


FACTSHEET Women, HIV and reproductive choices

Women have the right to a pleasurable, safe and healthy sex life based on choice and bodily autonomy throughout their lives. Women's needs, desires and choices around contraception, reproductive health services, and family planning services, will vary throughout the life course. At different times, women may choose to use barrier or hormonal contraceptives, to have children, or to seek other services and support. This resource focuses on women's reproductive and contraceptive choices, although we recognise that men may play a role in decision-making and make reproductive choices in their own right.

HIV is closely interlinked with reproductive choices. For example, HIV can be transmitted through condomless sex, pregnancy, childbirth and breastfeeding. In addition, there is now emerging evidence that using progesterone only injectable contraceptives, like Depo-Provera, may lead to an increased risk of acquiring HIV.¹ Sexually transmitted infections (STIs) can also increase the likelihood of HIV transmission.² More broadly, the disproportionate impact of HIV and (other) STIs on women and girls and the scale of the unmet family planning needs are fuelled by similar structural drivers, including economic inequality, limited access to appropriate information, gender inequality and gender-based violence, harmful cultural norms, legally disabling environments, and the marginalisation of the most vulnerable populations.³

For women living with HIV, support to have children if they choose, or alternatively to access condoms and/or other contraception to prevent pregnancy and STIs, or to access other reproductive services, are human rights, that are still not consistently upheld. For women seeking to prevent HIV and (other) STI acquisition, comprehensive services that ensure they are also able to prevent pregnancy, or to safely conceive if they choose, are equally important.

INTEGRATION OF HIV AND FAMILY PLANNING SERVICES

The integration of HIV and family planning services, within a comprehensive package of sexual and reproductive health (SRH) services, can be an effective way to meet women's holistic needs and improve the quality of care they receive.

DEFINITION

Integration refers to different kinds of family planning and HIV interventions and services that can be joined together to enhance outcomes. Integration can be bi-directional – meaning that HIV components can be included in family planning programmes and family planning components can be included in HIV programmes.

Adapted from International HIV/AIDS Alliance (2015) *Sexual and reproductive health and rights, and HIV 101 workshop guide*.

Offering integrated sex-positive services can increase the number of women who are able to access services by reducing barriers including travel costs, time and stigma.⁴ Integration can also drive uptake of services by appealing to a broader group of women.⁵ Integrated services may be more cost effective, enabling greater impact with scarce resources, however health providers should not be asked to take on the delivery of additional services without any additional support.⁶ For integration to succeed health services providers must be trained to provide human rights-based, stigma and discrimination-free care.⁷

Integration has been identified as a key strategy for achieving the SDGs.⁸ SDG target 3.7 on universal access to SRH including family planning by 2030 and SDG target 3.3 on ending AIDS as a public health threat by 2030 are closely linked, and both rely on increasing coverage and uptake of services. Both the SRH and HIV targets depend on and contribute to SDG5 – achieve gender equality and empower all women and girls. Target 5.6 under this goal also recognises access to SRH and achieving reproductive rights as key building blocks towards gender equity and equality.

UK LEADERSHIP

The UK has been a global leader in family planning. In recognition of the scale of unmet need for family planning, the UK Government convened the London Family Planning Summit in 2012, to focus efforts, resources and attention to scaling up access to modern contraceptive methods and choices. It also aimed to recognise the links between family planning and sexual and reproductive rights (SRHR) more broadly, including HIV. The summit launched the FP2020 initiative, a global partnership to enable 120 million more women and girls to use contraceptives by 2020.

In preparation for the 2012 summit, STOPAIDS and the UK Sexual Reproductive Health and Rights Network developed RAISE the Bar, a framework for successfully integrating women's reproductive health, including HIV.⁹

STOPAIDS side event on HIV integration at the 2012 Family Planning Summit.
© STOPAIDS



The RAISE framework is based on: Rights, Access, Investment, Security, Equity. Critically, this framework applies equally to women in all their diversity, regardless of their age, HIV status, work, identity or sexuality, including young women, lesbian and bisexual women, trans women, women who use drugs and female sex workers. No-one should be left behind.

As the UK Department for International Development (DFID), United Nations Population Fund (UNFPA) and the Bill & Melinda Gates Foundation prepare to hold a second Family Planning Summit to take stock of achievements made and re-energise commitment on the road to 2020, these five starting blocks remain the essential foundation for effectively upholding women's SRHR and addressing HIV.

The RAISE framework is particularly important because DFID has identified integration as a priority for its strategy on HIV and pledged to "increasingly address HIV alongside other health and social problems".¹⁰ Since the 2012 Family Planning Summit, DFID bilateral investment in programmes focused on HIV has declined dramatically, falling from £115m in 2012/2013 to just £16m in 2015/2016.¹¹ In contrast, the UK committed to doubling spend on family planning programmes between 2012–2020.¹² The RAISE framework will be key to ensuring DFID are able to successfully address HIV within the context of wider health and development programmes, including family planning programmes.



David Cameron and Melinda Gates meet with young people at the 2012 Family Planning Summit. © DFID

RAISE THE BAR FOR WOMEN'S HEALTH

* Rights

- Uphold the sexual and reproductive rights of women and girls in all their diversity, and throughout their lives.
- Ensure that HIV and family planning services are confidential, voluntary and free from denial, coercion, force, violence or discrimination of any kind.

* Access

- Review and address structural, legal, financial and cultural frameworks which impede women and girls' free and voluntary access to the full range of family planning, HIV and wider SRH services.

* Investment

- Invest in tailored, sustainable, context-specific services suited to women's needs.
- Strengthen networks of women living with HIV or most affected by HIV, poverty and marginalisation, to ensure their meaningful participation and partnership in policy and programme design, delivery and evaluation.

* Security

- Protect and promote the safety and security of women and girls in all their diversity and throughout their lives.
- Eliminate structural violence against key affected populations at increased risk for HIV, including discriminatory institutional policies and practices related to HIV transmission, young people, sex work and drug use, which restrict access to HIV and SRHR services.

* Equity

- Guarantee full equity in accessing quality holistic services, ensuring that services are specifically tailored to women and girls in all their diversity.
- Ensure that all women and girls can choose the family planning method that best suits their circumstances including access to dual protection, method mix and legal and safe abortion.

Source: UK Consortium on AIDS and International Development and UK Network on SRHR (2012) *RAISE the Bar*. Available at: <http://stopaids.org.uk/wp-content/uploads/2013/08/Raise-the-Bar-final.pdf>

GOOD PRACTICE INTEGRATED FAMILY PLANNING AND HIV PROGRAMMING ACROSS THE LIFE COURSE

For each individual woman, her reproductive and contraceptive choices and desires will vary over time, influenced by both biological development and changes within her individual experiences, circumstances and desires. Effective interventions will recognise and address these changing needs, and consider how they interact with HIV and (other) STI programming needs.

At each stage, a range of significant factors will intersect, including external factors such as poverty, access to information and resources, health and wellbeing, and gender-based violence and discrimination. While there are differences between each stage of life, The RAISE Framework applies to women throughout the life course.

The World Health Organization's (WHO) 2014 *Framework for ensuring human rights in the provision of contraceptive information and services* applies internationally recognised human rights laws to aspects of healthcare delivery. The framework also provides concrete examples of how rights dimensions must be respected, protected and fulfilled in the context of SRHR.

Principles and standards:

- Non-discrimination in provision of contraceptive information and services
- Availability of contraceptive information and services
- Accessibility of contraceptive information and services
- Acceptability of contraceptive information and services
- Quality of contraceptive information and services
- Informed decision-making in provision of contraceptive information and services
- Privacy and confidentiality in provision of contraceptive information and services
- Participation in provision of contraceptive information and services
- Accountability in provision of contraceptive information and services.

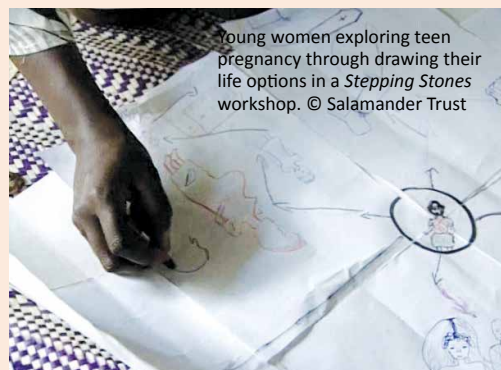
WHO has also developed SRHR guidelines for women living with HIV that recommend a women-centred approach based on the guiding principles of human rights and gender equality. WHO (2017) *Consolidated Guidelines on Sexual and Reproductive Health and Rights of Women Living with HIV*.

STOPAIDS members are demonstrating good practice integrated HIV and family planning programmes throughout the life course.

1. Pubescent girls



As girls approach puberty, they need accurate information about menstruation, sex and pregnancy in order to make informed decisions about contraception, staying STI-free and HIV prevention or mitigation. Stepping Stones is a holistic interactive training process in gender, intergenerational issues, human rights, communication and relationship skills, in the context of HIV, supported by Salamander Trust. In Kenya, the programme found that girls were afraid of telling their parents, especially their mothers, when they started to menstruate. Without parental support to buy sanitary towels, these girls often missed whole weeks of school during their periods and, in some cases, they dropped out of school entirely. Other girls reported that they would exchange sexual favours for money in order to buy sanitary pads, putting themselves at risk of pregnancy and sexually transmitted infections, including HIV. The girls' mothers had themselves married when they were still very young, as was common for their generation, and only began menstruating once married and living in their husband's home. As a result, they had assumed that this bleeding was something that only happened to girls after marriage, as a result of becoming sexually active. The young girls knew this wasn't true but they were still too scared to tell their mothers about getting their periods, because they would be accused of having sex. *Stepping Stones* sessions purposely split the group by age and by gender, and girls in the programme used the sessions to request that their parents be trained on reproductive health. The parents were later educated on sexual and reproductive health and learnt that menstruation is not related to any sexual relationship. Families and the Kenyan authorities began to support their daughters to access sanitary products, without any stigma or secrecy and girls were thus enabled to stay in school.¹³



2. Adolescent girls and young women



The Link Up project (2013-2016), implemented by a consortium including, the ATHENA Network, Global Youth Coalition on HIV and AIDS (GYCA), Marie Stopes international, Population Council, STOP AIDS NOW, and led by the International HIV/AIDS Alliance, aimed to advance the SRHR of young people most affected by HIV in five countries. The project addressed barriers to young people’s access to SRHR including family planning and HIV services.

As well as material and legal barriers, a Link Up consultation with young people identified social factors including negative attitudes and taboos around sexuality (particularly for young people living with HIV); a lack of knowledge of the range of contraceptives available and gender inequality. Young women living with HIV face additional barriers including stigma and discrimination at the community and health service level. In Uganda one strategy implemented by the project to address these barriers was to train peer educators and community health workers to distribute vouchers for health services to young people, which could be redeemed at Link Up



Link Up youth voucher for HIV and SRH services. © Georgina Caswell/International HIV/AIDS Alliance

partner facilities for HIV and SRHR counselling and services. The vouchers were designed with input from young Ugandans to accomplish three goals: 1) generate demand for services by being attractive and

removing cost barriers; 2) help young clients navigate the healthcare system; and 3) monitor service utilization through an easy-to remember unique identifying code. In one year of the 3 year project, 35,000 vouchers were distributed, 79% of which were redeemed at Marie Stopes BlueStar facilities resulting in an estimated total of 18,996 couple years of protection (CYP).

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Peer educator, Pius Kimuli, distributes information materials to a clinic in Kajjansi, Uganda. ©International HIV/AIDS Alliance

LINKUP

Overall, The Link Up project reached nearly 1 million young people aged 10-24 living with and most affected by HIV. Project data showed that family planning services were among the most popular of the services offered by the programme, accessed by about a third of Link Up clients through a range of community and facility-based services. The three top-most combination of HIV and SRHR services were:

- Safer sex/basic HIV and SRH counselling with family planning
- Voluntary HIV counselling and testing with family planning
- Safer sex/basic HIV and SRH counselling with gender and sexuality counselling

Altogether, nearly 400,000 young people accessed family planning services, and 62% of these young people chose to access family planning in combination with HIV services.



Mercy, her husband Joseph, baby David and 'Mother Buddy' Rosemary. © Chasing Zero

3.1 Women of reproductive age



The IMPACT (improving parent and child outcomes) project, funded by Tearfund and Chasing Zero is a comprehensive and integrated approach to improving maternal and infant health and reducing

HIV vertical transmission, implemented in six African countries.

The project matches pregnant women with 'Mother Buddies', trusted peers from within the community who enable informed decision making about contraception, HIV and wider health. The programme focuses on women at greatest health risk during pregnancy and childbirth, including women living with HIV. By creating a relationship with families, Mother Buddies become trusted friends and advocates motivating families to follow their advice.

Mother Buddies are fully trained in relevant areas of healthcare, with assistance from the Ministry of Health and other NGOs, including mothers2mothers. They are also equipped with smartphones to consolidate training

and assist with decision support. Mercy, from Malawi, is one of the women who has benefited from IMPACT. Mercy and her husband had agreed to have no more children, but Mercy unexpectedly became pregnant. She was assigned a Mother Buddy who counselled the family on options available to prevent further pregnancies, including how to access family planning services and the options available in the local health centre. By the time Mercy's son was born, she and her husband had made informed decisions about their preferred method of contraception going forward.

IMPACT has increased access to counseling on family planning by 34% and the use of modern contraception by 11%. Mother Buddies have also been active in promoting access to counselling on unintended pregnancies. Mother Buddies have also increased the number of women who have 4 or more antenatal care visits, those giving birth in a professionally attended facility, food/nutritional support and male partner attendance and HIV testing in antenatal care. HIV vertical transmission rates have also reduced; in Malawi, for example, from 14% to <2% in targeted communities.

3.2 Women of reproductive age



The Shadows and Light Project (2012-2015) was funded by the German BACKUP Initiative and implemented by four Member Associations of the International Planned Parenthood Federation (IPPF) in Cameroon, India, Kenya, and Uganda. The project aimed to develop health service providers' capacity to address the linked SRH and HIV needs of key populations affected by HIV. The initial activities focused on preparing clinic sites, including training of service providers to provide stigma and discrimination free services, and consultations with key population networks and peer educators to inform the development of a full continuum of SRH/HIV services tailored towards the needs of key populations. The consultations also informed adaptations made to clinics including changes to opening hours, waiting areas and services offered; and highlighted the critical gaps around contraception, reproductive health, and family planning services specifically for female sex workers, women who inject drugs, women who have sex with women, and transgender men.

In Kenya, Family Health Options Kenya (FHOK) initiated the expanded provision of integrated SRH, HIV, and harm reduction services for people who use drugs in Mombasa. The project found that the limited services for people who use drugs often overlooked the specific needs of women who inject drugs. Women who inject drugs expressed a desire not just for HIV services but for wider SRH services, including access to contraception and family planning services. The most common challenges among the women consulted were access to female condoms, access to long-acting contraceptive methods, and lack of relevant information on family planning. The project found that women who use drugs experienced elevated levels of physical and sexual violence, often related to obtaining 'a dose' or while 'high'. These experiences of violence increased women's risk of acquiring HIV and other STIs and of unintended pregnancy. Through the involvement of women who use drugs in service delivery, the programme has seen an increase in women accessing services during community outreach and at the static clinic.

Demonstrating female condoms in Uganda.
© Daniel McCartney/IPPF



A LACK OF INTEGRATED HIV AND SRHR PROGRAMMES FOR OLDER WOMEN

4. Women during the menopause

About 85% of women will experience symptoms of menopause between the ages of 45 and 55 years, with symptoms sometimes lasting for several years. Some studies show that women living with HIV experience menopause earlier (by two to three years), and there are mixed findings about whether women living with HIV experience more symptoms.¹⁴ The risk of osteoporosis (fragile bones) is increased in women living with HIV and in women after the menopause, and so women living with HIV who have reached the menopause may be at particular risk of bone disease.^{15,16}

In addition, research has found that women living with HIV may face challenges in recognising and managing menopause symptoms, not knowing if symptoms are related to HIV or the menopause, and report feeling 'stuck' between primary healthcare and specialist HIV services.¹⁷

The SRHR of women during menopause are extremely under-researched and SRHR interventions focused on supporting women during menopause are scarce in countries at all stages along the development continuum, including the UK. When women no longer need contraception, integrated HIV and SRHR services must adapt to ensure continued provision of HIV services. Women in the peri-menopause can still become pregnant and will need focused and comprehensive services and support. Managing the termination of contraceptive use should be closely clinically managed and supported, and women should be advised to continue using barrier methods to prevent HIV and (other) STI acquisition.



PRIME

The PRIME study (Positive tRansitions through the MEnopause) is a three-year National Institute for Health Research (NIHR)-funded quantitative and qualitative study.

It will explore, for the first time in the UK, the impact of the menopause on HIV-positive women's wellbeing (e.g. sexual functioning, quality of life and mental health) and engagement with HIV care (e.g. adherence to antiretroviral therapy and HIV clinic attendance).¹⁸

5. Post-menopausal women

After menopause, women no longer require contraceptives to prevent pregnancy, but continue to require rights-based services and support to access information, commodities and services to prevent HIV and (other) STIs. UNAIDS has

identified people aged 50 and over as a population at risk of being left behind in the global HIV response.¹⁹ This includes the growing population of older people living with HIV, due to increased access to effective treatment, and increasing acquisition of HIV among older people. UNAIDS suggests that low perception of risk of HIV acquisition amongst older people, and barriers to accessing services, are drivers of this.²⁰ Perceptions of risk of HIV and (other) STI acquisition are often low among both older people themselves, and among those responsible for resourcing and delivering services, information and support. Women's sexuality and sexual practices are often understood within the limited context of conception, and so after menopause their ongoing needs and rights are not recognised. Lack of targeted information, education and support for older people may lead to limited knowledge and awareness of HIV.

SRHR PRIORITIES OF WOMEN LIVING WITH HIV IN MENOPAUSE AND POST-MENOPAUSE

Information and understanding relating to the menopause for women living with HIV including on:

- bodily changes associated with HIV and menopause
- management of post-menopausal effects
- whether HIV brings on early menopause.

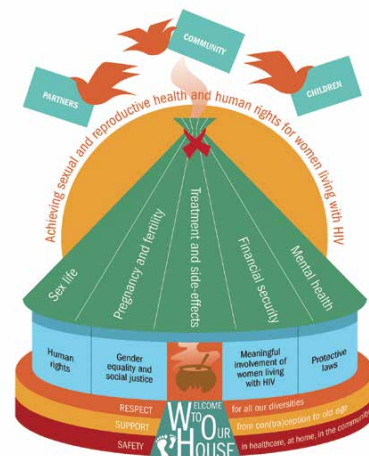
Sexual relationships counselling for older and post-menopausal women including:

- acknowledgement and promotion of sexuality and sexual pleasure among older women
- effect of ART and hormone therapies on libido.


Tailored services for older women living with HIV, including:


- peer support within primary care facilities
- mental health care and counselling
- attention to other health conditions related to menopause.


Source: Salamander Trust (2015) *Building a Safe House on Firm Ground: Key Findings from a Global Values and Preferences Survey Regarding the Sexual and Reproductive Health and Human Rights of Women Living with HIV*.²¹




CONCLUSION

 To tackle the unmet need for family planning and the disproportionate impact of HIV and other STIs on women and girls, we must take women and girls' diverse, changing and holistic desires, needs and rights as the starting point.

 The links between contraception, reproduction and HIV and (other) STIs suggest that integrated programmes can be an effective way to meet a broader range of women's and girls' needs.

 As a leader within family planning, the UK must ensure HIV components are effectively integrated into work on family planning, and vice versa.

 The RAISE framework provides a useful and still relevant framework for integrating and enhancing women's health and STOPAIDS members are putting this framework into practice through programmes.

ENDNOTES

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TRANSFORMING THE WAY WE THINK ABOUT HIV

STOPAIDS is the network of UK agencies working since 1986 to secure an effective global response to HIV and AIDS.

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