30 FOR 30 CAMPAIGN

**BRIEFING PAPER**

# Integrating HIV and Sexual and Reproductive Health Service Provision: A Proven Strategy for Providing More and Better Health Care to Women Living with and at Risk of HIV/AIDS

## Advocacy • Equity • Action

### Introduction:

In the US, over half (60%) of all adolescent and adult women of reproductive age identify family planning clinics as their "usual source of reproductive and general health care services."[1] Over one third report such clinics as their sole source of health care of any kind. In 2013, an estimated 38 million women needed contraceptive care. Over half (53% of them) needed access to publicly subsidized family planning services and supplies because of their low income level or because they were below the age of 20.[2]

These data show that such clinics are the main, and often the sole, entry point into the health care system for many women, especially those in populations most vulnerable to HIV. Nearly two-thirds (64%) of all women living with HIV survive on less than $10,000 per year, compared to 41% of men living with HIV.[3] Thus, there is a clear logic to integrating HIV testing, prevention and linkage to HIV care services into public family planning clinics, public health centers and other venues where low-income women are accessing health care. Using US tax dollars overseas, USAID has already demonstrated that the integration of "HIV and family planning activities provides opportunities to simultaneously reduce the incidence of HIV and AIDS and the unmet need for family planning."[4]

This brief makes the case for such integration by identifying how better incorporation of HIV prevention, treatment and care services into the larger Sexual and Reproductive Health (SRH) framework can facilitate care synergies, save time and resources, and improve access to essential care for the US women who need it most. The brief will conclude with policy recommendations, including a strong call for increased public investment into SRH services to support such integration.

The 30 for 30 Campaign is dedicated to ensuring that the unique needs of women living with and affected by HIV, including transgender women, are addressed in the national HIV response. We are especially committed to illuminating and eliminating the gaps in prevention and care services for Black and Latina women who currently make up over 80% of the epidemic among women but only 12% and 14% of the US female population, respectively.

The Campaign is concerned with the current state of HIV prevention and care for women as studies continue to show that women, especially women of color, have consistently poorer health outcomes despite there being no significant clinical difference in treating men or women living with HIV.

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## The Basics:

Most women acquire HIV the same way they become pregnant, through heterosexual sex. In the US, an estimated 84% of HIV acquisition among women occurs through sex with a male partner[5], as do 98.5% of pregnancies.[6] Women seeking to prevent unintended pregnancy face some of the same challenges as those actively avoiding transmission of HIV and other sexually transmitted infections (STI). Many women have both needs. The challenges they face may include lack of accurate information about their level of risk, lack of access to appropriate prevention tools, and difficulty insisting on consistent use of condoms or other contraceptive or disease-prevention tools.

Women living with HIV, including transgender women, continue to have sexual and reproductive health needs and desires after their HIV diagnosis.

The health care system should serve to enable women living with HIV to lead safe and healthy sex lives after a positive diagnosis, providing these women with the tools and treatments necessary to do so. Women living with HIV also have some unique reproductive health needs, such as information about their options for achieving conception without transmitting HIV to a negative partner and the implications of continuing their particular course of anti-retroviral treatment (ART) during pregnancy and breast-feeding.

These commonalities point to the importance of achieving both better integration of HIV care and SRH care services and the need for reproductive health care that is explicitly tailored for women living with HIV. Such integration also offers the unique and vitally important opportunity for educating women and girls about HIV and other STIs in the setting in which they are most likely to be present, as documented by the data above regarding how women access health care through family planning clinics. These are also the settings in which patients expect to talk about sex and where providers are most likely to be comfortable and experienced in taking sexual histories. In a 2010 survey in the US, 88% of young women said they would be uncomfortable asking a male health care provider for an STI test and 79% said they would be more comfortable seeking such testing from a specialist than a "family doctor."[7]

## The Intersection of HIV & Other STIs:

The risk of acquiring HIV is enhanced by the presence of other STIs in the body. Thus, investing in expanded and user-friendly access to STI screening and treatment is an HIV prevention step, as well as a general SRH priority.

**Human Papillomavirus (HPV):** HPV is the most common STI infecting women in the US.[8] Over 40 strains of HPV can infect the human genital tract.[9] Public awareness of these is relatively low because most HPV infections resolve spontaneously, without causing symptoms or requiring treatment. Some strains, however, cause visible genital warts; others are associated with cancer, particularly cervical cancer.[10] Some data suggest that having HPV may increase a woman's risk of HIV acquisition.[11] Women living with HIV may be more likely to acquire HPV if exposed to it and their HIV-compromised immune systems may render them more vulnerable to symptomatic HPV-related conditions.[12] Clear racial disparities exist in women's rates of both HIV and cervical cancer. Black women are 20 times more likely to acquire HIV and Latinas are four times more likely to do so than white women.[13] With regard to cervical cancer diagnoses, 11 occur per 100,000 Latinas, compared to nine per 100,000 black women and seven per 100,000 white women.[14]

**Bacterial Vaginosis (BV):** Because BV can be caused by factors other than sexual activity, it is not technically an STI. It is, rather, an imbalance in the natural ecology of the vagina. The most common causes of BV are sex with a new partner or multiple sexual partners[15] and/or douching.[16] In 2012, 29.2% of US women between the ages of 14-49 had BV, making it the most common vaginal infection among women of reproductive age.[17] A 2012 meta-analysis of 23 studies concluded that, "BV was consistently associated with an increased risk of HIV infection."[18] At least one study has also found an increase in HIV acquisition among men who have sex with women experiencing a BV infection.

BV is asymptomatic for most women but those experiencing symptoms often seek treatment from SRH care providers, offering yet another and relatively frequent opportunity to address HIV prevention in an SRH setting.

**Trichomoniasis, Syphilis, Herpes, Gonorrhea, Chlamydia and PID:** A vaginal infection called Trichomonas vaginalis is the world's most common non-viral STI[19] and appears to have a "substantial impact on the spread of HIV-1."[20] In one study, women with Trich were shown to be 50% more likely to acquire HIV than those who did not.[21] Trich is more common among women than men, is easily treated and can remain asymptomatic for long periods of time.[22]

Syphilis and Herpes Simplex Virus (HSV1 and HSV) are ulcerative STIs that cause sores or blisters on mucous membranes. These breaks in the skin can facilitate HIV entry into the bloodstream if exposure occurs.[23] Since having HIV weakens the immune system, women living with HIV are both more likely to acquire STIs, if exposed, and may be more likely to transmit viral STIs such as herpes and HSV due to increased amounts of STI virus in their vaginal secretions.

While the relationship between HIV and bacterial STIs is complicated, co-infection with HIV and either Gonorrhea or Chlamydia may affect acquisition of HIV and likely affects the body's ability to control HIV, once acquired.[24] Pelvic Inflammatory Disease (PID) -- an infection of the cervix, uterus, fallopian tubes, or ovaries -- can be caused by untreated Gonorrhea or Chlamydia."[25] Untreated PID can disastrously affect a woman's gynecological health, resulting in infertility, tubal pregnancy and chronic pelvic pain.[26] As a condition that indicates weakening of the immune system, PID may also be a symptom of untreated HIV and the CDC recommends HIV testing for all women diagnosed with PID. PID is "more common and more aggressive in women with HIV than in uninfected women"[27] – indicating another area in which SRH services need to be tailored to meet the needs of women living with HIV.

## Intimate Partner / Dating Violence:

The impact of intimate partner violence (IPV) and dating violence on the quality of women's reproductive health and sexual autonomy is well documented, as is the high prevalence of IPV (current or past) among women living with HIV.[28] In a 2010 study of young women (15-29) in California, 53% reported having experienced "physical or sexual violence from an intimate partner," 20% said they experienced pregnancy coercion, and 15% said their partner had engaged in contraceptive sabotage (removing a condom during sex, destroying contraceptive supplies, etc.).[29] The latter points out that unintended pregnancy belongs on the list of negative SRH consequences attributable to IPV. Thus, IPV screening and treatment should be added to the array of public health strategies designed to reduce unintended pregnancy.

The 2010 National Intimate Partner and Sexual Violence Survey (NISVS) reported that 35.6% of women in the US "have experienced rape, physical violence, or stalking by an intimate partner in their lifetime."[30] It also found that nearly 50% of women have experienced "other forms of sexual violence in their lifetime (e.g., sexual coercion, unwanted sexual contact)"[31] – an estimate concurring with the California study above. The CDC reports that, across multiple studies, the percentage of HIV-positive women reporting past or current IPV is roughly twice that of women overall, and "the rates of childhood sexual abuse (39%) and childhood physical abuse (42%) were more than double the national rate."[32]

A woman's SRH status, level of HIV risk, and overall well-being can all be deeply affected by past or present experiences with IPV and/or childhood abuse.

The damage left by violence and abuse is long-term and becomes an intrinsic part of the survivor's physical and mental health status. Health services for women are deficient if they do not explicitly screen for IPV and have sufficient, culturally competent staffing and resources to respond to the needs of those with abuse histories.

## HIV & Pregnancy Related Care:

**Pregnancy Desires /Infertility:** Three-quarters of the people living with HIV in the US are of reproductive age (75%). Their desires regarding child bearing tend to be similar to those of the general population.[33]

Studies done in developing countries show that AIDS-related opportunistic infections impair fertility in both women and men. These effects are far less common when people have access to ART to prevent the onset of such opportunistic infections.[34]

Attitudes in the general public and particularly those of health care providers about child-bearing by people living with HIV are still a major obstacle, however. Another obstacle is concern about HIV transmission in mixed status couples (in which one partner is living with HIV and the other is not). Fortunately, PrEP (pre-exposure prophylaxis) medication for the HIV negative partner combined with consistent use of ARTs by the partner living with HIV can now dramatically reduce the risk of HIV transmission in mixed status couples to practically zero.[35]

This combination of treatment and prevention provides the possibility of leading a healthy and low-risk sex life for mixed status couples who may not prefer to use condoms consistently. Furthermore, it provides an avenue of safe conception for a mixed status couple looking to have children.[36]

In 2013, 20% of new HIV infections were among women. Women of color, and particularly black women comprising 63% of those newly infected, were disproportionately impacted.[37] To date, however, research and marketing efforts on PrEP have largely focused on targeting PrEP to at-risk men who have sex with men (MSM). As a result, many HIV-negative at-risk women remain unaware that PrEP is available as a treatment option, or face unique barriers that current prevention and education campaigns do not take into account due to lack of research on the adherence of women – and particularly transgender women - to PrEP.

Prescribing PrEP at SRH facilities and educating SRH providers about PrEP and the risks of exposure facing women would ultimately improve access to PrEP for women – particularly for the number of women for whom an annual visit to an SRH provider may be her only regular exposure to health care. Furthermore, stigma exists around the act of taking a big blue PrEP pill daily. As such, more pronounced efforts into researching women's adherence to PrEP are needed, as are more innovative strategies to reach women – like providing PrEP in a discreet form such as a vaginal ring, combining PrEP with a birth control method, or changing the appearance of the pills to resemble a vitamin instead of an ART.

Attitudes on this topic may have improved over the last decade but a 2007 survey showed that, despite knowing that mother-to-child transmission could be prevented by ART, only 14% of Americans felt that women living with HIV should bear children.[38] This bias is particularly problematic when it occurs among SRH providers, including obstetricians and gynecologists. In one recent study, women living with HIV and considering pregnancy reported that they often had to raise the topic with their doctors themselves, and that doing so frequently elicited judgmental attitudes.[39] A survey conducted by the Positive Women's Network – USA showed "self-reported high rates of coerced abortion, tubal ligation, and sterilization" among women living with HIV, which is another indicator of resistance among providers regarding people living with HIV and their choice to bear children.[40] Coercion of an individual's reproductive future in this way is a violation of their human right to bodily autonomy and reproductive justice. Every person has the right to choose if, when, and how they will parent, and to do so free from coercion, fear and violence, and people living with HIV are in no way excluded from the enjoyment of this human right.

**Abortion:** Women of color with lower socio-economic status not only make up a widely disproportionate portion of all women living with HIV, they are also most heavily impacted by abortion restrictions. Half of all women in the US experience an unintended pregnancy and three in ten women have an abortion by the age of 45. Of those, it is women in lower socio-economic status who are more likely to face an unintended pregnancy and it has followed that rates of abortion have increased among women in lower socio-economic status. Some of these are women living with HIV and many are women at greater risk of acquiring HIV.

Women of low socio-economic status, who are disproportionately women of color, are more likely to qualify for Medicaid coverage.[41] For a woman whose

only source of health care coverage is Medicaid, she is restricted from applying that coverage to an abortion. The Hyde Amendment, a yearly provision added into the federal budget, restricts states from using any federal funds to cover abortion. This restriction becomes magnified for poor women in states without Medicaid expansion and with abortion-restricting legislation, where they have little, if any, access to pregnancy related services, including and in particular, safe abortion procedures. In Texas, 28% of all households are uninsured and are living at or below the poverty level, compared to 17% of all households nationally.[42] Texas has also passed a state restriction on abortion access that has closed all but 19 of the reproductive healthcare clinics providing abortion in a state whose size is exceeded only by Alaska.[43]

This law, in the words of a Supreme Court plaintiff, "will exacerbate African-American women's inferior access to reproductive health services and compound the myriad harms they already suffer as a result."[44]

Additionally, a majority of states have equally draconian stances on reproductive justice. 33 U.S. states restrict state funds from being used to cover abortion, causing low income women who rely on publicly funded health care coverage to pay out of pocket for this critical health procedure that, in Texas, may cost anywhere between $450 and $3,000.[45] These restrictions force one in four women seeking an abortion to carry an unwanted pregnancy to term.[46] Most black women with HIV are living in poverty and face enormous barriers to accessing abortion care, as well as other SRH services. This extreme violation of their human rights highlights the importance of demanding full sexual and reproductive health rights for all women, especially those living with HIV.

### Sexual and Reproductive Justice is Racial and Gender Justice:

Nationally, HIV prevalence rates are eight times higher for black people and three times higher for Latino/as than for whites.[47] While a web of social, structural and cultural issues contribute to this disparity, the connection between poverty and HIV vulnerability is particularly clear, given that "46% of Blacks and 40% of Latinos live in poverty areas as compared to 10% of whites."[48] The CDC summed it up with regard to impoverished urban poverty; "the lower the income, the higher the HIV prevalence rate."[49]

This economic inequity is demonstrated in all the sections above. Disparities in HIV and cervical cancer rates underscore the importance of ensuring that all women, especially those with low incomes, have culturally appropriate information about these health risks, regular screening, prevention tools (including HPV vaccines for young girls and boys), as well as expert, on-going care and support for those living with HIV and/or HPV.

The data also highlight the urgent need to develop HPV vaccines effective against the viral subtypes most commonly found in black women. The two existing HPV vaccines target HPV16 and HPV18, subtypes that cause about 70% of cervical cancers overall. Black women, however, are 50% less likely than white women to have these two subtypes.[50] The lack of HPV vaccines active against the viral subtypes more common among black women affect not only HPV rates but also, arguably, HIV rates among black women in the US.

BV prevalence is also higher among women of color. Over half (51%) of all black women in the US have likely had BV compared to 32% of Mexican American women and 23% of white women.[51] The possibility of a causal link between BV and HIV strengthens the importance of increasing BV awareness and culturally competent, readily available BV screening and treatment.

In 2012, Chlamydia rates were six times higher, Gonorrhea rates were 11 times higher, and Syphilis rates were 16 times higher among black women than white women.[52] Similar patterns are evident across other populations of color as well, with variations and some exceptions. These data highlight the urgent importance of generating meaningful public health approaches to raising awareness of the link between HIV and other STIs and making more and better SRH services available to provide screening and treatment for women, especially those with low incomes. These services can be appropriately provided by both SRH clinics and by HIV health care providers cross-trained in the provision of basic SRH screening and care to women in the communities they serve.

IPV is also linked to HIV risk and is a particular point of vulnerability and suffering for women at risk of and living with HIV. Its impact can no longer be ignored. Trauma-informed care must become a fundamental component of SRH services, especially those targeted to underserved communities of color with high HIV prevalence. Finally, publicly funded and SRH-provider-based support for the full spectrum of women's reproductive options must be restored, especially for uninsured women living in poverty.

The lack of accessible health coverage and state suppression of women's right to make their own decisions about their bodies and families is a human rights violation and a public health disaster.

It contributes to the spread of HIV by driving poor women further into poverty and limiting their agency with regard to employment, education and other risk-reducing decisions. Access to a full range of reproductive and sexual health care is vital component of health care for all women and especially women living with HIV.

## Policy Recommendations:

Given that HIV care and prevention is clearly an important component of women's reproductive health care and women living with HIV have unique reproductive health needs, the 30 for 30 Campaign supports the following policy recommendations:

- **Support increased funding and continue robust funding for Title X which is the only federal program solely dedicated to family planning and provides critical sexual and reproductive health services, like contraceptive services; infertility services; services to adolescents; breast and cervical cancer screening and prevention; STI and HIV prevention education.**[53]
- **Implementation of education programs for gynecologist specialists to become better versed on HIV treatment and culturally appropriate care for all women living with HIV – including transgender women.**
- **Remove abortion funding restrictions like the Hyde Amendment, which bans Medicaid abortion coverage, and support public funding for the full spectrum of women's reproductive health options.**
- **Link voluntary family planning and HIV programs to improve access to quality health services.**
- **Support efforts for increased options for female-controlled and discreet prevention tools, dual protection from pregnancy and HIV options.**
- **Increase research on the interaction between HIV-related treatments and contraceptives; further ensure that research specifically identifies interaction between HIV-related treatments and hormones.**
- **Support funding for research regarding effective public health approaches to raising awareness of the link between HIV and other STIs, like trichomoniasis, BV and HPV.**
- **Make more and better SRH services available to provide screening and treatment for women and include opt-out screening for STIs and HIV at routine gynecological visits.**
- **Support funding to develop HPV vaccines effective against the viral subtypes most commonly found in black women.**
- **Add trauma informed care in the form of Intimate Partner Violence (IPV) screening, counseling and treatment to the array of public health strategies designed to reduce unintended pregnancy.**
- **Require health care providers to routinely screen for IPV and HIV risk among female patients in primary care, HIV care, and reproductive health care settings in order to support women's risk reduction and early entrance into HIV treatment**

- **Support education efforts and access to PrEP for all women who are or may be at risk for HIV infection, including women who have HIV-positive partners.**
- **Support PLHIV and mixed status couples who wish to have children by providing them with comprehensive prenatal and perinatal care, including the prevention and treatment tools necessary to conceive and have a safe pregnancy and child birth without risk of HIV transmission**
- **Support PLHIV and mixed status couples who are looking to have children by providing them with the prevention and treatment tools necessary to conceive and have a safe pregnancy and child birth without risk of transmission, including prenatal and perinatal care.**
- **Prevent coerced abortion or sterilization for PLHIV through de-stigmatizing HIV training and culturally competency training for health care providers.**
- **Increase HIV prevention and self-empowerment programming designed with and by sex workers to effectively reduce their risk of HIV, STIs and violence risk and increase their access to sex worker-friendly health care services.**

Report prepared by
Melissa Torres-Montoya, J.D., MPH,
Anna Forbes and
Sabrina Rewald, JD

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