

Preventing Mother-to-Child HIV Transmission through Family Planning in Maternal and Child Health Services: Kenya, Rwanda, and South Africa

Family Planning

HIV/AIDS

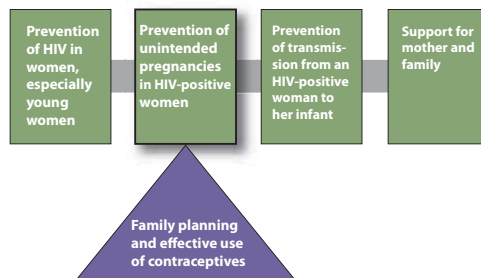
Key Points

- Study findings show unmet need for family planning among HIV-positive women and low provider readiness to provide family planning in maternal and child health services.
- Intention to use family planning is high but not accompanied by use in many clients. Those clients using methods primarily rely on condoms and injectables.
- Providers lack training in family planning, particularly in counseling HIV-positive women, and have misconceptions about appropriate methods for women with HIV.

Increasingly, countries are designing programs to prevent mother-to-child transmission (PMTCT) of HIV. These programs involve multiple strategies that focus on preventing the acquisition and transmission of HIV and supporting the needs of a woman and her family. The effective use of family planning (FP) plays an important role by preventing unintended pregnancies among women with HIV, thus reducing infant HIV infections and the number of children needing HIV treatment, care, and support. An FP intervention will also reduce the need for antiretroviral drugs for PMTCT.

Prevention of unintended pregnancies among HIV-positive women through FP is one of the four essential elements (see Figure 1) in a comprehensive PMTCT approach endorsed by global health leaders.¹⁻³

Figure 1. Comprehensive PMTCT Approach



Between 2007 and 2009, FHI undertook three studies of PMTCT services in Kenya, Rwanda, and South Africa.⁴⁻⁶ Researchers considered whether HIV-positive pregnant and recently postpartum women with unmet contraceptive need could be reached with FP services in facilities that offered antenatal care (ANC), postnatal care (PNC), and child welfare services* (CWS). They also assessed provider readiness to offer FP services.

Findings

While study methodologies varied slightly and the number of sites was low in some cases, finding similar situations in three unrelated settings underscores the common challenges in service integration. In each country, a sample of health facilities was purposively selected, with volume of PMTCT clients used as the primary selection criteria. All female clients interviewed were HIV-positive. (See Table 1, next page.)

High levels of unintended pregnancies.

Each of the studies documented high unmet need for contraceptive services among these clients. In Kenya, half of the women interviewed did not want their most recent pregnancy at the time it occurred. In Rwanda, between 50 percent and 60 percent of the respondents reported their most recent pregnancy was mistimed or unwanted. In South Africa, only 31 percent of women said that their most recent pregnancy was planned, and most did not want to have another child.

Low postpartum contraceptive use.

Consistent with the participants' reports of wanting to space or limit pregnancies, researchers found that the intention to use FP was high. The desire to avoid pregnancy, however, was not accompanied by contraceptive use in many clients. In Kenya, about 75 percent of women in PNC or CWS expressed interest in using a method in the future, and more than half had used a method in the past, but fewer than 25 percent of women intending to use a method were using one. In South Africa, nearly all of the women interviewed in ANC and delivery services said they intended to use a method, but researchers found that only about half the women reached in CHS had started to

* South Africa uses the term "child health services" (CHS).

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use a method. Of those women, few were using long-acting and permanent methods (LAPMs).

In contrast, postnatal FP use by PMTCT clients in Rwanda was high. But, despite a stated preference for LAPMs, very few women were using those methods, relying instead on condoms and injectables.

Lack of provider knowledge and training. While most providers in all three services state that they offer FP to their clients, study findings indicate that screening for unmet need and offering methods other than condoms is not being done consistently. Insufficiently trained providers are a major obstacle. In Rwanda, fewer than half of the providers of HIV services had been trained in FP, and only about one quarter had been trained in FP services specifically for HIV-positive women. Many of the South African providers lacked pre-service training in FP. Kenyan providers also lacked training in the particular FP needs of HIV-positive women.

Providers in all three countries evidenced widespread misconceptions about the safety of contraception for women living with HIV. Conservative attitudes about the health effects of contraceptives and biases or misconceptions about what methods are best for those clients result in inadequate FP messaging in ANC, PNC, and CWS. Many providers promote only condoms to HIV-positive women. Despite clients' expressed interest, LAPMs are neither promoted nor accessible.

Provision of FP in PMTCT services is also hampered by limits in the service delivery system. Most providers report their day as busy, but the majority of clients are served during the morning and the workload is considerably lighter later in the day. Reorganizing the flow of clients throughout the day may improve service provision. In some sites in South Africa, full privacy was not offered to clients, and there were few posters promoting integrated services.

Table 1. Number of Sites and Categories of Participants, by Country

Country	Number of sites	Category of participants
Kenya	10	<ul style="list-style-type: none"> ■ Providers ■ HIV-positive clients in ANC, PNC, CWS
Rwanda	30	<ul style="list-style-type: none"> ■ Providers ■ HIV-positive clients in ANC, PNC, CWS ■ Male partners
South Africa	6	<ul style="list-style-type: none"> ■ Providers ■ Managers ■ HIV-positive clients in ANC, PNC, CHS

Many providers do not recognize that preventing an unintended pregnancy through FP may prevent an HIV-positive birth. Just over half of the Kenyan and Rwandan providers agreed with the statement that “the use of family planning will prevent HIV-positive births.” Without strengthening this understanding, it will be difficult to strengthen FP interventions for PMTCT.

Conclusions

There is growing evidence of the unmet need for FP among women living with HIV. Offering FP counseling and services in ANC, PNC, and CWS provides ongoing opportunities to assess and address need at different life stages and contributes to the reduction of mother-to-child transmission by reducing subsequent unplanned pregnancies. To do so effectively, several actions could be taken:

- Promote the benefits of preventing unwanted pregnancies to PMTCT program managers.
- Offer FP counseling during ANC to inform women of appropriate postdelivery options.
- Equip providers to routinely screen PNC and CWS clients for their fertility intentions and unmet contraceptive need.
- Ensure that a full range of contraceptive methods, including LAPMs, are available on-site or through referrals at PMTCT services, particularly PNC or CWS.

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