

Better Together

Linking **Family Planning** and **Community Health** for **Health Equity and Impact**

A report prepared
on behalf of CORE Group
by **Karin Ringheim**



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Abstract

Family planning saves lives and promotes health and well being in a myriad of ways. It is cost effective, well understood and underutilized as a development strategy. Based on more than 125 references, the research presented in this paper provides compelling evidence that integration of family planning is a value-added strategy, saving lives, and spurring progress to prevent diseases, protect the environment, advance food security and nutrition, and improve the health of young people. Despite these benefits, more than 200 million women worldwide, especially poor women and those in rural and remote areas, still lack access to modern contraception. “Smart” integration of family planning is an important strategy to help address that shortfall—as it simultaneously supports other development goals, as described in this report.

Integrating family planning with existing health interventions *at the community level* not only broadens access and equity, but improves substantive understanding of the importance of family planning to the health of women, children and the family, and to reducing unintended pregnancies and abortions. With the endorsement of WHO, USAID and other policymaking bodies, integrated services, including family planning, represent the future of community and primary health care.

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Much of our dynamism is generated through our lively *Community Health Network*. CORE Group builds on the energy and knowledge of the *Network* to take on additional efforts: we run a Practitioner Academy for Community Health, design and administer community health grant programs, advocate for community health approaches, and develop technical guidance and tools—like this report. Learn more, and access our free resources and webinars at www.coregroup.org.

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Acronyms and Abbreviations

APHIA	AIDS, Population and Health Integrated Assistance
ANC	antenatal care
ART	antiretroviral therapy
BCC	behavior change communication
CBD	community-based distributor/distribution
CEDPA	Centre for Development and Population Activities
CHW	community health worker
CRM	coastal resource management
CYP	couple-years of protection
DCPP	Disease Control Priority project
DHS	Demographic and Health Survey
ENA	essential nutrition actions
EPI	Expanded Programme on Immunization
ESD	Extending Service Delivery project
FBO	faith-based organization
FHI	Family Health International
FIGO	International Federation of Gynecologists and Obstetricians
FP	family planning
GBV	gender-based violence
GHI	Global Health Initiative
HIV/AIDS	human immunodeficiency virus/Acquired Immune Deficiency Syndrome
HKI	Helen Keller International
HTSP	healthy timing and spacing of pregnancy
IYF	International Youth Foundation
IPOPCORM	Integrated Population and Coastal Resource Management project
IRH	Institute for Reproductive Health
IUD	intrauterine device
LAM	lactational amenorrhea method
MCH	maternal and child health
MDG	Millennium Development Goal
MIHV	Minnesota International Health Volunteers (now Wellshare International)
MMR	maternal mortality ratio
MNCH	maternal, neonatal and child health
MOH	Ministry of Health
NGO	nongovernmental organization

PEPFAR	President’s Emergency Plan for AIDS Relief (U.S.)
PHE	population, health and environment
PIH	Partners in Health
PMTCT	prevention of mother-to-child transmission of HIV
PPFP	postpartum family planning
PSI	Population Services International
RH	reproductive health
RHEW	rural health extension worker
RTI	Research Triangle Institute
SAFE	Growing Up Safe and Healthy project
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
TBA	traditional birth attendant
TIP	the Integrated Partnership
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UTTL	Unilever Tea Tanzania
VCT	voluntary counseling and testing for HIV
VHC	village health committees
WHO	World Health Organization

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I. Introduction

In 1978, emerging from the International Conference on Primary Health Care, the Alma Ata Declaration envisioned integrated and comprehensive primary health care, including family planning, as the route to achieve “Health for All by the Year 2000.” Thirty-four years later, this vision remains unrealized. While some early family planning programs were integrated, many were funded and administered separately from other preventive health services. Whether due to weak public health systems, competing interests or the impact of HIV/AIDS and AIDS-specific funding, many family planning programs (including a host of robust, high quality efforts) are missing opportunities for additional impact through integration with other health and development programs. Not coincidentally, countries lacking a strong, integrated public health system are now among the poorest and most fragile states in the world, struggling with high levels of rapid population growth, unintended pregnancies, preventable diseases, hunger, poverty and environmental degradation.

A. What are integrated services?

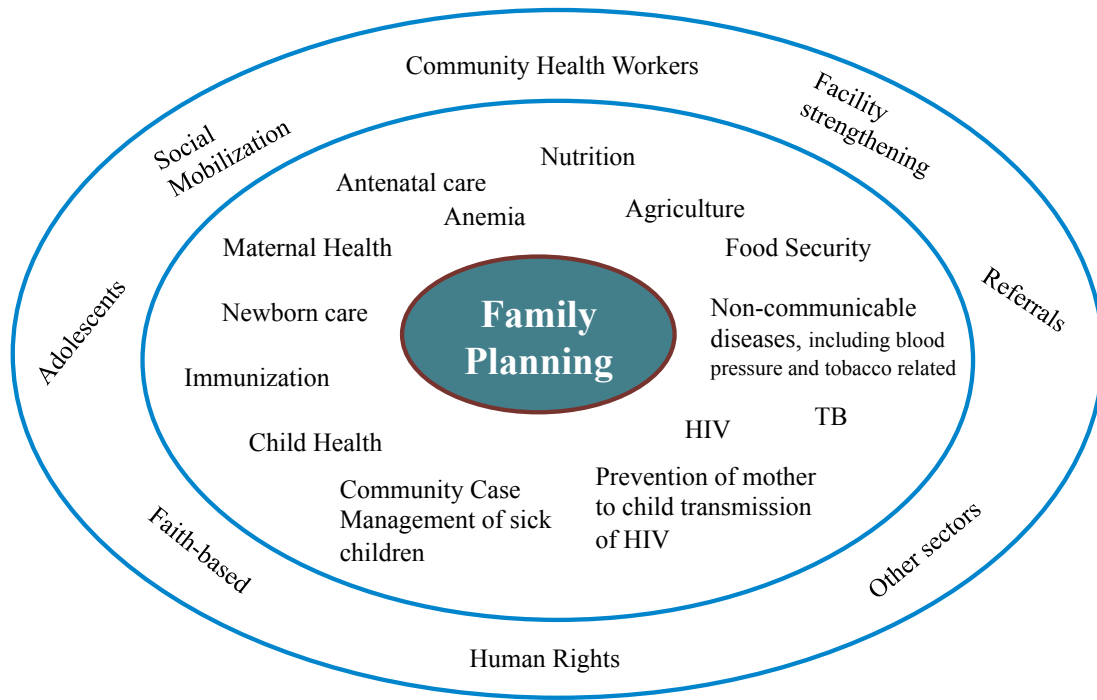
The World Health Organization (WHO) defines integrated service delivery as “the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money.”¹ Integration generally refers to joining two or more types of services that were previously separated into a single, coordinated and combined service. Integration may be a means of improving the quality of service delivery, expanding access to services and/or making the service more affordable and convenient to clients.²

“Providing an integrated reproductive health service starts with understanding people’s needs and continues with a willingness to change the way we do things. It means listening to women and men, young people and older people.”³

While in most cases, this means that people are able to get multiple services at the same place and at the same visit, some integrated services supply information and refer clients elsewhere for the actual service. This is often true for community-based services where referral to a health center for some services may be necessary.

Figure 1 below shows how family planning strengthens other primary health priorities.

Figure 1: Family Planning Integration for Health Impact



B. Why the renewed emphasis on integrated sexual and reproductive health (SRH) services?

In its most unequivocal statement to date, WHO has recently called for “universal,” “people-centered” primary health care with fully integrated SRH services:

“The crucial role of SRH to both the general health of the population and the social and economic development of a nation, and the lessons learned from past experiences, demonstrate that...SRH services must be delivered as a collection of integrated services that address the full range of SRH needs.”⁴

WHO has called for reforms aimed to improve health equity and strengthen primary health care delivery at the community level, and defined 13 core competencies in sexual and reproductive health, including family planning, as a minimum package of care that all clients throughout the world should receive. This guidance is intended to for use by all governmental, nongovernmental, or donor agency SRH training and education providers.


*“The primary health-care team member provides high quality family planning care.”
(See Appendix One for full details of Competency 7.)⁵*

At USAID’s Global Health Bureau, integration is a key principle of the President’s Global Health Initiative, (GHI), aimed to increase health impact. Consistent with its women and girl-centered approach, GHI is prioritizing the integration of family planning into a broad spectrum of health and development activities by helping countries integrate across WHO’s six health system building blocks (service delivery, human resources, medical supplies, vaccines and technology, health financing, information, leadership and governance).⁶

C. Why is family planning the centerpiece of integrated health programs?

Today, more than 200 million women—mainly in low and/or middle income countries—want to prevent or delay pregnancy but don’t have access. Missed opportunities to integrate family planning into primary health care are contributing to this enormous shortfall. The separation of family planning from broader preventative health care also may affect the basic right of women and couples to “decide freely and responsibly the number and spacing of their children and have the information, education and means to do so”⁷ and may have fueled fears that family planning weakens male control, interferes with religious teachings or aims to curtail reproduction among certain groups.

When an unintended pregnancy is prevented, a cascade of benefits ensues, improving the lives of individuals, families, communities and the environment. Therefore, the call to reform and reinvigorate primary health care places a big emphasis on integrating family planning to expand access. It also makes sense to integrate family planning into environment, agricultural or economic development programs when family planning can help such programs achieve their objectives.



When an unintended pregnancy is prevented, a cascade of benefits ensues, improving the lives of individuals, families, communities and the environment.

D. Why is family planning essential to comprehensive primary health care?

Enables healthy spacing between births

Six months after giving birth, even women who are exclusively breast feeding are at risk of another pregnancy. The great majority of these women do not want to become pregnant again so soon, yet most new mothers in low and/or middle income countries are not using contraception to prevent it.⁸ Family planning enables women to have a healthy space between births. Shorter birth intervals, especially of less than two years, increase the risk of death and low birth weight for the newborn as well as the risk of malnutrition and stunting for the next youngest sibling.⁹ Because birth intervals have such a profound effect on infant and child survival and maternal health, women will have the best chance for a healthy pregnancy and birth if they wait at least 24 months after a live birth before attempting a pregnancy.¹⁰ For maximum health benefits, the ideal length of time between a birth and the next pregnancy is 3 to 4 years (36 to 47 months).¹¹ If women waited 36 months after a delivery to become pregnant again, the lives of 1.8 million children under age five could be saved each year.¹² For most



women of reproductive age, family planning is the only feasible way to achieve healthy spacing of births.

Reduces high-risk pregnancies, maternal deaths, depletion and disabilities

The healthiest times for a pregnancy are when women are older than 18 years of age, but not yet 35.¹³ When women become pregnant outside of the prime ages for childbearing, or have had many previous births, they are at greater risk for complications to occur during pregnancy and birth. Women who have closely spaced pregnancies may not fully recover from one pregnancy before another pregnancy begins, resulting in “maternal depletion.” This syndrome is associated with increased risk of birth complications such as premature rupture of membranes, pre-eclampsia, high blood pressure, and even death.¹⁴

Increased use of family planning prevents such “high-risk” pregnancies, and saves many women’s lives.¹⁵ For example, a modeling study in India which compared various strategies to reduce the high maternal death rate found that increased use of family planning was the single most effective intervention. Fulfilling unmet need for contraception in India would prevent 150,000 maternal deaths over five years and save more than US \$1 billion dollars.¹⁶ Globally, maternal mortality could be cut by 20 percent if unintended and high-risk, high-parity and closely spaced pregnancies were prevented through effective family planning.¹⁷ Maternal morbidities such as obstetric fistulae, which affect 50,000 to 100,000 mostly young mothers each year, would also be greatly reduced.¹⁸

Contraception is cost-effective

Offering a full range of contraceptive methods is both medically and financially sound policy for public health programs. In addition to the cost-benefits for families and communities of having fewer, better spaced and healthier children, contraception saves more in public expenditures for unintended pregnancies than it costs to provide.¹⁹ A simultaneous investment in family planning and maternal and child health would more than pay for itself—saving an estimated US\$ 1.5 billion in the cost of maternal and newborn care, or about \$1.30 saved for every dollar invested.²⁰

Family planning is essential to reduce unsafe abortion

Unsafe abortion accounts for 13 percent of all maternal deaths. Of the 44 million abortions worldwide each year, nearly half are unsafe, and 98 percent of these occur in low-resource settings.²¹ In 2008, 47,000 women died as a result of abortions that were performed unsafely or under unsafe conditions.²²

Ninety percent of these abortion deaths were rooted in unmet need for effective contraception and could have been averted.²³ Responding to this unnecessary loss of life, the International Federation of Gynecologists and Obstetricians (FIGO), adopted six strategies in 2009 to address unsafe abortion, including integration of family planning into other reproductive health services. FIGO recognized that integrating family planning expands access, and responds to the urgent need to give women in low-resource countries the same opportunity to avoid an unintended pregnancy as most women in wealthy countries have.

Enables girls to finish school

Delayed childbearing enables more girls to finish school and to become economically productive. Educated girls have fewer, healthier children and contribute more to their communities. For these reasons, the World Bank recognizes that no investment is more effective in achieving development goals than girls' education.²⁴

E. How does integration improve access to family planning—a “best buy” for development?

For its multiplicity of benefits, family planning, like girls' education, is a “best buy” for development, contributing to all of the Millennium Development Goals.²⁵ However, access to this best buy is unequal, with the poorest women having the greatest number of unwanted births and the least access to family planning information and services.²⁶ Although the ability to plan one's family has been recognized as an important human right at least since the International Conference on Population and Development in 1984, this right has never been fully or equally implemented.²⁷

Task Shifting: Community-Based Health Workers Can Safely Administer Injectables

In 2010, WHO reviewed 16 studies and concluded that, with adequate training and supervision, community-based health workers can safely and effectively administer injectable contraceptives while achieving a high level of satisfaction among their clients.²⁸ Furthermore, a study in Ethiopia found that the safety and acceptability of injectables received through community health agents was not only comparable to an injectable administered at a health post, but also women who received injections from a community-based agent reported fewer side effects and were less likely to discontinue.²⁹ The government of Uganda and several other countries are taking steps to allow community-based workers to provide injectables as national policy.

Integrating family planning into primary health care and other health and development interventions and programs at the community level broadens access, especially for the poor who have less financial ability to pay for transportation and take time off from work to seek out stand-alone family planning services. Poor women may also lack freedom of movement to leave their homes or communities. Having more numerous and diverse providers trained to offer family planning, including through community-based distribution and home visits, can help maximize the reach of this “best buy” for the underserved, thereby improving health equity. Integrating family planning also adds value by strengthening the coverage and health impact of the core intervention, whether it is to improve child

health through immunization or nutrition programs, prevent mother-to-child transmission of HIV, or reduce environmental damage. Over time, fewer unintended pregnancies and births mean not only fewer infant and maternal deaths, but also fewer children at risk of disease, malnutrition and HIV infection. With lessened demand, services are able to meet the needs of a larger portion of their clientele, improving overall health. Where high fertility and rapid population growth are threatening environmental sustainability, integration of family planning slows the rate of population growth, enabling improvements in per capita agricultural output and food security and moderating loss of fishing and forests.³⁰ Thus integration of family planning can be a win-win strategy for a host of health and development programs.

By increasing access and equity, and by acting synergistically to reduce infant, child and maternal mortality,³¹ integration of family planning can speed achievement of the Millennium Development Goals (MDGs), especially MDG 3, to promote gender equity and empower women; MDG 4, to reduce child mortality; MDG 5, to improve maternal health and coverage of reproductive health; MDG 6, to combat HIV and other infectious diseases; and MDG 7 to promote environmental sustainability. Family planning makes the achievement of all other MDGs more feasible.³²

F. How does integration of family planning foster “people-centered” services?

Integrating family planning into existing health services serves client needs by meeting more than one health objective in a single visit. This improves client satisfaction and saves women time, energy and money, enabling them to devote more of themselves to schooling, employment, child development and community life. When women are able to prevent unintended pregnancies, they gain greater control over their lives, and can become economic engines that help lift their families and communities out of poverty.³³

Where family planning is underutilized, integrating family planning with trusted preventive health services reduces cultural and religious resistance and expands understanding of family planning—especially among men and other gate-keepers—as an important component of routine quality health care.³⁴ Integration can also benefit the health system by reducing competition for resources between

Family planning features prominently among the “essential interventions” and services for reproductive, maternal, newborn and child health.

programs, creating efficiency by maximizing use of facilities and personnel, and potentially reducing local costs.³⁵

For all the above reasons, family planning features prominently among the “essential interventions” and services for reproductive, maternal, newborn and child health. To meet women’s needs and for maximum health impact, family planning information and services should be routinely integrated into community-based as well as clinic and hospital-based services for adolescents, during pre-pregnancy and during postnatal care.³⁶

G. Why has the time finally come for integration of family planning?

Integration of family planning with other health interventions at the community level is not a new concept, and momentum for its revival has been building for some time. Now that strategic use of integration (where appropriate) has been singled out for support by WHO, USAID (as a principle of the Global Health Initiative), and a number of other policy-making bodies, it is useful to look at the evidence on the health impact of integrating family planning into various health and development programs, and examine some models and strategies for successful integration. This report gives attention to four of six technical priorities for USAID’s Global Bureau of Health: healthy timing and spacing of pregnancies (HTSP), community-based family planning, integration of family planning with maternal and child health, and integration of family planning with services for HIV/AIDS. In addition, it includes several other integration models. It concludes with a few principles for carrying this new mandate forward.



II. Integrating Family Planning into Health and Development Programs and Services

A. Maternal and child health services

For this discussion, maternal and child health services include antenatal, birth/delivery, post delivery, extended postpartum and well-child care and postpartum family planning.

Introduction

Broad international consensus has recently been reached on the essential role that family planning plays in reducing maternal, neonatal and child deaths. As noted by the WHO and the Partnership for Maternal, Newborn & Child Health in 2011:

“Although substantial progress has been made towards achieving the Millennium Development Goals (MDGs) 4 and 5, the rates of decline in maternal, newborn and under-five mortality remain insufficient to achieve these goals by 2015. Interventions and strategies for improving reproductive, maternal, newborn and child health and survival are closely related and must be provided through a continuum of care approach. When linked together and included as integrated programmes, these interventions can lower costs, promote greater efficiencies, and reduce duplication of resources.”³⁷

Based on a thorough review of the scientific evidence, the Partnership gave family planning the highest rating as an essential intervention. Not only is the evidence for family planning incontrovertible, but the Partnership concludes that delivery strategies are agreed upon and rapid scale up is possible. It recommends integrating family planning at the community, primary and referral levels.³⁸

Rationale

- Unmet need for contraception is highest among women who are within the first year after giving birth. This is a critical time for women to receive family planning information and services. Without access to postpartum family planning methods such as the lactational amenorrhea method

(LAM) and the intrauterine device (IUD), women are at high risk of a subsequent pregnancy. According to an analysis of Demographic and Health Survey (DHS) data from 27 countries, two out of three women who have given birth within the past 12 months have an unmet need for contraception.³⁹ Only 5 percent of these women want to have another child within two years⁴⁰ but, as a recent analysis of 52 DHS surveys shows, nearly a third (29%) of women become pregnant again within 18 months of a previous birth.⁴¹

- The shorter the birth to conception interval, the greater the risk. Women who become pregnant within six months of the last delivery have a 7.5-fold increased risk of abortion, a 3.3-fold increase in the risk of miscarriage, and a 1.7-fold increased risk of stillbirth.⁴² Infant mortality among those conceived less than six months after a previous birth is 265 percent higher than among infants conceived after 24 to 47 months.⁴³
- Women in the postpartum period may not realize that they are at risk of pregnancy, especially if they are breastfeeding. A study in Egypt found that the majority of breastfeeding women who conceived unintentionally within two years of a previous birth believed that breastfeeding would protect them against pregnancy.⁴⁴ Another study in Egypt showed that fifteen percent of breastfeeding women conceived prior to resumption of menses.⁴⁵ Women need to be counseled that breastfeeding is an effective contraceptive only for the first six months, and only if the mother is exclusively breastfeeding and her menses has not returned.
- Four out of five women see a health provider for antenatal care at least once during pregnancy.⁴⁶ After delivery, women are likely to make repeat visits for their child's health. These are key repeat opportunities to make sure that women understand how quickly fertility returns, the benefits of HTSP, the risks of a closely spaced pregnancy and how to prevent it through effective contraception.

Health impact

Women who are given family planning counseling near the time of delivery are more likely to adopt family planning than women who are not counseled, thus more able to prevent a closely-spaced pregnancy.⁴⁷ In Egypt, for example, women who chose to have an IUD inserted in the immediate postpartum period were ten times more likely to actually have the IUD inserted than women who preferred to have it done later.⁴⁸ Women who practice family planning not only have improved birth spacing, but also fewer unintended pregnancies and unsafe abortions, fewer total pregnancies and better health for themselves and their children.

Examples from the field

Village Health Committees as agents of change

Large families, averaging nearly six births per woman, are traditional in the West African country of Guinea. Nearly two-thirds of women ages 20 to 24 were married before age 18—among the very highest rates of early marriage in the world. As a result of early marriage and frequent childbearing, a woman in Guinea has a one in 26 chance of dying in her lifetime of causes related to pregnancy and childbirth, and only 9 percent of women use any form of family planning. Save the Children integrated family planning into its community-based child health activities in three regions of Guinea. Village

Health Committees (VHC) were established, each comprised of seven to nine respected community leaders who soon became agents of behavior change in these traditional communities. The committees included a religious leader, traditional health workers (e.g., birth attendants) district chiefs and elders. To overcome resistance from men and build trust for family planning within the community, one man and one woman from each VHC were trained to become community-based distributors (CBDs) of family planning methods. To encourage adequate birth spacing, the project focused particularly on women with a child under age two.

Within four years (2002–2006) modern contraceptive use by women with a child under age two tripled (from 16% to 49%). The successful project is still being replicated by other groups within Guinea, including Plan International and the Adventist Development and Relief Agency. Key factors in success included the VHCs, which brought family planning and birth spacing information out of the health facilities and into the community, and training of religious leaders (imans) about the importance of birth spacing, using teachings of the Koran regarding women's health and men's responsibility to the family. Male and female CBDs encouraged couple communication about family planning. Training VHCs to collect and aggregate village-level data and share it with district health personnel strengthened the linkages with district officials.⁴⁹

Integrating community- and home-based family planning into maternal and neonatal health services

The Healthy Fertility Study was initiated in 2007 in Sylhet district, a rural area of Northeast Bangladesh, which has the highest fertility in the country and where more than half of all birth intervals are less than 3 years. The study, to be completed in 2013, was begun under the ACCESS-FP program and continued through Maternal and Child Health Integrated Program (MCHIP) and the Johns Hopkins Bloomberg School of Public Health in partnership with the Bangladesh Ministry of Health and Family Welfare and Shimantik, a Bangladeshi nongovernmental organization (NGO).

The study is testing an integrated approach to improving birth spacing, practice of LAM and use of contraception to avoid unplanned pregnancies for more than 2,200 mothers. Community health workers (CHWs) are young women in the local community with a minimum of a tenth grade education. They receive 30 days of training in maternal and child health, HTSP, postpartum family planning, LAM and delivery of injectables. The CHWs make antenatal and postnatal visits to women in their homes, providing counseling on care of the newborn, the return to fertility, healthy timing and spacing of pregnancies, the conditions and benefits of LAM, and information on other modern methods. Male and female community mobilizers conduct meetings involving husbands and mother-in-laws to further their understanding and support for HTSP and family planning. Community-based distributors provide pills and condoms or referral to facilities for long-acting and permanent methods. Beginning in 2011, CHWs also provide follow-up doses of injectables at home.

A mid-term survey showed that 40 percent of women in the intervention area were exclusively breastfeeding 5 months after birth as compared to 25 percent of women in the control area. Helping assure that women adopt a contraceptive method after LAM is no longer effective is essential to prevent closely spaced pregnancies. Compared to women in the control area, women in the intervention area

were much more likely to be using a modern contraceptive method 12 months after giving birth (42% vs. 27%). The study has drawn attention to postpartum family planning and has influenced the government programs in Bangladesh.⁵⁰

CHWs help women use LAM and transition to other modern contraceptives


In Uttar Pradesh, India, a Population Council study in 2007 demonstrated that community health workers trained in behavior change communication (BCC) techniques could successfully increase HTSP by educating pregnant women, their husbands, mothers-in-law and community leaders. CHWs from two government agencies received two days of BCC training and a third day a month later. They were provided with an array of educational materials aimed to help individuals and communities understand the health benefits of birth spacing and how to achieve them through LAM and postpartum contraception. After counseling, each pregnant woman was given a brochure and asked to discuss it with her husband and mother-in-law.

At baseline, only six percent of women reported having been counseled about postpartum contraception. After the intervention, women who received counseling were twice as likely to be using a contraceptive nine months after giving birth as women who did not receive it. (62% vs. 31%). Of the 22 percent of women in the BCC communities who used LAM at four months postpartum, 68 percent transitioned to a modern contraceptive, providing evidence that when couples are given accurate information and services, they will use LAM correctly and transition to modern contraceptive methods. There were also fewer pregnancies in the BCC area (10%) than in the control area (16%), suggesting that women in the BCC area were delaying the next pregnancy. Cooperation between district-level officials responsible for health and family welfare and for women and child development was based on mutual understanding that increasing birth intervals would help them each achieve their program objectives.⁵¹

Involving men and religious leaders to overcome resistance and fear of contraceptives

In Afghanistan, where women still have an average of nearly seven births each and risk of maternal death is the second highest in the world, Management Sciences for Health worked with Ministry CHWs to broaden access to family planning in three rural areas where contraceptive prevalence ranged from 9 to 24 percent. Within eight months, CHWs were able to double the use of contraceptives, especially injectables.

The success of the project was attributed to designing interventions based on in-depth discussion with community leaders—both men and women—and religious leaders. Through these discussions, medical misconceptions about contraception were found to be more important barriers than culture and religion. CHWs were trained to provide good counseling which emphasized contraceptive safety



Cooperation between district-level officials responsible for health and family welfare and for women and child development was based on mutual understanding that increasing birth intervals would help them each achieve their program objectives.

as compared to the risk of pregnancy. Religious leaders were engaged to help overcome suspicions about modern contraceptives as a cause of infertility and poor health, and to support contraceptive use for spacing births two years apart. Women were engaged in supervising the CHWs and in women's community health committees. Men's involvement was critical: once they had been educated about the importance of birth spacing for maternal and child health and understood that it was consistent with Islamic teaching, men became supportive of contraceptive use for birth spacing. The Ministry of Health has now adopted the strategy for national scale-up.⁵²

Health of mothers and children a natural entrée to family planning

Faith-based organizations (FBOs) provide 30 to 70 percent of health services in sub-Saharan Africa. Many are engaged in providing family planning and more would like to be.⁵³ Because family planning may be seen as controversial in religiously conservative societies, FBOs may be well positioned to understand the social context and helpful in integrating family planning into MCH services.

Those working in the faith sector rarely approach family planning from the perspective of increasing contraceptive prevalence or lowering fertility. A survey of faith-based and secular organizations involved in family planning found that FBOs were more likely to focus on the effect of family planning on the health and well-being of mothers and children, as well as on family values, male involvement and economic responsibility.⁵⁴ A survey by the FBO Christian Connections in International Health found that all of its 160+ members support family planning.⁵⁵ In 2011, an Interfaith Declaration in support of family planning was signed by 200 Catholic, Protestant, Muslim, Hindu and Buddhist religious leaders.⁵⁶

"Whether a Muslim is liberal or conservative, [his or her] core values come from the Koran and religious teaching. Islam supports the health of the mother. If we can show that the mother's health is improved by timing and spacing (of pregnancies), we can make the case in our own language."

Muslim FBO representative.⁵⁷

Similarly in Egypt, the Population Council compared two strategies for providing birth spacing messages to women. In the first, women received messages from health service workers during their pre and postnatal visits. In the second, a community awareness strategy was added in which influential members

of the community were trained to target men with information about the importance of birth spacing to the health of their wives and children. Both messages led to increased use of family planning, but when men's awareness was raised, family planning use rose to 47 percent as compared to 36 percent where community awareness was not raised.⁵⁸

Expanding the range of actors who deliver family planning information and services

Women in Uganda have high awareness of family planning, and high unmet need, but for a variety of reasons, only 18 percent use modern methods of contraception and women continue to have more than six births per woman.⁵⁹ In 1996, Min-



nesota International Health Volunteers, (MIHV, now Wellshare International), began to integrate family planning into its ongoing child survival work in Ssembabule District, a rural area with only one health center and 25 health personnel to serve 160,000 people. Because health staff were stretched so thinly, MIHV reached out to traditional birth attendants (TBAs), drug vendors, peer educators, women's group members, professional association representatives, nursing and medical students and a nun from the Catholic church, and trained them as community health volunteers who could provide family planning information and referral. MIHV also built the capacity of health unit staff and mobilized communities on the importance of child spacing. Couple-years of protection (CYP) increased from 2,727 in 2007 to 17,789 in 2011 (total CYP of 47,242 from 2007–2011) across both districts. New users of modern contraception increased from 6,942 in 2007 to 21,429 in 2010. In 2011 there were 34,681 total users of both modern and natural contraceptive methods.

The Tanzania Child Survival Project (2006–2011), implemented by MIHV/Wellshare in Karatu District, Tanzania, also emphasized a) child spacing to 36 months, b) male involvement and c) partner communication in decisionmaking for family planning. Family planning was also integrated into Survive and Thrive Groups of approximately 20 young, single pregnant women and mothers led by TBAs, which met monthly for peer support, health education and small business activities. Promotion here focused on postpartum family planning.

Use of modern contraceptives increased from 31 percent at baseline in 2007 to 65 percent in 2011. Results for child spacing in the same period showed an increase in spacing of at least 24 months from 70 to 82 percent and an increase in spacing of at least 36 months from 50 to 53 percent.⁶⁰

Integrating family planning into maternal and child health (MCH) helped drive down maternal deaths in Sri Lanka

Sri Lanka took an integrated approach to offering family planning as part of community and hospital-based MCH services as early as the 1960s. By the 1970s, when the large private tea estates were nationalized, family planning was integrated into public health programs for isolated rural women who lived on these estates. Throughout the country, pregnant women were counseled about the importance of family planning and new mothers were offered a variety of methods. The dramatic reductions in the maternal mortality ratio that Sri Lanka achieved while spending only 3 percent of its GNP on health have been widely praised, and largely attributed to improvements in the basic health system, professional training of midwives and widespread girls' education.⁶¹ However, the role of family planning is now known to be substantial. Contraceptive prevalence in Sri Lanka had already reached 55 percent by 1987, far higher than for most of its neighbors.

By preventing unintended pregnancies, family planning reduced exposure to the risks of pregnancy and by preventing high-risk pregnancies, family planning reduced the likelihood that a woman would die of pregnancy-related causes. Together, these dual impacts of family planning are estimated to account for a third of the decline in the maternal mortality ratio (MMR). Among women ages 30–34, deaths declined from 300 per 100,000 in 1960 to 20 in 1996, similar to the MMR in many far wealthier countries.

Family planning was also integrated with nutrition and immunization programs, and widespread integration of family planning with other health initiatives helped avoid the cultural sensitivity that continues to impede widespread adoption of family planning in Pakistan. Today, women in Sri Lanka have, on average, fewer than two births each, and a woman's risk of dying of pregnancy-related causes is a small fraction of the risk faced by women in India and Pakistan.⁶² As was recently documented for the decline in maternal mortality in Bangladesh between 2001 and 2010, family planning had a lot to do with this Sri Lankan success story.⁶³

B. Integrating family planning into HIV/AIDS, including voluntary counseling and testing, (VCT), prevention of mother-to-child transmission (PMTCT), and treatment, care and support services

Introduction

Driven by the crisis of HIV and the urgent demands to expand access to life-saving antiretroviral retroviral therapy (ART), HIV programs have received far more resources in recent years than family planning and RH.⁶⁴ New, stand-alone HIV services were created with little attention to the impact that family planning could have on HIV prevention. The current infrastructure for HIV services is strong in many countries, offering a platform into which family planning can be integrated. However, separate funding and organization of HIV and family planning programs still stand in the way.⁶⁵

Rationale

HIV-positive women have a high unmet need for contraception

The great majority of HIV-positive women and their partners are in their reproductive years, and studies suggest that more than half of HIV-positive women have had an unintended pregnancy.⁶⁶ For example, in Zambia, couples who received joint voluntary counseling and testing for HIV were asked about their fertility preferences and offered long-term methods. The majority did not want another child for at least three years and more than a third chose an IUD or implant at the counseling visit.⁶⁷

Meeting this need is essential for eliminating mother-to-child transmission of HIV

Presently, only half of women in low and middle-income countries receive access to services to prevent mother-to-child transmission.⁶⁸ Preventing unintended pregnancies greatly reduces the number of women who need these services and makes it far more feasible to eliminate mother to child transmission.⁶⁹

Women with HIV want integrated family planning/HIV services

Integration responds to the rights and desires of HIV-positive men and women to have the number of children they desire.⁷⁰ Women with HIV may be especially in need of integrated services because of their multiple health challenges, reduced energy and income. A recent study in South Africa found that women who needed contraceptives “unambiguously desired” access to “everything you need under one roof.”⁷¹ Integration helps women avoid costly and time-consuming multiple visits to a health provider, and reduces waiting time.⁷² Integrated services are less subject to stigma and discrimination than stand-alone HIV services, or in some cultures, stand-alone family planning services.

Discordant couples need family planning information

Many people living with HIV are in a relationship with a partner who is not infected. These “discordant couples” are especially in need of information on dual protection, protecting the uninfected partner from HIV transmission through condom use while preventing an unintended pregnancy through use of an effective contraceptive method. Discordant couples aiming to achieve a pregnancy need counseling about the fertile period and limiting unprotected sex to fertile days.

Integrating family planning with HIV services can improve care

Studies show that clients of integrated services get more comprehensive care, and their adherence to treatment improves. In 2008, Family Health International (FHI) Nigeria integrated family planning into ART sites in five local government areas where unmet need for contraception ranged from 28 to 35 percent. The most significant impact was more consistent condom use, a recommended practice for all HIV-positive clients.⁷³ Integration also minimizes a client being ‘lost’ in the system. In addition, integration is more efficient for health personnel who can combine two tasks in one visit in less time than required for two separate visits.⁷⁴

Health Impact

Integrating family planning reduces new HIV infections and the costs of treating them

In sub-Saharan Africa alone, there are an estimated half million unintended pregnancies among HIV-positive women each year. Integrated services increase contraceptive use among HIV-positive women who want to prevent or delay the next birth.⁷⁵ Increased contraceptive use means fewer unintended pregnancies and fewer newborns exposed to the risk of mother-to-child transmission.⁷⁶ Counseling HIV-positive women and couples about contraception leads to increased use of dual protection (condom plus another method). Offering family planning at HIV treatment centers is cost effective, estimated to save almost US \$25 for every US\$1 dollar spent.⁷⁷

Integrating family planning helps HIV-positive women who want to become pregnant

The great majority of HIV-positive women are in their reproductive years, and many want to have children, either now or in the future.⁷⁸ Integrated family planning services increase the opportunity to counsel women about how to conceive more safely by first reducing the viral load as much as possible through antiretroviral treatment. This greatly reduces the risk of transmitting HIV to their children.⁷⁹

Examples from the Field

Integrated services for nomadic tribes

In Western Kenya, the AIDS, Population and Health Integrated Assistance (APHIA) II project has been integrating family planning along with tuberculosis (TB) and MCH services into HIV services, including for nomadic populations who are dispersed over a large geographical area with few health facilities or personnel. APHIA II worked closely with religious leaders to improve understanding of birth spacing and legitimize the use of family planning. Offering integrated services in mobile clinics or outreach enabled providers to address multiple services at the same time.⁸⁰

Improving gender relations and reducing risks of pregnancy and HIV on tea estates

In Tanzania, The Expanding Service Delivery project (ESD), managed by Pathfinder, worked with Unilever Tea Tanzania, (UTTTL) the largest tea producer in the country, to integrate family planning, healthy timing and spacing of pregnancy (FP/HTSP) and other RH information and services, including VCT for HIV into the company’s free medical care for its employees and their dependents. Of its 30,000 clients, about 21 percent are HIV positive, and 60 percent are men. In partnership, Unilever and ESD launched the Healthy Images of Manhood program to address harmful gender norms and promote healthier behaviors. A select group of UTTTL’s peer health educators who could serve as role

models and change agents were trained in behavior change communication and to raise awareness of harmful gender norms, family planning and HTSP in the community. Unintended and high-risk pregnancies were a concern for the company, but many HIV-positive employees want to have children. Peer health educators refer these clients to providers who can help them have a safer pregnancy and delivery. Between 2008 and 2009, family planning visits increased by 28 percent while the number of male employees seeking VCT increased by 60 percent. Workers reported improved gender relations in the workplace and at home. The Tanzania government cited the integration of family planning into counseling and treatment centers as a model approach for health facilities in the region. UTTL is now scaling up the project and replicating it at its tea estates in Kenya.⁸¹

Role Models and “Positive Deviant” Volunteers

CARE International has been implementing family planning and MCH projects in Ethiopia since the 1990s. It recently evaluated the community mobilization approaches used in the Family Planning & HIV/AIDS project, which had achieved a seven-fold increase in contraceptive use. One of the elements determined most responsible for behavior change was a community-based contraceptive distribution program that relied on “positive deviant” volunteers who used contraception themselves and had small families. By modeling the desired behavior change in their own lives, these volunteers had considerable influence and credibility within their communities.⁸²

Task shifting to extend services in rural areas

In Ethiopia, where the government has endorsed integrated services, 32,000 rural health extension workers (RHEW) are trained to provide several contraceptive methods, including injectables during home visits in rural areas. Some RHEWs have been trained to insert single-rod Implanon implants or to conduct HIV testing. RHEWs also supervise CHWs who reinforce integrated services by linking the community with the clinic.⁸³

Family planning and health equity for people living with HIV

In Haiti, where Partners in Health (PIH) has addressed HIV since 1985, thousands of community-based health workers have been trained to deliver quality health care to people living with HIV and TB. Family planning is seen as an integral part of women’s health, and essential to health equity. A women’s clinic offering family planning, MCH care, and screening and treatment of HIV was among PIH’s first projects. In 2003, PIH began to train and mobilize CHWs to specialize in women’s health. The CHWs travel throughout the rural areas, teaching women and men about contraception, STIs and HIV, distributing condoms and oral contraceptives, and referring pregnant women to clinics.

Today, each PIH clinic has a full-time nurse trained to counsel clients in sex education and reproductive health. PIH Haiti has over 25,000 active users of modern methods and is replicating this successful model in Rwanda and Lesotho.⁸⁴

C. Integrating family planning into immunization programs

Numerous efforts have been made to integrate family planning messages or services into immunization programs over the past several decades. A recent systematic review of the literature on the integration of various interventions into immunization programs included seven studies going back to 1983 in which mothers were given family planning counseling and referral at the time of a child's vaccination.⁸⁵



Rationale

Mothers are more likely to seek health care for their children than for themselves. Immunization services offer repeated contacts with the health system, especially during the critical window of the first year postpartum, providing multiple opportunities to counsel new mothers about the importance of birth spacing and provide methods or referral for contraception.

- A study in India concluded that immunization is less stigmatized than family planning, making it easier for some women to access family planning information while getting their children vaccinated.⁸⁶ In sub-Saharan Africa, where family planning need is greatest, immunization is arguably the strongest health program with the greatest coverage, making it a logical vehicle for add-on services. In 2008, immunization coverage of children in Africa reached 80 percent. Globally, immunization programs have more than 500 million annual regular contacts with all segments of the population.⁸⁷

Health Impact

Adding family planning to an immunization program with good coverage can lead to rapid uptake of family planning, yielding all of the benefits of reducing unintended pregnancies and improved timing and spacing of pregnancies described earlier, without affecting immunization rates. Studies included

in the systematic review on integrating family planning into immunization programs showed family planning use increasing from 4 percent in one year to 27 percent in two months.⁸⁸

Examples from the field

Spacing message resonates with new mothers

In Togo, a Population Council study in 1992 successfully linked family planning services to an immunization program in urban and rural clinics. Before immunizing each child, the provider in the experimental clinics made three statements to the mother. *“Your child is young and you should be concerned about having another pregnancy too soon.”* *“This clinic provides family planning services that can help you delay your next pregnancy.”* *“You should visit the family planning services after the immunization today for more information.”* In two months, these three simple messages led to an increase of 27 percent in the average number of family planning users in the experimental clinics.⁸⁹

Multiple opportunities reinforce importance of family planning to health

Fifteen years after the Togo study, Research Triangle Institute, (RTI) used these same three family planning messages in a pilot study conducted in the Polomolok municipality of the Philippines. These messages were repeated during each of the four to five visits that mothers made to child health facilities for immunizations during the first 11 months. Over a ten-month period, family planning acceptors increased by 38 percent and many women shifted from traditional methods such as withdrawal to modern methods. During that period, immunization rates increased from 96 to 99 percent.⁹⁰ In one health station where written as well as oral messages were given to women and the messages were displayed on posters, family planning acceptors increased by 126 percent over four months.⁹¹ This suggests that multiple formats as well as multiple messages may be important to reach women whose attention may be focused on their children during immunization visits.

Immediate availability of long-term methods has big impact

In Mali, where more than ten percent of infants die in the first year of life and contraceptive prevalence is only eight percent for all methods,⁹² access to family planning services is quite limited. Population Services International (PSI) found that nearly 80 percent of women at risk of a subsequent pregnancy were not using contraception. In 2008, PSI introduced family planning into child immunization days held at privately operated ProFam clinics. Midwives were trained to make family planning presentations and offer immediate access to long-acting methods. Women could choose to have an IUD or implant on the same day. By 2011, the project had expanded from five PSI-operated ProFam clinics to 72 public clinics. Nearly one in four women who heard the family planning presentations chose to have an IUD or implant inserted that same day.⁹³

D. Integrating family planning into tuberculosis diagnosis/treatment services

Rationale

Tuberculosis (TB) is the number one killer among the curable infectious diseases, claiming 1.5 million people a year. Women in the reproductive ages, 15 to 49, are more vulnerable to TB than men of

the same age, and once infected with TB, women are more susceptible to developing the disease.⁹⁴ Pregnancy presents a risk to both mother and infant when the mother has active TB. Infants born to women with untreated TB may be of lower birth weight and may be born with TB.⁹⁵ Complications include pre-term labor, and spontaneous abortion.

HIV-positive people are more likely to develop TB and one in four HIV-related deaths is caused by TB. UNAIDS has called for integrated HIV and TB services and WHO has just issued new HIV-TB policy guidelines.⁹⁶ Integrating family planning into services for women with TB or co-infected with HIV and TB prevents unintended pregnancies and enables women to postpone a desired pregnancy until they are healthier.

Health Impact

A new study shows that HIV-positive mothers with TB are two and a half times as likely to transmit HIV to their infants as mothers without TB.⁹⁷ Avoiding unintended pregnancy and postponing pregnancy until treatment can improve health reduces the number of infants who acquire HIV and/or TB through their mothers. Women who are already pregnant can be counseled to receive two weeks of treatment before they begin to breastfeed their infant. This will reduce the risk of transmission through breast milk.

Examples from the Field

Full integration of family planning, TB and HIV services

Because active TB is common among HIV-positive individuals, most interventions to integrate family planning into TB services have been done in the context of HIV prevention and treatment programs. In Haiti, for example, the Partners in Health (PIH) clinics described earlier fully integrate TB diagnosis and treatment and family planning into HIV prevention, care and treatment programs. PIH used its experience in providing integrated services, including family planning, to help WHO produce clinical guidance for managing multiple drug-resistant TB.⁹⁸

Advocacy for greater integration

A new two-year initiative launched by Population Action International, Friends of the Global Fund Africa and Family Care International, called TIP—The Integrated Partnership—aims to accelerate demand and resources for increased integration of FP/RH and HIV and TB services in Burkina Faso, Ethiopia, Kenya, Nigeria, Tanzania and Zambia. TIP will target the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria to increase the priority placed on integrated activities.⁹⁹

Text messages for at risk populations

Laos is one of several TB-prevalent countries where Population Services International (PSI) is training private-sector clinics to screen for TB and offer family planning and management of childhood illnesses in rural and remote areas. PSI is also extending the work of outreach workers through cell phone text messaging to individuals at risk of TB, urging them to seek testing if they have symptoms.¹⁰⁰

E. Integrating family planning into adolescent programming

With more than a billion youth entering the reproductive ages, improving access to RH/FP and HIV prevention services for adolescents is a high priority for global development. Greater access to information and services is essential if youth are to avert more of the primary health threats facing them. It is well established that adolescents are more likely to use RH services that are exclusively for youth, or are at least youth friendly, respectful, and confidential.¹⁰¹ Reaching young people early in life with the knowledge and tools to help them protect their sexual and reproductive health can set the course for many years of more healthful behavior. Armed with such knowledge, these youth can make better decisions and choices for the rest of their lives.

Rationale

Many youth are sexually active before adulthood, either within or outside of marriage, and are more vulnerable than adults to reproductive health risks. Adolescents, in general, have poor knowledge about RH and prevention of unintended pregnancy and HIV.

- Each day, 2,500 youth become newly infected with HIV. The nearly 900,000 youth who became infected in 2009 represent 41 percent of those who became newly infected with HIV. Most youth do not know their status.¹⁰²
- One in three girls in low-resource settings is married before age 18.¹⁰³ Among married adolescents 15 to 19, unmet need for contraception is high. Globally, only one-third of married adolescents who want to avoid pregnancy are using contraception. Analysis of 64 DHS conducted between 1994 and 2008 found that in all regions, married women aged 15–19 have greater difficulty than older women in meeting their need for contraceptive services.¹⁰⁴
- Unmarried sexually active adolescents have a high unmet need for contraception, and limited access to services. As a result, adolescents have a high rate of unintended pregnancies which often end in abortion. Adolescents account for 14 percent of all unsafe abortions globally, about 2.5 million per year,¹⁰⁵ but they may account for a higher proportion of deaths because they are less likely than adult women to seek treatment for complications.
- Adolescents face a higher risk of complications and death from pregnancy-related causes than older mothers do.¹⁰⁶ In most low and middle income countries, complications in pregnancy and childbirth are the leading cause of death for adolescent girls.¹⁰⁷ Maternal deaths are up to twice as high for women ages 15 to 19 as compared to women 20–34, and deaths to infants born to adolescent mothers are also much higher.¹⁰⁸

With more than a billion youth entering the reproductive ages, improving access to RH/FP and HIV prevention services for adolescents is a high priority for global development.

Health Impact

More than seven million unintended pregnancies among adolescents in Asia, sub-Saharan Africa and Latin America could be prevented if adolescents had access to modern, effective contraceptives.¹⁰⁹

Averting these unintended pregnancies would reduce maternal and infant deaths and contribute to all of the related benefits described above.

Examples from the field

Promising partnership addresses youth issues

In Bangladesh, with support from the Netherlands, the new Growing Up Safe and Healthy (SAFE) project works with youth in urban slums to integrate RH services with legal services and human rights education, particularly around domestic violence and child marriage. Marie Stopes International provides sexual and reproductive health awareness education and access to services for youth. Bangladesh Legal Aid and Services Trust provides legal aid and support services through one-stop service centers located near slums, and the Population Council provides technical assistance and conducts research.¹¹⁰

Integrating family planning and reproductive health into youth development programs

The International Youth Foundation (IYF) believes that an integrated approach to RH is an effective route to improve youth reproductive health, and that programs that address multiple aspects of youth's lives are likely to have a lasting impact. IYF has integrated FP/RH into health programs focused on HIV prevention, malaria, infectious disease and maternal and child health; into education and leadership programs and into livelihoods and employability programs. The pillars of their Planning for Life approach, supported by USAID and World Learning, are to strengthen youth competence to make healthy RH/FP choices, involve parents, communities and peers in building a supportive and enabling environment, and increase access to quality family planning and RH services, all in the context of programming that affirms gender equality and meaningful youth participation. Between 2007 and 2011, in India, Jordan, Peru, the Philippines, Saint Lucia, Sri Lanka and Tanzania, IYF has educated youth and trained health providers in offering youth friendly services.¹¹¹

F. Integrating family planning into nutrition/anemia/parasite control programs

Rationale

Programs to improve nutritional status and control parasites, such as helminth infections and malaria, have high value to communities because their health impact can be seen, often in a short time. Where family planning use is low, integrating family planning with nutrition and parasite control can help legitimize family planning as a health intervention. Nutrition shares a special link with family planning in large part because a short interval between pregnancies has nutritional consequences for both the mother and the infant. Adequate nutrition of the mother is perhaps the single most important maternal contribution to a good pregnancy outcome,¹¹² and maternal nutrition can be affected by short intervals between pregnancies. Mothers with a deficiency of micronutrients, particularly iron and folate, are at greater risk of preterm birth and intrauterine growth retardation, both of which increase neonatal

mortality.¹¹³ Adequate nutrition is also vital to the cognitive development of the infant, especially during pregnancy and in the first 1,000 days of life.¹¹⁴

Lactational Amenorrhea Method (LAM) links nutrition and family planning

The importance of exclusive breastfeeding, preferably for six months is a key message for infant nutrition as well as a precondition for LAM, an effective modern method of family planning. Not only does LAM protect a woman against pregnancy until her baby is six months old, but breast milk is the preferred nutrient for infants, supplemented with complementary foods after six months, until the child is two years of age. Integrated family planning and nutrition services facilitate periodic conversations with the mother about the benefits of exclusive breastfeeding for child growth and development as well as the necessity that all three LAM preconditions are met in order to maintain a contraceptive benefit. Before the child reaches six months of age, it is important to emphasize the introduction of complementary foods to support healthy growth of the child, while helping the mother transition to another modern contraceptive method, if she wishes.



Nutrition, birth intervals and cognitive development

Nearly 200 million children under five years old are chronically undernourished (stunted), or severely wasted, and undernutrition is an underlying factor in a third of all deaths to children under five. Undernutrition can also cause severe and irreversible impairments to brain development, beginning early in life, which can affect a child's ability to perform well in school. When a mother shortens the duration of breastfeeding as a consequence of having another child shortly after the birth of her newborn, both children can be at risk of becoming malnourished.¹¹⁵ Because the effects of early undernutrition cannot be reversed and children who are undernourished achieve less schooling and income,¹¹⁶ averting closely spaced births through family planning is an important step in preventing the development of childhood undernutrition.

A lifecycle approach to integrating family planning and nutrition

Antenatal care visits can be an opportunity to provide messages and counseling on both family planning and nutrition interventions, such as iron-folate supplementation, use of iodized salt, and parasite control, such as deworming and treatments for malaria. Family planning can be integrated into infant and young child feeding messages to strengthen and reinforce the need for exclusive breastfeeding, introduction of complementary foods after six months and twice-yearly vitamin A supplementation. Appendix 3, adapted from a Maternal, Infant and Young Child Nutrition and Family Planning working

group technical brief, provides some examples of family planning and nutrition messages appropriate at different times in the pre-pregnancy, antenatal and postnatal period.

Health Impact

In addition to preventing undernutrition of children associated with short intervals between births, family planning integration can lead to reduced infant and maternal mortality and stunting in children, as well as reductions in low birth weight and anemia among infants. A Cochrane review of research on integrating family planning into MNCH and nutrition programs found that, overall, integration improved family planning service coverage, quality and use, and reduced costs in some studies. The review of family planning and nutrition integration included one study that reported increased infant weight and another study that reported reduced infant mortality.¹¹⁷ A systematic review of the effect of birth spacing on maternal and child health found that about half of the studies on child health showed a positive correlation between birth spacing and improved child nutrition, and half of the studies demonstrated that longer pregnancy intervals were associated with improved maternal weight and nutritional status.¹¹⁸

With funding from the European Union, Helen Keller International integrated family planning into child nutrition programs in 30 villages in Niger.

Examples from the Field

Japan's early leadership

There are many examples of integrated family planning and nutrition/ parasite control programs dating from the 1970s when the Japanese Organization for International Cooperation in Family Planning began its first integrated program in Taiwan. This was followed by Korea, Indonesia, the Philippines and Thailand in 1976; Tanzania and Sri Lanka in 1983; and China and Zambia in 1984. These programs used indigenous CHWs to identify problems related to family planning, parasites and nutrition, and educate family members and link them with health services. The integrated program was very successful in getting community participation in improving parasite control as an entrée for family planning. De-worming led to improved nutrition, and reducing eye and foot infections and other problems caused by parasites led communities to be more open to family planning. In Tanzania, contraceptive prevalence in the two project districts nearly tripled.¹¹⁹

Growth monitoring and contraception

Niger has among the highest fertility rates and lowest infant survival rates in the world, and is constantly facing food insecurity and widespread malnutrition. Over a number of years, Helen Keller International (HKI) has introduced the Essential Nutrition Actions (ENA) strategy to improve the nutritional status of women and young children by raising awareness and promoting behavior change at the household level. With funding from the European Union from 2007–2010, HKI integrated family planning into child nutrition programs for 30 villages in the Tanout and Matameye districts. During monthly community-wide growth monitoring events, where children were weighed and measured and mothers were counseled about optimal infant and child feeding practices, a station was provided to counsel women about healthy

timing and spacing of pregnancies. Here, women could obtain a prescription for contraceptives, or be given their first supply of oral pills.

Family planning was also promoted in the villages through theatrical performances and radio broadcasts, and through mobilizing “positive-deviant” men who ensure that their wives receive reproductive health care. A prominent local Islamic leader was engaged to visit communities and confirm that the Koran does not forbid the use of contraceptives. Knowledge of contraception had been very low initially. By the end of the project, knowledge and contraceptive use had increased dramatically, although population-based data was not available.¹²⁰

A large-scale effort improves nutrition through breastfeeding

Family planning was also added to an ENA program in Madagascar that had begun in 1997. From 2000 to 2006, more than 12,000 community health volunteers, 2,000 health workers, 4,500 women’s group members and 500 physicians were trained in a variety of integrated protocols that included family planning and exclusive breastfeeding and LAM. Pre and post surveys showed that the percent of infants under five months exclusively breastfed increased from 42 to 70 percent.¹²¹

Title II food aid and food security assessment shows strong integration with family planning

As part of an ongoing assessment of USAID’s Title II Food Aid and Food Security programs (2003–2009), a review of maternal child health and nutrition activities supported by food aid resources found that 35 percent of 69 programs worked on family planning as part of maternal child health and nutrition services. A number of these programs were able to increase contraceptive prevalence and lengthen birth intervals. Further information is forthcoming.¹²²

G. Integrating family planning into agriculture/coastal management/food security programs

Rationale

Large family size and rapid population growth strain natural resources, and food sufficiency. Niger is a striking example of where the hunger crisis, deforestation, and soil depletion have all been aggravated by one of the fastest population growth rates in the world and a lack of attention to family planning.¹²³ An analysis of 40 National Adaptation Programmes of Action for climate change showed that all of the environmental impacts raised in these programs, from water scarcity to depletion of fishing reserves, were aggravated by rapid population growth. The authors called for “*increased support for rights-based family planning services, including those integrated with HIV/AIDS services, as an important complementary measure to climate change adaptation programmes in developing countries*” and urged that “*integration of family planning should be recognized as an important addition to international efforts to assist least developed countries to adapt to climate change.*”¹²⁴ Integrating family planning with agriculture and food security programs, especially in largely agrarian societies, introduces agricultural workers and agents (often men) to the benefits of birth spacing and the importance of smaller families for sustainable agriculture and environment. Linking family planning and reproductive health also capitalizes on the envi-



ronmental concerns of youth while building their capacity to remain healthy.

Health Impact

Population, health and environment programs are increasingly recognized to have synergistic benefits. Engaging men (and women) through such programs helps overcome their resistance or lack of knowledge about the benefits of family planning and increases their support. This can lead to increased uptake of family planning, reduced unintended pregnancies and a slower rate of population growth. Having fewer people lessens environmental impact on soils, forests and marine life. Improved management of wetlands, water and soil improves nutrition, advancing child development, reducing stunting and providing other benefits previously described.

Examples from the Field

Improving environmental sustainability through integrated programs

At 87 million people, and adding two million people per year, Ethiopia is Africa's second largest country.¹²⁵ Recognizing the link between this rapid population growth and environmental degradation, a project responsible for watershed and wetlands management partnered with the Consortium for Integration of Population, Health and Environment in eastern Ethiopia to integrate family planning into the agricultural sector between 2005 and 2007. The aim was to improve crop production and minimize loss of biodiversity for almost 3,000 rural households that had been severely affected by drought, deforestation and soil erosion. In the context of rehabilitating uplands and wetlands through reforestation, residents were trained in sustainable land management practices, and learned about the impact of rapid population growth on the environment, family planning and HIV/AIDS awareness. By 2009, project results showed that soil degradation had been reversed through improved irrigation, compost and tree planting; and nutritional levels and use of family planning have risen.¹²⁶

Coastal management and family planning integration reduces poverty

The majority of the 100 million people in the Philippines live in coastal regions where rapid population growth is threatening food security, nutrition and the livelihood of fishermen. PATH Philippines found that an integrated approach which combined coastal resource management (CRM) and FP/RH had the greatest impact while holistically addressing the diverse needs of communities dependent on fishing. The Integrated Population and Coastal Resource Management (IPOPCORM) project built local capacity to manage resources and deliver Pop/RH services to improve food security. A baseline survey was taken in 2001, and six years later, the IPOPCORM intervention had greater success than

separate Pop/RH and CRM approaches in terms of greater use of family planning methods among adults and youth, significant decline in use of dynamite and cyanide in fishing, and fewer young adults reporting income levels below the poverty threshold. Fish catch rates doubled and the average monthly income of fishermen increased by 21 percent in the IPOPCORM area. IPOPCORM was also better able than the non-integrated project areas to deflect opposition from religious leaders because family planning was an integral part of a program to improve food security.¹²⁷ Today, in Bohol Island, another of PATH Philippines project areas, family planning is fully integrated into the government's rural primary health care, and, in contrast to the majority of the country, families here can plan their families and family sizes have plummeted.¹²⁸

Integrating family planning into remote marine conservation areas creates synergies

Madagascar is the world's fourth largest island and a least developed country with a population of 20 million that is expected to double in 25 years. In a remote coastal area where fertility exceeds six births per woman and population growth is outstripping resources, Britain-based Blue Ventures started as a social enterprise running research expeditions and promoting marine conservation. Recognizing that the closest family planning services were 50 km away from the coastal area, in 2007, Blue Ventures, with support from USAID, the United Nations Population Fund (UNFPA) and the MacArthur Foundation, began offering family planning as part of its effort to support the sustainable use of marine resources.

By 2011, clinics and community-based distribution reached 40 remote villages, some by dugout canoe. Contraceptive use grew from 8 percent in 2007 to nearly 35 percent in 2011. Raising awareness of the links between sustainable fishing and family planning through peer education programs, films, radio, community theatre, sporting and cultural events, the program takes an integrated approach to achieving interrelated health and conservation goals. The integrated program has created synergies and fostered greater cooperation from communities, and family planning services are highly valued, especially by women who are empowered for the first time to plan their families. The services are provided at minimal additional cost to the organization, whose conservation work is largely covered by expeditions it conducts for paying volunteers. Based on its experience, Blue Ventures has developed a model for family planning integration in remote areas that is ready for replication.¹²⁹



III. What Works? Principles for Community-Based Integration


There are many examples of integrating family planning into health and development programs but few with good data on outcomes. Most implementing agencies and local partners are too busy implementing or have too few resources to collect population-based data or conduct implementation research on what works in which context, and why. A few factors have been scientifically tested or stand out as critical features in numerous interventions.

- Conduct formative research to assess community readiness for new services and identify barriers and enablers.
- Assess the strength of the existing system and reinforce if needed. Adding responsibility for family planning to a weak system will not expand access.
- Engage communities in improving service delivery. Generate demand and support for sustainable community-based services.¹³⁰
- Assist Ministries of Health and their local-level health systems in developing integrated systems for supervision, data collection, recordkeeping, and strong referral protocol and follow-up.
- Build local capacity to ensure adequate supplies of contraceptive and other commodities.
- Build support for integrated services from health workers.
- Overcome resistance and build trust. Involve men, youth and their parents, and religious leaders in awareness raising.
- Select “positive deviants” who model desired behavior change as community health workers/advocates/volunteers. (See Text Box on Positive Deviance on page 17.)
- Train TBAs to promote family planning information and provide referral.¹³¹
- Train community health workers to administer injectable contraceptives and distribute other family planning methods as appropriate.¹³² (See Text Box on Task Shifting on page 5.)

- Link communities with district health staff to share data and increase visibility.¹³³
- Use participatory learning approaches and job aids.¹³⁴
- Develop community capacity to carry out monitoring and evaluation activities.
- Provide ongoing in-service training, supportive supervision and contraceptive updates.

Challenges

While it is beyond the scope of this paper to describe the many challenges that integration entails, it is important to point out that even when services are integrated, they are often underutilized. Clients must be made aware of existing services and of their need for preventive services. One thing providers can do is to improve their screening protocols—the questions they ask women to determine their need for family planning information or services. In a five-country study of HIV service sites that were supposed to have integrated family planning services, FHI found that clients were frequently not being screened for family planning needs. Often this was because a provider trained to offer family planning was not on duty. In addition, many providers had incorrect knowledge, for example that pills or IUDs were not suitable for women with HIV. Stockouts of contraceptives, lack of job aids and posters or communication materials about family planning were also noted in these sites. The evaluation stressed the need for in-service training, supervision and job aids to assist family planning counseling.¹³⁵



One thing all providers can do is to improve their screening protocols—the questions they ask women to determine their need for family planning information or services.

Recommendations

As evidenced in a survey conducted by CORE Group among its *Community Health Network*, NGOs want resources to help facilitate integration such as training materials for local staff and partners, learning aids and curricula, as well as models or best practices. A number of *Community Health Network* participants are currently developing or have developed algorithms, job aids and curricula. For example, the Centre for Development and Population Activities (CEDPA) is developing a screening algorithm and Wellshare International is soon to release a family planning best practices manual. Standards for management and supervision of staff providing integrated services are also needed. It would be important to first assess what is available and how these materials could be made available to other practitioners.

Also needed are clearly written, easily accessible summaries of key policy documents and guidance (such as the WHO Core Competency guidance). These summaries, designed to keep community health practitioners informed of new mandates, should emphasize practical implications, and how principles and guidance can be applied to actual programs.

A CORE Group small grants program has, in the past, enabled members to document strategies and outcomes of their best programs. This type of effort fills a critical gap: the dearth of feedback from programs as to what works in real life settings. Such grants enable staff time to collect data, document results, reflect and make recommendations. This strategy to disseminate best practices to CORE Group members, associates, partners and community health practitioners worldwide should be continued.

In general, CORE Group and the *Community Health Network* urge health and development donors, policymakers, advocates, civil society organizations, the private sector and others to recognize and support the power and potential of family planning integration, with a focus on community level efforts.

Conclusion

The research presented in this paper provides evidence that integrating family planning is a value-added strategy, saving lives, and spurring progress to prevent disease, protect the environment, advance food security and nutrition, and improve the health of young people. Integrating family planning further enables communities to contribute to achieving the Millennium Development Goals for their countries. Despite these benefits, more than 200 million women worldwide, especially poor women and those in rural and remote areas, still lack access to modern contraception. Integrating family planning with existing health interventions at the community level not only broadens access and equity, but improves understanding of the importance of family planning to the health of women, children and the family, and to reducing unintended pregnancies and abortions. With the strong endorsement of WHO, USAID and other policymaking bodies, integrated services including family planning clearly represent the future of community and primary health care.

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Appendix 1

EXCERPT: Sexual and Reproductive Health: Core Competencies in Primary Health Care, WHO, 2011

Competency 7: The primary health-care team member/s provide high-quality family planning care

Tasks as per Competencies 4–6, plus:	Knowledge, skills as per Competencies 4–6, plus:
<p>1. Collect accurate family planning history</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • how FP improves the health of women and their babies, and contributes to the reduction of maternal deaths, and perinatal morbidities and deaths • variety of available contraceptive methods • conditions that affect FP use (medical, social and individual circumstances), rumours and myths related to FP • gender norms and roles affecting the use of, and access to, FP services • gender issues regarding FP • community concerns regarding FP local statistics and targets on FP use • signs and symptoms of gender-based violence (GBV), rape, and vulnerable groups and their needs (GBV is high in couples with fertility problems) • connection between FP and environment, education, etc. <p>Skills – ability to:</p> <ul style="list-style-type: none"> • address myths • rule out pregnancy without a pregnancy test or knowing that the woman is having her period • deal with chronic conditions like HIV • apply Competency 5 to FP
<p>2. Provide correct information on FP (birth spacing, contraception and infertility) to individuals, couples and groups</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • basic understanding of human reproduction, infertility, fertility and fertility regulation • FP benefits, limitations, effectiveness, side effects and health risks, etc. • variety of contraceptive methods • emergency contraception • FP care standards and protocols • The male and his responsibility/involvement in FP • FP as an issue for the couple • how contraceptive methods work: hormonal methods, postpartum and emergency contraception, lactational amenorrhoea method (LAM) and transitioning from LAM to other contraception, intrauterine device (IUD) and post-placental IUD insertion, etc.

Tasks as per Competencies 4–6, plus:	Knowledge, skills as per Competencies 4–6, plus:
<p>2. Provide correct information on FP (birth spacing, contraception and infertility) to individuals, couples and groups (continued)</p>	<p>Knowledge (continued):</p> <ul style="list-style-type: none"> • the effectiveness of different methods compared with one another • contraceptive choices for adolescents • contraceptive choices for individuals living with HIV/acquired immunodeficiency syndrome (AIDS) • management of side effects, method failure, complications • when to provide HIV post-exposure prophylaxis • when and where to refer any clients for special needs • where each FP method can be obtained <p>Skills – ability to:</p> <ul style="list-style-type: none"> • explore about past and current FP use, and future fertility plans • provide tailored and personalized information to help the client and her/his partner to make FP informed, • voluntary decisions • explain method use
<p>3. Assess the client for medical eligibility for FP, performing, where necessary and appropriate, physical examination and tests</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • medical eligibility criteria for the use of FP methods <p>Skills – ability to:</p> <ul style="list-style-type: none"> • rule out if a woman is pregnant, in order to be able to provide contraception when desired • perform physical examination and history-taking to detect conditions that would contraindicate the use of • contraceptive methods
<p>4. Carry out FP procedures</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • FP planning methods <p>Skills – ability to:</p> <ul style="list-style-type: none"> • demonstrate male and female condom use • fit cervical barrier methods • give injections • provide emergency contraception and HIV post-exposure prophylaxis • insert and remove IUDs, implants and other contraceptive devices • provide or refer for male and female sterilization services • discuss and explain the “standard days” method and other natural FP methods

Tasks as per Competencies 4–6, plus:	Knowledge, skills as per Competencies 4–6, plus:
<p>5. Assess satisfaction with and correct use of method with return clients, helping dissatisfied clients or clients experiencing problems to switch to other methods</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • interviewing and history-taking methods • side effects and problems with use • follow-up needs • schedule of follow-up, resupply <p>Skills – ability to:</p> <ul style="list-style-type: none"> • interview and take history • reassure client about the method they chose • assist them in solving issues • help them in switching methods
<p>6. Assess individual/couple for infertility and refer if needed</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> • concepts of infertility, causes and management (links to STI, reproductive tract infection (RTI) management, • cervical screening, infectious diseases such as tuberculosis (TB), HIV, hepatitis B and C • guidelines on when to refer if needed for evaluation, treatment, negative behaviour (i.e., smoking cessation, stress reduction) or to fertility support groups • sociocultural beliefs and practices that are either useful, neutral or harmful (i.e. unacceptability of men masturbating in order to obtain a semen sample, traditional healers to be consulted prior to modern medicine) • factors that could lead to infertility: nutrition/folic acid, age (sex differences), birth weight, smoking • relationship and other stress, over-the-counter and recreational drugs (alcohol), occupational hazards • scrotal injury or temperature (men) • laboratory procedures, e.g., simplified semen analysis (volume, pH, sperm count and motility), postcoital test or referral • fertility-awareness methods <p>Skills – ability to:</p> <ul style="list-style-type: none"> • provide couple-centred management • take a history for infertility (specific criteria) • administer a physical examination to identify gross morphology of male or female genitalia • conduct preconception counselling on lifestyle: nutrition/ folic acid, age (sex differences), birth weight, smoking, relationship and other stress, over-the-counter and recreational drugs (alcohol), occupational • hazards, scrotal injury or temperature (men)

Appendix 2

Selected Programmatic Tools

A Framework for Integrating Reproductive Health and Family Planning into Youth Development Programs. Baltimore: International Youth Foundation, (IYF), 2012.

Basics of community-based family planning training curriculum facilitators guide. (Includes session on family planning integration.) Child Survival Technical Support Plus Project, Macro International, 2009

Decision-making tool for family planning clients and providers: a resource for high quality counseling, Geneva: WHO, 2005 and implementation guide, 2007.

Family planning: a global handbook for providers, 2007. Available online at http://whqlibdoc.who.int/publications/2011/9780978856373_eng.pdf

Family planning and HIV integration: approaching the tipping point. (Contains technical guidance, tools and programmatic resources for FP/HIV integration.) Research Triangle Park: FHI, 2010.

Increasing access to contraception for clients with HIV: A toolkit, Research Triangle Park: FHI, 2010.

Integrating Family Planning into Maternal and Child Health Programming: How to design social and behavior change activities. Training Curriculum. Washington, D.C: CORE Group. Forthcoming.

Mobilizing Muslim religious leaders for reproductive health and family planning at the community level, a training manual. Washington DC: Extending Service Delivery Project (ESD) and Pathfinder International, 2009.

Management of MDR-TB: A Field Guide. Geneva: WHO and Partners in Health, 2008.

Medical eligibility criteria for contraceptive use, WHO, 2010. available online at http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf

Appendix 3

Examples of integrated Maternal, Infant and Young Child Nutrition and Family Planning Counseling and Services*

Time	Family planning counseling and messages	Nutrition counseling and messages
Adolescence	<ul style="list-style-type: none"> • Advise parents and young girls to delay early marriage and childbearing. • Counsel on and offer a range of FP methods. 	Educate youth, especially girls, on the importance of good nutrition.
Before pregnancy	Counsel on the benefits of healthy timing and spacing of pregnancies.	<ul style="list-style-type: none"> • Counsel on the need for iron folate and iodized salt and the importance of maternal nutrition during pregnancy and breastfeeding. • Counsel on the value of immediate and exclusive breastfeeding for six months.
During pregnancy	<ul style="list-style-type: none"> • Counsel on family planning methods that can be initiated immediately after birth, such as LAM and the IUD. • Encourage giving birth with a skilled birth attendant. 	Counsel on the early use of iron-folate supplements and use of iodized salt, maternal nutrition and adequate weight gain during pregnancy; immediate and exclusive breastfeeding for six months; and continued breastfeeding while giving complementary foods from 6 to 24 months.
Birth through 7 days	Counsel on LAM and the benefits of healthy spacing of pregnancies.	<ul style="list-style-type: none"> • Encourage giving colostrum; provide support for immediate breastfeeding; and counsel on the benefits of exclusive breastfeeding. Provide iron-folate supplements for mothers. • Encourage all mothers to consume food that is rich in vitamin A on a daily basis.

Time	Family planning counseling and messages	Nutrition counseling and messages
6 to 8 weeks	<ul style="list-style-type: none"> • Encourage postnatal care. • Remind women of the three LAM conditions and that return to fertility can occur prior to onset of menses when women are not exclusively breastfeeding. • Counsel on family planning methods compatible with breastfeeding if not using LAM (progestin-only hormonal contraception, IUD, tubal ligation, vasectomy, condoms). 	<ul style="list-style-type: none"> • Continue to support exclusive breastfeeding to 6 months (baby needs no other fluids, not even water). • Ensure that mothers receive a vitamin A supplement by eight weeks after birth (if consistent with national policy). • Provide iron/folate supplements for anemic mothers.
3 to 6 months	<ul style="list-style-type: none"> • Counsel on healthy birth spacing, return to fertility, and family planning methods based on breastfeeding status • Screen for LAM transition. • Provide family planning methods. 	<ul style="list-style-type: none"> • Counsel on maternal nutrition and provide iron/folate supplements as needed. • Continue to support exclusive breastfeeding.
6 to 9 months	<ul style="list-style-type: none"> • Counsel on the need to initiate another modern family planning method even if menses has not yet started. • Provide or refer for family planning methods. 	<ul style="list-style-type: none"> • Ensure introduction of complementary foods at 6 months. • Counsel on providing energy- and nutrient-dense complementary foods and continued breastfeeding for two years or beyond.
9 to 12 months	<ul style="list-style-type: none"> • Counsel on family planning. • Provide family planning methods or refer. 	<ul style="list-style-type: none"> • Counsel on nutrition for breastfeeding mothers and optimal complementary feeding. • Counsel on and provide support for continuing breastfeeding for two years or beyond.

Time	Family planning counseling and messages	Nutrition counseling and messages
12 to 24 months	<ul style="list-style-type: none"> • Remind mothers about healthy birth spacing. • Provide family planning methods or refer. 	<ul style="list-style-type: none"> • Support optimal complementary feeding and continued breastfeeding for two years or beyond. • Counsel on the benefits of extended breastfeeding for the mother's health, such as reduced risk for some cancers and heart disease.

*Adapted from Maximizing Synergies Between Maternal, Infant, and Young Child Nutrition and Family Planning, a technical brief produced by the MIYCN/FP working group under MCHIP/JPHIEGO, with funding from USAID.



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