Opportunities and Pitfalls in Integration of Family Planning and HIV Prevention Efforts in Developing Countries

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Recognizing that HIV/AIDS is a paramount health priority for virtually all the developing world, "integrating" HIV with existing services such as family planning is highly attractive. At first blush, it would seem that the same reproductive health arena that both interventions share should provide opportunities for integration. But the reality is far more complex. Our central proposition is that in the developing world, the family planning *clinic* arena—with its emphasis on providing contraceptive methods—is a weak platform to promote the behavior change so essential to HIV prevention. On the other hand, other elements of family planning programming that operate outside the clinic (though they support clinical services) often provide a strong platform for HIV prevention. At the same time, growing areas of HIV programming, such as Voluntary Counseling and Testing (VCT), Mother-to-Child Transmission (MTCT), and long-term Antiretroviral Therapy (ART) offer strong programmatic opportunities to fulfill the unmet need for family planning.

PRINCIPLES OF INTEGRATION

In both domestic and international settings, integrating two health interventions can often be appealing. After all, it seems like getting two good things for the price of one. However, integration is an operational issue. It must play out in a specific set of program activities in a specific place and time. In order to justify the inevitable process costs to bring about integration, it must fulfill certain basic requirements. First, the interventions being integrated should both be effective. Public health resources are too precious to be devoted to ineffective approaches. Second, the interventions need a common field of operation (e.g., within clinical services, mass media behavior change activities, or high-level policy making) as well as common target audiences. Third, there should be synergies between the two interventions (1+1=3) that enhance the impact of both. A good example of potentially effective integration is the provision of postpartum family planning services along with early childhood immunization. Both are proven cost-effective interventions, and the overlap in

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timing, providers, and service settings creates an excellent opportunity for saved efforts and synergy.

The fragility of health systems is a stark reality in the developing world. Health workers are all too often poorly paid and lack training, supervision, supplies, adequate facilities, and other support systems. In such situations, it pays to be judicious to the country context, and take care before adding yet more duties to the typically over-burdened primary health worker. Similarly, because the nature and stage of the HIV epidemic varies from place to place, prevention strategies must be adjusted accordingly.

BEHAVIOR CHANGE: THE *SINE QUA NON* OF HIV PREVENTION

To help significantly with HIV prevention, family planning efforts must support sexual behavior change. Current thinking, especially with respect to heterosexual transmission, supports a simultaneous "ABC" approach to behavior change: abstain, be faithful (or reduce number of partners), and use condoms.[1] Clearly, either abstinence or complete mutual monogamy are the only ways to avoid risk entirely, but are not realistic for everyone. Therefore, reducing partners and using condoms (especially with non-regular partners) are particularly important from an overall epidemiologic disease transmission perspective.

Evidence from the two most prominent HIV "success stories" in the developing world illustrates the importance of the ABC approach. Uganda has seen major declines from high HIV prevalence (especially among young women) through a reduction in number of sex partners, delayed age at sexual debut, and especially more recently, increased use of condoms with casual partners.[2] Thailand successfully reversed an early HIV epidemic through its "one hundred percent" condom distribution in brothels and a concomitant change in client behavior that reduced visits to brothels.[3] In these and other instances, a key element was an open, enlightened public policy environment that acknowledged the AIDS problem and recommended desired behavior (e.g., the "zero grazing" admonition in Uganda to stick to one partner).[4]

CLINIC VS. NON-CLINIC VENUES

Family planning program activities can typically be divided into two arenas. Because most contraception involves a product (such as oral contraceptives, IUDs, or sterilization), much of family planning programming relates to service delivery of such products. This is typically provided in clinics and often integrated with other maternal child health activities such as antenatal care and immunization.

On the other hand, many family planning activities, especially in the developing world, operate outside clinics. Examples include behavior change communication, efforts to promote policies favorable to family planning, non-clinical distribution of contraceptives, and youth activities designed to promote responsible decision-making.

In our view, the health clinic is generally a weak platform to bring about the behavior change so vital to HIV prevention. First, the fragility of typical clinical services is a serious constraint. Counseling for clinical health services is notoriously weak, continuation rates are poor, and contact with women is intermittent. Moreover, typical family planning clients are older-aged married women, who are generally the least likely to transmit HIV and are poorly empowered to negotiate condom use. For the most part, men (who play such a vital role in HIV transmission) are not involved in clinical family planning service delivery.

Instead, the most potent synergies lie in the family planning program "support" activities that occur outside the clinic. They are more effective for behavior change. For example, mass media or targeted community efforts through entities such as non-governmental organizations can promote both responsible family planning and HIV norms at the same time across a broad population. Similarly, activities aimed at youth can promote responsible sexual behavior that prevents both HIV transmission and unintended pregnancy (as well as promoting other healthy behaviors related to alcohol, violence, smoking, etc.) Also, efforts to convince policy makers to encourage the availability of family planning services and create an open environment for family planning can be expanded to address the stigma often attached to AIDS and make a case for a vocal, open approach to the AIDS problem.

A very prominent mode of family planning service delivery in the developing world, especially for condoms, is "social marketing," which includes support for sales of condoms—at subsidized prices—through commercial outlets such as pharmacies, shops, and stalls.[5] Social marketing typically includes vigorous promotion efforts through public media. Unlike clinical family planning services, these programs effectively reach men in large numbers. Such widespread non-clinical condom distribution can make condoms readily available for both contraception and HIV prevention. The accompanying media promotion can further encourage responsible sexual behavior.

THE STI TREATMENT PITFALL

Sexually transmitted infection (STI) treatment is one area that has offered promise against HIV. Epidemiologic evidence indicates that STIs, especially ulcerative ones, enhance HIV transmission.[6] And clearly, STIs represent a major health priority in their own right. However, recent community clinical treatment trials that failed to show an impact of STI treatment on HIV incidence have called into question the entire approach of STI treatment as a valid public health strategy against HIV.[7,8]

Moreover, the approach most widely promoted for treating STIs in primary health clinics in developing countries has been so-called syndromic management, which uses standard treatments for presenting syndromes rather than seeking a precise etiologic agent. This approach is technically sound for individual treatment of some syndromes, such as male urethral discharge. Unfortunately, syndromic management of vaginal discharge—the most common syndrome in the family planning context—appears technically unsound against cervical STIs and not programmatically feasible in such settings.[9,10] Relatively few women in general maternal-child health settings who have a vaginal discharge actually have gonorrhea or chlamydia, while many with those same diseases have no discharge. Drug costs and provider failure to follow treatment algorithms are other major problems. The future development of simpler, cheaper STI diagnostics would of course help. In the meantime, some evidence suggests that the ABC behavior change approach may be at least as effective against STDs as it is against HIV.[11]

PRUDENT CONDOM PROMOTION

Condoms are clearly important as contraception and are important for HIV prevention, especially when used with non-regular partners, among sex workers, and for sexually active young adults. However, condom promotion should support, not undermine, the A or B message. We know that when used correctly and consistently, condoms can prevent HIV transmission; however, condoms are often not used correctly and consistently.[12] Therefore, promotion of condoms must not create overconfidence or over-reliance on them, leading to riskier behaviors and thus increasing risk of transmission. In addition, the use of condoms for contraception has never been highly popular in the developing world, in part because it is often difficult for women to negotiate condom use with their partners. However, uninfected couples using effective contraception other than condoms can still be protected against HIV if they are consistently mutually monogamous.

FAMILY PLANNING INTEGRATION WITH NEW HIV PROGRAMS

As HIV programs such as Voluntary Counseling and Testing (VCT), Mother-to-Child Transmission (MTCT), and long-term antiretroviral therapy (ART) continue to grow and evolve, new opportunities for integration with family planning emerge. The HIV crisis in no way diminishes the high unmet need for family planning—to the contrary. Some HIV-positive women will want additional children, but for many others the desire for contraception may increase significantly. VCT has typically been provided in specialized VCT centers that offer both HIV testing and intensive counseling. Most clients are sexually active and of reproductive age. Thus, family planning counseling and provision of contraception (either directly or through referral) appear feasible and sensible. Likewise, family planning has an obvious role in preventing maternal-to-child transmission by providing HIV-positive women access to contraception. Moreover, for HIV-positive women who do become pregnant, MTCT clinic-based programs should include not only antiretroviral drugs but also access to postpartum services including contraception to prevent undesired repeat pregnancies. Lastly, in response to concerns about potential teratogenicity, World Health Organization (WHO) guidelines call for the availability of "effective and appropriate" contraceptive methods to women receiving ARTs.[13] Service delivery of ARTs is only now emerging in the developing world, but will likely follow a number of different models. Any of these will present opportunities to integrate family planning.

CONCLUSION

The struggle against HIV will continue to escalate. The unmet need for family planning will remain unabated. With our limited resources, we must avoid the pitfalls and build on evidence-based, effective interventions that provide opportunities for integration with real synergy for both family planning and HIV.

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