

# CQUIN FP/HIV Integration Activities

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**Integrating non-HIV Services into HIV Programs**

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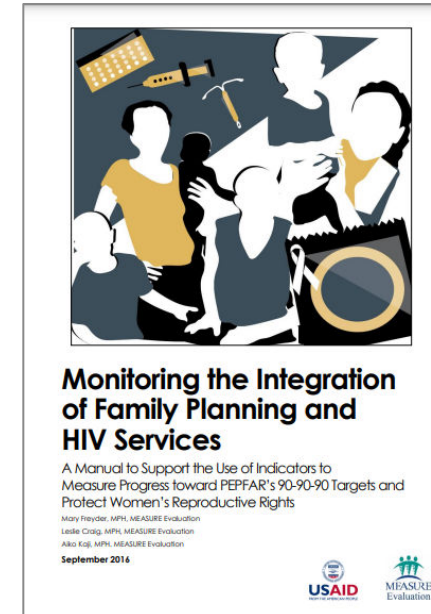
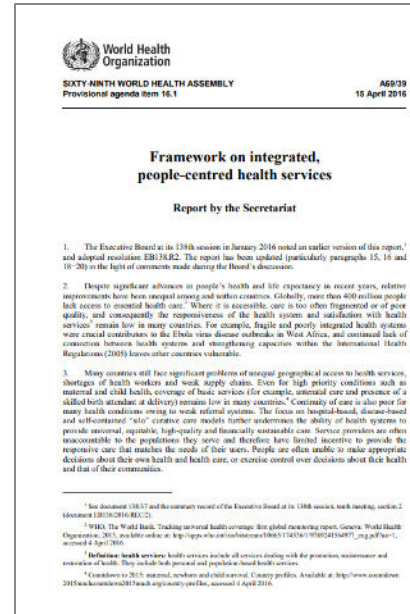
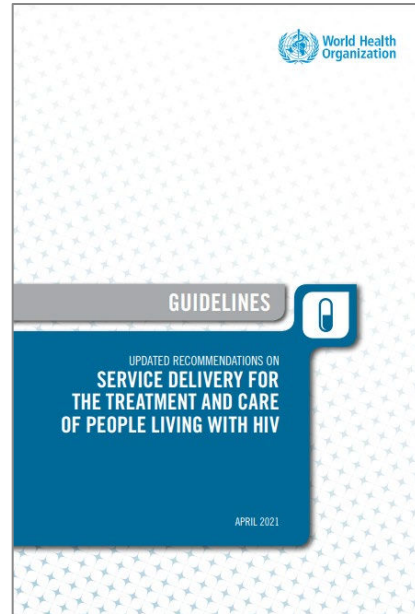
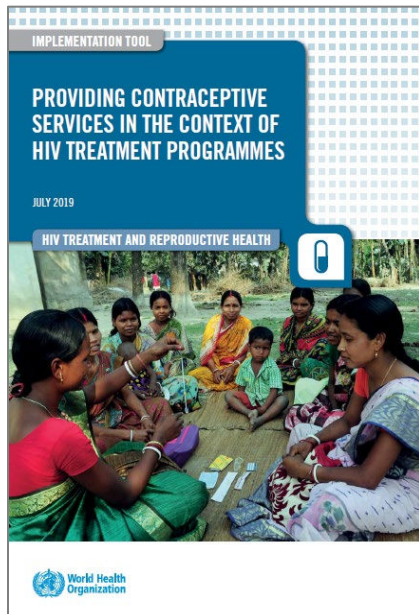


# Outline

- **CQUIN's approach to FP and HIV Integration**
- **CQUIN Situational Assessment on FP/HIV Integration**
- **Enhanced Country to Country Exchange Visits and the Progress on FP/HIV Integration**

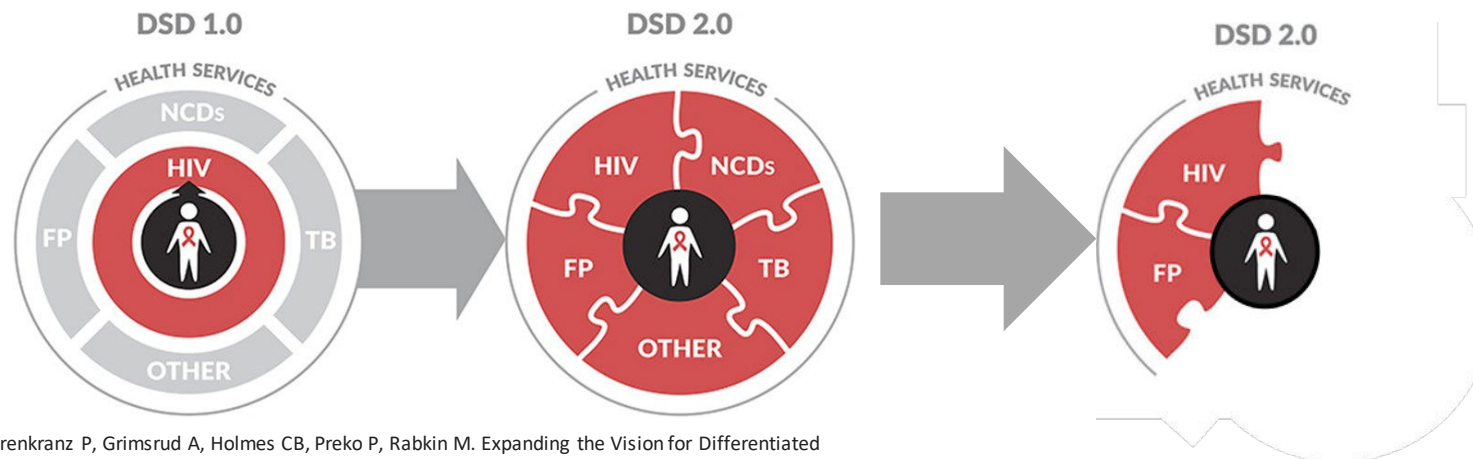
# Introduction

- Global guidance on family planning (FP) integration into HIV service delivery have been developed and used by many countries to successfully implement FP / HIV integration within projects.
- There remains a persistent gap in sustaining these integration models beyond the life of the project as well as in taking these demonstration projects to scale nationally.



# CQUIN 2.0

- CQUIN 2.0 aims to provide holistic person-centered care to people living with HIV. It has an expanded focus that includes **integrating non-HIV services into HIV programs, specifically into Differentiated Service Delivery (DSD) models.**
- Integration is a means not an end. The goal is not integration itself, but improved coverage, quality, and impact of health services for people living with HIV. Our hypothesis is that integrating non-HIV services into HIV programs will expand and accelerate these efforts.
- The CQUIN MCH community of practice is focused on **integrating family planning (FP) services into HIV service delivery,** particularly within Differentiated Treatment Models.



Ehrenkrantz 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. PMID: 33136818; PMCID: PMC7803437.

# CQUIN Situational Assessment on FP/HIV Integration

CQUIN's situational assessment revealed that the term “integration” is often not clearly defined, and descriptions of how non-HIV services are integrated into HIV programs frequently lack specificity.

Commonalities include:

- ✓ **Co-location** of services (*e.g.*, both provided at the same site)
- ✓ **Co-scheduling** of services (*e.g.*, both provided at the same time)
- ✓ **Coordination of medication refills** to maximize recipient of care convenience and minimize visits to health facilities / pharmacies

# FP/HIV service delivery

From the CQUIN perspective, FP/HIV service delivery was defined *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 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 and to shared medical records/communication between clinics.

**3. Non-coordinated intra-facility referral:**

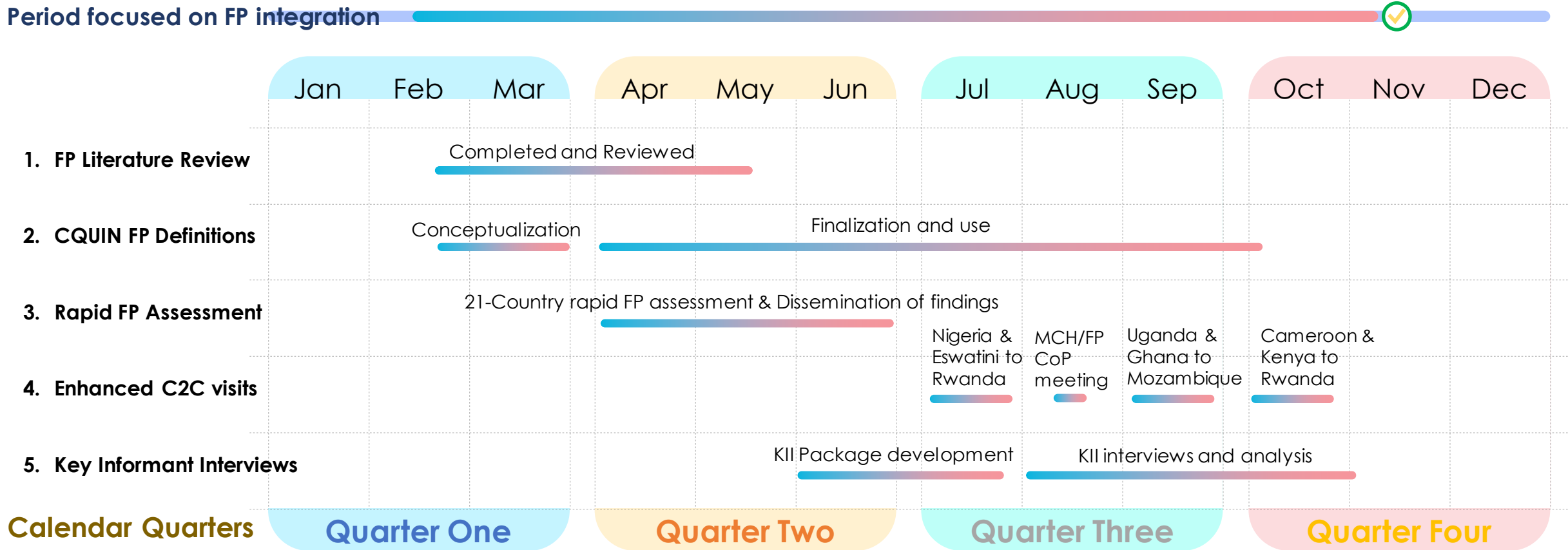
- WLHIV receive ART from the HIV clinic and are referred from the HIV clinic to a different service delivery point for FP (MCH, OPD, etc.), without attention to co-scheduling and same-day appointments.

**4. Inter-facility referral:**

- Referral to a different site for FP services not available on site. This includes referrals between facilities (e.g., to a higher-level HF, from a faith-based HF to another HF providing FP); from HF to community-based FP service delivery points; from public HF to the private sector and more

**5. Other**

# CQUIN Situational Assessment on FP/HIV Integration – 2023



# Methods

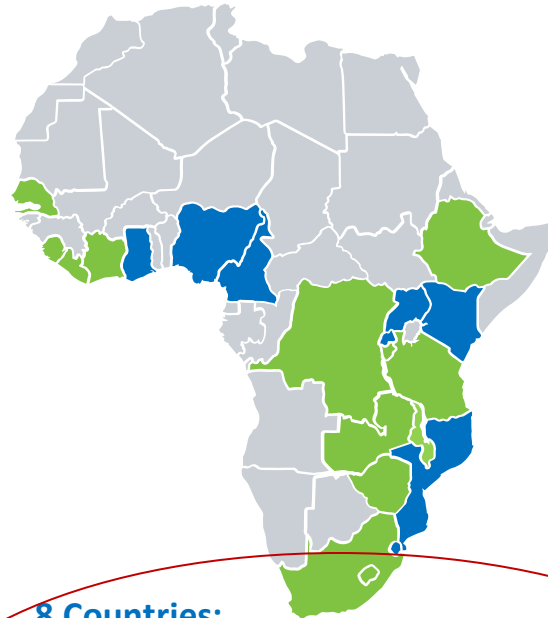
## Rapid FP survey (April 2023)



83 respondents from **21 countries**  
(MOH DSD, MOH MCH, implementing partners, recipients of care and others)



## Country-to-country visits (July-Oct 2023)

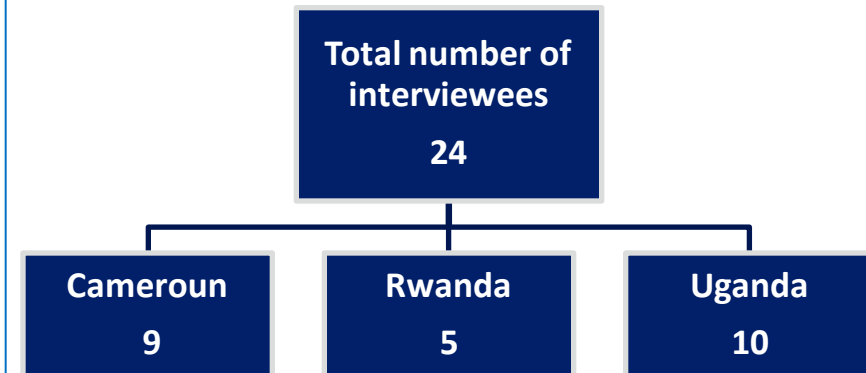


### 8 Countries:

- Nigeria and Eswatini to Rwanda
- Uganda and Ghana to Mozambique
- Cameroun and Kenya to Rwanda



## Key informant interviews (July-Sept 2023)

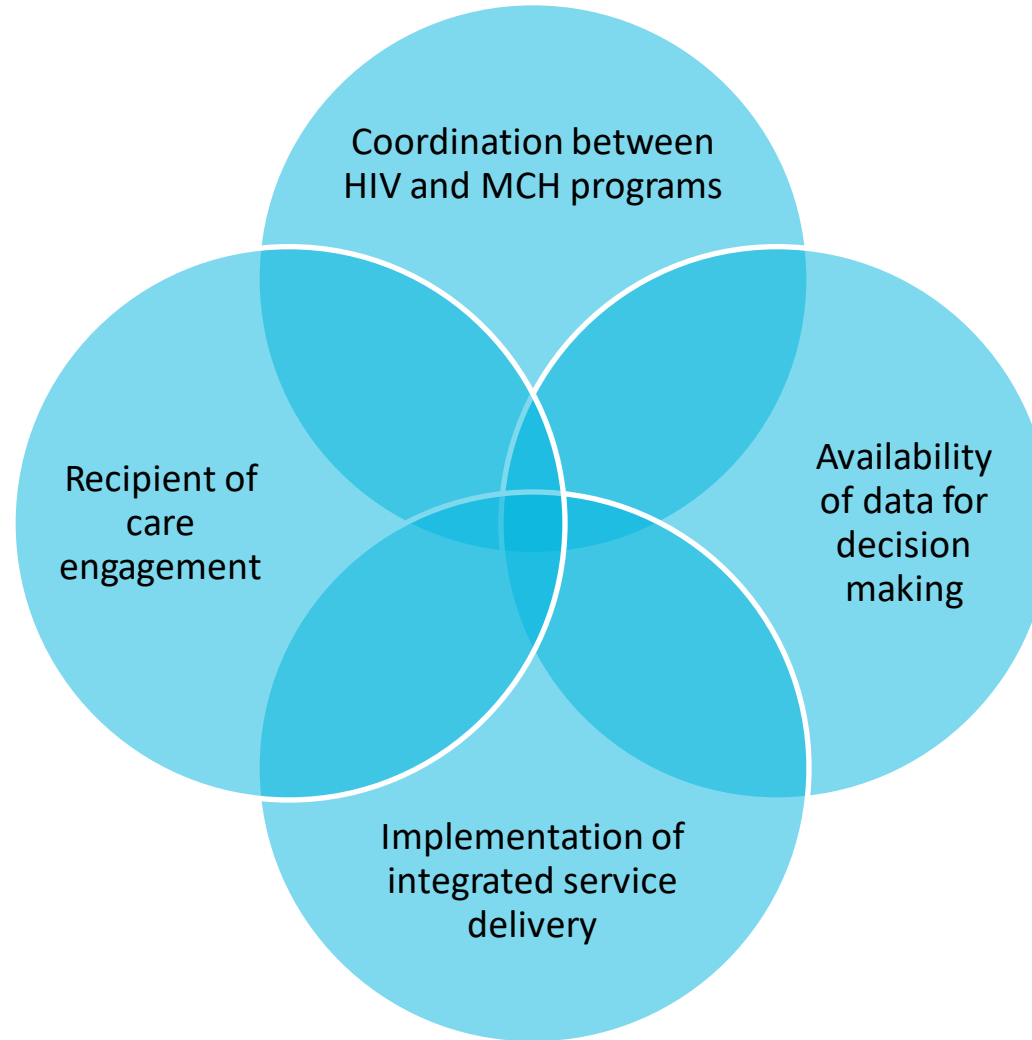


- 24 interviewees from **3 countries** (Cameroun, Rwanda, Uganda)
- MOH (HIV treatment lead, MCH lead), facility-level staff, implementing partners, recipients of care

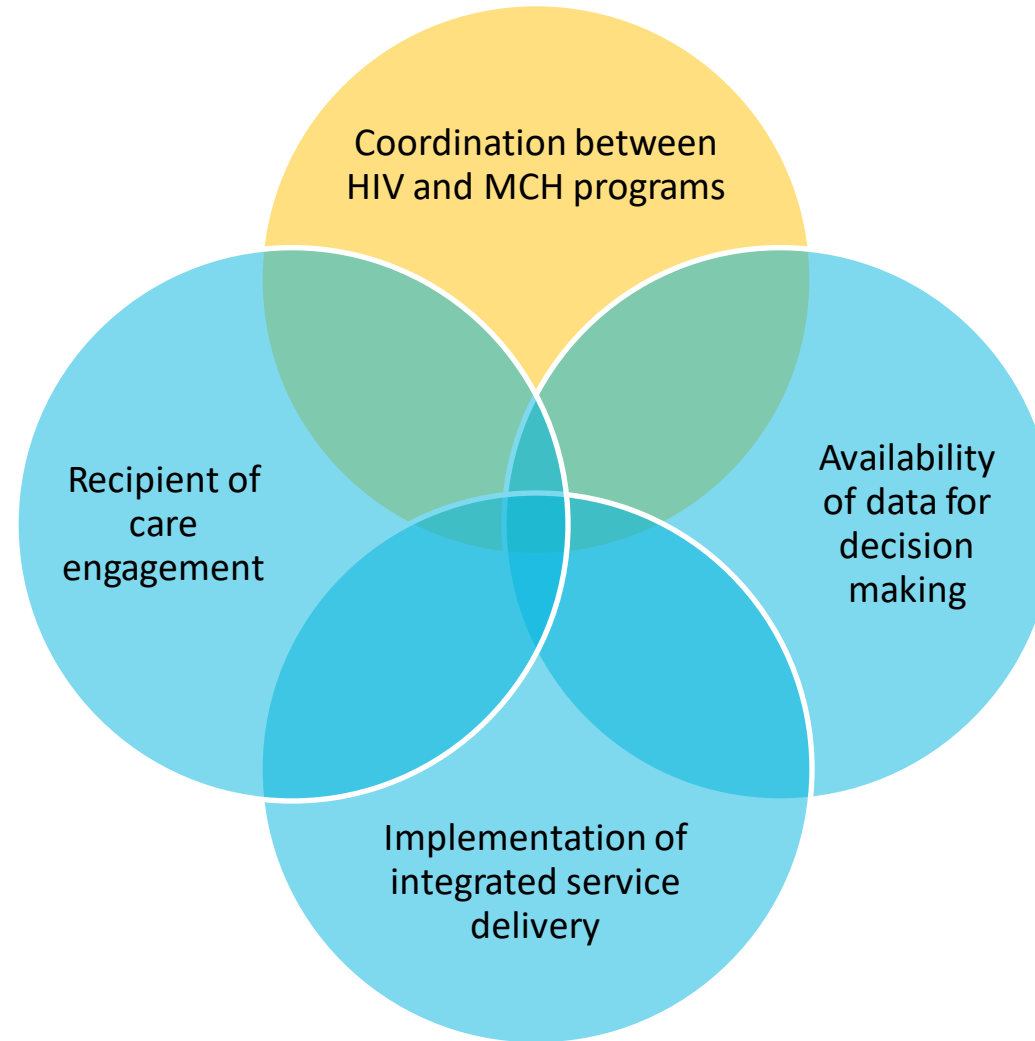




# Key Themes



# Key Themes



# Coordination between HIV and MCH programs - 1



- **Lack of supportive policies** was the **#1 barrier** to FP/HIV integration *in less-intensive DART models*
- **Siloed funding and decision-making** limited development of helpful FP/HIV integration policies, guidelines, and HCW training more broadly
- Very few respondents had **information** about where **WLHIV in community-based models received their FP services**



- All 8 countries had **policies/guidelines** that were supportive of FP/HIV integration
- **National coordination mechanisms were variable** – only two out of eight countries had a single point person or designated team responsible for FP/HIV integration



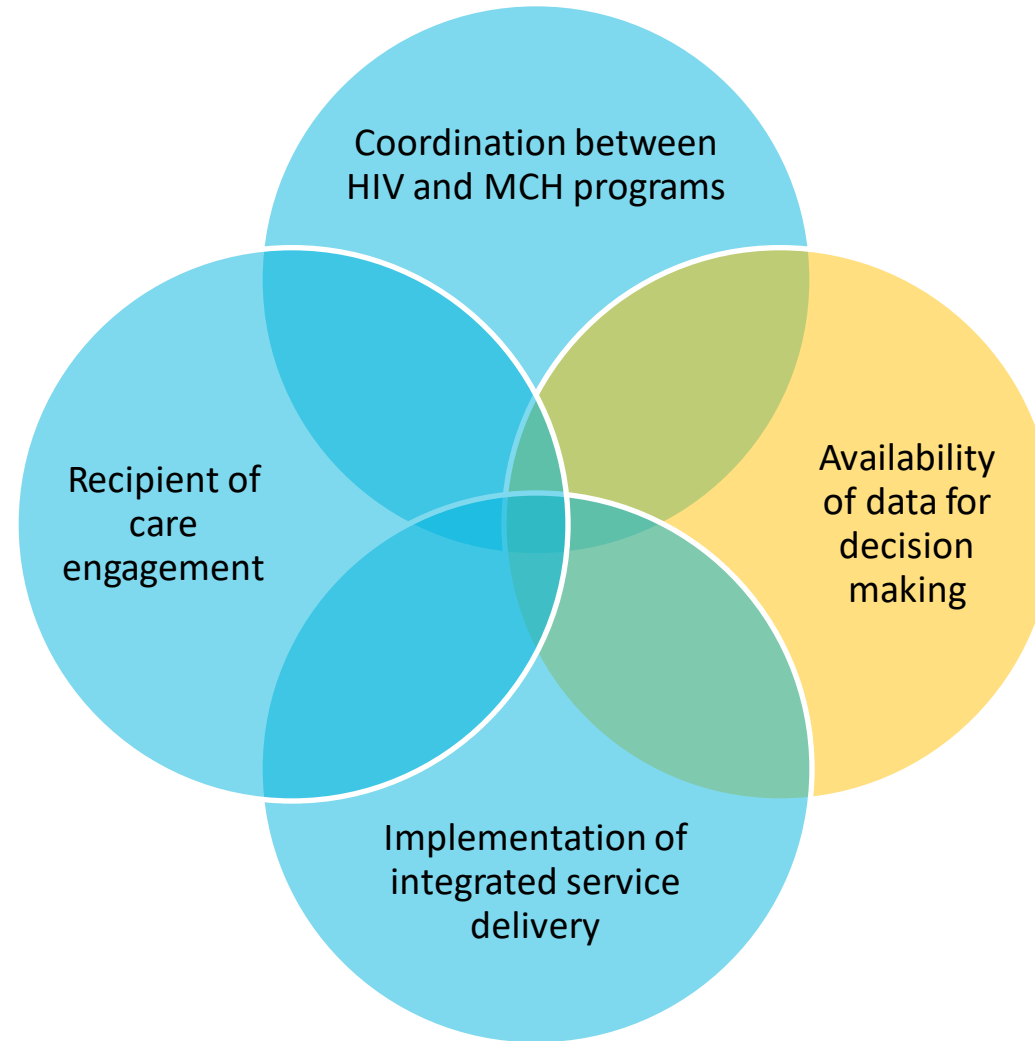
- **Mixed perspectives on** coordination – reported as both a success and a barrier, depending on country, respondent, and health system level
- HIV stakeholders were less likely to be aware of **FP coverage targets and indicators**
- Integration at the **health facility level** was perceived as **less coordinated**

# Coordination between HIV and MCH programs - 2

## In summary:

- **Mixed perspectives**, varied by level of health system
- **Different approaches to coordination** between HIV and MCH/SRH departments
- **HIV departments were not always familiar with FP targets**
- **Facility-level FP/HIV service delivery** occasionally described as a bit “orphaned” – unclear which program is responsible

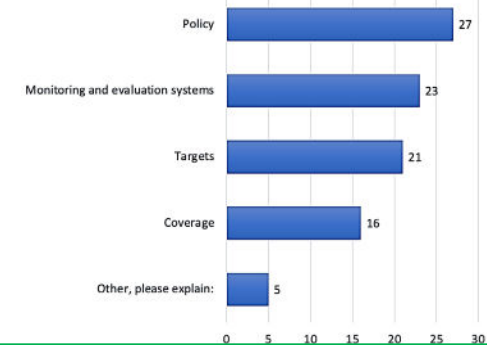
# Key Themes



# Availability of Data for Decision-Making - 1



- **Three of the top five barriers** to achieving mature scores on the CQUIN FP/HIV integration domain were **data-related (M&E systems, targets and coverage)**
- Detailed **definitions of “integrated” FP/HIV services** were rare, and the availability of integrated services is **not routinely tracked**



- **None of the 8 countries had separate FP coverage targets for WLHIV**
- **Lack of data** was highlighted as a key barrier - data on FP coverage for WLHIV is either missing, incomplete, or poor quality
- Some participants felt **routine reporting of presence/absence of integrated services and/or disaggregation of FP access by DART model might be unrealistic**



Use of **FP coverage targets for WLHIV** complicated by multiple factors:

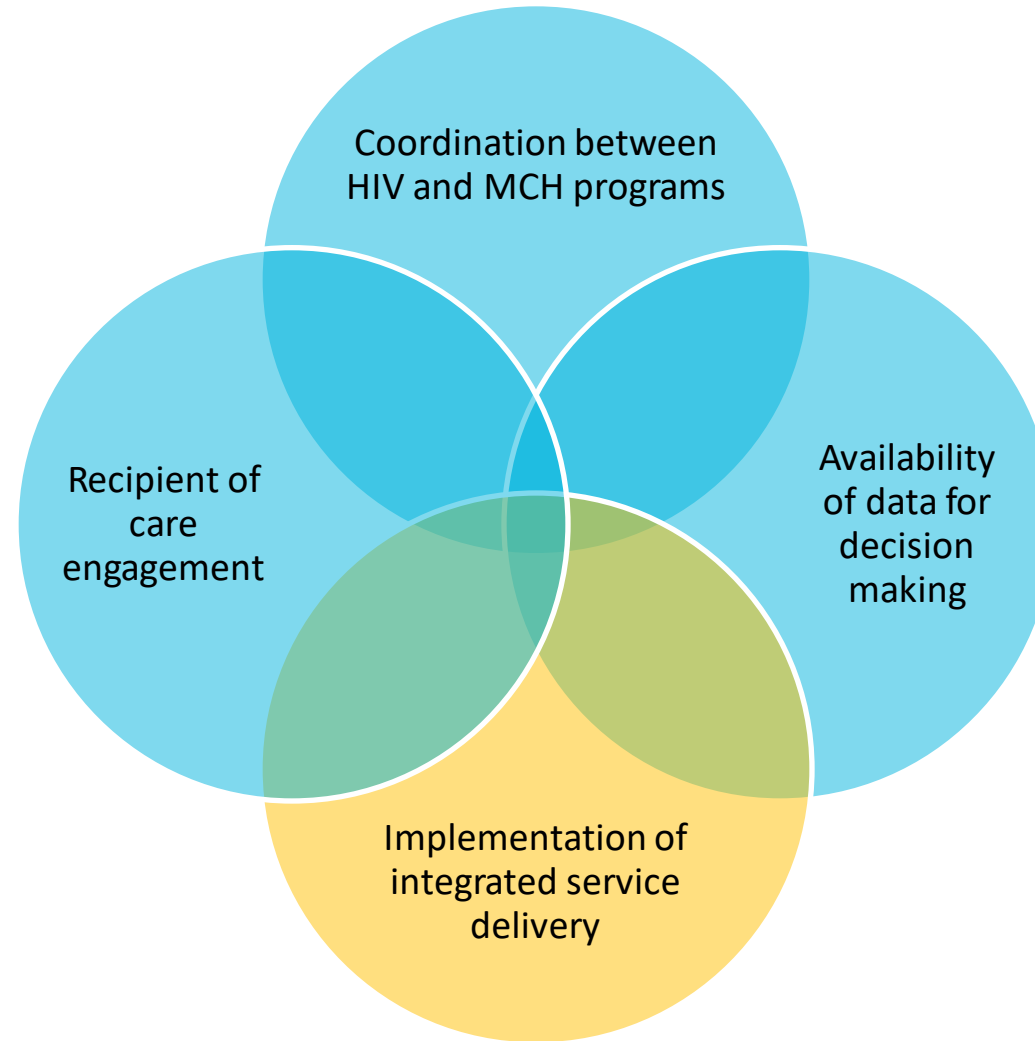
- Most respondents said their country **did not have FP targets specifically for WLHIV**
- No M&E framework for FP integration for WLHIV
- **Disaggregation of FP use by HIV status** was frequently not available
- **Disaggregation of FP coverage for WLHIV by treatment model not routinely available** in any country

# Availability of Data for Decision-Making - 2

## In summary:

- **Target-setting** can be limited by lack of clear definitions and indicators
  - For FP coverage
  - For integration
- Vertical **HIV and FP M&E tools and systems** is a barrier at program/facility level
- Many countries **lack FP coverage data for WLHIV** (vs. all women)
- All countries **lack data on FP coverage that is disaggregated by DART model type**

# Key Themes



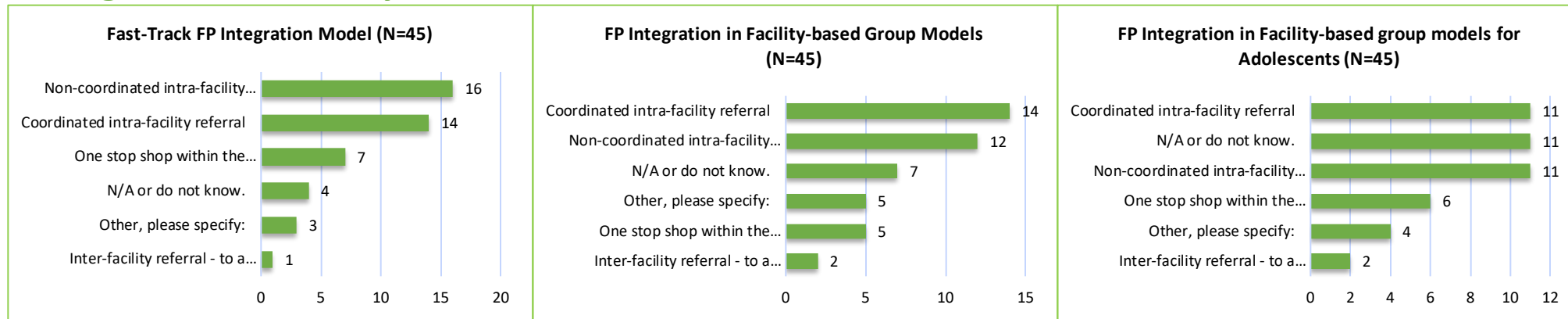


# Implementation of integrated service delivery - 1



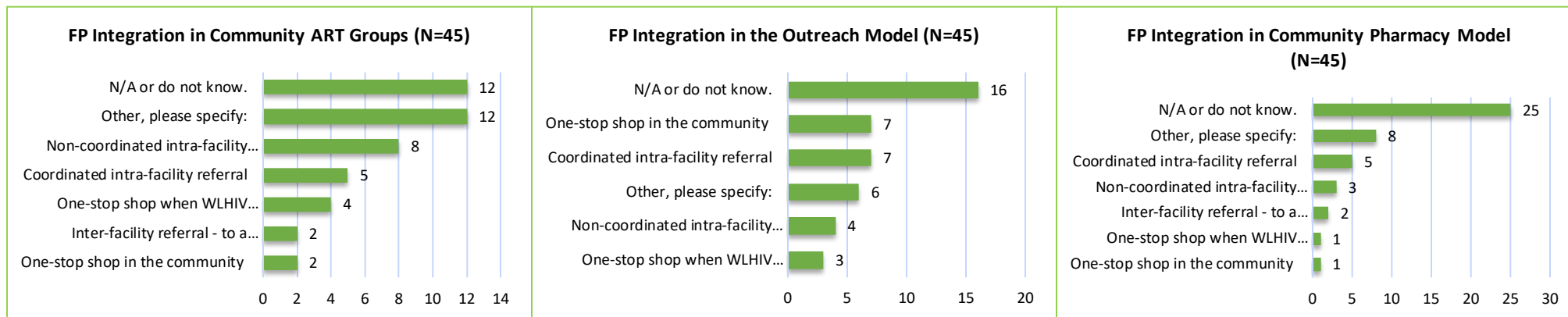
- Out of 40 responses on the **most common method of FP integration**, both **Coordinated** and **Non-Coordinated** intra-facility referral models were the most common models for FP service delivery

## FP Integration into Facility-based DSD Models



- The most common **facility-based group model** of FP/HIV service delivery was **Coordinated FP referral**
- In the **fast-track model**, the **Non-coordinated intra-facility referral** was common.

## FP Integration into Community-based DSD Models



Integration of FP into community models = Largely unknown & likely not happening.

# Implementation of integrated service delivery - 1



- Implementation varied from country to country with as strong sense that **implementation guidance is lacking** – multiple requests for step-by-step guidance/SOPs on different approaches to FP/HIV service delivery
- In many countries, **clinicians providing HIV services** were perceived to have **limited skills providing FP services** ← a barrier to “one stop shop” models
- **Training and job aides** related to integrated FP/HIV services also lacking in some countries



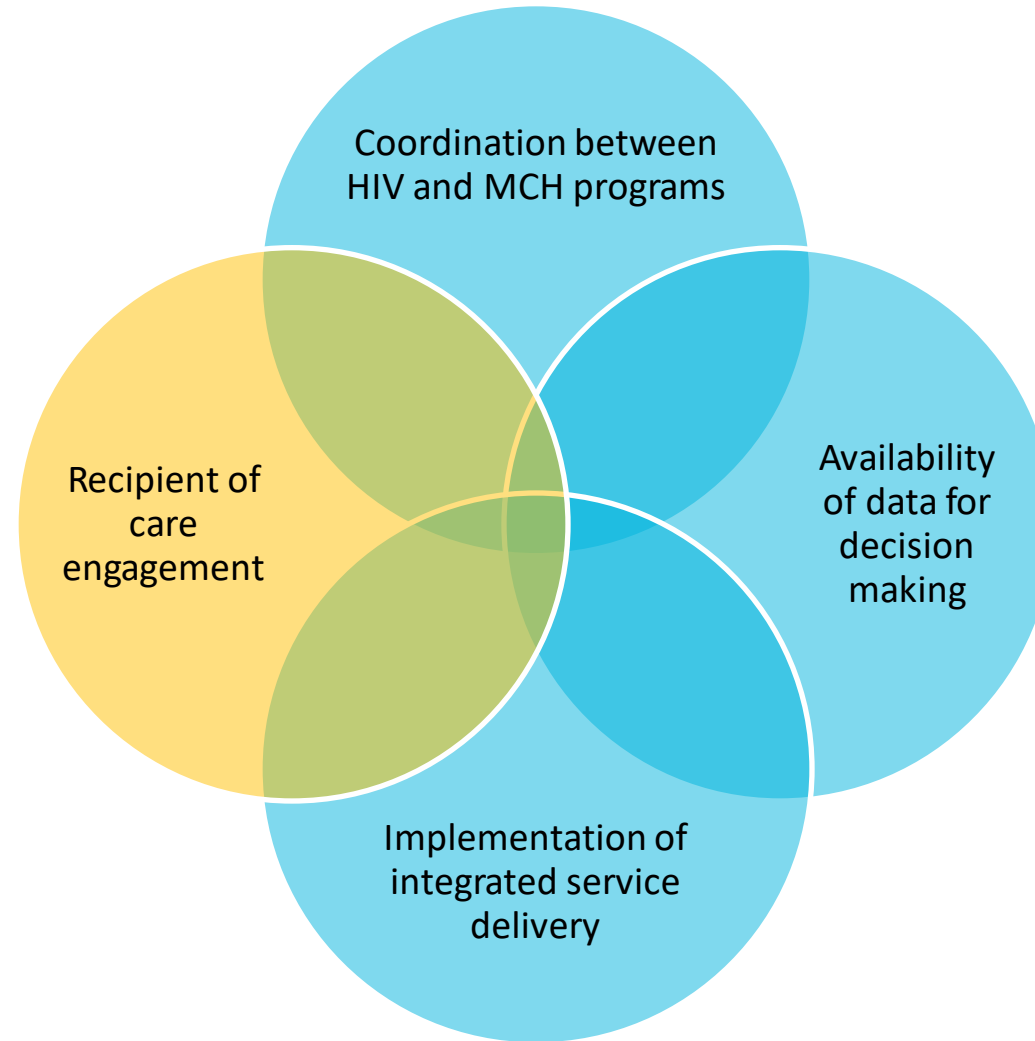
- “the **HIV service delivery framework** does not, from my understanding, does not fully expound on **how family planning integration should be accomplished.**”
- “I think that [for] integration the problems would be more on the side of the **health worker. The fact that they are already overloaded**, and the numbers are not adequate these together can prove a little challenging and ultimately might compromise on the quality of services of on either side. But also, the environment where this is offered some of the long-acting family planning they require added **space that may not be available in the HIV clinic** and that might be a bit challenging.”

# Implementation of integrated service delivery - 2

## In summary:

- **Delivery of integrated FP/HIV services varies within and between countries**
- **Detailed implementation guidance is often lacking**
- **Step-by-step SOPs, HCW training, and performance indicators are in high demand**

# Key Themes



# Recipient of care engagement

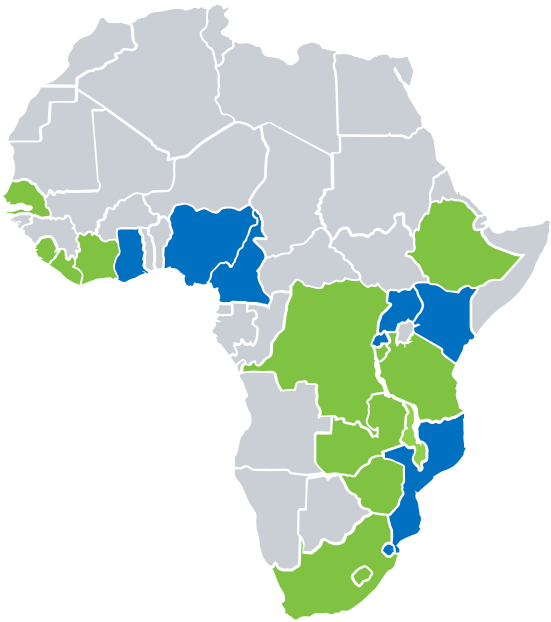


- **Limited awareness of modern FP methods** among WLHIV perceived as a barrier in some countries
- Suggestions included making sure that FP information is provided during morning health education talks, actively asking WLHIV specific questions related to FP, and requiring a data point in patient ART care booklet or EPMRs



- **Community-led monitoring** rarely includes the topic of FP/HIV integration – a missed opportunity to get the perspective of WLHIV

# Enhanced Country to Country Exchange Visits and the Progress on FP/HIV Integration



## 8 Countries:

- Nigeria and Eswatini to Rwanda
- Uganda and Ghana to Mozambique
- Cameroun and Kenya to Rwanda

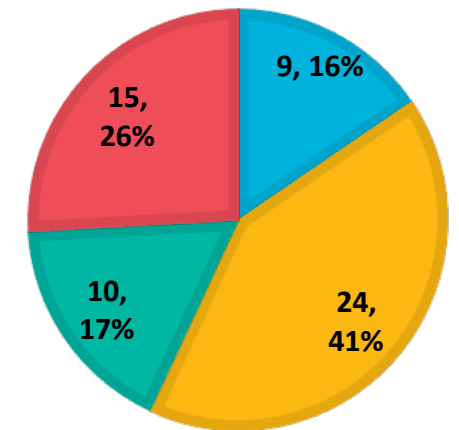
- Enhanced Country-to-country learning visits conducted between July and October 2023
- 58 Activities in the country action plans following the learning visit were centered on 13 areas:

Country	Number of Activities
Cameroon	14
Eswatini	4
Ghana	7
Kenya	12
Mozambique	2
Nigeria	10
Rwanda	5
Uganda	4
<b>Grand Total</b>	<b>58</b>

### Summary of Activities:

- M&E System update – most frequent activity
- Policy/Guideline development or revision
- Coordination
- Implementation/scale up
- HCW capacity building
- Supply chain coordination
- Demand creation
- Research/baseline assessment/program evaluation
- IEC materials
- Training curriculum development/revision
- Community engagement
- Post visit feedback
- Improve Quality of service delivery

### Third month progress post visit



- Completed
- In progress
- Not started - Behind schedule
- Not started - On schedule

# 10 early adopter countries for FP/HIV integration

Country	Block	2022 score	2023 score	2024 projected score
1 Burundi	C	Red	Red	Yellow
2 Cameroon	C	Red	Orange	Yellow
3 Eswatini	N	Orange	Orange	Yellow
4 Ethiopia	N	Orange	Orange	Green
5 Ghana	Q	Orange	Orange	Yellow
6 Kenya	I	Orange	Orange	Yellow
7 Mozambique	N	Red	Red	Orange
8 Nigeria	Q	Orange	Orange	Yellow
9 Rwanda	N	Yellow	Orange	Green
10 Uganda	Q	Orange	Orange	Green

Coordination between HIV and MCH programs

- Provide tailored TA to operationalize the FP/HIV services integration

Availability of data for decision making

- Work with SI to support country teams to define targets, and track coverage of FP/HIV integrated services provided within existing DSD treatment models

Implementation of integrated service delivery

- Track ongoing FP/HIV integration implementation, resources, tools, and best practices

RoC engagement

- Work with the CE CoP and country liaisons to strategize on how to include FP/HIV integration indicators in the CLM Toolkit



# Thank You!

