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Linkages Between HIV and Family Planning Services Under PEPFAR: Room for Improvement

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In 2003, Congress enacted the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act, the landmark legislation establishing the President's Emergency Plan for AIDS Relief (PEPFAR). This signature Bush administration initiative prioritized treatment over prevention and adopted a highly conservative approach to combating sexual transmission of the virus, including requirements that at least one-third of all HIV prevention funds be reserved for abstinence-until-marriage programs. In 2008, when Congress renewed PEPFAR for another five years, it bolstered the original law's treatment focus, but it also allowed for greater flexibility in prevention efforts overall. The 2008 law also included a new emphasis on programs that reduce women's risk of acquiring HIV and on promoting linkages between HIV programs and other health sectors.

Ever since President Obama came into office in 2009, reproductive health and HIV program implementers and advocates alike have been seeking clarity on how the new administration would act to strengthen linkages between HIV services and family planning services. Over the course of this year, the administration finally released several new guidances to the field.[1–4] These guidances make clear that linkages between these two program areas are essential for effective HIV prevention, specifically acknowledging the importance of unintended pregnancy prevention in lowering the rate of new HIV infections. They fully endorse making HIV counseling and testing—as well as referrals for prevention of mother-to-child transmission and HIV care and treatment services—available in family planning programs, and they endorse the use of PEPFAR funds for this purpose. They also endorse family planning counseling and referrals for contraceptives for women in HIV programs and the use of PEPFAR funds for that purpose. This is not the case, however, when it comes to contraceptives themselves. The new PEPFAR guidances prohibit the use of PEPFAR funds for this purpose, implicitly shifting responsibility to the U.S. Agency for International Development's (USAID) family planning program.

This failure to fully connect the dots is problematic in two respects. First, the USAID family planning assistance program is already hard-pressed to meet the ever-rising demand for family planning services and is a Republican target for budget cuts, not increases. Second, there are places—both entire countries and within countries—where there is a PEPFAR treatment program, but not a corresponding U.S. family planning program. Looking ahead, although much can be done under the new guidances to advance linkages between HIV and family planning services, some remedial actions will be needed to fully realize the benefits of integration as an HIV strategy.

What Are Linkages?

The World Health Organization (WHO) endorses a comprehensive conception of linkages that emphasizes the many synergies between HIV services and sexual and reproductive health broadly, not family planning alone, and underscores the wide-ranging health and social benefits of integrating services for women, their families and their communities.[5] Indeed, the benefits of investing in linkages for maternal, infant and child health are indisputable. There is also a com-

pelling case, however, for viewing linkages more narrowly, as an important HIV prevention strategy. This is how linkages between HIV and family planning services are conceptualized in the new PEPFAR guidances, and they are seen as "bidirectional."

In one direction, the role of family planning programs is easy to understand. Millions of women at risk of HIV—as well as women living with HIV who may not know it—come into contact with the health care system, either within clinical settings or through community-based distribution programs, seeking to prevent unintended pregnancy. Their interaction with family planning providers is an opportunity to receive HIV prevention information, counseling and testing, and referrals for care and treatment as appropriate. The importance of integrating HIV services into family planning programs is almost universally accepted.

The importance of integrating family planning services into HIV programs may be less intuitive, but it is no less salient. A substantial number of HIV-positive women in HIV care and treatment programs or prevention of mother-to-child transmission (PMTCT) programs experience an unplanned pregnancy. For example, several studies conducted in Sub-Saharan Africa suggest that the proportion of pregnancies that are unintended among HIV-positive women in HIV programs ranges between 51% and 92%.[6] Making contraceptive services more widely available through HIV care, treatment and PMTCT programs would make it easier for these women to coordinate their HIV-related care with their pregnancy prevention goals, and at the same time, help prevent mother-to-child HIV transmission. It is this aspect of linkages that has been historically underappreciated and that the new PEPFAR guidances—although a significant step forward—only partially address.

PEPFAR Policy

The new guidances recognize the significant contribution of unintended pregnancy prevention in averting new infant infections and recommend that "voluntary family planning should be part of comprehensive quality care for persons living with HIV."[2] This is a far cry from the position of the Bush administration just a few years ago. In 2008, during the debate over legislation renewing PEPFAR, the administration and antiabortion activists objected to a draft PEPFAR bill that listed family planning programs among those that should have good referral networks with HIV-related programs, despite the administration's own policies at the time supporting family planning counseling and referral in PEPFAR-funded programs for HIV-positive women. In a letter to then–House Foreign Affairs Committee Chairman Tom Lantos (D-CA), the Department of State insisted that all references to "family planning" and "reproductive health" be deleted from the bill.[7]

In the same letter, the Bush administration objected specifically to the provisions in the chairman's bill that would have permitted PEPFAR funds to pay for contraceptives for women in HIV treatment programs and for postpartum mothers in PMTCT programs. This idea is "contrary to PEPFAR's life-saving principles," wrote the State Department, and "wrongly suggests it is necessary to prevent children from being born in order to prevent them from being born with HIV."

The Obama administration has rejected this analysis and, instead, encourages countries to actively pursue linkages between HIV and family planning services as an evidence-based approach to HIV prevention. The various new guidances assist PEPFAR country teams in the development of their AIDS strategies and provide a basis for tracking PEPFAR funding and targets as an annual workplan for the U.S. government. Taken together, these guidances highlight the importance of linkages, and specifically encourage the integration of family planning services into two different types of HIV programs: HIV care, treatment and support programs and PMTCT programs.

Links with HIV Care, Treatment and Support Programs

As the quality of life of people living with HIV has improved worldwide, PEPFAR has increased its focus on the prevention needs of HIV-positive

women being served in HIV care, treatment and support programs. According to PEPFAR, prevention interventions with HIV-positive women are a core component of a comprehensive HIV strategy and "contribute to preventing mother-to-child HIV transmission through provision of family planning counseling and services to reduce unintended pregnancies among HIV-infected women."[3] PEPFAR recommends that all clinic- and community-based programs serving HIV-positive women offer a comprehensive package of HIV prevention messages and services—including delivery of and referral to family planning services—on an ongoing basis. "Family planning counseling and provision of contraceptive services ideally should be integrated within most HIV-related clinical settings. [In addition,] support group and mothers-to-mothers group facilitators and community care providers who interact with pregnant [women living with HIV] and their partners should have the capacity to provide ongoing family planning counseling and support for safer pregnancies."

Links with PMTCT Programs

PEPFAR also strives to reach HIV-positive women who are already pregnant and being served in PMTCT programs. PMTCT programs justifiably enjoy broad political support and continue to be a funding priority within the U.S. global AIDS effort. The U.S. focus on PMTCT predates PEPFAR itself, reaching back to 2002, when the Bush administration launched the International Mother and Child HIV Prevention Initiative. In 2008, Congress reinforced its support by mandating that PEPFAR ramp up PMTCT efforts to reach at least 80% of pregnant women in countries most affected by HIV by 2013. In addition, PEPFAR, along with global partners such as the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on AIDS (UNAIDS) and WHO, recently committed to the goal of virtual elimination of mother-to-child transmission of HIV by 2015.[8]

Recognizing that PMTCT is a complex package of interventions, PEPFAR bases its approach to PMTCT on WHO's 2002 recommended comprehensive strategy to prevent HIV transmission from mothers to their infants. This strategy consists of four prongs: preventing primary HIV infection in women, preventing unintended pregnancies among women living with HIV, preventing HIV infection in infants, and treatment, care and support for HIV-positive women and their families.[9]

The guidances encourage PEPFAR-funded PMTCT programs to specifically address "prong 2" of WHO's strategy, preventing unintended pregnancies through increased access to family planning services for postpartum women. In fact, PEPFAR emphasizes that efforts should be made to support the availability of family planning services to all women who desire them. The guidances raise several tactics for PMTCT programs, including co-locating and linking with family planning programs, providing training about PMTCT to family planning providers working in generalized HIV epidemics, and providing postpartum family planning services as part of PMTCT.[3]

Two Major Problems

Unfortunately, even as PEPFAR encourages bidirectional linkages conceptually and as policy, PEPFAR funding is not a two-way street. Whereas PEPFAR will pay for HIV counseling and testing within family planning programs, PEPFAR prohibits the use of its funds for contraceptives for women in HIV care, treatment and PMTCT programs, even in settings where contraceptive services are not readily available elsewhere.[2] Methods of family planning, other than male and female condoms, must be paid from non-HIV accounts. The bottom line is that the administration recognizes the critical role of unintended pregnancy prevention in preventing HIV, but does not complete the loop by paying for contraceptives for HIV-positive women who want to prevent pregnancy.

On its face, the notion that PEPFAR funds should not be used for contraceptives may seem to make sense. After all, the United States has a separate funding stream within USAID dedicated entirely to the provision of family planning and reproductive health services. But PEPFAR's inflexible policy creates two major problems.

First, it is undeniable that USAID's family planning program is currently underfunded and under attack, and unless funding is increased immediately, there will be a serious shortfall of resources to meet the growing demand. At $615 million annually, U.S. funding for family planning is only a fraction of what it should be to meet the needs of women in the developing world, of which 215 million want to avoid a pregnancy but are not using an effective method of contraception.[10] U.S. advocates have been calling for at least $1 billion annually. A recently released report by five former directors of the Population and Reproductive Health Program at USAID goes even further, making the case that funding for USAID's family planning budget be set at $1.2 billion—and raised to $1.5 billion by fiscal year 2014.[11] But these increases are unlikely if congressional House leaders have their way. Three times in 2011 alone, the Republican House has moved to slash funding for international family planning aid.

The second problem arising from PEPFAR's policy is a matter of matching access to HIV services with access to family planning services. HIV providers are now obligated under PEPFAR to provide family planning counseling and referrals for contraceptives, but what are they to do when no local family planning program exists for women to be referred to? There are, in fact, a substantial number of countries that receive PEPFAR funding—including such countries as Botswana, Lesotho, Namibia and Swaziland, in which HIV-prevalence rates are among the highest in the world—but do not receive any U.S. family planning aid (see chart).[12,13] By the same token, women may not have access to contraceptives even within those countries that receive both PEPFAR funding and U.S. family planning aid, because not every region within a country may receive both types of aid. That is why advocates of linkages—both in the family planning and HIV communities—have been urging the administration to endorse the use of PEPFAR funds for contraceptives at least in those settings where women do not have access to these methods through USAID or other local family planning programs.

MISSING LINKS

Six of the top 20 recipients of PEPFAR funding—including three with the world's highest HIV-prevalence rates—receive no U.S. family planning assistance.

Country	HIV Prevalence (%)
Swaziland	25.9
Botswana	24.8
Lesotho	23.6
South Africa	17.8
Zimbabwe	14.3
Zambia	13.5
Namibia	13.1
Mozambique	11.5
Malawi	11.0
Uganda	6.5
Kenya	6.3
Tanzania	5.6
Nigeria	3.6
Cote d'Ivoire	3.4
Rwanda	2.9
Haiti	1.9
Vietnam	0.4
India	0.3
Congo (Dem. Republic of)	na
Ethiopia	na

Notes: HIV prevalence for 2009 among the population aged 15–49. na = prevalence data not available. *Sources:* References 12 and 13.

Closing the Loop

In 2009, President Obama announced the launch of the Global Health Initiative (GHI), a six-year, $63 billion effort to sustain and strengthen existing health programs. The GHI is a comprehensive, "whole-of-government" approach to global health and a blueprint for integration and linkages on the ground. It is an acknowledgement that there is too little integration in the delivery of global health services and an attempt to coordinate health care across these funding silos. Speaking about the GHI in August 2010, Secretary of State Hillary Rodham Clinton explained, "We're shifting our focus from solving problems, one at a time, to serving people, by considering more fully the circumstances of their lives and ensuring they can get the care they need most over the course of their lifetimes."[14]

PEPFAR and USAID's family planning program are both pillars of the GHI, and the new PEPFAR guidances outline much that countries can do to create better linkages between these two program areas. Countries should take full advantage of this opportunity and consider a broad range of activities—from developing and disseminating policies and guidelines that support linkages, to building the capacity of health care providers to routinely counsel women living with HIV on their family planning desires and their contraceptive options, to strengthening referral systems between HIV and family planning services.

For its part, PEPFAR's implementing agencies—the Office of the Global AIDS Coordinator at the State Department, USAID and the Centers for Disease Control and Prevention, in particular—need to take the lead in encouraging countries to pursue and scale up these efforts. The guidances are an important first step, but more could be done to communicate with U.S. missions, implementing partners and others in the field about how to strengthen linkages and increase access to contraceptives for women living with HIV. This may mean holding workshops or presenting at international conferences or providing technical resources (such as WHO's *Strategic Considerations for Strengthening the Linkages Between Family Planning and HIV/AIDS Policies, Programs, and Services*[15]) to support these efforts. PEPFAR should also consider selecting a handful of countries to highlight where integration and coordination is happening in a more substantial way and show how it is both scalable and cost-effective.

At the same time, it must be acknowledged that the Obama administration's policy on HIV–family planning linkages is not all that it could—or should—be. The administration can redress some of this by fighting for increased funding for USAID's family planning program. Contraceptive use among HIV-positive women—most of whom do not know their status and are simply seeking to prevent unwanted pregnancies—is an important, if largely "invisible," intervention for the prevention of mother-to-child transmission of the virus. In fact, current levels of contraceptive use among HIV-positive women living in Sub-Saharan Africa may already be preventing some 173,000 HIV-positive births annually.[16]

Equally important, the administration must address the fact that PEPFAR policy obligates HIV providers to refer women for contraceptive services, but a provider to receive the referral may not exist. First, it should undertake an analysis of the level of access to family planning services in areas where PEPFAR programs are in place. It then needs to consider how any gaps can be closed. One possibility would be to convene international health organizations and country-level program implementers to develop a plan for closing gaps where they exist.

As a matter of policy, PEPFAR under the Obama administration has come very far in encouraging linkages between HIV services and family planning services. The United States now should go all the way to ensure that every woman has access to critical HIV prevention, care and treatment services, including access to the contraceptive services she wants and needs.

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