Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits?

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It has been widely believed that, by combining the services for preventing and treating sexually transmitted infections (STI) with those for family planning (FP), STI coverage would increase and the combined service would be of higher quality and more responsive to the needs of women. So far, there is little concrete evidence that integration has had such an impact. Besides the absence of documentation, a clear definition of integration is lacking. We therefore carried out a comprehensive review of concrete experiences with integrated services, and present a summary of our findings in this article. The results indicate that the tasks of STI prevention, such as education for risk reduction and counselling, have been integrated into family planning services much more frequently than the tasks of STI diagnosis and treatment. Some STI/FP integration efforts appear to have been beneficial, for instance when the integration of STI/HIV prevention had a positive impact on client satisfaction, and on the acceptance of family planning. Less clear is whether STI prevention, when concentrated among traditional FP clients, is having a positive impact on STI risk behaviours or condom use. A few projects have reported increases in STI caseloads following integration. In some projects, FP providers were trained in STI case management, but few clients were subsequently treated.

Keywords: sexually transmitted diseases, prevention and control; family planning, organization and administration; delivery of health care; counselling; evidence-based medicine; review literature.

Voir page 635 le résumé en français. En la página 636 figura un resumen en español.

Introduction

Numerous reasons have been proposed why services for prevention and care of sexually transmitted infections (STIs) should be integrated with family planning (FP) services. The expectations associated with integration have included expanding STIs service coverage, reducing STI morbidity, diversifying the services to improve their quality, be more responsive to the needs of women, and making service delivery more efficient and ultimately less expensive. The two principal rationales that led policy-makers to consider integration of STI and FP services were the recognition that STIs constitute a major public health problem in developing countries and the expectation that FP programmes which more broadly promote reproductive health will be more attractive to clients, will enhance contraceptive use, and will lead to greater exercise of reproductive intentions and well-being (*1*).

The need for expansion of STI services is further strengthened by the high STI incidence in many developing countries (*2–4*), the established association of STIs with increased transmissibility of human immunodeficiency virus (HIV) (*5–7*), and the finding that treatment of symptomatic STI may significantly lower incidence of HIV infection (*8*). In East Africa, which has the highest STI prevalence in the world (*2*), MCH (mother and child care) services, which are often combined with FP services, are attended by more than 90% of women (*9*). The combination of STI prevention and care with FP/MCH services has therefore been proposed as one way of increasing access to STI services for women.

The recommendations of the 1994 International Conference on Population and Development (ICPD), held in Cairo, increased the impetus for integration of reproductive health services, and for specific attention to STI prevention and care (*10*). The proposed re-definition of "family planning programmes to emphasize helping individuals to achieve their reproductive intentions in a healthful manner" (*11*) has been endorsed by many governments (*12*). Integrating STI prevention and care into FP programmes was regarded as an achievable first step towards such a goal (*13*). Implicit in the expectations from STI/FP integration has been the assumption that it will improve access, information,

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and client–provider interaction, and thus the overall quality of FP services.

So far there is little concrete evidence on whether integration actually confers improvements in service quality and client satisfaction. Neither is there much evidence with regard to the other two expected positive outcomes: improvements in STI care coverage and in service delivery efficiency. Experimental studies to evaluate algorithms to treat vaginal discharge, an important component of STI care among women, suggest a low accuracy of currently affordable diagnostic tools (*3*). Perhaps even worse, fears have been voiced that the association of FP with the less respectable STI (prevention or care) services and with "the whole sphere of extramarital sexual activity" (*14*) might lower the acceptance and use of modern FP methods by conventional clients.

In general, the absence of systematic documentation on such integration is compounded by the lack of uniformity in what is meant by integration. At its simplest, dedicated service providers, on their own initiative, may respond to client needs for an increased array of reproductive health services and start implementing tasks such as STI risk education or condom promotion. In other instances, integration may involve the training of providers in counselling and/or in clinical care as well as modifications in logistics supply (*15*). Experience with the integration of FP with interventions other than STI programmes suggests that optimal packages of activities may be highly location-specific (*16*). Without a clear idea of what type of STI/FP integration is being promoted, it is not surprising that while opinions about the likely impact are abundant, the actual evidence is scarce.

In an effort to address the documentation gap, we undertook a comprehensive review of operational experiences with STI/FP integration in 1998 (*17*). Both the specific meanings of integration and the impact of this integration on public health outcomes, which are evident in the available documentation on integrated services, were reviewed. This article presents a summary of the key findings of this review and highlights the needed areas of work.

Methodology

Data collection for the review included searches for published work through standard databases and for unpublished work through contacts with key persons working internationally in FP and in STI prevention and care. Published materials included case studies by The Population Council, reviews of STI/FP integration documented in the USAID publication *Network*, and reports from American Public Health Association meetings in 1993, 1995 and 1998. Several other reviews, background papers, and conference and workshop reports proved useful in that they contained scattered evidence of the effects of integrated services and of gaps between policies and services (*15, 18–20*).

Altogether, 62 HIV/STI and FP key informants were interviewed, 23 of them working at regional or headquarters level. United Nations Population Fund (UNFPA) AIDS Updates, and the British Department for International Development (DFID) and German Technical Cooperation (GTZ) project lists were screened, and those projects that had planned to integrate both prevention and care of STI into FP services were contacted directly. In cases where no documentation of country experiences or project or programme evaluations was available, anecdotal evidence and/or project planning documents on the success or failure of integrated programmes were accepted.

Results

Many governments have been slow in operationalizing the ICPD recommendations (*12, 20*), and nationwide efforts to integrate both STI prevention and care activities into FP programmes were therefore few and largely limited to sub-Saharan Africa. Most relevant information was obtained from small-scale and nongovernmental organization (NGO) projects.

Range of integration models

In the context of concrete STI management and FP service delivery, integration has taken a variety of meanings. These variations largely reflect differences in the type of family planning services into which STI management has been incorporated, in the range and type of specific elements of STI management added, and/or in the level of care (community, health centre or hospital) at which integration has taken place. Most efforts to integrate STI prevention and/or care into family planning services have concentrated on an intermediate (clinic, health centre) level of services (*15*). Integrated community-based projects such as condom social marketing for dual contraception and HIV/STI prevention purposes have also been fairly common (*21*).

In the vast majority of cases reviewed, FP services were the pre-existing infrastructure into which STI management was being integrated; in virtually no case was the integration process a matter of reconciling two equivalent vertical programmes (*17*). Hence, the structure, reach and quality of the pre-existing FP services were found largely to dictate the nature and pace of STI/FP integration.

While many public sector FP programmes in Africa, Asia and the Middle East were integrated with primary health care services prior to ICPD, important separate vertical FP administrations persist in several countries, some even outside the Ministry of Health. Examples include China, Ghana, Indonesia, Peru and Zimbabwe (*16*). However, in some of these countries, FP programmes are, at least in practice, partially integrated with MCH at the clinic level. The

relevance of these differences lies in the tasks which FP workers are already trained to perform before STI integration takes place. Syphilis screening and pelvic examinations, for example, are more likely to be routinely carried out in services that are integrated with MCH and antenatal care than in separate FP-only programmes.

The most common model: integrating STI/HIV prevention tasks

STI *prevention* tasks — such as information, education, and communication, counselling, and condom promotion — have been integrated into family planning services much more frequently than *care* tasks, such as laboratory screening, clinical diagnosis, treatment or referral, and partner notification and treatment (*17*). A total of 63 out of 124 UNFPA-supported projects, 28 out of 40 GTZ reproductive health and primary health care projects that were reviewed, and 35 out of 46 International Planned Parenthood Federation (IPPF) affiliated country programmes had planned and/or implemented the integration of STI prevention activities. A large number of guidelines, checklists, and worksheets had been developed to assist FP workers to integrate STI/FP education and counselling (*19*). A few associations such as Profamilia, in Colombia, had also become involved in media campaigns on STI/HIV.

Counselling. Many programme and project documents from all regions mention counselling as a specific task of HIV/STI prevention. Few, however, have provided detailed documentation about the type and content of counselling, for example on whether it comprises counselling on STI risk, the medical and social consequences of HIV infection, sexual behaviour, gender relations, and sexual negotiation. The depth and quality of counselling also seemed to vary considerably. Health providers in many projects tended to provide information at the end of the discussion rather than integrating it into FP services (19). In Indonesia, a study showed that education on STI risk reduction was a consistently neglected component of FP client care, even after the initial and follow-up training of care providers. Histories were taken by most doctors, but by few primary care providers, and most were taken in order to clarify diagnoses and not for purposes of risk reduction education (22).

Some of the Latin American projects appear to have placed greater emphasis on risk reduction and on in-depth reproductive health counselling in general (*23–25*). For example, some have trained FP providers in value clarification, the use of sexual language, information about sexual development, and in discussions of gender and power relations, and sexual pleasure.

Condom promotion. Documentation on expansion or changes in condom promotion activities after integration included the following: condom promotion within community-based distribution schemes (which reach many men); free condom distribution in group counselling sessions at clinics (e.g. in Brazil); promotion of condom use for dual protection (e.g. in Brazil, Kenya, Philippines); and more subtle changes in attitudes towards condoms by care providers and clients (*17*).

The following quote from Jamaica describes a typical shift of attitudes in favour of condom promotion: "Before condoms were often considered ineffective as a barrier method of contraception, later they were informally distributed, and now in many places they are actively promoted as a primary and/or secondary method" (*26*).

Many other integrated STI/FP projects and programmes have not documented any specific efforts to promote condoms. Given the traditional FP view that condoms are less effective than other contraceptive methods (*27, 28*), this lack of documentation may well reflect the real situation. On the other hand, in FP services where condom promotion, distribution and demonstration were explicitly reported as crucial STI/HIV prevention tasks, this was apparently indicative of a new emphasis following the decision to integrate services *(29–32)*. Female condoms were not routinely promoted in any of the FP services described as integrated.

New clientele. The addition of STI prevention activities to FP services frequently includes efforts to reach out to new client groups, many of whom are at high risk for STIs. Many integrated programmes have established services for groups such as homosexuals, street children (*33*), factory women (*34*), truck drivers (*35*), and sex workers and their clients (*32, 36, 37*). Several projects were also found to provide STI treatment or referral in addition to prevention activities.

Some of the case study and project reports, especially those from Africa, found new integrated initiatives targeting schools, or linked to community-based contraceptive distribution or condom social marketing schemes (*38*). Integrated STI/FP programmes also included several IPPF affiliates in Latin America such as Profamilia (Colombia), as well as Mary Stopes International clinics in Bangladesh and Philippines, which have established special clinics for men (*39*).

Limited integration of STI care services

Although the integration of some types of STI *prevention* (often combined with HIV education) into FP services is frequent — and in many case dates back to the pre-Cairo era, i.e. before 1994 — the integration of STI *care* tasks is more recent, and far less common. With the exception of sub-Saharan Africa, where many projects and programmes, including several at the national level, are now experimenting with integration, the systematic integration of a full complement of STI *care* tasks into FP services is limited to small-scale efforts. STI clinical services were being integrated into UNFPA-supported reproductive health services in 10 country

programmes, while most IPPF affiliates in the western hemisphere appeared *not* to provide STI treatment, but to refer patients to specialized services. Only two of the 40 GTZ reproductive health projects that were reviewed provided STI care (*40*). By contrast, among the more than 70 projects inventoried in East Africa by Kisubi, 72% attempted to screen FP clients for common STIs (*38*).

Laboratory diagnosis. In many developing countries, routine screening of FP clients for STIs — such as syphilis, gonorrhoea or chlamydial infections — using laboratory methods is not affordable, and the poor accuracy of most tests has further limited their use (*3, 41*). In the Philippines, integrated projects have started using Gram stains, wet smears, and syphilis serology (*37*). In other services, for example in Brazil, Jamaica, the Russian Federation, and Zimbabwe, STI screening among FP clients is selectively associated with prescriptions for intrauterine devices (*23, 42–44*). Syphilis screening, unlike other STI screening, is cheap and effective, and has long been promoted as part of routine MCH clinic activities in many places (*15*), although implementation is often poor.

HIV screening tests are relatively accurate and easy to perform, but their use is inhibited by certain sensitivities surrounding their use. Under certain circumstances, HIV screening in FP settings may be both acceptable and feasible (*45, 46*). Nevertheless, the systematic provision of voluntary counselling and testing for HIV within FP services in developing countries is probably rare. A few IPPF affiliates in the Americas — such as in Brazil, El Salvador and Nicaragua — have reported HIV testing (and care) services (*47*), but many African countries lack the resources to provide counselling and testing outside major urban centres. UNFPA has initiated a large-scale project in Rwanda, which offers FP clients routine HIV testing and counselling as well as syphilis screening (*48*). No cases of the integration of HIV counselling and testing into FP in Asia were found during this review, although it is likely that examples exist in urban and private clinics.

Pelvic examinations. In many of the projects reviewed, FP providers had already been performing gynaecological examinations as part of their routine duties before integration, while other projects had introduced systematic gynaecological examinations as a new task. In newly integrated services evaluated in East Africa, the proportion of new FP clients observed to have had a pelvic examination varied between 50% and 70% at different study sites (*9*). By contrast, in a study of an integrated reproductive health service in Indonesia, speculum examinations were conducted in almost 100% of client visits while bi-manual pelvic examinations were conducted in 28% (*22*).

Risk assessments and syndromic diagnosis. Training in syndromic STI case management, including risk assessments, is relatively frequently undertaken as a means of integrating STI management into FP services. For example, the above-mentioned 10 UNFPA projects and programmes all contained such a training element. This training occurred despite findings showing that sociodemographic and behavioural risk assessment is not an accurate screening tool in identifying (mostly asymptomatic) women with cervical infection in family planning clinic settings (*3, 49–52*).

In practice, although they are an integral part of many training programmes, risk assessments seem to be rarely carried out. When client–provider interactions were observed in services described as integrated, few FP clients were asked many of the key behavioural questions, and in one clinic in Kenya no risk assessment questions were asked at all (*9*). Instead, STI diagnosis was largely based on clinical signs, including those detected on vaginal/pelvic examinations.

STI referral and treatment. Few project reports directly mention the scope or quality of STI treatment offered, although lack of local research and of clear guidelines (*9*), poor results of training (*42*), and lack of funds must all have an adverse effect on the quality of care. Partially based on local research, but also reflecting the dilemma posed by the inherent difficulties of the syndromic approach to the treatment of vaginal discharge, the various projects have chosen widely different regimens. For instance, in Nakuru in Kenya, all women with a complaint and/or symptom of vaginal discharge were treated for vaginitis on their first visit, whereas in pilot clinics in Zimbabwe all were treated for cervicitis (*9*).

In few settings, FP clients seemed to be receiving the additional services on a single visit, one of the rationales for the syndromic approach, and from the same delivery or provider. Even among those FP services that had recently integrated STI prevention and detection, not all offered treatment on site. Many IPPF affiliates in Africa and the Americas have trained their staff in the detection and syndromic management of STIs, but refer clients with symptoms or signs of STIs to specialized clinics for treatment. Neither do reports about on-site STI management necessarily imply that FP providers give the treatment, or that one-stop services are always available. In an NGO project in Kenya, for example, STI patients were referred to the deputy manager/nurse for treatment, since one person had to be in charge of the revolving drug fund (*53*).

The experience with STI care in integrated FP/STI programmes and projects is greatly affected by the availability of STI drugs. In India, most public services did not have the necessary drugs, and therefore were unable to provide treatment (*54*). In Botswana, where STI drugs are funded by the government, more than 18% of the health facilities sampled did not have the first-line drugs recommended for gonorrhoea treatment (*55*). In the public-sector Nakuru programme in Kenya, drugs effective in the treatment of infections other than STIs were reserved for STI treatment despite severe general drug shortages. When providers became frustrated with these constraints, the programme started a cost-

recovery mechanism using drugs donated by external donors (*9*). Other integrated projects were also found to be relying on donor support, or to have subsidized STI treatment funds, or to have started cost-recovery schemes (*17*).

Partner notification. Partner notification was fairly frequently mentioned as an integral component of FP-provider training for STI prevention and care (*41, 56, 57*), although the potential of family planning settings for successful partner notification may seem modest. Some findings from studies carried out in settings other than FP clinics seem to suggest that women are more successful than men in referring partners (*58–60*). However, the risk of the women facing severe consequences, including domestic violence, may often be unjustifiably high, considering the low accuracy of many STI diagnoses, especially if partner notification is not performed with sufficient delicacy (*61*).

In the projects reviewed, encouraging FP clients to refer their partners was often considered difficult and was inconsistently implemented. In the East African case studies, attempts were made to notify the clients' partners in 15–58% of the cases observed (*9*). Provider referral through home visits by social workers did not prove to be a feasible option in these projects (*9, 15*). Similarly, in Uganda, women with STIs did not want anyone else to know about their condition and did not want clinic staff to contact their partners (*57*). In Mombassa, Kenya, where polygamy is common, women feared that they would be accused of being responsible for introducing the STI into the home if their spouses were informed (*62*). In India, the existing social environment in which postpartum centres operated did not encourage men to come for consultations or treatment with their spouses (*54*). The findings of a study in Jakarta, Indonesia, suggested that provider and client referral were both difficult to achieve (*22*).

The impact of integration

In view of the variety of expectations for the integration of STI management into FP services, and the variety of interpretations of integration, it is perhaps not surprising that its impact can be, and has been measured in a variety of ways. These different ways of measuring integration make it particularly difficult to summarize the value of integration, as it may successfully reach some goals, but fall short of others. We focus on five key areas: client satisfaction, family planning acceptance, changes in STI risk behaviours, condom use, and STI care coverage. No new information on the impact of STI/FP integration on community level indicators, for instance STI or HIV prevalence, was obtained.

Client satisfaction. The interpersonal and sexual counselling skills acquired by providers of integrated services appeared to be having a positive impact on the quality of FP counselling. Efforts to overcome cultural barriers to the meaningful discussion of sexuality and partner relationships and to overcome the resistance of service providers to the integration of these new tasks seemed to have been largely successful and worthwhile. Attitudes towards counselling, as well as counselling skills and performance, improved significantly.

Although largely anecdotal, the available reports were also consistent in their message that STI/FP integration was improving client satisfaction. The integration of STI services in East Africa, for example, had a positive effect on the acceptability of clinic-based and outreach activities because communities perceived integrated services to be a more comprehensive response to their needs (*9*). Exit interviews confirmed this statement. In Busoga, Uganda, the image of health workers had been enhanced through the provision of STI care (*57*). The majority of clients attending MCH/FP/STI clinics in Botswana were satisfied with the integrated services provided (*63*).

Client satisfaction also increased after provision of integrated services in Latin America. At the FP clinics of Sociedade Civil Bem-Estar Familiar (BENFAM), in Brazil, clients appreciated the high quality of services, with group counselling sessions being judged by many women to be the most positive feature offered (*25, 34*). In two experimental studies conducted in FP clinics in Asia, in Thailand and Viet Nam, twice as many women were satisfied with services where FP providers had been trained in STI prevention and care management, as compared with control services where no staff had been trained (*64, 65*).

In many cases, it could reasonably be assumed that little or no counselling on sexual behaviour, risk of infections, and power and gender relationships was taking place in FP services before integration. The reported service quality therefore might well constitute a significant improvement over what occurred previously. For many policy-makers after ICPD, client satisfaction outweighs other measures of success such as provider satisfaction, output, or even contraceptive outcome. The positive indications of client satisfaction following ST/FP integration should also assuage fears that STI counselling might overload staff, increase waiting times, and thereby reduce service quality (*18*).

Family planning acceptance. In general, the available (albeit limited) data confirm Walsh & Pollock's (*66*) finding that "expanding services, training staff and educating clients can serve to enhance staff motivation, quality of services, client satisfaction and programme image". Already in 1994, Roitstein, Director of the IPPF/Western Hemisphere Region integration project, had observed that: "Although many FP associations feared that integrating HIV/STI prevention into their work would dilute the mission of FP, those who have done so have actually found that it enhances the quality of their services by meeting the reproductive and sexual health needs of their clients" (*67*).

We found no evidence for a decline in the number of clients attending FP services after

integration. Indeed, the opposite trend may be in evidence. Increases in new FP acceptors following integration were noted in several projects. Two of these — Mkomani (Kenya) and Busoga (Uganda) — have determined that these gains were above and beyond increases in new condom acceptors (*57, 62*). The Mkomani clinic has documented increases in average quarterly couples' years of protection of 112% since integration of services began in 1992 (*15*). Three other reports also mention trends in new contraceptive acceptors prior to and after integration, making it possible to attribute the reported gains in contraceptive prevalence to integration (*17*).

Notably, the extensive documentation of IPPF integration efforts in the Western Hemisphere Region does not make specific reference to changes in overall contraceptive prevalence coinciding with integration. BENFAM's evaluation of its integration project in Brazil coincided with the introduction of new fees; it is most likely that this led to a drop in the overall use of services in the first year, followed by a subsequent rise (*44*). Other project reports have not noted changes in overall contraceptive acceptance.

Changes in STI risk behaviours. Many FP services have demonstrated that they can contribute to the promotion of safer sex messages through media campaigns, community-based condom distribution or marketing, or peer outreach to men, unmarried women and young people. Nevertheless, empirical evidence that the usual FP services — reaching mostly married women — can successfully promote condom use or sexual behaviour change is scarce. In Brazil, where women's empowerment through group discussion is a key feature of integration, the initial results have been encouraging, since some women perceived these efforts as beneficial. Participation in group counselling facilitated the communication with partners, and 51% of participants talked with their partners about the groups. But whether these reported changes affected sexual or contraceptive behaviours is not clear (*23, 26*).

The main constraint is that so few married women clients report behaviours associated with increased STI risk other than having sex with their husbands. In a study of FP clients treated for STIs in Kenya, over two-thirds of married women said that they had been infected by their spouses (*68*). In another study in a high STI prevalence area in the same country, only 7% of all women reported having had more than one sexual partner during the previous year (*69*). Only 2 of 312 women reported having had more than one sexual partner in north Jakarta (*22*).

Condom use. The evidence that STI/FP integrated services are able to increase the distribution of condoms (be it for disease prevention, FP, or both) is clear and consistent. Most reports of increases in condom knowledge and use as a result of interventions of integrated FP/STI programmes came from Latin America. In a programme in Jamaica, the number of condoms distributed increased from 60 000 in 1992 to 245 000 in 1994 after FP providers were trained in STI/HIV prevention (*30*). In Colombia, knowledge of condom use as an AIDS prevention method increased after information, education and communication outreach and a radio campaign, and the evaluation of programme performance noted large increases in condom sales (*67*). Similarly in many African programmes, condom distribution significantly increased. For example, the distribution of condoms in the Busoga programme in Uganda increased substantially. Virtually all these programmes have an extensive outreach.

There is less evidence that integrated programmes contribute directly to improved disease protection among classic FP clients (i.e. married women) by empowering them to negotiate regular or even inconsistent condom use with their (unfaithful) husbands. In the four East African case studies, although condoms were almost universally available at MCH/FP clinics and are frequently discussed with female FP clients, very few couples used them regularly (*9*). On the other hand, in Honduras and Jamaica, the fact that more than 90% of FP clients accepted free samples of condoms was judged a success (*25*).

BENFAM in Brazil is probably the best-documented example of a contribution made to STI/HIV prevention by a FP service. In one of the BENFAM clinics evaluated (in Pernambuco), knowledge of sexuality and HIV/AIDS issues were found to have increased by 50%, as had condom use among participants of groups sessions. Some 90% of women attending the groups asked for condoms, and 40% were also using another contraceptive method (*33*). The programme therefore appeared to be successful in promoting condom use for dual protection among new acceptors.

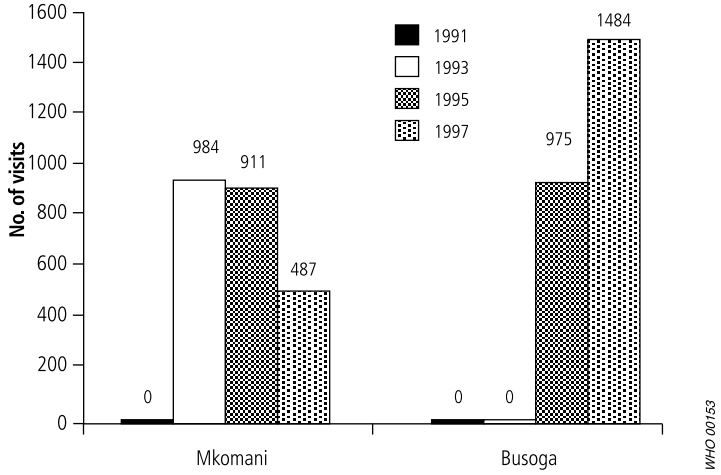
STI care coverage. The evidence collected does *not* support the conclusion that "consistent with the rhetoric integration does serve to increase access to STD care via cross-utilization of services, increased confidentiality and through implementation of screening programmes" (*66*). The claim that integration is leading to improved access to STI care can be challenged on the following grounds:

- the relative dearth of quantitative data to confirm significant increases in the utilization of STI care services following any type of STI/FP integration;
- the nature of integration where programmes have apparently been successful;
- evidence of considerable differences between regions.

In Africa, although STI caseloads increased in several projects following integration, absolute numbers were small. In Mkomani (Mombasa, Kenya), 4% (894/22 551) of FP clients were treated for STIs (*62*). The STI caseload rapidly increased between 1991 and 1993, but then dropped because donor-funded staff were reduced and consumer fees were introduced to cover drug costs (see Fig. 1) (*70*). In Busoga, Uganda, the STI caseload increased, with the main change being an increase in men's attendance (*57*).

Some of the more successful examples seem to be clinics that have tended to provide comprehensive

Fig. 1. **Sexually transmitted infection (STI) clinic visits, Mkomani (Kenya) and Bugosa (Uganda): quarterly averages**



Source: ref. *70*.

services that respond to a wide range of client needs, including men's, from the onset, rather than later integrating STI services into pre-existing FP services. Evaluations of large integration programmes that had involved massive training (mostly in syndromic management) and drug procurement components were not yet available at the time of the review.

Many of the programmes that have been successful in increasing access to and utilization of STI services in the other regions were not fully integrated in terms of administrative or managerial incorporation of previously vertical (government) programmes providing one-stop or supermarket services. The Latin American programmes that were successful in increasing STI coverage did so mainly through the creation of demand for services and the establishment of clinics for men, not through integrating STI care into existing FP settings. In Asia, integration seems to have had some benefit with regard to STI care where high-risk populations have been accessed with services, as in Nepal and the Philippines (*36, 56*).

Box 1. **Main findings of the review**

- STI prevention tasks have been integrated into FP services more frequently than care tasks. Some integrated services have started reaching out to young and unmarried women, men and/or high-risk groups.
- Many projects have trained FP providers in syndromic STI management, but few have documented a significant increase in the number of STI cases treated.
- The integration of STI education for prevention and counselling seems to have a positive impact on client satisfaction, and family planning acceptance.
- There is little evidence that STI prevention efforts, when concentrated among traditional FP clients, are having a positive impact on STI risk behaviours or condom use.
- The integration of STD/HIV prevention/care into FP does not drive away traditional FP clients.
- The monitoring and evaluation components of many integrated projects and programmes are poor.

Conclusions

Calls for the integration of STI management into FP services have largely been made for ideological reasons (*20*). Not surprisingly, therefore, the available evidence shows neither benefits of full programmatic integration nor of systematic integration of a wide range of STI prevention and care activities. The most obvious conclusion of the recent global review is that many integration projects are weak in their monitoring and evaluation components. As a consequence, large investments are being undertaken without a clear definition of expectations, without optimal preconditions for STI/FP integration, and with no indication of the most effective tasks to integrate and in which settings.

Certain STI tasks, such as education in risk reduction and referral of the few symptomatic STI cases presenting at family planning clinics, may have been more easily and more frequently integrated into FP services than others. However, the frequency of implementation, by itself, says nothing about the meaningfulness of such integration. Indeed, it may well be argued that those STI tasks that have been more difficult to integrate may have a greater potential for public health benefits than the ones more easily implemented. Further integration, for example in terms of condom promotion for dual protection or laboratory diagnosis and care, would have either required the prior re-thinking of reproductive health concepts or major financial investments. With regard to the importance of and the opportunities for promotion of dual protection, some re-thinking now seems to be occurring (*71*). A new focus on screening of syphilis and on provision of HIV testing and counselling, including in family planning settings, is also emerging (*60, 72*).

Our findings on the integration of syndromic diagnosis largely support the conclusions drawn from research studies that suggest a low utility of risk assessments in the STI screening of asymptomatic women (*3, 60, 72*). For the projects reviewed, the fact that risk assessments were inconsistently (or not at all) implemented following training in syndromic management, and that many providers in these programmes relied on pelvic examinations for clinical diagnosis of STIs, is additional indication of the difficulties faced by projects that are considering the integration of such STI tasks. Diagnosis based on clinical examinations is notoriously inaccurate, which was the principal justification for introducing the syndromic approach in the first place. Moreover, many (non-integrated) FP programmes, particularly in Asia, have identified the requirement to be able to conduct clinical examinations as a largely unnecessary barrier for the safe prescription of hormonal contraceptives. The introduction of pelvic examination for STI diagnosis would therefore pose a new dilemma.

As the expansion of coverage for care was at the core of recommendations to integrate STI and FP services, the dearth of quantitative data showing increased STI case-loads several years after ICPD, and several years following experimentation with integrated services, should be a major concern of policy-makers and programme planners. Many programmes and projects reaching mostly low-risk and asymptomatic FP clients might have never achieved a substantial expansion in STI care coverage, even under the best circumstances. However, some projects did start reaching out to men, and to high-risk groups, and the reported lack of evidence of increased STI case-loads was at least partially due to failures to improve drug supplies following syndromic case management training.

The question as to whether the integration of syndromic (or any non-laboratory-based) STI management into FP services — to increase the access to STI care by *symptomatic* clients — is justified remains valid, although the focus should perhaps no longer be exclusively, or even mainly, on women and vaginal discharge. In high-prevalence areas and settings, which have the potential to attract FP clients' partners (i.e. through couple counselling), as well as other men or women at high-risk including sex workers, or where STIs associated with genital ulcers are common, the need for syndromic STI care provision is difficult to deny (*72*). FP or integrated MCH/FP clinics may often provide one of the few options for the needed service provision, especially if both women and men are to be reached. On the other hand, many FP programmes may not be the optimal service for contacting high-risk individuals, despite the undeniable success of some programmes (*20*).

Other efforts within STI/FP integration do appear to be beneficial, particularly the positive impact of integrating prevention education and counselling on client satisfaction and family planning acceptance. Certainly, there are no available indications that integration has had a negative impact on either of these factors, a finding that should diminish concerns that the addition of STI/AIDS counselling and related prevention activities to traditional FP services will drive away conventional FP clients. Training in syndromic case management might have contributed to this positive impact. A large proportion of the standard WHO syndromic approach training package is dedicated to the improvement of service providers' communication skills rather than clinical skills (*73*).

Less clear is whether these efforts, when concentrated among traditional FP clients, are having a positive impact on STI risk behaviours or condom use. The promotion of safe sex behaviours through counselling in FP settings is likely to have a positive impact only to the extent that it either empowers married women to negotiate safe sex with their husbands, or reaches higher-risk segments of the population. Ironically — because most resistance to integration came from those who were advocating the pursuit of undiluted fertility reduction objectives — the integration of STI/HIV prevention and sexual counselling, and the widening of the scope of reproductive health services in general might contribute more to enhance family planning objectives than to reduce morbidity.

With few exceptions, no operational research using appropriate study designs, such as control trials, has been carried out to measure the extent of the benefits of integration, or the costs. It is clear therefore that more rigid evaluations of the integration into FP services of both individual STI tasks (such as partner notifications, different types of counselling, syphilis screening and HIV testing) and defined sets of STI activities, as well as costing studies of STI/FP integration, must be undertaken. The current state of evidence on the benefits of integration is still very much in the realm of intuition and calls for systematic appraisal. ■

Résumé

L'intégration des services de prévention et de traitement des infections sexuellement transmissibles aux services de planification familiale présente-t-elle réellement des avantages pour la santé publique ?

Récemment, on a beaucoup compté sur l'intégration de la prévention et du traitement des infections sexuellement transmissibles (IST) aux prestations de planification familiale pour étendre la couverture des services de lutte contre les IST et proposer ainsi des prestations de meilleure qualité mieux adaptées aux besoins des femmes. Cette démarche, recommandée par la Quatrième Conférence internationale sur la population et le développement tenue au Caire en 1994, a été considérée comme l'une des premières mesures concrètes à prendre pour atteindre les buts de la Conférence. En même temps cependant, certains se sont demandé si cette intégration ne risquait pas d'avoir un impact négatif sur les services existants de planification familiale. Jusqu'ici, on n'a guère de preuves concrètes de telles conséquences. En plus de cette absence de documentation, on manque d'une définition précise de l'intégration.

Afin de combler ces lacunes, on a entrepris de dresser un bilan complet des expériences d'intégration de la lutte contre les IST et de la planification familiale, aussi bien en recherchant dans des bases de données classiques ce qui a été publié sur la question qu'en interrogeant des personnes exerçant des fonctions clés, au niveau international, dans les domaines de la planification familiale et de la lutte contre les IST.

Les résultats que nous avons obtenus montrent que l'intégration a été définie différemment, d'une part selon la nature des prestations de planification familiale auxquelles a été associée la prise en charge des IST et, d'autre part, selon la gamme et le type des services

considérés de lutte contre les IST. La prévention des IST, par exemple les activités d'éducation et de conseil sur les moyens de réduire les risques, a été beaucoup plus souvent intégrée aux prestations de planification familiale que le diagnostic et le traitement de ces infections. Les données recueillies montrent que le sérieux et la qualité des services intégrés d'éducation et de conseil sur les IST varient considérablement. Parmi les effets constatés de l'intégration sur l'expansion ou l'évolution des activités de promotion de l'emploi du préservatif, on citera la mise en place de programmes communautaires de distribution de préservatifs, des distributions gratuites de préservatifs à l'occasion de séances d'information de groupe dans des dispensaires, la promotion de l'emploi du préservatif pour une double protection, et des changements plus subtils d'attitude de la part des agents de santé et des clients. D'une manière générale, la promotion de l'usage du préservatif pour une double protection paraît être rare.

Là où l'on a cherché à intégrer la prévention des IST aux services de planification familiale, la qualité des prestations ainsi que les attitudes du personnel et ses compétences en matière de communication ont été améliorées. La crainte que l'intégration de la prise en charge des IST n'entame la crédibilité des services de planification familiale était apparemment infondée ; au contraire, le fait d'avoir intégré certains éléments de la prévention des IST semble avoir fait davantage pour les objectifs de la planification familiale que pour ceux de la lutte contre les IST. On a par exemple noté, dans plusieurs projets, une augmentation du nombre des personnes ralliées à la planification familiale. Il est en revanche moins certain que les efforts de prévention des IST fournis à l'intention des utilisateurs traditionnels des prestations de planification familiale aient un impact positif sur les comportements à risque pour les IST ou sur l'emploi du préservatif.

Les documents examinés permettent difficilement de conclure à une augmentation de la couverture de la prise en charge des IST, qu'elle soit due à une expansion du dépistage en laboratoire ou à la prise en charge « syndromique » des malades symptomatiques et de leurs partenaires. Dans certains projets, les personnels des services de planification familiale ont été formés au traitement des IST mais ces compétences ont été rarement mises en pratique. De même, il n'y a eu que peu d'évaluations des risques malgré une formation préalable à la prise en charge basée sur les manifestations syndromiques. Étant donné le manque de précision des instruments actuels de diagnostic des IST, même dans les conditions les meilleures, beaucoup des programmes et projets qui s'adressent essentiellement à des femmes asymptomatiques n'auraient sans doute jamais abouti à une augmentation importante de la couverture des services de lutte contre les IST. Dans d'autres cas, l'absence de données faisant état d'une augmentation du nombre des cas traités d'IST semble tenir, du moins en partie, au fait que la formation des personnels n'ait pas été suivie d'une amélioration des approvisionnements en médicaments.

Nombre de projets d'intégration sont étonnamment faibles au niveau de la surveillance et de l'évaluation. Par ailleurs, à quelques exceptions près, aucun plan approprié n'a été établi, par exemple au moyen d'essais contrôlés, pour mesurer les avantages liés à l'intégration ou les coûts. Des évaluations opérationnelles plus rigoureuses de l'intégration, dans les services de planification familiale, d'ensembles bien définis d'activités de lutte contre les IST ou d'activités précises comme la notification des partenaires, les conseils aux couples et le dépistage sélectif ainsi que des études du coût de cette intégration s'imposent.

Resumen

Integración de los servicios de prevención y tratamiento de las infecciones de transmisión sexual y los servicios de planificación familiar: ¿sale beneficiada la salud pública?

En los últimos tiempos se ha confiado en que la integración de los servicios de prevención y tratamiento de las infecciones de transmisión sexual (ITS) y los servicios de planificación familiar (PF) permitiría aumentar la cobertura contra las ITS, y en que esos servicios combinados serían de mayor calidad y más sensibles a las necesidades de las mujeres. Esa última expectativa se corresponde con las recomendaciones emanadas de la Cuarta Conferencia Internacional sobre la Población y el Desarrollo (CIPD), celebrada en El Cairo en 1994. La integración de los servicios de prevención y tratamiento de las ITS en los programas de PF se ha considerado como un primer paso práctico hacia la consecución de las metas de la conferencia. Al mismo tiempo, sin embargo, han suscitado inquietud las eventuales repercusiones negativas de esa integración en los servicios de planificación familiar existentes. Hasta la fecha, no hay apenas indicios concretos de que la integración haya tenido tales repercusiones. Al problema que supone la inexistencia de documentación en ese sentido, se añade la falta de una definición clara de esa integración.

Con el propósito de colmar esa laguna de información, se emprendió un análisis detallado de la experiencia de los servicios integrados. Los datos reunidos son el resultado de las búsquedas realizadas entre los trabajos publicados mediante las bases de datos habituales, y entre diversos trabajos inéditos mediante contactos con personas clave implicadas en el ámbito internacional en la planificación familiar y en la prevención y el tratamiento de las ITS.

Nuestros resultados muestran que la integración ha adoptado diversas formas, en función del tipo de servicios de planificación familiar en que ha quedado subsumido el manejo de las ITS, así como del tipo y variedad de elementos concretos de manejo de las ITS añadidos. Las tareas de prevención de las ITS, como la educación para la reducción del riesgo y el apoyo psicológico, han sido

integradas en los servicios de planificación familiar con mucha más frecuencia que el diagnóstico y el tratamiento de las ITS. La profundidad y la calidad notificadas de la educación sobre los riesgos y el asesoramiento en materia de ITS en los servicios integrados son muy variables. Entre las pruebas de que las actividades de fomento del uso de preservativos han aumentado o experimentado cambios tras la integración, cabe citar las siguientes: la promoción del preservativo en los planes de distribución basados en la comunidad; la distribución gratuita de preservativos en reuniones colectivas de apoyo psicológico celebradas en los dispensarios; la promoción del uso del preservativo como protección doble; y algunos cambios más sutiles observados en la actitud de los dispensadores de atención y los usuarios en lo relativo al uso de preservativos. Por lo general, la promoción del preservativo para una protección doble parece poco frecuente.

En los casos en que se ha procurado integrar las tareas de prevención, la calidad de los servicios y la actitud y la capacidad de comunicación de los dispensadores de atención han mejorado. El temor de que la credibilidad de los servicios de planificación familiar se resentiría cuando se integraran con el manejo de las ITS se ha revelado infundado; de hecho, los datos disponibles llevan a pensar que la integración de los elementos de prevención de las ITS pueden incluso haber facilitado los objetivos de la PF más que los de la lucha contra las ITS. En varios proyectos se registró un aumento del número de nuevos usuarios de los servicios de PF después de la integración. Más débiles son en cambio los indicios de que las actividades de prevención de las ITS, al concentrarse entre los usuarios tradicionales de la PF, estén repercutiendo positivamente en los comportamientos de riesgo de ITS o en el uso de preservativos.

La documentación revisada difícilmente permite discernir si ha aumentado la cobertura de tratamiento de las ITS, como resultado ya sea de un mayor cribado de laboratorio o del tratamiento sindrómico de los usuarios sintomáticos y sus parejas. En algunos proyectos se procedió a adiestrar a los dispensadores de servicios de PF en el manejo de los casos de ITS, pero los usuarios tratados posteriormente fueron pocos. Rara vez se llevaron a cabo evaluaciones del riesgo, a pesar de la capacitación previa en el tratamiento sindrómico. Habida cuenta de la baja precisión de los actuales medios de diagnóstico de las ITS, muchos de los programas y proyectos destinados fundamentalmente a mujeres asintomáticas podrían no llegar a traducirse nunca en una ampliación sustancial de la cobertura de tratamiento de las ITS, incluso en las mejores circunstancias. En otros casos, el hecho de que no se registrara un aumento del número de casos de ITS manejados podría deberse, al menos parcialmente, a que no se logró mejorar el suministro de medicamentos tras la capacitación de los dispensadores de atención.

Muchos proyectos de integración adolecen de sorprendentes deficiencias en lo que respecta a sus componentes de vigilancia y evaluación. Además, con escasas excepciones, no se han empleado diseños de estudio adecuados, como ensayos controlados, para medir los beneficios de la integración o sus costos. Es necesario emprender evaluaciones operacionales más rígidas de la integración en los servicios de PF de medidas individuales contra las ITS (como la notificación al consorte, el asesoramiento a la pareja y el cribado selectivo) o de paquetes de actividades contra esas infecciones, y llevar a cabo estudios de los costos de la integración de las ITS y la PF.

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