

The Role of Reproductive Health Providers in Preventing HIV

Reproductive health providers serve millions of women in developing countries now at the center of the global HIV pandemic and are increasingly reaching out to young people and to men. As such, they are poised to play an important role in reducing the incidence of new HIV infections over the coming years. Policymakers, donors, researchers and activists should recognize the benefits of supporting the fuller integration of HIV prevention efforts with reproductive health services.

Fueled by the development of relatively effective antiretroviral therapies, providing treatment for those living with HIV and AIDS is now a major focus of global efforts to combat the pandemic. But AIDS experts warn that long-term success will require the simultaneous expansion of prevention efforts alongside care and treatment. In the absence of stepped-up prevention efforts to check the spread of the virus, treatment services will be unable to keep pace with the number of people who will need them.

To date, only a fraction of the people at risk of HIV exposure in low- and middle-income developing countries have meaningful access to basic prevention services, according to a survey conducted by the POLICY Project for the U.S. Agency for International Development (USAID) of 73 countries with more than 10,000 people living with HIV in 2003. The survey found that in these countries, only about one in

10 pregnant women had been offered HIV counseling and testing, antiretroviral therapy to prevent mother-to-child transmission or counseling on breastfeeding options. An even smaller proportion of 15–49-year-olds had had access to counseling and testing. The POLICY Project estimates that the annual need for testing is 12–14% of the general adult population in these countries, yet less than 0.2% of adults aged 15–49 were tested in 2003.

By virtue of their experience in providing a range of services—including, sometimes, HIV services—to millions of women in developing countries, reproductive health service providers could make a significant contribution in closing the gap in HIV prevention. This analysis discusses the capacity of these providers to more fully integrate HIV-related activities into their service set and the benefits that would accrue, as well as the benefits of integrating reproductive health services into HIV programs.

A READY INFRASTRUCTURE

Over the last three decades, donors and governments have invested heavily in reproductive health services,* reaching millions of women who are now at the center of the HIV pandemic. By 2003, women accounted for nearly half of all adults living with HIV worldwide—and almost six in 10 (57%) in Sub-Saharan Africa. Though reproductive health providers in developing countries largely serve married women, many of these women are at increased risk of infection by virtue of being married. Unprotected sex with a nonmonogamous husband increases a woman's likelihood of being exposed to HIV. Indeed, married women in the world's poorest countries often possess less power than do unmarried women to negotiate whether to have sex and under what conditions, and whether to use condoms.

Many women come into contact with the health care system seeking reproductive

*Reproductive health services comprise a range of women's health interventions, often provided under the rubric of maternal and child health care—which, itself, can be substantially integrated into primary health care. These interventions include family planning information, education and communication; contraceptive counseling and provision of contraceptives; basic screening of sexually transmitted infections; prenatal or newborn care; and breastfeeding support.

†HIV prevention services include public education, such as through mass media campaigns; behavior change communication; risk-reduction counseling; condom provision; HIV counseling and testing; diagnosis, referral for and treatment of sexually transmitted infections; and activities to prevent mother-to-child transmission of HIV, such as antiretroviral therapy and counseling on breastfeeding options.

health services, either within clinical settings or through community-based distribution programs, and these points of contact are opportunities to reach women with HIV prevention information and services.[†] Some 500 million women in developing countries use a modern contraceptive method. In addition, the majority of pregnant women make at least one visit for prenatal care during pregnancy, and a significant proportion of women make at least one postnatal clinic visit.

The Program of Action agreed to by more than 180 countries at the 1994 International Conference on Population and Development articulated a dramatically new approach to population issues. Under the rubric of sexual and reproductive health, it called for an expansion of services in three ways that are of direct relevance and importance to HIV prevention: to move beyond a narrow focus on fertility control to include the identification and treatment of sexually transmitted infections (STIs); to acknowledge and address the sexual and reproductive health needs of adolescents; and to reach out to men. The Program of Action also recognized the emergence of the HIV pandemic.

In the last decade, progress has been made on all three fronts. Prior to the 1990s, STIs were viewed primarily as conditions affecting men rather than women, with most services being provided through a small number of specialized clinics at hospitals. Reproductive health providers have made deliberate attempts over the last decade to add STI management to their existing services. Recognizing

that the majority of young people have had sex by age 20 and are at high risk of HIV, other STIs and unwanted pregnancy, many reproductive health providers are working to build programs where young people feel supported as clients and where their confidentiality will be protected (see box). Moreover, there has been a growing awareness of the importance of devising innovative strategies to attract men to clinics—both as partners of women and in their own right.

Finally, reproductive health providers, to a considerable extent, already have the counseling and educational skills needed to offer HIV prevention information. Indeed, they are sometimes the only professionals in a position to have a dialogue with clients about sex and the risks of unsafe sex. Some already provide HIV counseling and testing, and have undertaken community-based HIV communications campaigns with apparent success. Many of the challenges facing HIV prevention, including compliance over the long term, are not new to the reproductive health community, and there are overlapping techniques and principles about which the HIV community could learn.

STEPPING UP PREVENTION

Providers of reproductive health services have the knowledge and skills that form a solid basis upon which stepped-up interventions for HIV prevention can be built. Although there are many things that providers can do, they can begin by emphasizing HIV counseling and testing, condom promotion, management of other STIs, and

contraceptive services as HIV prevention.

HIV counseling and testing, and condom promotion. To meet the ambitious goals of the “3 by 5 Initiative”—a global effort to provide three million people living in developing countries with antiretroviral therapies by 2005—developing countries will need to expand the number of service sites at which HIV counseling and testing are offered. In this regard, reproductive health service providers may offer certain advantages over free-standing HIV testing centers, in

that many women may be more receptive to HIV counseling and testing where the services are to some extent “camouflaged” and integrated with services that woman use anyway.

Condom promotion, of course, is an integral component of HIV counseling—and here, too, reproductive health providers can make a critical contribution. Indeed, whether within or outside the context of HIV counseling and testing programs, many reproductive health providers already incorporate condom promotion as

Meeting the Needs of Young People: Challenges and Lessons Learned

Youth in many developing countries are at high risk of STIs and HIV, as well as unwanted pregnancy, yet many do not have access to health clinic services. Some young people have to travel long distances, do not have transportation or avoid seeking care because they feel unwelcome, embarrassed or apprehensive about having their parents or others in the community find out they have had sex. In an attempt to reduce these barriers, reproductive health providers have undertaken initiatives to make their services “youth friendly.” In a 2003 article published in the *Journal of Adolescent Health*, Ilene Speizer reviewed and synthesized the emerging body of evidence on the effectiveness of these programs, to understand better “what works” in the developing world. The available evidence suggests that youth-friendly service programs work best when paired with other efforts aimed at changing community attitudes about young people’s sexuality and the risks they face. Youth-friendly services that have been simply added on to existing programs had little impact on service utilization by youth.

The Promotion of Youth Responsibility Project in Zimbabwe, for example, consisted of a six-month multimedia campaign directed toward young people and training health care providers in interpersonal communication and youth counseling skills. An evaluation of the project found that youth in campaign sites were more likely than youth in comparison sites to abstain from sex, have fewer recent sexual partners, and use contraceptives and clinic services. The campaign had the greatest impact on clinic attendance among some of the groups least likely to seek services: male, single and sexually inexperienced youth.

Another evaluation compared three youth-friendly pilot projects in Zambia. In each, peer educators and health care providers were trained; two of the projects included a community outreach component designed to increase the project’s reach in the community. The study found no relationship between the degree of clinic youth-friendliness and trends in service utilization. Instead, utilization was more closely related to community attitudes toward the provision of services to youth. Based on these findings, Speizer concludes that more must be done in the way of community outreach for facility-based services or, alternatively, finding more socially acceptable ways of providing these services. “In view of the critical role that STI testing and HIV voluntary counseling and testing (VCT) are likely to play in helping to contain the HIV/AIDS epidemic in the developing world,” Speizer writes, “finding ways to get these clinical services to youth is a high priority.”

part of counseling efforts about unsafe sex. They all should be going beyond this by including partners in the counseling and by encouraging couples to use condoms, even when the woman chooses another contraceptive method to protect against pregnancy.

STI management. Although preventing, diagnosing and treating STIs other than HIV are important goals in and of themselves, they are also essential components of an effective HIV prevention strategy. Other STIs, especially those that cause ulcers, dramatically increase the risk of HIV transmission through unprotected sex. Despite strong advocacy in favor of integration, however, the introduction of STI prevention, diagnostic and treatment services into reproductive health services has proved to be difficult, and STI service provision at the country level remains disjointed and disorganized. There are many reasons for this, not the least of which is the fact that not enough resources have been put toward integration. The delivery of quality services depends on skilled clinical personnel, diagnostic tests and adequate drug supplies that are expensive and often beyond the resources of many developing countries.

Nevertheless, public health experts agree that, given the scale of the HIV pandemic, efforts to control the spread of other STIs need to be significantly scaled up. A comprehensive review commissioned by the World Health Organization found that efforts to add STI services to preexisting family planning services have increased user satisfaction, improved provider

attitudes and counseling skills and, in some cases, increased condom distribution. Providers of reproductive health services can play a key role in offering lower cost interventions, such as education, counseling and condom promotion, which can more easily be incorporated with family planning advice and community outreach activities. Providers who have the capacity—namely the skills, laboratory equipment and clinical supplies—should also diagnose and treat STIs, and those who do not should build relationships with services to which clients can be referred.

Pregnancy prevention as HIV prevention. In 2003, an estimated 630,000 infants worldwide became infected with HIV during their mother's pregnancy, labor and delivery, or as a result of breastfeeding. Many of these infections could be avoided by expanding access to a regimen to prevent mother-to-child transmission; however, progress so far has been slow. UNAIDS data from 2003, for example, shows that less than 1% of HIV-positive women in Burkina Faso, Ethiopia, Malawi, Nigeria and South Africa had access to such a regimen.

Voluntary contraceptive services to help HIV-positive women prevent unwanted pregnancies is now accepted as an integral component of programs to prevent mother-to-child transmission, and indeed, contraceptive services in and of themselves should be recognized as a significant contribution to the HIV prevention effort. Moreover, studies have repeatedly found that contraceptive use among HIV-positive

women who do not want to become pregnant is at least as cost-effective as reducing mother-to-child HIV transmission by using the antiretroviral drug nevirapine, regardless whether contraceptive services are offered within or outside formal programs.

MONEY AND SEX

Two persistent problems threaten to slow the integration of HIV and reproductive health services. First, providers are already hard-pressed to meet the worldwide need for contraceptive services. According to a joint report published in 2003 by The Alan Guttmacher Institute (AGI) and the United Nations Population Fund (UNFPA), about 200 million women have an "unmet need" for effective contraceptives. Nearly \$4 billion is needed immediately to provide these contraceptive services, and costs are only expected to escalate in the next decade as the largest generation of 10–19-year-olds in history comes of age. According to the United Nations, the number of women of reproductive age (15–49) is expected to grow by 17% worldwide between 2000 and 2015—and by 22% in developing regions. Unless donor funding increases immediately, there will be a serious shortfall of resources to meet the growing demand.

Thus, to include HIV prevention as part of its package of services, reproductive health providers require a larger family planning budget, access to dedicated HIV funds or both. Resources intended for preventing unwanted pregnancies should not be diverted to support HIV activities, if for no

other reason than because voluntary, high-risk pregnancy prevention is itself an important HIV prevention service.

The second major challenge for integration efforts has to do with social and cultural issues. Most societies are conflicted about sexuality in general and about expectations for adolescent behavior in particular, and some, including the United States, have responded to the HIV pandemic by focusing much of their prevention activities around promoting abstinence for unmarried people. Often this results in the exclusion of information about how people can use condoms to protect themselves. This approach ignores the reality that the majority of young men and women will become sexually active during their teens or soon thereafter—by choice or under such societal pressures as early marriage—and that many adults engage in sex outside of marriage.

Because many policymakers and even some donors may not want to be perceived as promoting sexual activity among unmarried people, they may overlook the potential benefits of expanding the capacity of reproductive health providers to provide HIV prevention services, going so far as to deliberately keep reproductive health providers from receiving dedicated HIV funds. This is a serious mistake. More than 70% of infections worldwide occur as a result of heterosexual intercourse; in Sub-Saharan Africa, the proportion reaches 90%. Failure to realistically confront HIV as an STI is self-defeating. Not only is it an obstacle to innovation where integration is concerned,

it may also actually exacerbate the spread of HIV.

FUTURE DIRECTIONS

Despite its vast potential, integrating HIV prevention with reproductive health services is not a one-size-fits-all proposition. For example, reproductive health providers are unlikely to be the primary source for health services for men and thus not a logical entry point for HIV prevention services for them. In addition, greater levels of integration are most urgent in countries where population-wide prevalence is high and where HIV prevention depends on sustaining a broad range of safer sex behaviors across the general population. This is currently the case in almost every nation in Sub-Saharan Africa and in the Caribbean, and a few in Southeast Asia. In countries where prevalence is more concentrated and overall prevalence is low, targeted HIV prevention measures that address particularly vulnerable segments of the population (such as sex workers, men who have sex with men or migrant populations) may have more impact.

Moreover, integration is not a one-way street. To date, many HIV-related programs and policies in developing countries treat reproductive health and HIV services as separate and unrelated. A January 2004 POLICY Project analysis of 16 countries with high HIV prevalence rates found that, despite some attempts at integration, HIV policies seldom acknowledge or mention the role of family planning. Any reference to family planning is usually reserved for discussions about equipping reproductive health

providers with STI/HIV counseling facilities. Opportunities for integration in the other direction are rarely addressed.

Dedicated HIV prevention and, especially, HIV treatment providers need to address a range of reproductive health needs, either by referral or—whenever feasible—by directly providing these services. Programs to prevent mother-to-child transmission of HIV should include contraceptive services to prevent future children from becoming infected. HIV counseling and testing centers should provide men and women who are engaging in risky sexual behavior with information to help prevent all unintended outcomes of unprotected sex, including unwanted pregnancies. Providers of HIV-related care and treatment need to be aware that for most HIV-positive men and women, diagnosis does not mean an end to their sexual lives or to their child-bearing aspirations. HIV-positive individuals will have continuing reproductive health desires and needs that must be attended to: For example, many will want to have a baby, whereas others will want to avoid pregnancy. And as more HIV-positive people live longer, healthier lives, this reality will only intensify.

In conclusion, policymakers, donors, service providers, activists and academics at all levels must give more consideration to integrating HIV prevention into reproductive health services as appropriate—and to integrating reproductive health services into HIV-related programs. They must identify approaches that will work and under what condi-

tions integration makes sense. They should assess what will be needed to move forward in terms of planning, logistics, monitoring and evaluation and to upgrade the competency and capacity of personnel, services and health systems. Finally, they must advocate for better policies and increased funding to support integration. The synergies resulting from integration will inevitably accelerate progress towards achieving the ambitious targets set by the global community over the past 10 years. As the HIV pandemic evolves, countries can no longer afford to overlook the new opportunities arising from integration.

This Issues in Brief, written by Heather Boonstra of The Alan Guttmacher Institute (AGI), is published jointly by AGI and the Joint United Nations Programme on HIV/AIDS (UNAIDS). It has been produced with the collaboration of The United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF). Special thanks go to the following colleagues who reviewed the issue brief and provided input: Ward Cates and Rose Wilcher, Family Health International; Nomi Fuchs, U.S. Agency for International Development (USAID); Michele Sumilas, Global Health Council; Paul Zeitz, Global AIDS Alliance; Aurorita Mendoza and Purnima Mane, UNAIDS; Lynn Elizabeth Collins and Steve Kraus, UNFPA; and Kevin Osborne, IPPF. A version of the Issues in Brief with full citations is available on AGI's website at <www.guttmacher.org>, on UNAIDS's website at <www.unaids.org> and on UNFPA's website at <www.unfpa.org>.

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Reprinted January/2007