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The CQUIN Project for Differentiated Service Delivery
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Integrating Family Planning Services into Differentiated HIV Treatment Models:

Case Studies from Rwanda and Mozambique

A CQUIN Webinar | June 6, 2023

HIV Coverage, Quality, and Impact Network

Welcome/ Bienvenue/ Bem-vindos

Miriam Rabkin, MD, MPH
Associate Professor of Medicine & Epidemiology
ICAP at Columbia University

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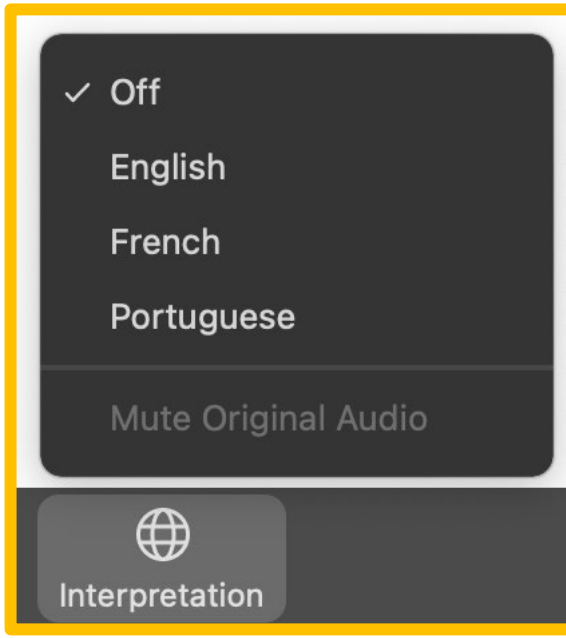


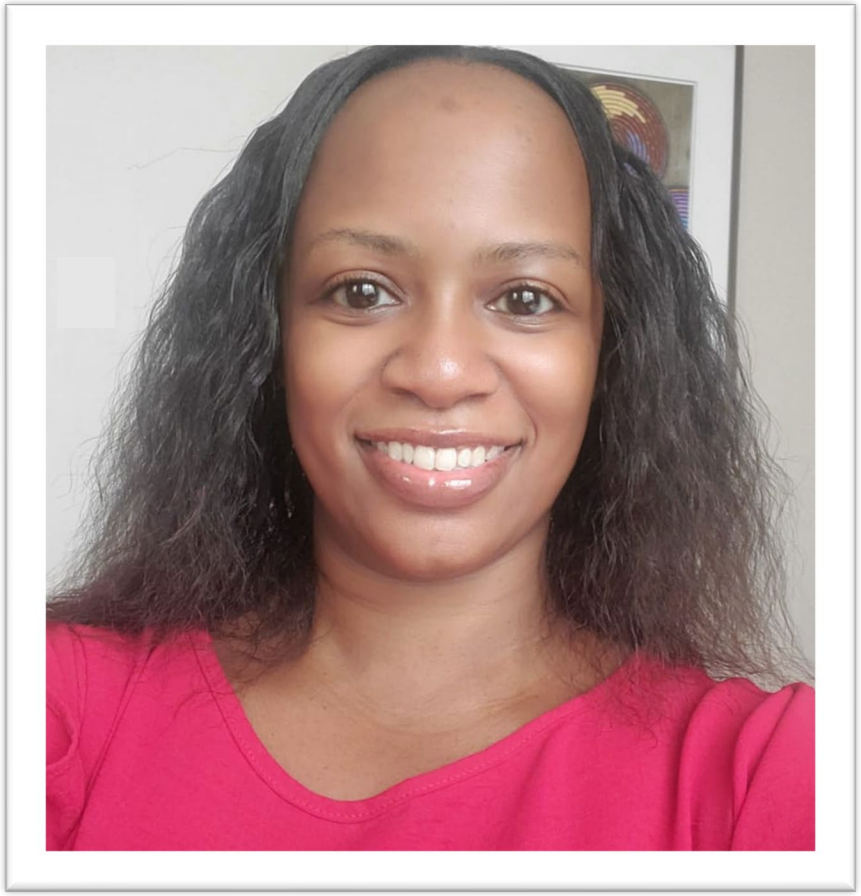
Housekeeping

- 90-minute webinar with presentations followed by a panel discussion with Q&A
- Slides and recording will be available on the CQUIN website (www.cquin.icap.columbia.edu)
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the “raise hand” function on the toolbar and we will unmute you so that you have control of your microphone
- If you are a French, Portuguese or English speaker, please ask your question in your language of choice and the interpreters will translate as needed

Agenda

- **Framing Remarks**
  - Maureen Syowai, CQUIN Deputy Director/Technical, ICAP Kenya
- **Case Studies**
  - Alexandre Alfredo Uaeca, Senior Advisor, Maternal & Child Health, ICAP in Mozambique
  - Brian Kwizera, DSD Technical Advisor, RBC Rwanda & Suzanne Mukakabanda, RBC Rwanda
- **Panel Discussion**
  - Fatima Tsiouris, EGPAF (Moderator)
  - Morkor Newman, WHO
  - Anna Grimsrud, IAS
  - Robinah Babirye, Africa Young Positives Network
  - Namita Eliseu, MOH Mozambique
  - Brian Kwizera, MOH Rwanda
  - Suzanne Mukakabanda, RBC Rwanda
- **Closing Remarks**
  - Peter Preko, CQUIN Project Director, ICAP Eswatini

Framing Remarks



Maureen Syowai, MBChB, MSc
CQUIN Deputy Director / Technical
ICAP Kenya

Framing Remarks: Family Planning Integration into DSD Models

Dr Maureen Syowai
CQUIN Deputy Director / Technical

6 June 2023

HIV Coverage, Quality, and Impact Network

Outline

1. CQUIN 2.0

2. Introduction to CQUIN's stream of work on integration

3. Findings from the CQUIN survey on FP/HIV integration

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CQUIN 2.0

The CQUIN Network

The HIV Coverage, Quality, and Impact Network (CQUIN) is an African learning network designed to advance HIV differentiated service delivery to enhance recipient of care outcomes and strengthen health systems

- The CQUIN network is funded by the Bill & Melinda Gates Foundation and convened by ICAP at Columbia University
- Supported by an Advisory Group inclusive of Ministries of Health, civil society, PEPFAR, CDC, USAID, WHO, Global Fund, UNAIDS, ITPC
- Supported by a Community Advocacy Network chaired by ITPC

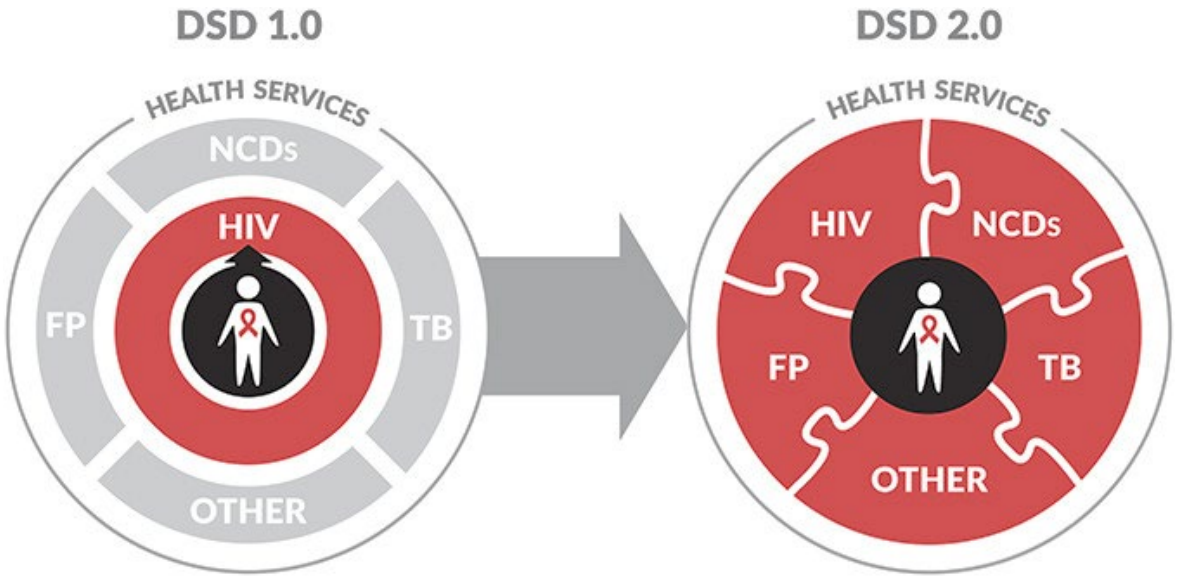
22-country African learning network

The CQUIN Approach

- CQUIN is a **multi-stakeholder learning community** designed to support countries to move beyond pilot programs to DSD implementation at scale.
- The network supports experience-sharing, peer-to-peer learning, and collaborative problem-solving that is focused on the gap between policy and implementation at scale.
- Ministries of health that opt into the network gain access to a wide range of resources, including technical assistance, workshops, **webinars,** country-to-country learning exchange visits, and communities of practice, as well as support for DSD program evaluation, quality improvement initiatives, and strategic planning.

CQUIN 2.0

- The CQUIN project has been extended through June 2027 (CQUIN 2.0)
- Its focus will expand to include differentiated HIV testing and linkage and the integration of non-HIV services into DSD models (DSD 2.0)
- DSD 2.0 envisions a holistic person-centered approach to care for people living with HIV



Ehrenkranz P, Grimsrud A, Holmes CB, Preko P, Rabkin M. Expanding the Vision for Differentiated Service Delivery: A Call for More Inclusive and Truly Patient-Centered Care for People Living With HIV. J Acquir Immune Defic Syndr. 2021 Feb 1;86(2):147-152. doi: 10.1097/QAI.0000000000002549. PMID: 33136818; PMCID: PMC7803437.

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Introduction to CQUIN's stream of work on integration

Defining Integration

"The action or process of combining two or more things in an effective way"

- Oxford English Dictionary

"The organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services …"

- PEPFAR

"Joining together different kinds of services or operational programmes in order to maximize outcomes, *e.g.*, by organizing referrals from one service to another or offering one-stop comprehensive and integrated services."

- UNAIDS

"The…assimilation of health interventions into each of the critical functions of a health system" including governance, financing, planning, service delivery, monitoring and evaluation, and demand generation.

- Atun et al.

What does integration look like?

To a **recipient** of health services:

- Person-centered
- Family-focused
- Multidisciplinary
- Co-located or coordinated
- Fewer referrals – “one stop model”
- Services throughout lifecycle
- Seamless and easy to navigate care

To a **provider** of health services:

- Team approach to service delivery
- Harmonized scheduling
- Unified medical chart
- “Medical home”

What does integration look like?

To a **manager** of health services:

- One staffing, training and supervisory system
- One procurement system for medications and supplies
- One M&E and reporting system
- One financing system

To a **steward** of health services (*e.g.*, MOH):

"Control Knobs"

- Financing
- Payment
- Organization
- Regulation
- Behavior

Integration of Health *Services*

Integration of clinical services at the point of care can be thought of as services integration

- ✓ integration of clinical services for HIV and TB
- ✓ integration of clinical services for PMTCT and MCH
- ✓ integration of services for infants and children (IMCI)
- ✓ integration of HIV and sexual and reproductive health services

Benefits and Risks of Services Integration

Potential Benefits:

- More person-centered
- More efficient for recipient of care
- Minimizes missed opportunities – treat the people in front of you
- Likely more effective

Potential Risks:

- Tradeoffs involving time
- Tradeoffs involving staff
- Tradeoffs involving funding
- Health workforce challenges – training, licensure, scopes of work

Integration into Health *Systems*

The integration of priority programs into broader health systems can be thought of as systems integration

- ✓ inclusion of HIV financing in national budgets and strategic planning
- ✓ inclusion of TB program staff in national health workforce planning
- ✓ inclusion of NTD monitoring and evaluation activities in national M&E systems
- ✓ integration of HIV programs into primary care systems?

Benefits and Risks of Systems Integration

Potential Benefits:

- Integrated systems may be more sustainable
- May achieve greater coverage – *e.g.*, national scale – and be more equitable
- May be more country-driven than donor-driven
- May be more efficient and harmonized

Potential Risks:

- Integrated systems may be less nimble
- May be less intensive
- May be harder to tailor for specific populations
- May have more limited data (quality and quantity)
- Individual programs may have less control
- May be harder to establish program impact

CQUIN's Integration Approach

In the context of CQUIN 2.0, CQUIN will initially focus on:

1. **SRH / Triple Elimination:** starting with integration of FP services into HIV treatment models
2. **NCDs:** starting with integration of HTN services into differentiated HIV treatment (DART) models
3. **TB:** continued focus on integrating TPT and case finding into DART models
4. **Mental health:** details TBD

Defining FP/HIV integration

The term “integration” is often not clearly defined.

- A recent literature review of FP/HIV integration shows multiple definitions, many lacking specificity / granularity
- At the level of health services, common elements typically include:
  - ✓ **Co-location** of FP and HIV services (*e.g.*, both provided at the same site)
  - ✓ **Co-scheduling** of FP and HIV services (*e.g.*, both provided at the same time)
  - ✓ **Coordination of FP and HIV medication refills** to maximize client convenience and minimize visits to health facilities / pharmacies

Integrating FP into DART models: the building blocks

IAS Decision Framework

Defining "integration"

From the CQUIN perspective, we would like to learn more about FP/HIV service delivery *within each type of differentiated treatment model* using the following definitions:

1. **One stop shop within the HIV/ART clinic or in the community:**
   WLHIV receive their FP and ART in the same service delivery point, at the same time.
2. **Coordinated intra-facility referral:**
   WLHIV receive ART from the HIV clinic and are referred from the HIV clinic to a different service delivery point for FP at another service delivery point (MCH, OPD, etc.), but attention is paid to co-scheduling appointments on the same day to maximize convenience and minimize queuing and wait times.
3. **Non-coordinated intra-facility referral:**
   WLHIV receive ART from the HIV clinic and are referred from the HIV clinic to a different service delivery point for FP (MCH, OPD, etc.), without attention to co-scheduling and same-day appointments.
4. **Inter-facility referral:**
   Referral to a higher-level facility for FP services not available on site.
5. **Other:**

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Findings from the CQUIN survey on FP/HIV integration

2022 CQUIN Capability Maturity Model (CMM) staging results

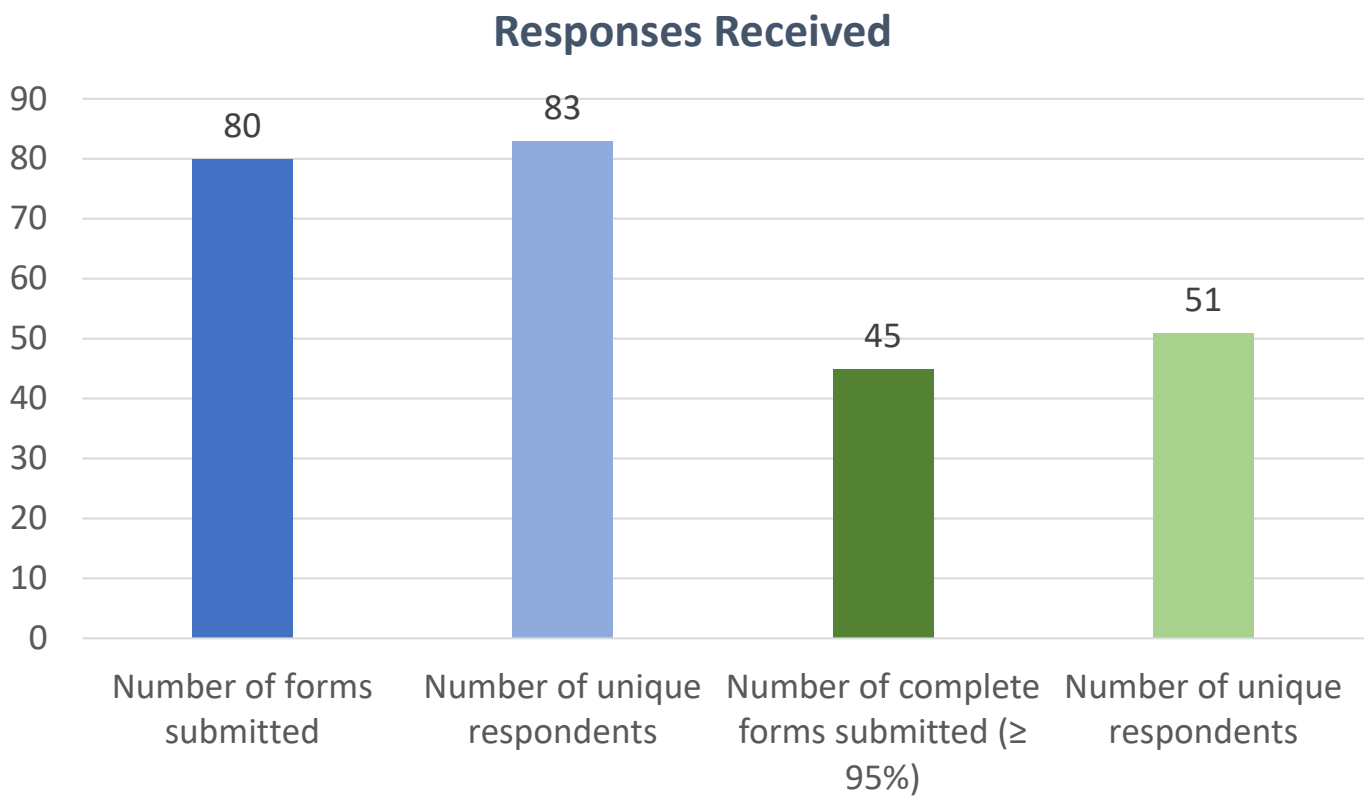
	Country	Integration of FP into DART Models
1	Burundi	
2	Cameroon	
3	Cote d'Ivoire	
4	DR Congo	
5	Eswatini	
6	Ethiopia	
7	Ghana	
8	Kenya	
9	Lesotho	
10	Liberia	
11	Malawi	
12	Mozambique	
13	Nigeria	
14	Rwanda	
15	Senegal	
16	Sierra Leone	
17	South Africa	
18	Tanzania	
19	Uganda	
20	Zambia	
21	Zimbabwe	

- No CQUIN member country has achieved a mature state with regards to FP integration into DART models
- Critical to understand the barriers to taking FP integration to scale despite demonstrable success in small-scale / pilot projects

CQUIN MCH Community of Practice Survey

- CQUIN recently circulated an online survey to country teams, asking for information about FP/HIV integration
  - Policy level
  - Program level
  - Steps taken to improve CMM staging
- 83 unique respondents from 21 countries to date
  - MOH (DSD coordinator, MCH coordinator)
  - Implementing partners
  - Recipients of care / national networks of PLHIV
  - Others

Survey Responses

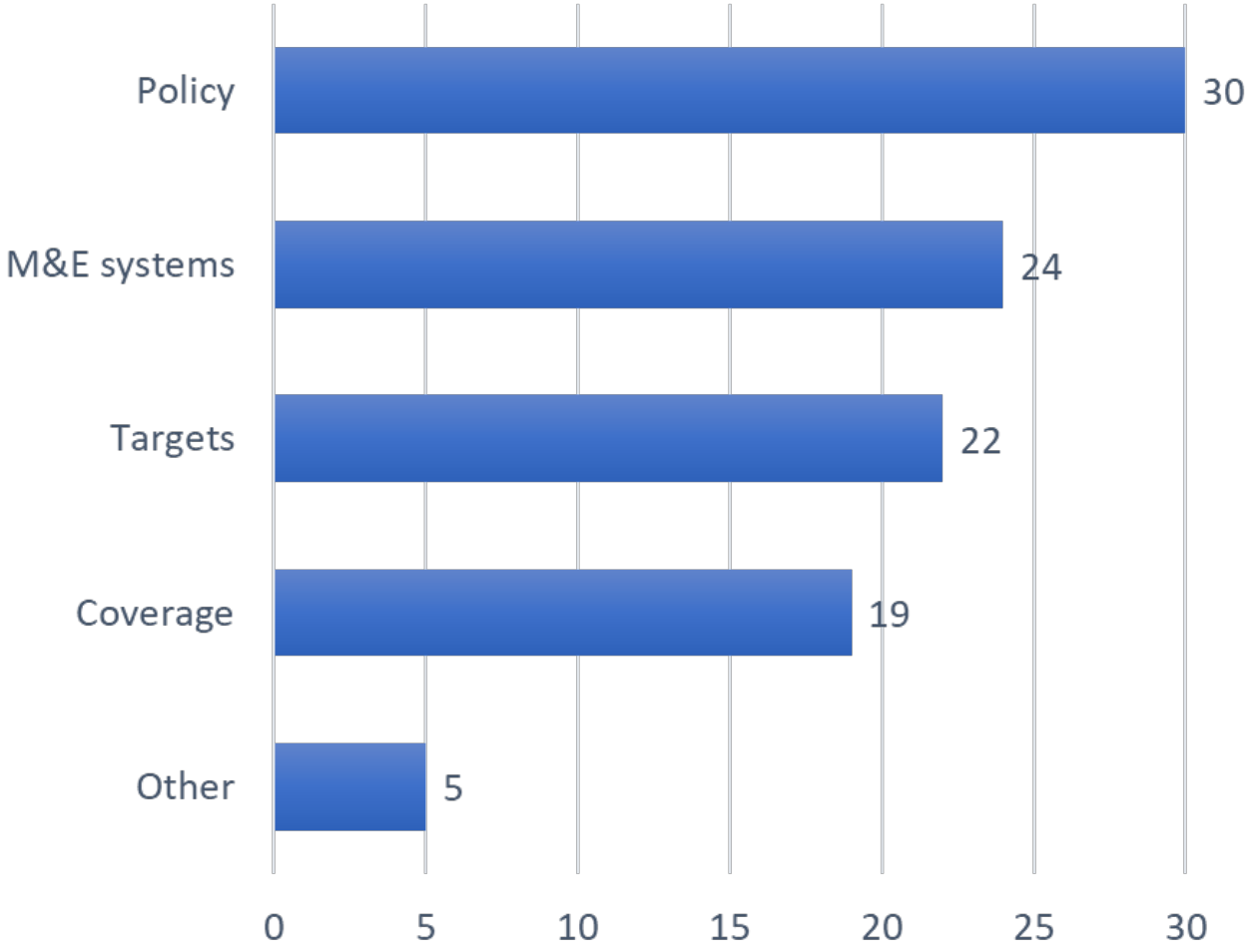


45 out of 80 (56%) forms submitted were complete

3 forms completed by a group of respondents

Countries: 21 countries responded

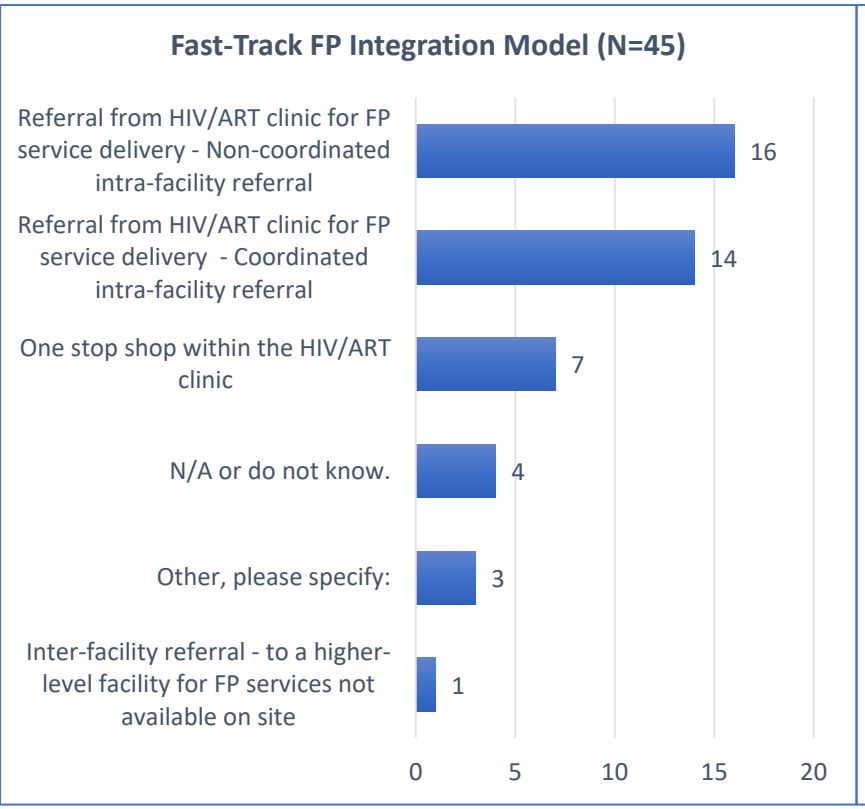
The top two most important issues that led to the FP domain score in the 2022 capability maturity model staging (N=100)

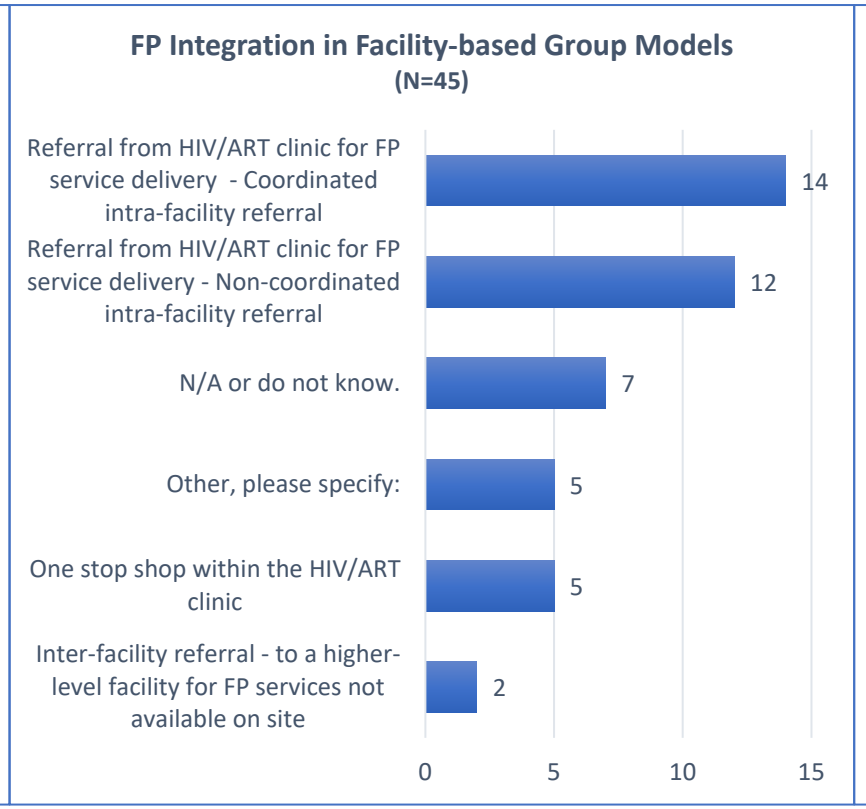


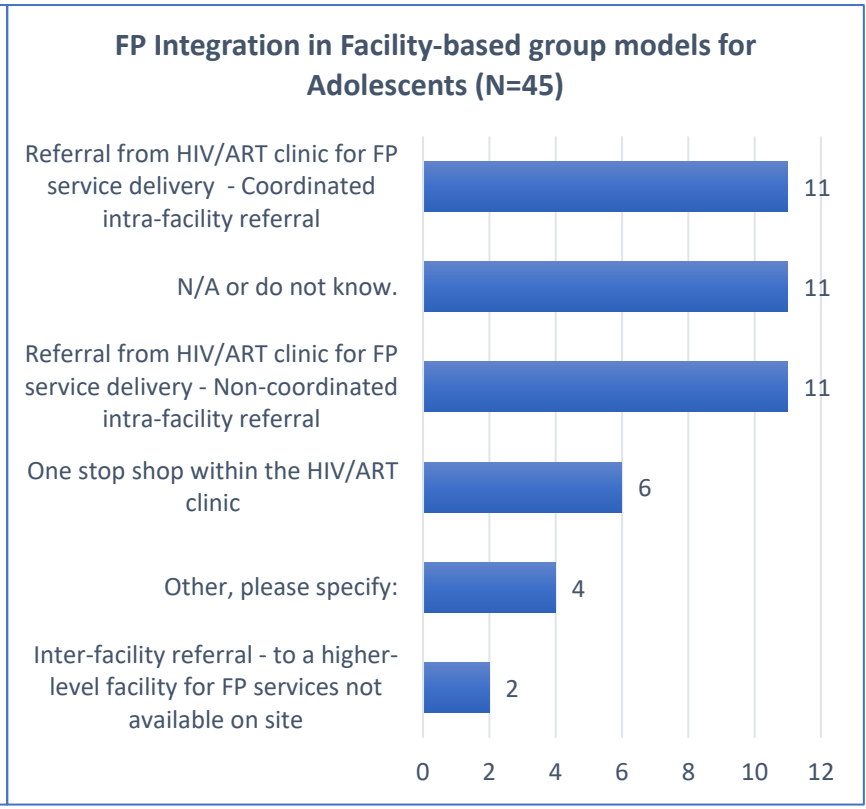
Other:

- Integration not yet fully in place mainly due to the different funding streams for the 2 programmes
- Le PF se fait au BURUNDI, mais pas de suivi évaluation car les données ne sont pas rapportées
  [FP is done in BURUNDI, but no monitoring and evaluation because data is not reported]
- FP uptake from General PLHIV who are on ART
- L'attention se porte sur l'elimination de la transmission mère enfant dans tous les programmes finances ; que ca soit PEPFAR ou Fonds Mondial et non sur la planification Familiale ; le Gap est programmatique et Financier
  [The focus is on eliminating mother-to-child transmission in all financial programmes, whether PEPFAR or Global Fund, not on family planning; the gap is programmatic and financial]
- FP services are not integrated with HIV due to lack of training

FP Integration into Facility-based DSD Models

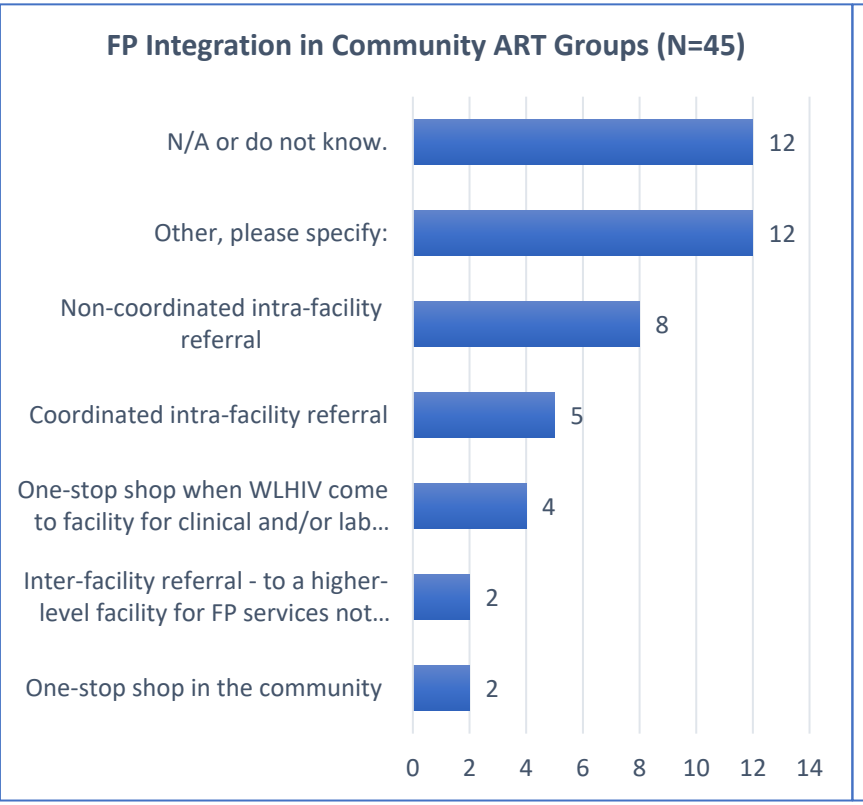


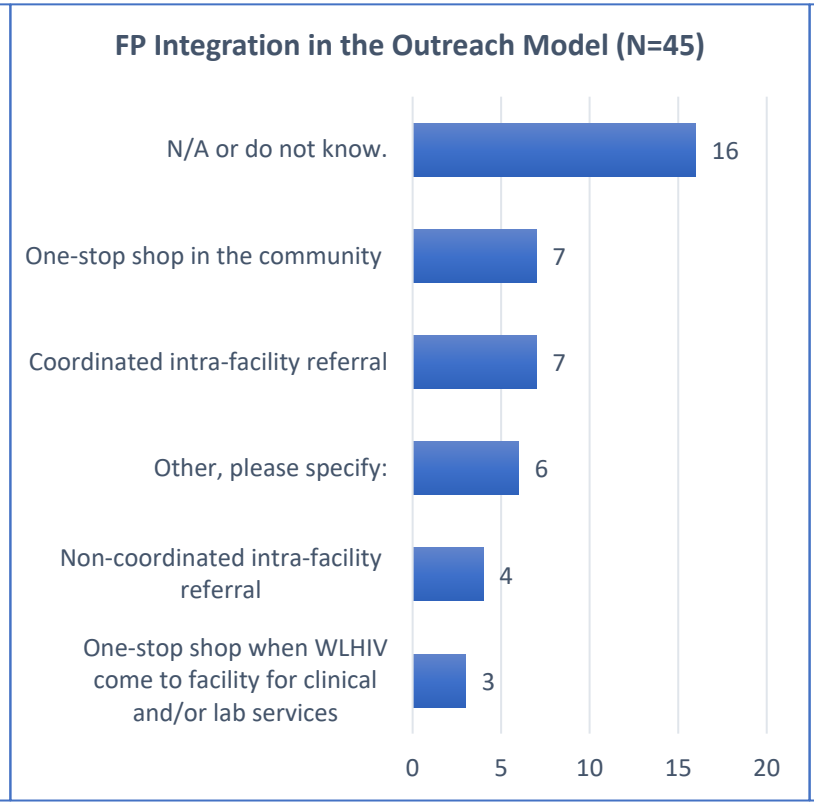


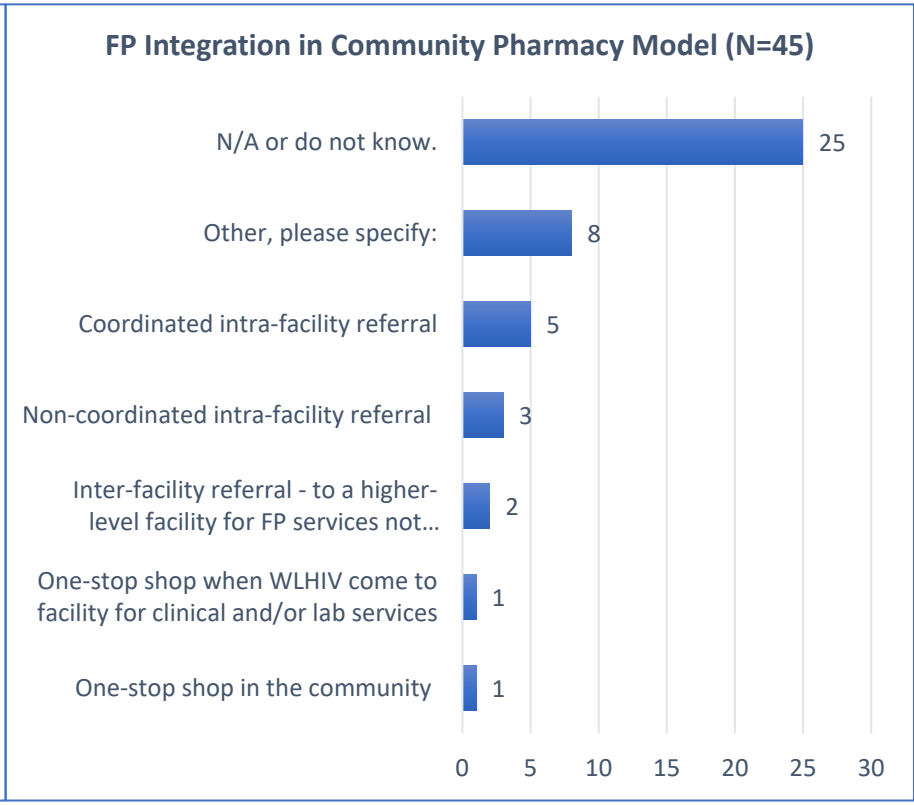


- **Non-coordinated intra-facility referrals -** most common model of FP integration for WLHIV in fast-track models: **16 (36%)**
- **Coordinated intra-facility referrals -** most common model of FP integration for WLHIV in facility-based group models: **14 (34%)**
- **Coordinated intra-facility referral model -** most common models for adolescent facility-based group models: **11 (24%)**

FP Integration into Community-based DSD Models

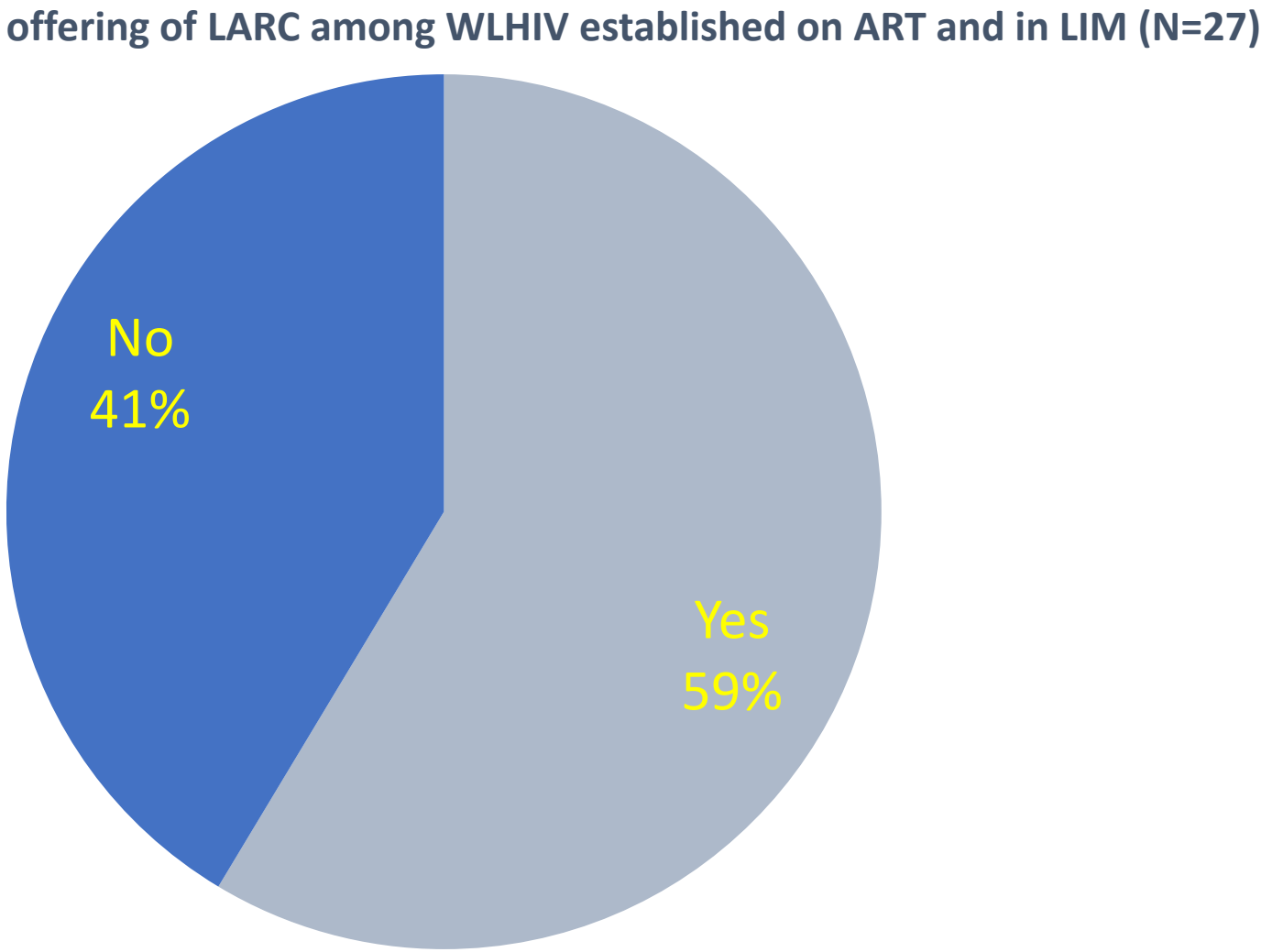






- Majority of responses **24/45 (53%)** indicated that **FP integration into CAGs** was either unknown or were provided through an un-listed approach
- **16 (37%)** of responses indicated that **FP integration into the outreach model** was N/A or unknown
- **Over half, 25 (56%),** of responses indicated that **FP integration into the community pharmacy model** was N/A or unknown

Are long-acting-reversible contraceptives (LARC) methods preferentially offered to WLHIV who are established on ART and in LIMs?



Conclusions

- The survey was designed to enrich our understanding of FP/HIV integration in the context of differentiated HIV treatment models
  - Strengths: Provides more granular information about what integration looks like for WLHIV enrolled in DART models
  - Limitations: Convenience sample, does not include site-level data
- Key observations:
  - The “one stop shop” approach to FP/HIV integration is not in wide use
  - Informants have limited information about how WLHIV in community-based models receive FP services
  - Barriers to integration include policies, separate funding streams, and lack of relevant M&E data

Next Steps

2023:

- Key Informant Interviews
- Enhanced C2C visits
- Ongoing discussion at MCH/FP COP meetings
- July webinar on integration of HIV and HTN services
- August webinar on integration of HIV and mental health services

2024:

- All-network Integration meeting (March 2024)

Thank you!

Presenters

Dr. Alexandre Alfredo Uaeca
Senior Advisor,
Maternal & Child Health
ICAP in Mozambique

Dr. Brian Kwizera
DSD Technical Advisor
Ministry of Health, Rwanda

Ms. Suzanne Mukakabanda
RH/FP Quality of Care Specialist
Rwanda Biomedical Center

Family Planning integrated into community activities in Nampula

Alexandre Uaeca
ICAP Mozambique
June 2023

Content

- Background
- Models and package of services provided in Nampula Province
- Mobile Unit outreach
- Family planning integrated into mobile outreach activities
- Methods of family planning
- Results
- Challenges
- Next steps

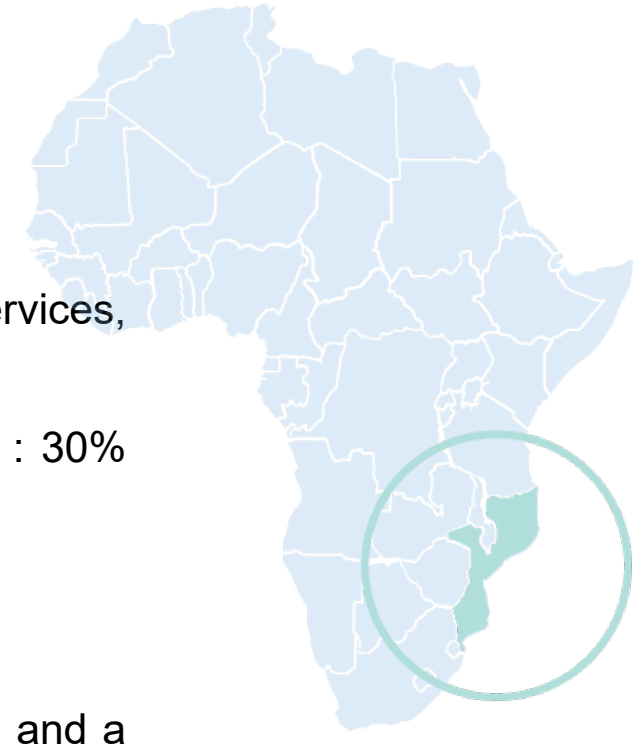
Background

Mozambique

- Estimated HIV prevalence: 12.5% (IMASIDA 2021)
- Estimated number of PLHIV: 2,101,222 (Spectrum 6.06, 2021)
- Fertility Rate (TGF) is around 5.9 (guidelines for integrating FP into other services, MOH 2016; IDS 2011)
- Estimated contraception methods coverage among women of childbearing age : 30% (IDS 2011)

Nampula Province

- 23 districts and 246 government health facilities (HF)
- ICAP supports HIV/TB prevention, care and treatment (C&T) services at 62 HF and a referral hospital across 19 districts
- Estimated contraception methods coverage among women of childbearing age: 5% (INE 2013)



Models and package of services provided in Nampula Province

ICAP-supported community health services:

- **Community-based** services through mobile units, which can be mobile clinics (MC) or double-cabin vehicles equipped with tents, foldable tables and chairs.
- **Services also offered at the female prison in Nampula city**

Logistics support:

- Transport and sample collection
- Transport HCW from HF to the prison on a monthly basis
- Allocate M&E tools and job aids
- Provide materials and consumables

HIV prevention and C&T services integrated with general health services in all models.

Services include:

- Outpatient consultation
- COVID-19 and HIV screening and testing
- Condom and lubricant distribution
- PrEP initiation and continuation
- STI and TB screening and treatment initiation
- Psychosocial support
- Sample collection (EID, VL and TB)
- Maternal and child health services (ANC, FP, at-risk children consultation, cervical cancer services)
- ART initiation and continuation including 3 multi-month dispensing (3MMD)

Mobile Unit community services

- HIV package delivered through 5 mobile clinics and 70 mobile brigades serving general population, key population (KP), adolescent young population (AYP) during day, night, on Islands, companies, penitentiaries and educational institutions.
    - General population- mobile units operate daytime on weekdays
    - AYP-focused mobile units operate on weekends where they congregate and integrating services at technical schools and universities.
    - KP-focused mobile units operate at night and on weekends in hotspots where PWID, FSW and clients of SW congregate.
- Mobile units are staffed by ICAP staff (including a clinical officer, lay counselor, MCH nurse, and MC driver); or HF staff (including a clinical officer, MCH nurse and lay counselor), with ICAP support for logistics and fees.

Mobile clinic serving AYP in Nampula

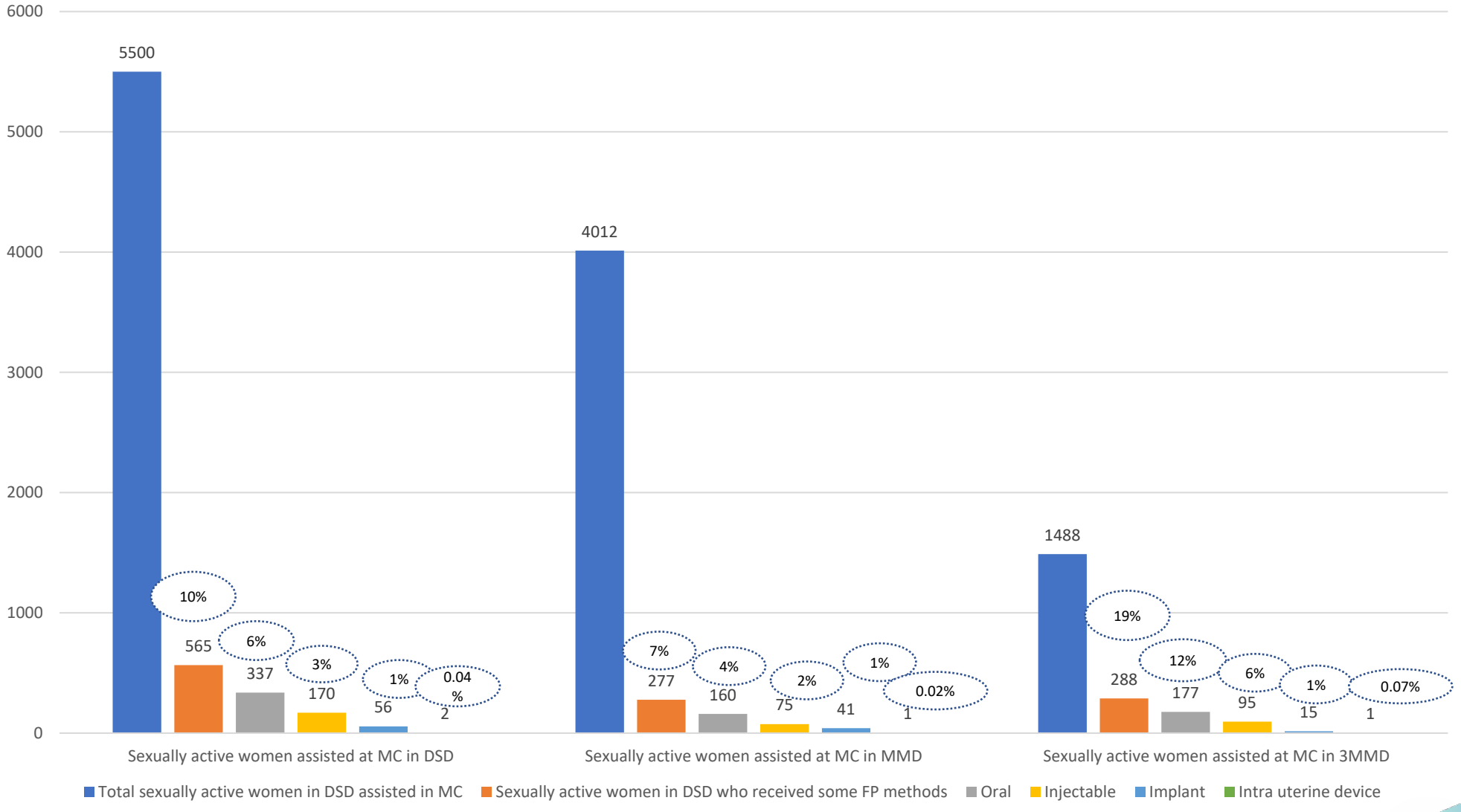
Family planning integrated into health services provided by mobile units

- Family planning counseling and demand creation is performed by lay counselors and volunteers at waiting areas and reinforced during clinical consultations
    - This includes the different methods options and its advantages for each client;
    - The choice of method is always an informed, voluntary and free choice, and PLHIV women are informed about safe pregnancy.
    - Clients on multi-month dispensations are counseled to take long-term methods;
- Mobile unit offers the same FP methods as primary HF
- FP methods are offered in all clinical consultations (outpatient consultation, MCH, HIV and PrEP consultations) by the mobile unit clinical staff and delivered to the client at the same consultation room by the same provider
- Family planning methods offer is registered in the MOH FP M&E tools and reported through the referral HF
- Medication is allocated weekly to the mobile units based on the consumption report

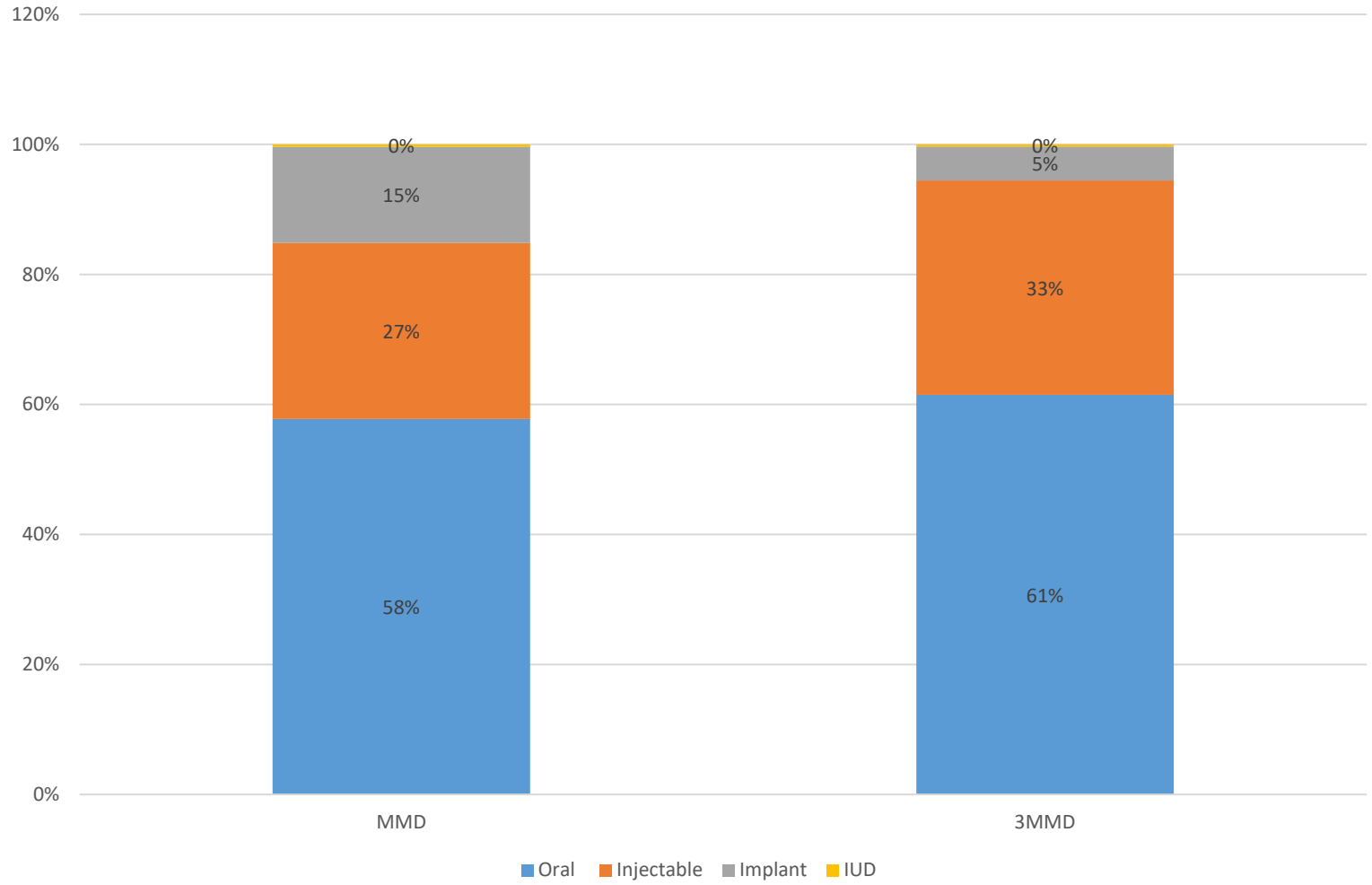
Methods of family planning

Family planning method	HF	Mobile Units
Condom	Yes	Yes
Oral method	Yes	Yes
Injectable	Yes	Yes
Implant	Yes	Yes
Intrauterine device (IUD)	Yes	Yes
Tubal ligation	Yes (referral Hospital)	No
Vasectomy	Yes (referral Hospital)	No
Lactational Amenorrhea Method	Yes	Yes

Women of childbearing age living with HIV attending mobile units - Nov 22 to April 23



FP methods among women living with HIV attending Mobile Units (Nov 22 to April 23)



Challenges

- Frequent stock outs, especially injectable
- Loss of opportunities for FP counselling and FP offer in mobile unit due to high demand for activities
- HCWs reluctant to discuss sexuality due to stigma and lack of adequate space/confidentiality
- Cultural norms impacting women accessing FP due to lack of consent from partner/family members

Next steps

- Continue to train CHWs to provide integrated messages and to offer FP counseling and services during HIV services to improve acceptability and availability of FP service
- Provide intensive monitoring and TA to CHWs at the Mobile Units to scale up the FP offer services
- Continue to support HF and mobile unit teams on supply management for FP methods, including proper register and reports to minimize stock outs
- Improve community literacy about the benefits of family planning and create demand for FP services to dispel myths and reduce barriers through dissemination of key messages at community level including radios spots and debates
- Monthly data on service delivery is reviewed and discussed with HF teams

Thank you

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FP/HIV integration in Rwanda: Experience and lessons learned

Brian Kwizera, National DSD Coordinator, MOH Rwanda
Suzanne Mukakabanda, RH/FP Quality of Care Specialist, RBC Rwanda

June 6, 2023

HIV Coverage, Quality, and Impact Network

Outline

- **Overview of Family Planning in Rwanda: Policy Framework**
- **Where are we: CQUIN Capability Maturity Model (CMM) Staging results**
- **What did we do differently in HIV/FP integration**
  - The process (methods, tools, funding justification)
  - Model of Integration/Approach (How)
- **Key preliminary findings**
- **Lessons learnt and challenges**
- **Next steps**

Overview of Family Planning in Rwanda – 1

- The government of Rwanda has embraced family planning (FP) as a **central component of development**.
- Beyond the timing and limiting of children, the government views **FP as a vehicle to better health through decreased maternal, infant, and child mortality**
- The *4th Health Sector Strategic Plan (2018-2024)* suggests among its strategies: **"To increase the demand for adolescent SRH services, including FP, by increasing access to services for all including adolescents and youths."**

Focus	Quantitative indicators and targets
Increase mCPR (MW)	From 48% to 60% by 2024
Reduce fertility rate to improve MCH outcomes	From 4.1 to 3.3 by 2024
Reduce unmet FP needs	From 19% to 15% by 2024
Demand satisfied	From 72% to 82% by 2024
Percentage of teenage pregnancy	From 7.3% to < 7.0% by 2024

Policy Framework

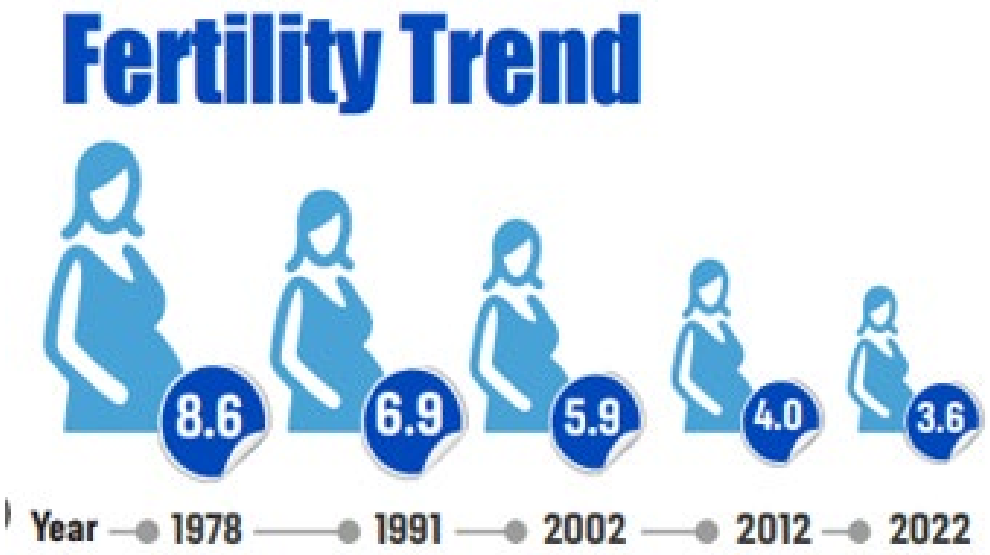
Key strategies to achieve target prevalence rate of modern contraceptive methods amongst women of childbearing age:

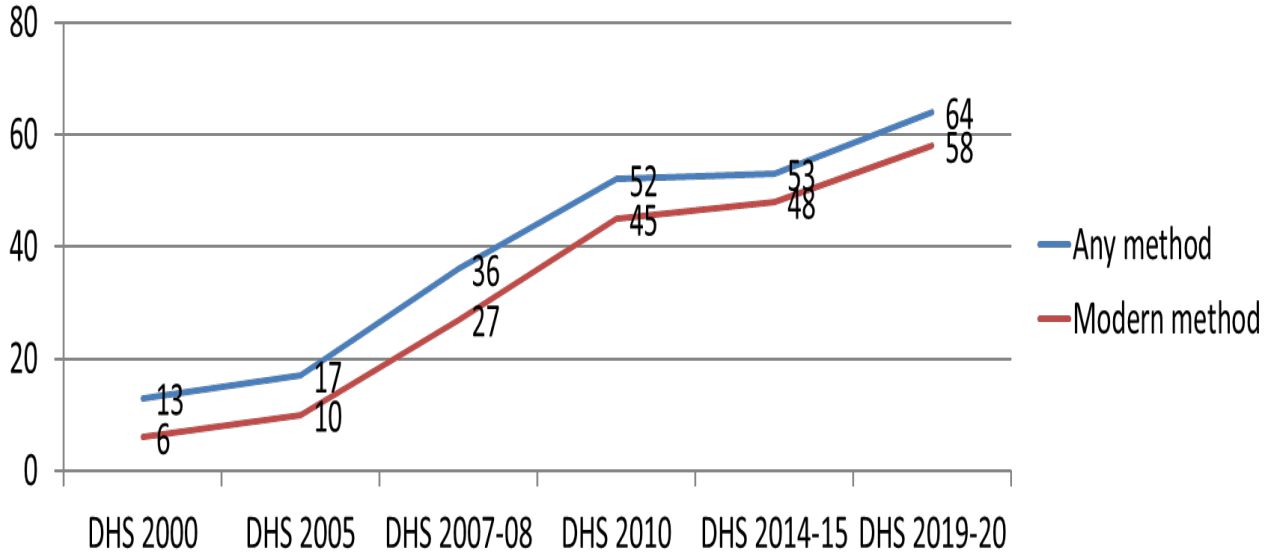
- ✓ Increase awareness-raising by different communication channels
- ✓ Increase access: CBP/FP by CHWs and secondary health posts, reviving FP services in app public and private HFs
- ✓ **Integration of services** (ANC, maternity, PNC, **HIV,** immunization, nutrition and others)
- ✓ Introduction of new methods
- ✓ Establishing a system to monitor FP activities in all public health facilities at all levels

User Fee for FP services

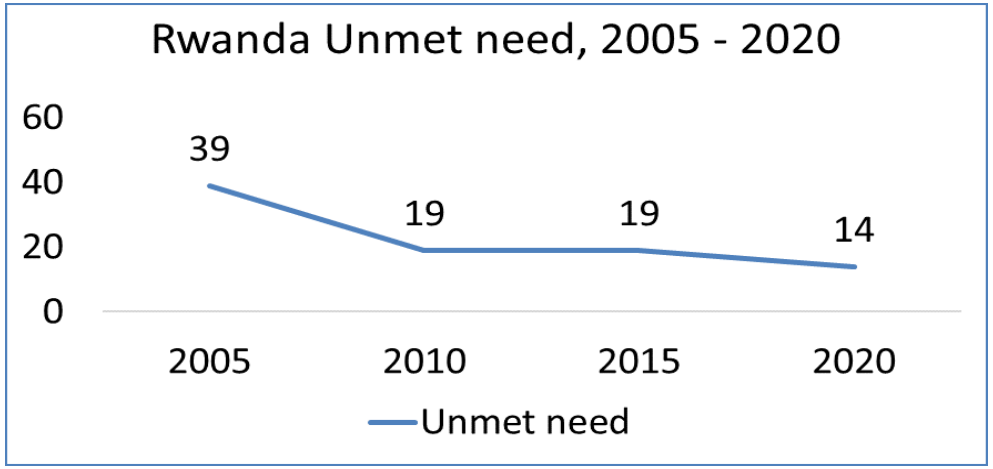
- In all public health facilities, including at the community level, FP methods are **free of charge.**
- A small fee is charged for consultative services and FP procedures at the level of HF under Community-based health insurance (CBHI).

Trend of Contraceptive Use in Rwanda (2012-2022)





> The current total fertility rate (women aged 15-49) is 3.8 in rural areas and 3.2 in urban areas



CMM Staging Results for FP Domain: 2022

In 2022, Rwanda's country team conducted the CQUIN capability maturity model self-staging exercise and gave themselves a yellow score in the FP domain

Integration of Family Planning into DART models	National policies **do not** support integration of family planning (FP) services into less-intensive DART models	National policies **do** support integration of FP services into less-intensive DART models **BUT** there are no national coverage targets for the number or proportion of eligible women enrolled in DART who receive integrated FP services **OR** there are targets, but no data with which to assess progress towards targets in the past year	National policies do support integration of FP services into less-intensive DART models **AND** there are national coverage targets for the number or proportion of eligible women enrolled in DART who receive integrated FP services **AND** the country has achieved < 50% of its national targets in the past year	National policies do support integration of FP services into less-intensive DART models **AND** there are national coverage targets for the number or proportion of eligible women enrolled in DART who receive integrated FP services **AND** the country has achieved 50-75% of its national targets in the past year	National policies do support integration of FP services into less-intensive DART models **AND** there are national coverage targets for the number or proportion of eligible women enrolled in DART who receive integrated FP services **AND** the country has achieved over 75% of its national targets in the past year

CMM Staging results for FP Domain – 2

National policies do support integration of FP services into less-intensive DART models

AND there are national coverage targets for the number or proportion of eligible women enrolled in DART who receive integrated FP services

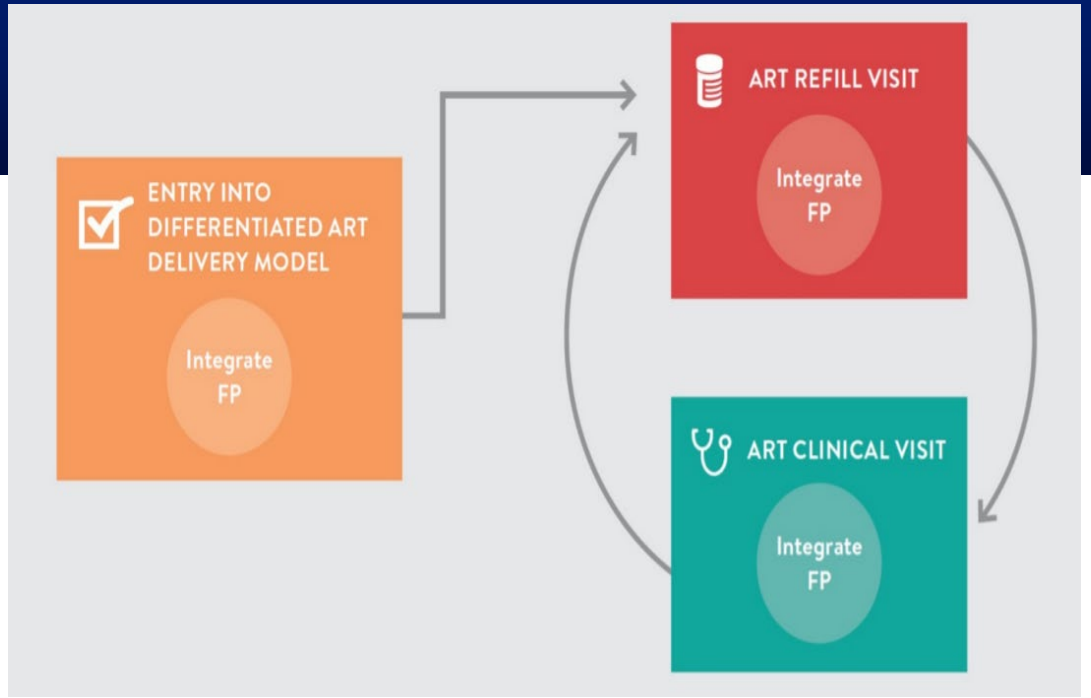
AND the country has achieved < 50% of its national targets in the past year

- ✓ National policies do support the integration of FP services into less-intensive DART models: FP reference manual
- ✓ There are starting coverage targets, just for selected facilities in Kigali.
- ✓ And we have data from the targeted facilities, achieving <50 by the time we did staging the last annual meeting.

- In addition, country has achieved < 50% of its national targets in the past year **(for general population, PLHIV included)**
- BUT there are no national coverage targets or there are targets, but no data with which to assess progress towards targets in the past year

Approaches to FP Integration

- Utilized DSD referral and follow-up as an opportunity for linking PLHIV to FP care.
- Encouraged promotion of long-acting reversible contraception (LARC, IUD, Implant) in DSD models
- Aligned FP and ART re-supplies in DSD models, including community refills and linkage
- Integrate FP and ART care in DSD models in facilities and promote community linkages (pre-defined who needs to be linked-CHWs)
- MOH/RBC: Senior Officer for AGYW (Development of Minimum package for AGYW includes FP and SRH)



Summary of FP integration into DSDM approaches in Rwanda

What: Counseling, condoms, long-acting reversible contraception (LARC, IUD, Implant)

When: Depends on the method of choice

Who: Trained MD, trained nurses, CHWs

Where: Both Facility-based and Community-based

Integration Strategies:

1. Co-location of FP and HIV treatment services (*e.g.,* both provided at the same site)
2. Co-scheduling of FP and HIV treatment services (*e.g.*, both provided at the same visit)
3. Coordination of FP and HIV medication refills to maximize client convenience and minimize visits to health facilities/ pharmacies.

Differentiated approaches to HIV/FP Integration

- **Community-level,** CHWs offer FP at the community level and refills for clients with transfer from the facility. They refer for method initiation, procedure methods (like IUD, implants, ligation) and management of side effects

Table 4. Types and Functions of FP Services by Provider and training required for FP service providers

Service Provider	Natural Methods	Barrier Methods	Oral contra-ceptives	Inject-able	Implants	IUD	Tubal Ligation	Vasectomy
CHWs	V	V	V	V				
Nurse/ Midwife	V	V	V	V	V	V		

- **Health posts** offer FP services
- **Youth corners** at the facility and at the sector level offer youth-friendly FP services including Isange One-stop centers dedicated to GBV
- **Outreach**
- **Facility level:** all methods can be offered at facility (Health centers, district and referral hospitals)

Table 1. Screening for other Sexual and Reproductive Health Issues During FP service provision, by Level of the Health System

Type of Screening	Community Level	Health post	Health center	District Hospital	Provin-cial Hospital	Referral Hospital
Sexually transmitted infection and HIV risk assessment		V	V	V	V	V
HIV counseling and testing		V	V	V	V	V
Cervical cancer screening			V	V	V	V
Breast cancer screening		V	V	V	V	V
Reproductive tract infection screening	V	V	V	V	V	V
Prostate cancer screening			V	V	V	V

DSDM Flow for FP aligned with ART Services

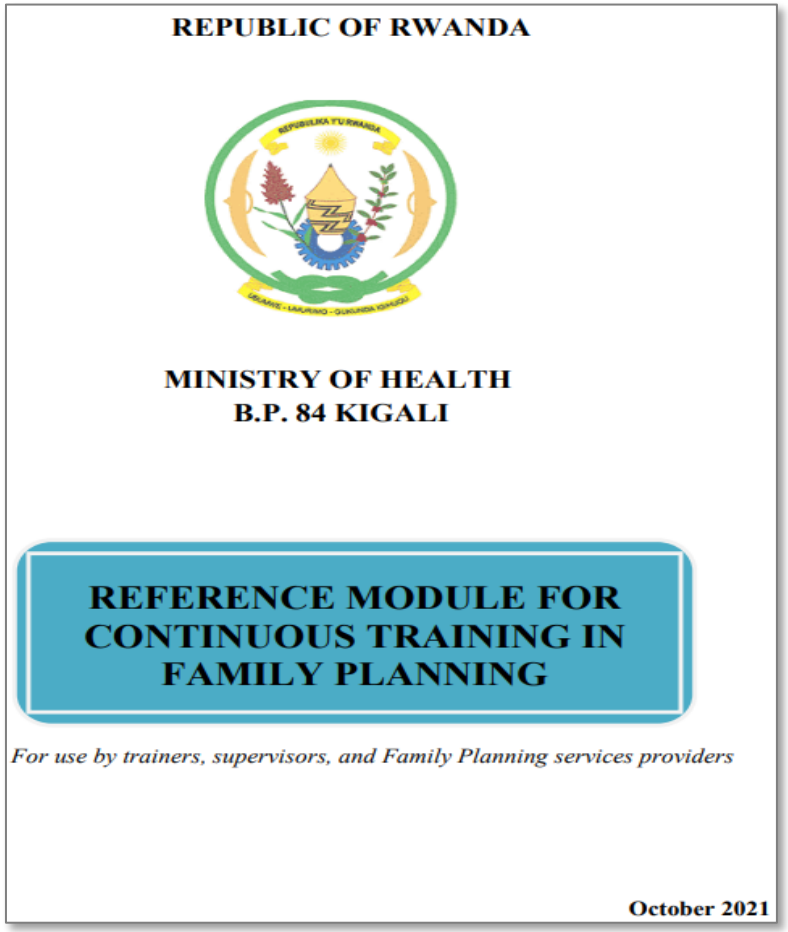
	Oral pills	Injectables	Implants	IUDs
WHEN	Every 3 months, aligned	Every 3 months, aligned	At DSD entry At DSD clinical visits At facility walk-in services Between visits as needed	Upon request
WHERE	Collect ART and FP script from same clinic room Trained CHWs in the community	Injection given in same room as ART assessment	At same facility as ART where transition to DSD was initiated Collected by peer educator/CHWs for distribution where possible	FP service unit
WHO	FP trained HIV provider, nurse provides script	FP trained HIV provider, nurse	Implant-trained peer doctor, clinical officer, midwife or nurse	ARV provider trained in FP
WHAT	Information, counseling, either of COC or PP, script for pills, management of side effects	Information, counseling, injectables, management of side effects	Information, counseling, implant insertion / removal, management of side effects	Information, counseling, IUD product, insertion and removal, management of side effects

Summary of FP integration into DSDM approaches in Rwanda

	WHERE	*WHO*	*WHAT*
Less-intensive models	**Community-based model**	**CHW-led FP model**	• **Counselling + Natural and modern CP method initiation** • **CHW provided CP refills and referral for advanced contraceptive methods**
		Outreach model: CP distribution coordinated by implementing partners (SFH, MCH/ RBC…)	• **CP community distribution**
	Facility-based model (500+ Health centers, 42 Hospitals) **Point of entry : HIV, FP/MCH, PMTCT/PNC**	**Youth corners (a form of FBG led by a peer youth coordinated by FP focal person or a PMTCT provider at health center/health post)**	• **Youth-friendly services** • **Counselling + Natural and all CP methods** • **CP refills**
		ART nurse, FP nurse, PMTCT nurse, MD	

Progress towards FP integration

- We collaborated with the MCCH division and partners to develop the Family Planning Reference Manual that includes STI, SRH and FP service integration within HIV (pages 146-164)
- FP registers, tools for reference and documentation have been identified, updated and requisition process of commodities between FP units and HIV units in health facilities have been addressed.
- Stakeholders: **UNFPA, CHAI, GF, MCCH/MOH**


REPUBLIC OF RWANDA

MINISTRY OF HEALTH
B.P. 84 KIGALI

REFERENCE MODULE FOR CONTINUOUS TRAINING IN FAMILY PLANNING

For use by trainers, supervisors, and Family Planning services providers

October 2021

Training sessions

- Consultative meeting; MCCH/FP leads + HIV/C&T TWG acknowledges the unmet need for integration of FP services in HIV service delivery.
- Developed concept note, secured GF funding for training nurses in HIV service delivery to equip them with comprehensive SRH, STI and FP services in HIV service delivery (2 rounds)
- Leveraged National FP Trainers to train HIV providers: coverage target being **WLHIV of reproductive age** population **(15-49 years)** of close to **20,000 WLHIV** served in Kigali Public Health Centers.

Trainings were both theoretical and practical

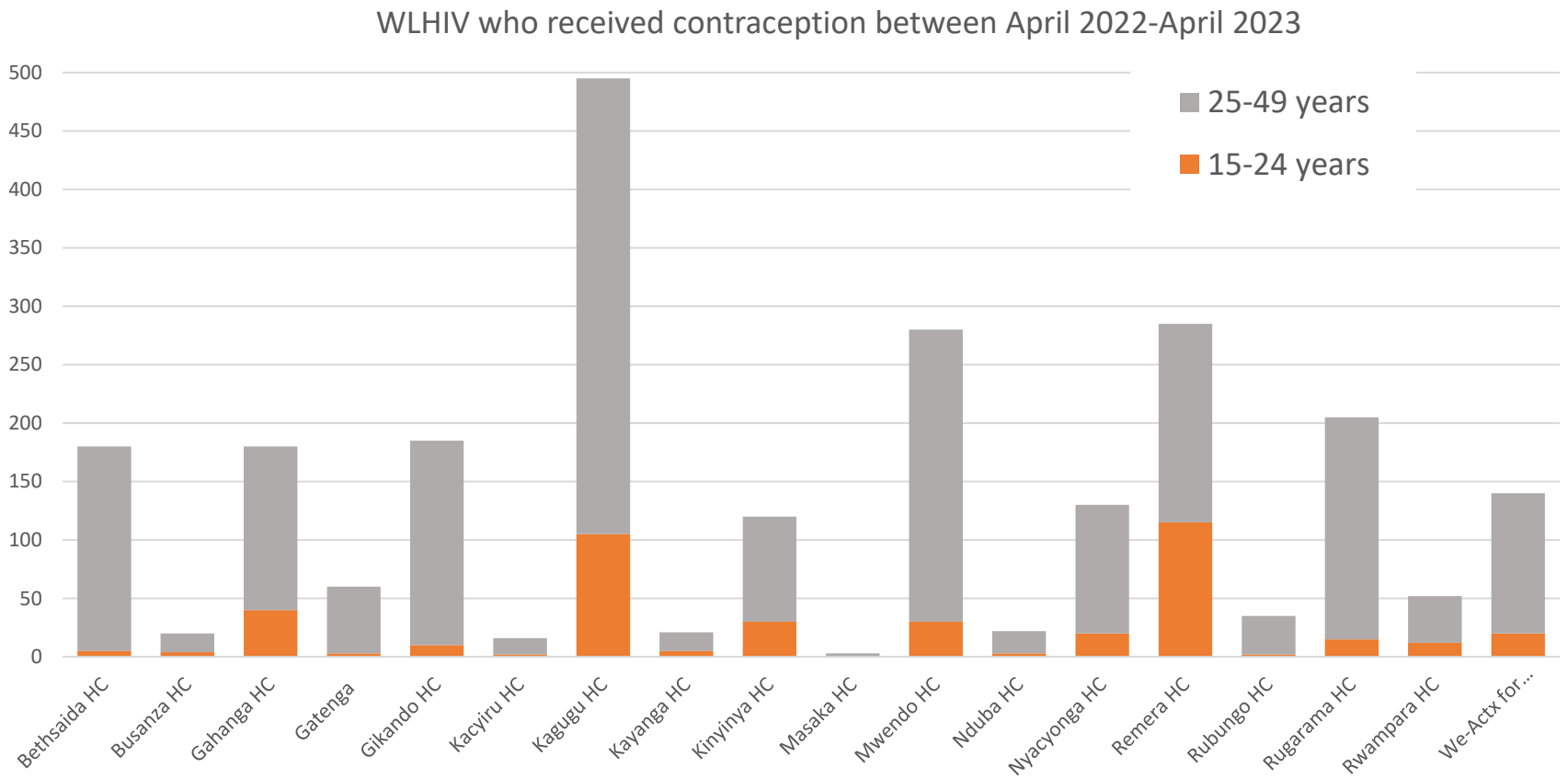
M&E for FP (HMIS monthly report)

I. Family Planning / *Planification familiale*						
A	**Methods**	New Acceptors in the program / *Nouveaux (elles) Acceptant(es) dans le programme*	PPFP uptake (Before discharge)/ *PF en postpartum avant la sortie de maternité*	New Users of FP methods / *Nouveaux (elles) Utilisateurs(trices) de la methods de PF*	Stopped FP Method / *Arrêt de la methode PF*	Active users at end of month / *Utilisateur /trice a la fin du mois*
1	Oral Contraceptives, progestative/ *Contraceptifs oraux, progestatif*					
2	Oral Contraceptives, combined /*Contraceptifs oraux, combiné*					
3	Injectables (Depo-Provera/*Injectables (Depo-Provera)*					
4	Injectables_DMPA-SC/*Injectables_DMPA SC*					
5	Injectables (norristerat)					
6	Implants/Implanon NXT					
7	Implants/Jadelle*					
8	IUD_Copper / *DIU*					
9	IUD_Hormonal					
10	Male condoms / *Préservatifs masculins*					
11	Female condoms / *Préservatifs féminins*					
12	Cycle beads / *MJF (Collier)*					
13	Lactational amenorrhea (LAM) / MAMA					
14	Auto-observation					

B	**Summary by age**	15-19 Yrs/ *Ans*	20 – 24 Yrs/ *Ans*	25yrs and above
	New Acceptors in the program by age group(All methods) / *Nouveaux (elles) Acceptant (es)dans le programme*			

Preliminary findings in supported health facilities

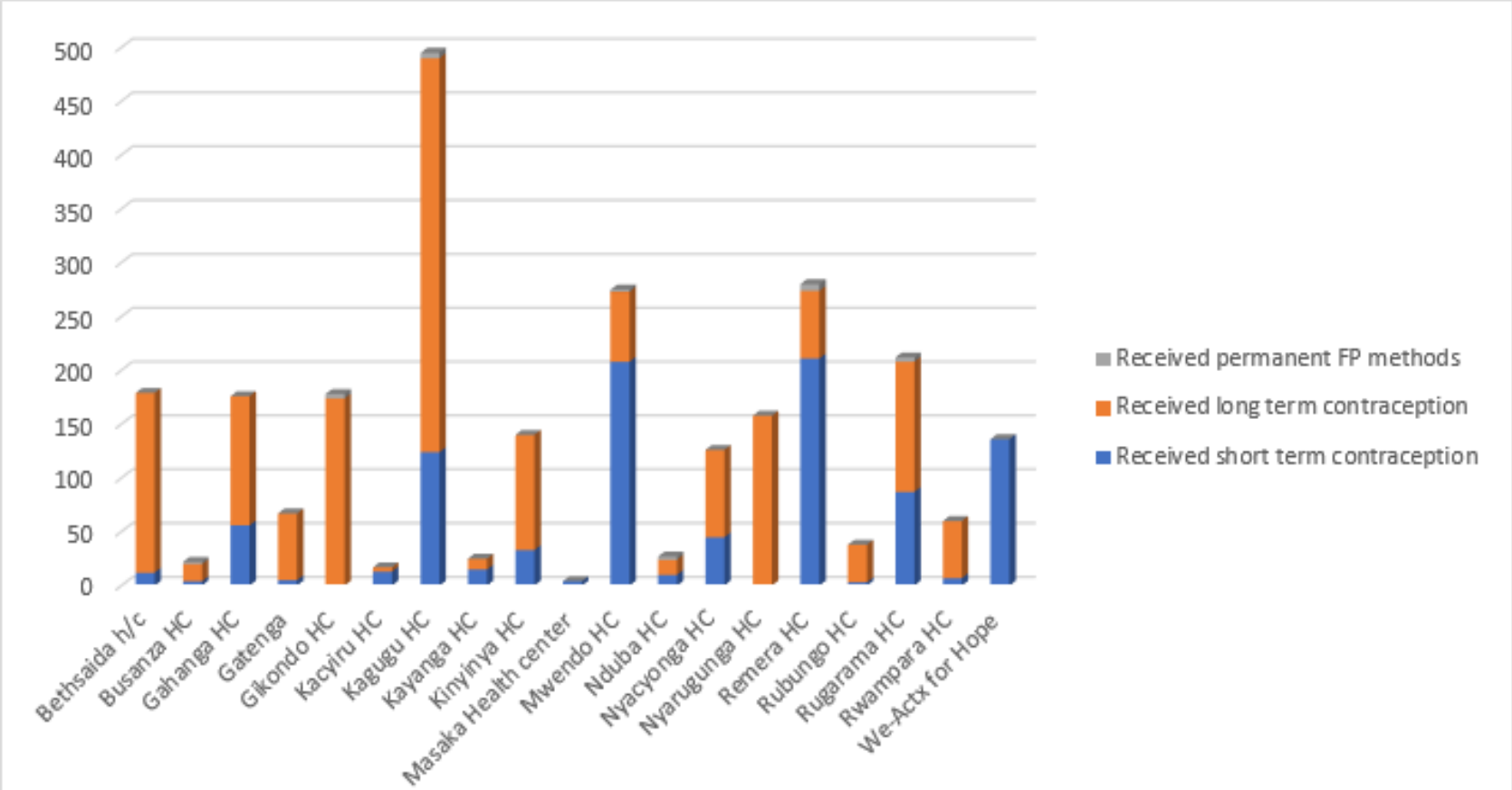
Contraception use among WLHIV (15-49 years)



ART pickup aligned with Contraception?	
Yes	57%
No	63%

WLHIV (15-49 Years) received CP	WLHIV (15-24 years)	WLHIV(25- 49years)
2644	475 (18%)	2169 (82%)

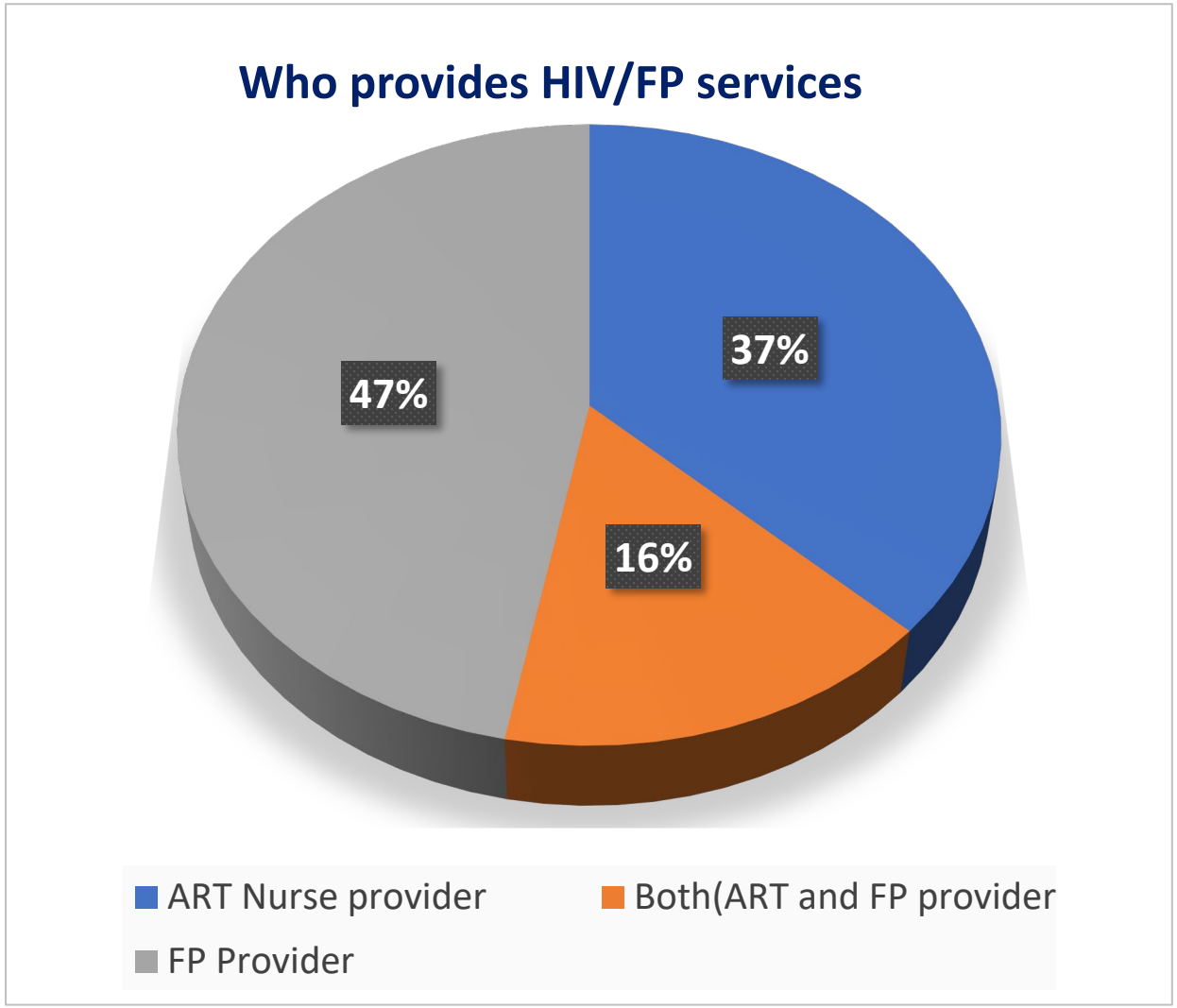
Choice of Contraception use among WLHIV(1)



Short term Contraceptive	Long term Contraceptive	Permanent methods
978	1640	26
37%	61%	1%

- 30 Trained facilities
- Target: 20,000 WLHIV (15-49 years) in 30 sites in the City of Kigali.
- Data in 19 sites shows that 2644/14067 WLHIV enrolled on FP (as new acceptors between (April 2022-April 2023)=18.7% of WLHIV of reproductive age (15-49 years)

Choice of Contraception use among WLHIV(2)



Who provides/offers FP services to WLHIV?	
ART Nurse provider 37%	53% HIV/FP fully integrated
Both ART and FP provider 16%	
FP Provider 47%	47% have coordinated HIV/FP services

Lessons learnt and Challenges

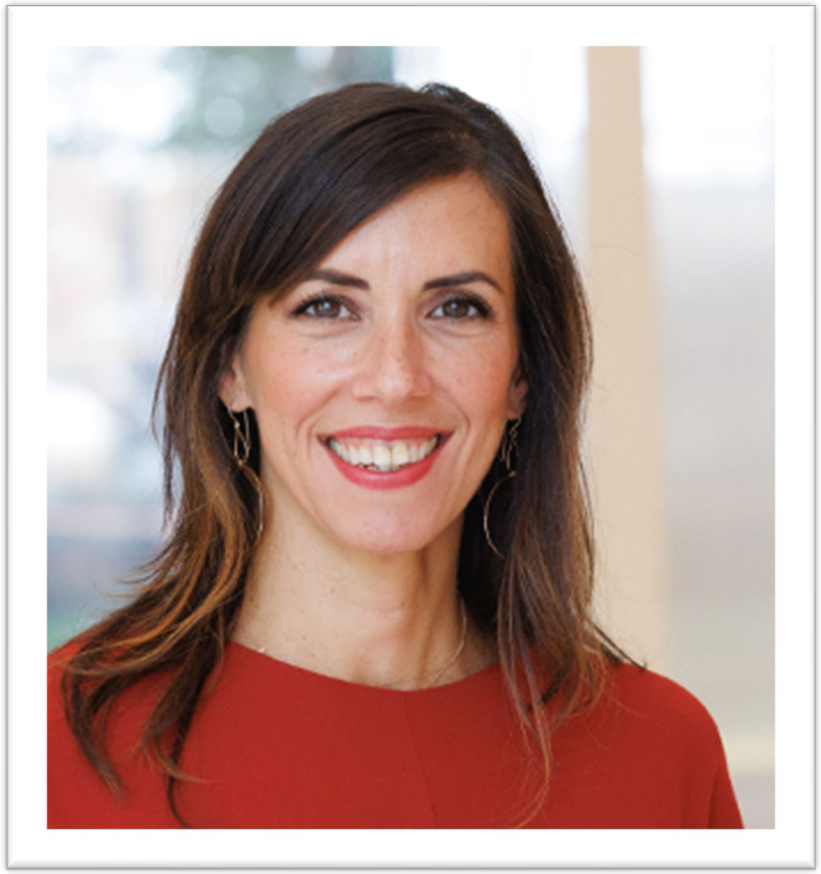
- Expanding access to a wider range of methods has resulted in higher overall contraceptive use and offers clients more choices and ways to exercise their right to choose the number and timing of the children and their partner's desire.
- HIV programs promote use of Long-acting reversible contraception (LARC, IUD, Implant) in DSD models, However, it is a contested matter in FP principles/guidelines (Right-to-choice).
- Setting targets for sub-populations remains a gap. There is primary data at HF level but not reported in the national M&E systems.
- Faith-based facilities do not offer modern contraception. Thus contribute to a large proportion of the unmeet need. However, the policy is that they refer to the nearest health facility/post de Sante.
- Standalone programs, limited coordination between HIV and MCCH programs.

Next steps

- M&E for HIV/FP (Indicator trackers to monitor FP trends in PLHIV).
- Target setting based on unmet need of WLHIV.
- Re-enforce close collaboration between MCCH and HIV divisions (build on the current data to inform on the need of national coverage targets for PLHIV AND achieving >50% of the national target.
- Collaborate with faith-based facilities to co-create solutions to address unmet needs of FP services, particularly for PLHIV.

Thank you!

Panel Discussion Moderator



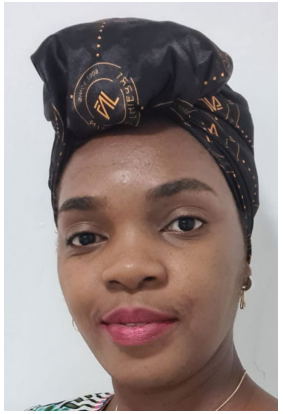
Fatima Oliveira-Tsiouris, MSc, MPA
Senior Director, Catalytic Initiatives and Program Optimization
Elizabeth Glaser Pediatric AIDS Foundation

Panel Discussants

Morkor Newman
Medical Officer
World Health Organization

Anna Grimsrud
Lead Technical Advisor
IAS

Robinah Babirye
Program Officer
AYP+ Uganda



Namita Elizeu
PMTCT Lead,
MOH Mozambique

Alexandre Alfredo Uaeca
Senior Advisor,
Maternal & Child Health
ICAP in Mozambique

Brian Kwizera
DSD Technical Advisor
MOH Rwanda

Suzanne Mukakabanda
RH/FP Quality of Care Specialist
RBC Rwanda

Slides and recordings from today's session will be posted on the CQUIN website:
https://cquin.icap.columbia.edu/

Join us on 11th of July for the next CQUIN webinar:
"Integration of HIV and Hypertension Services"

icap Global Health

HIV Learning Network
The CQUIN Project for Differentiated Service Delivery

Thank you!