



**International  
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## **IMAP statement on the management of HIV infection within sexual and reproductive health services**

*For an overview of HIV/AIDS, see “IMAP Statement on HIV/AIDS: an overview”, IPPF Medical Bulletin 2005; 39 (2): 1-4*

### **Introduction**

There are powerful arguments for integration of HIV/AIDS prevention and care into sexual and reproductive health services. A comprehensive approach includes prevention, counselling, diagnosis, contraceptive services, safe abortion where legal, prevention of mother-to-child transmission, antiretroviral therapy, psychosocial support, and palliative care.

### **Comprehensive HIV management**

#### **Counselling and testing**

All clients who use sexual and reproductive health services should be encouraged to learn their HIV status. If HIV-positive they will then be able to obtain advice on treatment and to make necessary changes to their lifestyles and sexual behavior. If resources are insufficient for all, highest priority for HIV testing should go to clients at excess risk such as those with tuberculosis, other opportunistic infections, or sexually transmitted infections (particularly genital ulcer disease), and those who engage in risky behaviour such as having multiple sexual partners or using intravenous drugs.

It is particularly important for pregnant women to learn their HIV status, because there are several effective ways to reduce the likelihood of mother-to-child transmission – for example, the use of antiretroviral drugs and obstetric interventions such as caesarean section. Where adult treatment for HIV is available, this too can also be offered to the mother before and after delivery.

The conditions under which people undergo HIV testing must be anchored in a human rights approach that respects fundamental ethical principles. The counselling should be confidential, non-judgmental, and tailored individually to the client's needs. Counselling and testing should be conducted not in isolation but as part of a comprehensive package of reproductive health services including referral, where necessary, to other sources of treatment, care, and support. This will help reduce barriers to testing. The technique used for HIV testing should be approved by the medical authorities in the country concerned.

### Pre-test counselling

The client should be made aware that the process is entirely voluntary and confidential. The session must:

- Ensure that the client understands the advantages and implications of knowing his or her HIV status
- Accurately describe the type of test to be used (rapid or laboratory-based), the limitations of the test, and the significance of the 'window' period between infection and test positivity
- Evaluate the client's capacity to cope with an HIV positive result
- Ensure that client consent has been given before the test is done.

After such a counselling session some clients will decide not to have an HIV test, and health providers must respect this decision.

### Post- test counselling

*Negative test result.* - Counselling should:

- Discuss the window period and the limitations of the test. A repeat test may be necessary after three months if potential exposure was within the past six weeks. A test for the virus itself, if locally available, can be positive earlier than the HIV antibody test
- Reinforce risk reduction strategies including safer sexual behaviour, the correct use of condoms, and the opportunity to stay negative
- Explain the need to persuade sex partner(s) to be tested as well.

*Positive test result.* - Clients should be:

- Informed about the results and the availability of treatment
- Provided with continuing psychosocial support and offered the best standard of care and treatment accessible in their areas
- Reassured that, with proper care, positive HIV status is compatible with a healthy life and does not imply a rapid demise.

Other issues which should be explored include:

- Helping the client identify sources of support, both personal and in the community (treatment and access, psychosocial support, networks, etc)
- Reviewing immediate plans, intentions, and actions
- Discussing disclosure of HIV status to partner/family; if there is a risk of consequent domestic violence, arrange suitable referral where necessary
- Discussing the risk of transmitting HIV to others, the risk of acquiring other sexually transmitted infections, and safe sex practices
- Encouraging testing of partner(s) and of any children potentially infected.

A follow-up counselling plan should be established with the client to discuss health and lifestyle issues, such as further testing and CD4 monitoring, treatment and access, being part of a support group, healthy living, and the advantages of accessing care early.

### **Lifestyle counselling for the HIV-positive client**

The first weeks after a positive HIV test are a crucial time for the individual to establish good lifestyle routines – not only in gaining access to medical and other support services but also in changing behaviour so as to reduce the likelihood of transmitting the virus to others. In some individuals this process of coming to terms with HIV positive status precipitates depressive symptoms. Providers must be alert to this possibility and either offer treatment themselves or refer to experts elsewhere.

An important matter to stress during counselling is that successful antiretroviral treatment does not prevent HIV transmission. The client needs to be advised on preventive measures such as the use of condoms and safer sex practices and, if an injection drug user, on the necessity for clean needles. There is a tendency for women, traditionally care givers rather than receivers, to neglect their own health needs; providers must make clear to such women that ‘care for oneself’ is integral to effective HIV management.

### **Partner notification**

Partners of HIV-positive persons, at risk because of either sexual contact or shared drug-injecting apparatus, should be advised that they may have been exposed to the virus and encouraged to obtain HIV counselling and testing. The partner can be notified by the source patient, or by the health provider (with client consent), or by the combined efforts of both. Note that partner notification, though highly desirable, is not mandatory. Providers must be aware of the legal and ethical implications; they must be sensitive to a conflict of rights – between the right of the HIV-positive person to privacy and the right of his or her partner to know about possible exposure to HIV infection. In explaining the purposes of partner notification the provider should indicate that:

- It helps individuals who have been exposed to HIV to learn about their risk and encourages them to be tested
- If they are positive, they can learn how to protect others from HIV infection by practising safer sex or not sharing needles, and how to get access to care, treatment, and support
- If they are negative, they can get information on how to remain uninfected.

If there is a possibility that notification will engender violence or seriously disrupt the relationship, preventive action should be taken. Providers should be trained to create an environment favourable to disclosure, which will include counselling techniques and knowledge of when and where to refer outside.

### **Sexual behaviour**

After learning they are HIV-positive, most clients try to adopt safer sex practices; however, where the partner has not been told of the infection, such changes can be very difficult to start and continue. The client may need intensive counselling to cope with these challenges, and at all times the provider must be supportive and non-judgmental.

With advances in treatment of HIV infection and the better prospects for health in the long term, clients show a renewed interest in sexual activity and procreation. Successful HIV treatment lowers the viral load and may thus reduce the risk of HIV

transmission to an HIV-negative partner; the risk, however, is not eliminated. Factors that favour sexual transmission of the virus include the presence of other sexually transmitted infections (eg, with genital ulceration) and retention of the male foreskin (non-circumcision).

### **Post-exposure prophylaxis**

Post-exposure prophylaxis consists of short-term antiretroviral treatment to reduce the likelihood of HIV infection after risky sexual contact or occupational exposure such as needle-stick. It should be started as soon as possible after the incident, ideally within 2-4 hours. Combinations of drugs are believed to be more effective than single agents; the choice of agents will be dictated by national protocols and guidelines.

### **Promoting condom use**

In serodiscordant couples (one person HIV-positive, the other HIV-negative) there is compelling evidence that consistent condom use protects the seronegative partner against infection; such couples, therefore, must be counselled on the crucial importance of safer sex and the proper use of condoms. In cases where both partners are positive, the adoption of safer sex practices is recommended to prevent reinfection with new or mutant strains of HIV.

### **Reproductive decision-making**

HIV infection raises difficult issues relating to contraception and pregnancy. Counselling should be conducted with particular sensitivity. Whenever possible, the partners should be counselled both separately and together.

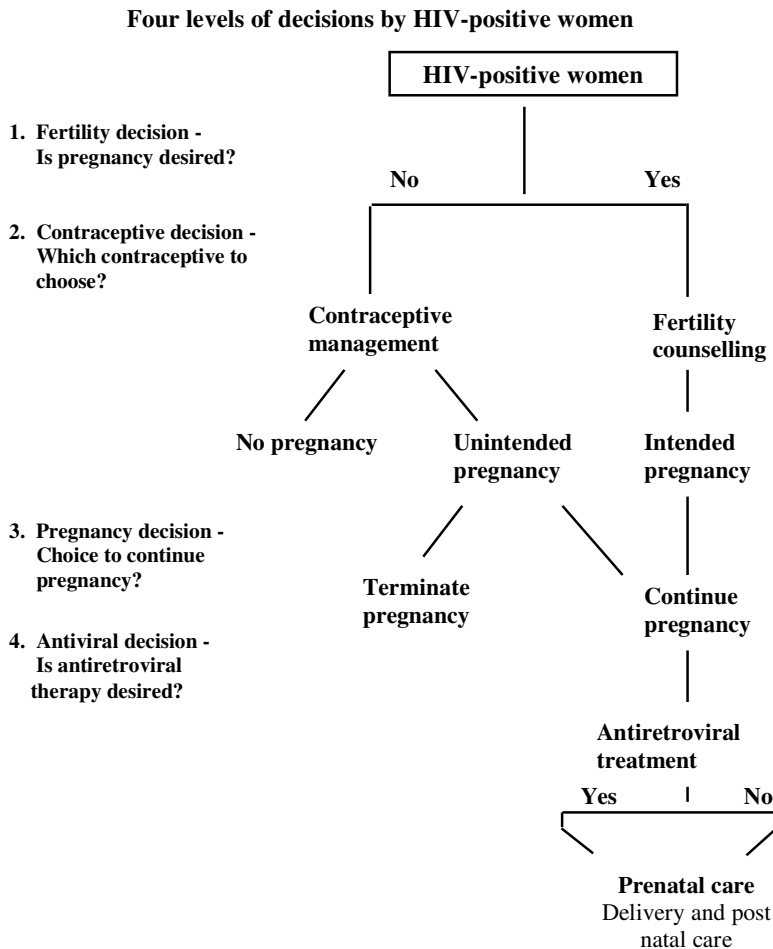
Couples in which one or both partners are HIV-positive must make choices on whether to have a child, how they should avoid pregnancy, and what to do in case of an unintended pregnancy. They must make these choices without coercion and should have access to high-quality services.

If a serodiscordant couple consider trying for a pregnancy, they must bear in mind that unprotected sexual intercourse will put the uninfected partner at risk of infection. Special difficulties arise when the infected partner is the woman: she may feel under pressure because of a perceived duty to bear children, and providers have an important role in helping such women reach a decision (see Figure).

If an HIV-positive woman does not currently wish to become pregnant, she should be provided with contraceptive counselling and services or be referred to a family planning programme. To optimise reproductive choices, counselling and testing services should link directly with family planning and antenatal preventive services. If she wishes to become pregnant, she should be advised on the fertile phase of the menstrual cycle. In addition she should be given information on local prenatal and infertility services and the measures available to reduce the risks of HIV transmission to her child.

Once pregnant, a woman must decide about whether or not to continue her pregnancy. She should be counselled and offered services accordingly.

**Figure: Reproductive decision-making by HIV-infected couples**  
 Adapted from Cates W, Jr. *IPPF Med Bull* 2001; 35 (1): 1-2



**Contraception**

If an HIV-positive woman or a woman with an HIV-positive partner does not wish to become pregnant, the couple should be advised on the options for contraception, including sterilisation, as well as methods to avoid transmission of the infection.

For the HIV-positive woman who wishes to avoid pregnancy, highly effective contraceptive methods should be recommended and made available. In serodiscordant couples, the correct and consistent use of condoms is essential to prevent HIV transmission even when another method is chosen to prevent pregnancy.

In general, HIV-positive women have the same range of contraceptive options as other women. The WHO Medical Eligibility Criteria for Contraceptive Use include 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 acquisition of sexually transmitted infections and HIV. The proper use of male condoms is an effective way to prevent HIV transmission within HIV-serodiscordant couples.

When male condoms have failed to protect against pregnancy and infection, the usual reason is that they were not used on the relevant occasion or were used incorrectly; only a small fraction of these failures is due to condom breakage or slippage.

Clients should be given clear instructions on the proper use of the method, including a demonstration, together with advice on lubrication, storage, and handling. A hormonal emergency contraception pack should be given in advance, as back-up.

### Female condom

The female condom, now available in many countries, offers an alternative to the male condom. It 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 female barrier methods but lower than that of male condoms. Laboratory studies have shown that the female condom is an effective barrier not only to sperm but also to bacteria and viruses including HIV. Female condoms are more expensive than male condoms.

Although ideally a new female condom should be used for each act of intercourse, under certain circumstances re-use may be safe and acceptable. The decision whether or not to support re-use of the female condom should be taken locally.

### Diaphragm

Like the female condom, the diaphragm has the advantages of being a woman-controlled method and insertable several hours before intercourse. Again, its contraceptive efficacy is lower than that of the male condom. Studies are underway to determine whether the diaphragm reduces the risk of sexually transmitted infections including HIV.

For serodiscordant couples, the use of a diaphragm with spermicide is not recommended because of a possible increase in risk of HIV acquisition associated with the use of a spermicide containing nonoxynol-9.

### Spermicides

When used on their own, spermicides containing nonoxynol-9 have lower contraceptive efficacy than other barrier methods and they do not protect against sexually transmitted infections or HIV. This method is not recommended for HIV-negative women in a discordant couple. HIV-positive women should use it only if no other contraceptive option is available and acceptable.

### Hormonal contraceptives

When correctly used, hormonal contraceptives are highly effective for pregnancy prevention. On existing evidence, they are safe for use by HIV-positive women and by uninfected women in a serodiscordant couple. Since they do not protect against sexually transmitted infections/HIV, correct and consistent use of condoms is recommended in addition.

Antiretroviral drugs (particularly some non-nucleoside reverse transcriptase inhibitors and protease inhibitors) have the potential either to decrease or to increase the bioavailability of hormonal contraceptives and the reverse may also be true. Thus, if a woman on antiretroviral drugs wishes to start or continue use of hormonal contraception, consistent use of condoms should be recommended in addition, to compensate for any possible reduction in the effectiveness of the hormonal preparation. The data are from oral contraceptives but this advice should be taken to apply also to other hormonal methods - combined injectables, patches, and rings.

### Intrauterine devices (IUDs)

The IUD is a highly effective method which can be used not only by HIV-infected women without AIDS but also by women with AIDS who are clinically well on antiretroviral therapy. Women with AIDS who are not clinically well should generally not have an IUD inserted unless other methods are not available or not acceptable. Potential users should be screened by means of the WHO Medical Eligibility Criteria.

Among women judged suitable for the IUD by proper screening, the risk of upper genital tract infection is low and largely confined to the 2-3 weeks after insertion. Even among populations with high HIV prevalence, the use of currently available IUDs by HIV-positive women has not been associated with increased risks of either infection-related complications or HIV cervical shedding. Limited data exist on the safety of IUD use among women with advanced disease, and regular follow-up is recommended. For the HIV-positive person, IUDs do not protect against acquisition of sexually transmitted infections or transmission of HIV. Correct and consistent use of condoms is recommended.

The data to support these recommendations are for copper-containing IUDs. No data exist for the levonorgestrel IUD.

### 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. For women who may require it, advance provision of hormonal emergency contraception is strongly recommended.

The IUD can be used by an HIV-positive woman for emergency contraception provided she meets the Medical Eligibility Criteria referred to above for IUDs.

### Male or female sterilization

Because sterilization is permanent, special care must be taken to ensure that the client makes an informed and voluntary choice. It can be provided to HIV-positive clients, with scrupulous attention to infection prevention procedures. Sterilization

does not protect against acquisition or transmission of sexually transmitted infections/HIV, so correct and consistent use of condoms is recommended thereafter.

### **Pregnancy**

A woman who is pregnant and HIV-positive can transmit the infection to her unborn infant. In the absence of any intervention, rates of mother-to-child transmission of HIV can be 15-30% without breastfeeding and as high as 45% with prolonged breastfeeding. Transmission during the peripartum period accounts for between one-third and two-thirds of the overall transmission rate, depending on whether the child breastfeeds or not.

HIV does not necessarily have a negative impact on pregnancy, although data from resource-poor countries show excess rates of preterm delivery, low birth weight, and stillbirth.

### **When pregnancy is desired**

#### *Serodiscordant couples*

Women should be advised about the time in their cycle when they will be most fertile. If the male partner is HIV-negative, a home insemination technique with his sperm may be feasible, to spare him exposure to HIV. Where the woman is HIV-negative and her partner positive, the couple should be given information on the availability and cost of sperm washing.

As with all HIV-positive clients, HIV-positive women who desire pregnancy should be referred to appropriate services for clinical evaluation, including CD4 staging, and for provision of antiretroviral drugs if these are indicated. Care in pregnancy and delivery should have the double aim of keeping the mother in optimum health and preventing mother-to-child transmission of HIV (for which the antiretroviral regimen will be determined by local guidelines). The mother will also need to be counselled on the infant-feeding options.

### **HIV-positive women with an unwanted pregnancy**

If the client is pregnant but does not wish to continue her pregnancy, she should be referred to a safe abortion service if the law permits. Postabortion contraception should be offered or postpartum contraception if the pregnancy is completed.

### **Breastfeeding**

Between 5% and 20% of infants born to HIV-positive women acquire the infection through breastfeeding. However, in resource-poor settings, an infant who is denied breastmilk so as to reduce the risk of HIV transmission can be at increased risk of other life-threatening conditions. Where replacement feeding is acceptable, feasible, affordable, sustainable, and safe, HIV-positive mothers should avoid all breastfeeding; otherwise, exclusive breastfeeding is recommended during the first six months of life.

### **Orphans and loss of a child**

Where antiretroviral treatment is not available, most children who become infected perinatally or during breastfeeding will die within two to five years; moreover, those children who survive without infection are likely to lose one or both parents from the

disease. Consideration should be given to the support and care of the child in such circumstances.

### **Sexually transmitted infections**

In populations with a high HIV prevalence, clients presenting with sexually transmitted infection are at excess risk of being HIV-positive. Moreover, the infection makes it more likely that they will transmit HIV to their partners. Therefore, all clients with a sexually transmitted infection who do not know their HIV status should be referred for counselling and testing.

In HIV-positive persons, because of their immunodeficiency, viral sexually transmitted infections tend to be frequent and severe; thus, treatment and prophylaxis should be offered where available.

### **Genital cancer**

Women infected with HIV have excess rates of genital cancer, which tends to progress rapidly. Therefore, early detection is more critical than usual and frequent cervical smears are recommended.

### **Antiretroviral therapy**

The aim of antiretroviral therapy is to maintain health by reducing the HIV load to an undetectable level (below 50 copies per mL plasma) within 16-20 weeks. The latest treatment regimens are now becoming more widely available in resource-poor countries. Where feasible, antiretroviral drugs should be introduced as part of sexual and reproductive health services, and provided at primary care level.

Antiretroviral therapy is effective in decreasing HIV-related morbidity and mortality. The possible advantages of widespread community availability include an increased uptake of counselling and testing with a consequent reduction in high-risk behaviour, a lower rate of mother-to-child transmission, and a reduction in transmission in serodiscordant couples by lowering of viral load. Antiretroviral therapy can keep an individual symptom-free and can abolish symptoms, but it is not a cure for HIV.

Providers should be aware that HIV drug treatment is complex and adverse events present in many different ways. When antiretroviral drugs are prescribed, national treatment guidelines should be followed. Close adherence to prescribed therapy is particularly important in HIV treatment since drug resistance tends to develop when doses are skipped. Adherence refers to how closely the client follows - or adheres to - a prescribed drug treatment plan; it includes a patient's willingness to begin treatment and his or her ability to take medications as directed every single day.

### **Opportunistic infections**

HIV-positive people, because their immune systems are compromised, are susceptible to "opportunistic" infections including tuberculosis, candidiasis, *Pneumocystis carinii* pneumonia, toxoplasmosis, cryptococcal meningitis, chronic diarrhoea (often of unknown cause), and malaria. The symptoms in an HIV-positive person may be atypical.

The lower a person's CD4 count, the higher the risk of opportunistic infection. Where possible, antiretroviral treatment should be offered to patients who have stage-4 HIV or CD4 cell counts of less than 200/ $\mu$ L. If treatment is not available at a particular site, they should be referred elsewhere. Treatment should follow national protocols.

The diagnosis and treatment of opportunistic infections can be time-consuming and expensive; the use of antiretroviral therapy to strengthen the immune system saves time and money.

In high HIV risk areas, tuberculosis is a marker for HIV. In such an area, a person with tuberculosis should be referred for HIV counselling and testing.

### **General health advice**

A healthy lifestyle, important for everyone, is particularly important for the HIV-positive person.

### **Nutrition**

HIV infection affects nutrition through increases in resting energy expenditure, reductions in food intake, nutrient malabsorption, and complex metabolic alterations that culminate in the weight loss and wasting seen in AIDS.

Nutrition counselling, care, and support are integral to comprehensive HIV care. Appropriate actions depend on local conditions, the individual's lifestyle, the stage of the disease, and whether antiretroviral therapy has been started.

The main nutritional interventions are counselling regarding specific behaviours, referral to food-based interventions and programmes, and targeted food provision – of which the three methods to be considered are supplements to manage weight loss and nutritional-related side-effects of antiretroviral therapy, micronutrient supplements for specific HIV-positive risk groups, and therapeutic foods for rehabilitation in moderate to severe malnutrition.

### **Nutrition for positive living**

This includes nutrition counselling and support to maintain weight and prevent food-borne and water-borne infections. In food-insecure areas, pregnant and lactating women may need food support.

### **Nutritional management of HIV-related illnesses**

This includes counselling to manage nutrition-related symptoms of common HIV-related illness – eg, loss of appetite, mouth sores, and fat malabsorption. In some areas home-based care programmes are available to help HIV-positive individuals and their families maintain a food supply.

### **Management of antiretroviral interactions with food and nutrition**

This includes information and support to help clients cope with drug side-effects such as nausea and vomiting and to avoid drug/food interactions. Side-effects and interactions can negatively affect medication adherence and efficacy.

Many other specific interventions for advanced HIV and AIDS can be found in guidelines developed specifically for these interventions.

### **Lifestyle**

Lifestyle counselling of the HIV-positive individual should include encouragement to take exercise and obtain adequate sleep, together with ways to reduce stress, and discouragement of unhealthy behaviours such as smoking and excessive drinking (with referral to special prevention or treatment programmes where indicated). Counselling should be available to deal with new issues as they arise; left unaddressed, such issues can negatively impact on a client's mental health and hamper adherence to treatment.

The HIV-positive person needs emotional care and psychological support to cope with a life-threatening disease as well as the possible stigma attached to it.

### **Support services**

The aims of palliative care, which should be provided or arranged when HIV disease reaches its final phase, are to meet the complete needs of the client - physical, psychological, social, and spiritual. Palliative care benefits from a team approach involving family, caregivers, and other health and social service providers and includes medical and nursing care, social and emotional support, counselling, and spiritual guidance. It emphasizes living, encourages hope, and helps people to make the most of each moment or day. Members of the palliative care team will respect the client's right to privacy and confidentiality. At the end of life, the aim is to lessen fear and enable the person to die in comfort, with dignity and in keeping with his or her wishes.

### **What IPPF Member Associations can do**

To address the HIV pandemic, possible interventions by IPPF Member Associations include:

- Provide integrated services for sexual and reproductive health and HIV in which prevention, infection management, contraception, voluntary counselling and testing, and access to treatment are all part of the continuum of care
- Promote and provide measures to prevent mother-to-child HIV transmission
- Address the sexual and reproductive health needs of groups who are not the "traditional client base" of many Associations – including HIV-positive people
- Expand and strengthen access to prevention and care services for young people along the care continuum – with an emphasis on reaching young women and girls
- Ensure that programmes implemented are sustainable and are run to high standards.

*The statement was developed by the International Medical Advisory Panel (IMAP) at its meeting in October 2004  
IMAP reserves the right to amend this Statement in the light of further developments in this field.*

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