

TECHNICAL BRIEF

After the ECHO Trial – Expanding Access and Choice through Integrated Services

A women's risk of HIV does not restrict her contraceptive choice. Efforts to expand contraceptive method options and ensure full and equitable access to family planning services must continue.

Purpose

This technical brief was developed to support IPPF Member Associations (MAs) and frontline service providers' work regarding the provision of integrated contraceptive, HIV and other sexually transmitted infections (STIs) programmes to expand access and contraceptive choice, following the release of the results of the Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial and the World Health Organization's (WHO) latest guidance statement and revised Medical Eligibility Criteria (MEC) for contraceptive use.

Background

To understand whether using progestogen-only contraception increases women's risk of acquiring HIV, the ECHO trial was designed to compare three highly effective, long-acting, reversible methods of contraception – a progestogen-only intramuscular injectable, depot medroxyprogesterone acetate (DMPA-IM); a progestogen implant (Jadelle®); and the non-hormonal copper intrauterine device (Cu-IUD). The ECHO trial found that all three contraceptive methods were safe and highly effective for pregnancy prevention, and there was no statistically significant difference in HIV acquisition among users of the three methods. However, it was observed that the HIV incidence among the study population was alarmingly high, even with access to existing HIV prevention methods.

For additional information on the historical evidence regarding hormonal contraception and HIV risk, see IPPF's IMAP statement on the ECHO trial.

After the ECHO Trial

In response to this new evidence, WHO issued a guidance statement on Contraceptive

Eligibility for Women at High Risk of HIV and revised its Medical Eligibility Criteria (MEC) for contraceptive use for women at high risk of HIV in August 2019. In this guidance statement, WHO provided three key messages for policy makers, programme managers, and health care providers.

KEY MESSAGES

- A woman's risk of HIV does not restrict her contraceptive choice.
- Efforts to expand contraceptive method options and ensure full and equitable access to family planning services must continue.
- A renewed emphasis on HIV/STI testing and prevention services is urgently needed, including the integration of family planning and HIV/STI services as appropriate, along with sexual and reproductive health packages.

Implications for IPPF

As a leading service provider and advocate of sexual and reproductive health and rights (SRHR), it is IPPF's responsibility to disseminate the latest available evidence. IPPF aims to use this opportunity to reaffirm to MAs, the importance of providing integrated rights-based SRH information and services, particularly ensuring maximized contraceptive method-mix and HIV/STI prevention, testing and management services.

INFORMED DECISION-MAKING

All individuals, especially young people, should have access to accurate sexual and reproductive health (SRH) information and services free of stigma, discrimination, and coercion so that they can decide freely about their contraceptive options and protect themselves against HIV and STIs.

There is a need for an integrated approach to SRH services, including the integration of contraceptive and HIV/STI services along with other SRH packages.

According to the revised WHO MEC, women at high risk of HIV acquisition are eligible to use all methods of contraception without restriction (MEC Category 1) including progestogen-only pills (POPs); DMPA-IM and DMPA-SC, norethisterone enanthate (NET-EN) injectables; levonorgestrel (LNG) and etonogestrel (ETG) implants; Cu-IUDs and LNG-IUDs; and combined hormonal contraceptive methods, such as combined oral contraceptives (COCs), combined injectable contraceptives (CICs), combined contraceptive patches and combined vaginal rings. This is a change from WHO's 2017 guidance statement, where some contraceptive options, such as DMPA-IM, were classified as MEC Category 2.

CONTRACEPTIVE METHOD-MIX

All individuals should have access to a wide range of contraceptive methods to allow them to select a method of their choice, as well as to freely switch between methods according to their needs over the course of their lives.

While there is no ideal method mix, it is important to remember that adding contraceptive options can significantly increase uptake and continuation rates. Clients should not be compelled to select a specific method due to a limited method mix, concerns about the continued availability of other methods, resources constraints, or social norms discouraging contraceptive use. To avoid this, MAs and clinic managers should continuously assess and update the technical competence of service providers; strengthen their clinic's supply chain management; and ensure a wide method mix as a prerequisite of quality contraceptive service provision.

INTEGRATED APPROACH

IPPF's Integrated Package of Essential Services (IPES) ensures clients' most pressing SRH needs are addressed. The high HIV prevalence among ECHO study participants underlines the urgent need for integrating contraceptive and HIV/STI services, including HIV/STI prevention, testing and management. For example, as clients at risk of HIV are also at risk of other STIs, HIV/STI counselling and testing should also be promoted to clients seeking contraceptive services.

Currently, condoms are the only method which can avoid both unintended pregnancy and prevent transmission of HIV and other STIs (dual/triple protection). However, IPPF MAs and clinic managers should accelerate HIV/STI prevention through providing broader prevention options at primary care level according to client needs, sexual behaviours and preferences.

In SRH settings, it is encouraged that everyone be offered an HIV test if they do not know their HIV status, are pregnant, or are determined to be at on-going risk for HIV acquisition. HIV prevention options include risk reduction counselling, male (external) and female (internal) condoms with compatible lubricants, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and [in some contexts] voluntary medical male circumcision (VMMC). If these options are not available in MA clinics, service providers should provide clients with full and comprehensible information and refer them to partner sites where they can access the desired services.

The epidemiological synergy between HIV and STIs is well-established. The presence of an STI is also an important indicator for higher risk sexual behaviour and risk of HIV transmission. The ECHO trial and other studies reflected the limitation of syndromic management of STIs. To address this, service providers should ensure clients are aware the benefit of receiving STI testing even though they do not have symptoms and signs of infection.

SRHR FOR ALL

IPPF places clients at the centre of our programmes and services. This requires adapting our approaches to ensure everyone, particularly young and marginalised people, are provided with the information and care they need. Service providers should ensure services are based on respect and confidentiality and that messages and materials, both in clinic settings and through outreach, are youth-friendly, rights-based and non-judgemental. In addition, there is a strong need for comprehensive sexuality education (CSE) both in and out of school settings, to further support SRH awareness and behaviour change.

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Useful resources

- **WHO Guidance Statement -- Contraceptive eligibility for women at high risk of HIV** <https://www.who.int/reproductivehealth/publications/contraceptive-eligibility-women-at-high-risk-of-HIV/en/>
- **IPPF IMAP Statement on the ECHO trial** <https://www.ippf.org/resource/imap-statement-echo-trial>
- **IPPF Technical Brief on the ECHO trial** <https://www.ippf.org/resource/ippf-technical-brief-echo-trial>
- **WHO Consolidated guidelines on HIV testing services** <https://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>