

**ICAP Collaborative PMTCT and Pediatric HIV Strategic Planning Workshop
In Partnership with Tygerberg Children's Hospital, South Africa and S2S**

Title:	Integrating HIV and family planning services for women living with HIV: In search of optimum models of care
Country:	Rwanda
Host Name/Title:	Landry Tsague, MD, MPH, PMTCT/VCT Senior Program Manager
Session Goal:	To review and share better practices and determine the optimal package of non-HIV clinical care for women living with HIV
Learning Objectives:	<ol style="list-style-type: none"> 1. Describe the Family Planning needs for HIV infected women 2. Define and analyze the components of a FP package of services 3. To design and compare different models of FP/HIV services integration in the context of HIV continuum of care. 4. To review best practices and determine the optimal model for FP/HIV integration.
Instructional Method(s):	<ul style="list-style-type: none"> • Brainstorming in two working groups • Concept mapping • Case study
Session Description :	<p>0-15 minutes:</p> <ul style="list-style-type: none"> • The host will introduce the topic by describing the main FP needs for HIV infected women. • He will end the presentation by presenting the live cycle of an HIV infected woman in the HIV continuum of care. <p>16-45 minutes:</p> <ul style="list-style-type: none"> • The host will then ask participants to reflect on that framework to describe their analysis of the “who”, “where” and “what” as they relate to FP assessment and services provision for HIV infected women. • The host will guide participant in listing components of the FP package at each point of the HIV+ women continuum of care, and encourage innovative ideas. Conversely, the host will ask the large group to share their ideas about the elements of HIV services to be integrated in the FP services. <p>46- 75 minutes: Participants will be break into small groups of 4</p> <ul style="list-style-type: none"> • They will be asked to share and compare their country experiences as concern FP services organizations and how HIV and FP services are integrated, using a checklist provided by the host. • The host will present one different scenario to each group and will guide them in designing an optimum and alternative models of integration between FP and HIV services to meet specifically the FP needs of the woman. • Group 1 will address the case of an HIV infected woman on ART in the Care and treatment program in need of FP methods. • Group 2 will deal with an HIV infected woman diagnosed during pregnancy, and in need of FP methods. <p>76-90 minutes: Teams will present back their best and alternative models on integration and the action plan they developed to meet the needs of different models.</p> <ul style="list-style-type: none"> • Host will summarize and close session
Pre-session Activities:	Participants will are asked to complete the following 3 reflective questions prior to the

	<p>session:</p> <ol style="list-style-type: none"> 1. Describe the organization and package of FP services at different levels of your country health system? 2. Who is responsible of providing FP services at different levels of the health system? 3. Describe best practices and tools used to strengthen integration between FP and HIV?
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Session Notes and Summary

Session name: Integrating HIV and family planning services for women living with HIV: In search of optimum models of care

Note taker name: Asqual Getaneh

Major Discussion Points and/or Conclusions:

1. Elements of FP services: FP counselling, referrals, contraceptive choices such as condoms, pills, injectables, implants, IUCD, sterilization.

2. Scenarios for integration of HIV and FP services:

- Training nurses at ART /PMTCT clinics will increase the accessibility of FP services: While this is desirable, it might overwhelm the nurses and may compromise both ART/PMTCT and FP services. Additionally the differential in the cost of the two services in some settings complicates the logistics of providing FP services in ART/PMTCT clinics. ART is given free while FP services are provided at cost. The intensive FP counselling requires significant time allocation that might lead to limited time being spent on each service. In many countries cross training of ART or ANC nurses in FP will be required.
- The ideal model is to have a one stop shop at the CTC where the full package of FP services are provided by a trained FP clinician in a different room .
The disadvantage of this model is its requirement for increased number of staff and space at CTC
- Alternatively, FP services can be provided at MCH/Labour ward as providers are available. However this might exclude men.
- To increase utilization of FP services escort services can be used. This will also strengthen the linkages between ART sites and FP clinic by physically escorting patients. Peer educators have been used to accompany women to FP clinics in some sites and countries.

Conclusion:

Programs should work on strengthening the linkage between ART to FP services while working towards a one stop ART centre.

3. Notes from group discussions:

GROUP 1

Model 1 – Vertical Approach

Advantages:

- better adherence to contraception methods
- longer counselling time

Disadvantages:

- long waiting time
- repeat visits
- high defaulter rate (for FP methods)
- low awareness of FP methods for ART patients

Model 2 – “One-Stop Shop” Approach (including injection)

Advantages:

- less queues, one wait only
- more services in one day
- lower FP defaulter rate
 - o higher adherence to FP
 - o easier to integrate FP into ART package
- easier to monitor progress of FP/ART uptake
- easier for providers to understand the bigger picture,
- easier for patients to understand the bigger picture
- easier to tackle myths about FP and ART (especially when taken together)
- easier to link both, and encourage dual protection
- More room for male involvement and family approach

Disadvantages:

- lack of HCWs,
- greater workload
- greater wait time in one clinic for patients
- less quality for FP or ART provision
- staff resistance to new services

Addressing Barriers:

- training HCWs, but adding incentives (for example, the clinics distributing the most FP methods for women provide a retreat)
- hiring more HCWs
- ensuring availability of methods
- educating population/community

GROUP 2

Model 1 – Vertical Approach

- Escort system so there is an active linkage
- Cross-training nurses at the ANC, ART, so both do FP, while working towards one-stop shop
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Model 2 – Integrated Approach

- Overwhelming for staff
- Cost: ART is free, FP is not
- Space: ART too small
- Resource shortage – not feasible right now

Other points:

In the meantime, good examples – i.e., Rwanda has male days, men attend ANC visits through incentives, women who come with men are prioritized. Men who complete 4 ANC visits have the delivery free of charge.

- Must have couple testing, then disclosure is facilitated by HCW
- 25% of more infections occur amongst discordant couples