

Promoting FP/RH-HIV/AIDS Integration: A Summary of Global Health Initiative Strategies in Ethiopia, Kenya, Tanzania, and Zambia

The Global Health Initiative (GHI) is an integrated approach to global health launched by President Obama in 2009. It aims to unify and maximize the U.S. government's investments in HIV/AIDS, malaria, TB, maternal and child health, nutrition, neglected tropical diseases, and family planning and reproductive health (FP/RH). U.S. government country teams, in collaboration with host governments, have created country strategies that coordinate U.S. programs and incorporate the seven GHI principles to improve the health indicators. To date, GHI strategies have been publicized for 34 countries.



The GHI has seven core principles that form the basis for country strategies. This policy brief looks at how the “integration” principle (#5) and to a lesser degree the “country ownership” principle (#2) are applied to FP/RH and HIV/AIDS services and civil society engagement in the GHI country strategies in Ethiopia, Kenya, Tanzania, and Zambia. The U.S. has longstanding programs in each of these countries and the terminology used in this brief (FP/RH and HIV/AIDS) reflects how the U.S. government describes these investments.

Despite the development of strong country strategies, implementation of GHI at the country level has been slow. The first three years of GHI have had a heavy focus on improving coordination among the leadership of U.S. agencies that deliver global health services, including the Centers for Disease Control (CDC), the U.S. Agency for International Development (USAID) and the Office of the Global AIDS Coordinator (OGAC). In July 2012, the GHI announced that it will be shifting its focus away from this internal focus to an external focus on country-leadership and global health diplomacy.

THE SEVEN CORE GHI PRINCIPLES

- 1 Focus on women, girls, and gender equality
- 2 Encourage country ownership and invest in country-led plans
- 3 Build sustainability through health systems strengthening (HSS)
- 4 Strengthen and leverage key multilaterals and other partnerships
- 5 Increase impact through strategic coordination and integration
- 6 Improve metrics, monitoring, and evaluation
- 7 Promote research and innovation

ENTRY POINTS FOR FP/RH AND HIV/AIDS INTEGRATION

- Preventing Mother-to-Child Transmission (PMTCT): Family planning is integral to prevention of unintended pregnancy (Prong 2 of PMTCT)
- Family planning counseling and services with voluntary counseling and testing, and provision of condoms for dual protection
- Family planning counseling and services with home-based care and support for people living with HIV
- Evidence-based sex education for young people, including contraceptive options and prevention of HIV and other sexually transmitted infections (STIs)

This change in focus includes the closing of the GHI office and the opening of an Office of Global Health Diplomacy. While USAID, CDC, and OGAC have indicated their commitment to continuing what has begun under GHI, it remains to be seen how these changes will impact implementation of the GHI principles at country level. As the strategies of Ethiopia, Kenya, Tanzania and Zambia show, the GHI process has yielded creative thinking on ways to integrate programs and engage civil society at the country-level. It is important that these gains are not lost during this time of GHI transition.

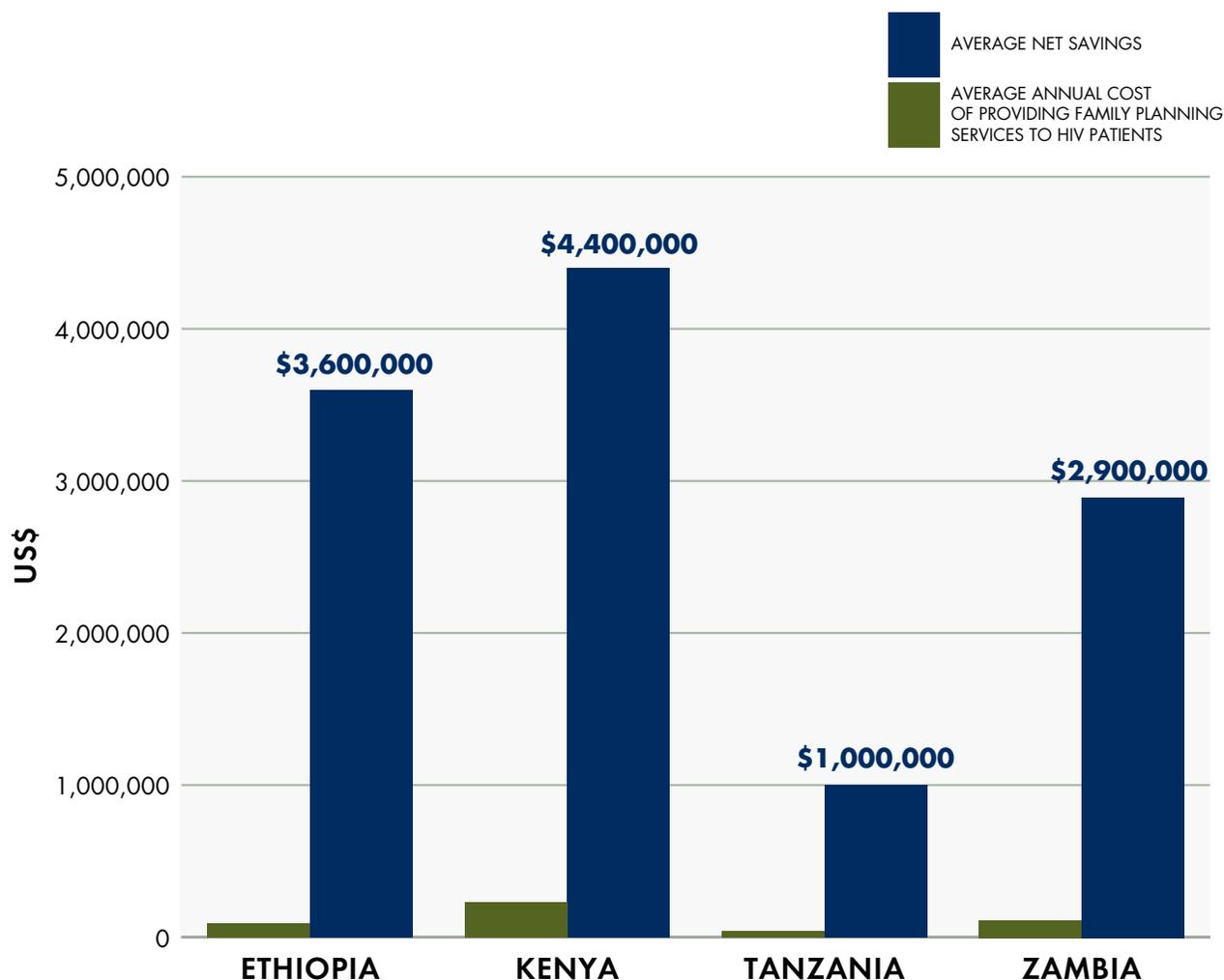
INTEGRATION (PRINCIPLE #5) AND COUNTRY OWNERSHIP (PRINCIPLE #2)

Integrating FP/RH and HIV/AIDS services can improve health outcomes, increase value for money, reach more people—including women and girls—and reduce stigma. Prioritizing integration is critical to meeting GHI goals. In the strategies for Ethiopia, Kenya, Tanzania and Zambia, FP/RH and HIV/AIDS integration is prioritized to varying degrees. In each country, there are opportunities to increase integrated service delivery and U.S. funding, policy, and programmatic changes that could support these efforts.

Ethiopia, Kenya, Tanzania and Zambia each face significant challenges with regard to HIV/AIDS prevention, treatment and care; access to contraception; and maternal mortality. Current U.S. funding for HIV/AIDS in each of these countries far outweighs investments in FP/RH. Integrating FP/RH and HIV/AIDS programs in these countries is a smart way to improve health and use scarce and unbalanced resources.

The GHI seeks to transition from a U.S.-led planning and management approach to a more country-owned process. In the GHI strategies of Ethiopia, Kenya, Tanzania and Zambia, advancing country ownership often emphasizes the leadership of the host country government. While the ministries and agencies play a critical role in coordinating the health sector, civil society should be included in the planning and implementation of integrated services. Civil society and community based organizations play an essential role in providing services at the community level, particularly for key populations otherwise neglected by mainstream programming. Further attention and effort is needed however to communicate with civil society and facilitate their meaningful participation in the GHI. Sustainable programs will not be possible without civil society buy in and active support.

AVERAGE NET SAVINGS OF PROVIDING FP TO HIV PATIENTS (IN US\$)



ETHIOPIA AT-A-GLANCE

Fertility Rate	4.8
Contraceptive Prevalence Rate	50.7%
Unmet Family Planning Need	25.3%
Maternal Mortality Ratio	670/100,000 live births
HIV Prevalence Rate	2.3% (urban 7.7%; rural 0.9%)
PLHIV	1.2 million (60% urban; 40% rural)
PMTCT Coverage (% HIV+ women who receive ARVs)	17%
PMTCT Coverage (% of pregnant HIV+ women receiving ARVs in 2009)	73%
FY2010 US Government Funding (in US\$ Thousands)	
FP/RH Funding	\$25,000
HIV/AIDS Funding	\$323,679
Average Net Savings of Providing FP to HIV Patients (in US\$)	
Average annual cost of providing family planning services to HIV patients (\$)	\$93,000
Average savings in PMTCT treatment and OVC support costs avoided (\$)	\$3,700,000
Average net savings (\$)	\$3,600,000

ETHIOPIA GHI STRATEGY OVERVIEW

The strategy is built on national health priorities and seeks to reduce maternal, newborn and child (MNCH) mortality and prevent communicable diseases, including HIV, by strengthening health systems.

The MNCH strategy centers on three areas: 1) improving access to health care services, 2) increasing demand of health services, and 3) improving health systems.

Improved Access to Health Care Services: The strategy builds on U.S. government and Government of Ethiopia supported integrated programming, including the Family Health Project and the Health Extension Program (HEP), and aims to address remaining gaps through a women- and girl-centered approach to scale up quality services. This includes “expanding reproductive care and family planning services, improving antenatal care, delivery and post-partum care” via PMTCT programs. With investments in both FP and HIV, the U.S. government is well-positioned to move this agenda forward, however, funding levels between the two portfolios are disparate: PEPFAR has more than 10 times as much funding as FP/RH programs.

Increased Demand for Health Services: The U.S. government will strengthen prevention, health promotion and behavioral change communication through the Ethiopia’s HEP. The program includes integrated messages on FP, adolescent RH and HIV prevention. Promotion of increased antenatal care and PMTCT uptake is a focus, though the strategy does not explicitly state how it will ensure that the HEP will link family planning and HIV prevention packages.

Improved Health Systems: While policy restrictions limit the use of PEPFAR funds for the purchase of contraceptives, the U.S. government team in Ethiopia has been able to utilize PEPFAR resources to build the overall health system platform to provide FP/RH. The strategy seeks to strengthen information and evidence-based planning, policy, and decision-making, increase health commodity security, and improve health infrastructure, which are all critical to FP/RH - HIV/AIDS integration.

COUNTRY OWNERSHIP: THE ROLE OF CIVIL SOCIETY

The strategy is strong on FP/RH - HIV/AIDS integration, but it is weak on championing civil society. FP/RH and HIV targets will be harder to achieve without their engagement and may not prove sustainable over the long run.

KENYA AT-A-GLANCE

Fertility Rate	4.7
Contraceptive Prevalence Rate	46%
Unmet Family Planning Need	26%
Maternal Mortality Ratio	530/100,000 live births
HIV Prevalence Rate Adults (15-49 yrs)	6.3%
Women, Men (15-24 yrs) Prevalence Rate	4.1%; 1.8%
PLHIV	1,300,000
PMTCT Coverage (% of pregnant HIV+ women receiving ARVs in 2009)	73%
FY2010 US Government Funding (in US\$ Thousands)	
FP/RH Funding	\$20,800
HIV/AIDS Funding	\$528,760
Average Net Savings of Providing FP to HIV Patients (in US\$)	
Average annual cost of providing family planning services to HIV patients (\$)	\$230,000
Average savings in PMTCT treatment and OVC support costs avoided (\$)	\$4,700,000
Average net savings (\$)	\$4,400,000

KENYA GHI STRATEGY OVERVIEW

The strategy builds on existing national and U.S. government strategies and aims to improve health outcomes related to maternal, neonatal and child health (MNCH) and neglected tropical diseases (NTDs). Integrated programs, like APHIA (AIDS, Population and Health Integrated Assistance) have been part of the U.S. government’s health investment, but the strategy identifies additional opportunities to increase integrated service delivery and improve coordination.

The strategy takes an integrated approach to prevention and management of NTDs, but FP/RH and HIV/AIDS integration features most prominently in the MNCH section’s three priorities:

Health Systems Strengthening: The health systems strengthening efforts focus on addressing human resource capacity, health facility infrastructure, supply chain systems, financial resources, national and district health management and information systems—all of which are also key to FP/RH - HIV/AIDS integration. The strategy rightly recognizes that supporting advocacy by local civil society for funding and the implementation of policies and guidelines is an essential part of health systems strengthening and in line with the GHI’s country ownership principle.

Integrated Service Provision: Both family planning and HIV/AIDS services are listed as key components of an integrated package of services. The strategy states that U.S. government programs, such as PEPFAR and President’s Malaria Initiative (PMI), will have to realign their programs, although specific details about how these programs will change remain largely undefined.

Demand Creation: Family planning is cited as a key component of the demand creation goal. Demand creation for family planning will focus on creating communications tools to reach key populations, increasing both the demand for and (secure) supply of modern contraceptives, and expanding integrated FP/RH - HIV/AIDS services delivery, particularly through increased PMTCT coverage. PMTCT is a logical—and underutilized—entry point for integrated service delivery.

UNDERSTANDING INTEGRATION

The strategy prioritizes an exploration of the effectiveness, feasibility, and costs of current and intensified policy, health systems and service delivery integration. This is a strategic approach since current U.S. investments in HIV/AIDS dwarf family planning funding and new money is unlikely in the current political environment.

COUNTRY OWNERSHIP: THE ROLE OF CIVIL SOCIETY

The strategy rightly recognizes that achieving the strategy’s goals requires coordinated action from all key stakeholders, including civil society. It remains unclear however who will ensure that these constituencies are included throughout the implementation of this strategy.

TANZANIA AT-A-GLANCE

Fertility Rate	5.4
Contraceptive Prevalence Rate	34%
Unmet Family Planning Need	20.7%
Maternal Mortality Ratio	454/100,000 live births
HIV Prevalence Rate	5.6%
Women, Men (15-24 yrs) Prevalence Rate	3.9%; 1.7%
PLHIV	1,200,000
PMTCT Coverage (% of pregnant HIV+ women receiving ARVs in 2009)	70%

FY2010 US Government Funding (in US\$ Thousands)

FP/RH Funding	\$20,000
HIV/AIDS Funding	\$336,254

Average Net Savings of Providing FP to HIV Patients (in US\$)

Average annual cost of providing family planning services to HIV patients (\$)	\$43,000
Average savings in PMTCT treatment and OVC support costs avoided (\$)	\$1,100,000
Average net savings (\$)	\$1,000,000

TANZANIA GHI STRATEGY OVERVIEW

The strategy builds on existing national plans and aims to intensify interventions within three overarching goals: quality integrated services, health systems strengthening, and healthy behaviors.

Quality Integrated Services: Three of four focus areas in this section directly address critical entry points for integration: reducing the unmet need for family planning services, increasing access to quality delivery and newborn care, and increasing access to quality integrated services for women and newborns. The strategy intends to utilize PEPFAR and PMI platforms to integrate FP/RH into the full range of health services. Despite this broad agenda, the strategy misses an opportunity to strengthen counseling and provision of FP/RH services within the context of increasing access to quality delivery and newborn care. The strategy also prioritizes expanding current PMTCT programming. Ensuring quality PMTCT services—including the provision of voluntary contraception for women living with HIV/AIDS—is a model of successful integrated programming and a key to healthy pregnancies and newborns.

Health Systems Strengthening: The strategy focuses on health systems strengthening areas that directly relate to the provision of quality integrated services. These include improved integration and effectiveness of monitoring and evaluation systems, accountability of national policies and systems, and improved supply chains.

Healthy Behaviors with Focus on Girls and Women:

Integration-related activities include creating demand for both HIV/AIDS and FP/RH services and moving away from vertical disease-specific programs. Expanding community outreach programming and partnerships to educate families and communities about HIV/AIDS and FP/RH services is also prioritized.

COUNTRY OWNERSHIP: THE ROLE OF CIVIL SOCIETY

The strategy includes civil society engagement as a key tactic to increase coverage of reproductive health education and subsequent uptake of modern contraceptives, in addition to strengthened referral and transportation systems, increased provision of antiretroviral therapy for HIV-infected pregnant women, and increased access to HIV counseling and testing. Civil society's role is not captured in the five-year indicator measurements, making their involvement difficult to track.

ZAMBIA AT-A-GLANCE

Fertility Rate	6.2
Contraceptive Prevalence Rate	32.7%
Unmet Family Planning Need	27%
Maternal Mortality Ratio	591/100,000 live births
HIV Prevalence Rate	14.2%
PLHIV	980,000
PMTCT coverage (% HIV+ women who receive ARVs)	69%

FY2010 US Government Funding (in US\$ Thousands)

FP/RH Funding	N/A
HIV/AIDS Funding	\$283,661

Average Net Savings of Providing FP to HIV Patients (in US\$)

Average annual cost of providing family planning services to HIV patients (\$)	\$120,000
Average savings in PMTCT treatment and OVC support costs avoided (\$)	\$3,100,000
Average net savings (\$)	\$2,900,000

ZAMBIA GHI STRATEGY OVERVIEW

The strategy builds on national health and development goals to reduce maternal, neonatal, and childhood deaths (MDG 4 and 5) and focuses on: quality integrated services, appropriate human resources for health, and improved governance.

The strategy takes a broader integrated approach on FP/RH - HIV in its efforts to improve MNCH. Through the GHI-led *Saving Mothers Giving Life and Helping Babies Breathe* partnerships, the U.S. government, together with the Government of Zambia, will focus on reducing maternal mortality and newborn mortality in the first 24 hours post-partum by integrating services across the continuum of care.

Maternal, Newborn and Child Health (MNCH): MNCH activities are concentrated in four districts where the U.S. and Zambia seek to reduce maternal mortality by 50 percent in the next year. Because Zambia has a high maternal mortality rate and one of the highest total fertility rates in the world (6.2) the strategy focuses on strengthening the health system to scale-up integrated family planning and MNCH services. These GHI priorities match the commitments in Zambia's Campaign to Accelerate the Reduction of Maternal and Neonatal Mortality, a national and regional initiative.

Delivering Integrated Services through One-Stop MNCH Clinics:

Unlike other GHI countries that often use the HIV/AIDS platform to deliver related services, Zambia will use a one-stop MNCH clinic model to provide FP/RH - HIV integrated services, including PMTCT. While Zambia is on track to reach the HIV targets in MDG 6, addressing the needs of women, who are disproportionately affected by HIV, is still a challenge. HIV prevalence among pregnant women is 16.6 percent, significantly higher than male adults (12.3 percent). To address the needs of women living with HIV comprehensively, the strategy includes increasing gender equity in HIV/AIDS programs and services, including reproductive health.

COUNTRY OWNERSHIP: THE ROLE OF CIVIL SOCIETY

The strategy reaffirms the role of civil society in holding government accountable for the provision of health services. The strategy acknowledges the link between civil society and the provision of community-based services and promotion of health-seeking behavior. However, the strategy does not reflect how the U.S. government will strengthen civil society or consult with them in future strategies and implementation.



RECOMMENDATIONS

1. Build upon progress made in GHI Phase 1.

As GHI enters its next phase, housed within the new Office of Global Health Diplomacy, it is important that the progress and gains made during GHI's first phase are not lost. The development of 34 country strategies, while imperfect, demonstrate a commitment from OGAC, USAID, CDC, and country-level partners to think creatively and innovatively about ways of implementing the GHI's core principles. This momentum should not be lost and clear communication is needed about the future direction and priorities of the GHI. Leadership needs to be transparent in order to avoid confusion and stall progress among agencies and country partners towards implementing these country strategies as the GHI moves forward.

2. Implement GHI country strategies.

The strategies lack clarity about how operationalization will occur, including around the integration of FP/RH - HIV services. GHI country teams and planning leaders, under the leadership of the U.S. Ambassador should incorporate GHI principles and strategy goals into U.S. country-level documents, including PEPFAR's Country Operational Plans (COPs). These operational documents will serve as accountability tools to ensure that the GHI and FP/RH - HIV/AIDS integration is implemented.

3. Advance policy and flexible funding initiatives that promote FP/RH and HIV/AIDS integration.

The U.S. should provide robust and flexible funding for both FP/RH and HIV/AIDS programs under the GHI. Policies should also support integrated programming (GHI principle #5) and work to ensure that an individual can receive the services they want and need, regardless of where they enter the health care system. As part of this effort, PEPFAR (HIV/AIDS) funds should be made available for the purchase of contraceptives.

4. Improve and strengthen monitoring and evaluation systems.

Having a set of standard FP/RH - HIV/AIDS integration indicators, reported routinely, will further increase the body of evidence on health outcomes and will enhance support for integration. Such indicators should be feasible, client- and service-focused and should be promoted in U.S. and global indicator frameworks, including within PEPFAR and the UN General Assembly Special Session on HIV/AIDS (UNGASS) list of core indicators.

5. Increase civil society engagement.

In order to successfully reach GHI objectives and to integrate FP/RH - HIV services, civil society needs to have more involvement in the planning and implementation process. True country ownership (GHI principle #2) must include civil society, not only national governments. Because of their role in the community, civil society can help in designing more sustainable FP/RH - HIV/AIDS integration efforts. They also play a vital role in championing health and integration at the national level and ensuring that political commitments are translated into action and results.

6. Promote best practices and research on FP/RH - HIV integration.

More funding for research on best practices and operational research is needed to delineate how to best integrate and bring successful programs to scale. Some GHI country strategies have prioritized this research in their "learning agenda" and the results should be shared widely with all stakeholders. Research findings should be used to inform funding decisions, policy change, request for proposal development, and program design.

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