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An Unmet Need: Family Planning Integration

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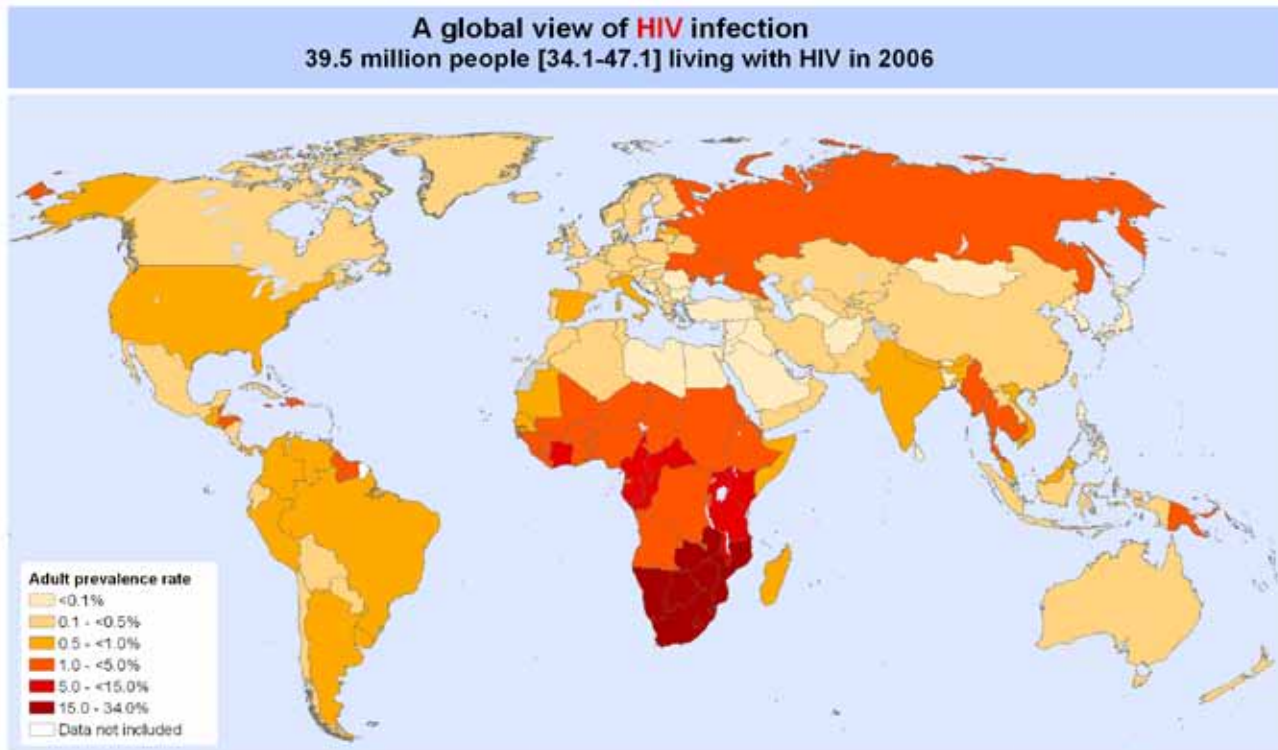
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FAMILY PLANNING an unmet need INTEGRATION

SUB-SAHARAN AFRICA has been experiencing steady population growth since the beginning of the twentieth century. The latest United Nations projections, published in March 2007, estimated a figure of 1.5 to 2 billion inhabitants by the year 2050. Recommended by the International Conference on Population and Development (ICPD) in 1994, the integration of reproductive health (RH) and family planning (FP) in various health services of Africa and other developing countries is highly controversial. It is supported by the World Health Organization, but it has been difficult to accomplish in view of the weak health systems and the lack of human and material resources. In most parts of the world, family planning and HIV services are usually offered separately through what are called vertical programs. Family planning services target married women of reproductive age



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: WHO / UNAIDS
Map Production: Public Health Mapping and GIS
Communicable Diseases (CCD)
World Health Organization



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and HIV services target individuals at high risk of infection. However, the integration of family planning in HIV programs or vice versa would permit women of reproductive age who are affected or infected by HIV to benefit from family planning and/or HIV prevention counseling and services.

In Sub-Saharan Africa, less than 20 percent of married women in the age group 15-49 use modern contraceptive methods, and 30 percent claim an unmet need for contraception (AIDS Epidemic Update, December, 2007, UNAIDS). In addition, it is estimated that 36,000 women die from unsafe abortion complications each year in Sub-Saharan Africa (Van Look, *Levels and trends in the incidence of unsafe abortion and related mortality*, 2007). Women age 15-24 are infected with the HIV virus at rates two or three times higher than men and boys of the same age, and in 2007

there were 2.3 million children infected with HIV/AIDS, of which 90 percent were living in Sub-Saharan Africa (UNAIDS 2008). The use of contraception would permit HIV-positive women to avoid unintended pregnancies and would prevent the birth of children infected by the virus. However, funding for family planning has decreased by an estimated 40 percent over the last 10 years and donors have switched their goals and interests to the fight against HIV/AIDS. Large grants are mostly allocated for HIV/AIDS treatment, care, and prevention programs.

Attempts have been made to integrate family planning in Ethiopia, Kenya, Uganda, and South Africa, with a variety of services such as voluntary counseling and testing (VCT) for HIV/AIDS, sexual transmitted infections (STIs) diagnosis, prevention of

Van Look, P. Levels and trends in the incidence of unsafe abortion and related mortality, Department of Reproductive Health and Research, World Health Organization, 19 October 2007.

mother-to-child transmission (PMTCT), and antiretroviral therapy (ART). Most common have been (1) the integration of services that combine VCT with counseling and referrals to FP or (2) maternal and child health (MCH) and PMTCT services with counseling and referrals about contraceptive methods and HIV prevention. Having all of these services delivered from one health center would constitute a holistic approach, meaning that integration would render comprehensive reproductive health services to include all aspects of HIV/AIDS and family planning services. But, this programmatic approach would need sustainable funding and a solid infrastructure between national and regional districts along with adequately trained personnel and efficient service delivery. It would also require well-thought coordination between reproductive health,

family planning, and HIV/AIDS services along with an efficient computerized administration established between the Ministry of Health, international donors, and administrative agencies.

Multilateral integration of several services is very challenging for most countries where the health systems are weak and the infrastructure is inadequate. In addition, family planning programs have been eroding since President G.W. Bush enforced the Global Gag Rule. The Global Gag Rule, based on the Mexico City Policy, prevents non-governmental organizations (NGOs) from receiving federal funding for performing or promoting abortion services as a method of family planning (the exception for abortions are rape, incest, or life-threatening conditions). The Global Gag Rule was initiated by President Reagan in 1984, canceled by President Clinton in 1993,

reinstated by President G. W. Bush in 2001, and reversed by President Obama in January 2009. Over the last decade the Global Gag Rule has impacted the services delivery of family planning by reducing funding from the U.S. Congress by 40 percent. It is blamed for

women's high mortality because of an increased use of unsafe abortions and pregnancy-related complications due to the unmet need for family planning services. The United Nations estimates that at least 200 million women worldwide every year want to use

contraceptive methods, but are unable to do so because of lack of information and services about family planning or community support. Furthermore, donors have switched their interests and goals from supporting family planning services to the fight against HIV/AIDS. Yet, the situation is critical.

Women constitute 60 percent of those living with HIV/AIDS in Sub-Saharan Africa and infection rates are rising. Each year 20 million women suffer from pregnancy-related complications and over half a million die. Of this figure, 265,000 women die each year in Sub-Saharan Africa (UNICEF 2008). Providing access to family planning for women living with HIV/AIDS could reduce the number of unintended pregnancies, unsafe abortions, and decrease the number of children born with HIV. Further, HIV-positive women enrolled in a family planning program with HIV/

AIDS services would have access to prevention with mother-to-child-transmission during pregnancy and breastfeeding. In the literature, findings from evaluation projects about integrated family planning services in Kenya and Uganda revealed that they are less costly than vertical programs and that women like getting family planning and HIV services from the same health center.

Major cultural barriers to contraceptive use include the belief that there are no advantages to a small family, lack of knowledge, lack of access, fear of side effects, and male dominance in sexual decision-making. In urban regions some of these obstacles are decreasing, but in semi-urban and rural regions there is a need for information, access, and more community effort to inform men and women about the benefits of contraception and the advantages of smaller families. Rural regions

show high fertility prevalence based on beliefs that children are “assets for the future” and/or are “proof of men’s virility.”

Male partners or husbands play a major role in women’s lives, as they are the decision-makers

The Challenge, 2008, UNICEF

about reproductive matters and contraceptive use. But, men are not the focus of most family planning programs—women are—and in many societies women have no power to make decisions about their reproductive

functions. The role of men in family planning is important; it has been disregarded and the lack of success of family planning programs could be attributable to the failure of studying men's attitudes and cultural upbringing as it relates to reproduction and contraception. Integration of reproductive health services that includes sexually transmitted diseases and family planning with HIV/AIDS counseling or referrals is one way to reach men and educate them about the use of contraception, such as dual methods (condoms plus another method), and to inform them about STIs and HIV infections. In the literature, women's subservient role in reproductive decision-making is explained by a lack of economic independence and a lack of schooling compared to men, in addition to the cultural norms that emphasize women's fertility

and reproductive role. However, women's passive attitudes toward reproduction would change with education opportunities, skills empowerment, and economic independence.

To conclude, despite the huge need for the integration of family planning and HIV/AIDS services in most countries, the number of services currently available to people living with HIV/AIDS is inadequate, and the number of HIV/AIDS services that integrate family planning is minimal. Integration of family planning into HIV programs or vice versa would be very beneficial for clients, but may be challenging for health systems and medical personnel because of additional activities. Consequently, family planning should be integrated into HIV/AIDS programs, when it is feasible and with sustainable goals. Patterns of integration depend on

local situations and should not be generalized. For instance, a holistic approach to RH-FP and HIV services in a one-stop health center would function well in hospitals or urban clinics where they have the epidemiological and medical staff along with the material and supplies available. But, a holistic approach would be difficult to implement in rural regions because of lack of human and material resources. For the present, there is a need for perseverance and for strong support from local governments, the international community, and local communities encouraging family planning integration in all major health services. This is a mandate that will better men's and women's future

lives and health in developing countries and Sub-Saharan Africa.

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