



Weekly News Review – 11 August 2017

A round-up of the week's most important, Africa-focused Family Planning and Reproductive Health reporting

Context in foreign assistance

Access and delivery of family planning services depend on many factors. This week saw a number of discussions and research reports about the effects of cultural sensitivity and technology appropriateness on that access and delivery.

The international discussion continues to start with the [“foreseeable harm of Trump’s Global Gag Rule”](#), which an analysis in *Studies in Family Planning* concludes fails to accomplish its primary aim, harms the health and well-being of individuals and populations (including an increase in maternal mortality), and slows governments’ towards meeting international obligations across the board, including the SDG’s.

The effects can be felt across Africa. The founder of [Everywoman Everywhere](#) [noted](#) that on a recent trip to **Kenya**, **DRC** and **Somalia**, “Despite widely varied contexts, two refrains were consistent: an acute awareness that their survival depends on choosing to have smaller families, and an utter lack of agency in making that a reality.” A VICE news report from [Malawi](#) shows the negative consequences for contraception and STI and HIV treatment.

The Sustainable Development Goals (SDGs) on maternal health call for reducing the global maternal mortality ratio (MMR) to below 70 per 100,000 live births by 2030, with no single country having an MMR of more than 140. At a Wilson Center event, UNFPA’s Rachel Snow noted, “One of the ways to achieve these goals is by collecting [comprehensive and disaggregated data on maternal health](#) in every country that has committed itself to the SDGs.’ But how can countries collect the most reliable and indicative data, and what are the gaps that need to be filled? Doris Chou of the World Health Organization explained that countries are not all on the same page when it comes to maternal health measurement; some country databases have not been updated since the Millennium Development Goals (MDGs) ended in 2015.” Another SDG focus is births attended by a skilled birth attendant. Yet an analysis in *Devex* notes [“the focus on SBAs could be distracting](#) from even more fundamental health system reforms,” with a UK NGO adviser suggesting “a more holistic means of measurement.”

[“Achieving the targets of FP2020 is essentially a challenge of the Global South,”](#) according to an essay from Partners in Population and Development, yet “most of the Family Planning policy research is led by the institutions of the Global North... South-South Collaboration has great potential to lessen inequity in access to family planning commodities and make progress toward universal access to family planning.”

Studies promoting smaller families as “[the most effective way to mitigate climate change](#)”, as an [economic development](#) tool, or finding “[linkages between family planning, inclusive economic growth, and resilience](#)” can sometimes be seen out of context as well.

Context in local solutions

Across Africa, addressing healthcare access is particularly urgent. “[Africa currently has 24% of the world’s burden of diseases yet has only 3% of the global health workforce](#). Added to this challenge, was the “brain drain” of health professionals, including nurses, which continued to plague countries across Africa.” Some local responses: **Ethiopia** “is part of an emerging global movement to provide [quality basic surgical care](#) to families so women in need of caesarean sections don’t die” by training “health care workers like nurses, clinical officers, general practitioners, and midwives who are already on the job.” [Local health workers in Angola](#) are receiving specific sexual health train or their communities. In **Sierra Leone** and **Somaliland**, a study from *BMC Health Services Research* on [traditional birth attendants](#) shows that “through further integrating them into the formal health system... their potential is arguably critically important in promoting universal health coverage in fragile and conflict affected states where... maternal and newborn health care needs particularly acute.” In Kenya, researchers used “[behavioral economics to help women decide where to give birth in Nairobi](#).”

A number of articles and studies about **Nigeria** this week: MamaYe is working to make [maternal health intervention sustainable](#). Other successes reported in Nigeria include “[a 10 percentage-point increase in the use of modern contraceptive methods](#) and a similar increase in the desire of women to have fewer children” in part attributable to a sustained, four-year communications effort led by the Johns Hopkins Center for Communication Programs (CCP). “In clinics, on television programs, in brochures, the message of the CCP program was the same: Know, Talk, Go. Know the facts. Talk to your partner. Go for services.” And in Lagos state, “[in less than six months, there was uptake of family planning by 600,000 women](#), following improved services, enabling the state to prevent 46,000 unsafe abortions, 143,000 unintended pregnancies and 800 maternal deaths, according to its Ministry of Health.” And another recent study shows “[changing attitudes towards family planning and desired family size among rural dwellers](#)... so more women and couples will be seeking family planning services. Addressing obstacles such as access, affordability, and availability will help meet these needs and ensure that women and couples can meet their childbearing and reproductive health goals.” And *Global Health Now* spoke with Margaret Bolaji, a youth activist for girls’ health and rights in northern Nigeria, who noted “[policy barriers that prevent young people from accessing the resources they need to plan their families](#). Also, the few youth-friendly services available are not evidence-based, and do not meet context-specific needs (differences in sex, age, marital status or parity) and do not include a full range of methods.”

The Universal Access Project calls for support in the ongoing [famine crises](#) in **South Sudan**, **Nigeria**, Yemen and **Somalia**, where “girls and women have the least power and status, and often at times of crisis, their basic needs are de-prioritized or neglected, and the fulfillment of their essential health and rights – including the ability to plan their family and futures – is left by the wayside... In many places, access to family planning services and information is limited or nonexistent for girls and women who wish to delay or prevent pregnancy. If and when a woman does become pregnant, her health and that of her future child are at risk.”

A report from **Uganda** says the government has spent \$600,000 on [female condoms, but a low uptake is leading to fears of a rise in HIV](#). That story is balanced by news of a local NGO, HEPS-Uganda, which has helped [health centers change their procurement policies](#) to attune to local needs.

In West Africa, as a part of the Ouagadougou Partnership, [family planning youth ambassadors](#) are being deployed. Concerts to reach young people with family planning and maternal health information are taking place in [Ghana](#) and [Zimbabwe](#). Four **Tanzanian** university students were feted for creating a [smartphone app to spread SRH information](#).

[PopWorks Africa](#) partners with leaders in the community, NGOs, and government sectors to create development programs that are innovative and sustainable in their support of healthy communities. Focusing on youth and social movements on the African continent, its mission is “to break silos...while highlighting the innovative work and activism already being done.”

An assessment of **Malawi** undertaken by UNFPA and UNHCR [linked SRMNCH to the human rights](#) context: “The poor SRMNCH indicators are intricately linked with violence against women, poor health seeking, marginalization, women’s minimal participation in decision making, the under-prioritisation and under-funding of services and goods only women require and lack of accountability mechanisms to respond to maternal deaths and grievous injuries. Human rights violations are therefore both a cause and consequence of poor performance in SRMNCH.”

A women’s group in **Liberia** is pushing for a [law against FGM](#), though another article refers to a [“shadow society that controls women’s bodies.”](#)

In **Rwanda** where the maternity mortality ratio dropped from 1,071 out of 100,000 in 2000 to 210 out of 100,000 in 2015, Health Minister Dr. Diane Gashumba lists addressing [“the social determinants of poor maternal health outcomes”](#) as her top priority, because that “will help to identify major obstacles and the most effective coordination mechanisms.”

And [Pathfinder International](#) is shifting its operational focus to the field, “breaking down the headquarters/field divide, working with refugees and host-country populations, and combining family planning with conservation,” among other innovations.

Stigma, conscientious objection and bearing witness

The stigma barrier also shows itself differently in a variety of contexts.

Western Sydney University published research which shows that for [refugee and migrant women](#), “a cycle of misinformation, shyness and fear is preventing [these] women from receiving adequate sexual and reproductive health care and support.”

A study in *BMJ Global Health* says that “the [global taboo surrounding vaginal bleeding](#) is putting women and girls around the world at risk.” Silence can also be harmful when it comes to [fighting malaria](#): pregnant women across sub-Saharan Africa do not seek prevention or treatment, mostly because of lack of knowledge, but sometimes even a belief in “supernatural forces.”

“[Conscientious objection](#)” to providing family planning services is on the increase. Recently, “50 experts from 20 countries in Africa, the Americas and Europe, gathered at the first international convening on conscientious objection to abortion concluded that the refusal to provide legal abortion services is hurting women all over the world and must be tackled.”

[Abortion storytelling](#) gives women “the capacity to change their friends’ perspectives on abortion with their own stories,” according to recent research, even if they bring up [painful memories](#). As one writer who had an abortion at 19 puts it, “If you’ve terminated a pregnancy, talk about your abortion, even if you are afraid. Talk about it because you’re afraid. If it’s too scary to tell the truth for yourself, then tell it for others and we’ll all be free.” In western **Kenya**, “community groups now encourage women — and men — to freely share their [unsafe abortion experiences](#).”

The volatile US context

The Democratic Party is having an internal, though public, [debate about supporting anti-abortion candidates](#), for which some say “[women would pay an enormous price](#).” More action in [Congress](#), legislatures and the courts (“[Trump’s picks are “terrible”](#)”) about abortion access in [Texas](#) (“[If Only Texas Regulated Gun Ownership Like it Does Reproductive Rights](#)”), [New Jersey](#), [Illinois](#), and [Missouri](#), including [cuts for programs that fight teenage pregnancy](#).

Meanwhile, in Ontario [Mifegymiso will be available for free](#), joining two other provinces, in a policy that attempts to “[completely remove what is often a significant barrier to abortion](#) — i.e. financial constraints — and make it accessible to women of all socioeconomic levels.”

Good reads

[Development + Cooperation](#) issue on pregnancy and childbirth; [Under-served and Over-looked](#) and [DELIVER+ENABLE TOOLKIT: Scaling-up comprehensive sexuality education \(CSE\)](#) from IPPF; a compendium of articles about “[Conscientious objection](#)” from the International Campaign for Women’s Right to Safe Abortion.

CIRHT!

And just for fun, have a look at the nascent [CIRHT Flickr account](#). More to come there as well.

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