BRIEF REPORT

Without Strong Integration of Family Planning into PMTCT Services in Rwanda, Clients Remain with a High Unmet Need for Effective Family Planning

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Introduction

In 2008, about 33.4 million people were estimated to be living with HIV worldwide, including about 15.7 million women and 2.1 million children under the age of 15.[1] The majority of new infections in children occur as a result of vertical transmission, either in the course of pregnancy, during labour, or through breastfeeding. The risk of mother to child transmission can be reduced from 15-45 percent to less than 2 percent with highly active antiretroviral therapy which, along with the practice of delivering babies of HIV-positive mothers by elective Caesarean section and bottle feeding, has effectively eliminated vertical transmission in high-income countries.[2-4]

Prevention of unintended pregnancies and adequate birth spacing among HIV-positive women have been shown to be cost-effective and essential components of a comprehensive approach to prevention of mother to child transmission (PMTCT).[5-7] However, low-income countries that have implemented PMTCT programs have tended to focus almost entirely on delivery of antiretrovirals, and have neglected measures to reduce the rate of unintended pregnancies among HIV-positive women. This practice has been attributed to factors such as funding exigencies created by spending limitations placed on the purchase of contraceptives, lack of clear policy and operational guidance on how prevention of unintended pregnancies should be implemented in the context of PMTCT and within the framework of national HIV prevention programs, as well as stigma directed towards HIV-positive clients seeking reproductive health care services.[8]

In Rwanda, along with a continuing need for FP services, there is a generalised HIV epidemic, with 3 percent prevalence in the general population and 4.3 percent prevalence among pregnant women. Recognising the importance of the role of FP in the HIV response, the government initiated family planning-HIV (FP-HIV) integration in 2007, linking FP to PMTCT services. At the request of Rwanda's National Committee for the Fight against AIDS and the Ministry of Health, a situation analysis of family planning-PMTCT (FP-PMTCT) integration was conducted in 2008 with the goal of providing information to improve integrated services and to optimise the potential for scale-up.[9] This brief provides a report on two of the study objectives, focusing on HIV-positive women and their service providers: (1) to determine the need for family planning services among PMTCT clients after birth and (2) to describe the readiness of antenatal and postnatal service providers to offer FP.

Methods

A comprehensive database of PMTCT sites maintained by TRAC Plus (Center for Treatment on Research on AIDS, Malaria, Tuberculosis and other Epidemics), was used to purposively select eligible health facilities based on daily client volume in PMTCT services; number of HIV-infected women enrolled in PMTCT services; geographic distribution; and whether they were public or faith-based facilities. Thirty health facilities with integrated services in 15 administrative districts were selected, representing approximately 10 percent of the total number of health facilities with PMTCT services in the country. Within each facility, all managers and providers of antenatal care (ANC) and postnatal care (PNC), as well as female clients aged 18-45 years who came to receive ANC/PNC, agreed to participate. In all, 34 health professionals, 84 ANC clients, and 120 PNC clients were interviewed.

Interviews were conducted by trained research assistants using a pre-tested, structured questionnaire administered in the local language,

Kinyarwanda. Data collection was carried out in November 2008. The need for family planning among PMTCT clients after birth was calculated by considering current contraceptive use, desire for pregnancy, self-report of fecundity (return of menses) and resumed sexual activity post-pregnancy.

Ethical approval to conduct the study was granted by the Protection of Human Subjects Committee of Family Health International (FHI) and the Rwanda National Ethics Committee. Participating providers and managers gave informed oral consent, while clients gave informed written consent.

Data were entered into EpiInfo 6.04d, and analysed with SAS version 9.1. Descriptive statistics were calculated. Providers and managers were merged into a single group because of small numbers.

Results

Unmet need for FP among PNC clients was 12 percent; 20 percent of women were identified as having no current need based on calculations described above and 68 percent as currently using FP. Of FP users, 43 percent said they were using male condoms as their contraceptive method, but use was inconsistent. Nearly all ANC clients (90 percent) expressed a desire not to have children in the future, with 49 percent indicating a preference for sterilization and 35 percent a preference for implant postpartum. Among the PNC clients using FP, only 5 percent were using long-acting or permanent methods. A majority (69 percent) of PNC clients and 48 percent of ANC clients reported that their most recent pregnancy was either mistimed or unwanted. Women who were found to have no current need for FP gave the following reasons: husband away or deceased; pregnancy-related; or against religion.

Most providers (80 percent) reported that they raised the topic of FP with their clients and referred those who expressed a need to the FP clinic. However, only a few clients reported that their providers discussed their desire for children in the future (30 percent ANC, 15 percent PNC), referred them for FP services (5 percent ANC, 12 percent PNC), or gave them a FP method (7 percent ANC, 12 percent PNC). Analysis of provider attitudes regarding FP and HIV revealed that while providers were opposed to an HIV-negative woman being sterilised if she had no living children (88 percent), they were in favour of an HIV-positive woman undergoing tubal ligation (91 percent).

Discussion

For many women, pregnancy and child care constitute the two main reasons they come into contact with the health system. This contact provides an excellent opportunity for delivering PMTCT interventions and engaging women in a comprehensive continuum of HIV prevention, care, and treatment services during pregnancy, the puerperium, and thereafter.

The reasons given by women in PNC for not needing contraception do not suggest abstinence, and thus, such women may be engaging in unprotected intercourse and be vulnerable to unwanted pregnancies and sexually transmitted infections. When calculating the need for family planning among PMTCT clients after birth, questions about the age of the child or the breastfeeding status of women were not included, which may have contributed to an underestimate of unmet need. Supporting this idea is the fact that many women in ANC and PNC reported mistimed or unwanted pregnancies.

The discrepancy between the number of providers who said they discuss FP with their clients and client reports that providers seldom raise the issue of FP is striking and suggests that providers might benefit from further training in communication skills and FP.

Provider attitudes indicate that the reason they favour FP is not to help HIV-infected women make informed choices about birth spacing and limiting but simply to encourage them not to have children at all. This attitude seems to reflect a tension between prioritising public health, which emphasises prevention of pregnancies, and protecting women's reproductive rights, which advocates for a woman's right to choose her future reproduction, as described in Rutenberg and Baek's analysis of varied field experiences integrating FP into PMTCT programs.[10] They observed that in the Dominican Republic, India, and Thailand, HIV-positive women are routinely offered sterilisation, and most women accept.

We suggest that a balance between these two perspectives could be achieved through a service that has better linkages between FP and maternal health services, as well as better linkages between ANC and PNC. We envisage a situation where a woman seeks medical advice prior to her next conception so that provider and client could work together towards her optimal health (reduced viral load, increased CD4 count, no opportunistic infections). For those women who do not wish to become pregnant, providers must be able to discuss feasible, safe, and effective contraceptive options. As in traditional FP programmes, informed-choice counselling must be the cornerstone of

contraceptive services in HIV-service delivery settings. Care must be taken to ensure that HIV-infected women are not coerced into a particular reproductive decision as they, like all women, have the right to make informed reproductive choices for themselves.

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