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Do no harm! Opportunities in integrating family planning and immunization services

Rebecca Fields
Senior Technical Advisor for Immunization
Maternal and Child Survival Program /JSI
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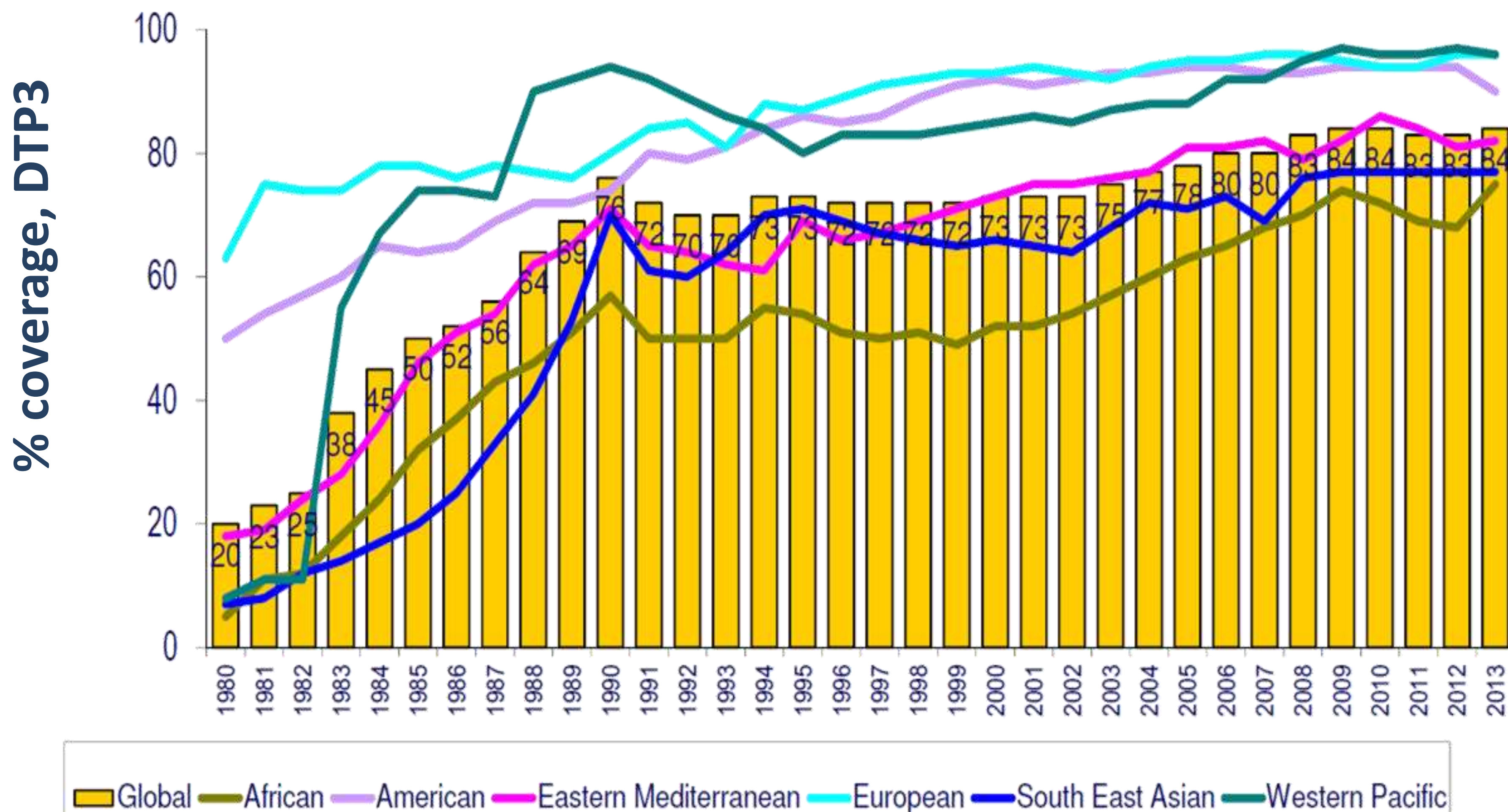
What is the opportunity?

- Use the platform of child immunization contacts to refer mothers (post-partum women) for family planning services
- Key considerations in using the child immunization platform:
  - ***HOW MANY*** can be reached
  - ***WHO*** can be reached
  - ***WHEN*** can they be reached
  - ***HOW*** can they be reached in a way that is good for FP and does no harm to immunization?

How many can be reached through immunization?
Depends on how many reached with immunization

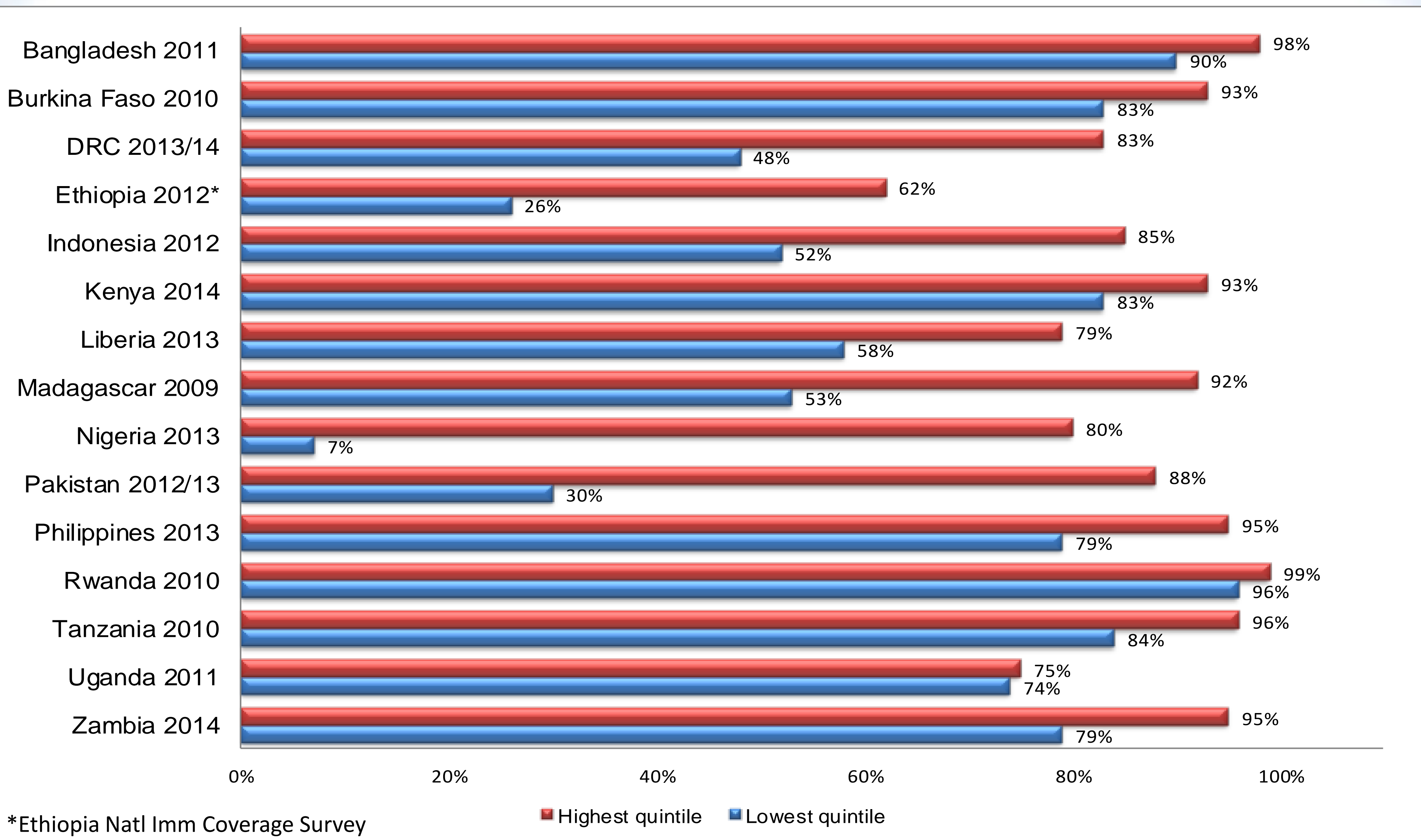


Source: WHO/UNICEF coverage estimates 2013 revision. July 2014
Immunization Vaccines and Biologicals, (IVB), World Health Organization.
194 WHO Member States. Date of slide: 15 July 2014.

WHO can be reached through immunization?

DTP3 coverage is lower in poorest wealth quintiles

Source: DHS surveys in 15 African and Asian countries 2009-2014*



*Ethiopia Natl Imm Coverage Survey

WHEN can women be reached through immunization? **Dependent on the routine immunization schedule. In most countries:**

- Birth
- 6 weeks
- 10 weeks
- 14 weeks
- 9 months
- Actual time of immunization is often later but this is not desirable as it prolongs exposure to disease

A. Diallo, MCSP

HOW can women be reached through immunization?

Recognize positive and negative effects for immunization

Positive:

- Secure support for immunization by using it as platform to serve another program
- By increasing convenience to caregivers through "one stop shopping" increase utilization of services and vaccination coverage

Negative:

- Deter mothers who accept EPI but not FP
- Create confusion that EPI is really FP and a masked attempt to sterilize women or children

Extensive documentation of rumors in Africa that vaccines cause sterility, 1950s-2006*

Date	Country	Health intervention	Details of rumor	Source
1950s	Rhodesia	Childhood vaccination	Causes sterility	Kaler 2004
1959	Congo	Polio vaccine	Makes children sterile	Hooper 2004
1960	Nyasaland	Smallpox vaccine	Causes sterility	Vaughan 1994
1980	Uganda	Polio vaccination	Makes children sterile	
1983	Burundi	Childhood vaccination	Makes children st	
1986	Kenya	Childhood vaccination	Contains co	
1990	Cameroon	Tetanus toxoid	Makes ch	
1992	Nigeria	Childhood vaccination	Makes c	
1994	Tanzania	Tetanus toxoid	Is “ant	
1996	Kenya	Childhood vaccination	Makes	
1996	Malawi	Childhood vaccination	Makes	
1996	Uganda	Polio vaccine	Contain	
1997	Kenya	Polio vaccine	Contains	
1998	Angola	Childhood vaccination	Contains con	
1999	Mozambique	Childhood vaccination	Causes sterility	
2003	Niger	Childhood vaccination	Makes children sterile	
2003	Nigeria	Polio vaccine	Causes sterility	Yahya 2006
2003	Zambia	Measles vaccine	Makes children sterile	Kokic 2003
2004	Somalia	Polio vaccine	Makes children sterile	Chitnavis 2004
2005	Guinea	Childhood vaccination	Contains “family planning”	Millimouno 2006
2006	“West Africa”	Childhood vaccination	Causes sterility	Jegede 2007
2006	Djibouti	Polio vaccine	Makes children sterile	IRIN 2007

plus Philippines (1990s), Madagascar (2007), Pakistan (2013 onward), Kenya (2015)

Often associated with mass vaccination campaigns

*from Kaler, *Soc. Sci. Med* **68** (2009): 1171-1719

Do No Harm: Mitigate the risks

Reduce risks

- Design approaches with win/win appeal that recognize and address risks
- Involve immunization staff at multiple levels

Measure effects

- Actively monitor effects of integration on EPI
- Share data that demonstrate gains; address areas needing improvement

Share experience

- Disseminate experience
- Engage country level immunization staff in sharing experiences with integration

Conclusions

- Routine immunization contacts are opportunities for PPFP referral but their limits must be recognized
- Win-win models for FP/immunization integration should be designed with input from FP and immunization staff and monitored for effects on both services
- Maintaining a strong platform of immunization is vital to both FP and EPI - and to the health of women and children

Jos Vandelaer, UNICEF

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