

EC AND HIV/AIDS/STIs

EDITORIAL

The increasing access to and knowledge of EC pills across Africa presents opportunities and challenges. On the one hand, they provide an opportunity for those who engage in unprotected sex or experience method failure to avoid the risk of pregnancy. Moreover, and especially in a high HIV prevalence setting, EC clients might have also exposed themselves to the risk of sexually transmitted infections (STIs) and HIV/AIDs. The provision of EC therefore provides an opportunity to counsel these clients on regular family planning methods and to refer them for further STI/HIV prevention services.

On the other hand, there are concerns that more women might be over-relying on the pills as the method of choice because they are convenient and easy to use, which further exposes them to the risk of STI/HIV infection as the pills do not protect against these infections.

The relationship between EC and the risk of STI/HIV infection and prevention therefore raises a number of important research and program questions. Is there evidence that increased access to EC is associated with increased risk of STI/HIV infection? How about evidence of the association between increased access to EC and awareness about such risk? Are there examples of research studies and programs that show the alternative scenario-- that increased access to EC is associated with increased uptake of other STI/HIV prevention services such as counseling and testing? How best can programs ensure that increased access to EC contributes to STI/HIV prevention rather than to increased risk of infection?

It is, however, apparent from articles appearing in this issue that answers to these important questions might not be readily available. For one, there are still no known studies that have rigorously examined the relationship between EC use and the risk of HIV infection. The available evidence on the relationship between the use of hormonal contraceptives (HC) and the risk of STI/HIV infection could provide some indications of what to expect with respect to EC use. Nonetheless, such evidence is mixed: whereas some studies have found HC use to be associated with increased risk of STI infection, others have not found such association.

As others rightly note, this contradiction could partly be attributed to different study designs and methodological shortcomings. This highlights the other important challenge to obtaining answers to the questions posed here, that is, how best to design studies that provide answers to these questions.

Perhaps, it is time researchers and program managers started giving serious thoughts to these issues since concerns will often be raised about repeat EC use and the potential risk

of STI/HIV infection, especially in high STI/HIV prevalence settings. The challenge is to provide evidence based on solid research that addresses these concerns.

This raises the dilemma of how to proceed with scaling up EC services for now, especially in Africa where HIV prevalence is high. Perhaps, the best response is provided by the first contributor who notes that it is necessary to take into account the individual and programmatic needs as well as the scope and relevance of the HIV epidemic during scale-ups.

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The essentials of scaling-up EC services in diverse HIV/AIDS contexts

The actual and potential demand for EC pills requires large-scale programs that facilitate information dissemination, provider training and counseling, and method access to girls and women throughout the world. In high HIV prevalence settings, EC scale-ups imply a need to develop a nuanced response to the risks associated with unprotected sex. Where HIV/AIDS programs have already been scaled up, through both public and private means, inclusion of EC services could ensure the provision of comprehensive reproductive health (RH) services. Yet, before jumping into conjoined program scale-up, one must consider the context of HIV prevalence, and determine when it is appropriate and beneficial to provide EC and HIV services concurrently.

Understanding the individual country needs and potential demand for EC is fundamental for shaping the trajectory of program scale-up. Where HIV prevalence is low, as in many countries of West Africa, the inclusion of EC in HIV/AIDS treatment services might not promote comprehensive service provision since EC will only be available to HIV infected women not currently using any other method of contraception. In this context, the scale-up of EC programs should be distinct from HIV services. The scale-up should follow its own operational blue print, with specific strategic steps and indicators of service provision, to ensure that EC is available to all women through various delivery outlets. Guidelines and operations models currently exist, from Bangladesh and other countries for example, to assist in scaling-up, presenting national experiences and the lessons learned.

EC provision and HIV services should also be provided separately in areas where most (if not all) women learn their HIV status as part of antenatal care services, as is the case in many parts of Africa. In this context, the provision of EC is not relevant since women receiving antenatal care services are not eligible method acceptors at that time. EC programs may be more successfully implemented and scaled up as separate entities in this situation, possibly incorporating EC provision in post-natal check-ups as an option for postpartum family planning. EC could in this case be used during the transition period between lactational amenorrhea (LAM) and the adoption of a regular method.

That said, pregnancy has often emerged as a greater health concern among young women in Africa than HIV infection. EC provision should therefore be included within a range of existing reproductive health services, including HIV prevention programs where appropriate. Women who seek testing or care after unprotected sex should be offered EC pills. Access to EC in settings with high HIV prevalence is also vital for the prevention of mother-to-child transmission, as well as for the rights of women to reproductive choice. Specifically, in the case of sexual violence or rape, EC and post-exposure prophylaxis (PEP) should be included in the emergency care package. The success of this strategy has been demonstrated in the Population Council's work in South Africa.

Scaling-up EC programs in Africa is often challenging, as weak health systems and social and political barriers continue to test the robustness of implementation strategies. When taken in the context of HIV, EC program scale-up faces even additional challenges. It is important to consider the individual and programmatic needs when planning the large-scale programs, while also keeping the scope and relevance of the HIV epidemic in context.

This will ensure that all women have access to EC information and method, yet allow for special attention allotted to HIV-positive women.

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Hormonal contraceptives and HIV acquisition

There is mixed evidence on whether hormonal contraceptives (HC) increase the risk of HIV infection among women. A study among female sex workers in Nairobi, Kenya, for instance found that the use of OC was associated with an increased risk of HIV infection. Similarly, two out of 30 studies reviewed by Family Health International (FHI) found increased risk of HIV infection among HC users.

However, other studies did not find such association or found a decreased risk of HIV infection among HC users. For example, most of the studies reviewed by FHI found no or non-significant association between HC use and the risk of HIV infection. A prospective study examining the use of HC in a very large cohort of women from the general population found that HC use was not associated with an increased risk of HIV acquisition. A multicentre prospective cohort study in HIV-uninfected women age 18-35 from FP clinics in Uganda, Zimbabwe and Thailand found no association between HC use and HIV-1 acquisition.

A number of factors account for these contradictory findings. First, the studies employed different designs. Most studies that found an increased risk of HIV infection among HC users were, for instance, done among high-risk groups such as commercial sex workers or women attending STI clinics. STI prevalence among such high-risk groups could confound the relationship between HC use and the risk of HIV infection. Second, some of the studies had serious methodological flaws such as low study power, poor measurement of HC use, and poor follow-up.

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RESEARCH

Systematic review of hormonal contraception and risk of HIV transmission:
When to resist meta-analysis

The author contends that whereas OC pill is a highly efficacious and safe form of contraception that has transformed the lives of many women world-wide, its relationship to HIV transmission remains uncertain. Based on a review of 32 studies, the author argues that the question of whether women taking oral or injectable hormonal contraceptives are at increased risk of HIV infection will be hard to answer for various reasons. First,

statistical meta-analysis of existing observational studies cannot overcome their formidable methodological problems. Second, randomized trials are not an option for ethical and practical reasons. Third, retrospective studies are unlikely to resolve the problem of confounding between sexual risk-taking and the choice of contraceptive method, or to estimate the level of HIV exposure before infection accurately. The author therefore feels that current approaches to promote hormonal contraception when it is appropriate to family planning needs should continue. In addition, the importance and effectiveness of consistent condom use against HIV transmission should be stressed whether other contraceptive methods are being used or not.

Source: Stephenson JM. (1998). Systematic review of hormonal contraception and risk of HIV transmission: When to resist meta-analysis. *AIDS* 12: 545-553.

Risk of HIV infection in oral contraceptive pill users: A meta-analysis

In this study, the authors estimated the magnitude of association between HIV and oral contraceptive (OC) pills based on statistical analysis of 28 separate but similar studies published since 1985. They found a significant association between OC use and HIV-1 sero-prevalence and sero-incidence. The authors conclude that although women may be counseled to use pregnancy prevention methods (such as hormonal contraception, intrauterine devices, or tubal ligation), condoms should also be emphasized as the only means to prevent sexually transmitted infections including HIV, especially in contexts such as Africa where heterosexual contact is the predominant mode of HIV infection.

Source: Wang CC, Kreiss JK, Reilly Marie. (1999). Risk of HIV Infection in Oral Contraceptive Pill Users: A Meta-analysis. *JAIDS: Journal of Acquired Immune Deficiency Syndromes* 21(1): 51-58.

Hormonal contraception and risk of sexually transmitted disease acquisition: Results from a prospective study

This study examined the relationship between the use of HC pills and the risk of sexually transmitted infections among 948 prostitutes in Kenya. It found that compared to women who were using no contraception, users of OC pills were at increased risk of chlamydia and vaginal candidiasis; they were, however, at decreased risk of bacterial vaginosis. Similarly, women using depot medroxyprogesterone acetate (DMPA) had significantly increased risk of chlamydia infection and significantly decreased risk of bacterial vaginosis, trichomoniasis, and pelvic inflammatory infections. Consistent condom use was also found to be significantly associated with decreased risk of gonorrhea, chlamydia, genital ulcers,

bacterial vaginosis, and pelvic inflammatory infections. The authors conclude that the use of oral or injectable hormonal contraception altered susceptibility to STIs among the study sample, and that this may in turn influence the transmission of HIV. They recommend consistent condom use for prevention of STIs and HIV among women who use hormonal contraception.

Source: Baeten, JM a, Nyange PM b, Richardson BA a, Lavreys L, Chohan B b, Martin HL, Mandaliya K, Ndinya-Achola JO, Bwayo JJ, Kreiss JK. (2001).

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Results from a prospective study. American Journal of Obstetrics and Gynecology
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Prospective study of hormonal contraception and women's risk of HIV infection in South Africa

The premise of this article is that many women using HC are also at risk of HIV infection, yet data are mixed on whether HC increases the risk of acquiring HIV. It examined the association between HIV incidence and the use of combined oral contraceptives (COC), norethindrone enanthate (NET-EN) or DMPA in a cohort of 4,200 women aged 35-49 years in South Africa. It found that after adjusting for sexual risk behaviors and sexually transmitted infections, there was no difference in HIV incidence between women using COC, NET-EN or DMPA and those not using any hormonal method. The authors conclude that this is evidence, from cohorts of women in the general population, of the lack of association between HC use and increased risk of HIV infection.

Nonetheless, they note that family planning services are an important venue for HIV prevention activities.

Source: Myer L, Denny L, Wright TC, Kuhn L. (2007). Prospective study of hormonal contraception and women's risk of HIV infection in South Africa.

International Journal of Epidemiology 36: 166-174.

NEWS AND EVENTS

ECafrique welcomes a new face

Wilson Liambila joined the EC family in June 2008. He is currently working on mainstreaming EC in the public sector in Kenya, and on improving the provision and use of EC in the private sector. He is further working with Population Services International (PSI), the Ministry of Health (MOH)-Kenya, the Kenya Medical Supplies Agency (KEMSA), EC distributors, the Pharmaceutical Society of Kenya (PSK), and the Pharmacy and Poisons Board (PPB) to address some of the challenges that EC users face, and those encountered by the supply side regarding quantification, distribution as well as other supply chain issues.

Wilson brings to the EC project a wealth of experience in the health sector. He has been coordinating the pilot project on integrating counseling and testing for HIV within Family Planning services in Central Kenya for the past three years. As a member of the National RH-HIV Integration Steering Committee, he has worked closely with the MOH teams at national, provincial and district levels. He has over 20 years of experience in health policy analysis, health sector reforms, and in health care financing issues including developing appropriate mechanisms for mobilizing resources and for devising other innovative strategies to be applied in resource poor settings. He has over the years trained health managers in the application of logical framework methodologies in project planning, implementation, monitoring and evaluation as well as developing standards and norms for effective health service delivery.

On EC, Wilson is happy with what has been accomplished in terms of mainstreaming the method in to the public health sector. Nonetheless, he feels that there is still much to be done by researchers and policy makers to streamline the messages on EC. He points out that there are conflicting messages on regimens and efficacy. For instance, some publications advocate for a stat-dose (swallowed at once) while others advocate for a repeat dose after twelve hours. In addition, whereas some documents mention the 72-hour efficacy, others mention 120 hours which confuses policy makers, program personnel, providers, and clients.

Three grants for African EC projects awarded in 2008

Through support from the William and Flora Hewlett Foundation, ECafrique awarded its 2008 grants to three non-governmental organizations (NGOs) working on EC mainstreaming in Africa. These are:

- * Ghana: "Mainstreaming emergency contraception in Uganda: An operations research on bridging emergency contraceptive to oral contraceptives among young women in the University of Ghana," GSMF International
- * Uganda: "Mainstreaming EC knowledge among pre-service and in-service health care providers in Uganda," Association of Obstetricians and Gynaecologists of Uganda (AOGU)
- * Côte d'Ivoire: "Promotion de la contraception d'urgence chez les jeunes femmes en milieu urbain en Côte d'Ivoire," Agence Ivoirienne de Marketing Social (AIMAS)

Three NGOs from Anglophone and another three from Francophone Africa were invited to week-long workshops in Nairobi in May and in Dakar in July, 2008 respectively. Similar to the previous workshops (see ECafrique Bulletin volume 5/1, p. 14), participants were provided with skills for developing internationally competitive proposals. The range of issues covered during the workshops included the logical framework, budgeting, narrative writing, and monitoring and evaluation of projects.

However, only three of the six projects were selected for the 2008 grants due to funding limitations. Since the projects that were not funded were also of high quality, ECafrique is working with them on how to secure alternative funding. These projects include:

- * Kenya: "Mainstreaming emergency contraception through community-based approaches in Homabay District, Nyanza Province in Kenya," Africa Alive!; E-mail: africaalivek@wananchi.com or afalivek@yahoo.com
- * Senegal: "Projet contraception d'urgence," Association Sénégalaise pour le Bien-Etre Familial (ASBEF); E-mail: asbefdk@orange.sn
- * Benin: "Projet promotion de la contraception d'urgence au Bénin," Association Béninoise pour la Promotion de la Famille (ABPF); E-mail: abpf@leland.bj

For the funded projects, ECafrique will continue to provide technical support during the award period.

NorLevo is launched in Morocco

About 300,000 abortions are performed in Morocco every year. Out of these, 99% occur outside the legal framework provided for performing an abortion. Since 2000, HRA Pharma has been involved in efforts to introduce NorLevo in Morocco in a bid to reduce the many unwanted pregnancies that lead to abortion. It, however, took a total of eight years of concerted efforts to get the pill into the market.

One of the challenges faced was getting the endorsement and support of the medical fraternity. On an average, the cost of performing an abortion is 100 Euros. This is a huge business in the Moroccan context. Despite the risks taken by doctors, they feared losing a large slice of revenue from performing abortions.

The second hurdle was that of obtaining the legal authorization from the successive governments, who feared a backlash from the largest political, religious, and civil society organizations in the country. Two Health Ministers, for instance, declined to authorize EC in 2000 and 2004. They made it clear that they were not ready to make decisions that could jeopardize their political careers.

Efforts to introduce the pill through the Moroccan family planning programme were fruitless. In the meantime, anecdotal evidence shows that a black market for NorLevo thrived in the country. The appointment of a female Health Minister towards the end of 2007, however, changed the whole story. Coming from the women empowerment movement, she allowed the registration of the pill in the country.

EC was in the headline news and became the talk of the town for weeks. Millions of Moroccan women now have access to a safe, efficient and affordable alternative to prevent unwanted pregnancies and subsequent unsafe abortion.

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