



# IPPF Medical Bulletin

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## Reproductive decision-making for HIV positive persons

*The following text is an advance excerpt from the forthcoming third edition of the IPPF Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services, which will be published in October 2004. The complete chapter on HIV infection and AIDS in the Guidelines discusses HIV/AIDS in more detail, and includes information on prevention, modes of transmission, voluntary testing and counselling, antiretroviral therapy, treatment, and care.*

*The text below focuses on reproductive decision-making for HIV positive persons, and highlights the contraceptive choices available to them. The information is consistent with the latest World Health Organization Medical Eligibility Criteria for Contraceptive Use, updated in 2004.<sup>1</sup>*

### Reproductive decision-making

HIV infection raises difficult issues relating to contraception and pregnancy. Because of the special circumstances of HIV-positive clients, counselling should be conducted with particular sensitivity. Once pregnant women decide about whether or not to continue their pregnancy they should be counselled and offered services based on their choice. Providers have an important role to play in facilitating a woman's decision-making process. Whenever possible, the partners should be counselled both separately and together.

Couples where one or both partners are positive face challenging reproductive decisions which include:

- Desire for pregnancy
- Contraceptive practices
- Choices for the outcome of an unintended pregnancy.

HIV-positive couples should be able to make informed choices, free of coercion, and have access to services of a quality that allows them to implement these choices.

### Desire for pregnancy

HIV-positive individuals or couples who are considering pregnancy should be informed clearly of the risk of transmission to the uninfected partner during the unprotected sexual intercourse required to achieve pregnancy. They should also know that, for an infected

woman who is already showing symptoms of AIDS, pregnancy might accelerate the course of the disease. If an HIV-positive woman wishes to become pregnant, she should be educated about the local fertility and prenatal services, as well as the types of chemoprophylaxis available to reduce the risks of transmission to her child.

### Prevention of mother-to-child transmission

Transmission of HIV from an infected mother to her infant can occur in utero; at the time of delivery; and through breast milk. To reduce the risk of transmission from mother to child, providers should keep in mind:

- The use of antiretroviral drugs
- Delivery by caesarean section
- Breastfeeding choices.

#### Antiretroviral therapy

The use of antiretroviral drugs (ARVs) during pregnancy and delivery has been shown to be effective in reducing transmission of HIV from mothers to infants. ARVs reduce the risk of transmission by decreasing viral replication in the mother and by helping to protect the infant during and after exposure to the virus. There are many regimens, differing in terms of efficacy, costs, practicality, and safety. All these regimens include an intrapartum treatment, with varying durations of antepartum and/or postpartum treatment. Regimens which start early in pregnancy and are relatively complex have been shown to be more effective than those that are simple and start late in pregnancy or just during labour. However, the practicality of the latter regimens makes them an attractive option for women who obtain antenatal care late in pregnancy and/or who cannot easily adhere to the ARV regimen. The choice of antiretroviral prophylactic regimen to be included in a service delivery programme will depend on availability, feasibility, and cost.

#### Delivery by caesarean section

About 60% of HIV transmissions from mother to child occur around the time of labour and delivery. Delivery by elective caesarean section reduces the risk of mother-to-child transmission irrespective of viral load and prophylactic ARV therapy. However, the potential benefits have to be balanced against the risk to the mother. Caesarean sections should be done in settings where the operation can be safely carried out and where overall maternal mortality is low. In facilities where caesarean section is not available, vaginal cleansing by use of chlorhexidine 0.25% to cleanse the birth canal after each vaginal examination and during labour and delivery has been shown to be effective in reducing transmission.

### Breastfeeding choices

The risk of mother-to-child transmission increases if a woman breastfeeds her infant. The decision to breastfeed or not has to be weighed against the benefits of

breastfeeding. It is the best way to feed an infant as it not only provides essential nutrients but also protects the infant from gastrointestinal infections and malnutrition. In certain cultures it is the normal practice and therefore its avoidance may lead to stigma and discrimination as the community will suspect that the woman has HIV. A decision regarding replacement feeding should be made after ensuring that it would be:

- Acceptable
- Feasible
- Affordable
- Sustainable
- *And safe.*

Providers of services should:

- Educate the woman about safe preparation of replacement feeds, correct cleaning of utensils, and methods of sterilisation
- Monitor the growth and development of the child to ensure adequate infant feeding and nutrition
- Provide information to the mother on how to inspect her child's mouth for thrush and breakages in the mucous membrane (an added risk for HIV transmission)
- Teach the mother about the increased risk of HIV transmission should she suffer from mastitis, breast abscesses, and bleeding or cracked nipples.

If the woman decides to breastfeed her infant she should be advised on exclusive breastfeeding for the first six months. It should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation, and the risks of replacement feeding (including infections other than HIV and malnutrition).

### **Options for unintended pregnancy**

HIV does not necessarily have a negative impact on the pregnancy but might have an adverse effect on the health of the mother especially if her CD4 count is low and ARVs are not available. HIV also leads to increased rates of complications after delivery and is associated with an increase in maternal mortality. If the client is currently pregnant but does not wish to continue her pregnancy, she should be referred to safe abortion services, where legally permitted. Postpartum contraception should be offered as an option for those who do not wish to become pregnant again.

### **Contraception**

If an HIV-positive woman or a woman with an HIV-positive partner does not wish to become pregnant, she and her partner should be advised of the appropriate methods of contraception as well as the best way to avoid transmission of the infection.

The couple should be provided with contraceptive counselling and services or be referred to a programme that offers such services. To optimise reproductive choices, voluntary counselling and testing (VCT) services should link directly with family planning and antenatal preventive services. Highly effective contraceptive methods should be recommended. In discordant couples, the correct and consistent use of condoms is the only method to prevent HIV transmission. They should be used even when another method is chosen to prevent pregnancy.

In general, HIV-infected women have the same range of contraceptive options as other women. The World Health Organization Medical Eligibility Criteria for Contraceptive Use<sup>1</sup> have been developed for persons with HIV infection which include specific circumstances under which the use of certain methods is restricted, as outlined below.

#### ***Male condom***

The correct and consistent use of male condoms has high efficacy against both unintended pregnancy and transmission of HIV/sexually transmitted infections (STIs). The proper use of male condoms effectively prevents HIV transmission within HIV-discordant couples. When male condoms fail to protect against pregnancy and infection, the main reason is that they were used incorrectly; only a small fraction of these failures occur because of condom breakage/slippage.

Clients should be given clear instructions on the proper use of the method including a demonstration, together with advice on the correct lubrication, storage, and handling. Emergency contraception should be provided as a back-up method.

#### ***Female condom***

The female condom is available in many countries and offers an alternative to male condoms. The female condom affords women more control over the initiation of barrier contraception and can be inserted hours before intercourse. The contraceptive use-effectiveness of the female condom is within the wide range quoted for other barrier methods, but lower than that of male condoms.

Although clinical data are limited, laboratory studies have shown that the female condom is an effective barrier not only to sperm but also to bacteria and viruses including HIV.

The use of female condoms is limited by cost factors. While it is always preferable to use a new female condom for each act of intercourse, under certain circumstances re-use of the female condom may be acceptable, feasible, and safe. The final decision about whether or not to support re-use of the female condom should be taken locally.

#### ***Diaphragm***

The diaphragm has the advantage of being woman-controlled and can be inserted several hours before intercourse. It offers contraceptive protection similar to other barrier methods.

For HIV-discordant couples, and whenever there is risk of infection, the use of diaphragms with spermicides is not recommended, because of a possible increased risk of HIV infection associated with the use of spermicides containing nonoxynol-9. Studies are under way to determine whether the diaphragm reduces the risk of transmission of STIs and HIV.

#### ***Spermicides***

When used on their own, spermicides have lower contraceptive efficacy than other barrier methods and they do not protect against STIs. Spermicides containing nonoxynol-9 do not protect against HIV infection and may even increase the risk of HIV infection in women using these products frequently. This method is therefore not recommended for HIV-negative women in a discordant couple. This method may be used by HIV-positive women only if no other options are available and acceptable. If a spermicidal method is chosen, the client should be advised to use it in combination with another barrier method.

### **Hormonal contraceptives**

The correct use of hormonal contraceptives is highly effective for pregnancy prevention. Available evidence also indicates that hormonal contraceptives are safe for use by HIV-positive women and for uninfected women in a discordant couple. They do not protect against STIs/HIV, therefore the correct and consistent use of condoms is recommended.

ARV drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives. The limited data available indicate that potential drug interactions between many ARVs and hormonal contraceptives may alter the safety and effectiveness of both the hormonal contraceptives and the ARVs.

If a woman on ARV treatment decides to start or continue hormonal contraceptive use, the consistent use of condoms must be recommended to prevent HIV transmission and may also compensate for any possible reduction in the effectiveness of the hormonal contraceptive.

### **IUDs**

The IUD is a highly effective method of contraception, which can be used by HIV-positive women without AIDS and women with AIDS who are clinically well on ARV

therapy. Women with AIDS who are not clinically well should generally not have an IUD inserted unless other methods are not available or acceptable. IUDs do not protect against STIs/HIV, therefore the correct and consistent use of condoms is recommended.

### **Emergency contraception**

For HIV-positive women who have unprotected sex and may be at risk of an unwanted pregnancy, access to emergency contraception is essential. The IUD can be used by an HIV-infected woman for emergency contraception provided she meets the medical eligibility criteria.

### **Male or female sterilisation**

Sterilisation can be provided to HIV-positive clients if an informed voluntary choice is made. Appropriate infection prevention procedures must be carefully observed. However, this method does not protect against STIs/HIV transmission and therefore the correct and consistent use of condoms is recommended following the procedure.

### **Reference**

1. World Health Organization. *Medical Eligibility Criteria for Contraceptive Use*. Third edition, WHO: Geneva, 2004.

## **A declaration on sexual and reproductive health and rights for all**

*Ten years ago at the International Conference on Population and Development (ICPD) the global community promised to make basic sexual and reproductive health services available to all by the year 2015. This year – 2004 – is the tenth anniversary of that promise, halfway to the target year of 2015. IPPF's advocacy efforts to mark this occasion included heading up a global campaign to reinvigorate the Cairo spirit among non-governmental organisations and the donor community, raise the public and media visibility of these issues, review the progress so far and agree an action agenda for taking the implementation of the ICPD Programme of Action into the next and crucial decade. A Global Roundtable, hosted by IPPF in London at the end of August in partnership with other non-governmental organisations and the sexual and reproductive health community, brought together some 600 activists, experts, young people, journalists, donors, and inter-governmental agencies from 109 countries to focus on priority areas within the Cairo vision and define the work needed for the next decade. A Declaration was agreed, as well as a fuller outline of recommendations and calls for action to make ICPD a reality. Here below, is the final declaration produced by the Global Roundtable.*

*For further information, visit the Countdown 2015 website, at <http://www.countdown2015.org>*

### **Declaration of the Global Roundtable for Countdown 2015**

Queen Elizabeth II Centre, London  
2 September 2004

We have come from 109 countries to meet in London on the tenth anniversary of the International Conference on Population and Development, Cairo, 1994. We come from

small villages and big cities; we come from groups and networks representing a broad spectrum of civil society. We speak as individuals, and we seek to speak also for our membership and those we serve.

We are youth leaders, service providers, feminist activists, community-based organisers, women's health advocates, policymakers, academics, religious leaders, physicians, researchers, artists, and parliamentarians. Many of us took part in the Cairo conference; others have become active in the decade between. All of us are working to realise the main objective of Cairo: universal access to sexual and reproductive health and rights for all by 2015.

### **What we believe**

We believe in the promise of Cairo. We believe that the Cairo Programme of Action permanently altered the framework for discussion and action on sexual and reproductive health and rights. We affirm the right to health, and that sexual and reproductive rights are human rights—universal, interdependent, and indivisible. We believe that these rights must be at the centre of sexual and reproductive health plans, programmes, and interventions. We are a diverse group, and we celebrate diversity.

We strive for gender equality, women's empowerment, and social justice. We believe that young people and adolescents, not only adults, have the right to make free and informed choices about their sexuality and their reproductive lives.

We know that implementing the Cairo Programme of Action is an essential condition for achieving the Millennium Development Goals. We cannot end poverty without equitable access to sexual and reproductive health and rights.

Human rights, public health, and sustainable economic development, in harmony with the natural environment,

can and must reinforce each other. Sexual and reproductive health cannot exist in the absence of livelihood and property rights.

We believe that investments in health and education cannot be sacrificed in the name of the free market. We believe that we must rely on science, not ideology, in promoting human development.

### The world we have

We have seen progress in the ten years since Cairo, but many gaps remain.

- We have seen the quality of reproductive health improve in many countries; but we have seen new charges for basic services, and more poor women who cannot afford them
- We have seen more attention to maternity care, but we have seen no decline in maternal mortality in the poorest countries
- We have seen more infants survive the first years of life; but we have seen more of them lose their parents to HIV/AIDS
- We have seen more girls go to school, but we have seen more girls kept out of school by rising costs, and we have seen schools close for lack of funds
- We have seen women's participation in all spheres of life increase; but we have also seen increasing violence and sexual oppression against them
- We have recognised the important role that women and girls play in peace-building; yet we have seen violence against women and girls used as a weapon of war
- We have seen successful condom marketing campaigns; but we have seen supplies of condoms dry up
- We have seen HIV/AIDS treatments improve and prices fall; but we have seen countless young men and women infected with HIV/AIDS, with scarcely a possibility of treatment to extend their lives
- We have applauded international solidarity behind the Cairo Programme of Action; but we have seen an increasingly strident and determined opposition, whose actions cost lives, health, and progress
- We have participated in the Millennium Summit and helped to forge the Millennium Development Goals of halving extreme poverty by 2015; but we have seen little urgency to reach them. For many policymakers, the free market has crowded out the vision
- Global indicators show less poverty: but local realities reveal growing disparities between rich and poor. We who work on the ground can see who is benefiting, and who is being left behind

Our experience since Cairo, and experience in all countries, shows what is possible. The goals of the Cairo Programme of Action are realistic and attainable. We see what to do and how urgent it is that we do it. We call on all

those who share the vision of Cairo to join in making it a reality.

### We want a world

- Where poverty has ended and inequalities are reduced; where macro-economic and trade policies allow developing countries to prosper
- Where governments guarantee the rights of people irrespective of age, ethnic origin, race, physical and mental ability, indigenous status, HIV status, gender identity, or sexual orientation; where governments decide policy on secular, pluralistic principles; and where the work of civil society organisations is supported, their autonomy respected, and true partnerships established
- Where democracy means equal participation of women, and the full involvement of young people, the excluded, migrants, the displaced, and rural populations in decision-making at all levels; where women can exercise their human rights, and secure their equal partnership with men, in families and in society, for the benefit of all; and where all kinds of families, and people outside families, have the same respect and protection
- Where young people have a supportive environment in which to practise their human rights and engage as active citizens; and where all adolescents in and out of school have access to comprehensive sexuality education
- Where all who need them have access to health, education, and social services; and where spending on books replaces spending on missiles and warplanes
- Where health systems are well funded and staffed, and respond to people's needs; and where all health services respect confidentiality and privacy
- Where all have access to uncensored, medically accurate information, and to the means to prevent HIV infection and treat HIV/AIDS; where HIV interventions are integrated in sexual and reproductive health programmes; and where affordable drugs are available to all who need them
- Where sexual pleasure is recognized as part of a full human life
- Where personal safety is guaranteed, and violence against women and girls does not exist
- Where women and girls do not die in childbirth and pregnancy; where they have access to safe and legal abortion; and where women and men can decide freely and responsibly whether and when to have children.

Ten years after Cairo, we continue to be inspired by its vision of a world of justice, rights, possibilities, and choices. We are working to help bring this world into being, and call on others to join us.

Ten years still remain: the goals of the Programme of Action are within reach. We dedicate ourselves once more to the vision of Cairo.