NATIONAL FAMILY PLANNING BOARD

The Health Provider

A PUBLICATION OF THE NATIONAL FAMILY PLANNING BOARD VOLUME 6, NUMBER 4

FAMILY PLANNING, INTEGRAL TO HIV/AIDS PREVENTION

WHAT'S INSIDE:

EDITORIAL

When it comes to HIV/AIDS, the Caribbean accounts for a small percentage of the global epidemic; however, its HIV prevalence among adults is estimated at 1.7 percent which is higher than all other regions except for sub-Saharan Africa; which is at 4.9 percent. According to the Ministry of Health's National Knowledge, Attitude, Behaviour and Practices (KABP) 2012 study, Jamaica has an adult HIV prevalence estimated at 1.7 percent; that is 32,000 persons living with HIV in Jamaica, the third largest island in the Caribbean. The Caribbean currently has an estimated 230,000 cases.

Jamaica's National HIV Strategic Plan 2012 – 2017 describes the HIV epidemic as mixed because it demonstrates features of both a concentrated and generalized epidemic. According to a 2012 survey of high risk groups, including Commercial Sex Workers, HIV prevalence is 4.1% among females and 32% among men who have sex with men." HIV infected and of 453 Men who have sex with Men in a 2011 survey, one out of three was HIV infected. While the prevalence in the general population has remained under 2 percent over the last few years, great concern has been expressed about the high risk groups. The prevalence among other high risk groups range between 5 and 10 per cent including prison inmates - 4.8 percent, crack/cocaine users – 5 percent and the homeless – 10 per cent (Duncan et al, Ministry of Health, Jamaica 2010, Figueroa et al 2008, UNAIDS 2010).

The KABP 2012 study reports that surveillance of STI clinic attendees in 2011 indicated that for every 1000 persons with a sexually transmitted infection, approximately 26 were infected with HIV. Another troubling fact is that, it is estimated that 50 per cent of those living with HIV are unaware of their status. Socio-cultural and economic vulnerabilities are reportedly among the main drivers of the epidemic which result in high risk behaviours such as multiple partnerships, forced/coerced sex, early initiation of sexual activity, crack/ cocaine usage and infrequent condom use. However, Jamaica has made strident moves in creating an enabling environment to reduce vulnerability to HIV and other infections.

Reportedly, in Jamaica, HIV is primarily transmitted through sexual intercourse. Globally, over 33 million adults and children are living with HIV/AIDS and women of childbearing age account for nearly half of the infected population, according to the United States Agency for International Development (USAID). USAID recommends that integrating programmes will provide opportunities to reach important populations with critical information and services. USAID's family planning and HIV/AIDS key areas for integration include:

- prevention of mother-to-child transmission (PMTCT);
- voluntary counselling and testing (VCT);
- antiretroviral treatment (ART);
- development of innovative contraceptive technologies such as microbicides.

This integration can potentially reduce missed opportunities and provide comprehensive reproductive health care that addresses the dual risk of HIV infection and unintended pregnancy.

This issue of The Health Provider will examine Family Planning as an indispensable component of HIV/AIDS prevention and treatment, with a view to providing readers with information that can be used in day-to-day interactions with clients and for the purpose of analytical discourse.

> “There are approximately 32,000 Jamaicans currently living with HIV and AIDS; which constitutes a rate of 1.7 per cent of the general population.”

THE HIV/AIDS EPIDEMIC IN JAMAICA

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome, has become one of the world's most serious health and development challenges. It first became an issue for Jamaica in 1982, when the first case was reported. Today, more than 30 years later, there are approximately 32,000 () Jamaicans currently living with HIV and AIDS; which constitutes a rate of 1.7 per cent of the general population. On the other hand, the total number of reported AIDS deaths in Jamaica between January 1982 and December 2011 was 8,498. The Jamaica National STI Strategic Plan 2012 - 2017 revealed:

- **Transmission of HIV**
  - In Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (77 per cent of cases), heterosexual practice is reported by 95 per cent of persons.
  - In 2011, the sexual practice of 44 per cent of men reported with HIV (and 41 per cent of men reported with AIDS) was unknown. This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices. Of the total number of men reported with HIV, 4 per cent (595) were identified as Bisexual and 3.5 percent (494) identified as Homosexual.
  - Among reported HIV cases on whom risk data are available, the main risk factors are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. 'No high risk behaviour' was reported for a significant proportion of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.
- **Gender, Age and AIDS**
  - The overall male:female ratio for persons reported with AIDS is 1.33:1, and the ratio of men:women reported in 2011 is 1.25:1. The cumulative AIDS case rates are higher among males (689.3 cases per 100,000) compared to females (504.9 cases per 100,000 females).
  - Approximately 74 per cent of all AIDS cases reported between 1982 and 2011 are in the 20-49 year old age group and 86 per cent of all AIDS cases reported from 1982 to 2011 were between 20 and 60 years old.

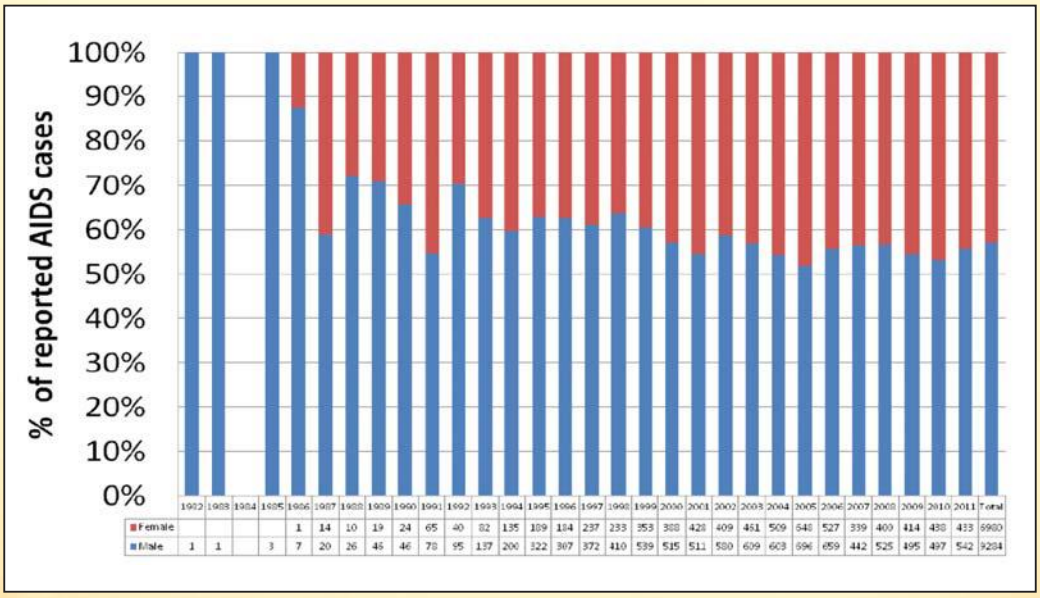
> “Adult males account for a larger proportion of the cases reported in the 30 to 79 age group. Females account for the larger share of cases in the 10 to 29, age group.”

- Although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually.

- There is variation in the gender distribution of reported AIDS cases across the lifespan. Females account for the larger share of cases in the 10 to 29, age group. Among cases reported in the 15 to 19 age groups, four times as many young women have been reported with AIDS than young men; Adult males account for a larger proportion of the cases reported in the 30 to 79 age group.

- Cumulatively, the number of AIDS cases reported among 20-24 year olds (959 cases) is over 4.52 times the number of cases reported among 15 -19 year olds (212 cases).

Annual Female:Male distribution of reported AIDS cases, 1982 – 2011



	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Female					1	14	10	19	24	65	40	82	135	189	184	237	233	353	388	428	409	461	509	648	527	339	409	414	430	433	6980
Male	1	1		3	7	20	26	46	46	78	95	137	200	322	307	372	410	539	515	511	580	609	668	696	659	442	525	495	497	542	9284



FAMILY PLANNING IS INTEGRAL TO THE SUCCESS OF HIV/AIDS PREVENTION:
Key Areas of Integration

With approximately 34 million adults and children living with HIV/AIDS, and with women of childbearing age reportedly accounting for nearly half the infected population, family planning has a critical role to play in curbing the HIV/AIDS epidemic. Integrating programmes provides opportunities to reach important populations with critical information and services. The more than 222 million women, globally, who want to delay or avoid pregnancy but are not using a modern method of contraception include women who are HIV-positive and those at risk of HIV. Determining the number, timing, and spacing of children is a right of all women and couples no matter their HIV status, and since sexually active individuals are at risk of both unintended pregnancies and HIV, integrating both services will ultimately address both risks.

The rationale for integrating family planning and HIV services, especially in high HIV prevalence settings, has long been apparent. Family planning can help achieve HIV prevention goals and improve maternal and child health outcomes. Likewise, HIV services can help expand access to family planning services. Family planning and HIV/AIDS programmes often serve similar populations, particularly in countries with generalised HIV epidemics driven by heterosexual transmission. When programmes and services meet multiple client needs, satisfaction with the health system increases, and scarce financial and human resources are better utilised.

Both family planning and HIV/AIDS prevention, care, and treatment services are useful entry points for many types of services that people in their reproductive years need:

The majority of new HIV infections are sexually transmitted.

The same people who are at risk of unintended pregnancy are also at risk of HIV infection. Voluntary family planning programmes give women, youth, and men the information and services they need to protect themselves and their partners from unintended pregnancies, HIV, and other sexually transmitted infections. Recent studies have identified particular populations, such as youth who seek HIV testing, who may not be able to readily access family planning services. Local statistics show that for every 1000 pregnant women attending public antenatal clinics, at least 10 were HIV infected.

Voluntary family planning programmes increase access to and uptake of HIV prevention information and services.

Voluntary family planning and other reproductive health services are an important entry point to addressing HIV risk factors (including gender-based violence and sexual coercion), safe sex negotiation, voluntary counselling and testing, prevention of vertical transmission of HIV, and other prevention interventions. These services also reach women, youth, and men who would not seek out HIV services independent of other health services because of stigma or other barriers.

FAMILY PLANNING IS INTEGRAL TO THE SUCCESS OF HIV/AIDS PREVENTION: KEY AREAS OF INTEGRATION

Linking voluntary family planning and HIV programmes improves access to quality health services.

Linking HIV and reproductive health programmes, like voluntary family planning and maternal health, improves access to both HIV and reproductive health services, reduces HIV-related stigma and discrimination, and extends programmes to underserved populations. Antiretroviral therapy services are expanding to enable a growing number of individuals living with HIV to have access to care and support. As people begin to feel better, they may resume sexual activity, thus increasing the need for reproductive health care within treatment services.

Access to voluntary family planning services promotes human rights and increases the quality of life of women, youth, and men living with HIV.

All individuals - including those living with HIV - have the basic right to decide the number and spacing of their children and to have the information, education, and means to do so, free from discrimination, coercion, and violence. Access to voluntary family planning services ensures that women, youth and men living with HIV can exercise their right to the highest attainable standard of sexual and reproductive health, and allows for the management of family size and prevention of vertical transmission of HIV.

Voluntary family planning services provide access to critical prevention methods, including female and male condoms.

Women, youth, and men living with HIV have a higher risk of contracting sexually transmitted infections, including additional strains of HIV. Correct and consistent use of female and male condoms is the only method that reduces both this risk and that of unintended pregnancy.

Access to voluntary family planning services decreases maternal deaths among women and girls living with HIV.

Women and girls living with HIV are more likely to experience pregnancy complications, and are at a higher risk of maternal death. Voluntary family planning and other reproductive health programmes empower women living with HIV to prevent health complications related to unintended pregnancies and to plan pregnancies based on their child-bearing desires and health needs. Also, interventions to prevent mother-to-child HIV transmission provide an opportunity to integrate family planning services and contribute to reducing HIV infections among infants.

Voluntary family planning is an indispensable component of HIV prevention and treatment. Integrated family planning and HIV/AIDS services have the potential to reduce missed opportunities and provide comprehensive reproductive health care that addresses the dual risk of HIV infection and unintended pregnancy. Community outreach and coordination between the health facility and the community is extremely important for educating community members about their health and where to obtain services. Community health workers help bridge this link by providing some services and monitoring client use and challenges, which in turn assist the health providers and the District Health Management Team to improve the quality of services.

CARING FOR A CLIENT WITH HIV/AIDS

All clients for FP have the right to:

Information: to learn about the benefits and availability of contraceptive methods.

Access: to obtain services regardless of sex, age, marital status, creed, ethnic origin, colour, or location.

Choice: to decide freely whether to practice FP and which method to use.

Safety: to use safe and effective contraception.

Privacy: to have a private environment during counselling or services.

Confidentiality: to be assured that personal information will remain confidential.

Dignity: to be treated with courtesy, consideration, and attentiveness.

Comfort: to feel comfortable when receiving services.

Continuity: to receive contraceptive services and supplies for as long as needed.

Opinion: to express views on the services needed.

It is important for Health Care Providers to:

- Be aware of and address their own values/beliefs so as not to impose them on their clients.
- Understand that it is important for the clients to feel safe and protected, so that they can share their concerns and get the services they need.
- Know that the decision to use contraception, choose a particular method, or stop/change a method is the right of the client regardless of their age, marital status, and/or HIV status. Family Planning must be based on volunteerism and the informed decision of the client, regardless of their HIV status.
- People living with HIV (PLHIV) are entitled to make their own reproductive decisions, have the right to a safe and satisfying sex life, and the right to a full range of sexual and reproductive health services.
- Health workers have a professional obligation to remain objective and nonjudgmental with clients and to avoid letting their personal beliefs, values, and attitudes become barriers to providing quality care to HIV positive clients or those perceived to be HIV-positive or at-risk.

The advantages of Client satisfaction are:

- Fewer unintended or high-risk pregnancies to handle
- Fewer clients with unintended pregnancies seeking PMTCT services
- Fewer time-consuming minor complaints and side effects
- Increased trust and respect between client and provider
- Positive promotion of FP by the client to his/her community or peers

ADVANCEMENT IN SRH TECHNOLOGY

ANTIRETROVIRAL THERAPY (ART)

Standard antiretroviral therapy (ART) consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV and stop the progression of the disease. Huge reductions have been seen in rates of death and suffering when use is made of a potent ARV regimen, particularly in early stages of the disease. The classes of anti-HIV drugs include:

- Non-nucleoside reverse transcriptase inhibitors (NNRTIs). NNRTIs disable a protein needed by HIV to make copies of itself. Examples include efavirenz (Sustiva), etravirine (Intelence) and nevirapine (Viramune).

- Nucleoside reverse transcriptase inhibitors (NRTIs). NRTIs are faulty versions of building blocks that HIV needs to make copies of itself. Examples include Abacavir (Ziagen), and the combination drugs emtricitabine and tenofovir (Truvada), and lamivudine and zidovudine (Combivir).

- Protease inhibitors (PIs). PIs disable protease, another protein that HIV needs to make copies of itself. Examples include atazanavir (Reyataz), darunavir (Prezista), fosamprenavir (Lexiva) and ritonavir (Norvir).

- Entry or fusion inhibitors. These drugs block HIV's entry into CD4 cells. Examples include enfuvirtide (Fuzeon) and maraviroc (Selzentry).

- Integrase inhibitors. Raltegravir (Isentress) works by disabling integrase, a protein that HIV uses to insert its genetic material into CD4 cells.

Contact the National HIV/STI Programme at the Ministry of Health,
2-4 King Street for details on how to get tested and access to treatment and care of HIV/AIDS:

- **Prevention 967-4286 (2559)**
- **Treatment 967-1100 (2569/2652)**
- **HIV/STI Helpline 1-888-991-4444, 967-3830, 967-3764**

> “HIV/AIDS is a major threat to the world of work.”

HIV/AIDS IN THE WORKPLACE

The International Labour Organisation (ILO) highlights the HIV/AIDS epidemic as a global crisis, which constitutes one of the most formidable challenges to development and social progress. In the most affected countries, the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilizing societies.

Beyond the impact on individuals and their families, the epidemic is profoundly affecting the social and economic fabric of societies. HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and reducing earnings, and it is imposing huge costs on enterprises in all sectors through declining productivity, increasing labour costs and loss of skills and experience. In addition, HIV/AIDS is affecting fundamental rights at work, particularly with respect to discrimination and stigmatization aimed at workers and people living with and affected by HIV/AIDS. The epidemic and its impact strike hardest at persons ages 20 – 49, the core group forming the workforce.

The Organisation (ILO) therefore developed a Code of Practice on HIV/AIDS and the World of Work which Jamaica has adapted in an effort to help to prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease. It covers key principles, such as:

1. HIV/AIDS as a Workplace Issue

Jamaica recognises HIV/AIDS as a workplace issue that impacts on productivity and the country’s development and also recognises that it should be treated like any other serious illness or condition in the workplace. It is also a workplace issue, not only because it affects the workforce but also because the workplace can play a vital role in limiting the spread and effect of the HIV/AIDS epidemic.

2. Non-Discrimination

There should be no discrimination against workers based on real or perceived HIV status. Discrimination and stigma inhibit prevention and support efforts.

3. Gender Equality

The gender dimensions of HIV/AIDS should be recognised. Women and girls are more vulnerable to HIV than men and boys due to biological, socio-cultural and economic reasons. Some men and boys are marginalised and also vulnerable to HIV infection. HIV and AIDS should therefore be discussed and treated with gender sensitivity.

> "The workplace is an appropriate setting for interventions and strategies related to the prevention of HIV."

4. Healthy Work Environment

The work atmosphere must be as healthy and as safe as possible for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No. 155) and Jamaica's proposed Occupational Safety and Health Act. Management and employees should have access to and apply the guidelines for accidental exposure to HIV. Universal precautions should be applied when handling body fluids and sharp instruments. Universal precautions are standard infection control practice to be used in the care of all patients and persons at all times.

5. Social Dialogue

The principle of social dialogue, trust and cooperation between employers, workers, their representatives and government should be upheld and sustained to ensure the effective implementation of this and other related guidelines.

6. No Screening for exclusion from employment or other work processes

There is no justification for any HIV/AIDS screening for purposes of exclusion from employment or work processes. HIV/AIDS screening should not be required of job applicants or employees.

7. Confidentiality

Confidentiality should be maintained. No job applicant or worker should be asked to disclose his or her HIV status or HIV-related information and no co-worker should be asked to reveal such information about fellow employees. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO Code of Practice on the Protection of Workers' Personal Data, 1997.

8. Continuation of Employment

HIV infection cannot be a cause for termination of employment. HIV/AIDS should be treated like any other medical/health condition. Persons who are living with HIV should be able to work for as long as they are medically fit in available, appropriate work.

9. Prevention

The workplace is an appropriate setting for interventions and strategies related to the prevention of HIV, which should be appropriately targeted to local conditions, and should be culturally sensitive and involve all the social partners. Changing attitudes and behaviour through education and training is important to promote prevention.

10. Care and Support

The workplace is appropriate to promote care and support for all workers, including those affected or infected by HIV/AIDS, and their entitlement to affordable health care. All workers should have full access to benefits from any relevant social security programmes and occupational schemes.

SEXUAL AND REPRODUCTIVE HEALTH TIP:
SAFE SEX = HEALTHY PEOPLE = HEALTHY FAMILIES = HEALTHY NATION

RESOURCES

1. **HIV/AIDS Workplace Policy & Action Plan,** 2011. Ministry of Health, Jamaica

2. **United States Agency for International Development (USAID)**
http://transition.usaid.gov/our_work/global_health/pop/techareas/fphiv.html -

3. **Jamaica's National HIV Strategic Plan 2012 – 17**
http://www.jamaica-nap.org/hiv_jam.html

4. (2001). **An ILO Code of Practice on HIV/AIDS and the World of Work**
International Labour Organisation. Geneva: International Labour Office

5. Nouga, A. and Ayalew, A. (2010).
Integration of Family Planning into HIV Counseling and Testing, Prevention of Mother-to-Child Transmission, and Antiretroviral Therapy Services.
Pathfinder International. Watertown, MA

6. **Treatments and Drugs** By Mayo Clinic staff
http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=treatments-and-drugs

NATIONAL FAMILY PLANNING BOARD
5 Sylvan Avenue, Kingston 5, Jamaica
Telephone: (876) 968-1627 / 968-1631 / 968-1633