

## **Learning guide**

HIV, contraception, conception and pregnancy

This learning guide has been prepared in conjunction with the Women for Positive Action slide presentation and speaker notes resource concerning contraception, conception and pregnancy.

The guide identifies the key learning objectives for this module and suggests topics for discussion and self-learning. The modules are intended for use by both health professionals and community representatives who want to create or participate in learning opportunities relating to improving the care of women with HIV.

## **Learning objectives**

After completing this module, participants will be able to discuss the following issues and appreciate their implications for both patients and providers of health care.

### **Unacceptably high rate of mother-to-child HIV transmission**

- The share of HIV infections among women is growing globally.
- Most HIV-positive women are of child-bearing potential.
- Over 3.28 million HIV-positive women give birth each year.
- Up to 410,000 children are infected with HIV, mostly through mother-to-child transmission (MTCT).

### **Planning for pregnancy... even if the woman is not**

- Preparing for the possibility of pregnancy, whether planned or unplanned, is an important component of HIV care. Giving birth to a healthy HIV-negative baby is feasible.
- The possibility of pregnancy should be considered in all HIV-positive women of child-bearing potential. Treatment should be chosen that would be suitable if a pregnancy was to occur. This includes avoiding exposure to efavirenz and ddI+d4T regimens.
- Risk factors for unplanned pregnancy are similar to those for HIV: substance abuse, mental illness, domestic violence, frequent unstable sexual relationships and unsafe sexual practices.
- The impact of pregnancy on treatment or vice versa is often not addressed among HIV-positive women before pregnancy.

- Reproductive counselling should be considered for all women of child-bearing potential as part of routine primary care. For HIV-positive women, this education should be given early in the course of the disease – rather than being delayed until pregnancy occurs – so informed decisions about contraception and pregnancy can be made.

### **Helping women with fertility problems**

- Conception represents a potential risk for serodiscordant couples. Pre-conceptual counselling and fertility treatment for such couples has significant ethical and practical implications.
- HIV-positive women have a higher prevalence of fertility disorders than HIV-negative women.
- Data on the success of fertility treatments for HIV-positive women are limited.

### **Reducing the risk of MTCT**

- HIV transmission from mother to child can occur during gestation, labour and delivery and breastfeeding.
- Without optimal therapy and prevention methods the risk of MTCT is 12–25% in the developed world. Intervention with ART reduces this risk to less than 2%.
- Lack of awareness of HIV status is the main barrier to preventing MTCT.
- Other factors increasing the risk of MTCT include high viral load, low CD4 counts, advanced disease stage, frequent unprotected sex, smoking and substance abuse, and lack of ART prophylaxis during pregnancy. Vaginal deliveries present a higher risk for transmission as do allowing a long period of ruptured foetal membranes, chorioamnionitis and invasive procedures. Premature babies may be at higher risk of MTCT.
- Interventions to reduce MTCT include HIV testing and counselling during pregnancy, improved availability of antenatal services, use of ART, avoidance of amniotomy, procedures and episiotomies, preference for elective caesarean delivery, scrupulous infection control practices and exclusive formula feeding.

## **HIV treatment in pregnancy**

- HIV treatment in pregnant women should aim for full suppression of HIV RNA by the time of delivery, and preferably by the third trimester to prevent MTCT. This should be balanced with the risks of ART to the unborn child and the burden side effects of ART in the mother.
- Boosted protease inhibitors are preferred for women wishing to become pregnant. Nevirapine is an alternative but should be avoided in women with high CD4 counts. Efavirenz should be avoided due to its teratogenic potential.
- Regimens for pregnant women are the same as for non-pregnant women except efavirenz should be avoided as should the ddI + d4T combination. Abacavir and nevirapine should not be newly started but can be continued. Preferred protease inhibitors are lopinavir/ritonavir and ritonavir-boosted saquinavir. Zidovudine should be included in the regimen if possible due to its ability to prevent HIV MTCT.
- ART resistance should be assessed in pregnant women.

## **Post-exposure prophylaxis for infants**

- Most infants should be given zidovudine monotherapy twice daily for 4 weeks (or an alternative ART monotherapy if the maternal therapy does not include this agent). Triple therapy should be given to infants of untreated HIV-positive mothers or those with detectable viraemia despite treatment.

## **Contraception**

- There is no 'ideal' form of contraception for women. The best contraception for an HIV-positive woman currently must involve condoms, although these may not adequately protect against pregnancy.
- Many of the contraception choices interact with ART or are unsuitable if a resultant pregnancy was to continue.
- The Swiss statement suggests that in cases of full viral suppression, stable partnerships and no other STDs, there is minimal risk of HIV transmission. There is much debate over this statement.

## **Discussion guide**

Consider the following questions when completing this module – the questions can be used for both reflective self-learning purposes and as a guide to discussion as part of a group learning experience.

### **Reducing the number of HIV-infected infants**

The burden of HIV infection continues to rise in women; and infants are born with HIV despite effective means of reducing the risk of MTCT. Measures to reduce MTCT include reducing the infection rate among women of childbearing potential, reducing the rate of unplanned pregnancies among HIV-positive women and reducing the risk of transmission during pregnancy, labour, delivery and breastfeeding.

- What are the barriers to achieving each of these measures?
- Do the barriers alter according to the women affected; for example by age, socioeconomic class, migrant status, concurrent mental illness, history of drug abuse, culture, religion?
- How might these barriers be overcome?

### **Helping women navigate a healthy pregnancy and birth**

Pregnancy and childbirth trigger a number of questions and concerns for any women. For those with HIV, there are a multitude of additional issues to consider including preventing transmitting the virus to the baby, the effect of treatment on the baby and the effect of the pregnancy on the woman's disease. Each woman has their own specific needs for support and information, depending on their personal circumstances.

- How can HIV treatment be maximized prior to conception?
- How can HIV-positive women become pregnant without infecting an HIV-negative partner? How can an HIV-negative woman become pregnant without contracting HIV from her HIV-positive partner?
- How can women reduce the risk of MTCT during conception, pregnancy, childbirth and feeding?
- How will a woman's treatment regimen affect her child?
- How will pregnancy and childbirth affect a woman's disease, and her ability to care for her child? How can the risks be reduced?
- Which psychosocial issues might a woman be exposed to? For example, judgment and stigmatization by family and community.

## **Protecting the welfare of the child**

In certain situations, a child may be taken into care against a mother's wishes; for example, to provide treatment or to limit the risk of HIV transmission.

- Under which circumstances can and should a child be removed from its mother? And for how long?
- Which steps should be taken to avoid enforced separation and possible treatment of infants?
- Which medical and/or lay personnel should be involved in this process?

## **The Swiss statement**

The Swiss statement suggests that under certain conditions there is minimal risk of HIV transmission through sexual contact.

- Under which conditions does the Swiss statement suggest that HIV transmission is of minimal risk?
- How does this affect the contraceptive choices of women?
- How does this affect the risk of MTCT of HIV and the risks associated with breastfeeding?

## **Acknowledging beliefs**

Beliefs are important for many women living with HIV. Wherever possible it is best to work alongside these beliefs rather than trying to change them. For some women, there may be an underlying mistrust of western medicines and healthcare, or their religious or cultural background may conflict with the medical advice they are given.

- What is the best way to manage women who refuse medical treatment as they prefer to use only complementary or traditional medicine?
- How can communication gaps be bridged and trust established in women who are suspicious or disagree with the medical advice provided to them?