

Strategic Communication for Hormonal Contraception and HIV: An Evidence Review



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Hormonal contraception (HC) – oral contraceptive pills, emergency contraceptive pills, injectables, patches, rings, implants or hormonal intrauterine devices (IUDs) – are highly effective methods of family planning (FP) and important options for women who wish to delay or prevent unintended pregnancy. These methods are critical tools for reducing maternal and infant morbidity and mortality.¹ However, in recent years, the use of progestogen-only injectable contraception, particularly Depot Medroxyprogesterone acetate (DMPA) which is most commonly known as Depo-Provera, has been linked to an increased risk of HIV acquisition in HIV-negative women in some observational research studies²⁻⁸. Other studies have generated conflicting results⁹⁻¹⁵.

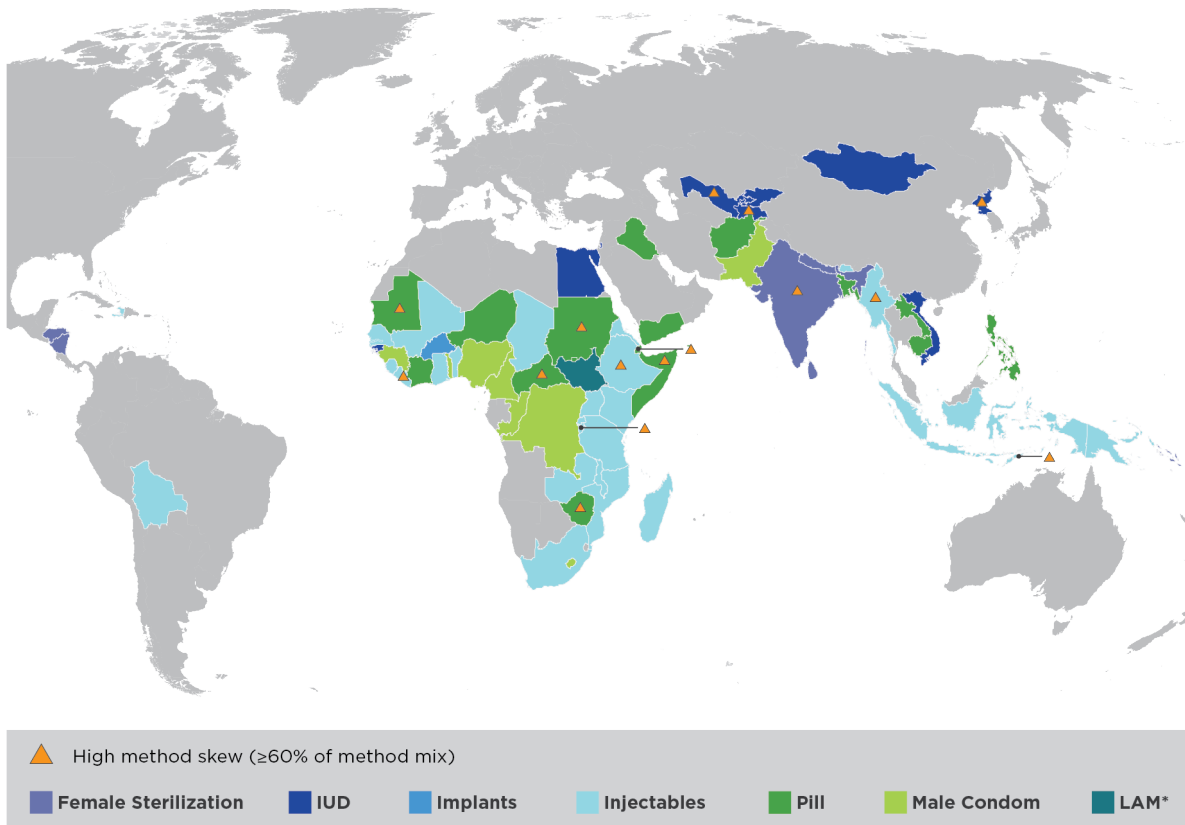
To address this concern about possible increased HIV risk related to progestogen-only injectable contraceptives, the World Health Organization (WHO) convened three technical consultations of the Guideline Development Group (GDG) to provide guidance on HC use among women at high risk or living with HIV, initially in 2012 and again in 2014 and 2016 when new studies were released.¹⁶ In 2012¹⁷ and 2014¹⁸, the GDG found that the epidemiological data regarding the interaction between progestogen-only injectables and risk of HIV acquisition did not warrant a change to the Medical Eligibility Criteria (MEC) and continued to recommend no restriction (MEC category 1) for the use of progestogen-only pills, progestogen-only injectables (DMPA and Norethisterone Oenanthate [NET-EN]) and levonorgestrel and etonogestrel implants. Due to the inconclusive nature about the possible increased risk of HIV acquisition, and the lack of experimental study data at the time, the MEC included a new clarification recommending that women at risk of HIV using progestogen-only injectable

contraception should be strongly advised to also always use condoms, male or female, and of other HIV preventive measures. This type of clarification was unprecedented in the MEC and civil society groups, including advocates for women living with HIV, were extremely concerned about its ambiguity and implications for the health and well-being of women.

Any potential association between progestogen-only injectable contraception and HIV infection must also be understood against the background of the epidemiological context of a given country and balanced against the life-saving benefits of using modern contraceptive methods to reduce risk of unintended pregnancy, maternal and infant morbidity and mortality, and unsafe abortion. Hypothetical modeling¹⁹, based on different assumptions about the true effect size of the interaction between injectable contraceptive use and HIV risk, has shown that the country-specific epidemiological context, including the HIV prevalence, maternal mortality rate, prevalence of injectable contraceptive use, and alternate contraceptive method options available, would affect the mortality and morbidity impact differently.

In 27 countries, injectable use makes up the largest percentage of the method mix (Figure 1.)²⁰. Many of these countries are in east and southern Africa, where HIV prevalence is also high. The implications therefore of balancing the risk between HIV acquisition and unintended pregnancies are acute in this region.

Figure 1. Most Common FP Method by Country



*Lactational Amenorrhea Method (LAM) was excluded from mCPR in Chad, CAR, Cameroon, and Somalia due to unusually high levels reported in MICS surveys.

Note: Methods shown on the map make up the largest percentage of each country's method mix. When the prevalence of a single method is 60% or greater, we consider this to be a high level of method skew. See Indicator No. 9 Estimate Table for method mix by country.

Given these epidemiological contexts, and the lack of definitive data, there was strong support from many stakeholders, including civil society groups, WHO, UNFPA, UNAIDS and others, regarding the need to develop clear communication guidance for both HIV and FP health care providers, as well as client-centered messages, so that women may make their own informed decisions about HIV risk and FP method adoption. This led to the development of the [*Strategic Communication Framework for Hormonal Contraceptive Methods and Potential HIV-Related Risks*](#) as part of the Health Communication Capacity Collaborative (HC3), with support from the United States Agency for International Development (USAID) and using in-depth stakeholder

review and engagement.

The *Framework* uses an evidence-based approach to share information about this complex matter to those women who most need it as well as their sexual partners and social networks. It was updated in 2017 after the GDG changed the MEC for progestogen-only injectables (NET-EN and DMPA, intramuscular (IM) or subcutaneous (SC)), to a Category 2, based on increasing strength of observational data²¹ for women at high risk of acquiring HIV, meaning that the advantages of these methods generally outweighs the possible increased risk of HIV acquisition.

The *Framework* provides a generic communication strategy that can be contextualized for any given country, with key messages for eight intended audiences (five primary and three influencing), including helpful information for providers to use when counseling women to ensure they understand the risks and can make informed decisions to protect themselves both from HIV acquisition and unintended pregnancy. For example, a key message for a clinical health providers is that women at high-risk of acquiring HIV can still use progestogen-only injectables because the advantages outweigh any possible increased risk (MEC category 2). However, women considering progestogen-only injectables should be advised about the uncertainty over an increased risk of HIV acquisition and about how they can minimize this risk through the use of male and female condoms, in addition to other HIV prevention methods.

Based on the change in the MEC, the 2017 updated [Family Planning: A Global Handbook for Providers](#), added a job aide for health care providers with brief counseling messages and tips to

discuss the issue with clients. For example, it advises the provider to help the client consider whether they are doing something to protect themselves from HIV and reassure her that she can choose a progestin-only injectable if she prefers it, but also ask whether she would like to discuss and think about other methods, too.

While unresolved questions remain pertaining to the association between progestogen-only injectables and an increased risk of HIV acquisition in HIV-negative women, the issue of how to communicate the available information to women warrants greater attention, particularly in light of changes in the MEC guidance. The purpose of the *Framework*, therefore, was to provide a road map for countries interested in adapting it for country-specific use to guide communication messaging and activities in a clear and consistent manner to ensure women at high risk, their partners, providers and communities are aware of the potential increase in risk and have access to HIV preventive measures. This adaptation process has now been rolled out in three countries: Malawi, Swaziland and Tanzania, which have provided key insights into the challenges and opportunities for communication around this important topic in different settings.

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