This module provides an overview of the reproductive health decisions faced by women and couples living with HIV. The module includes a special emphasis on contraception for women with HIV, including women receiving antiretroviral therapy, also known as ARV therapy. It summarizes the most current scientific evidence available and underscores the importance of providing high-quality family planning services to meet the needs of women and couples with HIV. With this knowledge and insight, providers can help clients with HIV make voluntary, informed decisions about their reproductive health and contraceptive options.

Note to presenter:

1. The [ ] in the script indicates when to “click the mouse” to either reveal more information on the current slide (e.g., the next bullet point) or advance to the next slide.

2. When information is available, adapt slides that include epidemiological data to show local statistics. Modify the suggested narrative to highlight the information from your country.
Introduction

1. HIV/AIDS epidemic disproportionately affects women
2. Role of family planning in alleviating the burden of HIV
3. Reproductive choices and decisions for clients with HIV
4. ARV therapy basics in the context of family planning
5. Ensuring that services meet the needs of clients with HIV
6. Contraceptive options for women and couples with HIV
7. Family planning counselling for clients with HIV

This module is divided into seven sections.

First, it describes the impact of the HIV/AIDS epidemic on women and children.

Second, it explores the important role that family planning plays in helping to alleviate the burden of HIV and reinforces the need to ensure that all women and couples have access to contraceptives and reproductive health services.

Next comes an examination of the reproductive choices faced by women and couples with HIV.

The fourth section provides a brief overview of ARV therapy and describes the benefits and concerns related to providing contraceptives to women on ARV therapy.

The fifth section discusses how to ensure that the family planning needs of clients with HIV are met.

The sixth section describes contraceptive options available to women with HIV and how their HIV status affects their eligibility for various methods.

The final section discusses the providers’ role in ensuring that women with HIV are able to make informed, voluntary decisions about having children and using contraception.

Note to presenter:

To facilitate use, the divider slides that mark the beginning of each section are indicated below.

Section 1, slide 3; Section 2, slide 11; Section 3, slide 17; Section 4, slide 23; Section 5, slide 29; Section 6, slide 36; Section 7, slide 82.
HIV/AIDS Epidemic Disproportionately Affects Women

According to the Joint United Nations Programme on HIV/AIDS, or UNAIDS, women are disproportionately affected by the HIV epidemic.

Note to presenter:
For general information on HIV/AIDS see: Fact Sheet #11: Facts About HIV/AIDS.
In sub-Saharan Africa, women make up 57% of HIV Cases


Women account for nearly half of the 39.4 million adults living with HIV worldwide. In the worst-affected region – sub-Saharan Africa – almost 57 percent of adults living with HIV are women.
Young Women Are Disproportionately Affected

HIV among 15- to 24-year-olds in sub-Saharan Africa

75% young women

25% young men


Millions of young people are becoming sexually active each day with no access to HIV prevention services. In sub-Saharan Africa, three-quarters of all 15- to 24-year-olds living with HIV are female. The prevalence of HIV infection among young women in this region is three times that of young men.2
As an example, this chart shows the prevalence of HIV in Kenya by age and sex. While HIV prevalence is highest among both men and women in the age groups 25 to 44; women, especially young women, in the age categories 15 to 24, are considerably more affected than men of their same age.\(^3\)

Note to presenter:
Create a slide similar to this using DHS data from the appropriate country.
Pregnant Women Share Burden

In many countries of southern Africa, one in five pregnant women are HIV infected.


UNAIDS also estimates that about 2.5 million of the 200 million women worldwide who become pregnant each year are infected with HIV. In many countries of southern Africa, one in five pregnant women is HIV infected.
Among children, 640,000 new HIV infections worldwide in 2004

Among children, 640,000 new HIV infections worldwide in 2004

Among children, 640,000 new HIV infections worldwide in 2004

The overwhelming majority of children with HIV contract the infection from their mothers during pregnancy or delivery or through breastfeeding – often from mothers who were unaware of their serostatus. Every day more than 1,700 children become infected through vertical transmission of HIV. As a result, annual new HIV infections among children have reached 640,000. As depicted in the chart, the majority of these childhood infections are in sub-Saharan Africa – about 560,000 children younger than 15 years of age were infected with HIV during 2004.6

Women’s vulnerability to HIV has a direct impact on their children and families. By 2001, about 14 million children younger than 15 had been orphaned by the AIDS-related deaths of one or both of their parents. The vast majority of these children – 11 million – live in sub-Saharan Africa. Losing one or both parents can have dramatic psychosocial, as well as health and nutritional consequences. It can also result in severe economic deprivation. And, AIDS orphans may be at greater risk of contracting HIV infection themselves if they are forced to live in dire poverty with limited access to health care.
Why Are Women Vulnerable?

Cultural and societal factors
- gender inequities
- limited opportunities
- economic dependence on men
- imbalance in sexual relationships

Possible biological factors
- large vaginal surface allows more exposure
- cervical ectopy may facilitate acquisition

Women’s vulnerability to HIV has several causes. First, women are more vulnerable to HIV infection because of cultural and societal factors. These factors include gender inequities that limit women’s opportunities, often making them economically dependent on men. Inequitable relations between men and women also make it more difficult for women to refuse unwanted sex or to negotiate safer sex.

Women may also be more susceptible to HIV infection for biological reasons. Their exposure to HIV virus can be greater than men’s because they have a larger surface area, the vagina, exposed to sexual fluids during intercourse. A complicating factor is the preference for “dry sex” among some partners, which makes the vagina more susceptible to lacerations. In addition, a common physiological condition known as cervical ectopy may increase the risk of chlamydia infection, which may in turn facilitate acquisition of HIV infection. Cervical ectopy occurs when the regular (squamous) cervical epithelium on the outer surface of the cervix is replaced by thinner, more fragile (columnar) epithelium from the cervical channel.

In the next section we will explore how family planning and access to effective contraception can help to alleviate some of the burden on women with HIV.
Family planning can play an important role in helping to alleviate the burden of HIV shared by women and couples with HIV. In this section we will explore the role of family planning in HIV prevention, the benefits of providing family planning to women and couples with HIV, and the struggle to meet the demand for effective contraception.
Family planning, also known as FP, plays several roles in helping to maintain the health of individuals, families, and communities. With the AIDS epidemic growing, family planning has expanded its role by helping to prevent the spread of HIV.  

As shown in the diagram, comprehensive programs designed to prevent mother-to-child transmission of HIV, also known as PMTCT, typically employ multiple strategies that focus on preventing the acquisition and transmission of HIV and supporting the needs of a woman and her family.  

Family planning and effective use of contraceptives play an important role in these multipronged approaches by preventing unintended pregnancies among women who are infected with HIV, thus decreasing the likelihood of HIV infection in children and helping to reduce the chance that a child will become an orphan.  

On the next slide we will examine the potential impact of these strategies, specifically the benefits that can be achieved when family planning services are integrated with other services.  

Increasing access to family planning services for women with HIV can reduce births of children who have a high probability of being infected with HIV and dying. A study of PMTCT programs in 14 countries compared programs that offered the antiretroviral drug, nevirapine to women at the time of delivery or nevirapine plus family planning services. By preventing unintended pregnancies with family planning services, the combined FP/nevirapine programs can sharply increase the number of HIV infections averted among infants from 39,000 to over 70,000, which in turn could significantly reduce the number of child deaths. The projected number of child deaths averted each year increases from 20,000 to 75,000 when family planning services are added to nevirapine programs.9
Benefits of Providing FP Services

For women and couples with HIV:

• improves health/well-being of families and communities
  – spacing/limiting births

• prevents unintended pregnancies, thus reducing:
  – number of infants born infected
  – number of future orphans

Providing integrated reproductive health services that include family planning counselling and access to contraception to women and couples with HIV can improve their lives and those of their families.

• When FP services are accessible, clients with HIV experience the same health benefits as others in their communities. Couples can limit the size of their family to the number of children they desire and are able to care for. Women can space their children properly and reduce the risks associated with too many pregnancies or pregnancies spaced too closely.

• Family planning can also reduce HIV infections among children by helping women with HIV who do not want to have children avoid pregnancy.

• Women with HIV who are concerned that they may eventually die of AIDS may decide to use contraception to avoid having children who may some day become orphans.

As we have seen, there are many benefits in providing family planning and effective contraception. Unfortunately, as we will see on the next slide, there is also a large and growing unmet need for contraception and other family planning services.
Surveys estimate that more than 150 million married women of reproductive age worldwide have an unmet need for contraception to postpone or avoid pregnancy. In the majority of countries in sub-Saharan Africa, more than 20 percent of married women of reproductive age have an unmet need for contraception. This chart shows the contraceptive prevalence rate for modern methods, in the light bars, and unmet need for family planning, in the dark bars. As you can see, most countries in sub-Saharan Africa have a very high percentage of women with unmet need. Unmet need for contraception creates a particular hardship for women with HIV who may wish to avoid pregnancy but do not have access to contraceptives or family planning services.
One of the largest groups whose reproductive health needs, also known as RH needs, are not being met is young women.

Evidence of unmet need in this group is seen in the high rates of sexually transmitted infections, or STIs, including HIV; unintended pregnancy; and mortality and morbidity resulting from unsafe abortion.

Some of the causes of this unmet need include a lack of information and education about sexuality, reproduction, and contraception, as well as limited skills for establishing personal goals, developing strategies, and communicating expectations with partners. Additionally, many young people do not have access to reproductive health services that are prepared to meet the specific needs of adolescents.

The next section of the module will examine the reproductive decisions women with HIV face and the kind of information and support they need from providers.
Women with HIV and their partners often need to make a variety of reproductive health decisions about pregnancy, childbearing, and contraceptive practice. They should be free to make these reproductive choices for themselves, just as other women and couples do. However, being HIV-positive may make women more vulnerable to societal, religious, or family pressures than women who are not infected with HIV. Counsellors must take special care to ensure that women with HIV do not feel coerced or pressured into making certain reproductive choices.

In this section of the module we will look at reproductive choices and decisions and consider why some women with HIV might desire pregnancy while others want to avoid childbearing.
Based on current research findings, it appears that pregnancy in women with HIV does not accelerate progression of the disease. However, pregnancy often carries serious consequences for the infants. Without treatment, about one-third of HIV-infected mothers pass the virus to their newborns during pregnancy, delivery, and breastfeeding. Some evidence suggests that pregnancy in women with HIV increases the risk of stillbirths and infants with low birth weight. Nonetheless, for many couples with HIV who choose to conceive, the perceived benefits of having a child outweigh the increased risk of adverse pregnancy outcome.

Three positive developments – the impact of ARV therapy on the health and longevity of many people with HIV; the increasing availability of effective means for reducing mother-to-child HIV transmission; and wider availability of support and care services for families dealing with HIV – may encourage women with HIV to reconsider decisions about sex, relationships, and childbearing.
The reasons many women with HIV consider pregnancy include:15

• An intense, emotional need to bear children.
• Societal, familial, and other relationship pressures to have children.
• Fear that the children they already have may die.
• Concern about reduced fertility related to HIV infection.
• Reassurance that PMTCT programs reduce the risk of having an HIV-infected child.
• Expectations of receiving ARV therapy and living long enough to see their children grow up.
• Concern that avoidance of pregnancy might generate suspicion about one’s HIV status.
• Fear that the potential consequences of disclosing one’s HIV-positive status to a partner, might include violence, abandonment, and loss of finances for children.
Clients with HIV:
Reasons to Avoid Childbearing

- Similar concerns to women without HIV:
  - economic status
  - desired family size
  - ideal spacing
- Concerns about health and quality of life
- Fear of transmitting HIV
- Anxiety about leaving orphans
- Concerns about limited access to help

On the other hand, many sexually active women with HIV might not want to bear children and therefore desire contraception. Their reasons to avoid or postpone pregnancy are often the same as those of women who are not infected with HIV: maintaining family economic status, achieving desired family size, and spacing the births of their children.

A woman with HIV may also want to avoid childbearing for other reasons, such as:

- Concern that pregnancy will further compromise her health, especially if it is already compromised by AIDS-related symptoms. Her partner or spouse may be infected or have already developed symptoms. In the absence of ARV therapy and treatment for opportunistic infections, the length and quality of life may be severely compromised.
- Fear of transmitting HIV to children she might conceive.
- Fear of leaving orphans, because HIV infection is likely to shorten her life, particularly without treatment. Parents are naturally concerned about who will care for their children if they are no longer able to do so.
- Fear that others will be unwilling to care for the family during illness due to AIDS-related stigma and discrimination.
Access to Information/Services is Key

- Consider reproductive choices
- Plan for the future
- Avoid unintended pregnancy
- Reduce HIV transmission to children
- Reduce transmission to partners

In both resource-poor and resource-rich countries, women who learned that they were HIV-infected reported lower desired fertility levels than did women in the general population.\textsuperscript{16} However, HIV-infected women’s knowledge of contraception and their access to family planning services can be limited.

Such services help women with HIV consider their reproductive choices, plan for the future, avoid unintended pregnancy, and reduce HIV transmission to their children. Contraceptive counselling sessions also offer opportunities for prevention counselling to reduce the chances that women will transmit HIV to their partners.

The next slide shows that, when provided access, women with HIV will use family planning.
When family planning services are made available and accessible to women with HIV, many women use them. As shown in the chart, the one-year incident pregnancy rate among women with HIV participating in a voluntary counselling and testing program, also known as a VCT program in Rwanda was 22 percent before family planning was offered. After family planning services were introduced, the rate dropped to 9 percent. During this period, contraceptive use increased from 16 percent to 24 percent.
Now we will provide a quick overview of ARV therapy. This foundation is required for understanding how ARVs affect the contraceptive options of women with HIV, which will be discussed in detail later in the module. After the brief introduction to ARV therapy, we will also address how women on ARV therapy can benefit from contraception.
ARV Therapy Overview

- Inhibits replication of the virus
- Slows disease progression; improves quality of life
- Different drugs attack virus at different stages of replication
- Combine three drugs into HAART “cocktail” for best results

The introduction of antiretroviral drugs as part of HIV clinical care has transformed HIV infection into a manageable chronic illness for many individuals infected with HIV. ARVs are not a cure. They cannot completely eradicate HIV. But they can inhibit replication of the virus, which effectively slows disease progression and improves a patient’s quality of life.

Different ARV drugs attack HIV at different steps in the process of copying itself – first when it enters the cell and then when new copies want to leave the cell.

To date, the best results have been achieved by combining three drugs from two different classes of antiretrovirals into a “cocktail.” The cocktail attacks at least two targets, thus increasing the chance of stopping HIV replication and protecting new cells from infection.

This three-drug cocktail is called “highly active antiretroviral therapy,” or HAART. HAART can dramatically reduce the level of virus in the blood. As a result of this decrease in viral load, immune suppression is arrested, followed by improved immune function, which results in fewer opportunistic infections and illnesses and an overall improvement in the quality of life.
Classes of ARV Drugs

- NRTIs – Nucleoside reverse transcriptase inhibitors
- NtRTIs – Nucleotide reverse transcriptase inhibitors
- NNRTIs – Non-nucleoside reverse transcriptase inhibitors
- PIs – Protease inhibitors
- Entry inhibitors (other new classes under development)

There are several common classes of ARV drugs currently available. One class is NRTIs, or Nucleoside Reverse Transcriptase Inhibitors. Another class of ARV drugs is NtRTIs, or Nucleotide Reverse Transcriptase Inhibitors. The next class is NNRTIs, or Non-Nucleoside Reverse Transcriptase Inhibitors followed by PIs, Protease Inhibitors. Entry inhibitors and other new classes of drugs are also becoming available.

Note to presenter:
You may want to adapt this slide to show the drugs available in your country for all or some of the classes. Examples of drugs included in each class are listed below.

**NRTIs:** zidovudine (ZDV or AZT); didanosine (ddI); stavudine (d4T); lamivudine (3TC); abacavir (ABC); didanosine EC (enteric coated); emtricitabine (FTC)

**NtRTIs:** tenofovir (TDF)

**NNRTIs:** nevirapine (NVP); efavirenz (EFV also known as EFZ); delavirdine (DLV)

**PIs:** indinavir (IDV), ritonavir (RTV), lopinavir (LPV); nelfinavir (NFV); saquinavir (SPV); atazanavir (ATV); amprenavir (APV)

**Entry inhibitors and other new classes:** enfuvirtide (T20), also known as Fuzeon

ARVs are sometimes available as **fixed dose combinations (FDC)** – in this case each pill contains a certain amount of two or three different drugs (e.g., Trizivir, a FDC of ZDV+3TC+ABC).

For additional information on this topic see: Fact Sheet #9: Classes of ARV Drugs.
ARV therapy is complex and should only be offered by trained providers.


As depicted on this slide, the standard HAART regimen contains two NRTIs and one NNRTI or a protease inhibitor. The World Health Organization (WHO) recommends several regimens for HAART therapy using widely available ARV drugs. Other HAART regimens, using more than three ARV drugs, are currently being explored to counter drug resistance that develops in some patients.

Because of their side effects and the possibility of drug resistance, ARV therapy is not recommended for all patients infected with HIV. Several indicators are used to determine a patient’s eligibility to receive ARV therapy. Clients with HIV should be evaluated by a provider trained to determine the most appropriate course of action.

Note to presenter:
For additional information on this topic see: Fact Sheet #10: ARV Therapy Criteria.
Use of ARV Drugs for HIV Prophylaxis

- Prevent mother-to-child transmission (PMTCT)
  - drug regimen depends on availability, cost, resistance, possible side effects
  - reduces vertical transmission by 34% to 50%
- Postexposure prophylaxis (PEP)
  - start as soon as possible; continue 2 to 4 weeks
  - multidrug therapy is more effective
- Other uses under study


While HAART therapy is used for the treatment of patients with advanced HIV disease, ARV drugs can also be used for the prophylaxis, or prevention, of HIV infection.

ARV drugs play a major role in the prevention of mother-to-child transmission of HIV. Pregnant women with HIV who do not have indications for full-scale antiretroviral treatment or do not have access to treatment should be offered ARV prophylaxis to prevent transmitting HIV to their newborn. Currently, there are many different drug regimens available and their use depends on the availability of drugs, cost, in-country resistance patterns, and possible side effects. Clinical trials have demonstrated that these regimens can reduce the risk of MTCT by 34 percent to 50 percent.19

ARV drugs can also be used for postexposure prophylaxis, or PEP, in cases of known occupational exposure to HIV, such as a needle stick with infected blood, or when exposure cannot be ruled out, as in the case of rape. PEP should be started as soon as possible after the incident, ideally within hours. Dual or triple drug therapy is administered because it is believed to be more effective than a single agent. A minimum treatment of two weeks and maximum of four weeks is recommended.

Other prophylactic uses of ARV drugs to prevent HIV infection are currently under study.

Note to presenter:

The ARVs, zidovudine (ZDV), lamivudine (3TC) and nevirapine (NVP), have been demonstrated to be safe and effective for PMTCT prophylaxis when they are used alone (AZT or NVP) or in combination (AZT+3TC, AZT+NVP or AZT+3TC+NVP).
Why ARV Clients Benefit from Contraception

- Reduce stress related to unintended pregnancy
- Avoid complicated pregnancy (ARVs can aggravate anaemia and insulin resistance, which are common in pregnancy)
- Have access to wider range of ARV drugs if not pregnant or at risk of pregnancy (some ARVs have potential harmful effects on foetus)

“EFZ should not be given to women of childbearing potential unless effective contraception can be assured.”
– WHO, 2003

Women with HIV who receive ARV therapy receive the same contraceptive benefits as all other women.

Some additional benefits include:
- Removing the potential for unintended pregnancy in an already complicated life situation. Without concern about pregnancy, women can focus more on their ARV regimens and other demands related to HIV infection.
- Avoiding complicated pregnancy. Antiretrovirals can aggravate anaemia and insulin resistance that are common during pregnancy. When health is already compromised, such effects could be severe.
- Having access to a wider range of antiretroviral therapy when a woman is protected from pregnancy. This is because some ARV drugs have harmful effects on the foetus and should not be offered to women who may become pregnant while on ARVs. For example, the drug efavirenz, known as EFZ or EFV, is believed to be a potent early teratogen – that is, an agent that may induce birth defects. WHO guidance states that “EFZ should not be given to women of childbearing potential unless effective contraception can be assured.”

Relationships between ARV drugs and some contraceptive methods will be discussed later in the module.
Ensuring That Services Meet the Needs of Clients with HIV

This section of the module discusses the importance of guiding clients with HIV through reproductive health decisions and ensuring that services meet their needs. Providers who counsel women with HIV should be sensitive to their needs and desires and ensure that none of their clients’ reproductive choices are coerced.
 Providers should help clients with HIV realize their reproductive goals by structuring services that are customized to fulfil their needs, including either pregnancy counselling and services or accurate, unbiased counselling about contraception and access to the client’s method of choice. In addition, all clients should receive counselling and information about HIV/AIDS and possible treatment options.

Depending on the circumstances, the decisions a provider should guide a woman through may include:

• A decision about fertility: Is pregnancy desired at this point in time or not?
• If pregnancy is not desired, there are reproductive health decisions, such as which contraceptive method to choose and what to do about HIV/STI prevention.
• If pregnant, or if pregnancy is desired, there are decisions about PMTCT and considerations related to breastfeeding and the risk of HIV transmission.
• If ARV therapy is available: Is it indicated and desired?23
Clients’ Family Planning Rights

All individuals and couples have the right to:
• access information and services
• a variety of methods from which to choose
• make an informed, voluntary choice of contraceptive method
• receive their method of choice

Clients should be supported in exercising their reproductive rights, regardless of their HIV status.

When providing health care services, providers should respect the rights of all their clients, regardless of their HIV status. With regard to family planning, a client’s rights include the right to decide whether to use family planning and which contraceptive method to use.

To exercise that right, all individuals and couples should:
• Have access to information and services, free of any barriers. Barriers to access can be geographic, economic, administrative, medical, psychosocial or cognitive – that is, when women do not know where to obtain services.
• Have a variety of modern contraceptive methods from which to choose. Each person’s method preference is influenced by a number of factors that need to be considered during counselling.
• Be supported to make an informed, voluntary choice of contraceptive method.
• Receive the contraceptive method of their choice whenever possible. Research has shown that a woman who receives her contraceptive choice is more likely to continue using the method.

Women with HIV should be able to exercise their reproductive rights freely, whether they choose to plan a pregnancy, space their children’s births, or limit childbearing.
Ensuring Informed Choice

Effective counsellors:
• listen carefully
• empathize with client
• help clients make their own decisions
• are not influenced by personal biases
• provide accurate information

Providers are the key to ensuring that clients’ rights are guaranteed.

Effective counsellors:
- listen carefully to the client’s questions and concerns.
- empathize with the client’s situation.
- help clients make their own reproductive health decisions without letting personal biases and preferences influence the information they present to clients.

They provide clients with accurate information to enable them to choose the method that best suits their needs, as well as, provide the information that allows clients to use their chosen method safely and effectively.

Specific issues to consider when counselling clients with HIV will be discussed later in the module.
Clients seeking HIV-related services and those seeking FP services share many common needs and concerns which may make service integration appropriate in some situations.

Women seeking HIV-related services, such as PMTCT, VCT, or ARV treatment, are often sexually active and fertile.

A significant, though unknown, proportion of individuals seeking family planning services are at risk for HIV infection or are already infected.

Some of these individuals know their HIV status, but many have not been tested.

Both groups need information about and access to contraceptives and possibly information about how HIV affects their contraceptive options.

Therefore, it is important that HIV/AIDS programs provide family planning information and services or referrals. It is equally important that family planning programs take into consideration the needs of women with HIV and at a minimum have strong links to HIV care and treatment programs and services.
Why Integrate HIV and FP Services

continued...

Creates programmatic synergies including:

• more attractive to potential clients
  – increases access to wider range of services
  – helps overcome HIV stigma

• opportunities for follow-up and support for drug or method adherence

Programmatic synergies can result from providing family planning and HIV services together.

An entry point that provides a range of services – such as family planning; other maternal and child health services; and HIV testing, counselling, and treatment – may be more attractive to clients. Clients may benefit when they can have multiple health needs addressed in a single visit by providers who are able to take a more holistic approach to client care. Combining services can also help overcome the stigma related to HIV/AIDS, which is one of the major constraints to accessing HIV services.

In addition, offering more than one service creates more contact opportunities for clients and providers, giving providers more occasions to follow-up with clients and support drug and method adherence and giving clients more chances to ask questions and become involved in their own health care.

Providing integrated services to clients with HIV requires that providers be cross-trained in a variety of issues. All providers need to know the different combinations of antiretroviral drugs that may be used to treat HIV. They also need to know which contraceptive methods are appropriate for women with HIV/AIDS and other medical conditions that affect eligibility for specific methods.

It is not always feasible or practical to provide integrated services. In such cases, a referral network should be in place and referrals to specialized services should be offered.
Benefits of Involving Men

- Encourages partner counselling, testing, and disclosure
- Helps women act on prevention messages
- Helps couples make informed decisions on reproductive goals and prevention strategies
- Improves client satisfaction and adoption, continuation, and successful method use

*Integrated RH services can provide a valuable opportunity to involve men in a meaningful way.*

Offering integrated services may also make them more appealing to men and male partners. Individual providers and programs, whether integrated or not, should make an effort to reach out to men with reproductive health messages and services. Involving men in family planning and other reproductive health programs could have several benefits.

Male partner cooperation and participation can:
- encourage male partners to seek HIV counselling and testing and support disclosure of both partners’ HIV status.
- help women to act on HIV prevention messages delivered through reproductive health services.
- help couples to make joint informed decisions about their reproductive goals and prevention strategies.
- improve client satisfaction and the adoption, continuation, and successful use of a contraceptive method.

Although attracting men to reproductive health services often presents a challenge, integrated reproductive health services offer a valuable opportunity to reach men and involve them in RH decisions in a more meaningful way.
A client’s decisions about contraception are shaped by many factors. It is important for providers to understand these factors so that they can help clients to make informed decisions about which method to use. In this section, we will explore the many factors that may shape these decisions and discuss contraceptive options for women and couples with HIV.
Factors Affecting Decision to Use Contraception

- Health/well-being of self, partner, children
- Access to ARV therapy
- Fears related to disclosing HIV status (rejection, violence, financial loss)
- Knowledge about contraceptives (including cultural myths and misconceptions)
- Gender issues/partner opposition
- Stigma regarding condom use

For a woman with HIV, there are many factors that influence her decisions about whether or not to use contraception.

These factors may include her own health, her partner’s health, and her children’s health.

It may also include whether she and her partner have access to long-term ARV therapy.

Another important factor is whether a woman feels she can disclose her HIV status to her partner or family without risking rejection, violence, or financial loss.

Cultural myths and misconceptions may also play a role in decision-making. For example, some women may erroneously believe that they cannot get pregnant because of HIV infection.

Gender issues often affect decisions about contraception and HIV/STI prevention. Partner opposition is one of the most common reasons women cite for not beginning or continuing to use contraception.

Fear of disclosing their HIV status, and the stigma generally associated with condom use, makes many clients reluctant to discuss condom use with their partners.

It is important to involve men in decision-making whenever possible because reproductive health decisions are more likely to be implemented when they are made jointly by both partners. Clear information about contraceptive methods is essential for women and couples to make an informed choice.
Factors Affecting Method Choice

Women with HIV may consider:
- safety and effectiveness of the method
- whether it is short-term, long-term, or permanent
- possible side effects
- ease of use
- cost and access to resupply
- effect on breastfeeding (if postpartum)

Factors that women with HIV may consider when they decide which contraceptive method to use include:
- how safe and effective the method will be.
- whether it is appropriate for short-term or long-term use or whether it is considered permanent.
- possible side effects of the method in women with HIV.
- how easy it will be to use.
- whether the method is affordable and access to resupply is easy.

If a woman is postpartum, the effect that the method may have on breastfeeding could also play a role.
Factors Affecting Method Choice

continued...

- how it interacts with other medications, including ARVs
- whether it provides protection from HIV/STI transmission and acquisition
- whether partner involvement or negotiation is required

Other factors that may affect method choice include:
- how it may interact with other medications, including ARVs.
- whether it provides protection from HIV/STI transmission and acquisition.
- whether partner involvement or negotiation are required.
As we’ve just reviewed, the characteristics of contraceptive methods and how these fit with an individual’s lifestyle influence a client’s decisions about method choice. Another consideration is whether the client has any medical conditions that would make use of a particular method unsafe.

Several years ago WHO assembled a team of experts to review the available evidence and organize the findings in a manner that could be readily used by providers to determine a client’s medical eligibility for a particular method. The recommendations of the expert review team are summarized in the document Medical Eligibility Criteria for Contraceptive Use.26

The team of experts meets periodically to review new research findings and update their recommendations. The most recent version, the third edition, was published in 2004.

The document provides guidance on the safety of 19 contraceptive methods by women and men with specific characteristics or known medical conditions. These characteristics and conditions range from age, smoking, and parity to cardiovascular disease, cancer, and infections. Of particular interest to users of this module are the recommendations related to infection with HIV, the presence of AIDS, and the use of ARV therapy. We will discuss these recommendations in detail as we review each method.
For each contraceptive method, medical conditions are classified into categories based on the risks and benefits associated with use of the method among women with those conditions.

The WHO Medical Eligibility Criteria use four categories to classify medical conditions:

- **Category 1:** For women with these conditions, the method presents no risk and can be used without restrictions.

- **Category 2:** For women with these conditions, the benefits of using the method generally outweigh the theoretical or proven risks. Women with category 2 conditions generally can use the method, but follow-up by the provider may be appropriate in some cases.

- **Category 3:** For women with these conditions, the theoretical or proven risks of using the method generally outweigh the benefits. Women with category 3 conditions generally should not use the method. However, if no better options for contraception are available or acceptable, the provider may judge that the method is appropriate, depending on the severity of the condition. In such cases, ongoing access to clinical services and careful follow-up by the provider are required.

- **Category 4:** For women with these conditions, the method presents an unacceptable health risk and should not be used.

In some cases, a particular condition is assigned to one category for initiation and another for continuation of the method. In other words, the category may depend on whether a woman with the condition wishes to initiate a contraceptive method or was already using that method when she developed the condition.27
In situations where clinical judgment is limited, such as community-based distribution programs, the four-category classification framework can be simplified into two categories.

When simplified for these situations, categories 1 and 2 indicate that the method can be used, while categories 3 and 4 indicate that the woman is not medically eligible to use the method.28

The next slide provides some examples from the WHO recommendations.
WHO Eligibility Criteria: Examples

<table>
<thead>
<tr>
<th>Medical Condition/Characteristic</th>
<th>Contraceptive Method</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>uterine fibroids</td>
<td>COCs</td>
<td>1</td>
</tr>
<tr>
<td>anaemia</td>
<td>IUD</td>
<td>2</td>
</tr>
<tr>
<td>breastfeeding a baby less than 6 weeks postpartum</td>
<td>DMPA</td>
<td>3</td>
</tr>
<tr>
<td>current breast cancer</td>
<td>hormonal implants</td>
<td>4</td>
</tr>
</tbody>
</table>


This table includes a few examples from the WHO recommendations to demonstrate how methods and medical conditions are categorized. For instance, the recommendations state that:

• Women with uterine fibroids who wish to use combined oral contraceptives, or COCs, can use them without restrictions as this method presents no risk to women with this condition.

• Women with anaemia who wish to use an intrauterine device, or IUD, can generally use the method because the benefits of using the IUD generally outweigh the theoretical or proven risks associated with the effect that IUD use may have on increased blood loss and anaemia. Follow-up by the provider may be appropriate in some cases.

• Women who are breastfeeding a baby less than six weeks postpartum generally should not use Depo-Provera, also known as DMPA, because of theoretical concerns that the infant may be at risk due to exposure to steroid hormones during the first six weeks postpartum when the infant’s liver may not be fully capable of metabolizing the hormone.

• Among women with current breast cancer, the use of hormonal implants is unacceptable and should be avoided. This is because breast cancer is a hormone-sensitive tumour, and hormonal use may accelerate growth.
Contraceptive Method Options

- barrier methods
- oral contraceptive pills
- injectables
- implants
- intrauterine device (IUD)
- female and male sterilization
- lactational amenorrhoa method (LAM)
- fertility awareness-based methods

**Couples with HIV have a wide range of methods from which to choose.**

Contraceptive options for women with HIV are similar to those of noninfected women and include barrier methods; hormonal methods; the IUD; female and male sterilization; the lactational amenorrhea method, also known as LAM; and fertility awareness-based methods.

As we will discuss in this section, most of these methods are appropriate for women and couples with HIV.
Contraceptive method effectiveness is one of the most important characteristics for women who want to avoid childbearing. As you can see on this slide, contraceptive failure can occur with any method. However, some methods are more effective than others. This slide shows pregnancy rates for various contraceptive methods. The light rectangles show pregnancy rates for “perfect” use, reflecting how often a contraceptive method fails when it is used both correctly and consistently. The dark rectangles show pregnancy rates for “typical” use, reflecting how often a contraceptive method fails in real life situations, when it may not always be used correctly and consistently. Typical use rates vary depending on user characteristics, user behaviour, the adequacy of counselling, and access to resupply.

Differences between correct and typical use rates are greater for some methods than for others. Client-controlled methods may have low pregnancy rates with correct and consistent use but higher pregnancy rates with typical use. For example, combined oral contraceptives have a pregnancy rate of 0.3 percent when used correctly and consistently but a pregnancy rate of 8 percent with typical use. In contrast, the pregnancy rates for typical use of IUDs or injectable contraceptives are almost the same as those for their correct and consistent use because the effectiveness of these methods depends little on user behaviour. For example, the TCu-380A IUD has a pregnancy rate of 0.6 percent with correct and consistent use and a rate of 0.8 percent in typical use. When considering the pregnancy rates for various methods, keep in mind that women who use no method at all have a risk of pregnancy as high as 85% over a period of one year.

In this section, we will consider each method in detail.
Condoms

- Prevent both pregnancy and STIs/HIV when used consistently and correctly
- In real-life situations, correct and consistent use may be difficult to achieve

<table>
<thead>
<tr>
<th>Pregnancy rates:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>perfect use</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>typical use</td>
<td>15%</td>
<td>21%</td>
</tr>
</tbody>
</table>


We will start with condoms first because they are the only method that has the unique ability to prevent transmission of STIs/HIV in addition to preventing pregnancy. However, the effectiveness for both pregnancy and STI/HIV prevention depends greatly on the client’s ability to use condoms consistently and correctly.

In real-life situations, correct and consistent use may be difficult to achieve. Condoms may not be used with every act of intercourse or are sometimes used incorrectly.

When used correctly every time a couple has intercourse, the male condom has a pregnancy rate as low as 2 percent, and the female condom has a rate of 5 percent. In common use, their pregnancy rates are much higher – around 15 percent for the male condom and 21 percent for female condom.31

Note to presenter:

Researchers attribute the 5 percent perfect use pregnancy rate for the female condom to “misreporting” by users who were under the impression that the condom was used correctly when in fact, it was not. Although the female condom may be used consistently with each act of intercourse and inserted correctly, it is possible for the male partner to insert his penis on the outside of the condom without the couple noticing it.

For additional information on this topic see: Fact Sheet #1: Male and Female Condoms.
Condoms Prevent HIV/STI Transmission

- Typical use: 80% reduction in HIV incidence
- Consistent use: infection rate less than 1% per year in discordant couples
- With infected partner: inconsistent condom use is as risky as using no condom at all
- Prevents STIs transmitted through body fluids – less effective for skin-to-skin contact STIs


Condoms are the only method proven to reduce the risk of all STIs, including HIV.

One recent review of multiple studies found that typical condom use results in an eighty percent reduction in HIV incidence, a level of protection slightly less effective than for pregnancy.

The most conclusive evidence of condom effectiveness in reducing HIV transmission has come from studies of serodiscordant couples, in which one person is infected with HIV and the other person is not. One study demonstrated that with consistent condom use, the HIV infection rate among the uninfected partners was less than one percent per year.

However, in situations where one partner is definitely infected, inconsistent condom use was shown to be as risky as not using condoms at all – 13.3 percent of inconsistent users became infected compared to 14.4 percent of non-users.

Condoms are most effective in preventing STIs that are transmitted through bodily fluids, such as HIV, gonorrhoea, and chlamydia. They are apt to be less effective against STIs that are transmitted through skin-to-skin contact, such as genital herpes and warts, because the condom may not cover the entire affected area.
Condom Use by Clients with HIV

<table>
<thead>
<tr>
<th>WHO Eligibility Criteria</th>
<th>Condition</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV-infected</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>AIDS</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>ARV Therapy</td>
<td>1</td>
</tr>
</tbody>
</table>

• Prevent STI/HIV transmission
• Prevent possible superinfection with a different HIV strain
• Are less effective in typical use than some other methods for pregnancy prevention
• Consistent and correct use should be encouraged

The WHO Medical Eligibility Criteria classify the conditions HIV-infected, the presence of AIDS and use of ARV therapy as category 1 for condom use, meaning that condoms can be used without restrictions.35

Male and female condoms are the only methods that can prevent HIV and STI transmission between partners.

They also might prevent transmission of a different HIV strain to a person who is already infected with HIV, known as superinfection.

As typically used, condoms are less effective for pregnancy prevention than some other methods, while other methods provide no protection from HIV/STIs.

For these reasons, counselling of clients or couples should focus on strengthening their ability to consistently and correctly use condoms, either alone or in combination with another method to prevent both STI/HIV and pregnancy.
Why Encourage Dual Method Use

*Use condoms to protect against HIV/STIs and another method to prevent pregnancy.*

Reduces:
- risk of unintended pregnancy
- transmission of HIV between partners
- risk of acquiring or transmitting other STIs

*Dual method use may not be easy to achieve.*

Dual method use refers to a couple using a condom to protect against HIV/STI transmission while using another method for pregnancy prevention.

Dual method use helps to reduce:
- the risk of unintended pregnancy,
- the transmission of HIV between partners, including the transmission of a different strain of HIV to a partner already infected with HIV, and
- the risk of acquiring or transmitting other STIs.

Dual method use may not be easy for couples to achieve and requires ongoing support and encouragement by providers.
Counselling about Dual Method Use

Users of more effective methods may be less likely to use condoms.

Encourage clients to consider:
- limitations of a single-method approach
- their individual risk of pregnancy
- whether partners have HIV or other STIs
- the negative consequences that may result

Dual method use is an effective way to prevent both unintended pregnancy and STIs, including HIV. But studies have suggested that women with HIV who use more effective contraceptive methods are less likely to use condoms, even with a noninfected partner. These study results reinforce the importance of providers helping clients to understand the benefits of dual method use by considering the following:
- the limitations of a single-method approach,
- their individual risk of pregnancy,
- whether their partners have HIV or another STI, and
- the negative consequences of acquiring or transmitting HIV, especially as resistant strains of the virus emerge.
Counselling about Dual Method Use

continued...

Teach clients:
• to negotiate condom use
• how to use condoms
• importance of using condoms consistently with all partners

Encourage dual method use for all clients with HIV who wish to protect themselves.

Because clients often find it difficult to negotiate condom use with their partners, it is important for providers to teach skills for negotiating condom use and the correct use of condoms. This is typically done using demonstrations and role plays to simulate some of the more challenging obstacles clients may encounter when negotiating with their partners. When possible, and with the client’s consent, partner or couple counselling on the importance of condom use can also be an effective approach.

Men who may engage in intercourse with casual sex partners, should be counselled to use condoms even when their female partner is using another method of contraception. The advice to use condoms in addition to another method is particularly important for discordant couples. However, concordant couples, where both partners are infected with HIV, should also use condoms to avoid STIs and superinfection with another HIV strain.

Next we will discuss other contraceptive methods that could be used either alone for pregnancy prevention or in combination with condoms for dual protection against pregnancy and STIs, including HIV.
Hormonal contraceptives include combined oral contraceptive pills, that contain the hormones oestrogen and progestin and a group of methods that contain only progestin and no oestrogen. This group includes progestin-only oral contraceptive pills, or POPs; injectables such as Depo-Provera; and implants such as Norplant, Jadelle, and Implanon.

Note to presenter:
If there are other hormonal methods available in your country, include them in the list, for example, NET-EN (Norigynon) and combined injectables (Cyclofem).
Hormonal methods are appropriate for women with HIV, and most offer excellent pregnancy protection.

Pregnancy rates for injectables and implants are less than one-half percent in both perfect and typical use. Oral contraceptives can also be very effective when women remember to take pills on schedule.

All hormonal methods are easy to use, especially injectables and implants, which require very little action on the part of the client.

Implants offer long-term protection for up to five years, while other methods are suitable for both short- and long-term use.

All hormonal methods are reversible, although fertility return with DMPA may take somewhat longer than with other methods.

All hormonal methods offer some health benefits, including but not limited to reduced risk of reproductive tract cancers, anaemia, and clinical pelvic inflammatory disease.

In addition, serious complications are extremely rare with any of the hormonal methods, especially if women meet the eligibility criteria for initiating use.

While hormonal methods are appropriate for women with HIV, several biological concerns regarding the relationship between hormonal contraceptives and HIV exist. These concerns continue to be an important area of research, but there is insufficient knowledge at this time to justify changes to existing family planning practices.
Overview:
Theoretical Concerns About Hormonal Methods

For women with HIV:

• ARVs may reduce method effectiveness or increase side effects
• contraceptives may affect ARV efficacy
• hormonal methods may possibly affect
  – infectivity
  – disease progression

More research is needed before reviewing clinical practices.

Some antiretroviral drugs can reduce or increase blood levels of contraceptive hormones.\textsuperscript{37, 38} Theoretically, lower concentrations could reduce the effectiveness of hormonal contraceptives, while higher concentrations could increase hormone-related side effects.

Similarly, contraceptives may affect the efficacy of some ARV drugs.

Other issues that require further research include possible effects of hormonal contraception on HIV-infected women’s infectivity and possible relationships between hormonal contraception and HIV disease progression.

It is important to balance these concerns, which are primarily theoretical, against the real risk of unintended pregnancy and its impact on maternal and infant morbidity and mortality.

On the next several slides, we will consider each of these issues and how they might affect the use of different hormonal methods. To help reinforce which issues are theoretical – meaning that additional research is required before making changes to practice guidelines – this graphic appears on each slide where theoretical concerns are discussed.
How ARVs Interact with COCs

- May cause an increase or decrease of hormone levels
- Some ARVs speed up liver metabolism and could lower oestrogen blood levels, may reduce method effectiveness
- Not all ARV classes interact with contraceptive hormones (e.g., NRTIs)

A few small pharmacokinetic studies have examined the use of certain ARV therapies with limited courses of combined oral contraceptives.

These studies showed both positive and negative effects on hormone levels.

The main concern about COCs is that some ARVs affect liver enzymes, which then speed up liver metabolism of contraceptive hormones and could lower oestrogen blood levels by almost one-third. The reduced concentrations of contraceptive hormones in blood theoretically may lead to reduced effectiveness of hormonal contraceptives and increased risk of pregnancy.

Not all classes of ARVs interact with contraceptive hormones because not all ARVs affect liver enzymes. Drugs that do not affect liver enzymes, and therefore probably do not affect hormonal contraceptives, include NRTIs.

The charts on the next two slides summarize what is known to date.
Concerns about interactions with hormonal contraceptives focus on NNRTIs, shown here, and protease inhibitors, described on the next slide.\textsuperscript{39}

The chart shows the effects that were observed in the levels of contraceptive steroids and ARV drugs when they are taken concurrently. In the case of nevirapine, one study demonstrated a 29 percent decrease in plasma concentration of hormonal contraceptives among women taking concurrent estradiol/norethindrone and nevirapine.\textsuperscript{40} In the case of efavirenz and perhaps delavirdine, an increase in plasma concentration of hormonal contraceptives was observed. No changes in the blood concentrations of the ARV drugs were observed. \textsuperscript{▌}

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
Non-nucleoside reverse transcriptase inhibitors & Contraceptive hormone levels in blood & ARV levels in blood \\
\hline
Nevirapine (NVP) & $\downarrow$ & No change \\
Efavirenz (EVF or EFZ) & $\uparrow$ & No change \\
Delavirdine (DLV) & ? $\uparrow$ & No data \\
\hline
\end{tabular}
\end{table}

\textbf{Note to presenter:}

Limited studies show that:

Nevirapine, on average, reduces the blood level of oestrogen by 20 percent.

Efavirenz increases the blood level of oestrogen by 37 percent.

Interactions between COCs and PIs

<table>
<thead>
<tr>
<th>Protease inhibitors</th>
<th>Contraceptive hormone levels in blood</th>
<th>ARV levels in blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nelfinavir (NFV)</td>
<td>↓</td>
<td>No data</td>
</tr>
<tr>
<td>Ritonavir (RTV)</td>
<td>↓</td>
<td>No data</td>
</tr>
<tr>
<td>Lopinavir (LPV)/ Ritonavir (RTV)</td>
<td>↓</td>
<td>No data</td>
</tr>
<tr>
<td>Atazanavir (ATV)</td>
<td>↑</td>
<td>No data</td>
</tr>
<tr>
<td>Amprenavir (APV)</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>Indinavir (IDV)</td>
<td>↑</td>
<td>No data</td>
</tr>
<tr>
<td>Saquinavir (SQV)</td>
<td>No data</td>
<td>No change</td>
</tr>
</tbody>
</table>


This chart summarizes the interactions that were observed in the levels of contraceptive steroids and protease inhibitors. Notice that in some cases the contraceptive steroid levels decreased while in other cases an increase was noticed.\textsuperscript{41}

Limited evidence suggests that at least one ARV drug, amprenavir, increases blood levels of contraceptive hormones, while the blood levels of the ARV itself decrease.\textsuperscript{42} This may reduce the efficacy of ARV therapy for women who take contraceptive hormones. The increased level of contraceptive hormone may increase the risk of side effects associated with hormonal contraceptives.

While clinical significance of such interactions is unclear, we do know that ultra-low-dose, 20 microgram, oral contraceptives – which contain two-thirds the amount of oestrogen found in regular low-dose oral contraceptives – are widely used in countries where they are approved, and highly effective if taken correctly.  

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Note to presenter:

Limited studies show that:

- Ritonovir reduces oestrogen blood level by 40 percent,
- Nelfinavir reduces oestrogen by 47 percent and progestin by 18 percent,
- Lopinavir reduces oestrogen by 20 percent, and
- Atazanavir increases oestrogen by 48 percent.

The cumulative effect(s) of taking more than one ARV drug that interacts with the hormone levels of contraceptives is also unknown.
Clinical Significance of COC/ARV Interaction Is Unknown

- Not clear that effectiveness of contraceptives is affected by ARVs
- No studies of clinical outcomes completed (i.e., pregnancy rates, ovulation indicators)
- No data on interaction between ARVs and hormonal contraceptives other than COCs

More research is needed before reviewing clinical practices.

Currently, the concerns about interactions between hormonal contraceptives and ARV drugs are theoretical. It is not known yet whether the effectiveness of contraceptive hormones is appreciably affected when the blood levels of the hormones are somewhat reduced.

No studies of actual clinical outcomes, such as pregnancy rates or indicators of ovulation, have been completed.

Additionally, no clinical studies have been completed to clarify possible interactions between ARVs and other hormonal contraceptives including combined injectables; vaginal rings; patches; progestin-only injectables; progestin-only pills; emergency contraceptive pills, also known as ECPs; progestin implants; or the progestin intrauterine systems.

Until conclusive research can be conducted, there is insufficient evidence to consider more restrictive changes to clinical guidelines.

Now we will look more closely at the relationship between hormonal contraceptives, STI acquisition, and HIV transmission.
It appears that use of hormonal contraceptives may increase the risk of acquiring cervical STI infections, which, as you will see on the next several slides, may have some implications for women with HIV. A ten-year prospective study of HIV-infected Kenyan sex workers found that use of hormonal contraceptives was associated with a significantly increased risk of cervical chlamydial infection and cervicitis, even after controlling for demographic factors and sexual behaviour. Compared to women who used no hormonal contraceptives, women using DMPA had a threefold increased incidence of cervical chlamydial infection and a 1.6-fold increased incidence of nonspecific cervicitis. Women using oral contraceptive pills had more than double the increased incidence of nonspecific cervicitis. Use of hormonal contraceptives was not associated with an increased incidence of gonorrhoea infection, however.\textsuperscript{43}
A theoretical concern also exists that hormonal contraceptive use by women with HIV could increase HIV shedding therefore increasing risk of HIV transmission to an uninfected partner. However, data are conflicting about such a relationship. Some studies showed no increase in HIV shedding. Other data suggest that more HIV shedding does occur when women are using hormonal contraception.44

One prospective study conducted among family planning clients in Mombasa, Kenya, detected a modest but statistically significant increase in cervical shedding of HIV-infected cells. Cervical shedding in women with HIV rose from 42 percent to 52 percent after initiation of various hormonal contraceptives.45 However, no difference was detected in the amount of cell-free virus in genital secretions.

The relative impact of HIV-infected cells versus cell-free virus on infectivity is uncertain. The presence of both in maternal cervical secretions and in breast milk has been found to increase the risk of vertical transmission.46
Let us take a closer look at the relationship between the theoretical concerns raised on the last few slides.

It appears that use of hormonal contraceptives may increase the risk of acquiring STIs and the cervical shedding of HIV.

It is also known from research studies that cervical STIs increase HIV shedding in cervical secretions, even in women who are not using hormonal contraceptives.47, 48

The increased amount of virus may in turn increase the risk of HIV transmission to a sexual partner.

While some concern about an increased risk of HIV transmission among users of hormonal contraceptives is warranted, more data are needed before any changes to current service delivery guidelines are considered.
Hormonal Use: Theoretically May Affect Disease Progression

Use of hormonal contraceptives near the time of HIV acquisition is associated with:

- higher viral load set point (indicator of disease progression)
- infection with multiple subtypes of HIV, resulting in faster CD4 decline

More research is needed before reviewing clinical practices.

Source: Lavreys, 2004; Sagar, 2003.

Some studies have also raised concerns that hormonal contraceptives may affect disease progression in women with HIV. In a prospective cohort study of HIV acquisition among 1,337 sex workers in Mombasa, Kenya, the use of DMPA at the time of HIV infection was associated with a higher viral load set point.

Viral load set point is an important indicator of HIV disease progression. After a person initially becomes infected, his or her viral load increases. The killer cells of the immune system respond to the HIV virus by attacking infected cells, lowering the viral load to a certain level. This level is known as the viral set point. The higher the viral load set point, the faster HIV-related deterioration of the immune system occurs. Thus, the Mombasa study findings suggest that DMPA use may hasten the natural course of HIV infection.49

Similarly, Kenyan sex workers using hormonal contraceptives near the time of HIV acquisition were more likely to be infected with multiple genetically diverse subtypes of the same virus than women not using hormones. Infection with multiple subtypes appears to be related to a higher viral set point and to faster CD4 decline, which is another key indicator of HIV disease progression.50

Many of the studies on hormonal contraception and HIV disease progression have been conducted among sex workers in Kenya, and some of the findings have not been corroborated by other studies. Therefore, further research among other populations of women in other geographic locations is needed before any changes to service provision guidelines are made.
OC Use by Women with HIV

<table>
<thead>
<tr>
<th>WHO Eligibility Criteria</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected</td>
<td>1</td>
</tr>
<tr>
<td>AIDS</td>
<td>1</td>
</tr>
<tr>
<td>ARV Therapy</td>
<td>2</td>
</tr>
</tbody>
</table>

- Women with HIV/AIDS can use without restrictions
- May not be best choice for women on ARVs
- Using low-dose COC is reasonable if taken correctly by women on ARVs
- Dual method use should be encouraged


Based on the available research, WHO advises that women with HIV who may or may not have AIDS can use oral contraceptives without any restrictions – category 1. Because the evidence is not sufficient at this time to conclude that oral contraceptives are less effective in women on ARV therapy, the WHO Medical Eligibility Criteria suggest that OCs can generally be used by women on ARV therapy – category 2.51

Because of the possibility of reduced effectiveness, however, OCs may not be the most appropriate choice for some women on ARV therapy, particularly those who have difficulty remembering to take a pill on time.

If a woman on ARVs chooses COCs, providing the standard low-dose, 30 to 35 microgram oestrogen COCs can be reasonable if she will take them consistently. Although some providers suggest using higher doses of 50 micrograms, no studies have compared the effectiveness of high-dose versus low-dose COCs in women on ARV therapy. Also, higher-dose COCs may result in more side effects or complications.

A sensible approach may be to use condoms consistently as a backup method of contraception while taking low-dose COCs.

Regardless of the method chosen, counselling on condom use should be an integral part of contraceptive counselling for women with HIV because the condom is the only method that prevents HIV transmission between partners.

Next we will address the use of emergency contraceptive pills by women with HIV.

Note to presenter:
For additional information on this topic see: Fact Sheet #2: Combined Oral Contraceptives.
ECP Use by Women with HIV

- Use to prevent pregnancy after unprotected intercourse
  - progestin-only and combined oestrogen-progestin regimens (reduce risk of pregnancy by 75%)
  - start as soon as possible; counsel to adopt regular method
- Use if regular method was used incorrectly, failed, or was not used
- Safe for all women (including women with HIV/AIDS and taking ARV drugs)

*There is no evidence to justify changes to emergency contraceptive pill regimens for ARV clients.*


Emergency contraceptive pills – the most common method of emergency contraception – refer to the special regimen of oral contraceptives used to prevent pregnancy after unprotected intercourse. It does not provide any protection from STI/HIV transmission. Two common regimens of ECPs are:

- progestin-only regimen
- combined oestrogen-progestin, or Yuzpe regimen.

If taken within 120 hours after unprotected intercourse, ECPs reduce the risk of pregnancy by at least 75 percent, with the progestin-only regimen being more effective than the Yuzpe regimen. The sooner ECPs are started, the more effective they are. Providers who offer emergency contraception should also help women to choose a regular contraceptive method and counsel them about how to use the method correctly and when to begin using it.

Emergency contraception may be considered in a number of situations when unprotected intercourse takes place. These situations include occasions when a regular contraceptive method was used incorrectly or failed (e.g., the condom broke), or when no contraceptive method was used, including coercive sex or rape.

Emergency contraception is safe and should be available to all women, including women with HIV or AIDS, or those on ARV therapy.

Currently, no data are available on the extent and outcomes of interaction between emergency contraceptive regimens and ARVs. Because emergency contraception contains higher doses of hormones than regular oral contraceptives, its efficacy may not be significantly affected by ARV drugs. Even if the amount of hormones is reduced, ECPs still should provide some level of protection from unwanted pregnancy. There is no basis for changing clinical recommendations for ECP use in women with HIV who are receiving ARV therapy or who may receive ARV drugs as a prophylactic treatment after being raped or having coerced sex with a partner infected with HIV.

Next we will consider the use of other types of hormonal contraception – injectables and implants – by women with HIV.

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Note to presenter:
For additional information on this topic see: Fact Sheet #3: Emergency Contraceptive Pills.
Injectable Use by Women with HIV

<table>
<thead>
<tr>
<th>WHO Eligibility Criteria</th>
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</tr>
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<td>2</td>
</tr>
</tbody>
</table>

- Women with HIV/AIDS can use without restrictions
- Nevirapine reduces blood progestin level by ~20%
- DMPA dose provides wide margin of effectiveness
- Encourage to receive injections on time
- Dual method use should be encouraged


According to the WHO Medical Eligibility Criteria, injectables can be used without restrictions by women with HIV who may or may not have AIDS – category 1.

Women on ARV therapy can generally use injectables – category 2.54

It has been demonstrated that nevirapine reduces blood progestin level by about 20 percent.55 However, these reductions are probably not enough to affect contraceptive efficacy.

A dose of Depo-Provera is high enough to provide a very wide margin of effectiveness. For example, a WHO study comparing 100 mg versus the usual 150 mg dose found that the lower dose also had excellent contraceptive effectiveness.56 If any reduced effectiveness occurs, it is likely to be at the end of the three-month dosing period, when blood levels of Depo-Provera decrease.

Depo-Provera reinjection can normally be given as much as two weeks late. But providers should encourage women on ARV therapy to receive the next injection by the end of the three-month period.

Women with HIV who choose to use DMPA should be counselled about dual method use and should consider using condoms in addition to hormonal methods. Condoms provide both additional protection from pregnancy and protection from HIV/STI transmission between partners.

Note to presenter:
For additional information on this topic see: Fact Sheet #4: Progestin-only Injectables.
Implant Use by Women with HIV

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- Women with HIV/AIDS can use without restrictions
- Nevirapine reduces blood progestin level by ~20%
- Implants provide consistent dose of hormone over time
- No evidence that lower dose may be less effective
- Dual method use should be encouraged


According to the WHO Medical Eligibility Criteria, implants can be used without restrictions by women with HIV that may or may not have AIDS – category 1.

Women on ARV therapy can generally use implants – category 2.\(^57\)

Although progestin blood levels are somewhat reduced by nevirapine,\(^58\) these reductions are probably not enough to affect contraceptive efficacy.

Norplant, Jadelle, and Implanon provide a consistent dose of hormone over time.

There is no evidence at this time that a somewhat lower dose of hormone would make implants less effective.

However, women with HIV who choose to use implants should be counselled about dual method use and should consider using condoms in addition to hormonal methods. Condoms provide both additional protection from pregnancy and protection from HIV/STI transmission between partners.

Note to presenter:
For additional information on this topic see: Fact Sheet #5: Progestin-only Implants.
Hormonal Use and HIV:
What Providers Should Do

• Counsel clients that some ARV drugs may reduce the efficacy of some hormonal contraceptives (e.g., COCs)

• When there is a choice, prescribe ARV drugs that do not interact with hormonal methods

• Encourage correct and consistent use of contraceptive method

• Keep abreast of updates to guidelines

Given what is currently known about hormonal contraception and HIV, providers should:

• Counsel their clients that some ARV drugs may reduce the efficacy of some hormonal contraceptives.

• When possible, prescribe ARV drugs that do not interact with hormonal contraceptives.

• If this is not possible, encourage women to be very careful about using the methods correctly and consistently, and to consider using condoms for additional protection.

• Keep abreast of updates to clinical practice guidelines. As new research on these and other related topics becomes available, technical experts and policy-makers will make appropriate changes to clinical practice guidelines. For example, the available research on HIV disease progression and possible increased risk of transmission among hormonal contraceptive users is not conclusive. Until additional research on these topics can provide decisive information, there is no reason to change clinical practice or to counsel clients about these theoretical concerns.
Intrauterine Device

- Highly effective, long-term, reversible method
- Remains in place up to 12 years
- Almost 100 percent effective
- Has no effect on fertility when used by nulliparous women
- Attractive method for women with HIV who desire very reliable pregnancy protection


The IUD is a highly effective, long-term method of contraception with a failure rate of less than one percent. Its effectiveness compares to that of sterilization, but unlike sterilization, it is reversible.

The most commonly used IUD, the Copper T-380A, can remain in place for up to 12 years and possibly longer.

The IUD is almost 100 percent effective because it does not depend on a client’s ability to use it correctly.

It has also been shown that the IUD can be used by nulliparous women without having any negative effect on their future fertility.

High efficacy and ease of use can make IUDs an attractive option for women with HIV who want highly reliable protection from pregnancy.

Note to presenter:
For additional information on this topic see: Fact Sheet #6: Intrauterine Devices.
Research has found that women with HIV can use IUDs safely. A study conducted in Kenya examined over a two-year period the health of two groups of women who received an IUD: 486 women who were HIV-negative, and 150 women with HIV infection. Researchers looked for problems after insertion, such as IUD removal due to infection, bleeding, and pain; IUD expulsion; pregnancy; and pelvic inflammatory disease, an infectious complication that can cause severe pain, infertility, or even death.

As you can see in this slide, the percentage of women reporting complications after IUD insertion was almost identical for the two groups – 14.7 percent among women with HIV and 14.8 percent among women not infected with HIV. The percentage of women reporting problems related to some type of infection, including pelvic tenderness and IUD removal for infection or pain, was 10.7 percent among those who were HIV-infected and 8.8 percent among those who were HIV-free. While women with HIV tended to have slightly more problems related to infection, they were not significantly different from women in the noninfected group.

In short, little difference in side effects and infection-related complications was seen between HIV-infected and HIV-uninfected IUD acceptors. Overall 85 percent of women had no problems with IUD use. These findings suggest that the IUD is an appropriate contraceptive method for women with HIV. This is especially true for women who want to limit births for an extended period of time or where access to sterilization services might be limited.
IUD Use Does Not Increase HIV Transmission

Theoretical concern:
• IUD use by women with HIV may increase risk of transmission to partner

Research has found:
• no post-insertion increase in cervical shedding
• no increased risk of partner exposure to higher dose of virus

Source: Richardson, 1999.

Another theoretical concern about IUD use by women with HIV is that it could increase cervical shedding of HIV, thus increasing the risk of transmission to a sexual partner.

In a study conducted in Kenya, researchers calculated rates of cervical shedding of HIV-infected cells before IUD insertion and four months after insertion. Results showed no significant differences in cervical shedding among women with HIV before and after insertion. In other words, current evidence suggests that IUDs do not raise the amount of virus to which the women’s sexual partner is exposed.61
IUD Use by Women with HIV

<table>
<thead>
<tr>
<th>WHO Eligibility Criteria</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>Condition</td>
<td>Initiate</td>
<td>Continue</td>
<td></td>
</tr>
<tr>
<td>HIV-infected</td>
<td>2</td>
<td>2</td>
<td></td>
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<tr>
<td>AIDS (without ARVs)</td>
<td>3</td>
<td>2</td>
<td></td>
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<tr>
<td>ARV Therapy (clinically well)</td>
<td>2</td>
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- Safe for majority of women with HIV
- Initiation not recommended if woman has AIDS and is not on ARV therapy
- Dual method use should be encouraged

Based on the evidence shown in the previous slides, the WHO Medical Eligibility Criteria state that women with HIV can generally initiate and continue to use an IUD – category 2. This chart shows the specific WHO recommendations:

- An IUD can be provided to a woman with HIV if she has no symptoms of AIDS.
- A woman who developed AIDS while using an IUD can continue to use the device.
- A woman with AIDS who is doing clinically well on ARV therapy – meaning that the symptoms of AIDS are controlled by the ARVs – can both initiate and continue IUD use.

While IUD users who develop AIDS can continue using the method, IUD initiation is generally not recommended in women who already have AIDS. WHO determined that IUD initiation in such women should be a category 3 because of the theoretical risk that advanced immunosuppression could increase the risk of IUD-related complications, unless a woman is on ARV therapy.

While the IUD offers highly effective protection from pregnancy, it does not guard against HIV and STI transmission between partners. As with other methods, providers who counsel sexually active, HIV-infected clients about their contraceptive options should always encourage condom use in addition to any other contraceptive method clients may want to use.

Next we will consider barrier methods other than condoms, beginning with spermicides.
Spermicides

- Provide limited protection with pregnancy rates:
  - 18% perfect use
  - 29% typical use
- Provide no STI protection
- May increase risk of HIV (with frequent use)


Spermicides alone offer only limited protection from pregnancy. Failure rates for spermicides vary from 18 percent when used consistently and correctly to 29 percent with typical use. In typical use, spermicides may not be used on some occasions or may be used incorrectly.63

Spermicides containing nonoxynol-9 do not protect against HIV infection or other STIs.64, 65

Spermicides may even increase the risk of HIV infection in women using these products frequently.66 This may be because nonoxynol-9 can disrupt the epithelium, or lining, of the vagina, thereby facilitating invasion by an infective organism. Women who have multiple daily acts of intercourse should be advised to choose another method of contraception.67
In typical use, diaphragms are associated with relatively high rates of pregnancy. When diaphragms are used with spermicides as recommended, about 6 percent of users experience an unintended pregnancy during the first year with correct and consistent use, while the failure rate for typical use is about 20 percent.68

It is possible that diaphragms offer limited protection from STIs, including HIV. This is because a diaphragm blocks entrance to the cervix, and gonorrhoea and chlamydial infection are acquired in the cervix but not the vagina.69 The cervix is also an entry point for many HIV infections because the endocervical lining is thinner and more fragile than the lining of the vagina, and therefore more vulnerable to infection.70 Studies are under way to determine whether the diaphragm reduces the risk of transmission of HIV or other STIs.
Spermicide/Diaphragm:
Use By Women with HIV

- Use not recommended
- May increase the risk of HIV transmission
- If a woman desires reliable pregnancy protection, encourage consideration of other methods
- Encourage dual method use


The WHO Medical Eligibility Criteria do not recommend the use of spermicides and diaphragms for women with HIV/AIDS. Women with HIV/AIDS should not use spermicides because they may be at increased risk of infection with another strain of HIV, or superinfection. Documented instances of superinfection, while rare, have been associated with faster disease progression and failure of antiretroviral therapy.

If a woman with HIV desires reliable pregnancy protection, she should be encouraged to consider other, more effective methods of contraception.

Because spermicides provide no protection against transmitting STIs/HIV, and it is not clear whether and to what extent the diaphragm provides protection, condom use should be encouraged to prevent infection transmission between partners.
Surgical Sterilization

• Good for couples who want no more children
• Safe, simple surgical procedure
• Considered permanent
• Very effective; pregnancy rates:
  – Female: 0.5% after one year, increasing to 1.85% over ten years
  – Male: 0.1% - 0.15% (possibly higher)


For women and couples with HIV who have decided to have no more children, female or male sterilization may be a good option. Female sterilization is a safe, simple surgical procedure that involves cutting and closing off both fallopian tubes. It can usually be done with just local anaesthesia. Female sterilization is considered permanent and is very effective, with a pregnancy rate of about 0.5 percent during the first year. Over a period of ten years, pregnancy rates increase to 1.85 percent.

Male sterilization involves making a small opening in the man’s scrotum and closing off both tubes that carry sperm from his testicles. It provides permanent contraception and is very safe and effective, with pregnancy rates between 0.1 percent and 0.15 percent during the first year. Some studies reported vasectomy failure rates as high as 3 percent to 5 percent when using sperm count as the indicator of failure instead of pregnancy.

Note to presenter:
For additional information on this topic see: Fact Sheet #7: Male and Female Sterilization.
Sterilization Use by Clients with HIV

- No medical reasons to deny sterilization to clients with HIV
- Procedure may be delayed in event of acute HIV-related infection
- Encourage condom use


The WHO Medical Eligibility Criteria state that there are no medical reasons to deny sterilization to a client with HIV.

If a woman or man has an acute AIDS-related illness, sterilization should be delayed until their condition has improved. Because sterilization is a surgical procedure, any acute HIV-related opportunistic infection may complicate or prolong recovery.

Because neither male nor female sterilization offers protection from HIV transmission, couples should be counselled about condom use for STI/HIV prevention.
The lactational amenorrhoea method, also known as LAM, is a temporary contraceptive option used for up to six months postpartum by women who are fully or nearly fully breastfeeding and who continue to have no menses.

It is safe, convenient, and highly effective. Women who meet all three criteria for using LAM have only a 1 percent to 2 percent chance of getting pregnant.
LAM Use by Women with HIV

- Advise that children can become infected
  – risk of acquisition through breast milk ~16%

- Exclusive breastfeeding during first six months may reduce risk of acquisition by infant (compared to mixed feeding)

- Exclusive use of formula or other substitutes eliminates risk of transmission through breast milk (often not possible)


Women with HIV need to know that any children they bear may become infected with the virus during breastfeeding. The average risk of acquiring HIV infection through breast milk is at least 16 percent.

If there is no safe alternative form of milk, an HIV-infected mother should give her infant only breast milk. Exclusive breastfeeding means that no other food or drink, not even water, is given to an infant for the first few months of life. There is some evidence that exclusive breastfeeding during the first three months of life may carry a lower risk of HIV transmission than mixed feeding. Limiting exclusive breastfeeding to the first six months may also reduce the risk of HIV transmission.

When replacement feeding is acceptable, feasible, affordable, sustainable and safe, WHO recommends that HIV-infected mothers avoid all breastfeeding. An HIV-infected mother can eliminate the risk of HIV transmission through breast milk by using infant formula, modified animal milks, or heat treated/pasteurized expressed breast milk. However, she must have ongoing access to a sufficient, clean supply of this alternative form of milk, which is often not possible in many settings.

Note to presenter:
For additional information on this topic see: Fact Sheet #8: HIV and Breastfeeding.
Fertility awareness-based, or FAB, methods involve the identification of the fertile days of the menstrual cycle, either by observing fertility signs, such as cervical secretions and basal body temperature, or by monitoring cycle days.

FAB methods can be used in combination with abstinence or barrier methods during the fertile time.

Because the effectiveness of these methods depends heavily on a woman’s ability to identify fertile days correctly, pregnancy rates for FAB methods as commonly used are high – between 12 percent and 22 percent, depending upon the method used.

Thus, women and couples with HIV who do not want to have children should be counselled to consider other, more reliable methods of contraception.
FAB Methods Use by Women with HIV

Women who have HIV with/without AIDS and those on ARV therapy:

- can use without restrictions (calendar method relies on regular menstrual cycles)
- should be encouraged to use condoms


According to the WHO Medical Eligibility Criteria, women with HIV who may or may not have AIDS and those on ARV therapy can use FAB methods without restrictions, although women who want to use the calendar method should have regular menstrual cycles.

Women and couples relying on FAB methods should be counselled that they are not protected from STI and HIV transmission and should be encouraged to use condoms.
Summary of Contraceptive Choices

- Use two methods concurrently (condoms plus another contraceptive method)
- Use one method and understand its limitations (prevent pregnancy versus prevent transmission)
  - effective pregnancy prevention but no STI/HIV protection
  - condoms protect from STIs/HIV but typically less effective preventing pregnancy than other methods
- Use no method and abstain from sexual intercourse

Women with HIV have many contraceptive methods from which to choose. Given the available methods, the contraceptive options can be summarized as follows:

**Use two methods** concurrently, condoms plus another contraceptive method, or

**Use one method** and understand the limitations of the various methods to prevent pregnancy and to prevent transmission of the virus. Methods that are more effective for pregnancy prevention offer no STI/HIV protection. Condoms – the only method that provides protection from HIV and other STIs – as commonly used, are less effective at preventing pregnancy than other modern contraceptive methods. For these reasons, providers should offer counselling to encourage correct and consistent use of condoms.

**Use no method and abstain** from sexual intercourse, which may be a sensible option for some individuals, especially adolescents.
As we have discussed, clients with HIV have reproductive health choices that are similar to clients who are not infected.

Clients with HIV may be planning their families by evaluating their contraceptive options or considering the advantages and disadvantages of having a child.

The role of the provider is to offer the counselling and support that clients with HIV need to ensure that they can make informed choices that take into account the impact that HIV disease can have on these types of decisions.

In this section, we will briefly discuss the essential counselling skills that providers need, the main counselling points providers should address while helping clients with HIV make informed decisions related to their reproductive health, and the minimum program requirements to ensure that high-quality services can be delivered.
Essential Counselling Skills

- Be sensitive to circumstances of women and couples with HIV
- Respect clients’ rights
- Ensure that all women, regardless of HIV status, are free to make informed choices about pregnancy and contraception
- Assure privacy and confidentiality

Because of the special circumstances of clients with HIV, counselling should be conducted with particular sensitivity.

When counselling clients with HIV, providers must demonstrate respect for clients’ rights.

Counsellors should always remember that every woman, regardless of her HIV status, has the right to make a free and informed decision about whether and when she becomes pregnant or whether to use contraception and which method to use.

Counsellors should always ensure privacy and confidentiality as this may be a significant concern for clients with HIV.
Essential Counselling Skills

continued...

- Help clients consider how HIV affects individual circumstances and needs
- Tailor counselling session to needs of client
- Facilitate partner involvement and offer partner counselling
- Provide comprehensive, factual, unbiased information
- Support client’s FP decisions, even if you disagree

Avoid any type of coercion.

Providers should also help each woman or couple consider how HIV affects their individual circumstances and needs.

The discussion during the counselling session should be driven by the needs expressed by the client.

As much as possible, providers should facilitate the efforts of women to involve their partners. Women may need assistance with building communication skills and with developing strategies to address sensitive situations. As appropriate, providers should offer to meet jointly with a couple or meet directly with the woman’s partner.

A provider should adopt a neutral but supportive attitude and offer comprehensive, factual, unbiased information.

When counselling a woman or couple with a known or suspected HIV infection, providers should support the clients’ decisions, even if they do not agree with those decisions. For example, a counsellor may believe that permanent contraception is the best option for all women and men with HIV. Such personal beliefs and biases should not influence counselling.

Providers must ensure that they do not coerce clients – intimidating clients and forcing decisions has no place in counselling.
Counselling about Pregnancy

Providers should discuss:

- pregnancy does not accelerate HIV disease
- condom use to prevent STI/HIV transmission between partners
- risks/rates of mother-to-child transmission
- ARV drugs reduce transmission at delivery

Providers who counsel clients with HIV who are considering pregnancy should explain that pregnancy does not appear to accelerate HIV progression, even among women not receiving antiretroviral therapy.82, 83, 84, 85

Although pregnant women do not need contraception, condom use should be encouraged to prevent the transmission of HIV and other STIs between partners.

Providers should also emphasize the risk of transmitting HIV virus from mother to child. Rates of mother-to-child HIV transmission range from 15 percent to over 40 percent in the absence of antiretroviral treatment.86

Providers should advise that ARV treatment around the time of delivery can substantially reduce HIV transmission risks during childbirth and immediately postpartum.
Counselling about Pregnancy

continued...

• artificial feeding or exclusive breastfeeding reduces postpartum transmission
• implications of rearing a child with HIV
• availability of family support
• location/logistics of care and treatment

Other issues the provider should address during counselling include:
• the fact that artificial feeding or exclusive breastfeeding for the first six months can reduce postpartum HIV transmission to the child. However, it is important to keep in mind that while artificial feeding can reduce HIV transmission, it increases the risk of the infant dying from other infectious diseases, particularly in the first two months of life.37

• the implications of rearing an HIV-infected child, including the course of the child’s infection and likelihood of premature death.

• the need to consider whether family members will be available to raise children if their mother dies of AIDS, as may happen without treatment.

• where to go for care and treatment during and after pregnancy.
Counselling about Contraception

Providers should discuss:

• characteristics of contraceptive methods
• possible side effects and complications
• method effectiveness and ability to use correctly
• implications/drug interactions for women with HIV who choose hormonal contraception and:
  – are on ARV therapy
  – are taking rifampicin (co-infection with TB)

When counselling women with HIV about their contraceptive options, providers should consider the client’s medical eligibility for particular contraceptive methods and:

• Briefly discuss characteristics, including possible side effects and complications of available contraceptive methods.

• Discuss the effectiveness of available contraceptive methods and how effectiveness may be affected by a client’s ability to use a method correctly, such as remembering to take a pill daily. Because unintended pregnancy often presents greater challenges for women with HIV, they may want to choose a client-independent method.

• Help women who plan to use hormonal contraception consider the implications of possible interactions between contraceptive hormones and ARV drugs. For women on ARV therapy, these interactions include the potential for reduced contraceptive effectiveness or increased hormonal side effects. Also, make sure that women with HIV who are planning to use oral contraceptives or implants are not taking the anti-tuberculosis antibiotic rifampicin. Co-infection with tuberculosis is common among patients with HIV, and rifampicin speeds up the metabolism of contraceptive hormones, reducing their effectiveness.
Counselling about Contraception

continued...

• limitations of methods with regard to prevention of pregnancy and STI/HIV transmission
• advantages of dual protection, including dual method use
• partner’s willingness to use condoms, condom negotiation strategies
• when to return and where to access services

The provider should also:

• Discuss the limitations of methods to prevent pregnancy and STI/HIV transmission, emphasizing that methods that are most effective in preventing pregnancy do not offer protection from HIV and other STIs.

• Emphasize the advantages of dual protection, including dual method use. When a client chooses another more effective method for pregnancy prevention, encourage the client to also use condoms to prevent STI/HIV transmission.

• Help a client consider her partner’s willingness to use condoms, discuss possible condom negotiation strategies, and offer couples’ counselling.

• Ensure that women know when to return for regular follow-up; if they have questions, concerns, or problems with the method, and if they need resupply. In the event that a client’s chosen method cannot be provided on-site, refer the client to a facility where the method is offered.
ARVs and Hormonal Contraception

For women using ARV drugs and hormonal contraception, providers should discuss:

- need to take pills on schedule
- need to return for DMPA injection on time
- possibility of using condoms to provide additional protection from pregnancy (in case hormonal contraceptive effectiveness is compromised by ARVs)

The issues that should be addressed when a woman on ARV treatment plans to use hormonal contraception include:

- The ability to take oral contraceptive pills correctly. Because some ARV drugs decrease blood concentration of contraceptive hormones, the risk of contraceptive failure may be greater if a woman forgets to take pills.
- The need to come back for the next DMPA injection on time. Although the next injection usually can be given as much as two weeks late, in the presence of ARV therapy it is safer to follow a strict injection schedule.
- Willingness to use condoms to ensure additional protection from pregnancy because the effectiveness of hormonal contraceptives may be compromised by ARV therapy. Focusing on the pregnancy prevention role of condoms may help when negotiating condom use with a partner.
Additional Counselling Topics

- Importance of knowing partner’s HIV status
  - encourage partner testing if status is unknown
  - discuss health implications/prevention strategies for discordant/concordant couples

- Considerations in disclosing HIV status
  - risk of abandonment
  - violence
  - loss of financial support

During counselling a provider should explore whether a client knows her partner’s HIV status. When a partner’s HIV status is unknown, a provider should encourage clients to bring their partners for counselling and testing or provide referrals. Knowing a partner’s HIV status is important when making decisions about whether to have a child, what contraceptive methods to use, and how to best prevent STI/HIV transmission. Health implications and prevention strategies should be discussed for situations when either one or both partners has HIV infection.

A provider should also discuss whether the client has disclosed her HIV status to her partner or family. If a woman’s status is undisclosed, counsellors should help her determine whether disclosure of HIV status or use of contraceptives would pose a risk of abandonment, violence, or loss of financial support for herself and her children.
Additional Counselling Topics

continued...

• Offer referrals to other RH services as needed:
  – STI management and treatment
  – postpartum, postabortion, antenatal care
  – HIV care and treatment

• Discuss available support systems:
  – family
  – community
  – social
  – legal
  – nutritional
  – child health

Depending on the individual situation and needs of the client, the provider should be able to offer referrals to other reproductive health services if they are not provided on-site. These services may include STI management and treatment; postpartum, postabortion, and antenatal care; and HIV care and treatment services, including ARV therapy and prophylaxis.

Providers should also discuss what family, community, social, legal, nutritional, and child health supports are available to clients. If clients are interested in these services, discuss how to access them and provide written referrals if needed.
Program Requirements

To address contraceptive needs of clients with HIV, programs should:

- ensure providers have necessary skills
- ensure availability of FP commodities/supplies
- provide adequate counselling and storage facilities
- ensure supervision/management support
- have referral system in place

Family planning programs and programs that offer HIV treatment and care should enable providers to address the contraceptive needs of women and couples with HIV.

Both kinds of programs should update providers on the safety and efficacy of various contraceptive methods in the presence of HIV/AIDS. Programs that are adding a family planning component should ensure that providers have the necessary skills to provide FP counselling, initiate methods, and manage possible side effects.

Programs also need to ensure the availability of family planning commodities and supplies, and provide adequate counselling and storage facilities.

They should also make sure that supervision and management support is in place.

Depending on the situation, some programs may not be able to, or will decide not to, offer full contraceptive services. In these instances, it is necessary to have an established and functioning referral system in place to make certain that needs are met.
Role of Contraceptive Services

Contraceptive services can:

- be sources of information and methods
- assist with preventing HIV transmission
- help clients consider effect of HIV on family health
- assist clients to make informed RH choices

Contraceptive services can be important sources of information, methods, and assistance for preventing perinatal and heterosexual transmission of HIV. Discussions about contraception also represent important opportunities to address how HIV may affect family health and reproductive decisions. Family planning and HIV care and treatment programs have both an opportunity and an obligation to help women and couples make informed choices that will enable them to safeguard their own health and the health and well-being of their families.
Conclusion

With very limited exceptions, almost any method of contraception can be used by clients with HIV.

With very limited exceptions, almost any method of contraception can be used by women with HIV. Once a woman with HIV infection decides to avoid pregnancy, she needs supportive counselling and clear information about the benefits and drawbacks of various contraceptive options in general and in light of her HIV status. Providers are the key to making sure that clients with HIV can make informed choices about their reproductive health.
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