

HIV & Sexual and Reproductive Health Integration

Key Learnings from a Multipronged Review of Policies and Evidence



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A Resounding ECHO

Despite better access to contraception, women in sub-Saharan Africa (SSA) continue to acquire HIV at alarming rates

Evidence for Contraceptive Options in HIV Outcomes (ECHO) Trial¹

- **High rate of HIV incidence** (3.8%) among women seeking contraception; **higher rates of pregnancy among AGYW**
- Underscored **need to prioritize women-centered and integrated** contraception and HIV prevention options

¹ ECHO Trial Consortium, HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomised, multicentre, open-label trial (2019).

Access to, uptake and continued use of oral PrEP faces challenges that integration with FP/SRH services could ameliorate

- **Low rates of uptake and continuation** of PrEP among AGYW
- AGYW view **HIV prevention in the context of their sexual health needs and relationship goals**
- Emerging evidence of **higher uptake and continuation of PrEP when offered in FP settings**
- **Pregnancy prevention is a primary motivator** to seek health services, but AGYW **less likely to access both contraception and HIV prevention**

Objectives



Capture and distill learnings, barriers and enablers on the **provision of HIV prevention in family planning settings**, with **clear, specific recommendations for oral PrEP and next generation products**



Provide a comprehensive and nuanced understanding of the **role of providers** as barriers and enablers to HIV prevention services and products and **propose recommendations for policy makers and implementers to inform provider training and development**

Methodology

Literature reviews:

- Integration of HIV and SRH services: 1,077 results; **148 included** (Jan. 1, 2010-April 1, 2019)
- Provider barriers/enablers to HIV Px services: 965 results; **118 included** (Jan. 1, 2011-May 1, 2019)

Qualitative interviews:

- IDIs with 4 projects in Kenya, South Africa, Eswatini and Zimbabwe (2018, 2019) on provision of PrEP in FP/SRH settings
- IDIs with partners in South Africa, Kenya, Zimbabwe, Malawi, Zambia, Nigeria, Uganda, and Namibia on provider training requirements

Provider policy analysis: Desk review of existing PrEP & FP policies in SSA, age of consent policies, policies on same-sex criminalization & Global Gag Rule

Definitions

Full/provider-level integration (one-stop shop) – Comprehensive HIV and SRH services with one provider, in one place, at the same time.

Partial/facility-level integration – Internal referrals to sub-specialist providers or off-site facilities for services.^{2, 3}

Structural integration – Measurable elements of infrastructure, trained staff, and other facility-level factors.

Functional integration – Care received by a client is integrated.⁴

² JA Smit et al., Key informant perspectives on policy- and service-level challenges and opportunities for delivering integrated sexual and reproductive health and HIV care in South Africa (2012).

³ AB Spaulding et al., Linking family planning with HIV/AIDS interventions: a systematic review of the evidence (2009).

⁴ SH Mayhew et al., Numbers, systems, people: how interactions influence integration. Insights from case studies of HIV and reproductive health services delivery in Kenya (2017).

Top HIV/SRH Integration Learnings

Policies	Consumers/End Users
<ul style="list-style-type: none"> Lack of clarity and alignment on age of consent policies can hinder provision of SRH services, lead to fewer AGYW accessing services Reductions and volatility in funding and program capacity can reduce access to HIV/SRH services for young women Task-shifting for HIV Px (PrEP) in policies, guidelines is critical to reduce barriers to integrated service delivery 	<ul style="list-style-type: none"> Clients prefer to receive services where they already obtain care AGYW attribute side effects to oral PrEP when using FP or STI treatment, need support to address side effects Integration can increase privacy, trust, and confidentiality
Providers	
<ul style="list-style-type: none"> Nurses who are integration champions support other nurses to learn about new HIV/SRH services Integrated service delivery will likely require authorizing and training more providers to prescribe PrEP Task-shifting can be achieved efficiently and effectively by separating skilled tasks from non-skilled 	<ul style="list-style-type: none"> Ensure involvement and training of all staff (clinical and administrative) on integrated services In provider training, frame integration as a client-management approach, or person-centered care, rather than an imposed clinical protocol
Service Delivery	Health Systems
<ul style="list-style-type: none"> Continuous engagement of clients and communities can enhance client satisfaction and encourage buy-in for integrated services Coordinate and synchronize oral PrEP and contraception refills and visits Use innovative ways to ensure messaging adequately answers client questions and promotes full range of services on offer 	<ul style="list-style-type: none"> Integration requires strong coordination mechanisms and feedback at all levels of the health system People-centered management can mitigate commodity shortages Integration of M&E tools and registers can enhance planning, accountability, and client monitoring

Policies

KEY LEARNING

Lack of clarity and alignment around age of consent policies can hinder provision of comprehensive SRH services, and can lead to fewer AGYW accessing services, i.e. PrEP

SPECIFIC STRATEGIES AND EXAMPLES

WHO recommends setting minimum legal age of consent for HTS to 12 or 14 years.⁵

Most African countries: age of consent for HTS is 16 or 18 years. Some ([South Africa, Uganda](#)) permit independent access to HTS at 12 years.⁶

Many countries have no clear guidelines on PrEP for adolescents, age of consent; average age of consent is 15 years, higher than age required for contraceptive access (on avg 12 years).

⁵ B Mckinnon & A Vander Morris, National age-of-consent laws and adolescent HIV testing in sub-Saharan Africa: a propensity-score matched study (2018).

⁶ WHO, HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV, Annex 15: Adolescent consent to testing: a review of current policies and issues in sub-Saharan Africa (2013).

KEY LEARNING

Reductions and volatility in funding and program capacity can reduce access to HIV and SRH services for young women

SPECIFIC STRATEGIES AND EXAMPLES

The Global Gag Rule (GGR) **caused widespread funding cuts** for IPPF Member Associations in SSA (up to 70% annual funding) and loss of \$30 million/year for Marie Stopes International.⁷

Many orgs providing abortion-related services **are the same orgs providing HIV Px** to those at risk. Many orgs that did not certify GGR have cut HIV Px services specifically.⁸

⁷ Center for Health and Gender Equity (CHANGE), Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018 (2018).

⁸ amfAR, The Effect of the Expanded Mexico City Policy on HIV/AIDS Programming: Evidence from the PEPFAR Implementing Partners Survey (2019).

KEY LEARNING

Task-shifting for HIV prevention (oral PrEP) in policies and guidelines is critical to reduce barriers to integrated service delivery

SPECIFIC STRATEGIES AND EXAMPLES

Many countries **require doctors, ART/PrEP-certified nurses to prescribe PrEP.** (South Africa, Namibia, Zambia, Eswatini) POWER has paused PrEP delivery at mobile clinic when turnover of nurses w/correct credentials. (South Africa)

FP policies have **clear provisions for task-shifting** counseling and prescription duties **across cadres, i.e.** clinical officers/associates, pharmacists, community health workers. (Malawi, Kenya, Zambia)

Discrepancies between providers authorized to prescribe contraception and PrEP must be resolved in integrated services. (South Africa, Eswatini)

Consumers/End Users

KEY LEARNING

Clients prefer to receive services where they already obtain care (i.e., if HIV-positive, prefer services from an HIV-specific facility)

SPECIFIC STRATEGIES AND EXAMPLES

Majority ART clients preferred FP services at ART clinics where they receive care.^{9, 10}

In these settings, providers should ensure clients receive targeted information about FP and HIV drug interactions to quell concerns.
(Ethiopia, Kenya)

⁹ A Polisi et al., Modern contraceptive utilization among female ART attendees in health facilities of Gimbie town, West Ethiopia (2014).

¹⁰ R Patel et al., HIV-Positive Men's Experiences with Integrated Family Planning and HIV Services in Western Kenya: Integration Fosters Male Involvement (2014).

KEY LEARNING

AGYW tend to attribute side effects to oral PrEP when also using contraception or STI treatment, and need messaging and support to address real and perceived side effects

SPECIFIC STRATEGIES AND EXAMPLES

POWER project found AGYW attribute side effects of contraceptives or STI treatment to oral PrEP. For this reason, **they may be more likely to discontinue PrEP**. Clients less concerned when told side effects possible on PrEP but should be minimal. ([Kenya, South Africa](#))

Providers can use explanations, messages from contraceptives to counsel AGYW when starting PrEP. ([Kenya, South Africa](#)) In peer support groups, early PrEP adopters can assuage concerns of clients who have not initiated. Discuss barriers to continuation, reasons for discontinuation in counseling sessions. ([LVCT Health, Kenya](#))

KEY LEARNING

Integration can increase privacy, trust, and confidentiality

SPECIFIC STRATEGIES AND EXAMPLES

Clients preferred receiving services at HIV clinic, which offered more confidentiality than FP clinic because women counselled in groups there.¹¹ More clients willing to be tested for HIV at integrated clinics because fewer providers increased privacy.¹² (Kenya)

Clinic support hotline with same providers from the clinic answering the phone fostered trust for AGYW who spoke to providers they knew. Referrals to LVCT toll-free hotline for confidential counseling. (LVCT Health, Kenya)

¹¹ EK Harrington et al., Fertility intentions and interest in integrated family planning services among women living with HIV in Nyanza Province, Kenya: a qualitative study (2012).

¹² M Colombini et al., Experiences of stigma among women living with HIV attending sexual and reproductive health services in Kenya: a qualitative study (2014).

Providers

KEY LEARNING

Nurses who are integration champions support other nurses to learn about new HIV/SRH services

SPECIFIC STRATEGIES AND EXAMPLES

POWER faced challenges integrating PrEP in public FP clinic. Nurse champions successful at getting other nurses with similar backgrounds (age, cultural upbringing) to support AGYW PrEP use. (Kenya)

LINKAGES saw marked increase in clients interested in oral PrEP coming from FP unit after nurses were trained. Led to multiplier effect: a PrEP champion by example incentivized other nurses to take training.

Mentorship models: instrumental to reinforcing skills, training other nurses. Communication with peers via SMS/WhatsApp and with MOH focal point was effective for continued learning. (Eswatini)

KEY LEARNING

Task-shifting can be achieved efficiently and effectively by separating skilled tasks from non-skilled

SPECIFIC STRATEGIES AND EXAMPLES

Hard for nurses to find time to initiate clients on PrEP because means other clients wait in line for ART. ([LINKAGES, Eswatini](#))

Employ key staff members to perform more complex tasks requiring training, i.e. IUD/implant insertions, and lesser-skilled staff to screen, counsel clients.¹⁵ ([Malawi](#))

Health system “navigators” deliver talks on integrated services in waiting areas and community events, escort clients to services, follow up on referrals. Gives nurses more time for clinical and admin duties.¹⁶ ([South Africa](#))

Peer educators are highly accepted by clients to lead group and individual counseling and distribute vouchers for health services, which can drive uptake.¹⁷

¹⁵ S Phiri et al., Integrating reproductive health services into HIV care: strategies for successful implementation in a low-resource HIV clinic in Lilongwe, Malawi (2016).

¹⁶ C Milford et al., Developing a model for integrating sexual and reproductive health services with HIV prevention and care in KwaZulu-Natal, South Africa (2018).

¹⁷ L Stackpool-Moore et al., Linking Sexual and Reproductive Health and Rights and HIV Services for Young People: The Link Up Project (2017).

KEY LEARNING

Integrated service delivery will likely require **authorizing and training more providers to prescribe PrEP**

SPECIFIC STRATEGIES AND EXAMPLES

Training all providers to assess HIV risk, prescribe PrEP contributes to higher uptake. (CHAI, Zimbabwe)

Task-shifting certain duties for PrEP provision (i.e. counseling) to trained health educators, pharmacists, nurses can alleviate clinicians' workload (South Africa, Kenya) and minimize effects of frequent rotation and staff turnover. ^{13, 14}

¹³ A Liu et al., Early Experiences Implementing Pre-exposure Prophylaxis (PrEP) for HIV Prevention in San Francisco (2014).

¹⁴ J Myers et al., Pharmacists in HIV Prevention: An Untapped Potential (2019).

KEY LEARNING

Ensure involvement and training of all staff (clinical and administrative) on integrated services

SPECIFIC STRATEGIES AND EXAMPLES

Prior to introducing new services, clinical and admin staff met and identified RH services as a key missing service at HIV clinic. Discussed various scenarios of patient flow, rotating provider roles to ensure staff input/buy-in.

All staff (including non-clinical) trained on correct, consistent messaging to dispel myths before introducing a new service.¹⁸ (Malawi)

¹⁸ S Phiri et al., Integrating reproductive health services into HIV care: strategies for successful implementation in a low-resource HIV clinic in Lilongwe, Malawi (2016).

KEY LEARNING

In provider training, **frame integration as a client-management approach**, or person-centered care, rather than an imposed clinical protocol

SPECIFIC STRATEGIES AND EXAMPLES

Include **values clarification component** in training to address provider stigma, opposition to integration (i.e. reluctance to counsel clients on sexual behavior).¹⁹ (South Africa) LVCT Health invests in working with providers to address values, attitudes that affect objective service delivery. (Kenya)

Build in **agency/confidence component** to manage structural site deficits (i.e. lack of rooms); this facilitates integrated client-based care regardless of facility resources.²⁰ (Kenya)

¹⁹ JA Smit et al., Key informant perspectives on policy- and service-level challenges and opportunities for delivering integrated sexual and reproductive health and HIV care in South Africa (2012).

²⁰ SH Mayhew et al., Numbers, systems, people: how interactions influence integration. Insights from case studies of HIV and reproductive health services delivery in Kenya (2017).

Service Delivery

KEY LEARNING

Continuous engagement of clients and communities can enhance client satisfaction and encourage buy-in for integrated services

SPECIFIC STRATEGIES AND EXAMPLES

Group counseling and daily client education sessions

(oral/visual methods) allow providers to describe HIV and FP services at same time.²¹ Group counseling improves client comfort speaking to providers.²² (Malawi, Uganda)

Engaging community stakeholders in **training on integrated services**,²³ **regional sensitization workshops**²⁴ can improve community-facility linkages and service uptake. (South Africa, Ethiopia)

To **reach male partners**, LVCT identifies partners of AGYW to reach with HIV testing, Px services. PrEP education for all community members, including AGYW's sexual partners. (Kenya)

²¹ H Tweya et al., Contraceptive use and pregnancy rates among women receiving antiretroviral therapy in Malawi: a retrospective cohort study (2018).

²² L Vu et al., Increasing Uptake of HIV, Sexually Transmitted Infection, and Family Planning Services, and Reducing HIV-Related Risk Behaviors Among Youth Living With HIV in Uganda (2017).

²³ C Milford et al., Developing a model for integrating sexual and reproductive health services with HIV prevention and care in KwaZulu-Natal, South Africa (2018).

²⁴ Pathfinder International, Integrating Family Planning and HIV in Ethiopia: An Analysis of Pathfinder's Approach and Scale-Up (2011).

KEY LEARNING

Coordinate and synchronize oral PrEP and contraception refills and visits

SPECIFIC STRATEGIES AND EXAMPLES

Fit PrEP dispensing around contraceptive schedules, esp. with injectables. In POWER, AGYW initiating contraception more likely to initiate PrEP the same day, while fewer initiated contraception but declined PrEP the same visit. Pairing them fosters continuation for both products. (Kenya, South Africa)

In LINKAGES, AGYW can **sync PrEP and FP refills** and their **refill schedules with partners'**. While only NARTIS-trained nurses prescribe PrEP, **anyone (i.e. nurse's assistant) can provide refills.** (Eswatini)

At LVCT sites, after client sees clinician for month 1 follow-up for PrEP, client can pick up refill without seeing a clinician as defined in guidelines. This increased PrEP retention; AGYW report liking the service. (Kenya)

KEY LEARNING

Use innovative ways to ensure messaging adequately answers client questions and promotes full range of services on offer

SPECIFIC STRATEGIES AND EXAMPLES

LINKAGES put PrEP **promotional videos on a tablet** for clients to view while waiting for PrEP, HTS services. Videos answer clients' initial questions before interacting with provider. (Eswatini)

IEC materials remind providers to discuss new services with clients.²⁵ Integrated messaging can reduce stigma and discrimination of HIV,²⁶ increase uptake of new services.²⁷

LVCT promotes PrEP as **part of combination prevention of HIV**, rather than a standalone service. Clients given all options and they select the best method for them. PrEP is dispensed together with condoms. (Kenya)

²⁵ K Church et al., Exploring the Feasibility of Service Integration in a Low-Income Setting: A Mixed Methods Investigation into Different Models of Reproductive Health and HIV Care in Swaziland (2015).

²⁶ USAID, Integration of HIV and Family Planning Health Services in Sub-Saharan Africa: A Review of the Literature, Current Recommendations, and Evidence from the Service Provision Assessment Health Facility Surveys (2012).

²⁷ K Church et al., Impact of Integrated Services on HIV Testing: A Nonrandomized Trial among Kenyan Family Planning Clients (2017).

Health Systems

KEY LEARNING

Integration requires strong coordination mechanisms and feedback at all levels of the health system

SPECIFIC STRATEGIES AND EXAMPLES

Daily team meetings to allocate staff according to daily client flow manages provider workloads, supports team-working.²⁸ **Regular staff debriefing/“unwinding meetings”** to discuss occupational issues helps manage job stressors.²⁹

Real-time data collection through mobile tools motivates providers, who review data with supervisors in real-time to discuss findings.³⁰

Sustained mentorship with SRH/HIV skills-building component can overcome staffing constraints, improve quality of care, is feasible in low-resource settings.³¹

²⁸ M Siapka et al., Impact of integration of sexual and reproductive health services on consultation duration times: results from the Integra Initiative (2017).

²⁹ R Mutemwa et al., Experiences of health care providers with integrated HIV and reproductive health services in Kenya: a qualitative study (2013).

³⁰ S Agarwal et al., Family Planning Counseling in Your Pocket: A Mobile Job Aid for Community Health Workers in Tanzania (2016).

³¹ C Ndwiga et al. Exploring experiences in peer mentoring as a strategy for capacity building in sexual reproductive health and HIV service integration in Kenya (2014).

KEY LEARNING

People-centered management can mitigate commodity shortages

SPECIFIC STRATEGIES AND EXAMPLES

Leadership that **confers agency on frontline staff** to share workloads, make decisions is key to managing commodity stocks. Staff who feel motivated, ownership are encouraged to work flexibly together to tackle structural challenges.

When leadership styles focus more on tasks at hand than people/relationships, staff can be less motivated to track, re-order commodities.³²

³² SH Mayhew et al., Numbers, systems, people: how interactions influence integration. Insights from case studies of HIV and reproductive health services delivery in Kenya (2017).

KEY LEARNING

Integration of M&E tools and registers can enhance planning, accountability, and client monitoring

SPECIFIC STRATEGIES AND EXAMPLES

Consolidating, integrating national registers requires significant forethought, investment. Choose minimal additional indicators sufficient to capture key data.^{33, 34} (Nigeria)

Use **patient card systems, user-controlled cards based on unique IDs**, to track cross-service referrals at different sites.³⁵

Hold **regular feedback sessions on client statistics, facility-level data** to highlight importance of practicing record-keeping.^{36, 37, 38}

³³ O Chukwujekwu et al., Integrating Reproductive Health and HIV Indicators into the Nigerian Health System – Building an Evidence Base for Action (2010).

³⁴ FHI 360, GHAIN Support to RH-HIV Integration in Nigeria: End of Project Monograph (2012).

³⁵ SE Adamchak, FO Okello & I Kaboré, Developing a system to monitor family planning and HIV service integration: results from a pilot test of indicators (2016).

³⁶ C Milford et al., Developing a model for integrating sexual and reproductive health services with HIV prevention and care in KwaZulu-Natal, South Africa (2018).

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³⁸ Pathfinder International, Integrating Family Planning and HIV in Ethiopia: An Analysis of Pathfinder’s Approach and Scale-Up (2011).

The Path Forward

Key Considerations

Policies

- Align age of consent across HIV services, including PrEP, and FP
- Enshrine task-shifting for PrEP in guidelines
- Form HIV/SRH integration TWGs to provide technical oversight

People

- Revise messaging to reflect comprehensive HIV/SRH services for AGYW
- Scale up peer support services, which are critical during integration

Providers

- Train providers on integrated client-centered care
- Identify and train provider mentors/champions to engage colleagues
- All staff should be knowledgeable about all integrated services

Key Considerations

Service Delivery

- Staggered implementation of integration for buy-in, phase in workload
- Conduct community-based outreach on integrated services and engage influencers
- Pairing multiple services in one visit is optimal

Health Systems

- Effective management is critical for integration to relieve structural constraints, staff turnover and heavy workloads
- Invest in integration of M&E systems for accurate tracking and reporting of integrated services

Recommendations

ADVOCACY & RESEARCH

- Leverage relationships with MOH and partners at country level to influence policies on task-shifting, age of consent
- Conduct end-user research on HIV/SRH integrated services and products
- Support civil society advocacy around revision of pre-service training for providers
- Prioritize projects and programs that provide PrEP in integrated settings
- Accelerate R&D and introduction of next-gen products and multipurpose px technologies (MPTs)

HEALTH SYSTEMS

- Streamline age of consent for accessing oral PrEP and FP/SRH services
- Task-shift in policy and practice, particularly for PrEP provision
- Strengthen data management and M&E systems to fully integrate HIV prevention services
- Include values clarification in pre-service training for providers
- Implement differentiated service delivery models for HIV px

Future Implications

- Integrated service delivery has the potential **support expanded choice** for new HIV Px and contraceptive methods
- Lessons learned from SRH on **alternative service delivery** (private sector, community-based) can inform more effective and impactful provision of PrEP
- **MPTs can break down silos** in service delivery; for greatest impact, will need to be delivered by both HIV and FP providers
- How to achieve integration in a way that **improves both FP and HIV outcomes?**

Annex

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- ² AB Spaulding et al., Linking family planning with HIV/AIDS interventions: a systematic review of the evidence (2009).
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³⁰ ECHO Trial Consortium, HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomised, multicentre, open-label trial (2019).