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PREVENTION SERVICES AND CHOICES

PREVENTING HIV AND OTHER SEXUALLY
TRANSMITTED INFECTIONS AMONG WOMEN
AND GIRLS USING CONTRACEPTIVE SERVICES
IN CONTEXTS WITH HIGH HIV INCIDENCE

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POLICY BRIEF

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Introduction: Opportunities to address HIV and STIs in contraceptive services

According to the recent Evidence for Contraceptive Options and HIV Outcomes Study (ECHO) (Box 1) (1), the incidence of HIV infection and other sexually transmitted infections (STIs) remains high among adolescent girls and women in parts of East and Southern Africa. But, there and elsewhere, contraceptive services offer limited choices for HIV prevention and for contraception. Urgent action is required to invest in and expand HIV prevention, STI services and contraceptive choices in the broader context of providing sexual and reproductive health (SRH) services that uphold the rights of adolescent girls and women.

This programmatic brief explores how to expand HIV and STI prevention and contraceptive method options in contraceptive services and, thus, to reduce HIV and STI incidence among adolescent girls and women. It focuses on settings with extremely high HIV prevalence and incidence. This brief complements existing guidance on HIV prevention and sexual and reproductive health and rights (SRHR), amplifies calls for action and outlines more comprehensive approaches to integration of SRHR and HIV services (2,3). It also emphasizes the importance of SRHR for women living with HIV (4). It aligns with updated WHO recommendations for contraceptive eligibility for women at high risk of HIV (Annex 1, Table A1) (5) and other HIV guidance for adolescent girls and young women.¹

This brief is for national programme leaders, experts and members of national working groups on HIV and STI prevention in the context of contraceptive services. It is primarily relevant in settings with very high HIV prevalence in East and Southern Africa, in other high HIV prevalence settings in sub-Saharan Africa and for women from key populations in other regions.² At the same time, it proposes differentiated strategies for settings with low, medium, high and extremely high HIV prevalence among women.

Changes are needed

Changes are needed to better serve adolescent girls and women at high risk of acquiring HIV who are accessing contraception:

- Adolescent girls and women should have **more contraceptive choices** available in all types of service delivery settings, including family planning clinics and primary healthcare clinics. This should include free male and female condoms, which are the only available multipurpose tools for preventing HIV, STIs and unintended pregnancy.
- Adolescent girls and women accessing contraceptive services — especially in high HIV burden countries — should have **easy and affordable access to quality integrated HIV and STI testing, prevention and treatment services** that are responsive to the rights and preferences of adolescent girls and women.
- The **updated WHO recommendations for contraceptive eligibility for women at high risk of HIV** (Annex 1) should be widely disseminated, supported by updated provider training and made available in user-friendly formats and languages.
- The **rights of adolescent girls and women to full and unbiased information** should be guaranteed in all healthcare settings and in the community. This includes basic information on STI and HIV risk factors, advantages, disadvantages and risks of different contraceptive methods, including the message that methods other than condoms do not prevent STIs or HIV and all relevant regulatory changes and requirements.
- Contraceptive, HIV and STI services need to be part of a **broader health response that includes both SRH and primary healthcare services** in the context of universal health coverage.

¹ UNAIDS programming guidance on HIV prevention among adolescent girls and young women addresses behavioural, structural and biomedical prevention approaches. This comprehensive approach to HIV prevention remains relevant, especially in settings with high HIV and STI incidence. (HIV prevention among adolescent girls and young women. Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Geneva: UNAIDS; 2016 (https://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf).

² Key populations are men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people.

Box 1. The ECHO Study and its findings

What was the ECHO Study?

The Evidence for Contraceptive Options and HIV Outcomes, (ECHO) Study (1,6) was a randomized clinical trial that, for the first time, compared three highly effective, reversible contraceptive methods to evaluate whether there was any difference in the risk for their users of acquiring HIV. The methods studied were: (1) a progestogen-only hormone, depot medroxyprogesterone acetate, given by intramuscular injection (DMPA-IM); (2) a non-hormonal copper bearing intrauterine device (Cu-IUD); and (3) a subdermal implant containing the progestogen levonorgestrel (LNG).

Why was the ECHO Study done?

Over the past 30 years, researchers have been trying to determine whether or not hormonal methods increase the risk of HIV acquisition. The cumulative evidence from observational studies suggested a possible increased risk, particularly with DMPA-IM, but some studies showed no risk, and all were subject to limitations. Producing high-quality evidence was important for women to know whether using hormonal contraceptive methods increased their risk of HIV acquisition.

The ECHO Study randomly assigned 7829 women to use DMPA-IM, a copper bearing IUD or an LNG implant in nine clinics in South Africa and one each in Eswatini, Kenya and Zambia. The trial began in December 2015, enrolment officially closed in September 2017, and the study completed participant follow-up in October 2018.

What were the main findings?

- The ECHO study confirmed that the three methods of contraception are acceptable, safe and effective in preventing pregnancy.
- Despite receiving HIV testing and prevention counseling at study clinics, young women in the study had extremely high rates of HIV acquisition: 4.2 (3.54–4.94) per 100 person-years for users of DMPA-IM, 3.9 (3.31–4.66) for users of the copper bearing IUD and 3.3 (2.74–3.98) for users of the LNG-implant. The difference in HIV incidence between the three methods was not statistically significant (at the 95% confidence level), which suggests that there was no substantial difference in HIV acquisition risk. At the same time, the ECHO Study investigators noted that “for individual women at very high HIV risk, we acknowledge that even a relatively small effect might be important in contraceptive and HIV prevention decision-making” (1).

HIV incidence was highest among younger women (<25 years old); those in South Africa and Eswatini; those with antibodies to HSV-2 (the cause of genital herpes); those with gonorrhoea or chlamydia; those with multiple partners; and those with non-cohabitating partners. Despite syndromic STI screening and treatment, the high prevalence of STIs at study entry was unchanged at study exit. Specifically, chlamydia prevalence was 18%; gonorrhoea, 5%; and HSV-2, 38%.

1. Recommended approach to improving HIV and STI services for women using contraceptive services

A woman-centred approach

The starting point for programmatic action needs to be consultation with women, including adolescent girls and young women, on their needs and the type of services they want. The following specific actions could be considered.

At national policy level

1. Conduct a rapid assessment of:

- the types of contraception available and used;
- the contraceptives that women want, based on a range of options and comprehensive information available to inform choices;
- available HIV prevention options and women's values and preferences about HIV prevention;
- use of male and female condoms and women's perceptions on condom use to prevent HIV, STIs and unintended pregnancy;
- HIV and STI testing, including available diagnostic methods and treatment options and women's values and preferences about HIV and STI testing including preferred locations, partner testing, self-testing for HIV and specimen self-collection for STI testing;
- women's preferences for accessing SRH and HIV services, in particular contraception, HIV and STI testing, prevention, and treatment services;
- opportunities and barriers for women accessing contraception and HIV and STI services, including for adolescent girls and women from key population groups. This assessment may include logistic considerations, structural issues, user fees, healthcare workers' attitudes towards young and minority populations, stigma and discrimination against key populations, age of consent laws and limits on access for adolescent girls to contraception and HIV services;
- other factors relevant to service access and uptake, including adolescent girls' and women's knowledge of and attitudes towards HIV and STI prevention and contraceptives;

- additional insights on contraceptive service clients and potential clients obtained from data disaggregated by age, gender, residence, education level, economic status, marital status and other factors.

2. **Form a task force** (including users, providers, planners and funders) to address needs for HIV and STI testing, prevention and treatment within contraceptive service delivery as well as contraceptive choices.

At the community level: community-designed response

3. **Set up or integrate into existing structures a community consultation and monitoring mechanism** involving women, including young women, women from key populations and women with HIV, on HIV and STI prevention, contraception and wider SRHR priorities.
4. **Work with women, including adolescents and young women, through community-led networks** to design acceptable and effective programmes, ensure service quality and develop an approach based on human rights and gender equality.
5. **Ensure implementation of comprehensive sexuality education curricula** for adolescent girls and boys, as well as young women and men, on contraception and on risk and prevention of HIV and other STIs.

An evidence-based approach to understanding the diversity of needs

The majority of people living with HIV globally are women. At especially high risk of acquiring HIV are women in sub-Saharan Africa and, globally, women from key populations, such as sex workers and women who inject drugs, as well as female partners of men from key populations. How best to address HIV and STI prevention in contraceptive services

HIV and STI prevalence in a community affects how much focus to give HIV and STI prevention within contraceptive services.

will vary according to **local context, which can differ greatly between and within regions and countries.** Particularly, HIV and STI prevalence in a community affects how much focus needs to be given to HIV and STI prevention within contraceptive services.

In some countries in Southern Africa, HIV prevalence among women is very high throughout the country, while, in other countries in sub-Saharan Africa, there are specific locations with high HIV prevalence among women. In addition, individual needs of women differ. Generally, younger women, women who have an STI and women with more than one sexual partner face higher risk. Women have no risk if they are in a mutually monogamous relationship with a partner who has been tested and is HIV-negative or who is HIV-positive and virally suppressed on antiretroviral treatment (ART). In contrast, women everywhere who have a partner living with HIV who is not virally suppressed on ART are at high risk of acquiring HIV. As for STIs more broadly, transmission is prevalent in many different communities, with approximately 1 million curable STIs newly acquired globally every day.

This **diversity of HIV and STI prevention needs** in the context of contraceptive services requires a differentiated approach informed by the following process:

- Review and map any available information on prevalence and incidence of HIV and STIs, including on related risk factors, and on unintended pregnancies.

- Review information on available contraceptive choices (including condom promotion and distribution), their uptake and the types of contraceptive service delivery sites and mechanisms (such as public health centres, clinics operated by nongovernmental organizations, private clinics, hospitals, outreach workers, pharmacies and others).
- Review the current availability of HIV and STI services (including condom distribution, pre-exposure prophylaxis (PrEP), HIV testing services, ART referral and STI diagnosis and treatment) at contraceptive and other service delivery sites.
- Review service access for women from key populations, adolescent girls and young women (including through youth-friendly services) as well as existing service linkages for women and their male partners.

At the service delivery level, rapid HIV and STI risk and vulnerability assessments can determine an individual's service needs.

At the services level, rapid assessments can determine an individual woman's needs.

2. Implementation: how to provide better HIV and STI prevention services in the context of contraceptive services

Key issues and gaps

The current standard of care is not sufficient in most countries. One important finding from the ECHO Study is that HIV incidence and STI prevalence and incidence were high despite provision of basic HIV and STI risk reduction counselling and services within family planning services. Access to male and female condoms is critical. However, condom promotion to women without simultaneous programmes reaching men is likely to have limited effect. HIV and STI testing and provision of treatment for women is also critical, but in order to reduce HIV and STI incidence among women, ways to support HIV and STI testing and treatment of male partners are also needed. Despite a recognition for many years of the benefits of integrating SRH and HIV activities,¹ this has not been translated into changes in practice at any scale or consistency in high HIV burden settings.

Condom promotion to women in contraceptive services requires simultaneous efforts reaching men.

HIV and STI testing integrated into contraceptive clinics as recommended by WHO is rarely provided and needs to be prioritized. In particular, WHO recommends HIV self-testing and STI specimen self-collection (7,8). Multiple studies have shown these approaches to be highly acceptable and feasible for women, and they could be empowering choices for some women. In health facilities women could self-test for HIV or self-collect specimens for STI testing as they wait for contraceptive services. This would enable them to meet immediately with a health worker to confirm their results and help them make choices about treatment and prevention. WHO also recommends voluntary assisted partner testing, where HIV testing is offered, with their consent, to the partners of people with HIV. Partner services have been found to be highly acceptable to both women and men, when implemented according to WHO guidelines. The potential for intimate partner violence needs to be considered to help women to decide whether to accept or decline this option (9).

Adequate STI case management services are needed, delivered in locations and ways acceptable to women. STIs are not only a marker of HIV risk for women, but, if undiagnosed and untreated, also increase the risk of HIV acquisition. For women, STIs also can have serious reproductive health consequences beyond the immediate impact of the infection itself, including ectopic pregnancy and infertility. Furthermore, STIs can be transmitted from a woman to her child during pregnancy or childbirth. Transmission of STIs to the foetus during pregnancy can lead to adverse birth outcomes for infants, including prematurity, stillbirths and new-born deaths (10). STI case management should include appropriate treatment of symptomatic women (based on specific laboratory tests or, if that is not possible, signs and symptoms), targeted screening and treatment of both higher-risk symptomatic and asymptomatic women seeking contraceptive services, using accurate STI diagnostic tests, and partner management (including voluntary expedited partner treatment²).

PrEP is an additional effective HIV prevention option. WHO recommends offering PrEP to anyone at substantial HIV risk (11), defined as being in a population that has an incidence of greater than 3 per 100 person-years. PrEP was offered only late in the ECHO Study, and only a small number of women had the opportunity to benefit from taking it. At the time of this writing, PrEP is not commonly available to women at contraceptive service delivery sites. There is a need to increase access, in particular in locations with high HIV incidence as well as in sites that serve key populations.

Priority actions in high HIV burden settings

In high HIV burden settings, the following key actions can be considered in order to provide more effective HIV and STI prevention in contraceptive service delivery:

1. In contraceptive services provide:

- **HIV prevention options**, including prevention counselling, male and female condoms with lubricants and PrEP;

¹ The Gilon Call to Action on Family Planning and HIV/AIDS in Women and Children 3–5 May 2004 (http://srhhivlinkages.org/wp-content/uploads/2013/04/glioncalltoaction_2004_en.pdf).

² Expedited partner treatment (EPT) is the clinical practice of treating the sex partners of patients diagnosed with STIs such as chlamydia or gonorrhoea by providing prescriptions or medications to the patient to take to his/her partner without the healthcare provider first examining the partner.

- **symptomatic STI diagnosis and treatment**, targeted STI screening (when etiological diagnosis for syphilis, chlamydial infection and gonorrhoea are feasible) and treatment of asymptomatic women with infections and partner notification and management when feasible;
 - **HIV testing** with linkage to **ART services** for women who are diagnosed with HIV. Offering **HIV self-testing** to women as they wait for contraception services can be considered;
 - **voluntary assisted male partner testing services**. This could include offering women HIV self-tests for their male partners. Follow-up services for partners could include prevention counselling, information about and referral for voluntary medical male circumcision (VMMC), referral for ART and partner testing and treatment for STIs.
2. **Rapidly introduce PrEP** (prioritized in settings (geographic locations) with high HIV incidence for women with individual risk factors (that is, younger age, history of STIs, more than one sexual partner). In high HIV burden settings women who request PrEP will have identified their risk and should be provided with PrEP and supported to take it. In all settings PrEP should be offered to HIV-negative women in sero-discordant relationships whose partners are not virally suppressed on ART. Ideally, PrEP should be fully integrated into contraceptive services. Pending that, an important first step is discussing PrEP with eligible clients and providing linkage to local PrEP services. STI prevention messages need to be integrated into counselling on PrEP.
 3. **Training, mentoring and support** for healthcare workers in contraceptive services on providing the above-mentioned HIV services. Leadership and training are needed to understand and address healthcare workers' barriers to providing inclusive and non-judgmental services for adolescent girls, young women and people from key populations. Training needs to cover communicating empathically and effectively with diverse clients and particularly how best to raise the issue of HIV and STI risk with clients who come for contraception.
 4. **Strengthen community outreach** that provides information about the benefits of services for HIV, STIs and contraception and generates demand for these services and for condoms, promotes and distributes condoms and lubricants, overcomes barriers to access

and follows up clinically provided services such as PrEP with women and men.

5. **Efficiently manage provider workload** in innovative ways while increasing diagnosis of HIV and other STIs. For HIV this could be through self-testing or use of lay counsellors, peer outreach and support workers. For STI testing etiological diagnosis using point-of-care or near-care testing platforms could be considered.
6. **Ensure the availability of male and female condoms** as well as lubricants in all services where women access contraception.

Complementary actions building on existing guidance include the five pillars of **primary prevention** (12),³ scaling up **multiple modern contraceptive choices** and **providing a range of other SRH and other health services**.

Prioritization by HIV prevalence

Table 1 provides a detailed typology for prioritization in line with the prevalence of HIV among women in different settings. It describes a differentiated approach, according to national or regional HIV and STI epidemiology, for the routine offer of HIV and STI services along with contraceptive services and also considers when individual factors should prompt a focused offer to women who may need HIV and STI services. The area of the table in the red line is the focus of immediate action. In all scenarios the first step is consulting women, including young women, women from key populations and women living with HIV, on the choices they want and how they would like to access SRH and HIV services, in particular contraceptive and HIV prevention services.

As Table 1 shows, the most urgent need for better HIV prevention in contraceptive service delivery is in the areas with highest HIV incidence – large parts of South Africa, Eswatini, Lesotho, Botswana, southern Zimbabwe and southern Mozambique plus specific sites in Zambia, Namibia, southern Malawi and Kenya. In these settings provision of HIV services within contraceptive services requires urgent attention and should be prioritized for immediate action within longer-term HIV/SRH integration processes.

In high burden settings, integration of HIV services into contraceptive services requires urgent attention and top priority.

³ The five pillars of primary prevention are: (1) combination prevention for adolescent girls and young women; (2) combination prevention with key populations; (3) comprehensive condom programmes; (4) VMMC and SRH services for men and boys; and (5) rapid introduction of PrEP.

Table 1. Suggested approaches to integrating HIV into contraceptive services, by HIV prevalence

		HIV prevalence among adult women*			
		Low (<1%)	Medium (1–5%)	High (5–20%)	Extremely high (>20%)
General approach to integrating HIV services into contraceptive services		Likely only a few changes needed; key population focus Mix of referral & on-site integration	Part of SRH–HIV programme development Mix of referral & on-site integration	Rapid action (change operating procedures) On-site integration where possible	Immediate action (executive orders, change operating procedures) Immediate on-site integration
Offer as part of contraceptive service delivery	Male and female condoms and lubricant	YES	YES	YES	YES
	HIV risk assessment	YES Focused offer	YES Routine offer	YES Routine offer	YES Routine offer
	STI risk assessment	YES Focused offer (routine offer if high STI prevalence)	YES Focused offer (routine offer if high STI prevalence)	YES Routine offer	YES Routine offer
	Condom promotion & skills building	YES Focused offer	YES Routine offer	YES Routine offer	YES Routine offer
	HIV prevention & risk reduction counselling	YES Focused offer	YES Routine offer	YES Routine offer	YES Routine offer
	HIV testing services (including self-test) + ART	YES Focused offer	YES Focused offer	YES Routine offer	YES Routine offer
	STI diagnosis & treatment of asymptomatic women (including partner STI services)	Focus on key populations	Focus on key populations	YES Focused offer (routine offer if high STI prevalence)	YES Routine offer
	STI diagnosis & treatment of symptomatic women (including partner STI services)	YES	YES	YES	YES
	Partner HIV testing (for example, invitation letter + self-test) + ART	Referrals for partners of HIV-positive women	Referrals for partners of HIV-positive women	YES Routine offer	YES Routine offer
	Community outreach for HIV prevention for women using contraception and their partners	Focus on key populations	Focus on key populations	YES Focused outreach	YES Expanded outreach
	Pre-exposure prophylaxis	NO (but referrals for women at higher risk)	NO (but referrals for women at higher risk)	YES Focused offer	YES Routine offer
Prioritize complementary services and focus by population/location and scale up	Primary HIV prevention (the five pillars of prevention)	Key populations (full package**)	Key populations (full package**), condoms	Young women & male partners, key populations, condoms, VMMC, PrEP	Young women & male partners, key populations, condoms, VMMC, PrEP
	Expand contraceptive choices for women, including young women and women from key populations	Range of short-term and long-term contraceptive methods, counselling on advantages and disadvantages of different methods to support informed choices			
	Other health services	HIV/STI testing and treatment, full package of SRH – including adolescent/youth-friendly services, mental health, gender-based violence prevention and support, comprehensive sexuality education, women's empowerment.			

Focused offer: service available and known to women; active offer made to women from key populations or with an HIV-positive partner

Routine offer: service offered to all women and provided with informed choice and consent

*Examples of areas by HIV prevalence

Low prevalence (<1%): most of Asia–Pacific, the Americas, Europe, Middle East and North Africa, parts of West Africa

Medium prevalence (1–5%): other parts of East, Central and West Africa, a very few small locations in the Caribbean, Asia, Eastern Europe

High prevalence (5–20%): parts of Kenya, Malawi, Mozambique, Namibia, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe, few other locations in Africa

Extremely high prevalence (>20%): Botswana, Eswatini, Lesotho, several parts of South Africa, southern Mozambique, northern Namibia, southern Zimbabwe

**Essential health-sector interventions in the full package of services for key populations consist of:

1. HIV prevention
2. Harm reductions interventions for substance use
3. HIV testing and counselling
4. HIV treatment and care
5. Prevention and management of coinfections and comorbidities
6. Sexual and reproductive health.

Beyond the health sector: strengthened community responses

In settings with high HIV incidence, there is also need for a broader, multisectoral approach to preventing HIV among adolescent girls, young women and their male partners. As outlined in UNAIDS guidance (13), this approach requires a combination of **health sector, education sector and community platforms** reaching women and their male partners with services and communication on contraception and HIV and STI prevention, including approaches to HIV prevention and SRH that address gender norms. Community action involving local leadership also can help to transform social and gender norms affecting HIV and SRH service uptake. Community outreach workers, involving women reaching their peers, can play an important role in empowering women to make informed choices and in increasing demand for, uptake of and retention in HIV and SRH services. Community outreach workers also can support couple-centred approaches and male partner services.

Improving access for key populations, other vulnerable women, unmarried women and adolescents where HIV prevalence is low or medium

In settings with low or medium levels of HIV incidence, HIV prevention choices within contraceptive services remain critical for women at higher risk of HIV. Key population programmes that address SRH, including offering contraception, and HIV and STI services for sex workers and women who use drugs are critical globally, even where HIV prevalence in the general population is low. Equally important, contraceptive services need to be inclusive and acceptable to women from key populations. Health service providers require training and support to provide non-judgmental contraceptive services for young women and for women who sell sex or use drugs. STI prevention, treatment and case management services need to be scaled up and adequately resourced in all settings

3. Barriers: how to change underlying norms and practices in contraceptive, STI and HIV service delivery

In improving HIV and SRHR outcomes for women and men, there are underlying barriers to be addressed, going beyond consultation with intended beneficiaries, planning and implementation. Country contexts vary, but there may be administrative **divisions, biases, practices, policy implementation gaps, discrimination and stigma** in many settings that remain barriers to effective integration of HIV prevention into SRH services. Addressing these requires a bold approach that creates new partnerships.

Actions to address such barriers need to be specific and direct. They may include the following:

- Strengthen country and community leadership via partnerships, advocacy and engagement at the highest level in ministries of health to ensure HIV and SRHR collaboration.
- Design programmes explicitly to comprehensively address women's SRHR needs.
- Shift to more youth-friendly health systems; identify, support and enable sensitive and non-judgmental healthcare providers who are motivated to serve adolescent girls and all women and provide them training and mentoring.
- Develop the capacity of healthcare providers to discuss HIV, STIs and sexuality, including diverse sexual orientations, gender identity and expression, relationships, gender-based violence and other complex sexual health issues — alongside contraception.
- Ensure that staffing profiles reinforce integration, and address staff concerns (for example, that time spent counselling or providing services for HIV or STIs may distract from providing contraceptive services, or that addressing HIV may be a barrier for women seeking contraceptive services).
- Introduce and integrate STI diagnoses and treatments that go beyond syndromic approaches.
- Consider partner-care treatment options and partner services to prevent reinfection between partners.

In countries where HIV, STI and SRHR responses are co-financed by international partners, these changes will require the involvement of external partners and relevant working groups. While strengthened HIV and STI prevention in contraceptive services should, ideally, be part of broader HIV and SRHR integration, prioritizing mutually agreed and feasible key steps may be needed initially in many contexts.

Conclusion: a dynamic transformation required

Improving HIV, STI and SRHR outcomes for women requires a dynamic transformation that makes services more responsive to community needs. Women need more contraceptive choices and improved integration of effective HIV and STI testing, prevention and care options into contraceptive services as well as strengthened community-level HIV and SRHR prevention outreach for women and men. To achieve this, countries need to:

1. analyse and expand women's contraceptive choices in the context of SRHR needs and vulnerability to HIV
2. implement HIV and STI testing and combination prevention services as part of contraceptive services
3. address underlying logistics and systemic barriers, including provider attitudes, norms and incentives.

Successful HIV and contraceptive service integration will require close collaboration with and among the leadership in departments within ministries of health responsible for HIV and contraception. Understanding and addressing anxieties of contraception providers about additional workload, new needs for expertise, logistic issues and additional financial and human resources will be needed.

Women at high risk of HIV, including young women in sub-Saharan Africa and women from key populations, have called for decisive action. Their call requires urgent response to improve HIV, STI and contraceptive services and choices for women.

Annex 1. WHO updated recommendations for contraceptive eligibility for women at high risk of HIV <https://www.who.int/reproductivehealth/contraceptive-eligibility-women-at-high-risk-of-HIV/en/>

Table A1. Contraceptive eligibility recommendations for women at high risk of HIV

Contraceptive method	Recommendation*	Clarification/evidence
Combined oral contraceptives (COCs)	<i>No restrictions</i>	Low-to-moderate quality evidence from 11 observational studies suggests no association between COC use (it was assumed that studies that did not specify oral contraceptive type examined mostly, if not exclusively, COC use) and HIV acquisition. No studies of P, CVR or CIC were identified.
Combined transdermal patch (P)	<i>No restrictions</i>	
Combined vaginal ring (CVR)	<i>No restrictions</i>	
Combined injectable contraceptives (CIC)	<i>No restrictions</i>	
Progestogen-only pills	<i>No restrictions</i>	High-quality evidence from one randomized clinical trial observed no statistically significant differences in HIV acquisition between: DMPA-IM versus Cu-IUD, DMPA-IM versus LNG implant, and Cu-IUD versus LNG implant. Of the low-to-moderate quality evidence from 14 observational studies, some studies suggested a possible increased risk of HIV with progestogen-only injectable use, which was most likely due to unmeasured confounding. Low-quality evidence from 3 observational studies did not suggest an increased HIV risk for implant users. No studies of sufficient quality were identified for progestin-only pills (POPs).
Progestogen-only injectables (DMPA [intramuscular and sub-cutaneous]/NET-EN)	<i>No restrictions</i>	
Progestogen-only implants (LNG or ETG)	<i>No restrictions</i>	
Copper-bearing intrauterine device (Cu-IUD)	<i>No restrictions</i>	CLARIFICATION: Many women at a high risk of HIV are also at risk of other STIs. For these women, refer to the recommendation in the <i>Medical eligibility criteria for contraceptive use</i> on women at an increased risk of STIs**, and the Selected practice recommendations for contraceptive use on STI screening before IUD insertion***. High-quality evidence from one randomized clinical trial, along with low-quality evidence from two observational studies, suggested no increased risk of HIV acquisition with LNG-IUD.
LNG-releasing intrauterine device (LNG-IUD)	<i>No restrictions</i>	

*WHO acknowledges that, for an individual woman at high risk of HIV, any change in risk may be important. (5).

**Many women with increased risk of STIs can generally undergo either Cu-IUD or LNG-IUD initiation (MEC Category 2). Some women at increased risk of STIs generally should not have an IUD inserted until appropriate testing and treatment occur (MEC Category 3). Risk of STIs varies by individual behaviour and local STI prevalence.

***Women at increased risk of STIs can generally continue use of either Cu-IUD or LNG-IUD (MEC Category 2).

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POLICY BRIEF

PREVENTING HIV AND OTHER SEXUALLY
TRANSMITTED INFECTIONS AMONG WOMEN
AND GIRLS USING CONTRACEPTIVE SERVICES