From effectiveness to impact: contraception as an HIV prevention intervention

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From effectiveness to impact: contraception as an HIV prevention intervention

R Wilcher, T Petruney, H W Reynolds, W Cates

ABSTRACT

Background: Most efforts to date to prevent mother-to-child transmission of HIV have focused on provision of antiretroviral prophylaxis to HIV-infected pregnant women. Increasing voluntary contraceptive use has been an underused approach, despite clear evidence that preventing pregnancies in HIV-infected women who do not wish to become pregnant is an effective strategy for reducing HIV-positive births. This paper reviews international, country and service delivery level opportunities for and obstacles to translating contraceptive efficacy into interventions that will have an impact on the effectiveness of HIV prevention.

Methods: The integration of family planning services and HIV programmes as a potential intervention were specifically reviewed.

Results and conclusions: Despite substantial policy support for the integration of family planning and HIV programmes, burgeoning resources for HIV ignore the potential impact of contraception on HIV prevention. Moreover, separate funding for these two programmes and the resulting vertical organisation of health ministries and service facilities undermine coordination between departments and limit providers’ ability to address the contraceptive needs of HIV-positive clients. Projects integrating family planning and HIV services are being implemented, allowing for documentation of factors that facilitate or impede integrated service delivery. However, few have been evaluated to demonstrate impact on contraceptive uptake and HIV-positive births averted.

With women of childbearing age accounting for nearly half of those infected with HIV, contraception to prevent unintended pregnancies in HIV-infected women can have a major impact on reducing HIV-positive births and, by extension, the number of AIDS orphans. Contraception in the form of correct and consistent condom use can also prevent the sexual transmission of HIV, thereby contributing to the prevention of HIV in both infants and the general population. Indeed, primary prevention of HIV in women and prevention of unintended pregnancies in HIV-positive women are two of the four cornerstones of the strategy recommended by the World Health Organization and its United Nations partners for preventing mother-to-child transmission of HIV (PMTCT) (fig 1). However, to date, the majority of resources and attention for PMTCT have been directed towards identifying HIV-infected pregnant women and providing them with antiretroviral prophylaxis. Increasing voluntary contraceptive use has been an underused intervention, despite clear evidence that it can make a substantial contribution to HIV prevention efforts. This paper focuses specifically on the prevention of unintended pregnancies in HIV-infected women who do not wish to become pregnant as an effective strategy for reducing mother-to-child transmission of HIV.

Current levels of contraceptive use in sub-Saharan Africa may already be preventing 22% (or 175 000) of HIV-positive births annually, despite the fact that contraception is not widely available in sub-Saharan Africa. Increasing contraceptive use to prevent unintended pregnancies could enhance the contribution of contraception to HIV prevention efforts. If all women in the region who did not wish to get pregnant accessed contraceptive services, as many as an additional 160 000 HIV-positive births could be averted every year. A similar analysis of the potential effect of increasing contraceptive use has been done for each of the focus countries for the President’s Emergency Plan for AIDS Relief (PEPFAR), also producing impressive results (table 1). For example, using estimates of the percentage of unintended births among women in the general population and the annual number of births to HIV-infected women, researchers estimated that nearly 29 700 unintended births still occur to HIV-positive women in Zambia (40% of all births), resulting in 8900 unintended HIV-positive births annually. Another analysis showed that moderate decreases in the number of pregnancies to HIV-infected women—ranging from 6% to 35% depending on the country—could result in numbers of averted HIV-positive births equivalent to those averted by antiretroviral drugs.

Contraception is also a cost-effective HIV prevention intervention. One model demonstrated that, for the same level of expenditure, increasing contraceptive use among non-users who do not want to get pregnant through traditional family planning services and outreach averts almost 50% more HIV-positive births than HIV counselling and testing coupled with nevirapine prophylaxis. Another study found that, by adding family planning to PMTCT services, the cost of each HIV infection averted would be an estimated $660 compared with $1300 per infection averted with treatment alone.

The lack of attention to contraception as an effective HIV prevention strategy is particularly disconcerting given that the evidence of contraceptive efficacy is juxtaposed by high levels of unintended pregnancies among HIV-positive women. Unintended pregnancies account for 14–58% of all births in countries where the burden of HIV is the greatest. Growing evidence suggests that rates of unintended pregnancy are even higher...
Figure 1 Four-phase strategy for perinatal HIV prevention.

Among HIV-infected women there is an efficacious HIV prevention intervention, why is more not done to increase access to contraceptive services among HIV-positive women? One approach is to strengthen traditional family planning programmes and increase access to contraception among all women. Reducing unintended pregnancies in the general population can make a major contribution to averting vertical transmission of HIV. Traditional family planning programmes are also well positioned to promote barrier contraceptive use—either alone or with another contraceptive method—for dual protection against unintended pregnancy and primary HIV infection, thereby reducing the risk of sexual transmission as well as vertical transmission. However, another more targeted approach that has received increasing attention in recent years is to integrate family planning services into HIV programmes such as counselling and testing, PMTCT, care and treatment, and home-based care services, and vice versa. While some advances have been made in establishing family planning/HIV service integration as a crucial strategy for addressing the family planning needs of HIV-infected women, a number of challenges must be addressed to translate individual-level contraceptive efficacy into effective, scaleable population-level interventions.

In this paper we review support for and obstacles to meeting the contraceptive needs of HIV-infected women and couples at the international, country and service delivery levels. At the international level we examine the policy environment and funding trends for family planning and HIV programmes in recent years and discuss the implications for efforts to integrate the two programmes. At the national level we explore policy support and funding trends as well, but emphasise structures within ministries of health that pose obstacles to advancing access to contraceptive services. Finally, at the service delivery level we review the current efforts to integrate family planning and HIV services and discuss the challenges to scaling up these efforts.

INTERNATIONAL LEVEL

Internationally, policy support for family planning, and particularly for the integration of family planning and HIV services, is substantial. Enabling women to prevent unintended pregnancies is consistent with the right of all women “to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights”. Moreover, linking reproductive health and HIV services is increasingly acknowledged as an essential strategy for meeting international development goals and targets, including the UN Millennium Development Goals. In summary, over the past 3 years, six major international agencies have issued strong statements calling for closer integration of sexual health, reproductive rights and HIV/AIDS services (table 2).

Despite the growth of international policy support for stronger linkages between reproductive health and HIV/AIDS efforts, global funding trends do not reflect this support and represent a key obstacle to the wide-scale implementation of contraception as an HIV prevention strategy. Between 1995 and 2004, funding for international family planning fell from more than half of all spending on population assistance to less than 10%. Funding for family planning from the United States Agency for International Development (USAID) in particular fell from $541.6 million in 1995 to $458.1 million in 2006.

Table 1 Estimated number of unintended HIV-positive births per year in PEPFAR countries in the absence of antiretroviral prophylaxis

<table>
<thead>
<tr>
<th>PEPFAR country*</th>
<th>Percentage of unintended births of women in the general population (A)</th>
<th>Annual no of births to HIV+ women (B)</th>
<th>No of unintended births to HIV+ women (A × B)</th>
<th>No of unintended HIV+ births (A × B &gt; 0.3)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>58.4</td>
<td>11370</td>
<td>6640</td>
<td>1992</td>
</tr>
<tr>
<td>Mozambique</td>
<td>19.7</td>
<td>95482</td>
<td>18810</td>
<td>5643</td>
</tr>
<tr>
<td>Namibia</td>
<td>33.7</td>
<td>9316</td>
<td>3139</td>
<td>942</td>
</tr>
<tr>
<td>South Africa</td>
<td>52.8</td>
<td>222415</td>
<td>117435</td>
<td>35231</td>
</tr>
<tr>
<td>Zambia</td>
<td>40.3</td>
<td>73688</td>
<td>29688</td>
<td>8006</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>34.9</td>
<td>65585</td>
<td>22889</td>
<td>6867</td>
</tr>
<tr>
<td>Kenya</td>
<td>44.5</td>
<td>77799</td>
<td>34621</td>
<td>10336</td>
</tr>
<tr>
<td>Rwanda</td>
<td>39.8</td>
<td>14107</td>
<td>5615</td>
<td>1684</td>
</tr>
<tr>
<td>Tanzania</td>
<td>23.5</td>
<td>99775</td>
<td>23447</td>
<td>703</td>
</tr>
<tr>
<td>Uganda</td>
<td>45.8</td>
<td>79950</td>
<td>36617</td>
<td>10985</td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>28.7</td>
<td>30412</td>
<td>8728</td>
<td>2618</td>
</tr>
<tr>
<td>Nigeria</td>
<td>14.5</td>
<td>187544</td>
<td>27194</td>
<td>8158</td>
</tr>
<tr>
<td>Haiti</td>
<td>47.4</td>
<td>4946</td>
<td>2344</td>
<td>703</td>
</tr>
<tr>
<td>Vietnam</td>
<td>22.9</td>
<td>3796</td>
<td>869</td>
<td>261</td>
</tr>
</tbody>
</table>

PEPFAR, President’s Emergency Plan for AIDS Relief.

Table adapted from Reynolds et al.1

*Guyana is excluded due to lack of data.

130% vertical HIV transmission rate in the absence of antiretroviral prophylaxis from DeCock et al.21
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Supplement

Table 2 International statements on family planning/HIV integration

<table>
<thead>
<tr>
<th>Year</th>
<th>Group</th>
<th>Report/policy</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>WHO/UNFPA</td>
<td>Glion consultation on strengthening the linkages between reproductive health and HIV/AIDS</td>
<td>Includes recommendations for integration policy and advocacy, programme development, resource mobilisation and monitoring and evaluation research.</td>
</tr>
<tr>
<td>2004</td>
<td>UNFPA/UNAIDS/Family Care International</td>
<td>New York call to commitment: linking HIV/AIDS and sexual and reproductive health</td>
<td>Calls for an urgent effort to strengthen links between corresponding sexual and reproductive health and HIV policies, programmes and services.</td>
</tr>
<tr>
<td>2006</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
<td>Declaration of commitment to HIV/AIDS</td>
<td>Recommends strengthening policy and programming linkages between sexual and reproductive health and HIV/AIDS.</td>
</tr>
<tr>
<td>2006</td>
<td>African Union</td>
<td>Universal access to comprehensive sexual and reproductive health services in Africa</td>
<td>Recommends integration of HIV/AIDS services into sexual and reproductive health services.</td>
</tr>
<tr>
<td>2007</td>
<td>Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children</td>
<td>Guidance for global scale up of the prevention of mother-to-child transmission of HIV</td>
<td>States that linkages between PMTCT and sexual and reproductive health services are a key strategic approach to realising comprehensive PMTCT services.</td>
</tr>
</tbody>
</table>

PMTCT, prevention of mother-to-child transmission of HIV.

Additionally, a severe funding shortfall currently exists (known as a deficit in “contraceptive security”) for the provision of reproductive health supplies at a global level, including contraceptives and condoms. The United Nations Fund for Population Activities (UNFPA) estimates that the gap between the need for essential condom and contraceptive supplies and the funds allocated for purchasing them is projected to reach hundreds of millions of dollars annually by 2015.22

At the same time that traditional family planning programmes are losing ground globally, resources for HIV priorities are rapidly increasing (fig 2). In 2008, $3.6 billion was requested in HIV funds for the 15 PEPFAR focus countries compared with $67.5 million requested for family planning/reproductive health.23 This represents a 225% increase for HIV programmes over the 2006 allocated level and an 11% decrease for family planning/reproductive health. Unfortunately, these HIV resources ignore the potential impact of contraception on HIV prevention. Not only do major HIV funding initiatives prioritise treatment (50% of PEPFAR funds in 2006 were allocated to treatment compared with 22% for prevention), but even PMTCT programmes—which accounted for only 5% of PEPFAR prevention funding in 2006—focus almost exclusively on antiretroviral prophylaxis.24 Neither PEPFAR nor the Global Fund to Fight AIDS, Tuberculosis, and Malaria include contraceptive use as an indicator of programmatic success. In addition, resources from major HIV donors for evaluating family planning/HIV integration approaches have been insufficient to build an evidence base and identify best practices. Indeed, a key recommendation from the Institute of Medicine’s 2007 evaluation of the implementation of PEPFAR was for the programme to increase its contribution to the evidence base for HIV/AIDS interventions by providing more support for operations research and programme evaluation.25

Fortunately, some opportunities for addressing the contraceptive needs of HIV-infected women are beginning to emerge through these donors. For example, as a result of NGO advocacy efforts with the Global Fund and the country coordinating mechanisms that submit Global Fund proposals, a number of Round 7 HIV/AIDS proposals included sexual and reproductive health components and some were funded.26 In addition, PEPFAR’s Prevention with Positives initiative includes counseling on voluntary family planning and referring those who do not desire to become pregnant for contraceptive planning as a priority area.27 PEPFAR funds may not be used to purchase contraceptives other than condoms, but the funding initiative encourages linkages with “wrap-around” programmes such as those which support reproductive health infrastructures.

The vertical orientation of reproductive health and HIV/AIDS funding mechanisms reinforces the separation of these interventions.28 29 Within donor institutions, reproductive health and HIV/AIDS programmes occupy distinct domains with different programme managers and separate budgets. Global donors need to harmonise their efforts, improve the coordination between reproductive health and HIV/AIDS funding mechanisms, and mobilise resources in support of integrated efforts.

COUNTRY LEVEL

At the country level, policy support for family planning/HIV integration is not as robust as at the international level, but promising trends are emerging. A 2004 analysis of family planning content in the HIV, Voluntary Counselling and Testing (VCT) and PMTCT policies of 16 developing countries revealed that, of the national HIV/AIDS policies reviewed, slightly more than half included at least some mention of family planning.29 Six of nine national VCT policies and all five national PMTCT guidelines referred to family planning directly, although they exhibited variation in the extent to which they emphasised the role of family planning in these programmes. All policies and guidelines were limited by their lack of operational guidance on how to integrate family planning and HIV services. However, Kenya’s Ministry of Health has taken the implementation of its VCT policy a step further by creating the national document, “Strategy for the Integration of Family Planning and
HIV Voluntary Counseling and Services. This strategy provides detailed guidance on establishing integrated family planning/VCT services, including defining different levels of integration depending on facility resources.

Unlike international funding trends, several countries show evidence of progress towards stronger linkages between family planning and HIV prevention efforts in their funding trends. Specifically, recent USAID-funded health programmes in some countries such as Nigeria, Kenya and Zimbabwe have combined family planning and HIV funding into a single programme. The Global HIV/AIDS Initiative in Nigeria (GCHAIN), the AIDS, Population and Health Integrated Assistance II program in Kenya (APHIA II) and the Zimbabwe HIV and AIDS Partnership Project all acknowledge the importance of family planning to HIV prevention efforts and have strong integration components. HIV funds comprise the vast majority of the resources for these programmes and primarily support HIV service delivery, and the family planning funds largely support the integration of reproductive health services with the HIV services. While this funding approach reflects a model where reproductive health integration efforts are still the domain of family planning, it represents an important attempt at resource coordination between two programmatic areas with established synergies.

Despite emerging policy and funding support for family planning/HIV integration in many countries, any major progress in addressing the contraceptive needs of HIV-infected women remains hampered by country-level bureaucratic obstacles. The separate international funding streams for family planning and HIV programmes typically result in parallel reproductive health and HIV/AIDS departments within ministries of health. These, in turn, result in uncoordinated and potentially conflicting policies, strategies and training programmes originating from separate governmental bodies. Some countries have taken steps to enhance coordination between their reproductive health and HIV/AIDS departments by forming country-level technical task forces on integration. In Kenya, for example, a Ministry of Health-led task force which is co-chaired by representatives from the Division of Reproductive Health and the National AIDS and STI Control Program has been key to advancing family planning/HIV integration efforts throughout the country. However, such coordinating mechanisms are only beginning to take shape in most countries.

**SERVICE DELIVERY LEVEL**

Due to funding mechanisms and the structural organisation of ministries of health, family planning and HIV services have historically operated through distinct vertical systems. However, the rapid expansion of HIV prevention, care and treatment services in recent years provides an important opportunity to reach clients of these services, many of whom may not typically have access to vertical family planning services with contraceptive counselling, referrals and/or methods. Preliminary research found that integrating family planning into HIV services, particularly VCT and PMTCT services, is acceptable to both providers and clients. Moreover, an evaluation of a family planning/VCT integration intervention found that the addition of family planning services did not appear to affect the quality of the base VCT service negatively, although the intervention was acknowledged to be weak. Similarly, an evaluation of the reverse approach to integration found that incorporating HIV prevention information and routinely offering provider-initiated VCT in family planning settings is feasible. Not only were HIV services acceptable to providers and clients, but also they did not negatively affect the quality of the existing family planning services.

Further evidence of the benefit of ensuring that HIV-positive women have easy access to contraceptive services at the time they learn their HIV test results was documented in Lilongwe, Malawi. Women who were HIV-positive and not pregnant were followed for 1 year while receiving HIV care and access to family planning services. In this prospective assessment their desire for pregnancy declined significantly with knowledge of their HIV status. Likewise, contraceptive use increased from 38% before HIV testing to 52% 1 week later. The promise that integration holds as an approach to increasing access to health services has led donors, ministries of health and implementing agencies to pursue various family planning/HIV integration interventions.

Nevertheless, perhaps the biggest obstacle to meeting the contraceptive needs of HIV-infected women through family planning/HIV integration is the lack of evidence of effective integrated service delivery approaches. For example, family planning services can be integrated at several delivery points: HIV counselling and testing, PMTCT, and care and treatment services. In addition, HIV prevention and care services can be mainstreamed into the existing family planning infrastructure. Each approach offers its own set of potential benefits and challenges (table 3). Various strategies for achieving integrated services within these models have been implemented, but few have been rigorously evaluated to demonstrate their impact on contraceptive use and continuation. Some integration strategies may focus on group contraceptive counselling and ensuring that client referrals for family planning services are provided from the HIV service site, while other strategies may offer individual counselling and actual provision of a range of methods within the HIV service setting. In both scenarios we lack evidence of the effectiveness of these approaches.

In one of the few evaluations completed, a family planning/VCT integration intervention in Kenya was found to have improved providers’ discussions about fertility desires and contraceptive methods with clients; however, the improvements were not statistically significant and the intervention did not result in uptake of effective contraception, despite almost one-third of clients being at risk of unintended pregnancy. Similarly, in Zambia contraceptive uptake increased after introducing an intensive family planning/VCT integration intervention but no effect on pregnancy rates occurred, in large part due to contraceptive discontinuation. An evaluation of a family planning/antiretroviral therapy integration intervention in Ghana found that the intervention did not result in provision of family planning counselling or methods to clients receiving antiretroviral treatment.

The International Planned Parenthood Federation and other family planning groups are working to mainstream HIV/AIDS services into their existing sexual and reproductive health clinics, but data on the impact of these integration efforts are also scarce. However, a comprehensive review of efforts to integrate sexually transmitted infection prevention activities into maternal/child health and family planning services found that, in some cases, the integrated services resulted in new contraceptive acceptors.

We also lack data to guide when it is most appropriate to introduce messages about family planning during HIV services and how to deliver messages about contraceptive use in the context of also advising condom use to reduce HIV transmission. For example, guidance to clients about whether to use condoms alone or in combination with another contraceptive
method may need to vary depending on the individual’s risk factors for both unintended pregnancy and HIV infection. In addi-
tion, no consensus exists regarding what technical inputs are required to achieve certain levels of integration. Family planning/HIV integration efforts may include a range of activities such as advocacy with managers and policymakers, training of providers, supportive supervision, changes to client intake and reporting forms, revisions to service delivery guidelines and creation of referral mechanisms, among others. The relative importance of each of these activities to achieve a policy and practice “tipping point” is not known.

Finally, cultivating skilled and supportive providers represents a critical service delivery challenge that must be addressed. Meeting the contraceptive needs of HIV-infected and at-risk women requires providers who are adequately trained to seek out and understand client desires and facilitate their right to make reproductive choices for themselves. However, emerging research suggests that many providers lack updated knowledge of safe and effective contraceptive options for women with HIV, and that personal feelings about whether HIV-infected women should become pregnant may affect providers’ willingness and ability to provide informed choice counselling. Stronger more explicit support for family planning by major HIV funders and decision makers is essential if contraception is to take its rightful place among HIV prevention interventions. Use of effective contraception by HIV-infected women to prevent unintended pregnancies will directly and positively impact HIV prevention goals. Thus, just like use of antiretroviral treatment for pregnant infected women, integration of family planning services into HIV programmes should also be embraced by HIV funders and not assumed to be the domain of programmes with reproductive health resources. The inequities in HIV and family planning funding and the pressures on implementers to meet prevention targets demand that HIV donors be more proactive in defining a role for family planning within their programmes. Some signs of progress are beginning to emerge. Many proposals to the Global Fund for Round 7 included sexual and reproductive health components, and PEPFAR offers opportunities to address contraceptive needs through linkages with “wrap-around” programmes. However, more can be done. These programmes should not only include contraceptive uptake and continuation as indicators of programmatic success, but also invest in research to identify what integrated service delivery approaches are most effective at decreasing unintended pregnancies among women with HIV who want to limit or space pregnancies.

Regardless of the funding source, more evidence of effective integrated service delivery strategies is crucial to position contraception as an HIV prevention intervention. While the policy support that exists for stronger linkages between family planning and HIV programmes is important, implementation of these policies will continue to be limited without evidence-based guidance on how to establish and scale-up those linkages. We need to define a package of essential family planning services to integrate into HIV programmes and identify the technical activities necessary to achieve and sustain that integrated package. At the same time, we should not assume that a “one size fits all” approach to integration exists. The

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**Table 3** Potential benefits and challenges of different models of family planning/HIV service integration

<table>
<thead>
<tr>
<th>Type of integration model</th>
<th>Potential benefits</th>
<th>Potential challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning into HIV counselling and testing</td>
<td>Reaches the largest number of clients of any HIV service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaches both HIV+ and HIV− clients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reaches men, youth and unmarried women who may not use traditional family planning programmes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunity for all clients to avoid initial or subsequent unintended pregnancy</td>
<td>VCT typically provides only a one-time contact with client</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV+ clients may not be ready to absorb family planning messages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires referral systems, which are often weak, for initial supply, resupply and follow-up for complications and side effects</td>
</tr>
<tr>
<td>Family planning into PMTCT</td>
<td>Reaches clients of reproductive age with high probability of future pregnancy and with known HIV+ status</td>
<td>Most PMTCT clients are reached during antenatal care, a time when family planning messages may not resonate with clients</td>
</tr>
<tr>
<td>Family planning into care and treatment</td>
<td>Reaches only HIV+ clients, thereby maximising opportunities to prevent HIV+ births</td>
<td>Unmet need may be lower because clients may be older, ill, and/or not sexually active compared with clients in other HIV services</td>
</tr>
<tr>
<td></td>
<td>Repeat visits allow for repeated messages, resupply, follow-up for complications/side effects and to meet changing fertility desires</td>
<td></td>
</tr>
<tr>
<td>HIV services into family planning</td>
<td>May create new contraceptive users if the availability of the HIV services attracts clients who do not typically access family planning services</td>
<td>May not reach those at high risk of HIV infection</td>
</tr>
<tr>
<td></td>
<td>May increase uptake of HIV services among family planning clients, particularly VCT services, thereby allowing providers to tailor contraceptive counselling based on client’s HIV status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunity for HIV prevention counselling among women of reproductive age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The additional financial resources for HIV services may bolster existing family planning staff and facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability of more comprehensive services and support for family planning clients may help improve contraceptive adherence and continuation</td>
<td></td>
</tr>
</tbody>
</table>

PMTCT, prevention of mother-to-child transmission of HIV, VCT, Voluntary Counselling and Testing.
reproductive health and HIV/AIDS departments of ministries of health should work together to determine approaches that are most suitable for their country contexts, considering factors such as the strength of existing family planning programmes, the scale of the HIV epidemic, and the infrastructure for counselling and testing, PMTCT, care and treatment and other HIV services in the country.

Contraception is the best kept secret in HIV prevention. With a greater financial commitment to family planning from HIV donors and stronger political commitment from ministries of health to coordinate efforts to meet the dual reproductive health and HIV prevention and care needs of their citizens, the potential contribution of contraception as an effective HIV prevention intervention can be realised. Such efforts will not only produce concrete gains against the epidemic, but also improve maternal and child health and protect the reproductive rights of women.

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