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Ensuring Contraceptive Security for HIV-Positive Women

- *Contraceptive security plans often do not successfully accommodate the special needs of HIV-positive women.*
- *Ensuring contraceptive security for HIV-positive women is essential for achieving international development goals, including the reduction of mother-to-child transmission of HIV.*
- *Interventions that overcome common barriers faced by HIV-positive women when accessing family planning information and services are vital to preparing a contraceptive security plan that ensures access for all.*

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POLICY Issues in Planning and Finance, a series of policy briefs, presents the findings and implications of POLICY-supported research. The series is intended to focus attention on the importance of developing a favorable policy environment that encourages appropriate and adequate FP/RH and HIV/AIDS program financing.

POLICY

Ensuring Contraceptive Security for HIV-Positive Women

Contraceptive security will be achieved when every person is able to choose, obtain, and use contraceptives and other essential reproductive health supplies whenever she or he needs them.

Introduction

Contraceptive security (CS) is achieved when people are assured of access to an uninterrupted supply and adequate mix of contraceptive commodities and enjoy open access to information and services related to those commodities. As developing countries strive to achieve contraceptive security amid growing demand for contraceptives (see Box 1), they are increasingly cognizant of the impact of directing resources to vulnerable groups and their ability to ensure equitable access for all, including HIV-positive women (see Box 2).

Providing for the family planning needs of HIV-positive women is a vital component in the fight against HIV/AIDS and the achievement of international development goals. However, CS programs often do not successfully accommodate the special needs of HIV-positive women. Challenges to reaching this marginalized group include a limited choice of accessible contraceptive methods, lack of informed counseling regarding appropriate contraceptive options, stigma and discrimination that hinder their ability to access information and healthcare services, and operational barriers that thwart providers' effective delivery of medical care. Achieving access to family planning information, services, and commodities for this group can have a significant impact on the HIV/AIDS epidemic, and interventions that successfully overcome the challenges can help achieve this goal.

The World Health Organization (WHO) identifies four stages of perinatal HIV prevention at which women need support: (1) prevention of HIV infection in women, especially young women of reproductive age; (2) prevention of unintended pregnancy in HIV-positive women; (3) prevention of mother-to-child transmission; and (4) support for the HIV-positive mother and family (WHO, 2003). A comprehensive CS plan is consistent with supporting women at all four stages and can directly affect success at stages two and three by reducing the barriers faced by HIV-positive women in accessing family planning (FP) goods, services, and information.

The United Nations General Assembly Special Session's (UNGASS) goal of reducing the proportion of infants infected with HIV by 50 percent by 2010 cannot be met without including family planning in national and international health strategies to reduce the number of unintended pregnancies among HIV-positive women (Sweat, 2004). The U.S. President's Emergency Plan for AIDS Relief has set forth a goal of preventing 7 million new HIV infections, including those averted through the prevention of mother-to-child transmission (PMTCT) of HIV. A significant reduction in rates of mother-to-child transmission of HIV relies on the use of contraceptives by HIV-positive women to prevent unintended pregnancy in addition to HIV counseling and testing, infant feeding counseling, use of antiretroviral (ARV) therapy, and support for HIV-positive women to make informed reproductive choices. Given that the delivery of FP services to HIV-positive women can have an enormous impact on the achievement of development goals, a CS plan that considers HIV-positive women's access to information and services in addition to access to contraceptive commodities may have the greatest affect.

This brief describes the importance of ensuring contraceptive security for HIV-positive women. It also reviews common barriers faced by HIV-positive women as

Box 1. Donor support for contraceptive security evolves

Until recently, international donors have been largely responsible for providing contraceptive supplies to developing countries. By providing procurement guidance, logistics coordination, research, and marketing in addition to the contraceptive products themselves, outside sources have cultivated and sustained demand for contraceptives and other reproductive health supplies around the world. However, after many years, developing countries are being increasingly "graduated" from donor support and must now take full responsibility for ensuring secure access to contraceptive supplies, services, and information for their citizens.

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they attempt to access FP services[1] and illustrates interventions that can increase the likelihood of overcoming these barriers (see Box 3 for a summary of these interventions).

Importance of Contraceptive Security for HIV-Positive Women

Meeting HIV-Positive Women's Needs Affects Development

The HIV/AIDS epidemic hits women hard. A woman's HIV-positive status exacerbates her already unequal economic, social, and legal status (ICW, 2004a). Not only do women lack the resources and influence to protect themselves adequately from HIV infection, but they also almost always take responsibility for caring for sick family and community members. Pregnancy takes a major toll on HIV-positive women's bodies and, in the absence of high-quality medical care and counseling, can sometimes advance the progression of HIV/AIDS. At the same time, in the absence of intervention, a pregnant woman who is HIV-positive faces a 30 to 40 percent chance that she will pass the virus to the fetus during delivery or while breastfeeding the infant (Mitchell et al., 2004). A CS strategy that supports the needs of HIV-positive women to access a variety of services and information can help protect the health of women and infants alike.

The vast majority of HIV-positive women are between the ages of 15 and 49—prime reproductive age. Pregnancies among HIV-positive women have the potential for greatly increasing the number of orphaned and terminally ill children, further straining the limited resources of families and social service providers in developing countries. Today, there are more than 15 million AIDS orphans (single and double orphans) worldwide (UNICEF et al., 2004). The emotional and financial toll on surviving parents, families, and communities is huge. A CS plan that ensures access to information on family planning and HIV for all women and their partners, both before a woman becomes pregnant and during antenatal care, can help a couple make more informed choices about pregnancy (gaining access to ARV prophylaxis for the mother and infant) and the care of children in the event of the death of one or both parents.

Providing access to family planning for HIV-positive women also offers a

[1] Even though this brief discusses some of the issues faced by HIV-positive women, it is not meant to be a comprehensive assessment of the challenges facing this vulnerable group. The brief focuses only on those issues directly linked to ensuring contraceptive security for HIV-positive women as one of many vulnerable groups served by government resources.

Box 2. Using a CS approach to increase access for vulnerable groups

The Strategic Pathway to Achieve Reproductive Health Commodity Security (SPARHCS) framework is a tool designed for comprehensively assessing barriers to family planning. Identifying and addressing barriers to access to contraceptive commodities, information, and services is a critical step for developing countries now charged with the contraceptive security of growing populations and emerging vulnerable groups such as HIV-positive women, youth, and the poor. HIV/AIDS affects women on several levels (social, emotional, physical, and financial). Through an examination of specific contraceptive security issues—such as human and organizational capacity, logistics, policy, service delivery, demand, finance, and private sector involvement—SPARHCS can aid in the identification and elimination of barriers, ultimately leading to increased access to information and services for all vulnerable groups.

Box 3. Interventions that promote CS for HIV-positive women

Advocacy and Stakeholder Inclusion

- Include HIV-positive women in CS initiatives and planning
- Include men in family planning as a means of increasing access and choice for women
- Mobilize civil society to advocate for HIV-positive women
- Partner with community leaders

Healthcare Provider Training and Regulation

- Expand the responsibilities of nurses and community healthcare workers through policy formulation
- Reduce stigma and discrimination through healthcare worker training and guidelines
- Include family planning and HIV/AIDS in informal and formal health worker curricula

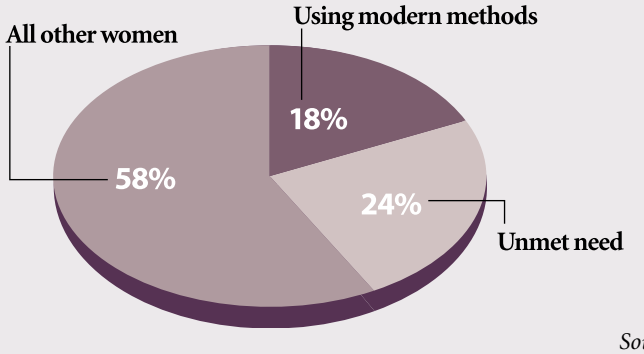
HIV/AIDS and FP Program Coordination

- Include family planning in HIV-related services, including HIV counseling and testing

variety of added health benefits that extend beyond the prevention of virus transmission to the fetus. Correct and consistent use of family planning not only reduces the number of children that could become infected with HIV through mother-to-child transmission but also facilitates birth spacing, avoids the stress of pregnancy for women with already compromised immune systems, and reduces the potential number of orphans resulting from AIDS-related deaths. The benefits support the health of HIV-positive women who choose to avoid pregnancy as well as those who plan to have children.

FIGURE 1.
Unmet Need Among Married Women of Reproductive Age

(U.S. International Mother and Child HIV Prevention Initiative Countries)



Source: POLICY Project, 2005

Securing Access to Integrated PMTCT and Family Planning Supports Achievement of Development Goals

Given the prominent role that PMTCT of HIV plays in achieving international development goals, particularly the goals set forth by UNGASS and the U.S. President's Emergency Plan, PMTCT interventions and meeting the needs of HIV-positive women are drawing considerable attention. In the 14 countries involved in the U.S. International Mother and Child HIV Prevention Initiative,[2] 13 percent of new infections in 2003 can be attributed to mother-to-child transmission (POLICY Project, 2005). The successful provision of family planning before pregnancy and through PMTCT programs has the potential to influence several key development indicators as well as the achievement of the international development goal of reducing the number of HIV-infected infants.

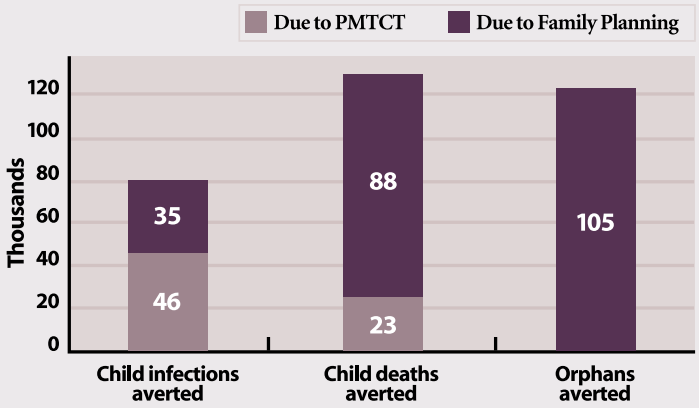
Research conducted in the 14 countries included in the U.S. initiative indicates high unmet need for family planning. Among married women of reproductive age, 18 percent are currently using a modern contraceptive while 24 percent would like to limit or space births but are not using contraception (see Figure 1). Assessments of the benefits and costs of adding FP services to PMTCT programs[3] in the 14 countries indicate that family planning alone could help avert one-quarter of the HIV-positive births per year through the prevention of unintended pregnancies—a big step toward achieving UNGASS goals (POLICY Project, 2005). Increasing contraceptive use by HIV-positive women has been found to be at least as cost-effective as providing ARV prophylaxis to the mother during pregnancy and to the newborn. The impact on child death and infection rates and number of orphans is greatly increased when PMTCT and family planning are provided simultaneously (see Figure 2). A look at the impact of adding family planning in the 14 countries suggests that PMTCT inclusive of family planning resulted in 105,000 orphans averted owing to fewer future pregnancies among HIV-positive women, 12,000 mothers' lives saved owing to reduced risks of pregnancy and delivery among HIV-positive women, and 88,000 child deaths averted as a consequence of improved child spacing (POLICY Project, 2005). As the benefits of family planning for HIV-positive women become clearer and awareness of the importance of family planning increases among policymakers, practitioners, and HIV-positive women, decisionmakers will recognize that it is critical to maintain access to contraceptives and FP services for HIV-positive women.

One unfortunate consequence of focusing only on PMTCT is that women are seen as vectors of HIV transmission. As a result, HIV-positive women are often told either not to have babies or to participate in ARV prophylaxis programs to prevent infection of the child at birth (De Bruyn, 2002; ICW, 2004a). Both approaches focus on preserving the health of the child only, not the health of the mother, and dismiss an HIV-positive woman's potential desire to conceive. Providing family planning information and services to prevent mother-to-child transmission is one important avenue for increasing contraceptive security for HIV-positive women, but it does not meet

[2] Countries involved in the U.S. International Mother and Child HIV Prevention Initiative are Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Zambia, Tanzania, and Uganda.

[3] PMTCT programs examined in this study included nevarapine-only (NVP) or zidovudine plus nevarapine (AZT + NVP) treatment.

FIGURE 2.
Benefits of Family Planning and PMTCT Services in 14 High HIV Prevalence Countries in 2007



Source: POLICY Project, 2005

all their family planning needs. The increase in access to FP information and services is meant to serve all women who want to make informed decisions about whether to become pregnant—a decision that needs to be a *choice* made by a woman herself and her partner and by women looking to control the number and spacing of their children. Respecting the reproductive choices of HIV-positive women and supporting their FP/RH decisions are preconditions to discussions about contraceptive options.

Barriers Are High for HIV-Positive Women

Limited Methods Are Available and Accessible to HIV-Positive Women

HIV-positive women have special needs, and their family planning choices are limited by both social and financial barriers. Personal preference, religion, marital status, availability and cost of clinical care and commodities, and serostatus are just a few factors that may affect a woman's choice of contraceptive method. Although dual method use (use of a barrier method in combination with a secondary form of contraception) and abstinence remain the best protection against pregnancy and sexually transmitted infections (STIs), including HIV, a combination of gender roles and social factors (i.e., male control of sexual activity and contraceptive use and the high value placed on fertility and large families) continue to hamper many women's attempts to practice methods consistently. Male household control not only increases the vulnerability of women by limiting their ability to control sexual activity and contraception, but it also affects women's access to healthcare. In a study of HIV-positive women in Zimbabwe, 44 percent of survey respondents reported that they had to ask permission from their husbands or in-laws to seek treatment (Feldman et al., 2002). In addition, few women have money of their own and may be denied funds when they ask their spouse for money to purchase contraceptives. These limitations decrease access to both information and commodities.

HIV-POSITIVE VOICES

"My husband is not interested [in condoms]. He never wanted to set eyes on those plastic things. If he ever found me with any, he would allege that I was being promiscuous. . . ."

~ HIV-positive woman in Zimbabwe (Feldman et al., 2002)

Accessing adequate and appropriate information about contraceptive options is further complicated by the fact that many women do not know their HIV status or choose not to disclose it to their healthcare provider for fear of discrimination. A POLICY Project study in Kenya found that women who were aware of their serostatus and expressed a desire for more information about the most appropriate FP methods still chose not to disclose their status to healthcare providers for fear of discrimination, thereby limiting their access to information specific to their circumstances (Gichuhi et al., 2004).

Ensuring HIV-positive women's access to a range of contraceptive methods is essential. While barrier methods serve a variety of purposes (prevention of unintended pregnancy and, hence, transmission to the fetus and prevention of transmission to a woman's partner and contraction of a co-infection), only condoms are readily available in most developing countries. Moreover, due to condoms' relatively high failure rates for pregnancy prevention, most experts recommend dual methods (e.g., condoms for protection from HIV along with another more reliable method for pregnancy prevention). However, in the face of stockouts, cost, and/or social and medical biases, many women face a limited number of available methods. When abstinence or the consistent and correct use of a condom is not an option for an HIV-positive woman, that woman should still have the option of protecting herself from unintended pregnancy and the chance of mother-to-child-

transmission of HIV. Therefore, any CS strategy must work to ensure access to information about method options, the full range of FP services, and all commodities.

Provider Discrimination Affects Care-Giving and Care-Seeking Behavior

Provider biases or beliefs can affect the care received by a patient. An essential aspect of a comprehensive CS plan is the enactment of policies and programs that reduce stigma and discrimination toward HIV-positive women, allowing unfettered access to the services and care to which such women are entitled. However, equally essential are interventions aimed at changing the discriminatory behavior and attitudes of individuals and groups. Focus groups held among HIV-positive women in Zimbabwe revealed that nearly half the women in the groups felt that nurses discriminated against them. They believed the discrimination stemmed from health workers' fear of infection and negative and judgmental attitudes. Fear of contracting the virus while providing care for HIV-positive women lowers the availability of procedures—such as IUD insertion and voluntary sterilization—that may be important contraceptive options depending on the stage of infection.[4] Healthcare providers in Zambia admitted that fear of contracting HIV was the basis for their refusal to perform certain procedures (Banda et al., 2004). In addition, the Zimbabwe focus group revealed that healthcare workers believed that nothing can be done for people with HIV and that interventions simply waste medicine, money, or time (Feldman et al., 2002). Discrimination took many forms—from rudeness and breaches in confidentiality to refusal to treat HIV-positive women. Forced sterilization of HIV-positive women has also been documented. Factors that prevent providers from offering counseling include a lack of guidelines; lack of information, education, and communication (IEC) materials and supplies; embarrassment; and judgmental attitudes toward clients (Askew and Maggwa, 2002).

Studies in Rwanda and Zambia have shown that the majority of HIV-positive women who do not want to become pregnant are unaware of appropriate contraceptive options (Cates, 2001). Such lack of knowledge may stem from the fact that risks associated with pregnancy for both mother and child are often not explained to women, in part because society often discourages HIV-positive women from engaging in sexual relations and becoming pregnant. These social judgments hinder women's access to essential knowledge that would allow them to make an informed decision.

HIV-Positive Voices

"I had problems with the nurses who took me for a very loose woman, and some would tell me straight to my face that my baby would die while a few tried to comfort me saying the baby might not die."

~ HIV-positive woman in Zimbabwe (Feldman et al., 2002)

Sub-Saharan Africa has one of the highest new child infection rates, yet only 5 percent of pregnant women in the region have access to PMTCT services (POLICY Project, 2004). To avoid stigma and discriminatory treatment, HIV-positive women or women who do not know their serostatus but have engaged in high-risk behavior may decide not to patronize clinics at all. Avoidance leads to the loss of an important opportunity for health providers/counselors to inform HIV-positive women about the risks of pregnancy, labor and delivery, and PMTCT and about FP options so that women can plan their fertility within the context of their HIV status. In addition, it is not unusual for HIV-positive women to choose to deliver at home to avoid judgment. In other cases, providers may refuse HIV-positive women access to delivery services because of their status, thereby barring access to essential ARV drugs necessary to prevent PMTCT.

An effective CS plan requires recognition that, despite cultural pressures to abstain, an HIV-positive woman may continue to be sexually active without the benefit of protection. Studies of HIV-positive women show that, while 70 percent are sexually active, their effective contraceptive use is variable such that unintended pregnancy frequently occurs (Mitchell and Stephens, 2004). Moreover, women using long-term contraceptive methods report low or inconsistent condom use. Essential to a comprehensive CS strategy are policies and interventions that reduce stigma and discrimination and help HIV-positive women seek and receive the care and information needed either to avoid unintended pregnancy or conceive as they so wish.

Policy Challenges Limit Access

In addition to clinical practices, provider attitudes, and medical barriers, policy barriers impede HIV-positive women's access to family planning. These barriers occur at both the national and operational levels but can be addressed by an effective CS plan. In many countries, counterproductive operational policies restrict the type of personnel authorized to perform certain procedures, thus limiting the availability of methods. For example, some countries do not permit nurses to insert IUDs. Such constraints can lead to restricted availability of an effective, long-term contraceptive method for women.

[4] For more information about contraceptive method choice by medical eligibility, access the "WHO Medical Eligibility Criteria for Contraceptive Use" report at http://www.who.int/reproductive-health/publications/mec/mec.pdf.

Anecdotal evidence shows that political pressure has motivated many governments to shift funding from family planning to HIV/AIDS activities, further limiting the resources available to retrain current healthcare workers to provide counseling and other services necessary to ensure contraceptive security for HIV-positive women. The division of services based on funding sources can hamper the provision of comprehensive services for all women. The importance of integrated programming and the provision of FP information in the context of HIV/AIDS should not be underestimated. For example, women seeking PMTCT services and many seeking HIV counseling and testing and ARV treatment are sexually active and fertile and can greatly benefit from additional counseling on family planning and high-risk fertility behavior (Strachan et al., 2004).

An exclusive, top-down policy process cultivates an environment that does not allow for stakeholder representation, resulting in ineffective policies that do not address citizens' needs. The 1994 principle of the Greater Involvement of People Living with HIV/AIDS (GIPA) has the goal of ensuring more participation of people living with HIV or AIDS (PLHAs) at all levels of policy- and decisionmaking. Nonetheless, GIPA remains an elusive goal. The International Community for Women Living with HIV/AIDS (ICW) has reported that PLHAs, and especially HIV-positive women, are still generally not included in the policymaking process (ICW, 2004b).

Family Planning Is Not a Priority in Resource Allocation

The ongoing competition for resources between HIV/AIDS and FP initiatives can undermine the achievement of contraceptive security. The message that emerged from the 2004 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children conference stressed the strengthening of linkages between FP and HIV/AIDS activities in order to reach international development goals; however, anecdotal evidence emerging from high-prevalence countries reveals constant tension between HIV/AIDS and FP initiatives in the competition for funds and attention. Both host-country resources and donor funding continue to flow toward HIV/AIDS while family planning, an essential aspect of prevention, tends to be overlooked. The decentralization of healthcare in many countries complicates funding for specific FP activities because money for these activities must be committed at the level of the individual clinic rather than at the national level. The emergence of basket funding schemes that provide funding for a broader portfolio of activities further limits the amount of money dedicated to FP activities.

The tug of war between HIV/AIDS and FP programs also extends to other essential areas such as human resources. Skilled workers from a variety of fields are following the funding to HIV/AIDS-related positions, leaving a vacuum in FP programs. As a result, staff reallocations arising from HIV/AIDS programming are reversing or halting the FP advances made by several countries in recent years. For example, in Kenya, contraceptive prevalence rose steadily from 27 percent in 1989 to 39 percent in 1998 but stalled and remained at 39 percent in 2003 while HIV/AIDS funding increased (Central Bureau of Statistics et al., 2003). The rapid decline in the total fertility rate (TFR) achieved by Kenya came to a stop and the rate turned slightly upward from 4.7 in 1998 to 4.8 in 2003 (Central Bureau of Statistics et al., 2004). Meanwhile, surveys continue to show an unmet need among Kenyan women who want to delay or limit future births but are not using any FP method (Gichuhi et al., 2004).

Taking a New Approach

A comprehensive CS plan can lay the groundwork for policies and initiatives that effectively target HIV-positive women and meet their needs. Implemented as a package, the interventions described below can bolster CS initiatives while also providing HIV-positive women with the additional support they need at each of WHO's four stages of perinatal HIV prevention. The interventions fall under three broad headings: advocacy and stakeholder inclusion; healthcare provider training and regulation; and coordination of HIV/AIDS and FP programming.

1. Interventions Addressing Advocacy and Stakeholder Inclusion

Including HIV-positive women in CS initiatives and planning

The initial CS planning process should assess the needs of all stakeholders, especially HIV-positive women, and draw on the direct testimony of affected subgroups. Countries such as Ukraine that have actively included HIV-positive women in their planning process (see Box 4) greatly increase the likelihood that their CS strategy will meet the needs of vulnerable groups.

All stages of the CS planning effort, including the forecasting and procurement components, should reflect the needs of HIV-positive women. Once forecasting for contraceptives and other reproductive health commodities addresses the needs of vulnerable groups, increased quantities of these commodities will be necessary to meet demand. For example, the estimated need for condoms doubled when Kenya started considering condoms for HIV prevention in addition to family planning (Kenya Ministry of Health, 2002). The implications of CS initiatives on forecasting must also be reflected in procurement. For example, if the dual

Box 4.
Ukraine involves HIV-positive women in CS strategy

Ukraine, which has the second-highest HIV prevalence rate in Eastern Europe, has invested significant resources in studies of existing policies and other areas of concern. The studies are feeding heavily into the country's CS planning process. Hands-on research into stakeholders' issues, including vulnerable groups such as HIV-positive women, increase the likelihood that Ukraine's CS strategy will improve access for all.

Solid research is informing development of the new 2006-2015 National Reproductive Health Program. The research yielded a comprehensive guide titled "Overcoming Operational Barriers to RH in Ukraine" (POLICY Project et al., 2003) and a study assessing the status of HIV-positive women's access to high-quality RH services and protection of their rights in Ukraine (Ukrainian Institute for Social Research et al., 2004).

Box 5.
Swaziland advocates for involvement of PLHAs

Together, the USAID Regional HIV/AIDS Program (RHAP) in South Africa and the POLICY Project provide support to local NGOs and civil society groups in Swaziland to mobilize resources for FP/RH and HIV/AIDS programs. RHAP is working with Swaziland to include the needs of HIV-positive women in its strategic plan to increase their access to FP/RH services and raise awareness about stigma and discrimination among service providers. The effort is particularly important because of the marginalized legal status of Swazi women. Women are legal minors in Swaziland, unable to own land or enter into contracts without the consent and cooperation of husbands or male family members. The legal status of women often affects women's social status and limits their decisionmaking power, forcing women to access FP information and services through men. The education and involvement of men and family members such as mothers-in-law will be integral to improving access to family planning for HIV-positive women.

protection message is better disseminated and FP counseling is more fully integrated into HIV counseling and testing for HIV/AIDS, condom demand will further increase.

Including men in family planning as a means of increasing access and choice for women

Given many cultures' societal and gender roles, women often lack the power to make choices about contraceptive methods or even whether to use contraception at all. Interventions that open channels of communication between partners increase the likelihood that a couple engaging in safer sexual practices and making decisions about reproductive options will be better informed about the available options and agree to a mutually acceptable method(s). CARE Cambodia's *Couples in the Know* initiative recruited couples to act as peer educators and led group discussions with other couples on sexual and reproductive health, including HIV transmission, dual protection use, and domestic violence. Although educating women in sexual health and condom use increases their knowledge, it does not necessarily increase women's ability to negotiate safer sex with their partners and practice reliable family planning. However, encouraging results from CARE's pilot project showed that once husbands learned about and participated in discussions about safer sex, women demonstrated increased confidence in initiating conversations about sex and condom use. Anecdotal evidence also suggested that domestic violence decreased and condom use increased among couples that participated in the program (Walston, 2005).

Mobilizing civil society to advocate for HIV-positive women

Strong government support of national programs is essential for project success, especially when the target audience is traditionally marginalized groups. PLHAs in Swaziland mobilized to increase their involvement in the development of the country's HIV/AIDS strategic plan, increasing the likelihood that the plan would address their needs (see Box 5). Interventions that mobilize civil society to advocate on behalf of marginalized groups in order to secure a place for such groups on the policy agenda play an important role in achieving contraceptive security.

Partnering with community leaders

The subject of family planning, especially for HIV-positive women, remains controversial in some communities where religious, cultural, and social resistance to family planning is high. Engaging influential community leaders in the public discussion about family planning can help lend legitimacy to a country's FP program and educate the community on the issues faced by HIV-positive women. Open dialogue can reduce stigma, allowing for more open access to information for HIV-positive women and increasing HIV-positive women's awareness of available FP services.

The USAID-funded Community REACH (Rapid and Effective Action Combating HIV/AIDS) program is a partnership between Pact and the Futures Group that awards grants to NGOs, such as the Adventist Development and Relief Agency (ADRA). In particular, ADRA works in Cambodia with traditional leaders, caregivers, healthcare providers, and families affected by HIV/AIDS to overcome stigma and discrimination at the community level (see Box 6). This grassroots effort in information dissemination is a first step toward creating an environment in which HIV-positive women can more easily access needed information and healthcare services.

2. Interventions Addressing Healthcare Provider Training and Regulation

Formulating policies to expand the responsibilities of nurses and community healthcare workers

The number of providers able to offer services to women seeking family planning is limited in part by policies that restrict the type of personnel authorized to perform procedures such as IUD insertion. Policies also restrict some health personnel from dispensing ARVs, an essential aspect of PMTCT.

In Jordan, the Minister of Health, recognizing the country's shortage of female physicians and the growing demand for IUDs, approved a pilot program to enable midwives to insert IUDs and thus respond to demand. Jordanian counterparts trained by POLICY/Egypt helped build the capacity of healthcare providers to advocate to the ministry for the midwives' involvement in IUD service provision. The decision can be considered a breakthrough in developing countries where physicians may oppose other medical professionals' delivery of a particular service.

Reducing stigma and discrimination through healthcare worker training and guidelines

As noted, stigma and discrimination are significant barriers to effective access to FP commodities, healthcare services, and information. Altering the attitudes of healthcare workers toward PLHAs will reduce discriminatory treatment, making information and services more accessible to HIV-positive women. Once barriers are removed, providers will be more willing to provide comprehensive information about all of the contraceptive options available to HIV-positive women. For their part, HIV-positive women will be more willing to visit providers for treatment and services. A recent study conducted in Mexico on a four-week training course in HIV for health professionals clearly showed that a change in healthcare professionals' attitudes toward and knowledge about HIV can go far to reduce HIV-related stigma (National Institute of Public Health et al., 2004). Developing guidelines to support healthcare workers caring for PLHAs can help establish safer working environments (see Box 7). Healthcare workers who feel

Box 6. NGO uses community leaders to disseminate its message in Cambodia

The Adventist Development and Relief Agency in Cambodia, a REACH grant award winner, empowers and mobilizes stakeholders, such as trained Buddhist leaders, local authorities, and PLHAs, to help reduce internal and external discrimination and facilitate widespread and enduring changes in social attitudes. These influential stakeholders are mobilized to disseminate accurate information, dispel myths surrounding HIV/AIDS and PLHAs, promote a compassionate community and individual response to PLHAs, and inform people about locally available voluntary counseling and testing and support services.

Box 7. Guidelines protect healthcare workers in South Africa

POLICY/South Africa's Guidelines for the Care and Support of Healthcare Personnel in the Context of HIV and AIDS articulate the rights, responsibilities, and entitlements of healthcare workers in the face of HIV/AIDS. The guidelines identify the requirements for safe and efficient healthcare environments and increase pressure on policymakers and administrators to uphold them. The guidelines also educate healthcare workers about their own rights. Healthcare workers who know that they are entitled to protection and have access to equipment, training, and products that maintain their safety against infection are likely to be more willing to provide comprehensive care and information to HIV-positive patients. The number of IUD insertions, C-sections, and other invasive procedures performed on HIV-positive women should increase as healthcare workers feel more secure in their protection against contracting HIV/AIDS.

HIV-Positive Voices

"There is a difference. Those who have gone for counseling [training] treat us better than those who are not trained … they just tell us to wait."

~ HIV-positive woman in Mexico (Banda et al., 2004)

better protected against infection in the workplace are more likely to provide proper care for HIV-positive patients. Counseling training of healthcare providers in Zambia has improved the level of care received by HIV-positive women.

Providers have been known not only to refuse treatment to HIV-positive women but also to coerce or pressure women into sterilizations or abortions. Sterilization procedures should be performed only after a woman has received the information she needs to make an informed decision and has voluntarily chosen to undergo the procedure. Reports indicating that women identified as HIV-positive through antenatal HIV counseling and testing are pressured into sterilizations after childbirth are clear examples of inappropriate FP program implementation as described in international conventions and U.S. government policy (TIAART amendment; Ipas et al., 2004). Healthcare workers need accurate medical information about HIV and its transmission, and they must also be knowledgeable about government policy regulating the delivery of healthcare services to HIV-positive women.

In an effort to reduce stigma and discrimination against PLHAs, the Jamaica Ministry of Health, NGOs, JHPIEGO, and the Pfizer Foundation have collaborated to create tools aimed at healthcare workers (JHPIEGO, 2004). The project's goal is to improve the quality of services provided by healthcare workers to HIV/AIDS patients. The project will train healthcare workers in opportunistic infections and infection prevention, relying on messages against stigma and discrimination portrayed through role plays and discussions. The project also involves the monitoring of service delivery by participants and the examination of stigma and discrimination issues addressed in client satisfaction surveys. The trained providers will be tracked to assess reductions in stigma and discriminatory behavior as a result of training. Data collected on behavior change and patients' perceptions of improvement in service will be used for advocacy purposes.

Including family planning and HIV/AIDS in both informal and formal healthcare worker curricula

The incorporation of comprehensive information about HIV/AIDS and family planning for HIV-positive women into the health training curricula for staff at all levels will make comprehensive services more available as well as reduce discrimination. Instruction for IUD insertion in HIV-positive women, for example, could be added to the curricula at medical schools as well as to midwife and nurse training. Such training, delivered during initial study and through continuing education programs, can help vest providers with the knowledge and skills they need for best serving HIV-positive women.

JHPIEGO has developed an orientation guide to update HIV/AIDS healthcare providers on essential messages about FP/RH. The guide enables providers to carry out preventive counseling, trains them to provide contraception for HIV-positive clients, and discusses how to negotiate condom use among sero-discordant partners. JHPIEGO has also prepared a series of ReproLearn® multimedia tutorials titled "Care of Women Living with HIV in Limited-Resource Settings" (JHPIEGO, online). The tutorials equip physicians, faculty, and healthcare trainers in limited-resource settings with the technical knowledge they need to provide high-quality healthcare services to women with HIV/AIDS and to train other healthcare providers. The tutorials can be used as job aids for trainers disseminating national HIV/AIDS guidelines or as reference materials for preservice training or for in-service HIV/AIDS training programs. The series includes modules on prevention, voluntary counseling and testing, reproductive health, PMTCT through pregnancy and breastfeeding, and nutrition.

3. HIV/AIDS and FP Program Coordination

Including family planning in voluntary counseling and testing and other HIV/AIDS healthcare services

The integration of HIV counseling and testing and FP services traditionally offered as vertical programs may lead to comprehensive service provision, expanded access to services, and lowered operating costs. Using voluntary testing and counseling (VCT) sessions as an opportunity to disseminate information on both family planning and the increased risk of pregnancy for HIV-positive women can help prevent unintended pregnancies and lower the rate of mother-to-child transmission (FHI, 2004). Given the large number of people unaware of their serostatus, it is essential to expand HIV counseling and testing to all people in a stigma- and discrimination-free environment, thus making available the appropriate information and services to those who need and want them. Efforts should also be made to target VCT services to those at high risk for infection and to incorporate FP messages and services.

Advance Africa works with community-based distribution (CBD) agents from the Zimbabwe National Family Planning Council to integrate HIV/AIDS prevention into the agents' current repertoire of FP activities. CBD agents are trained in how to counsel clients on HIV prevention and how to make referrals to VCT programs. The

agents also conduct group meetings on reproductive health, including family planning and HIV, and assist in stigma reduction within communities.[5]

Family Health International (FHI) has been leading efforts to integrate FP services into HIV/AIDS programs, to extend the dissemination of essential FP information to HIV-positive women who may not otherwise have access to such information, and to enhance the role of family planning in preventing new infections. Activities include an assessment of how home-based care (HBC) programs can be used to address the FP/RH needs of HBC clients and caregivers in Kenya and South Africa and an effort with the Kenyan Ministry of Health to integrate family planning into HIV counseling and testing services. A study to determine how to integrate family planning and HIV/AIDS services in Zimbabwe is also underway. In addition, FHI plans to collaborate with EngenderHealth to design a training module on providing contraception for HIV-positive women, including women on ARV therapy.

Ensuring that FP information is provided during HIV counseling and testing sessions is a complicated issue in an environment of provider bias and community pressure. Making sure that HIV counseling and testing providers are educated about FP issues and stock the appropriate materials for distribution to clients is only the first step in information dissemination. Jamaica rolled out a national VCT program but did not include FP-related topics in its training for counselors. Implementing an operational policy that requires providers to offer FP information during VCT visits is one way to increase the probability that FP information is disseminated. Offering incentives to providers to encourage them to distribute comprehensive information to all clients is another approach that may help ensure blanket dissemination.

Conclusion

The ability to choose, obtain, and use contraception that is appropriate and effective is essential for all women, including those who bear the added burden of an HIV-positive status. These women face increased barriers to accessing family planning as well as serious consequences when access is denied. Addressing the needs of this marginalized group will not only affect HIV-positive women directly but also their children, families, and communities. Ensuring contraceptive security for HIV-positive women requires coordination on several levels, from policy development and implementation to provider training and community education. Finally, as developing countries begin to formulate their own CS plans amid increased contraceptive demand and donor phaseout of FP products, strategies must call for the allocation of resources to meet the needs of vulnerable groups—including HIV-positive women, youth, and the poor. ■

[5] For more information, refer to Advance Africa's website at http://www.advanceafrica.org.

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