Illustrative Case Study for Evidence Use in Policy-Making
Evidence-Informed Policy Making Training

This case study provides a topic of public health interest as a scenario to refer to throughout the course. Though the evidence outlined within the case study is real, some portions of the case study exercise are hypothetical (e.g., being asked by a superior to do something). The case study content is organized in a way that will allow participants to demonstrate the various practical skills involved in evidence-based decisions and policymaking as applied to one consistent theme and scenario.

Session 2 Foundation: Developing a Policy Question

Background

The integration of family planning (FP) and HIV services improves sexual and reproductive health outcomes by providing both services under one programmatic umbrella. This type of integration refers to the delivery of health services, and it is a subset of closely related but broader linkages between family planning and HIV policies, funding, programs, and advocacy.

For close to a decade, governments, normative bodies, funders, implementing partners, and communities have issued statements supporting the integration of family planning and HIV policies, programs, and services. As a result, meeting the contraceptive and other reproductive health needs of people living with HIV through the provision of integrated services is a core component of key global health frameworks. Major HIV/AIDS funders such as PEPFAR and The Global Fund increasingly encourage the integration of family planning into programs they support. For example, recent PEPFAR guidance states that "The need for family planning for HIV-positive women who desire to space or limit births is an important component of the preventive care package of services for people living with HIV/AIDS and for women accessing PMTCT services…PEPFAR is a strong supporter of linkages between HIV/AIDS and voluntary family planning and [other] reproductive health programs" (PEPFAR Fiscal Year Country Operational Plan (COP) Guidance). At the country level, some government health leaders have established national coordination efforts between reproductive health and family planning departments and HIV departments, which, in turn, have led to measurable progress in policy and practice. At least 16 countries have implemented the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* to assess the current state of integration and develop action plans for strengthening efforts.

Given these developments, your superior has asked you to advance FP and HIV integration in your country. What policy question can be derived from this directive and mandate?

Potential answer:

Session 3: Accessing Evidence

What terms might you use in your search that would result in relevant research and evidence about family planning and HIV integration?

Terms relevant for the search strategy template and practice:

Session 4 Appraise: Interpreting Evidence

One of the next steps for evidence use after it has been appraised is to determine which findings are relevant for your situation. The evidence presented below has gone through the appraisal process and has been deemed high quality and credible. Please choose an institution or organization you are all familiar with, e.g. the MoH. Then, devise questions that should be asked to determine the evidence or

innovation's a) applicability (e.g., feasibility), and b) transferability (e.g., generalization) within the chosen institution or situation.

What is the impact of integrating family planning and HIV services?

Reviews of the evidence suggest that linking sexual and reproductive health or family planning with HIV services is beneficial and feasible (Kennedy 2010; Spaulding 2009; IPPF, UCSF, UNAIDS, UNFPA, WHO 2009); that clinical and rights-based benefits accrue from integration (IntraHealth 2012); and that the evidence base for effective integrated models is expanding (Wilcher 2013a). Although the overall rigor of FP/HIV integration studies is low, the evidence of the benefits and the public health impact of integration is encouraging. In particular, research findings suggest that integrating family planning and HIV services:

Meets client desires and demand. Most clients would rather receive contraceptive services at the same place where they access HIV services (Asiimwe 2005; Farrell 2007; Harrington 2012; Newmann 2013).

Increases access to and uptake of contraception by people living with HIV who wish to prevent pregnancy. Three reviews report that the majority of studies evaluating interventions to deliver sexual and reproductive health services to women living with HIV have reported positive outcomes, including increases in voluntary contraceptive use or increases in completed referrals from HIV services to family planning clinics (Kennedy 2010, Wilcher 2013a; Lopez 2013).

Several studies suggest that both "one-stop-shop" models of integrated service delivery and referral-based approaches can improve family planning access and use (Mark 2007; Stephenson 2011; FHI 360 2012c; Wilcher 2013a; Baumgartner 2013; Grossman 2013). Additionally, programs in Zimbabwe, Kenya, Malawi, Tanzania, and Ethiopia found that community-based provision of integrated services contributed to large increases in new family planning clients (IntraHealth 2012; Daniel 2012).

Reduces unmet need. Results from a five-year research initiative that evaluated four different models of integrated SRH and HIV services in "real-world" settings in Kenya, Malawi, and Swaziland confirmed an existing unmet need for SRH services among women living with HIV (including family planning), and found that integrated services can help women realize their fertility intentions and meet their contraceptive needs (Integra Initiative 2013). A referral-based integrated intervention in Tanzania reduced unmet need of sexually active clients by 8% (Baumgartner 2013). In addition, two studies have documented decreases in the incidence of pregnancies following integration of family planning and HIV services (Ngure 2009; Wall 2013).

Compare and synthesize the participant answers to the following questions:

Assessment of Applicability & Transferability

Construct	Factors	Questions to Ask
Applicability (feasibility)	Political acceptability or leverage	▪ Will the intervention be allowed or supported in current political climate? ▪ Will there be public relations benefit for local government? ▪ Will this program enhance the stature of the organization? ▪ Will the public and target groups accept and support the intervention in its current format?
	Social acceptability	▪ Will the target population be interested in the intervention? Is it ethical?
	Available essential resources (personnel and financial)	▪ Who/what is available/essential for the local implementation? ▪ Are they adequately trained? If not, is training available and affordable? ▪ What is needed to tailor the intervention locally? ▪ What are the full costs (supplies, systems, space requirements for staff, training, technology/administrative supports) per unit of expected outcome? ▪ Are the incremental health benefits worth the costs of the intervention?
	Organizational expertise and capacity	▪ Is the current strategic plan/operational plan in alignment with the intervention to be offered? ▪ Does this intervention fit with its mission and local priorities? ▪ Does it conform to existing legislation or regulations (either local or provincial?) Does it overlap with existing programs or is it symbiotic?) ▪ Any organizational barriers/structural issues or approval processes to be addressed? ▪ Is the organization motivated (learning organization)?
Transferability (generalizability)	Magnitude of health issue in local setting	▪ Does the need exist? ▪ What is the baseline prevalence of the health issue locally? ▪ What is the difference in prevalence of the health issue (risk status) between study and local settings?
	Magnitude of the "reach" and cost effectiveness of the intervention above	▪ Will the intervention broadly "cover" the target population?
	Target population characteristics	▪ Are they comparable to the study population? ▪ Will any difference in characteristics (ethnicity, socio-demographic variables, number of persons affected) impact intervention effectiveness locally?

SOURCE: http://www.nccmt.ca/learningcentre/index.php?lang=en#main2.html

In a real scenario, you would likely identify many sources of evidence that you would then appraise and prioritize. To expedite the process in a training setting, please use the following lists of key research findings as the evidence base to be synthesized. What conclusions can you draw about what the bulk of the evidence suggests, particularly in regard to actions that can be taken to effectively advance integration?

KEY FACILITATORS OF SUCCESSFUL PROGRAMS

- Government leadership via supportive laws, policies, guidelines, frameworks, and technical working groups, but also through coordinated planning, budgeting, implementation and monitoring and evaluation (M & E) between the RH/FP and HIV departments of ministries of health
- Meaningful involvement of people living with HIV, national and local government staff, program managers, service providers, and community leaders in the design and rollout of integrated services
- Benefits of integration clearly articulated to policymakers, service providers, clients, and communities
- "Levels" of integrated services tailored to the local context and to the facility's capacities
- Pre- and in-service capacity building on family planning counseling and service delivery for HIV providers and supervisors, and the use of peer mentoring or training-of-trainer approaches to help diffuse new knowledge or skills to all program staff
- Task shifting for the delivery of integrated services, such as using lower-level workers to offer group FP information sessions in HIV clinics and community-based settings
- Improved M & E that captures the additional services being provided through changes to health management information systems (HMIS) and reporting structures, and better use of data to strengthen services
- Strong referral systems, which should include "facilitated" referrals from HIV clinics to family planning services where feasible and appropriate, and referrals for long-acting and permanent methods, which often are not available at lower-level facilities where clients seek FP and HIV services
- Functional supply chains and good commodity security measures that ensure adequate family planning supplies within HIV programs
- Services designed to attract and include men and youth, including family planning messages and counseling
- Collaboration with local groups to facilitate community involvement and accountability for comprehensive, integrated family planning and HIV services, including high-risk groups such as female sex workers, discordant couples, and youth

[This list of key facilitators was compiled through a search of the peer-reviewed literature and a variety of programmatic resources by identifying common themes and data that were linked to program successes. Sources: IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives; Population Reference Bureau; Scholl 2011; FHI 2012c; Pathfinder International 2011a; Pathfinder International 2011; WHO 2009; Global Health Learning Center 2009; IntraHealth 2012; Gay 2012; Kennedy 2012; Mahumane 2011; Smit 2012.]

BARRIERS THAT REDUCE THE EFFECTIVENESS OF INTEGRATED FP/HIV PROGRAMS

- Political, religious, or community opposition to family planning, which can limit support for FP/HIV integration from key stakeholders in decision-making positions
- Lack of government support, national policies and guidelines, and coordination between RH/FP and HIV departments of the ministries of health
- Vertical funding mechanisms among donors and governments
- Insufficient involvement of people living with HIV (PLHIV) in the design and implementation of integrated strategies
- Human resource constraints, including staff turnover, re-assignments, and shortages; actual or perceived heavy workloads; and high client/staff ratios
- Limited space in HIV clinics for private contraceptive counseling or method provision, particularly for longer-acting or permanent methods
- Lack of supportive supervision and performance expectations for the provision of integrated services
- Provider biases and stigma toward the sexual and reproductive health of people living with HIV, including poor knowledge about reproductive rights and biased or coercive contraceptive counseling that focuses only on condom promotion, and not a full range of methods and dual-method use
- Lack of knowledge among providers of the range of contraceptive methods that are safe for use by women living with HIV
- Insufficient screening of FP needs among sexually active clients
- Provider and client fears or lack of information about potential interactions between family planning methods and antiretroviral (ARV) medications
- Insufficient training of providers on informed-choice counseling for family planning and method provision
- Weak referral systems between HIV and family planning service delivery points, particularly when a full range of FP methods is not feasible to provide at the HIV clinic
- Separate record forms, reporting mechanisms, and HMIS for HIV and family planning services
- Lengthy processes for adapting policies, guidelines, training curricula, information, education and communication (IEC) materials, and HMIS to promote and monitor integrated service provision
- Contraceptive stockouts
- Lack of youth-friendly services
- Lack of attention paid to community mobilization for reproductive rights and access to integrated services

[This list of barriers was compiled through a search of peer-reviewed literature and a variety of programmatic resources by identifying common themes and data that were linked to program challenges. Sources: IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives; Gay 2012; FHI 360 2012a; Okundi 2009; Population Action International 2012b; IntraHealth 2012; Pathfinder International 2011a; Smit 2012.]

Synthesis conclusions to be drawn about actionable measures which can be taken to advance effective integration include explicitly addressing and improving multiple levels of the health system, including:

What type of elevator pitch might you deliver to convey the larger context and also your evidence-informed decision-making process and subsequent recommendations for action?

Potential elevator pitch:

Session 6: Applying - Communication strategy

Participants will use the case study and their own knowledge of their country networks to complete a communications strategy worksheet. The brief and case-study work to-date can be referenced but the activity is not dependent on technical content.