

## Hiding in Plain Sight: The Role of Contraception in Preventing HIV

By Susan A. Cohen

**A**s Congress embarks on the process of reauthorizing the U.S. program to fight HIV and AIDS, and as other global donors recalibrate levels and allocations of funding for HIV/AIDS programs, prevention seems to be making a comeback. At the inception of the President's Emergency Plan for AIDS Relief (PEPFAR) five years ago, both the funding and the programmatic emphasis tilted heavily toward treatment. Yet, the rate of new HIV infection continues to outpace the world's ability to deliver antiretroviral therapy, despite recent advances in access to such medications. A public health consensus is emerging, therefore, in favor of realigning the balance between treatment and prevention efforts.

Refocusing the priority on prevention is long overdue, as is an acknowledgment, especially within Congress, that HIV prevention cannot be accomplished with a disproportionate emphasis on abstinence. Indeed, preventing the sexual transmission of HIV requires going beyond the necessary but hardly sufficient strategy of ABC: *abstain, be faithful, use condoms*. It also requires increasing AIDS awareness through counseling and testing programs, investing in programs promoting the empowerment of women and girls, and increasing access to male circumcision. Other critical prevention interventions include ensuring a clean blood supply and clean medical injections, needle exchange programs for intravenous drug users and preventing the "vertical" transmission of HIV from a pregnant woman to her newborn infant.

Largely overlooked as an HIV prevention strategy, however, is the simple and low-cost act of helping HIV-positive women who do not want to have a child to avoid an unintended pregnancy through increased access to contraceptive services. Ward Cates, president for research of Family Health International (FHI), has dubbed contraception the "best-kept secret in HIV prevention," and certainly, the significant contribution of unintended pregnancy prevention toward reducing the perinatal transmission of HIV has gone virtually unrecognized. Yet, a revitalized and more robust effort focused on HIV prevention cannot afford not to fully capitalize on the critical role of contraceptive services in fighting AIDS.

### The Need for Progress on Prevention

Women of reproductive age comprise more than half of the 33 million people currently living with HIV around the world. The vast majority of these women live in Sub-Saharan Africa, and thus, it is not surprising that 90% of the 2.5 million children younger than 15 living with HIV live there as well. Almost all of these children became infected through their mothers during pregnancy, birth or breastfeeding.

An HIV-positive woman about to give birth can dramatically reduce the likelihood of transmitting the virus to her newborn by delivering in a hospital or a primary care setting where she and her infant can receive even a single dose of the antiretroviral drug nevirapine. However, the challenges to delivering even this seemingly simple prevention of mother-to-child transmission (PMTCT) service are substantial, especially in Sub-Saharan Africa. Pregnancy itself does not

usually drive women, especially those in rural areas, to facilities where they could receive prenatal care and, potentially, an HIV test. In addition, many pregnant women may not want to know their HIV status for fear of public disclosure and the stigma that often results. Considering the difficulties of delivering services to HIV-positive pregnant women, and the simple fact that most women who are HIV-positive do not know it, it is not entirely surprising that only 11% of all theoretically eligible women in poor countries are benefiting from any PMTCT intervention. And without intervention, about one-third of babies born to HIV-positive women likely will become infected.

A long-standing goal of global prevention efforts, therefore, is to ramp up PMTCT efforts so that more pregnant women are tested and that those who are positive receive the treatment that they and their infant will need. PMTCT programs justifiably enjoy broad political support and are certain to continue to be a funding priority within the U.S. global AIDS effort.

The United States does recognize the importance of at least establishing linkages between PMTCT and family planning programs, since PEPFAR requires family planning counseling and referral as one of four elements comprising the minimum package of services for preventing mother-to-child transmission. However, a high-level consultation sponsored by the World Health Organization (WHO) and the United Nations Population Fund in 2004 went considerably further, concluding that investing solely in narrowly defined PMTCT programs will not succeed in dramatically reducing the incidence of perinatal transmission. Rather, the Glion [Switzerland] Call to Action on Family Planning and HIV/AIDS in Women and Children emphasized that all four elements of the WHO approach to preventing HIV infection in infants are essential. PMTCT programs are key, but so are primary prevention of HIV infection in women; the provision of care, treatment and support for women living with HIV and their families; and prevention of unintended pregnancies among women living with HIV. Of these, the significant role that unintended pregnancy prevention already plays—and the much

greater role it potentially could play—in averting new cases of HIV has been least recognized and supported.

According to a 2007 Guttmacher Institute study, one in four married women in Sub-Saharan Africa is sexually active and does not want to have a child or another child in the next two years, but is not using any method of contraception. As a result, unintended births are common, and occur in the very countries that are a focus of PEPFAR—countries in which HIV prevalence is high and 60% of all adults living with HIV are women (see table).

Indeed, research into the HIV/AIDS health care system reveals that the unmet need for contraception among HIV-positive women and women at high risk of HIV is even greater than among women in the general population. According to a study published in *JAMA* in 2006, 84% of the pregnancies among women in three PMTCT programs in South Africa were unintended. Similarly, the Centers for Disease Control and Prevention reported earlier this year that 93% of the pregnancies among pregnant women receiving antiretroviral therapy in Uganda were unintended. And according to FHI research from 2006 of women in HIV counseling and testing clinics (where most women are HIV-negative but are at high risk for HIV), substantial majorities in Kenya (59%), Tanzania (66%), Zimbabwe (77%) and Haiti

## HIV AND UNINTENDED PREGNANCY

**In PEPFAR countries, high HIV/AIDS rates coexist with a high unmet need for contraceptive services and a high incidence of unplanned births.**

PEPFAR Focus Countries (selected)	Unmet Need for Contraception, Married Women	Unplanned Births (as % of total births)	HIV/AIDS Prevalence (ages 15–49)
Cote d'Ivoire	28	28	7
Ethiopia	34	35	1–3
Kenya	25	44	6
Mozambique	18	19	16
Namibia	22	45	20
Nigeria	17	14	4
Rwanda	38	39	3
South Africa	15	53	19
Tanzania	22	22	7
Uganda	35	38	7
Zambia	27	39	17

Source: Guttmacher Institute, 2007, and PEPFAR, 2007.

(92%) said they did not want another child in the next two years.

### Contraception as HIV Prevention

To be sure, many women living with HIV do want to have a child or another child, notwithstanding pressure to forego childbearing from family members, people in their community and health care providers. And, in fact, HIV-positive women are likely to be able to sustain a healthy pregnancy and safely deliver a healthy baby if they can avail themselves of appropriate therapy (related article, Fall 2006, page 17). Nonetheless, many HIV-positive women who know their HIV status seek out contraceptive services specifically because of their status—because they fear infecting their baby if they become pregnant or leaving behind children, whether HIV-positive or not, as orphans. And many more women seeking contraceptives services are, in fact, HIV-positive but do not know it.

FHI researchers estimate that if the HIV-positive women in Sub-Saharan Africa who are currently using modern contraceptive methods to prevent unintended pregnancy were not able to do so, the number of HIV-positive births in the region would be 31% higher than it is now. This would translate to 153,000 more HIV-infected unplanned births each year—or 419 more per day.\* Researchers at the Johns Hopkins University Bloomberg School of Public Health and WHO published an analysis in *AIDS* in 2004 demonstrating that even a modest decline in the number of unintended pregnancies among HIV-positive women in Botswana, Cote d'Ivoire, Kenya, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe could lead to the prevention of the same number of births of HIV-positive infants as prevented by the current PMTCT programs in these countries. "It is clear from this analysis," they wrote, "that only a combined approach utilizing all three intervention components simultaneously [reducing HIV infection among women, reducing unintended pregnancy and increasing the reach of PMTCT programs] will result in significant reductions" in new HIV infections among infants.

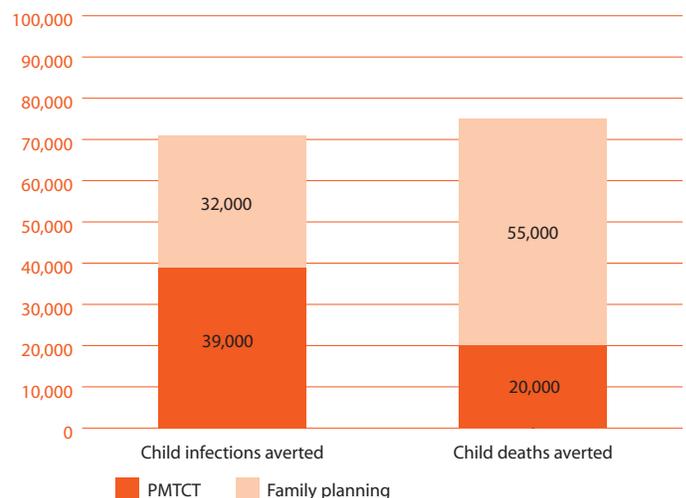
\*These data take into account the revised UNAIDS estimates released in late 2007 that indicate lower prevalence rates at the global and regional levels than in 2006. This explains most of the difference from FHI's previous estimate of 173,000.

Helping HIV-positive women avoid unwanted pregnancies not only lowers the rate of new infections, but does so at a relatively low cost. The U.S. Agency for International Development (USAID) examined PMTCT programs in the 14 countries comprising the Bush administration's original initiative starting in 2002 aimed at preventing mother-to-child transmission. USAID projected that over a five-year period, adding family planning services to PMTCT programs could prevent almost twice the number of infections to children, and nearly four times the number of deaths to children, as PMTCT alone could prevent (see chart). In addition, a 2006 analysis by FHI concluded that for the same cost, voluntary family planning services can avert nearly 30% more HIV-positive births—that would have been unintended—than averted by identifying HIV-positive women during their pregnancy and providing nevirapine.

Greater access to contraceptive services then—whether among women in HIV treatment programs, PMTCT programs or counseling and testing programs, or among women in traditional family planning programs in high-HIV-prevalence countries—is a "win-win-win situation." It increases the chances that women living with HIV can prevent future pregnancies they do not

### FAMILY PLANNING ENHANCES PMTCT

**Adding family planning to PMTCT programs could almost double the number of child infections averted and nearly quadruple the number of child deaths prevented compared to PMTCT programs without family planning.**



Source: USAID, 2006.

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want, thereby reducing the incidence of perinatal transmission and the number of potential child deaths, and it achieves these humanitarian ends in a highly cost-effective way.

### Implications for Prevention Policy

Outside the context of HIV prevention, it is indisputable that the health, social and economic benefits of investing in contraceptive services—for women, their families and their communities—are multiple and varied. By preventing pregnancies that are too early, too late or too closely spaced, contraception reduces the likelihood of infant mortality. And by helping women to avoid high-risk pregnancies and the need for unsafe abortions, it decreases the risk of maternal death or disability. A woman who can determine the timing and spacing of her children increases her own and her existing family's opportunities for educational, social and economic advancement. Moreover, the evidence is compelling that increasing access to family planning programs also amplifies the overall effort to slow the rate of new HIV infection.

Yet, despite the ever-rising demand for contraceptive services and the fact that a woman's ability to control her own fertility is integrally linked to almost all other aspects of health and development, U.S. funding for family planning has been lagging. Funding for family planning programs in developing countries through USAID peaked at about \$550 million at the time of the International Conference on Population and Development in Cairo in 1994 and early 1995. It dropped precipitously in 1997, after control of Congress shifted to lawmakers hostile to sexual and reproductive health programs, plummeting to below \$400 million. By 2001, the final year of the Clinton administration, funding had regained some ground (\$446 million), but that level has remained essentially constant ever since.

Clearly, USAID funding for family planning programs should be increased—both on their traditional merits and, in high-prevalence countries, as an HIV strategy. At the same time, as global donors to the fight against AIDS reconsider the new priority emphasis on prevention, particularly the United States through the reauthorization of

PEPFAR, it would be an opportune moment to legitimize contraceptive services as the core HIV prevention intervention they are. This would mean ensuring that HIV treatment programs, where women already predominate, also provide contraceptive services directly or by referral to make it easier for HIV-positive women to coordinate their treatment regimen with their pregnancy prevention goals. Similarly, it would mean making family planning services more widely available through PMTCT programs, because many HIV-positive new mothers wish to delay or prevent a subsequent pregnancy. Finally, in high-prevalence countries, it would mean promoting greater integration of HIV counseling and testing services into family planning programs, so that more sexually active women at risk of HIV are likely to be tested and to receive appropriate counseling and treatment.

These strategies are more than academic. The Elizabeth Glaser Pediatric AIDS Foundation, the largest provider of PMTCT services under PEPFAR, has been striving to incorporate contraceptive services into its programs because "care and treatment staff members are uniquely positioned to address HIV-positive women's needs concerning future pregnancy plans and counsel them based on their social circumstances, health status, and ART regimen." Indeed, as negotiations in Congress got underway last month to reauthorize PEPFAR, the Foundation wrote to the House Foreign Affairs Committee to urge broadening the use of PEPFAR funds in order to support these "essential prevention services....As implementers, we cannot overstate the importance of [integration] to the work we do on the ground to prevent the spread of HIV."

For individual women who live where HIV is rampant, the interrelatedness of HIV prevention and unintended pregnancy prevention is a practical reality. Yet most international program donors, including the United States government, have viewed them as complementary goals but separate and unrelated outcomes. All along, the fact of contraception as HIV prevention has been hiding in plain sight. It is time to seek it.

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