

# U.S. HIV/AIDS and Family Planning/Reproductive Health Assistance: A Growing Disparity Within PEPFAR Focus Countries

## HIV Prevalence Rates and Unmet Need for Family Planning and Reproductive Health Care

Since the implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2004, U.S. foreign assistance to fight HIV/AIDS has laudably increased in the program's fifteen focus countries in Africa, the Caribbean and Asia.<sup>1</sup> This commitment to the prevention, care and treatment of HIV/AIDS is welcome, as over 33 million individuals are currently living with the disease worldwide, and 2.5 million more are infected each year.<sup>2</sup> However, people living with and affected by HIV face many economic, social and psychological needs that are not met directly through PEPFAR. Women face the risk of unintended pregnancy and the need for access to family planning remains high in most PEPFAR countries.

## PEPFAR Acknowledges the Need for Family Planning and Reproductive Health Care

In their most recent report to Congress, the Office of the Global AIDS Coordinator (OGAC) espouses the importance of voluntary family planning and reproductive health (FP/RH) programs in preventing HIV among vulnerable populations; supporting people living with HIV/AIDS; preventing mother-to-child transmission of HIV; and preventing HIV transmission within discordant couples (couples in which one partner is HIV-positive, while the other remains HIV-negative).<sup>3</sup> This policy support acknowledges that FP/RH services provide opportunities to educate women about HIV prevention, including the correct use of male and female condoms – the only technologies currently available to prevent HIV. Further, many women living with HIV want to limit or space their childbearing. Providing these women with FP/RH care and contraceptive supplies improves their health and lowers the risk of mother-to-child HIV transmission. OGAC expects important programs like FP/RH to be funded through “wrap around” funding – in other words, funding for programs that are beneficial for people living with and affected by HIV and AIDS, such as nutrition and family planning/reproductive health, but which cannot be funded directly by PEPFAR due to PEPFAR policy restrictions.

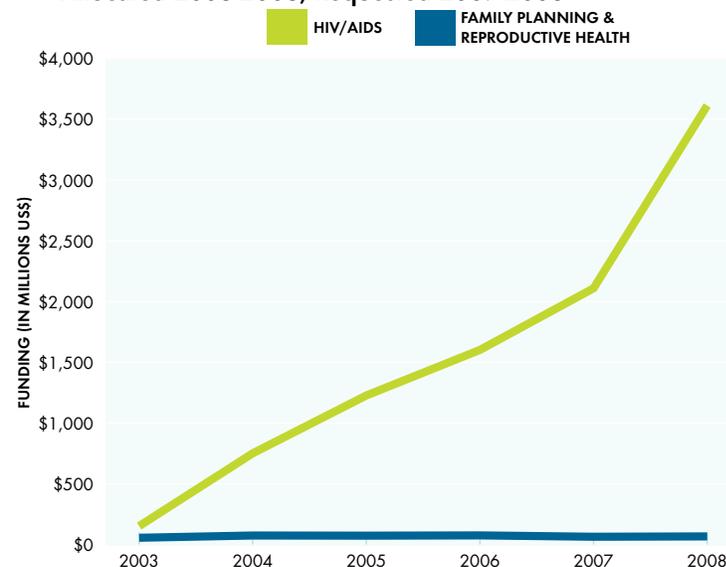
## Funding for HIV/AIDS Grows while Funding for FP/RH Falls

A common misperception about “wrap around” programs is that as funding for PEPFAR has grown, so too has funding for these programs. In reality, support for FP and RH programs – wrap around programs acknowledged by OGAC as critical to ensure their own health and the health of their families, as well as to the success of HIV programs – has stagnated.

As seen in Figure 1, the President's funding request for HIV programs in the 15 focus countries increased 225 percent in just two years over the 2006 allocated level. However, the

funding request for family planning and reproductive health fell by 11 percent. Further, the sheer scale of HIV funding in the focus countries (\$3.6 billion requested for 2008), dwarfs FP/RH funding (\$67.5 million requested for 2008, less than 2 percent the amount requested for HIV programming).

Figure 1: U.S. FP/RH and HIV Funding for Focus Countries, Allocated 2003-2006, Requested 2007-2008



## U.S. HIV/AIDS and FP/RH Policies and Funding Constraints

U.S. funding for both FP/RH and HIV/AIDS come with distinct restrictions that limit each program's effectiveness. With regards to FP/RH, the Mexico City Policy/Global Gag Rule (GGR) denies foreign organizations receiving U.S. FP/RH assistance the right to use their own non-U.S. funds to provide legal abortion, to counsel or refer for abortion, or lobby for the legalization of abortion in their country. Fortunately, the GGR does not apply to PEPFAR funds. With regards to HIV/AIDS funding, the “abstinence-until-marriage” earmark in PEPFAR requires one-third of all prevention funding (just 20% of all U.S. HIV/AIDS funding) to promote abstinence as the lead HIV prevention strategy. The “Loyalty Oath/Prostitution Pledge” requires all groups receiving PEPFAR funds sign a pledge opposing prostitution. Combining FP/RH and HIV/AIDS funding for programs on the ground risks extending all of the restrictions to both areas, further reducing effectiveness.<sup>4</sup> PEPFAR can only support condom use for individuals most at risk of transmitting or becoming infected with HIV, and cannot support other forms of contraception, despite their role in reducing HIV-infected births.<sup>5</sup> Despite these policy constraints, PEPFAR supports addressing the FP/RH needs of individuals through “wrap-around” programs, or linking to other services.<sup>6</sup> However, a successful wrap-around program is difficult when FP/RH programs are significantly overburdened and underfunded.

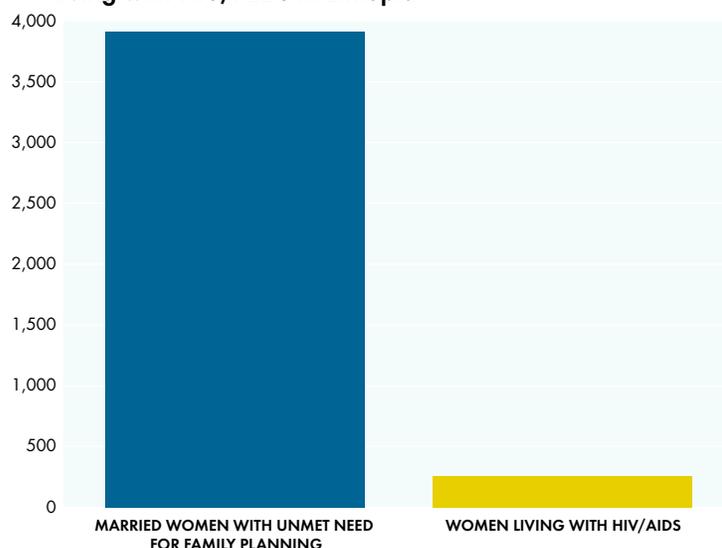
## Country-Level Perspectives

Nearly all of the 15 focus countries are experiencing a persistent need for, but a steady decline in, U.S. FP/RH assistance. The President has requested a decrease in FP/RH assistance in 10 of the 15 focus countries and a minimal increase in only one focus country – Rwanda. Four focus countries receive no FP/RH assistance. The 2008 Congressional Budget Justification stated that the reductions in FP/RH funding were due to low requests from the USAID country missions, citing the 40 year decline in fertility rates around the world. However, all 11 focus countries receiving FP/RH assistance have high fertility rates, and many also have high unmet need for contraception.

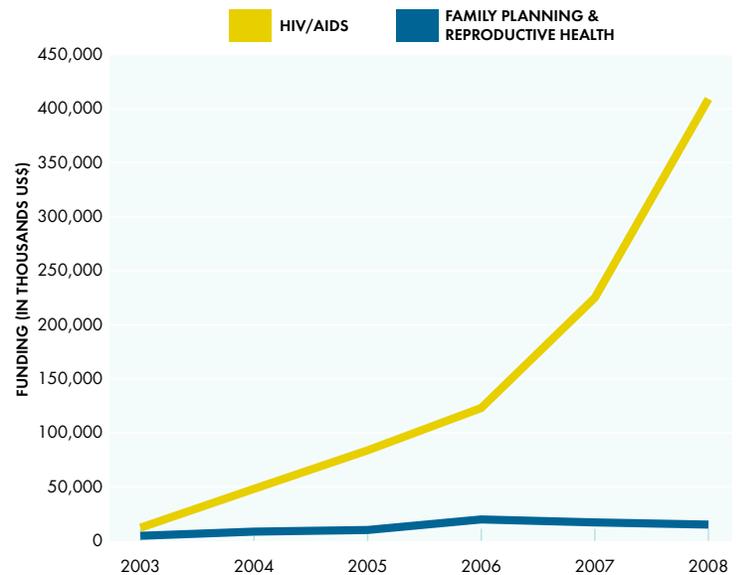
For example, Ethiopia saw a 24 percent drop in FP/RH funding between the 2006 allocation and 2008 request. Yet, the average Ethiopian woman will give birth 5.4 times in her lifetime, and 33.4 percent of married women have an unmet need for contraception – they wish to limit or space child-bearing, but are not using contraception (see Figure 2).<sup>7</sup> The 2008 request for FP/RH funding in Ethiopia is \$15 million. In contrast, the 2008 request for HIV/AIDS is \$409 million to address Ethiopia’s epidemic, estimated at 1.4 % prevalence (see figure 3).<sup>8</sup>

While the number of women living with HIV is high in Ethiopia, the number of women with unmet need is significantly higher, although these groups are not mutually exclusive (evidence shows that unmet need for contraception is common among women living with HIV/AIDS).<sup>9</sup> Far more FP/RH funding is needed to help women meet their reproductive intentions in order to promote the wellbeing and rights of Ethiopian women, regardless of HIV status.

**Figure 2: Married women with unmet need for FP and women living with HIV/AIDS in Ethiopia<sup>10</sup>**

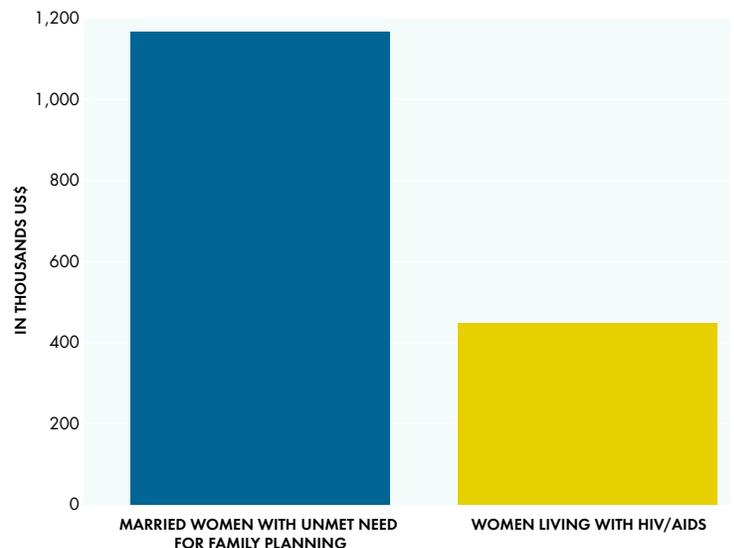


**Figure 3: U.S. FP/RH and HIV Funding for Ethiopia, Allocated 2003-2006, Requested 2007-2008**

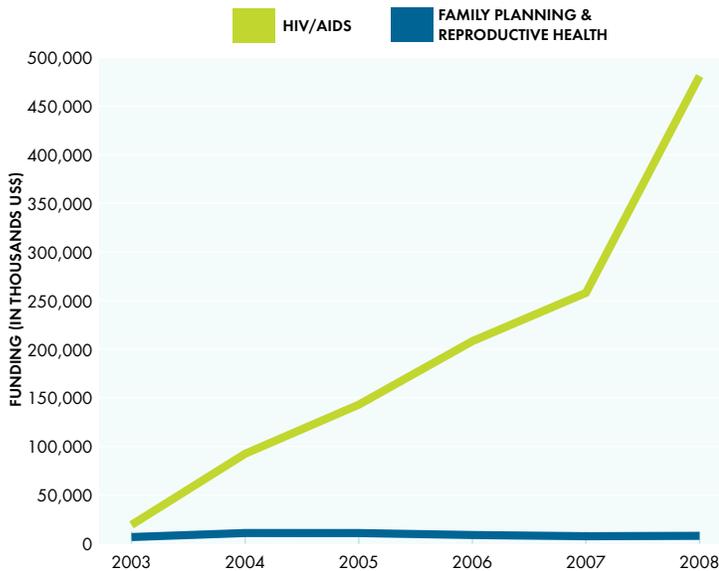


Kenya has also experienced a decline in FP/RH funding and currently has an unmet need for contraception of 24.5 percent.<sup>11</sup> While the Kenyan fertility rate has fallen significantly from 6.7 in 1989,<sup>12</sup> it recently increased from 4.7 in 1998 to 4.9 in 2003, a seemingly small but significant setback.<sup>13</sup> Had Kenya’s fertility rate continued its downward trajectory, the country’s population would have been 44 million in 2050, instead of 83 million currently projected, even assuming future declines in fertility.<sup>14</sup> The 2008 funding request to meet FP/RH demand in Kenya is \$7.7 million. In stark contrast, \$481 million has been requested to combat Kenya’s 5% prevalence HIV/AIDS epidemic<sup>15</sup> – a sum that exceeds the entire annual U.S. FP/RH budget globally (see figure 5).

**Figure 4: Married women with unmet need for FP in Kenya, and women living with HIV/AIDS in Kenya<sup>16</sup>**



**Figure 5: U.S. FP/RH and HIV Funding for Kenya, Allocated 2003-2006, Requested 2007-2008**



### Summary

Voluntary FP/RH programs, a proven successful intervention long supported by the U.S. government, is critical to the health and well being of women, children and families around the world, and is an acknowledged key component to the success of HIV prevention, care and treatment programs. Dangerously low and declining support for family planning, compounded by restrictive policies, jeopardizes gains in women's health, poverty reduction, and undermines the major investments attempting to curb the spread and impact of HIV/AIDS. To enhance PEPFAR's successes to date and ensure its sustainability in the future, improved funding for and coordination with FP/RH programs is paramount.

### Key Actions

- Substantially increase U.S. funding for international family planning and reproductive health to improve HIV prevention efforts for women and their children, and to reduce unintended pregnancies, especially among HIV-positive women.
- Remove policy restrictions, including the Global Gag Rule, the "abstinence earmark" and the "loyalty oath," which greatly limit access to the best available HIV/AIDS and FP/RH services for women and their families.

### Notes on methodology:

Funding amounts for fiscal years 2003 through the FY 2008 request are not completely comparable but do provide information on country funding trends over the time period. FY 2003-2004 data for FP/RH are expenditure levels derived from the USAID document *Agency-Wide Expenditures in Global Health, FY 2004* published in August 2005 – the latest version available, and is also the source for HIV/AIDS funding levels for 2003. FY2005-2006 data for FP/RH are expenditure

levels derived from USAID's Congressional Budget Justification (CBJ) documents – FY 2005 figures are drawn from the FY 2007 CBJ; FY 2006 figures from the FY 2008 CBJ. FY 2004-2006 data for HIV/AIDS are expenditure levels derived from OGAC's *The Power of Partnerships: Third Annual Report to Congress on PEPFAR (2007)*. FY 2007-2008 data for both HIV/AIDS and FP/RH are request levels derived from the 2007 and 2008 USAID CBJs.

### Sources

- 1 Focus countries include Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia in Africa; Guyana and Haiti in Latin America; and Vietnam in Asia.
- 2 Joint United Nations Programme on HIV/AIDS (UNAIDS). 2007. *2007 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.
- 3 Office of the Global AIDS Coordinator (OGAC). 2007. *The Power of Partnerships: Third Annual Report to Congress on PEPFAR (2007)*. Available online at <http://www.pepfar.gov/press/c21604.htm>; last accessed 30 October 2007.
- 4 [http://www.populationaction.org/Press\\_Room/Viewpoints\\_and\\_Statements/2007/05\\_14\\_Integration2.shtml](http://www.populationaction.org/Press_Room/Viewpoints_and_Statements/2007/05_14_Integration2.shtml)
- 5 Office of the Global AIDS Coordinator (OGAC). 2007. *The Power of Partnerships: Third Annual Report to Congress on PEPFAR (2007)*. Available online at <http://www.pepfar.gov/press/c21604.htm>; last accessed 30 October 2007.
- 6 Ibid.
- 7 Central Statistical Agency [Ethiopia] and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.
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- 9 Catherine Richey and Vidya Setty. 2007. "Supporting the Reproductive Decision of Women with HIV." *Population Reports*. Series L, Number 15: pgs. 3-9.
- 10 Central Statistical Agency [Ethiopia] and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro; Joint United Nations Programme on HIV/AIDS (UNAIDS). 2007. *2007 Report on the Global AIDS Epidemic*. Geneva: UNAIDS; United Nations Population Division. 2007: UNAIDS; United Nations Population Division. 2007. *World Population Prospects: The 2006 Revision*. New York: United Nations Population Division.
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- 12 National Council for Population and Development (NCPD), Central Bureau of Statistics (CBS) (Office of the Vice President and Ministry of Planning and National Development) [Kenya], and Macro International Inc. (MI). 1989. *Kenya Demographic and Health Survey 1989*. Calverton, Maryland: NDPD, CBS, and MI.
- 13 Ibid.
- 14 John Cleland and S. Bernstein et al. 2006. "Family planning: the unfinished agenda." *The Lancet*, 368(9549): 1810-1827.
- 15 Joint United Nations Programme on HIV/AIDS (UNAIDS). 2007. *2007 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.
- 16 Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH, and ORC Macro; and Joint United Nations Programme on HIV/AIDS (UNAIDS). 2007. *2007 Report on the Global AIDS Epidemic*. Geneva: UNAIDS; United Nations Population Division. 2007; UN Population Division, *World Population Prospects: The 2006 Revision Population Database*.