POLICY BRIEF

ACTIONS FOR IMPROVED CLINICAL AND PREVENTION SERVICES AND CHOICES

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

JUNE 2020

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Actions for improved clinical and 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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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 supressed on antiretroviral treatment (ART). In contrast, women everywhere who have a partner living with HIV who is not virally supressed 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.