Opportunities to strengthen integration of family planning into HIV platforms to achieve the UNAIDS 2030 fast-track targets

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\textbf{Introduction}

Voluntary family planning (FP)\textsuperscript{1} has long been recognized as an essential service that enables individuals and couples to determine whether, when, and how often to have children. The HIV clinical cascade offers women of reproductive age (WRA) a continuous opportunity for integrated care and access to a wide range of voluntary FP services. Strengthening the integration of voluntary FP into HIV services could be particularly impactful for the health of women in sub-Saharan Africa, who experience a double burden of high HIV incidence and high rates of unintended pregnancy [1,2].

FP provides additional benefits of reducing vertical transmission of HIV [also known as prevention of mother-to-child transmission (PMTCT)] for people with HIV (PWH) or people at high risk of HIV acquisition and facilitating a safe pregnancy for PWH wanting to have children. Through the implementation of the Joint United Nations Programme on HIV/AIDS (UNAIDS) endorsed four-pronged PMTCT approach, along with Option B\textsuperscript{+} and now Treat All programming,\textsuperscript{3} it is clear that the expansion of maternal use of antiretroviral therapy (ART) coverage for pregnant and breastfeeding women (PBFW) living with HIV has contributed to a steady decline in new pediatric infections. FP is also a fundamental prong of this approach, helping to reduce the incidence of unintended pregnancies and support safer conception for PWH who wish to become pregnant in the future. Recent modeling emphasizes the critical role access to and use of voluntary contraception plays in achieving HIV epidemic control [3–5]. Estimates indicate that contraception services avert 43,559 new infant HIV infections annually across 70 countries, while preventing unintended pregnancies among women living with HIV

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\textsuperscript{1}Voluntarism and informed choice are the guiding principles of U.S. government-funded family planning programs. Under these principles, clients are offered, either directly or through referral, a broad range of methods and services. Throughout the article, family planning is understood to mean voluntary family planning.

\textsuperscript{2}Option B+ was a strategy recommended by the World Health Organization beginning in 2012 to prevent vertical transmission of HIV by offering pregnant women living with HIV immediate and lifelong access to antiretroviral therapy.

\textsuperscript{3}In 2016, the World Health Organization recommended initiating HIV treatment in all people diagnosed with HIV, regardless of clinical stage of the disease.

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Integrated services have been recognized as the future of care by global leaders of the HIV response, including PEPFAR [6]. Under the UNAIDS Fast-Track strategy to end the AIDS epidemic by 2030, the interim targets for 2025 outline a clear vision for holistic, integrated, client-centered HIV care. Paramount to achieving this vision is the understanding that we must keep “people living with HIV and communities at risk at the centre” of our programming [7]. Recognizing the critical contribution comprehensive HIV and sexual and reproductive health (SRH) services make to reaching epidemic control, the interim targets explicitly outline two new interrelated 95 targets: 95% of women access HIV and SRH services; and 95% coverage of services for eliminating vertical transmission. Additionally, the interim targets set a goal that 90% of PWH and people at risk of acquiring HIV are linked to people-centered and context-specific integrated services, further highlighting the importance of integration and stigma reduction. Additionally, under The Global Fund to Fight AIDS, Tuberculosis and Malaria’s strategy for Fighting Pandemics and Building a Healthier, More Equitable World, delivering “integrated, people-centered quality services” is outlined as a key step towards building resilient and sustainable systems for health [8].

Discussion

Achieving high-quality integration of FP into HIV platforms is a laudable goal; however, the on-the-ground realities in many USAID-supported health programs often expose potential barriers to achieving this target. Such barriers may include vertical funding streams for HIV, SRHR, and maternal child health (MCH); siloed technical area programming at ministries of health leading to a lack of cohesion; insufficient human resources for health and overburdened healthcare providers; logistical constraints at the level of health facilities; a lack of dedicated infrastructure for these services; and/or bottlenecks in the HIV or FP supply chains (personal communication, Kandyang Jansuk). With the ongoing COVID–19 pandemic, many of these barriers are magnified and highlight the continued need to scale up and strengthen quality, integrated services [9,10].

Acknowledging that implementation has been uneven across countries, here we highlight two USAID-supported countries that receive FP and HIV funding, South Sudan and Tanzania, and discuss opportunities for strengthened integration. We believe that strengthening integration of FP into the existing HIV platform could improve voluntary FP uptake and the health of the woman while simultaneously decreasing the rate of unintended pregnancies and, subsequently, incident vertical transmissions. Ultimately, strengthening FP integration into HIV platforms is a win-win that can improve both FP uptake and HIV outcomes.

In South Sudan, where FP uptake remains extremely low at 3%, the integration of FP education, counseling and short acting contraceptive method provision into the routine outreach activities of PWH peer Mother’s Groups can be a key opportunity to increase awareness and access to FP for pregnant and postpartum PWH. The “Mentor Mothers” groups in South Sudan provide home visits to PWH during the prenatal and postpartum periods to offer social support and to encourage the practice of healthy behaviors such as facility deliveries, infant immunizations and early infant diagnosis (EID) for HIV. Their peer-led, community-based efforts are an effective way to reach and support PWH. Integrating FP into their package of care may provide a unique opportunity to reach PWH with FP services outside of health facilities. This community-based support is especially useful in helping women to transition from the Lactational Amenorrhea Method (LAM) to an alternative contraceptive method. ART community groups can also provide FP support and services to PWH as part of care and treatment services, ART distribution, and/or community viral load testing activities. FP education and counseling/provision of short-acting methods can be offered by ART community workers and long-acting reversible contraception (LARC) can be offered through structured outreach/mobile clinic services.

It is critical to note that the use of voluntary FP services is influenced by a woman’s environment and the existing social, economic, legal, political, and cultural norms of the community in which she resides. Creating an enabling environment to address systemic and structural barriers that might limit FP access and uptake – such as those related to policy, health systems, financing, and leadership and management – is critical [11–14]. In Tanzania, FP integration into the HIV platform provides an opportunity to address structural and/or technical barriers to the provision of routine, high-quality FP services. For example, there is limited attention to immediate postpartum FP services in many settings due to a lack of demand creation efforts during the prenatal period and limited capacity for labor and delivery staff to counsel and provide immediate FP services. PMTCT staff can counsel PWH on FP during prenatal care and help prepare women who want postpartum FP to voice their desire prior to and immediately following their facility period and limited capacity for labor and delivery staff to counsel and provide immediate FP services. PMTCT staff who are trained to offer immediate FP provision can help expand options for postpartum women by collaborating with MNCH teams to ensure that women receive integrated information and services on HIV, maternal and newborn health, and family planning before they leave.
the health facility or during the home visit if there was a home based delivery.

Another important entry point in PMTCT services where FP can be integrated more effectively is during facility or community EID testing. Facility- or community-based PMTCT staff can provide counseling in postpartum FP options and offer contraceptives, if feasible. When provision of contraceptives is not feasible due to policy, capacity, time constraints, or other challenges, PWH can be referred to FP service providers.

Conclusions

Delivering client-centered, high-quality HIV and SRH care is necessary to achieve HIV epidemic control and reduce the unmet need for FP. Specifically, minimizing missed opportunities to strengthen integration of voluntary FP services across the PMTCT cascade during pregnancy and postpartum can help reduce unintended pregnancies, keep women healthy, and also prevent vertical infections. Though only two countries were highlighted in our discussion, similar challenges exist in other countries as well, and our recommendations can be extrapolated to those settings, making necessary adjustments for the country context.

National ministries of health, policymakers, donors, and program implementers should work to strengthen integration by identifying and resolving service delivery gaps that prevent FP uptake at all HIV entry points. Further, PMTCT health providers should be trained to support WLHIV and women at elevated risk of HIV infection to speak openly about their reproductive intentions and desires; to assist them in making informed decisions regarding future childbearing and pregnancy prevention; and to provide contraceptive counseling, methods, and referrals, when appropriate. Finally, communities should be engaged as active participants in the design, delivery, and assessment of FP and HIV integrated services to ensure the comprehensive needs of WLHIV and women at risk of HIV acquisition are met, and to support health systems to operate in the most effective, equitable, and responsive way possible [15].

We invite all relevant stakeholders to commit to advancing this agenda to ensure that 95% of WRA have access to comprehensive HIV and SRH services throughout their reproductive life cycle by 2025 to achieve the UNAIDS interim targets. Implementation of these recommendations will not only promote woman-centered service delivery, but can make a real impact towards promoting healthy women, eliminating vertical transmission, and reaching HIV epidemic control.

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Conflicts of interest

There are no conflicts of interest.

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