



SPOTLIGHT ON PREVENTION

The Astonishing Neglect of an HIV-Prevention Strategy: The Value of Integrating Family Planning and HIV Services

In 2001, the United Nations General Assembly Special Sessions (UNGASS) set a target of reducing HIV-positive births by 50 percent by the year 2010. The goal was to be achieved with the implementation of a four-part strategy to prevent mother-to-child transmission (PMTCT) of HIV:

- 1 Prevent primary HIV infections in women
- 2 Prevent unintended pregnancies in HIV-positive women
- 3 Prevent mother-to-child transmission with antiretroviral (ARV) prophylaxis
- 4 Provide care, treatment, and support for HIV-infected women, their infants, and their families

We are now within sight of 2010, and it seems unlikely that we will reach the goal set by the UNGASS agenda. At least part of the reason is that the implementation of these four strategies has not been fully realized. The majority of the resources for PMTCT have been directed toward the provision of ARVs—such as the nevirapine regimen for HIV-positive pregnant women and their newborns. In contrast, preventing unintended

pregnancies among HIV-positive women—by increasing the voluntary use of contraception—has been undervalued and little-used.

The neglect of this strategy is disturbing given that unintended pregnancies are distressingly high among HIV-positive women. A study of three PMTCT programs in South Africa reported that 84 percent of the pregnancies were unplanned.¹ More than 90 percent of the pregnancies among women enrolled in a Ugandan antiretroviral treatment program were unintended.² Such studies are indicative of a larger trend, which finds that unintended pregnancies account for 14 to 58 percent of all births in countries with the greatest burden of HIV.³

Many HIV-positive women wish to control childbirth, but are unable to do so. What is preventing them? And what can be done to help them? Here we argue that contraception is a powerful HIV-prevention strategy that could reach many of these women if it were a core component of HIV prevention, care, and treatment initiatives.

¹ RoCHAT TJ, Richter LM, Doll HA, et al. Depression among pregnant rural South African women undergoing HIV testing. *JAMA* 2006;295:1376–8.

² Homsy J, Bunnell R, Moore D, King R, Malamba S, Nakityo R, et al. Reproductive intentions and outcomes among women on antiretroviral therapy in rural Uganda: a prospective cohort study. *PLoS One* 2009;4:e4149.

³ Reynolds HW, Janowitz B, Wilcher R, Cates W. Contraception to prevent HIV-positive births: current contribution and potential cost savings in PEPFAR countries. *Sex Transm Infect* 2008;84 (Suppl II):ii49–53.

Virtues of Contraception

Contraception offers a number of benefits for all women, regardless of their HIV status. By delaying first births, lengthening birth intervals, reducing the total number of children born to a woman, preventing unintended pregnancies, and reducing the need for unsafe abortions, contraception can have a major impact on improving overall maternal and infant health. For HIV-positive women who do not want to become pregnant, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV-related services.

The potential contribution of contraception to preventing HIV-positive births is well established. One study found that even modest decreases in the number of pregnancies to HIV-infected women—ranging from 6 percent to 35 percent—could avert HIV-positive births at the same rates as the use of ARVs for PMTCT.⁴ Another study demonstrated that the addition of family planning to PMTCT services could avert nearly twice as many HIV-positive births as the use of ARV-based prophylaxis does in countries with a high prevalence of HIV.⁵

Current levels of contraceptive use in all of sub-Saharan Africa are already preventing 173,000 HIV-positive

births annually, even though contraception is not widely available in the region.⁶ An additional 160,000 HIV-positive births could be averted every year if all women in the region who did not wish to get pregnant could get access to contraceptive services.⁶ A similar analysis of only the focus countries in the President's Emergency Plan for AIDS Relief (PEPFAR) found that contraception prevents a wide range of HIV-positive births every year—from 178 in Guyana to 120,256 in South Africa.³

Contraception is also a cost-effective way to avert HIV infections in infants. Dollar for dollar, family planning

programs have the potential to prevent nearly 30 percent more HIV-positive births than PMTCT programs that provide prophylaxis with nevirapine.⁷ Moreover, adding family planning to PMTCT services would cut the cost of each HIV infection averted in half—from \$1,300 per infection averted

with treatment alone to an estimated \$660 with family planning.⁵

Stumbling Blocks

Given the enormous public health benefits of contraception, one would think that family planning services would be a higher global health priority. But the long-term funding trends tell another story. Between 1995 and 2004, funding for international family planning

For HIV-positive women who do not want to become pregnant, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV-related services.

⁴ Sweat MD, O'Reilly KR, Schmid GP, et al. Cost-effectiveness of nevirapine to prevent mother-to-child HIV transmission in eight African countries. *AIDS* 2004;18:1661-71.

⁵ Stover J, Fuchs N, Halperin D, et al. Costs and benefits of adding family planning to services to prevent mother-to-child transmission of HIV (PMTCT). Washington, DC: The Futures Group, 2003.

⁶ Reynolds HW, Steiner MJ, Cates W. Contraception's proved potential to fight HIV. *Sex Transm Inf.* 2005;81:184-5.

⁷ Reynolds H, Janowitz B, Homan R, Johnson L. The value of contraception to prevent perinatal HIV transmission. *Sex Transm Dis.* 2006;33(6):350-6.

⁸ UNFPA. Decline in family planning funding must be reversed. 2006. <http://www.unfpa.org/news/news.cfm?ID=765> (accessed 03 August 2009).

fell from more than half of all spending on population assistance to less than one-tenth.⁸ This trend was slightly reversed in 2009, when the Obama administration increased funding for international family planning programs by 18 percent.⁹ This was an encouraging step, but much more is needed.

A global funding shortfall for the provision of reproductive health supplies—including contraceptives and condoms—has contributed to an enormous need for family planning services. The United Nations Fund for Population Activities (UNFPA) estimates that the gap between the need for essential condom and contraceptive supplies and the funds allocated for purchasing them will reach hundreds of millions of dollars annually by 2015.¹⁰

As traditional family planning programs are struggling, funds for HIV-related priorities are dramatically increasing. In 2008, \$3.6 billion was requested for HIV programs for the 15 PEPFAR focus countries compared with \$67.5 million requested for family planning and reproductive health—more than a 50-fold difference.¹¹ This represents a 225 percent increase for HIV programs over the amount allocated for 2006, and an 11 percent decrease for family planning and reproductive health. At these funding levels, family planning programs are constrained in their ability to

reduce the unmet need for family planning, especially for women with HIV. HIV funding to date has had only a limited impact on mitigating the shortfall in funding for family planning.

Major HIV funding initiatives also tend to prioritize

treatment and care, rather than prevention. In 2006, 50 percent of the PEPFAR funds were allocated to treatment, and only 22 percent were targeted for prevention. Unfortunately, congressional earmarks at that time prevented more strategic alignment of funds. But even PMTCT programs—

which accounted for only 5 percent of PEPFAR's HIV-prevention funding in 2006—focused almost exclusively on antiretroviral prophylaxis.¹² Neither PEPFAR nor the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) includes contraceptive use as an indicator of programmatic success.

Major HIV funding initiatives also tend to prioritize treatment and care, rather than prevention. In 2006, 50 percent of the PEPFAR funds were allocated to treatment, and only 22 percent were targeted for prevention.

Integration of Family Planning and HIV Services

Strengthening traditional family planning programs, particularly in countries with a generalized epidemic, is one way to increase access to contraception, including for HIV-positive women. However, another more targeted approach is to integrate family planning and HIV services. The union of these services has the potential to draw on the strengths of both programs to

⁹ Population Action International. International family planning programs receive nearly twenty percent increase. http://www.populationaction.org/Issues/US_Policies_and_Funding/omnibus_0309_FPincrease.shtml (accessed 03 August 2009).

¹⁰ UNFPA. Donor support for contraceptives and condoms for STI/HIV prevention. 2002. http://www.unfpa.org/upload/lib_pub_file/300_filename_contraceptives_02.pdf (accessed 03 August 2009).

¹¹ Population Action International. US HIV/AIDS and family planning/reproductivehealth assistance: a growing disparity within PEPFAR focus countries. 2008. http://www.populationaction.org/Issues/US_Policies_and_Funding/FPRH/Summary.shtml (accessed 13 August 2009).

¹² United States President's Emergency Plan for AIDS Relief. Focus countries: US President's emergency plan for AIDS relief FY 2006 planned funding for prevention, treatment and care. 2006. <http://www.pepfar.gov/pepfar/press/76019.htm> (accessed 13 August 2009).

address the client's dual need for reproductive health and HIV-related services.

Programs dedicated to HIV prevention and care—such as PMTCT, counseling and testing, and antiretroviral therapy—are expanding rapidly. The integration of family planning services into these programs could increase access to contraceptive methods and dramatically enhance the public health impact of HIV programs.¹³

HIV prevention and care activities could also be brought into the mainstream of existing reproductive health services. This approach has the potential to increase access to HIV services while strengthening traditional family planning programs. Both approaches to integration—with their emphasis on reducing organizational “silos”

to allow more comprehensive care—are central to the concept of health-systems strengthening, a rising global health priority, especially among HIV donors. The importance of family planning/HIV integration is even taking root within PEPFAR. In contrast to the field guidance issued in FY2009, administrators revised the most recent guidance to explicitly state that “PEPFAR is a strong supporter of linkages between HIV/AIDS and voluntary family planning and reproductive health programs.”

The achievement of integrated services has its challenges. The separate funding streams for family planning and HIV/AIDS pose major obstacles to strong linkages between the two fields. These funding mechanisms have driven the formation of parallel departments for

reproductive health and HIV/AIDS within ministries of health, which in turn have created vertically oriented policies, strategies, training programs, and, ultimately, service delivery systems. Increasingly, ministries of health and other implementers are working to overcome these barriers. For example, in several countries specific individuals have been designated to provide liaison for—and support integrated activities among—the array of government programs with both reproductive health and HIV responsibilities. Coordination of multisectorial input to national public health strategies is essential. As they move forward, we must also continue to invest in research to build an evidence base of integrated service delivery best practices.

In all efforts to integrate services, providers must be

equipped to assess the fertility desires of their clients and to counsel them effectively on their reproductive choices. As in traditional family planning programs, informed-choice counseling must be the cornerstone of contraceptive services in

HIV-service delivery settings. HIV-infected women, like all women, have the right to make reproductive choices for themselves—they should never be coerced into a particular reproductive decision. For those women who do not wish to become pregnant, providers must be able to discuss safe and effective contraceptive options.

As attention is increasingly diverted to the HIV epidemic, the world cannot afford to ignore the role of family planning in the fight against HIV. Reducing the unmet need for contraception will not only produce tangible gains against the HIV epidemic, it will

As attention is increasingly diverted to the HIV epidemic, the world cannot afford to ignore the role of family planning in the fight against HIV.

¹³ Wilcher R, Petruney T, Reynolds HW, Cates W. From effectiveness to impact: contraception as an HIV prevention intervention. *Sex. Transm. Inf.* 2008;ii54–ii60.

also improve the overall health of mothers and their children. The current U.S. administration has included both HIV and family planning as two of its top four priorities in the President's Global Health Initiative. In addition, the Secretary of State has identified Millennium Development Goal 3 — the empowerment of women and girls — as its “signature” foreign policy goal. Now is the time for contraception to take its rightful place among HIV-prevention strategies. ■

About the Authors

Rose Wilcher, MPH, is a Senior Technical Officer at Family Health International. She provides research utilization support and technical oversight to international reproductive health projects in Africa, particularly projects that address the integration of family planning and HIV policies, programs, and services. Ms. Wilcher has been at the forefront of FHI's global efforts to promote utilization of the evidence

supporting family planning as an HIV prevention intervention, and works closely with donor agencies, government representatives, advocacy groups, and staff from cooperative agencies to advance programming and research in family planning/HIV integration.

Willard Cates, MD, MPH, is President, Research at Family Health International. Before joining FHI 15 years ago, Dr. Cates was at CDC for two decades, where he directed the STD/HIV prevention efforts for half that time and headed CDC's abortion surveillance activities for the other half. Dr. Cates is co-author of *Contraceptive Technology* and a past co-editor of *Sexually Transmitted Diseases*, 2nd edition. He has been a strong advocate for integrating family planning and HIV services to 1) improve access for clients; 2) optimize use of available resources; 3) strengthen overall health systems; and 4) maximize public health impact.