



# IPPF Medical Bulletin

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## Incorporation of HIV/AIDS interventions into sexual and reproductive health programmes

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At the International Conference on Population and Development, Cairo, in 1994 the control of HIV/AIDS was identified as a central component of the reproductive health agenda. However, the decade since then has seen little integration of programmes – indeed, the gaps have widened. The reasons for this are in part political – notably, the hostility of the current US Administration to the Cairo agenda – and in part practical. Even some people who strongly favour integration in principle believe the strategy to be too unrealistic to be pursued at all; others insist that all obstacles must be swept aside in pursuit of this ideal. On this matter IPPF takes the middle ground, by favouring an approach known as “mainstreaming”.

In this paper I outline some of the major challenges posed by integration and offer recommendations based largely on the experience of the Federation, many of whose 148 member associations have long been addressing HIV/AIDS from a sexual and reproductive health (SRH) perspective. The three key questions are: What does integration actually mean? How should be it pursued? And what should we be doing differently at policy and programme levels?

### What does ‘integration’ mean in 2004 and beyond?

Differences in what is understood by ‘integration’ have resulted in confusion and frustration. At *service* level, integration is sometimes likened to the supermarket method, or “one-stop-shopping”, whereby clients have most of their needs met by a single provider – a unified system. To others, however, it signifies the team approach, in which providers refer clients to separate but linked services as necessary – the segmented system. The distinction is thus between previously separate services knitted together, or a linked system of parallel services.

At the *programme* level integration has been defined as cooperation across institutional and disease-specific or service-specific lines. The aims are to provide oversight of clinical and outreach services in a way that ensures comprehensive coverage without overlap of intervention programmes. In practice, integration again means different things in different types of facility and levels of administration. Furthermore, successful integration will often require external input, from individuals who can take a detached view on the measures required to secure cooperation between the programmes and facilities.

It is at the *policy* level that integration has proved most difficult to achieve – because at this level it often directly threatens institutions and bureaucracies. Improvement of efficiency and effectiveness (the primary purpose of integration) will require the dismantling of strong existing vertical or categorical programmes, removal or transfer of senior individuals, and disruption of lines of authority and control.

On the matter of SRH and HIV/AIDS programmes, several factors contributed to the trend towards separation rather than integration. I have referred to the opposition of the current US Administration, whose funding decisions have resulted in a global retreat from such policies, but there are other reasons for lack of progress.

First, traditional family planning service providers in many countries showed strong reluctance to get involved in HIV/AIDS work. Such was the stigma of HIV/AIDS that some family planning groups were afraid that working on HIV/AIDS would somehow make them disreputable.

Second, and a mirror image of the first point, HIV/AIDS activists, who drove much of the global policy dialogue on HIV/AIDS, were themselves disinclined to work with family planners, preferring to establish in many places free-standing services to address HIV/AIDS care and prevention. Many of these activists were veterans of the early days when HIV transmission was much more widely connected to gay sex and injecting drug use than to heterosexual activity. Therefore, the relevance to SRH programmes (primarily targeted at women) was not so obvious.

Third, the increasing focus on treatment has led to the stronger identification of HIV with other treatable infections such as tuberculosis and malaria, whereas the approach in sexual and reproductive health is essentially preventive. The separation of HIV/AIDS from the rest of SRH was symbolised by the World Health Organization’s action in shifting its HIV/AIDS programmes from the SRH sector to communicable disease control.

In the more than two decades since the debut of HIV/AIDS on the international stage, much has been learnt about the virus – its transmission routes, the prevention options, the care alternatives. As a result, some of the early ideas on integration require revision. The “middle ground” now taken by IPPF seeks to avoid some of the tensions that arise from the factors discussed above, while continuing to argue that HIV, being spread primarily through sexual contact (and with HIV/AIDS increasingly viewed as a chronically managed condition), must be part of the domain of a comprehensive SRH response. In 2004 we favour the term “mainstreaming”. For the SRH community this means each sector determining: (1) how the spread of HIV may be caused or exacerbated by activities within the sector; (2) how the epidemic is likely to affect the goals, objectives and programmes within the sector; and (3) where the sector/organisation has a comparative advantage to respond, to limit the spread of HIV, and mitigate the impact of the epidemic.

### When and how should integration be pursued?

If the complex process of integration is to be effective and long-lasting, it has to take place at several different levels concurrently.

### **Level 1: personal**

All the individuals involved – programme staff, service providers, clients – must feel that they are contributing to the process of change. This sense of “ownership” is a key step towards collective responsibility, as opposed to the traditional culture of separation. A commonly voiced fear is that the linking of family planning with HIV/AIDS prevention and care services (with their associated stigma) will lower the acceptance and use of modern family planning methods by conventional clients. However, in the experience of IPPF, these prejudices can be overcome by training and guidance. In some places, indeed, the integration of HIV and other sexually transmitted infection prevention elements may actually have advanced family planning objectives by lowering rates of infection. Integration thus means investing in people who are already providing services; this is cost-effective and makes good programmatic sense.

### **Level 2: Policy**

From a policy perspective, two avenues need to be more fully explored. The first relates to the broad structural national environment in which integration processes occur, and the other relates directly to the policies that flow from this environment. Without a clear understanding of how the one informs and influences the other, policy reform on integration will remain haphazard at best. In most developing countries, primary health care facilities are used mainly by women and children, and integration has meant adding new activities to these existing services. For the vertical programmes that support these services (family planning, malaria control, HIV/AIDS prevention and treatment), integration has implied collaboration rather than merged responsibility.

Difficulties with integration have in some instances been *worsened* by the activities of external donors. At present there is no consensus about how integration should be accomplished at the country level, and the set policy of a particularly donor can sometimes result in bad practice.

### **Level 3: Programmatic**

There are six key programmatic areas where integration should be attempted.

1. *Integrated prevention* – In this process to develop a “constituency” for prevention, key sectors are invited to identify what was learned from previous preventive efforts and to discuss how the gaps can be filled. HIV prevention has to be addressed not only as a public health intervention but also in terms of behaviour change, and this demands communications techniques that effectively alter health seeking behaviours. This is an area where the reproductive health sector already has vast experience. Indeed, probably no other sphere of public health has a comparable record of promoting changes in behaviour. The “demographic revolution” was the sum total of changed individual attitudes and behaviours regarding childbearing. Many of the techniques that succeeded in changing reproductive behaviour can be employed to change sexual behaviour and thus reduce HIV transmission.

2. *PMTCT* – SRH and HIV/AIDS prevention find a near perfect intersection in PMTCT (prevention of mother to child transmission) programmes. Prenatal and postnatal care are part of the standard package of maternal and child health services, but HIV-positive mothers require priority if we are to see a reduction in numbers of children who lose one or both parents. This PMTCT approach, aimed at preventing vertical transmission of HIV and prolonging the life of the mother means, among other things, ensuring that she has access to effective contraception.

PMTCT Plus programmes (adding treatment and care to the prevention dimension) are now getting underway in many countries, but why has this taken so long? The answer, as so

often, comes down to scarcity of resources and lack of political commitment. Whatever the size and nature of the epidemic there is no sense, in either ethical or practical terms, in confining efforts to child protection; yet many countries still ignore the needs of HIV-positive mothers. Integration of PMTCT Plus initiatives into family planning and maternal and child health programmes would involve (1) giving priority to the sexual health needs of HIV-positive women; (2) offering preventive and therapeutic support and counselling; and (3) creating a supportive environment that promotes disclosure of HIV status.

3. *Vulnerable groups* – How can we ensure that the sexual and reproductive health needs of those most vulnerable to infection are being met? We urgently need new and creative approaches to this dilemma, and these will depend on an understanding of the special features of the epidemic as it plays out across the different regions of the globe. Commonly it is men who drive the epidemic and, together with the low status and powerlessness of women in many countries, this makes for a lethal combination. The challenge is to ensure that service integration is aimed at those who are most at risk of HIV infection. If, for example, we want to protect the female partners of men who have sex with men, we need to find ways of getting through to these men.

Often a client will judge that the local primary care or family planning clinic offers greater privacy and confidentiality (and less risk of stigma) than a dedicated HIV/AIDS facility. Key to ensuring that integration achieves its desired impact are: (1) ensuring the availability of integrated services to those most vulnerable to infection (in countries with low prevalence this will often be marginalised groups not in the traditional client base); (2) empowering women and girls to make choices that are right for them; and (3) involving people living with HIV/AIDS in programmes and policies that affect their lives.

4. *Sexually transmitted infection (STI) prevention and treatment* – If a woman has an STI, this increases her risk of acquiring HIV by sexual transmission, and treatment of the STI will reduce this risk. This is strong reason for enhancement of STI services in many developing countries. The prevention and treatment of STIs, including HIV, should be one of the cornerstones of successful integration. Unfortunately, some large and expensive programmes for integrating STI and SRH services are being undertaken today without clear identification of expectations, without optimal pre-conditions for SRH/STI integration, and with no idea of which are the most effective tasks to integrate and in which settings. Indeed, it appears that the STI integration tasks that are the most difficult to integrate (i.e., STI diagnosis and treatment) have the potential for greater public health benefits than those that are more easily implemented (i.e., education for risk reduction and counselling).

5. *Voluntary counselling and testing (VCT)* – The World Health Organization hopes that 3 million HIV-positive individuals will be on antiretroviral treatment by 2005 – an ambitious aim that will put heavy demands on VCT services that at present cater largely for the “worried well”. IPPF’s experience from many years of offering VCT services yields the following lessons: (1) VCT is more acceptable where it is “camouflaged” (i.e., where the client’s motivations in coming to the facility are not easily identified, as would be the case for HIV-only facilities); (2) VCT cannot be defended on moral or practical grounds unless accompanied by treatment or effective referral for treatment; and (3) VCT services will be destroyed overnight if the community has reason to doubt the confidentiality of the provider-client relationship.

6. *Human rights* – Over recent years the importance of the link between human rights and health has gained increased

attention. This has implications not only for the type of work we do but also, in the context of integration, for the way we do the work. With its experience in successfully moving from “family planning”, the SRH community is well placed to apply these lessons to the challenges of integration – the issues of stigma and discrimination, of community ownership and participation. If we can document a resultant increase in uptake of services and an improvement in health-seeking patterns we shall have made a signal contribution to the global understanding of HIV/AIDS and how to combat it.

## **What should we be doing differently on the policy and programme levels?**

### ***Political commitment***

Successful integration can be achieved only through political commitment to institutional collaboration. Simple expansion of vertical programmes can never be the answer. At a time when the US Administration’s stance is worsening the segregation of SRH from HIV/AIDS programmes, the counter-arguments need to be heard more strongly in the policy and political community. In particular, the Global Fund to Fight AIDS, Tuberculosis and Malaria should also link SRH issues more concretely into its guidelines

### ***A consensus for action by governments and agencies***

A proper answer to the “how?” of integration demands a clear framework for global action. Those who formulated it would need to start by clarifying the terminology and by categorising the different models of integration. A consensus on how, where, and under what conditions integration works best would be help greatly in the efficient use of resources

### ***Expansion of responses along the care continuum***

At a service level, the components required for effective and comprehensive control of HIV/STIs (which are more complex and sensitive than those for other conditions) must be linked existing SRH provision – especially clinical care. Providers too are more likely to be knowledgeable, for

instance, on clinical matters than on HIV testing, condom promotion, or partner notification. One element will be syndromic management of STIs, but an integrated strategy will require reliable STI diagnostic services too.

### ***Expansion of capacity***

Integration needs to occur at several different levels – personal, policy, programmatic – and a comprehensive package of prevention and care demands strong technical support and input. A cost-effective solution, sometimes, is to invest in organisations that already provide comprehensive SRH services.

### ***Monitoring and evaluation of integration initiatives***

The programmatic reasons for HIV integration into SRH programmes are clear, but one of the most important reasons for integrating HIV/AIDS services into SRH is to mitigate the powerful and subtle influences of HIV/AIDS stigma. We know that HIV stigma deters people from ascertaining their HIV status and stops people from seeking treatment and care. We need to realign global programme indicators to include much stronger monitoring and evaluation of stigma. Currently the two UNAIDS indicators on stigma need to be revised and this could be done in the context of efforts to integrate services more effectively.

## **Conclusion**

In most societies HIV is a sexually transmitted infection whose defeat will require a multisectoral strategy. By working more closely with other sectors, without damaging its traditional activities, the SRH community can make a greater contribution to this global fight.

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## **IMAP update on breast and cervical cancer screening**

*At its October 2003 meeting, the International Medical Advisory Panel (IMAP) was asked to review its recommendations on breast and cervical cancer screening in light of new evidence. The advice below was finalised by the Panel after its April 2004 meeting.*

### **Breast cancer screening**

Guidance on the value of breast cancer screening programmes should take into consideration the needs and realities of resource-constrained settings. In these settings, the benefit of putting resources into breast cancer screening programmes should be weighed against the benefits of allocating them to other health services. The risks and benefits of screening will vary from setting to setting. The provision of follow-up services is crucial for effective screening programmes.

### ***Mammography***

The best currently available method for early detection of breast cancer is mammography combined with clinical breast examination. Where resources are available, regular mammography is usually offered to women aged 50–70. The frequency of mammography will depend on age-specific incidence rates and local health policy but is normally every 1–2 years. Current evidence does not show a survival benefit

for mass screening for breast cancer. Evidence on breast cancer mortality is inconclusive.

### ***Clinical breast examination***

When mammography is not available, clinical breast examination may be offered. At present, it is not possible to make evidence-based recommendations on which women should be examined or how often. However, it is prudent to offer clinical breast examination to women over 40 and those under 40 with other risk factors, which are primarily related to family history (eg. breast cancer in a first-degree relative).

### ***Breast self-examination***

Breast self-examination does not decrease mortality and should no longer be recommended as a screening tool. However, women should be “breast aware”; and a woman who finds an abnormality in the course of her regular activities should have it checked by a trained professional.

### **Cervical cancer screening**

### ***Cervical cytology (pap screening)***

Cervical cytology is currently the best available method for the detection of pre-malignant and malignant disease of the cervix. When routine pap screening is available it should start 2–3 years after the onset of sexual activity and be repeated every 1–3 years. When only limited pap screening is available, it should at the very least be offered at around the age of 35 to all women who have ever been sexually active.

### Visual inspection of the cervix

If pap screening is not available, visual inspection of the cervix should be offered. It should start 2–3 years after the onset of sexual activity and be repeated every 1–3 years.

### HPV DNA tests

Certain types of human papillomavirus (HPV) cause cervical

cancer and can be transmitted sexually. Highly specific HPV DNA tests have been developed and may eventually have a role in cervical screening. At present, HPV testing alone is not recommended for primary cervical screening. It may be used as an additional test for women with certain cytological findings, to exclude the need for further investigation or treatment for women at low risk of cervical cancer.

## News

### WHO updates its evidence-based guidance on family planning

The World Health Organization (WHO) has updated two of its key publications that provide evidence-based guidelines on family planning. The first document, *Medical Eligibility Criteria for Contraceptive Use*, provides guidance on who can use contraceptive methods safely. The second, *Selected Practice Recommendations for Contraceptive Use*, provides guidance on how to use contraceptive methods safely and effectively once they are deemed medically appropriate. Their broad aim is to help national family planning/reproductive health programmes in preparing guidelines for service delivery of contraceptives.

#### Medical Eligibility Criteria for Contraceptive Use

WHO updated its guidance on the medical eligibility criteria following an expert working group meeting in October 2003. The purpose of the criteria is threefold – (1) to improve the match between a contraceptive method and the user; (2) to improve access to contraceptive methods and services; and (3) to improve quality of care. The document classifies medical conditions affecting eligibility for the use of each contraceptive method under one of four categories: (1) no restrictions on use; (2) the advantages generally outweigh the theoretical or proven risks; (3) the theoretical or proven risks usually outweigh the advantages; (4) unacceptable health risk. In circumstances in which clinical judgment is limited, the four categories are reduced to a simple “use” (1 and 2), or “do not use” (3 and 4).

Some of the important changes from the 2000 edition relate to the use of IUDs and hormonal contraception in situations involving or related to HIV/AIDS. In terms of IUD initiation and continuation, the categorisation has been downgraded from 3 to 2 in conditions where a woman is HIV-infected, is at high risk of HIV infection, or has AIDS, provided she is receiving antiretroviral (ARV) therapy and is clinically well. Women with AIDS who are not clinically well should usually not have an IUD inserted (category 3), although they may continue using an IUD if it is already in place (category 2). Hormonal methods are generally safe to use by women who are HIV-infected, are at high risk for HIV, or who have AIDS (category 1), with the exception of the levonorgestrel-releasing IUD (category 3). However, whilst most clients on ARV therapy may use hormonal contraceptives, questions remain about the potential for ARV drugs to decrease or increase the bioavailability of steroid hormones in hormonal contraceptives (category 2). The use of spermicides by women who are HIV-infected, at high risk of HIV infection, or with AIDS is reclassified from category 2 to 4, and diaphragms used with spermicide from 1 to 3. Three new methods are included in the updated MEC – the combined hormonal patch, the combined hormone-releasing vaginal ring, and the etonogestrel-releasing implant (Implanon).

#### Selected Practice Recommendations for Contraceptive Use

The new *Selected Practice Recommendations* emerged from the meeting of an expert group in April 2004. One of the important changes to the existing recommendations is in response to the question: what can a woman do if she misses one or more combined contraceptive pills? In the opinion of

the working group, the inconsistent or incorrect use of pills is a major reason for unintended pregnancy. Seven days of continuous combined oral contraceptive use are deemed necessary for reliable prevention of ovulation. The updated document simplifies previous guidance by classifying the recommendation according to different pill dosages and by discussing the guidance in terms of two scenarios – one or two pills missed; or three or more pills missed. The revised guidance is shown in Box 1.

### Box 1: Recommendations on missed combined oral contraceptives (COCs)

#### 30-35 µg ethinylestradiol pills

##### Missed 1 or 2 active (hormonal) pills

- She should take an active (hormonal) pill as soon as possible and then continue taking pills daily, one each day\*
- She does not need any additional contraceptive protection

##### Missed 3 or more active (hormonal) pills or if she starts a pack 3 or more days late

- She should take an active (hormonal) pill as soon as possible and then continue taking pills daily, one each day\*
- She should also use condoms or abstain from sex until she has taken active (hormonal) pills for 7 days in a row
- If she missed the pills in the third week, she should finish the active (hormonal) pills in her current pack and start a new pack the next day. She should not take the 7 inactive pills
- If she missed the pills in the first week and had unprotected sex, she may wish to consider the use of emergency contraception

#### 20 µg or less ethinylestradiol pills

- If the woman misses 1 active (hormonal) pill, she should follow the guidance above for “Missed 1 or 2 active (hormonal) pills”
- If the woman misses 2 or more active (hormonal) pills or if she starts a pack 2 or more days late, she should follow the guidance above for “Missed 3 or more active (hormonal) pills or if she starts a pack 3 or more days late”

#### Both 30-35 µg and 20 µg or less ethinylestradiol pills

##### Missed any inactive (non-hormonal) pills

- She should discard the missed inactive (non-hormonal) pill(s) and then continue taking pills daily, one each day.

\* If a woman misses more than 1 active (hormonal) pill, she can take the first missed pill and then either continue taking the rest of the missed pills or discard them to stay on schedule. Depending on when she remembers that she missed a pill(s), she may take 2 pills on the same day (1 at the moment of remembering, and the other at the regular time) or even at the same time.

Neither document is yet available in print, but key new recommendations can be accessed on line at [http://www.who.int/reproductive-health/family\\_planning/index.html](http://www.who.int/reproductive-health/family_planning/index.html)