Collaboration for the Integration of HIV Prevention at Title X Family Planning Service Delivery Sites

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SYNOPSIS

Since 2001, the U.S. Department of Health and Human Services' Office of Family Planning (OFP), in collaboration with the Minority AIDS Initiative, has provided supplemental grant funds to Title X-funded family planning service delivery sites to expand the availability of human immunodeficiency virus (HIV) prevention services. This work has resulted in three major outcomes: (*1*) increased institutional capacity for the delivery of HIV-prevention services at Title X family planning service delivery sites, (*2*) the successful implementation of HIV-prevention services at these sites, and (*3*) the identification of HIV-positive individuals who were referred to care services. These efforts resulted in a total of 539,667 unduplicated individuals being tested for HIV. These tests resulted in the identification of 1,692 HIV-positive individuals who otherwise may not have been tested for HIV. More than 85% of the HIV-positive cases were detected among clients who self-identified as members of racial/ethnic minority groups. The integration of HIV-prevention services is a feasible and effective strategy for detecting HIV infection among women, including women in racial/ethnic minority groups.

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Human immunodeficiency virus (HIV) infection has increased steadily among females in the United States—particularly members of racial/ethnic minority groups—despite significant progress in slowing the spread of HIV among some populations.[1,2] According to recent estimates by the Centers for Disease Control and Prevention (CDC), as of 2007, approximately 146,692 adult and adolescent females in the U.S. live with HIV infection. Moreover, the proportion of females among reported cases of acquired immunodeficiency syndrome (AIDS) more than tripled from 7% in 1985 to 23% in 2004.[1] Since that time, the number of new HIV cases among females has continued to increase, with a rise of 8% between 2004 and 2007. Today, more than one-quarter of all new HIV diagnoses are among females who are infected through heterosexual contact.[1]

Integrating HIV-prevention education, counseling, and testing with family planning services has been shown to be an effective means of early detection of HIV infection among females and increasing program synergies and efficiencies.[3–6] Integrating these complementary services also allows for seamless access to effective family planning methods by HIV-positive women who wish to prevent pregnancy and offers greater opportunities to prevent mother-to-child transmission of HIV through early detection and treatment.[4] For these reasons, the integration of HIV-prevention services at family planning clinics has been practiced in international settings where women constitute more than half of all cases of HIV infection.[4,6,7]

In the U.S., however, the widespread integration of HIV-prevention services at family planning clinics did not occur until recently, due in part to the vertical nature of HIV funding, which has resulted in a separate infrastructure for HIV-related services.[6,8] This is evidenced by the numerous federal agencies with independent funding support for HIV/AIDS prevention, including the Health Resources and Services Administration (HRSA) through the Ryan White CARE Act, CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health, the Office of HIV/AIDS Policy, the Office of Minority Health, and the Office of Population Affairs.[9–14] This article details a collaborative effort by two federally funded programs, the Title X Family Planning Program and the Minority AIDS Initiative (MAI), to integrate HIV-prevention counseling and testing at family planning service delivery sites to address growing rates of HIV infection among females, including racial/ethnic minority women, as well as to increase coordination among federally funded programs.

BACKGROUND

The integration of HIV-prevention services at family planning service delivery sites is of great interest to the Office of Family Planning (OFP) within the Office of Population Affairs, the federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Family Planning Program authorized under Title X of the Public Health Service Act.[8] The client population served by Title X-funded clinics closely mirrors the demographic profile of individuals at greatest risk for HIV infection: sexually active, young, lower-income, and members of racial/ethnic minority groups; for many of these individuals, these clinics are the first point of entry into the health-care system.[15] Although basic HIV-prevention education services have been required at all Title X-funded family planning service delivery sites since 1987, not all sites had the resources to offer counseling and testing services, a critical component of HIV prevention.[8]

To address this gap, in 2001 OFP, in collaboration with MAI, initiated an effort to increase the capacity of existing Title X-funded family planning service delivery sites throughout the country to provide HIV-prevention education, counseling, testing, and other related referral services. Established in 1999, MAI was formed to reduce the disproportionate impact of HIV/AIDS among racial/ethnic minority communities through the promotion and facilitation of collaboration among agencies within HHS.[16] The collaboration between OFP and MAI was centered on two components: (*1*) the provision of supplemental grant funds (by both OFP and MAI) to expand capacity for enhanced HIV-prevention education, counseling, and testing services; and (*2*) the facilitation of collaboration among training centers supported by HRSA, CDC, SAMHSA, and OFP to streamline and support HIV/AIDS-related training for service delivery sites across the country. The use of this two-pronged approach ensured that the funding for services would be paired with support for capacity development as well as the consistency of messages included in training materials and information disseminated to project sites.

METHODS

Implementation

With funding from MAI discretionary funds and Title X appropriations, OFP competitively awarded supplemental grants ranging from $10,000 to $200,000 to support existing family planning service delivery sites—including both clinical and nonclinical sites—in

communities where racial/ethnic minority groups were underserved or disproportionately impacted by HIV/AIDS, as well as sites where few or no other resources were available for HIV-prevention services that extended beyond information and education. Requests for proposals were issued nationally and were open to all family planning service delivery sites meeting these criteria. OFP selected project sites based on objective reviews and availability of funds. The first cycle of the HIV-prevention integration initiative was launched in September 2001 with a combined total of $15,130,000 awarded to 33 projects in 19 states and U.S. territories for a three-year period. Three years later, in 2004, the second cycle began, and a total of $28,025,072 was awarded to 63 projects in 27 states and territories. The third cycle began in October 2007 with 77 projects in 34 states and territories and is ongoing. This article reports on data collected from the first two cycles of the project, from October 2001 to September 2007. A complete breakdown of funding provided by OFP and MAI for each year of the first and second cycles is shown in Table 1.

Funded projects fell into two categories: (*1*) those that requested funds to initiate HIV activities beyond basic HIV-prevention education, or (*2*) those that requested funds to supplement or enhance existing HIV-prevention activities. Irrespective of the category, all funded projects were required to include a training component for staff. Project sites included state, county, and city health departments; Indian health centers; community-based organizations; university health centers; hospital-based clinics; and freestanding family planning clinics. In the first cycle, grants were awarded to projects in eight of the 10 HHS Public Health Service (PHS) Regions; in the second cycle, projects in all 10 regions received grants. The distribution of projects within PHS Regions in the first two cycles is shown in Table 2.

OFP also established a federal interagency training collaborative to increase coordination for training on the delivery of HIV/AIDS-prevention education and the administration of HIV counseling and testing. This collaboration became known as the 4TC because it brought together, for the first time since their respective establishment, federally funded training initiatives with a shared interest in HIV prevention: the Sexually Transmitted Disease (STD)/HIV Prevention Training Centers funded by CDC; the regional Family Planning Training Centers funded by OFP; the AIDS Education and Training Centers funded under the Ryan White CARE Act within HRSA; and the Addiction Technology Transfer Centers funded by SAMHSA. The 4TC collaborative worked to achieve the following goals: (*1*) enhance communication and collaboration among federal program partners working on HIV/AIDS prevention efforts; (*2*) streamline data requirements; (*3*) collaborate on document and materials development; and (*4*) make effective and efficient use of federal training resources. The 4TC helped guide training activities at the project-site level and the development of implementation protocols used by family planning service providers to integrate HIV-prevention activities. In particular, the work of the 4TC addressed the legal and ethical considerations relating to the consent process, emergency mental health counseling and referrals for HIV-positive clients, and new training approaches and media to reach individuals at risk for HIV infection.

Data collection and management

Data on HIV counseling and testing were managed by Cicatelli Associates Inc. (CAI), a nonprofit training

Table 1. Funding by source for HIV-prevention integration initiative activities

Fiscal year	*Title X (OFP) appropriations*	*MAI discretionary*	*Total amount*	*Number of awards*	*Range of awards*
2001–2002	$2,004,000	$3,000,000	$5,004,000	33	$58,000–$185,000
2002–2003	$2,039,000	$3,000,000	$5,039,000	33	$55,000–$186,000
2003–2004	$2,087,000	$3,000,000	$5,087,000	33	$59,000–$192,000
2004–2005	$3,200,000	$6,000,000	$9,200,000	63	$65,000–$185,000
2005–2006	$3,435,500	$6,000,000	$9,435,500	63	$90,000–$195,000
2006–2007	$3,389,572	$6,000,000	$9,389,572	62[a]	$123,000–$215,000
Total amount awarded in cycle I (2001–2004)					$15,130,000
Total amount awarded in cycle II (2004–2007)					$28,025,072

[a]In 2006, one project voluntarily withdrew from the HIV-prevention integration initiative.

HIV = human immunodeficiency virus

OFP = Office of Family Planning

MAI = Minority AIDS Initiative

Table 2. Distribution of projects by region in cycles I and II of the HIV-prevention integration initiative

U.S. Public Health Service Region	*Number of projects, cycle I (2001–2004)*	*Number of projects, cycle II (2004–2007)*
Region I (CT, MA, MN, NH, RI, VT)	3	5
Region II (NJ, NY, Puerto Rico, U.S. Virgin Islands)	5	8
Region III (DC, DE, MD, PA, VA, WV)	5	10
Region IV (AL, FL, GA, KY, MS, NC, SC, TN)	2	4
Region V (IL, IN, MI, MO, OH, WI)	4	4
Region VI (AR, LA, NM, OK, TX)	4	5
Region VII (IA, KA, MO, NE)	2	3
Region VIII (CO, MT, ND, SD, UT, WY)	0	2
Region IX (AZ, CA, HI, NV, American Samoa, Northern Mariana Islands, Micronesia, Guam, Marshall Islands, Republic of Palau)	8	17
Region X (AK, ID, OR, WA)	0	5

HIV = human immunodeficiency virus

center based in New York City. Individual project sites collected HIV counseling and testing data and submitted the data to OFP Regional Program Consultants (RPCs) in the HHS regional offices using data reporting forms developed by CAI. Data reported in these forms included basic demographic variables used in the Family Planning Annual Report, the number of HIV tests performed, outcomes, and in cycle II, the type of test used. Prior to 2005, there were separate fields for race and ethnicity. Categories for ethnicity included Hispanic and non-Hispanic; categories for race included Caucasian/white, African American/black, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and mixed race. Beginning in July 2005, data collection forms were changed to collect information on race/ethnicity using the following categories: Caucasian/white (non-Hispanic), African American/black (non-Hispanic), Hispanic/Latino, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and mixed race. RPCs checked the data reported by the project sites for completeness and submitted the data for all sites within their regions to CAI. Data were collected at five intervals during the 36-month project cycle: October 1–June 30; July 1–December 31, January 1–June 30, July 1–December 31, and January 1–September 30. CAI compiled data from all project sites and reported outcomes based on fiscal years (October to September) for each cycle to OFP.

OUTCOMES

This work resulted in three major outcomes: (*1*) increased institutional capacity for the delivery of HIV-prevention services at Title X-funded family planning service delivery sites, (*2*) the successful implementation of HIV-prevention services at these sites, and (*3*) the identification of more than 1,500 HIV-positive individuals who were referred to care services.

Increased institutional capacity

As institutional capacity was considered integral to this integration initiative, OFP placed much emphasis on training, both at the national and project-site levels. From 2001 through 2007, OFP convened eight national training and technical support conferences for funded projects. In addition to these national trainings and conferences, more than 2,500 training events were carried out at the project-site level, producing 23,016 trained staff to administer HIV voluntary counseling and testing to patients. Additionally, all staff, including administrative and support staff, received training on cultural competency, confidentiality, informed consent, HIV reporting requirements, and other issues related to provision of HIV-prevention services. Comprehensive training of staff at all levels ensured that HIV-prevention services could be fully integrated into the family planning service delivery process rather than being perceived as ancillary services.

Implementation of HIV-prevention services

The integration approaches that were adopted varied from site to site. Some project sites adopted a fully integrated model where all trained staff and providers offered HIV-prevention services, while other sites used an internal referral system to refer clients to dedicated HIV-prevention staff. In some areas, funded projects developed mobile and off-site testing and counseling facilities that were set up at health fairs and other community events. One project site offered HIV-prevention education, counseling, and testing at correctional facilities. In other sites, greater focus was placed on the development of services and materials for clients with

limited English proficiency (LEP). Because more than half of the funded projects were in areas where more than 50% of the clients self-identified as members of racial/ethnic minority groups, many project sites have had to integrate cultural and linguistic competencies into their HIV-prevention efforts.

To address the diversity of its target population, which primarily comprises recent immigrants from China, Puerto Rico, and Haiti, one project site in New York City offered testing and HIV-related referral services in four languages, filling an important gap in HIV-prevention services accessible to LEP clients. Other sites have capitalized on "teachable moments" for males who accompany their partners to family planning visits. Because males were often present in waiting rooms, at some project sites, staff began using this time to provide them with family planning and HIV-prevention services. As a result of these efforts, males began to view family planning clinics as acceptable sites to obtain HIV-prevention services. Whereas males traditionally accounted for 5% of family planning services utilized, they now account for approximately 20% of all HIV tests performed at the project sites.

Beginning in 2004, all funded project sites were required to integrate the A-B-C approach to HIV prevention. This approach stresses that for adolescents and unmarried adults, the message should emphasize "A" for abstinence; for married people or those in committed relationships, the message should emphasize "B" for be faithful; and for individuals whose behaviors put them at risk for HIV infection, the message should emphasize "C" for condom use, in addition to "A" and "B." While this requirement was established at the start of the second cycle in 2004, the concepts behind this approach had already been incorporated into risk-reduction and STD-prevention counseling in all Title X-funded service delivery sites for a number of years.

At the start of this initiative, most of the project sites adopted a model of voluntary counseling and testing for HIV, whereby clients received HIV-prevention education and were encouraged to have an HIV test as part of their routine family planning visit. As more evidence of the benefits of this integrated model emerged, many project sites began to move toward an opt-out approach, where clients were given the option of declining HIV testing as part of the routine family planning visit. Since 2007, all funded projects have been required to offer opt-out testing for HIV during family planning visits. This is consistent with CDC's current recommendations for HIV testing of adults, adolescents, and pregnant females, which emphasize routine screening of patients in health-care settings.[17]

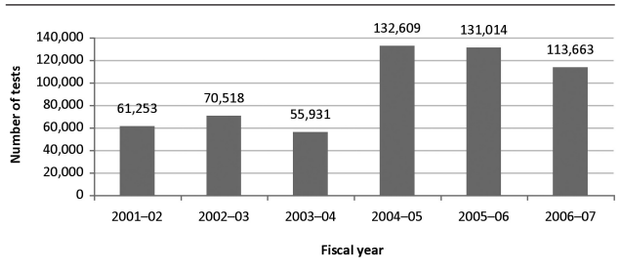
HIV testing at family planning service delivery sites

From 2001 to 2007, a total of 941,859 clients received HIV-prevention counseling at project sites; more than half (539,667) of these clients were subsequently tested for HIV. Figure 1 shows the total number of tests conducted each fiscal year for the first six years of the initiative. These tests resulted in the identification of 1,692 HIV-positive individuals (1,727 positive tests) who otherwise may not have been tested for HIV. Positive tests are shown by age, race/ethnicity (for 2005–2007 only), and gender in Table 3. As shown in Figure 2, adults aged 30–44 years comprised the largest share (42%) of the overall number of positive tests, although they comprised only 22% of the total tests. Comprising 30% of the total number of tests, young adults aged 20–24 years represented the largest share of tests among all age groups.

Figure 3 shows the distribution of HIV tests and positive cases by race/ethnicity and the disproportionate impact of HIV among racial/ethnic minority groups, who accounted for more than 85% of all positive cases. Non-Hispanic African American/black and Hispanic/Latino individuals accounted for 27% and 42% of tests and 44% and 40% of the total positive cases, respectively. Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and mixed-race individuals collectively accounted for 3% of all tests and less than 2% of all positive tests. Non-Hispanic Caucasian/white individuals comprised approximately 24% of all tests and 13% of positive cases. Although a large majority (80%) of the HIV tests given at project sites were performed on female clients, nearly half (49%) of all positive cases identified were among males (Figure 4).

The use of the rapid HIV test has also resulted in project sites achieving another important outcome—that is, an increase in the number of clients receiving

Figure 1. Number of HIV tests performed in cycles I and II of the HIV-prevention integration initiative (2001–2007)[a]



[a]The fiscal years represented by the data began on October 1 and ended on September 30.

HIV = human immunodeficiency virus

Table 3. Cumulative unduplicated individuals tested for HIV and positive cases identified, by age, race/ethnicity, and gender, in cycles I and II of the HIV-prevention integration initiative

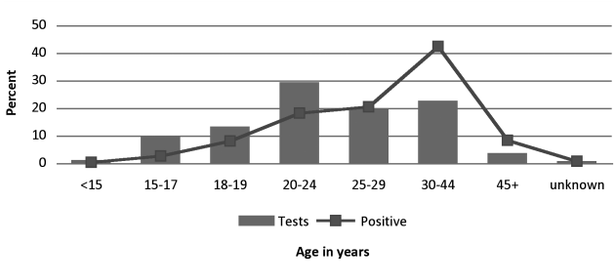
Demographic characteristic	*Number of HIV tests performed*	*Number of positive cases identified*
Age (in years)		
<15	6,297	4
15–17	52,590	43
18–19	71,515	134
20–24	157,700	305
25–29	106,518	344
30–44	121,387	712
≥45	19,819	139
Unknown	3,841	11
Total	539,667	1,692
Race/ethnicity[a]		
Caucasian/white (non-Hispanic)	70,794	113
African American/black (non-Hispanic)	80,373	381
Hispanic/Latino	122,546	346
Asian	5,646	3
American Indian/Alaska Native	1,835	4
Native Hawaiian/Pacific Islander	541	2
Mixed (more than one race)	2,243	1
Unknown/not identified	5,163	6
Total	289,141	856
Gender		
Female	436,526	863
Male	103,141	829
Total	539,667	1,692

[a]Data reported for period from July 1, 2005, through September 30, 2007

HIV = human immunodeficiency virus

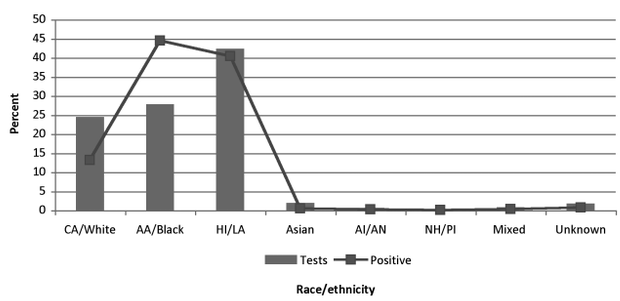
posttest counseling. With traditional HIV tests, clients were required to wait several days and make a follow-up visit to get their results and posttest counseling. With the use of rapid tests, the pretest counseling, administration of the test, and posttest counseling can all be carried out in a single visit. The benefits of this integrated approach using rapid tests are evident, based on the increased numbers of clients who received their results and posttest counseling. In 2004, at the start of the second cycle, approximately 20% of the HIV tests were administered using rapid tests; during this time, as shown in Figure 5, 58% of clients tested received

Figure 2. Distribution of unduplicated HIV tests and positive cases by age in cycles I and II of the HIV-prevention integration initiative (2001–2007)



HIV = human immunodeficiency virus

Figure 3. Distribution of unduplicated HIV tests and positive cases by race/ethnicity in cycles I and II of the HIV-prevention integration initiative (2001–2007)



HIV = human immunodeficiency virus

CA = Caucasian

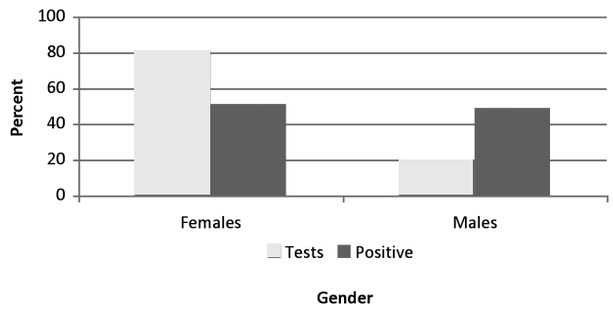
AA = African American

HI/LA = Hispanic/Latino

AI/AN = American Indian/Alaska Native

NH/PI = Native Hawaiian/Pacific Islander

Figure 4. Distribution of unduplicated HIV tests and positive cases by gender in cycles I and II of the HIV-prevention integration initiative (2001–2007)



HIV = human immunodeficiency virus

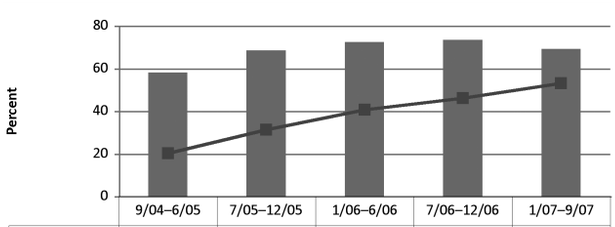
their results and posttest counseling. In fiscal year 2007, more than half of all HIV tests were administered using rapid tests; during this time, 69% of clients tested received their results and posttest counseling.

CONCLUSION

The success of the 33 projects in cycle I and 63 projects in cycle II in delivering HIV-prevention education, counseling, testing, and other HIV-related referral services to 539,667 clients is a strong indication of the feasibility of providing HIV-prevention services at family planning service delivery sites. The identification of 1,692 HIV-positive individuals is strong evidence that HIV-prevention services are important in the early detection of HIV and treatment referral for family planning clients, and are potentially critical to the prevention of mother-to-child transmission. The large number of positive cases among clients who self-identified as members of racial/ethnic minority groups suggests that these efforts also play an important role in reducing health disparities in the U.S. Moreover, as demonstrated by the large proportion of positive cases among males, counseling and testing services at family planning clinic sites can also serve as an access point for males at high risk for HIV infection and provide increased opportunity for both partners to be tested and referred to treatment.

Key to the success of integration efforts is the training and development of capacity at the site level. As illustrated by the number of training events conducted as part of this initiative, without trained staff and the infrastructure to support counseling and testing for HIV at family planning clinics, integration efforts are unlikely to succeed. The pooling of resources and expertise at the national level through collaborations such as the 4TC is also critical in preventing the duplication of services, as well as ensuring greater efficiencies and consistency of information at the clinic level.

Figure 5. Percentage of rapid tests and individuals receiving test results in cycle II of the HIV-prevention integration initiative (2004–2007)[a]



	9/04–6/05	7/05–12/05	1/06–6/06	7/06–12/06	1/07–9/07
% Results	58	68	72	73	69
% Rapid	20	31	40	46	53

[a]Data on rapid vs. standard testing were not collected in cycle I

HIV = human immunodeficiency virus

The Office of Family Planning, Office of Population Affairs, U.S. Department of Health and Human Services thanks the Minority AIDS Initiative for its support and the grantees, delegates, and sponsored projects for their tireless efforts in delivering crucial voluntary human immunodeficiency virus (HIV) counseling and testing services and other HIV-prevention services to communities across the country.

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