

FAMILY PLANNING AND PMTCT SERVICES: EXAMINING INTERRELATIONSHIPS, STRENGTHENING LINKAGES

Preventing unintended pregnancy among HIV-positive women through family planning services is one of the four cornerstones of a comprehensive program for prevention of mother-to-child HIV transmission (PMTCT).¹ According to the World Health Organization (WHO 2002), a moderate reduction in the number of pregnancies among HIV-infected women would yield a reduction equivalent to the number of infections averted among infants of HIV-positive pregnant women, given that so few of these women receive the full package of PMTCT interventions (from HIV counseling and testing to support for safer infant feeding practices).

Reducing unintended pregnancies among HIV-positive women through family planning also reduces the number of children potentially orphaned when parents die of AIDS-related illnesses. It also reduces HIV-positive women's vulnerability to morbidity and mortality related to pregnancy and lactation. In addition, family planning for both HIV-positive and -negative women safeguards their health by enabling them to space births.

This summary focuses on findings from Horizons studies on the extent to which voluntary counseling and testing (VCT) and PMTCT programs address family planning, and vice versa. In Kenya and Zambia, the Horizons Program collaborated with NARESA and the MTCT Working Group, respectively, and UNICEF to document the



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acceptability, operational barriers, costs, and impact of pilot PMTCT services. The major research activities in each country included tracking the utilization of various services, including VCT and family planning; following a cohort of clinic users for 12 to 18 months to determine the effect of PMTCT service utilization on knowledge, practices, and rates of mother-to-child HIV transmission; observation of the quality of care delivered by providers; and an economic analysis of the PMTCT program.

This summary also draws on data from a Horizons study in Uganda that tested a strategy for the integration of HIV counseling into health services, including family planning, and from a recent evaluation of United Nations-supported pilot PMTCT projects in 11 countries.² In the Uganda study, researchers used a combination of methods to determine the extent to which providers assessed client needs, discussed HIV-related issues, and made referrals for such related services as VCT. In the UN study, UNICEF and Horizons employed a mix of qualitative and quantitative methodologies, including a rapid assessment of services at pilot sites in Rwanda and Zambia, to identify strengths as well as gaps in service delivery (see Rutenberg et al. 2003a).

Key Findings

Most PMTCT sites offer family planning services.

During the evaluation of UN-supported sites, program managers were asked if family planning services were provided as part of the PMTCT program. Program managers at the national level in all 11 countries responded that family planning services were indeed part of their PMTCT

program, which was centered within antenatal care and maternal and child health (ANC/MCH) services. Most sites offer family planning counseling and contraceptive methods, either within the same building or adjacent to it. PMTCT clients—both HIV-positive and -negative—thus receive family planning counseling and services as part of their routine care. However, at some sites run by faith-based organizations (which include some of the most overall effective PMTCT sites that emerged from the evaluation), contraceptives are not provided. For instance, at two of the pilot sites in Rwanda supported by Catholic organizations, providers give information about family planning, yet women must go elsewhere to obtain contraceptives. This creates an additional step and potential barrier to accessing family planning methods.

Introducing PMTCT as a new service into ANC/MCH can improve the quality of existing family planning services.

In the two sites in Kenya, researchers observed client provider interactions of family planning sessions at three different points: before the PMTCT program was introduced, then 6 months and 27 months after its introduction. In Homa

Figure 1 Percent of PMTCT clients who received antenatal and postpartum family planning counseling in Lusaka, Zambia

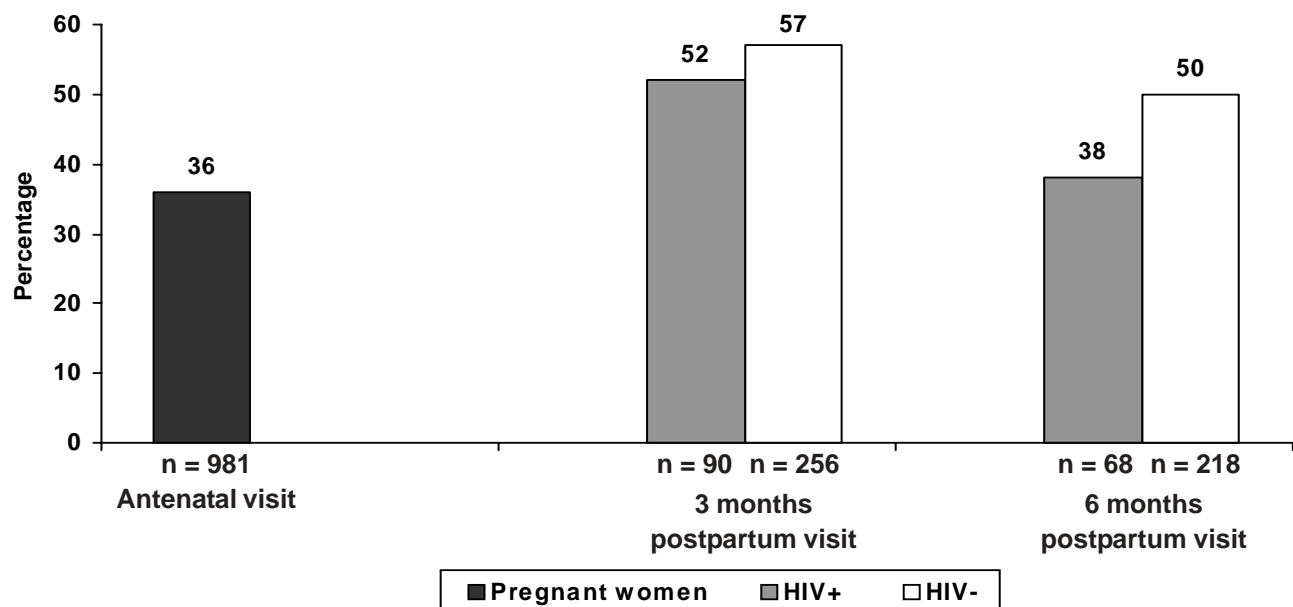


Table 1 Percent of family planning sessions containing adequate information or services (Kenya sites)

	Baseline (before PMTCT program introduced)	6 months after PMTCT program introduced	27 months after PMTCT program introduced
Exploration of client's reproductive health goals			
Homa Bay	61	46	98*
Karatina	96	94	75
Visual display of FP methods			
Homa Bay	29	67	100*
Karatina	95	95	95
Information on available FP methods			
Homa Bay	9	7	26*
Karatina	42	69	50
Discussion of benefits and side effects of different FP methods			
Homa Bay	8	17	15
Karatina	23	53	44*
Client examined for STI			
Homa Bay	11	29	11
Karatina	16	50	93*
Correct information on use of FP method			
Homa Bay	37	33	32
Karatina	46	79	93*
Guidance on optimal FP method			
Homa Bay	71	42	17
Karatina	no data	no data	no data

*Statistically significant improvement from baseline ($p < .05$)

Bay, researchers observed 47, 24, and 78 sessions for the three rounds, while in Karatina, researchers observed a greater number of sessions: 200, 99, and 123, respectively. The observed sessions were of all family planning clients and did not necessarily include members of the study cohorts in each site. Almost all of the components of quality (see Table 1) either remained the same or improved significantly from baseline to two years after the PMTCT program was introduced.

Far from negatively affecting the quality of family planning sessions, the data reveal that almost all

components of quality within family planning sessions plateaued or improved significantly. The improvements may be due to the fact that in many PMTCT sites, family planning was clearly articulated as an important strategy to reduce mother-to-child transmission.

PMTCT sites miss opportunities to provide clients with family planning counseling.

Family planning counseling can be provided at various points during the period that women attend ANC/MCH services. In Lusaka, Zambia,

Table 2 Percent of PMTCT clients who received antenatal and postpartum family planning counseling on day of interview at two sites in Kenya, by HIV status

	Antenatal		3 months postpartum		6 months postpartum	
	%	n	%	n	%	n
Homa Bay						
HIV+	29	212	0	72	0	62
HIV-	23	380	2	173	1	163
Karatina						
HIV+	21	89	0	32	3	37
HIV-	22	911	2	310	0	236

and may have been experienced family planning users; thus, they may have mainly seen family planning providers to continue their already chosen method. Interviews were also timed to coincide with immunization visits, and women may not have needed or sought out family planning counseling on these days.

In all three of the intervention sites there is a similar proportion of HIV-positive and -negative women who received (or did not receive) family planning counseling. This suggests that providers are not specifically targeting HIV-positive women with family planning messages.

where a cohort of 1,002 PMTCT clients were initially interviewed, a little more than a third of the pregnant clients received family planning counseling during their antenatal visit that day (see Figure 1). This is regardless of HIV status, since at this juncture in the study, most women had not taken an HIV test and did not know their serostatus. Among those re-interviewed at their three-month postpartum visit (37 percent of the women originally interviewed), a greater proportion of women received family planning counseling. More than half of HIV-positive and -negative women discussed family planning with the provider on that day. Attention to family planning decreased slightly at the six-month postpartum visit: 38 percent of HIV-positive women discussed family planning, while 50 percent of HIV-negative women did so. These data show that while providers mentioned family planning in some antenatal and postpartum sessions, there are many missed opportunities.

At the two Kenya PMTCT sites, more than one-fifth of women reported that they engaged in a discussion about family planning during their antenatal visit on that given day, but few women in the cohort study subsequently reported receiving any postpartum counseling on this topic (see Table 2). In Karatina, Kenya, many of the women interviewed were using injectable contraceptives

HIV-positive and HIV-negative women are just as likely to use family planning methods.

At six months postpartum, one-third of women in the cohort who received antenatal care at the PMTCT site in Lusaka and just less than one-quarter of clients at the PMTCT site at Homa Bay were using a modern method of family planning (see Table 3). Family planning prevalence in Karatina was considerably higher, with more than three-quarters of clients adopting a modern method of family planning. These rates are broadly comparable to the contraceptive prevalence figures reported for the respective districts in recent DHS studies, suggesting that the uptake of family planning by women at these sites reflects the overall level of family planning effort rather than the addition of PMTCT services.

The data reveal very similar rates of contraceptive use regardless of HIV status. In Homa Bay, there was no significant difference by family planning method between HIV-positive and HIV-negative women. In Lusaka, HIV-positive and HIV-negative women reported similar rates of specific contraceptive methods, with the exception of condoms. Nearly a quarter of HIV-positive women reported condom use at six months postpartum, which is more than double the use of condoms by HIV-negative women. The 9

percent of HIV-negative women who reported condom use is consistent with the DHS for Lusaka, while HIV-positive women reported much higher use than the general community practice. Again in Karatina, HIV-positive and HIV-negative women reported similar rates of specific contraceptive methods with the exception of condoms. The 1 percent of HIV-negative women who reported condom use is also consistent with the DHS for the central province in Kenya. Meanwhile, HIV-positive women reported significantly higher use of condoms. HIV-positive women may be concerned about infecting others and/or avoiding re-infection; post-test counseling at the PMTCT site may also help them raise the issue of condom use with their partners. HIV-negative women may receive

some counseling on risk reduction, but clearly more counseling and other types of support are needed for the challenging task of introducing condoms into their relationships.

Two-thirds of women interviewed in Homa Bay and more than one-third in Lusaka reported that they were not using any family planning method, although they did have a regular sexual partner. The lack of family planning use with a regular partner suggests potential future pregnancies among both HIV-positive and -negative women. In marked contrast to the other two sites, at Karatina only a small percentage of HIV-positive women (3 percent) and HIV-negative women (8 percent) who have a regular sexual partner reported no use of a family planning method.

Table 3 Percent of use and non-use of family planning of PMTCT clients at 6 months postpartum, by HIV status

	Pill	Injectable	Long-term	Condom	Total modern method ^a	Natural family planning	None, no partner	None, regular partner
Lusaka, Zambia								
HIV+ (n = 69)	7	4	0	23 ^b	32	3	15	39
HIV- (n = 220)	14	10	1	9 ^b	33	3	7	44
Homa Bay, Kenya								
HIV+ (n = 62)	2	16	2	0	19	3	11	65
HIV- (n = 163)	4	12	4	1	21	1	5	69
Karatina, Kenya								
HIV+ (n = 37)	24	49	3	11 ^b	87	0	11	3
HIV- (n = 237)	17	47	11	1 ^b	77	5	9	8

^a Total modern method may be different than the sum of individual modern methods due to dual method use or rounding.

^b Statistically significant difference ($p < .01$).

Overall, similar levels of contraceptive use by HIV-positive and -negative women suggest that such factors as local norms about fertility control and the acceptability of contraception play a greater role than HIV status in determining contraceptive use.

Community members express different attitudes about childbearing by HIV-positive women.

HIV-positive women may not use family planning because they desire another pregnancy. A literature review of attitudes and practices about childbearing among HIV-positive women in sub-Saharan Africa revealed that they have powerful motivations to have children. Many of these cultures are pro-natalist and thus expect women to have children. Women themselves are motivated by the desire for love from children, and also because caring for children provides a reason for living. Moreover, children are often seen as a source of financial security. Within the context of HIV/AIDS, having children may be seen as affirming one’s health or avoiding a partner’s suspicions about HIV infection, driven

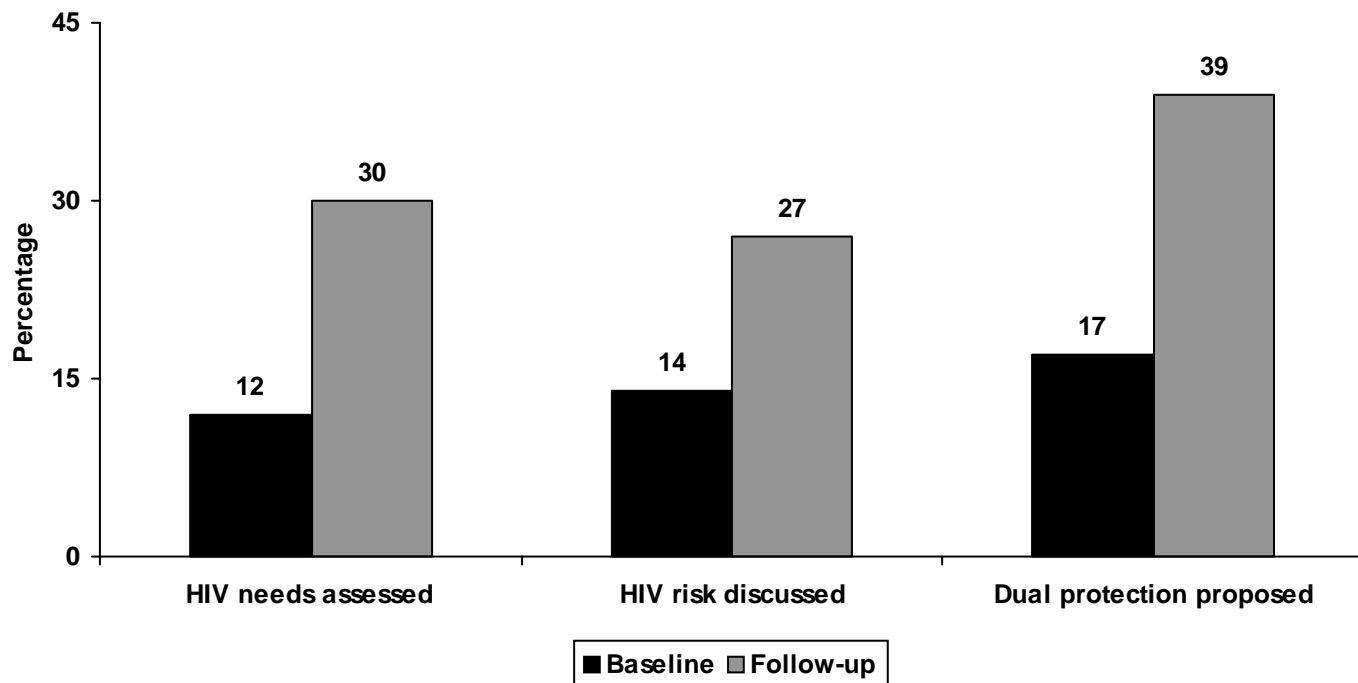
in some cases by fear of abandonment. It can also be a way to hide HIV status from the community or remain in denial (Rutenberg et al. 2003b).

During community focus group discussions in Zambia, some participants expressed pro-natalist views in light of PMTCT programs. They noted that PMTCT programs offer hope to HIV-positive couples who want to have children and that such programs would and should help parents have uninfected children.

“If a woman is HIV-positive and looks and feels healthy, then she can try having a baby.”

“Although family planning counseling is a good strategy of preventing mother-to-child transmission, the problem is if people were to use condoms all the time, there would be no children in the compound. So the drug [antiretrovirals for PMTCT] is giving hope to us HIV-positive individuals about the possibility of having healthy children. We must tell people not to use condoms but to go and access PMTCT in order for them to have children.”

Figure 2 Percent of observed family planning sessions in Uganda in which HIV issues are addressed



However, many individuals have witnessed children in their communities infected with HIV who fail to thrive and die or are orphaned. These experiences may offset pro-natalist views. Indeed, at the two sites in Kenya, the vast majority (roughly 80 percent of ANC women at baseline and follow-up) felt that HIV-infected couples should not have children. The overwhelming reason provided was that the children will be infected, then suffer and die. The second and third most mentioned reasons were that an HIV-infected woman's body would weaken during pregnancy, and that children of HIV-infected parents would become orphans. Of the small minority who felt that HIV-infected couples should bear children, most understood that interventions could reduce vertical transmission and/or that a child of an HIV-positive mother would not necessarily be infected.

Horizons conducts global operations research to improve HIV/AIDS prevention, care, and support programs. Horizons is implemented by the Population Council in partnership with the International Center for Research on Women (ICRW), the Program for Appropriate Technology in Health (PATH), the International HIV/AIDS Alliance, Tulane University, Family Health International, and Johns Hopkins University.

Availability of family planning services at PMTCT sites does not ensure integration of HIV and family planning messages.

During observations of family planning sessions at the six pilot sites in Zambia, the sessions were generally of good quality, with most providers exploring the client's reproductive health goals and explaining the advantages and disadvantages of various methods of family planning, as well as giving correct instruction in the family planning method selected or in use. However, there was little integration of HIV issues into family planning counseling. Among the 48 sessions observed, providers mentioned HIV transmission in only 12 sessions, HIV testing in nine sessions, and PMTCT in eight sessions. That the risk behaviors for HIV and pregnancy are the same was mentioned in 10 out of 48 sessions. Finally, providers brought up using condoms for dual protection against HIV and pregnancy in only 16 of 48 sessions observed.

There was also little integration of HIV issues in observations of family planning sessions in the two sites in Kenya despite the introduction of PMTCT. In Homa Bay, dual protection was discussed in 14 percent, 25 percent, and 10 percent of sessions for the three rounds of observation. In Karatina, dual protection was hardly mentioned, with less than 3 percent for all rounds. Providers improved significantly in informing clients that the risk behaviors for HIV and pregnancy are the same, yet by the third round this was brought up in less than half of the sessions in Homa Bay (43 percent), and just 16 percent in Karatina.

The low frequency of integrating HIV issues and exploring the potentially different needs of HIV-positive and HIV-negative women may be one factor contributing to the lack of difference in family planning practice relative to HIV status.

HIV issues can be integrated into family planning sessions.

Results from the Uganda study demonstrate that it is possible to increase integration of HIV issues into family planning sessions. In this intervention, family planning providers were trained to bring up HIV issues so that the specific needs of HIV-positive women, HIV-negative women, and those of unknown status could be addressed. Providers could then refer clients to such HIV services as VCT. Researchers observed more than 60 sessions. From the baseline observations conducted in 2000 to the follow-up observations in 2001, there was a dramatic increase in the percentage of family planning sessions where HIV needs were assessed, HIV risk was discussed, and dual protection was proposed (see Figure 2). Indeed, the percentage of sessions in which HIV needs were assessed more than doubled, as did the percentage of sessions in which the provider proposed dual protection.

Program Implications


Family planning services are being offered at PMTCT sites sometimes using the same workers who provide PMTCT services; however, there is considerable room for improvement. Programs should strive to eliminate missed opportunities to address client needs for both family planning and PMTCT. Group talks in the ANC/MCH setting should include information on how women can prevent mother-to-child transmission of HIV by avoiding unintended pregnancies.

Counseling sessions on family planning should be offered to more women, with better integration of HIV issues. During individual PMTCT contacts, staff should assess family planning preferences and discuss appropriate methods. Postpartum infant feeding counseling is another important chance to discuss family planning needs and methods. The PMTCT program should ensure that the counselors and mothers' groups that counsel and support women during their first few months of infant feeding also address the risks of pregnancy associated with the different infant feeding choices. Such counseling should also help women avoid closely spaced births that raise the health risk for themselves and their infants.

HIV-positive women need specific information and counseling to help them address health and sexuality concerns, as well as their reproductive needs and rights. Taking into consideration a woman's HIV status as well as her reproductive health goals may lead to more comprehensive family planning counseling and services.

Further operations research is needed at more sites to explore the family planning needs of women at PMTCT sites and the best way to meet these needs.

Finally, wherever women seek family planning services, health workers should give information

about the risk of HIV from unprotected intercourse, offer at least a referral to HIV counseling and testing, and promote dual protection from sexually transmitted infections and an unintended pregnancy. 

¹ The other three cornerstones are primary prevention of HIV infection in women, reducing transmission from HIV-infected pregnant and lactating women to their children, and care and support of women, infants, and families infected and affected by HIV/AIDS.

² These were the original 11 countries that began PMTCT interventions in 1999-2000. They include Botswana, Burundi, Honduras, India, Ivory Coast, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.

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