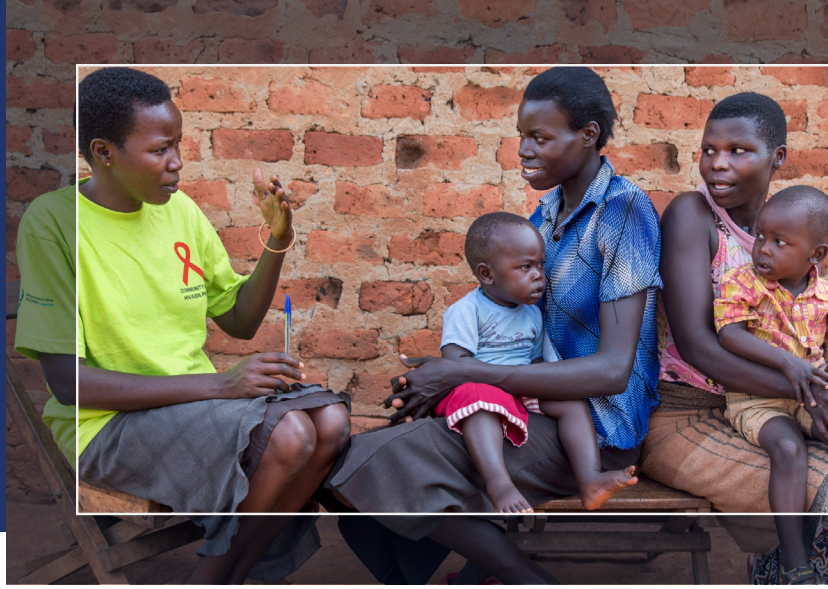
INTEGRATED FAMILY PLANNING AND HIV SERVICES FOR YOUTH: APPLYING ECHO STUDY FINDINGS IN THE COVID-19 PANDEMIC

By Mthobisi Simelane, Dr. Natasha Salifyanji Kaoma, Cate Lane, and Sandra Yin



Community health worker Agnes Apid (L) with Betty Akello (R) and Caroline Akunu (center). Photo credit: Jonathan Torgovnik/Getty Images/Images of Empowerment

The ECHO Study: Landmark Research Provides a Relevant Roadmap to Change for SRHR Programs[1]

Just over one year ago, the results of the Evidence for Contraceptive Options and HIV Outcomes Study (ECHO) study were released. ECHO was conducted to address years of concern that people who use the contraceptive depot medroxyprogesterone acetate (DMPA) might be at increased risk of HIV infection.

The study found that are that there was no substantial difference in HIV risk among women using the three contraceptive methods studied. All methods (listed below) were safe, highly effective, and acceptable to the study participants. The study also found that although study participants received high quality counseling and clinical contraceptive and HIV services, HIV and sexually transmitted infection (STI) acquisition remained alarmingly high. Here's the full ECHO Study.

The study evaluated women and adolescent girls' likelihood of acquiring HIV while using one of three contraceptive methods (see below), over a period of 18 months. The study compared the rate of HIV infection among 7,800 sexually active HIV-negative women between the ages of 16 and 35 in eSwatini, Kenya, South Africa, and Zambia, who wanted to prevent a pregnancy and volunteered to be randomly assigned to use one of the following contraceptive methods:[2]

> The [ECHO trial] found there was no substantial difference in HIV risk among women using the three contraceptive methods studied.

- The intramuscular injectable (also known as Depo Provera or DMPA);
- The copper IUCD (or intrauterine contraceptive device); or
- The levonorgestrel implant (also known as Jadelle)

The study confirmed all three methods are safe and effective in preventing unintended pregnancies. Women who used any one of the three contraceptive methods studied had very low rates of unintended pregnancies, and there was no substantial difference in risk of HIV among users of the three contraceptive methods studied.

However, it was discouraging to learn that after decades of efforts to lower the rates of HIV and STIs through a combination of behavior change, structural change, and biomedical approaches (i.e. the provision of counseling, HIV testing, condoms, and STI case management), HIV and STI rates are still unacceptably high.

Since the study findings were released in 2019, COVID-19 has changed everything. Nevertheless, the findings from the study remain relevant and useful, especially as countries consider ways for more effective and efficient use of limited resources that must address multiple health challenges.

1. The ECHO Consortium was led by FHI 360, the University of Washington, the Wits Reproductive Health and HIV Institute and the World Health Organization. Funders included Bill and Melinda Gates Foundation, US Agency for International Development, the President's Emergency Plan for AIDS Relief, Swedish International Development Cooperation Agency, South African Medical Research Council, and the UN Population Fund.

2. All women were fully informed about the potential SRH benefits and risks of the participating in the study, and were also counseled to use condoms, which they received at every study visit.

After the ECHO study was released, the World Health Organization released updated guidance on "Hormonal Contraceptive Eligibility for Women at High Risk of HIV" that shifts DMPA (Depo Provera), other progestogen-only injectables, and intrauterine devices (IUDs) to a classification that says the products can be used without restriction.

What are the implications of the study?

Young women remained alarmingly vulnerable to HIV, which is driven by a complex web of factors at the individual and environmental levels, including poverty and lack of educational and employment opportunities. A 2019 UNAIDS report reiterates that gender discrimination, gender-based violence, taboos about sexuality, and legal restrictions (e.g. parental or spousal consent laws), hinder young women's ability to make their own informed decisions about their reproductive health, including the use of condoms.

Sexual and reproductive health (SRH) information and services for young people must remain available during the pandemic. Young women's vulnerability to unintended pregnancy, HIV and STIs, are likely to increase due to the COVID-19 pandemic. ECHO suggests that an intentional focus on integrating contraceptive, HIV and STI services may help to create more efficient and cost-effective forms of service delivery which could alleviate stress within health systems and minimize the need for multiple facility visits, which will also reduce the exposure of both clients and providers to COVID-19.

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However, advocacy for high quality integrated services is not enough to achieve significant changes in health behaviors and outcomes. ECHO applied a gold standard to integration, yet rates of HIV remained virtually unchanged. Achieving a "new normal" will require changes in the ways that services are provided, but even more importantly, intentional efforts to address persistent and deeply ingrained socio-cultural norms and practices that prevent young women from adopting healthy and protective behaviors.

Sustaining the new normal

Young people have a universally acknowledged right to high quality health care, regardless of age, marital status, or history of childbirth, which is especially important in the context of COVID-19. It is not uncommon for adolescent needs and concerns to be overlooked in public health and humanitarian crises. Ensuring adolescents' access to SRH services and promoting integrated service delivery are important, but a sole focus on access to services is likely to be insufficient and must be complemented by efforts to address the structural drivers of poor health. COVID-19 threatens gains made in reducing harmful practices, as there are reports of increases in rates of early marriage and female genital mutilation. We suggest below important outcomes to work toward as well as illustrative actions to achieve the outcomes:

SRH SERVICES ARE PEOPLE-CENTERED AND ADOLESCENT-RESPONSIVE

Global public health programs increasingly emphasize "people-centered" care and equity, but adolescents have not benefitted much from these efforts to date, although they have different needs and face different challenges to obtaining health services than children and adults. As countries formulate responses to COVID-19, adolescent/youth sexual and reproductive health and rights (AYSRHR) advocates must underscore the importance of including adolescents in formal guidance, and promote the adoption of evidence-informed adolescent service delivery guidelines as part of "people-centered" approaches. Illustrative examples include:

- Promoting and providing easy access to condoms at a minimum
- Providing contraception as part of HIV services and offering HIV counseling and testing as part of contraceptive service delivery
- Reaching young mothers with information about postpartum contraception as part of prevention of mother-to-child transmission programs, and disseminating information about preventing HIV and unwanted pregnancy as part of nutrition and immunization campaigns (including HPV immunization)
- Including contraception, HIV and STI testing, pre-exposure prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) as part of safe abortion services and post-abortion care
- Making PrEP and PEP part of a standard minimum package that includes condoms and other contraceptive methods and that is made easily available to young people in areas of high HIV prevalence
- Mobilizing communities to support the SRH of young people

The World Health Organization's Accelerated Action for the Health of Adolescents (AA-HA) is a useful resource in developing adolescent responsive systems and services.

SRH PRODUCTS AND SERVICES SUCH AS CONTRACEPTION AND HIV TREATMENT/ PREVENTION DRUGS ARE EASILY AVAILABLE

Where possible, all methods must be made available to young people, as well as high-quality counseling that supports their preferred method choice. This must include long acting and reversible contraception and emergency contraception. Young people who are currently using antiretroviral drugs must also be guaranteed access to these medicines. Young people may be reluctant to seek facility-based services during the pandemic, and facilities may also cut back on "non-essential services" such as youth corners. Providers who have frequent interactions with young people at the community level, such as community health workers, community-based distributors or pharmacists/drug shops can help to address this service delivery gap. Where possible, contraception should be available without a prescription, and at a free or reduced price, and PrEP and emergency contraception should be easily available to young people, who may be vulnerable to sexual abuse, coerced sex, or violence.

PRODUCTS OFFERING DUAL PROTECTION ARE MADE WIDELY AVAILABLE TO THOSE WHO WANT THEM

Young women remain highly vulnerable to unintended pregnancy, HIV, and STIs, so dual protection is foundational to high quality, integrated care. While male and female condoms have existed for many years, it is essential that comprehensive condom programming be scaled-up everywhere. In addition, there are additional dual-purpose prevention products in development, and advocacy is needed to "fast track" testing, approval, and availability.

MEANINGFUL YOUTH ENGAGEMENT IS STANDARD PRACTICE

It is no longer sufficient to only see youth as program beneficiaries, or as a monolithic group with the same needs and challenges. Young people in all their diversities are ready to partner and make decisions with health policy makers and program developers on the initiatives intended to improve their health and other outcomes. Perspectives from LGBTI youth are essential to this process. The Global Consensus Statement on Meaningful Youth Engagement provides guidance which can be applied to partnering with young people in the development of COVID-19 messaging and other prevention efforts, especially around risk of and vulnerability to unintended pregnancy, HIV or STIs.

SERVICES ARE STIGMA FREE AND INCLUSIVE

Young people should not be stigmatized for their efforts to protect their health, especially during the pandemic. Support providers to adopt more inclusive attitudes and approaches to adolescents and to highly-stigmatized populations such as people living with disabilities, LGBTI youth, and the very poor, many of whom are also adolescents.

Taking action

As a start, spread the word. Do young people know that contraception is safe and effective for young people? Are they aware that contraception does not increase a woman's risk of HIV? Do they realize it is essential to continue to promote dual protection and condom use, and to facilitate young people's access to PrEP where HIV incidence is high?

Young people should not be stigmatized for their efforts to protect their health, especially during the pandemic.

Busting myths

Young people may believe myths and misinformation about contraception or HIV, which affects their ability to make informed decisions and protect their health. Use the myths on the next page to start conversations and provide the facts!

Additional information about COVID-19 and adolescents and youth is addressed in WHO's Frequently Asked Questions, which you can find here.

MYTHS vs. FACTS

A GUIDE FOR YOUTH ADVOCATES

CONTRACEPTION

MYTH	TRUTH
Contraceptives will make me infertile.	Contraceptives do not cause infertility. After you stop using contraceptives, you should be able to become pregnant once again.
Young women who use contraceptives must be promiscuous, "loose," or exchanging sex for money.	Young women who use contraception are protecting their futures, plans, and dreams. They should not be stigmatized for being responsible and protecting themselves again unplanned pregnancy.
Young people should only be provided with condoms.	Young people have different circumstances, needs, and preferences. They have the right to a wide range of contraceptive options. Young people can safely and effectively use any type of contraceptive, but only condoms provide protection against HIV, STIs, and pregnancy.
Young people shouldn't have sex. Abstinence is the only safe option for young people.	Adolescent sexuality and contraceptive use are taboo topics in many cultures, but data tell us that young people are having sex (or soon will be) whether within or outside marriage/union. Abstinence messages do not adequately prepare young people. Young people need factual, accurate information on - and the ability to obtain - condoms and contraceptive methods to protect themselves from unplanned pregnancy and HIV and STIs.
Free condoms are of poor quality and don't work.	Free condoms are not any less effective than those that one pays for.
Contraception is only for married and cisgender heterosexual people.	Anyone who wants to prevent an unintended pregnancy, whether married or not, should use an effective contraceptive method. Many LGBTI youth who have sex are at risk of unintended pregnancy and should have access to contraception.
Transgender and gender nonconforming youth who use hormone blockers or gender-affirming hormones do not need to use contraception.	Hormone blockers and gender-affirming hormones can be an important part of comprehensive healthcare for transgender and gender nonconforming youth. However, they do not replace the need for contraception.

HIV

MYTH	TRUTH
Although I'm sexually active, I won't get HIV.	Anyone can get HIV if you are sexually active and don't use condoms or PrEP. LGBTI youth who have are also potentially at risk of HIV, and often face heightened vulnerability due to structural factors, many stemming from stigma and discrimination.
I only need to worry about preventing an unintended pregnancy.	If I am sexually active, I should be thinking about preventing unintended pregnancy, HIV, and STIs.
Getting HIV is a death sentence.	Today there are medicines available that help many people live with HIV for years.
I can prevent HIV (or other STIs) by using traditional medicines.	There is no evidence that traditional medicines protect against STIs or HIV. If you are sexually active, condoms and PrEP are the best protection. Voluntary medical male circumcision (VMMC) can also reduce the risk of infection in men, which protects their partners from HIV.
PrEP is unsafe and doesn't work.	PrEP is the use of antiretroviral medications to reduce the risk of HIV infection in people who are HIV-negative. PrEP is safe and effective at preventing HIV. It does not protect against STIs or pregnancy. Many countries have approved the use of daily PrEP for people who are at high risk of HIV.
I cannot get HIV or an STI if my sexual partner(s) and I share the same gender.	Anyone can get HIV or an STI if you are sexually active and do not use barrier methods or PrEP.

Contraception & HIV/STIs

MYTH	TRUTH
If I use an intrauterine contraceptive device (IUCD), I could get HIV.	IUCDs do not cause HIV and do not contain HIV. IUCDs are highly effective, especially if used with PrEP, but only condoms prevent pregnancy, HIV, and STIs.
If I use a hormonal contraceptive, I am protected from both unintended pregnancy and sexually transmitted infections (STIs).	All contraceptive methods prevent pregnancy, but only dual protection prevents both pregnancy and HIV/STIs. Condoms can prevent HIV, STIs, and pregnancy. The use of PrEP with an effective contraceptive method can prevent both HIV and pregnancy.
If I experience rape, I am doomed to get pregnant and HIV.	After any type of sexual violence, abuse, or coerced sex, young women can use emergency contraception to prevent pregnancy and post-exposure prophylaxis (PEP) to prevent HIV. EC and PEP can be used after any type of sexual encounter when contraception and HIV prevention were not used and/or failed.
If I am in a long-term relationship or married, all I need to worry about preventing is an unintended pregnancy.	In any sexual relationship, young women are vulnerable to pregnancy, STIs, and HIV.
PrEP will make me infertile.	PrEP does not cause infertility and has very few side effects.

COVID-19 is an opportunity to build a new normal of integrated FP and HIV services that includes serious attention to persistent structural barriers to good health.

Further resources:

YOU(TH)DOIT! Resource Hub. *Download:* https://www.youthdoit.org/themes/advocacy/

CHOICE for Youth and Sexuality's Protecting the Reproductive Health and Rights of All Young People *Download:* https://www.youtube.com/watch?v=4VjyEI_GvI4&feature=emb_logo

Call to Action to Attain Universal Health Coverage Through Linked Sexual and Reproductive Health and Rights and HIV Interventions. *Download:* https://apps.who.int/iris/bitstream/handle/10665/273148/WHO-RHR-18.13-eng.pdf?ua=1

FHI 360's Integrating Family Planning into HIV Programs: Evidence-Based Practices. *Download:* https://www.fhi360.org/sites/default/files/media/documents/fp-hivevidence%20based%20practices%202013.pdf

Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context *Download:* https://www.who.int/publications/i/item/10665-332240

HIV and young transgender people: A technical brief *Download:* https://www.unaids.org/en/resources/documents/2015/2015_young_transgender

LGBTQ Health and Rights https://advocatesforyouth.org/issue/lgbtq-health-and-rights/

Stonewall Youth https://www.stonewallyouth.org

Transgender Children & Youth: Understanding the Basics https://www.hrc.org/resources/transgender-children-and-youth-understanding-the-basics

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Mthobisi Simelane is a volunteer with Elizabeth Glaser Pediatric AIDS Foundation's Committee of African Youth Advisors' Eswatini representative, youth leader facilitator with Baylor Swaziland, and advocate with Swaziland Network of Young Positives. Dr. Natasha Salifyanji Kaoma is CEO of Copper Rose Zambia and an FP2020 Youth Focal Point. Cate Lane is the Director of Adolescents and Youth at FP2020. Sandra Yin is an independent content consultant. AVAC contributed to this report.