSPs) and Nontraditional Condom Distributors (NTCDs). Integration of YFS into curriculum of nursing and midwifery training.	Use of PSPs and NTCDs appropriate and effective for contraceptive distribution: friendliness and easy access (distance previously a barrier). improvement in facilities (privacy, opening hours) and attitude of providers. Input from youth critical in improving quality of service	Increased numbers of youth visits to facilities. positive effects on sexual and reproductive health-seeking behaviours, knowledge, attitudes, and beliefs of peer educators and youth clients. Improved community attitude toward discussing SRH.	Socio-cultural norms remain strong barriers. Important to sustain enthusiasm and commitment of PSPs and NTCDs and supply of commodities. males tend to use outreach services more than facility services (which have traditionally been offered and perceived to be for females). Pathfinder International, 2005 (final evaluation)
Madagascar Top Réseau Social franchise of youth clinics Launched 2001. to date 184 doctors from 123 existing private clinics have been trained incorporated.	RH clinics for youth aged. Clinics supply youth friendly, high quality and affordable RH services to youth aged 15-24. Launch was complemented by communication campaign. supported by a strong youth peer educator program to attract new clients. In 2006 VCT will be offered by selected providers.	Exposure to both communication activities and clinics together essential for behaviour change.	2000-2002 surveys found: <ul style="list-style-type: none"> • Improvements in condom access and use. • Improved perception of efficacy of condoms for prevention of pregnancy, HIV/AIDS and STIs. • Increase in number of youth aware of availability of FP/STI services. • HIV risk perception increased among women. • Increased ability to identify correctly STI symptoms (males). In 2005 clinics reported more than 41,000 clients.	Initial assessment notes the small number of youth sought STI treatment at clinics – programs need to increase perceived need and attractiveness of clinic-based services. PSI, 2004.

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
<p>Mozambique</p> <p>Geração Biz</p> <p>Started in two urban sites and scaled up to 32 clinics in 36 districts</p> <p>1999- ongoing</p>	<p>Peer education and youth-friendly services for SHR/FP/STIs and HIV prevention.</p> <p>Includes school and community-based component.</p> <p>Youth Friendly Health Services (within existing PHCs) with specially trained staff to address the needs of young people.</p> <p>Clinic staff work closely with peer educators and youth activists from schools and the local community.</p> <p>Pupils and teachers are encouraged to become activists linked to the clinic.</p> <p>The estimated cost per person served is US\$80.76)</p>	<p>Success has been attributed to:</p> <p>Use of existing government sites (including clinics, hospitals and schools).</p> <p>Competent, friendly providers.</p> <p>Youth involved in program decision-making and implementation.</p> <p>Strong government commitment.</p> <p>Plans for scaling up in original program design ensured a smooth scale up.</p>	<p>After three years youth attendance at clinics had increased by 70 percent and condom use had increased by 28 percent.</p>	<p>Challenges:</p> <p>In Maputo, 83% of clients were female. Strategies are needed to increase use among male youth. Provision of VCT may be entry point (in 2004 only available at 1 site.</p> <p>Sources: World Bank 2003, UNFPA 2003. Pathfinder International website. Silva, 2004. Fernandes, 2004.</p>
<p>South Africa</p> <p>LoveLife</p> <p>Implemented through NGO consortium</p> <p>1999-</p>	<p>IEC and youth-friendly services for SHR/FP/STIs and HIV prevention</p> <p>Components:</p> <p>Multimedia campaign and outreach programme. has established recognised brand and programme has been franchised out.</p> <p>National Adolescent-Friendly Clinic Initiative (NAFCI) facilities provide PF provision, SH/STI/AIDS information and counselling, referrals.</p>		<p>National Youth Survey to track changes in HIV prevalence and sexual behaviour among South African youth has found that participation in loveLife programming is associated with decreased odds of HIV-positive status for all females. decreased odds of HIV infection for males. reduced odds of HIV infection overall. reduced odds of multiple partners for males age 20-24. increased odds of condom usage in the youth's most recent sexual encounter, and increased the odds that a youth "always uses a</p>	<p>Source: World Bank 2003. loveLife 2004.</p>

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
	Franchise holders involved in IEC activities.		condom” for both males and females.	
Tanzania MEMA Kwa Vijana Program AMREF + MoH and MoE + research institutions 1999-2002 followed by evaluation Randomised controlled trial of 9645 adolescents of whom half were control group)	IEC and youth-friendly services for SHR/FP/STIs and HIV prevention. Components: In-school sexual and reproductive health education. Youth-friendly reproductive health services within government-run PHC. Community-based condom promotion and distribution. Supported through community activities.	Benefits tended to be greater in males than females, and in those who received more of the in-school component. Cost: pilot phase: US\$17 per participant per year. second-year: US\$ 7.63. Annual implementation cost: US\$1.37.	Improved sexual health knowledge. Improved sexual attitudes (reported). Significant increase in reported use of condoms (but total use remained low). delayed reported sexual debut. reduction in reported number of partners. Biological outcomes (HIV and other STIs, and pregnancy): there was no evidence of substantial impact.	Intervention may need more time to produce visible impact on health. It is suggested that additional intervention may be needed. Source: WB 2003. DFID Knowledge Programme.

Approach 3: Integrating FP/SRH and HIV/AIDS programmes for key groups

3.4 Other Key Groups

Colombia PROFAMILIA 2004 35 clinics	Integrating HIV/AIDS, STIs, gender and sexual diversity activities, including a focus on MSM. Strategies: sensitization training on gender, sexuality and sexual diversity in the provision of SRH and HIV/AIDS prevention strategies. media and IEC efforts aimed to promote higher service use by MSM in its clinics, including female	Recognition of diversity: “MSM group” is not uniform reality. Messages take into account sexual diversity, socio-cultural context, power relationship and rights etc.		Source: IPPF 2005
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Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
	partners. specific, targeted and creative messages integrating gender, AIDS prevention, sexuality issues in SHR concept.			
India Sonagachi HIV-STD Intervention Project (SHIP) Government + NGOs and local CBOs Launched 1992	Integrating SRH and HIV/AIDS for sex workers. Begun as a health clinic and peer education programme in a red light district in Calcutta, it has since expanded to West Bengal and turned into broader self-empowerment movement by sex workers beyond original health focus. Initial components: provision of health services including STD treatment. use of sex workers as peer educators. condom programming. Relatively low-cost: relied heavily on part time peer educators and volunteers. condoms sold at bulk rates, not free.	Project has accepted the profession of sex workers as a legitimate one - no attempt was made at discouraging the practice, rescuing or rehabilitating sex workers. highlighted mutual benefits and shared interests for both sex workers and brokers of the sex trade – therefore ensuring collaboration. Risk of STD and HIV infection was seen as an occupational health problem for sex workers. The project has created an enabling environment for sex workers to practise safe sex – building confidence and self respect, cooperation with other actors in the sex trade. Has addressed health needs beyond STIs, providing a range of PHC services for sex workers and their children.	Significant increase in condom use by sex workers: from 3% in 1992, to 70% in 1994, to 90% in 1998. HIV prevalence has remained steady at about 5 percent since 1992. Drop in STI rates: the proportions of sex workers with recent syphilis and genital ulcers fell from 28% and 7%, respectively, in 1993, to 11% and 2% in 1998.	Reproductive Health Outlook website. UNAIDS 2000.
Philippines PRIME II, Cebu City NGOs	Integrating Family Planning with HIV prevention for high-risk youth including female sex workers, their clients and partners. Adolescent sex workers and their	Intervention concentrated on non-traditional, frontline providers – young CHOWs and peer educators because of reluctance among adolescents to access government-run health clinics,	Adolescents exposed to the intervention were significantly more likely to report condom and contraceptive use and significantly more likely to seek appropriate treatment for STI symptoms.	PRIME II project brief, 2003

Setting	Integration strategies attempted/implemented	What has been successful and why?	Evidence of impact/effectiveness	Other/comments
4 locations 2002-	<p>clients in red-light districts, port areas and city slums receive counselling sessions on FP, STI/HIV prevention, condom use stressing dual protection, risky behaviour with Community Health Outreach Workers (CHOWs).</p> <p>Establishment of referral mechanisms.</p>	<p>Delivered simple, targeted messages developed with input from target group.</p>		

Annex 4 References

Abdel-Tawab, N et al (2002). Integrating Issues of Sexuality into Egyptian Family Planning Counseling. USAID.

Adeokun L, et al (2002). Promoting dual protection in family planning clinics in Ibadan, Nigeria. *International Family Planning Perspectives* 28(2):87–95.

Advance Africa Project (2005) Advance Africa's Zimbabwe Program: Interventions, Achievements, and Lessons Learned, 2001 - 2005

Alford S, Cheetham, N and D Hauser (2005) *Science & Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections*. Washington, DC, Advocates for Youth.

Asiimwe D, Hardee K et al (2005) Study of the Integration of Family Planning and VCT/PMTCT/ART Programs in Uganda. Makerere Institute of Social Research and the POLICY Project for USAID.

Askew I and M Berer (2003) The Contribution of Sexual and Reproductive Health Services to the Fight Against HIV/AIDS: a Review. *Reproductive Health Matters* 11(22):51-73

Attawell K, Hayman J and N Khan (2004) PSI Zimbabwe Assessment Report. Prepared for USAID/Zimbabwe and DFID.

Bunnell R. et al (2006) Changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda. *AIDS*, 20:85–92

Chikamata DM, et al (2002). Dual needs: contraceptive and sexually transmitted infection protection in Lusaka, Zambia. *International Family Planning Perspectives* 28(2):96–104.

Colton TC (2005) Preventing Mother-to-Child Transmission of HIV in Kenya. Pathfinder International's Experience: 2002–2005

Dehne K, Snow R. (1999) *Integrating STI Management Services into Family Planning Services: What Are the Benefits?* Geneva: World Health Organization.

DFID Knowledge Programme on HIV/AIDS and STIs (undated) MEMA kwa Vijana: Randomised controlled trial of an adolescent sexual health programme in rural Mwanza, Tanzania. Briefing Note 2

Family Health International (2004) FHI Network, 23(3):2004.

Fernandes M (2004) We Don't Only Need Education, We Need Services. Presented at the 31st Annual International Conference on Global Health: "Youth & Health: Generation on the Edge", Washington, DC, June 1-4 2004.

FHI (2004) Integrating Family Planning and Voluntary Counseling and Testing Services in Kenya. FHI Brief. Family Health International, 2004.

Fitzgerald DW et al (2003). Decreased congenital syphilis incidence in Haiti's rural Artibonite region following decentralized prenatal screening. *American Journal of Public Health*, 93(3):444-446.

Global HIV Prevention Working Group (2004) HIV Prevention in the Era of Expanded Treatment Access.

Horizons Program (2002). Ndola Demonstration Project: a midterm analysis of lessons learned. Nairobi: Population Council.

IPPF (2005) Models of care project. Linking HIV/AIDS treatment, care and support in Sexual and Reproductive Health care settings: Examples in Action. London, International Planned Parenthood Federation.

Lazcano Ponce EC et al (2000). The power of choice of information and contraceptive choice in a family planning setting in Mexico. *Sexually Transmitted Infections*, 76(4):277-281.

LoveLife (2004) Report on activities and progress

Médecins Sans Frontières (MSF): <http://www.msf.org/>. <http://www.doctorswithoutborders.org/>

Myer L, et al (2002). Dual method use in South Africa. *International Family Planning Perspectives* 28(2):119–21.

Nierengarten M (2003) Haiti's HIV equity initiative. *The Lancet Infectious Diseases*, May 5, 2003

Pathfinder International (2005) Community-based reproductive health care: creating demand in Ethiopia. Pathfinder International, August 2005.

Pathfinder International (2005) Youth-Friendly Services: Ghana End of Program Evaluation Report. African Youth Alliance (AYA)

Pathfinder International: <http://www.pathfind.org/site/PageServer>

Peck R, et al (2003) The feasibility, demand and effect of integrating primary care services with HIV voluntary counselling and testing. *Journal of Acquired Immune Deficiency Syndromes*, 33:470-475.

Population Council: <http://www.popcouncil.org/index.html>

PRIME II Project (2003). Philippines: Integrating Family Planning with HIV Prevention for High-Risk Youth. PRIME Voices n.25.

PSI (2004) Franchised Youth Clinics Motivate Behavior Change in Madagascar. Research Brief n. 4

Reproductive Health Outlook: <http://www.rho.org/index.html>

Rutenberg N, Baek C (2004) Review of Field Experiences: Integration of Family Planning and PMTCT Services. Population Council.

Silva, C. (2004) Scaling Up Adolescent Sexual and Reproductive Health Programs: The Geração Biz Experience. Presented at the 31st Annual International Conference on Global Health: "Youth & Health: Generation on the Edge", Washington, DC, June 1-4 2004.

SMASH Project (2000) Social Marketing for Adolescent Sexual Health: Results of Operations Research projects in Botswana, Cameroon, Guinea and South Africa. PSI and Population Reference Bureau.

UN Millennium Project, HIV/AIDS Task Force (2005) Combating AIDS in the Developing World.

UNAIDS (2000) Female sex worker HIV prevention projects: Lessons learnt from Papua New Guinea, India and Bangladesh.

UNFPA (2003) State of the World Population 2003: Investing in adolescent's health and rights.

Wang B (2005) The Potential of Comprehensive Sex Education in China: Findings from Suburban Shanghai. *International Family Planning Perspectives*, 31(2):63-72

WHO (2005) Integrating Sexual Health Interventions Into Reproductive Health Services: Programme Experience from Developing Countries. Geneva: World Health Organization (draft)

World Bank (2003) Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs.