Since 2003, the U.S. government has been a leader in the global fight against HIV/AIDS. The Obama administration has improved the U.S. approach, particularly for women, by shifting U.S. efforts toward combination prevention—using a variety of tools to combat the spread of HIV. As women are now more than half of people living with HIV worldwide, the administration must prioritize interventions that give women the ability to protect themselves.

This paper outlines the reasons why the Office of the Global AIDS Coordinator (OGAC) and Congress must support a true combination prevention strategy, one that both scales up proven biomedical prevention tools and integrates sexual and reproductive health services into HIV prevention, while also pursuing structural attacks on barriers to HIV prevention. This paper views the situation through the lens of women’s needs.
U.S. POLICY AND HIV

In 2009, The Lancet called the President’s Emergency Plan for AIDS Relief (PEPFAR), the “largest and most successful bilateral HIV/AIDS program worldwide.”1 Launched in 2003, PEPFAR is credited with helping raise the number of people in low- and middle-income countries receiving anti-retroviral treatment (ART) more than 16-fold, from 400,000 in 20032 to 6.65 million in 2010,3 according to the World Health Organization (WHO). More than half those people accessed ART through U.S.-funded programs, most in sub-Saharan Africa.4 Despite this remarkable progress, fewer than half of those needing ARVs in that region5 are receiving them.

PEPFAR is now guided by President Obama’s Global Health Initiative (GHI) of 2009. The GHI seeks to strengthen and increase the efficiency of U.S. global health programs, including those promoting maternal and child health and family planning, and combating HIV/AIDS, tuberculosis, malaria and neglected tropical diseases.6 Together, PEPFAR and GFATM budgets were 70 percent of GHI-guided funding in FY 2011.

Secretary of State Hillary Clinton, in a November 2011 speech, described a new vision of an AIDS-free generation: one in which virtually no vertical (mother-to-child) HIV transmission occurs; HIV-free children have more and better prevention options, making them less likely to acquire HIV as they mature; and those that do acquire HIV have assured access to ART, which benefits their own health and greatly reduces their risk of transmitting HIV to anyone else.7

Clinton then outlined recent scientific breakthroughs underlying this vision. The first step expands access to the strategy of preventing vertical transmission by administering ART to pregnant women, new mothers and newborns. The second step involves advances in developing HIV microbicides and vaccine candidates, and evidence that medication before exposure (pre-exposure prophylaxis, or PrEP) and male circumcision are both effective in reducing HIV infections. The latest breakthrough is evidence that treatment-as-prevention (TasP) can almost eliminate the risk that an HIV-positive person will transmit HIV to someone else.

“Now of course,” Clinton added, “interventions like these can’t be successful in isolation. They work best when combined with condoms, counseling and testing, and other effective prevention interventions. And they rely on strong systems and personnel, including trained community health workers. They depend on institutional and social changes like ending stigma; reducing discrimination against women and girls; stopping gender-based violence and exploitation, which continue to put women and girls at higher risk of HIV infection; and repealing laws that make people criminals simply because of their sexual orientation.”

The most promising biomedical tools cannot realize their potential in the absence of attention to these other components, because people’s HIV-prevention decisions occur in the context of the rest of their lives. Male circumcision is less successful in communities where its purpose is not fully understood and embraced, for example.8 In the microbicide trial known as FEM-PrEP, the gel appeared to be ineffective because many participants did not use it regularly or perceive themselves to be at risk.9
REMOVING THE SILOS

In her November speech, Secretary Clinton implied the value of integrating sexual and reproductive health services with HIV prevention. PEPFAR, she said, is “one of the strong platforms upon which the Obama administration is building our Global Health Initiative, which supports one-stop clinics offering an array of health services while driving down costs, driving up impact, and saving more lives.”

Creating these “one-stop shops” is vital because women tend to put children and family needs before their own and they are therefore more likely to access HIV services when those are readily available at sites they already visit for other needs—sexual, reproductive, maternal and pediatric care, and financial and/or food assistance. Such integration saves time and money (child care and transport) and offers women HIV services in non-stigmatizing settings they already find comfortable.

Conversely, trained providers of HIV services are well-situated to help clients identify their care needs and initiate access to such services. Two of the four pillars UNAIDS calls essential to preventing vertical transmission are preventing HIV infection in women and providing family planning to prevent unintended pregnancies. These steps are closely related and can best be achieved with integration of sexual and reproductive health (SRH) care and HIV services: through cross-training, co-location of services and referral systems.

Experts find that the best ways of keeping women healthy also keep their infants and partners healthy. The World Health Organization has recommended “Option B+,” a protocol for treating HIV-positive pregnant women during pregnancy and the rest of their lives, regardless of viral load. This means women don’t start and stop treatment depending on their childbearing or breastfeeding status or CD4 count.

“If option B+ can be supported, funded, scaled up at the primary care level and sustained,” WHO said, “it will also likely provide the best protection for the mother’s health, and it offers a promising new approach to preventing sexual transmission and new HIV infections in the general population.”

To make this work, service providers should have current data on potential drug interactions and be able to assist women in making informed choices. Last year, one study suggested that injectable hormonal contraceptives might increase a woman’s risk of acquiring or transmitting HIV. But major health institutions including the Centers for Disease Control and WHO concluded that the evidence was not strong enough to justify advising women to switch birth control methods. Providers who focus only on family planning to the exclusion of HIV may not receive this message, or may not communicate it effectively. Family planning providers must fully understand implications of the available data about hormonal contraceptives and HIV risk.
Integrating, rather than siloing, HIV/AIDS care, treatment, and support with the other health and social services women use routinely is cost-effective, for three reasons:

1. Women are usually the primary caregivers for their children and often the unpaid caregivers for other ill or elderly family and community members. Enabling women to protect their own health protects their ability to fulfill this function.

2. Integration of SRH and HIV care makes efficient use of providers’ time and lowers infrastructure costs.\(^1\) It does require investment in cross-training and thoughtful use of providers’ skills. Providers of SRH care, for example, often need additional training to address the unique needs of women living with HIV. All staff also need training that counters stigma so that patients feel respected and comfortable discussing their needs, HIV status and sexual issues.

3. Without removal of barriers to women’s access to HIV services, treatment-as-prevention (TasP) cannot work. Much effort is required to improve current rates at which women living with HIV are enrolled and retained in care and adhere to treatment regimens.

**SOME STRUCTURAL IMPERATIVES**

In 2010, U.S. Global AIDS Coordinator Eric Goosby reported to Congress that structural factors influencing HIV acquisition included “gender-based violence (GBV); economic and educational constraints; inferior legal protection and rights to property and inheritance; and lack of leadership roles for women.” He added, “PEPFAR’s new strategy emphasizes programs to combat GBV.”\(^2\)

Cultural acceptance of GBV is a structural factor that cannot be ameliorated without structural interventions. Consultant Judith Auerbach defines such interventions as those designed to “modify social arrangements and social conditions, or both, to promote health and reduce risk in specific contexts. They include efforts to change social norms, laws, and policies; institutional and cultural practices; and economic and financial circumstances.”\(^3\)

PEPFAR has made significant commitments along these lines, including an initiative to “expand its work on the links between GBV and HIV, with $30 million in funding to support the scale-up of GBV prevention and response programmes”\(^4\) in three focus countries. Among other goals, this initiative proposes to “demonstrate that GBV programs can be brought to scale at the national or regional level.”\(^5\)

The link between GBV and HIV risk has been clearly established\(^6,7,8,9\) so the need to scale up such programming can hardly be overstated. In FY 2010, PEPFAR also spent some $38 million to support mainstreaming GBV components into existing HIV programs in 28 countries. U.S. investment in this area should not be curtailed.

Another vital component of PEPFAR’s gender strategy is increasing access to income, productive resources and education for women and girls. It works because completing secondary school reduces a girl’s risk of HIV infection and increases the likelihood that she will practice safe sex.\(^10\) Thus, HIV prevention and sexual and reproductive health are both advanced by removing barriers to education for girls.
FEMALE CONDOMS

The White House 2011 World AIDS Day Fact sheet cited vertical transmission, voluntary medical male circumcision, treatment-as-prevention and female and male condoms as priority areas for expanded efforts that “will dramatically reduce new HIV infections and save lives.”

The condom reference was a critical addition to the three priorities Secretary Clinton had listed in November. Female condoms are particularly important, because the other interventions do not allow women to initiate their own protection.

Research shows that female condoms are acceptable to diverse users across a variety of settings, and are effective in preventing pregnancy and HIV and other sexually transmitted infections when used correctly and consistently. Female condoms also offer unique benefits. When promoted and programmed alongside male condoms, they increase the total number of protected sex acts, because they are sometimes used when unprotected sex would otherwise occur. Studies also show that women view the female condom as helping their ability to negotiate safer sex. Some men who object to male condoms find female condoms acceptable, and even desirable, because they do not affect penile erection or interrupt pleasure if they are inserted in advance.

The White House plans to distribute more than 1 billion male and female condoms over the next two years, which is laudable, but there must also be an effort to ensure access to the condoms and training for their use. Although female condoms are now in theory available in 90 countries, they are only 1.3 percent of all condoms distributed worldwide. That puts the overall odds against being able to obtain a female condom at almost 99 to one.

Lack of investment also stymies efforts to educate and promote female condoms to potential users. But such efforts pay off. For example, Zimbabwe’s National Female Condom Strategy, supported by the United Nations Population Fund (UNFPA), ensured affordable access to female condoms, social marketing, and training of more than 1,500 service providers. It resulted in an increase from 500,000 female condoms distributed in 2005 to over 2.5 million in 2009.

Cost has been another limiting factor. In PEPFAR focus countries, the female condom price is US$0.55 versus US$.04 for male condoms. Decision-makers who balk at this fail to see that male and female condoms are not interchangeable: female condoms are the only alternative for women whose male partners refuse to use male condoms.

In 2011, USAID released its first guidance to PEPFAR grantees on female condoms, referring to them as a “largely untapped resource for HIV prevention.” Most health care providers have still not been active in educating people about female condoms and many are skeptical themselves about the tool’s benefit. Pilot projects in Zimbabwe, South Africa, Nigeria and the United States, however, verify that training can overcome these gatekeepers’ negative perceptions and encourage them to promote female condoms in a positive, supportive way.

More than half of all people living with HIV/AIDS are female. HIV transmission from male to female during sex occurs more easily than from female to male, and vulnerability is increased by gender-related social, political, and economic factors. It is self-evident that the United States needs federal priorities that reflect these facts.
A program that distributes free female condoms in Washington, D.C. prevented enough HIV infections during its first year to save $8 million in future medical costs, according to a study by Johns Hopkins University.\textsuperscript{38} The benefit was nearly $20 saved for every dollar spent. “This study really says you ought to include female condoms as one element of a comprehensive program because it’s acceptable, effective and cost-saving,” said David Holtgrave, study co-author and chairman of the Department of Health Behavior and Society at Johns Hopkins Bloomberg School of Public Health.\textsuperscript{39}

CONCLUSION

While celebrating the “full toolbox of effective HIV prevention interventions,” the White House World AIDS Day Fact Sheet notes that “not all interventions are equally effective, can be taken to scale, or are appropriate for all populations.”\textsuperscript{41} And as Clinton stated, they work best when combined with other measures, and depend on ending stigma and discrimination against women and girls. For example, circumcision can lower a man’s risk of acquiring HIV by more than 60 percent,\textsuperscript{42} and this eventually lowers HIV risk for women by reducing the likelihood that their partners have HIV. But on its own, circumcision offers no immediate protection for women—unless programs also motivate men to use condoms and stop gender-based violence. Expanding treatment-as-prevention and efforts against vertical transmission will also benefit women, although not immediately without the lifelong treatment of Option B+ (see text box, page 3).

The “take-home” implication of the four World AIDS Day priorities, along with Secretary Clinton’s AIDS-free Generation speech, is that that woman-centered interventions need continued investment. Thanks to PEPFAR, the GFATM and other funders, we know what works: integrating HIV and SRH services, programs to counter gender-based violence, and greater investment in educating girls, as well as income generation initiatives for women.\textsuperscript{43}

These largely structural interventions change the global environment that has fed the steady growth of women’s HIV risk for the last 30 years. A White House re-commitment to structural change is just as vital as continued biomedical research to prevent and eventually cure HIV/AIDS. It creates an environment in which HIV is not transmitted because people, especially women, have the right to protect themselves and can choose when and with whom they have sex. Ending AIDS means ending the constraints that deprive women of this right.
The U.S. government could take three steps in the near term that would improve health outcomes for women, strengthen U.S. HIV programs, and signal a shift in HIV policy.

**FIRST AND FOREMOST, WOMEN’S RIGHTS AND NEEDS MUST GUIDE HIV POLICY.** The pandemic thrives on gender inequalities that keep women from controlling their own sexual activity. Women’s rights must be recognized and respected so they can negotiate condom use and achieve financial independence. Women’s rights must also be the basis of structural interventions to address social risk factors such as child marriage, rape, and gender-based violence.

**SECONDLY, INCREASED U.S. FUNDING AND POLICY SUPPORT FOR PROCUREMENT, DISTRIBUTION AND PROGRAMMING OF FEMALE AND MALE CONDOMS IS CRITICAL.** These are the only existing dual-protection methods that, when used correctly and consistently, protect against HIV and allow women to plan their families. They have to be part of every program to prevent and treat HIV/AIDS.

**FINALLY, SEXUAL AND REPRODUCTIVE HEALTH SERVICES MUST BE INTEGRATED.** The two are inextricably linked; addressing them independently causes critical health gaps that fuel the pandemic. Women living with HIV may go untreated because their family planning provider does not test for HIV. Others may receive treatment at an HIV clinic, yet face stigma if they seek contraception or prenatal care because of perceptions that women living with HIV should not have sex.

Combination prevention protects everyone. It can provide both short- and long-term prevention and treatment, and it recognizes the root causes that have made HIV/AIDS a global pandemic. It also addresses the new shape of the pandemic: women are the majority of people living with HIV.

Comprehensive combination prevention should be the next step in the U.S. legacy as a leader in HIV prevention and treatment. It is the only way to truly turn the tide and create an AIDS-free generation.
NOTES


3. Ibid.


20. Ibid.


26 Dude A.M., Spousal Intimate Partner Violence is Associated with HIV and other STIs Among Married Rwandan Women. 2009. AIDS and Behavior, 15(1); 142-152. doi:10.1007/s10461-009-9526-1


42 Ibid.

ABOUT CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes the sexual and reproductive health and human rights of women and girls globally by shaping rights-based and just U.S. policies. CHANGE advocates for effective, evidence-based policies and increased funding for critical programs. CHANGE believes that every individual has the right to basic information, technologies, and services needed to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness.

This brief was written by Anna Forbes, MSS.

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