Integrating reproductive health: myth and ideology

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Since 1994, integrating human immunodeficiency virus/sexually transmitted disease (HIV/STD) services with primary health care, as part of reproductive health, has been advocated to address two major public health problems: to control the spread of HIV; and to improve women's reproductive health. However, integration is unlikely to succeed because primary health care and the political context within which this approach is taking place are unsuited to the task. In this paper, a historical comparison is made between the health systems of Ghana, Kenya and Zambia and that of South Africa, to examine progress on integration of HIV/STD services since 1994.

Our findings indicate that primary health care in Ghana, Kenya and Zambia has been used mainly by women and children and that integration has meant adding new activities to these services. For the vertical programmes which support these services, integration implies enhanced collaboration rather than merged responsibility. This compromise between comprehensive rhetoric and selective reality has resulted in little change to existing structures and processes; problems with integration have been exacerbated by the activities of external donors. By comparison, in South Africa integration has been achieved through political commitment to primary health care rather than expanding vertical programmes (top-down management systems).

The rhetoric of integration has been widely used in reproductive health despite lack of evidence for its feasibility, as a result of the convergence of four agendas: improving family planning quality; the need to improve women's health; the rapid spread of HIV; and conceptual shifts in primary health care. International reproductive health actors, however, have taken little account of political, financial and managerial constraints to implementation in low-income countries.

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Introduction and background

In 1994 at the International Conference on Population and Development in Cairo more than 180 governments committed themselves to providing a comprehensive set of reproductive health services for women, men and adolescents (*1*). Considerable attention was also paid to the best way to provide these services: in particular, there was an emphasis on integrating what had previously been separate services so that individual women could receive care for a range of problems during one visit to a health facility. Since 1994, substantial effort has gone into integrating these services in low-income countries. With the rapid spread of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) pandemic (*2*), high levels of associated sexually transmitted diseases (STDs) (*3, 4*), and the relative paucity of services to manage these problems in the general population, there has been a particular focus on integrating HIV/STD services with mainstream maternal and child health care (MCH) and family planning (FP) (*5*).

Such integration has therefore been advocated with a view to controlling the spread of HIV and improving women's overall reproductive health. Despite international agreement on these matters, however, there is little evidence that integration is an effective public health measure (*6*). Indeed, we argue here that integrating this limited range of services is unlikely to solve either problem. We link this anticipated failure, in part, to the inappropriate transfer of services between different settings, and to the gap between ideology and the reality of inadequate primary health care delivery systems and unsupportive political contexts in many low-income countries.

In 1978 the Declaration of Alma-Ata made an international commitment to comprehensive primary health care as part of a broader political and economic development agenda (*7*). During the last 20 years, however, the ideals of Alma-Ata have ceded to selective care based on service packages, which were perceived to be economically efficient. The reproductive health movement, which emerged late in this period after substantial reductions in child mortality, has, since its inception, been selective in its attention

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Ref. No. **0042**

to particular aspects of the health of adults: reproductive problems form a large part of the adult disease burden, particularly among women (*8*). However, unlike primary health care, this movement has accepted the financial difficulties of health sectors in low-income countries and focused on cost-effectiveness as opposed to equity in service delivery (*9, 10*). These ideological differences have influenced the integration of services.

In the present paper we consider a study conducted over the period 1997–98 in Ghana, Kenya, South Africa, and Zambia (*11–14*), the main objective of which was to investigate progress made in the development of policies for integrating HIV/STD and MCH/FP services. A secondary aim was to assess the extent to which policies had been implemented. We examine the problems that have arisen among health ministry officials, donors, and implementing organizations with regard to how to define integration and formulate policies to achieve it. A comparison is made between the health systems of Ghana, Kenya, and Zambia, which have been dominated by vertical programmes and donor involvement, and the health system in South Africa, where, since 1994, there has been a political commitment to providing a comprehensive primary care service to the entire population.

Integration in sub-Saharan Africa: definition and practice

In the 1970s and early 1980s, primary care in low-income countries promoted a comprehensive set of services to be provided, in the first instance, through basic health posts that were accessible and affordable to all; referral to more limited secondary and tertiary facilities took place as required. Early on, however, the position was undermined by ideological shifts and financial and logistic dilemmas. Instead of comprehensive primary care, a select set of services was provided by specialized nursing staff concentrating on child health, antenatal and postnatal care for mothers, or family planning. As a result, primary care services in Ghana, Kenya, and Zambia have been used mainly by women and children. Moreover, because of staff specialization, clients have had to seek care from various providers, perhaps on different days and at different sites, in order to meet all their health needs.

These separate *services* have been managed through distinct, top-down management *systems* (vertical programmes) that have often reflected greater concern for international and national policy-makers' goals than for community needs (*15*). In Ghana, Kenya, and Zambia, separate bodies responsible for MCH and the control of HIV and STDs have been established in the health ministries, while other bodies have been set up to oversee policy on family planning in population offices outside the ministries. Although formally designed to provide technical support for integrated service delivery where management capacity has been weak, vertical programmes have frequently perpetuated the separation of services through their independent systems for human resources, finance, logistics and monitoring. Attention has recently been directed towards strengthening the management of primary care through decentralized district teams. However, improvements in service delivery have yet to be demonstrated and tensions with vertical programmes continue. Efforts to devolve responsibility and accountability to districts have also been complicated by major health reforms and increasing participation by private or nongovernmental organizations (*16, 17*).

Policy-makers have had to take these factors into account when planning the provision of integrated reproductive health services. Integration was an assumed characteristic of primary care but it has taken on a new meaning in the 1990s as a compromise between the rhetoric of comprehensive care and the reality of selective service delivery. The ideal would be access by all to a full service, including reproductive health, during one visit. In practice, however, where primary care has been limited to MCH and FP, integration has come to mean adding new activities to these services. For the vertical programmes that support these services, integration implies enhanced collaboration rather than merged responsibility. The definitions of what is involved have varied in Ghana, Kenya, and Zambia and have rarely been formally documented. At service level, definitions have ranged from the supermarket approach in Kenya, in which clients have to see only one provider for all needs, to the teamwork approach in Ghana, where providers refer clients to separate services as required. At the programme level, integration has been defined as cooperation between staff over policy development through workshops, funding arrangements and joint appointments.

This compromise between comprehensive rhetoric and selective reality has not resulted in much change to existing structures and processes. There was evidence in all three countries that managers of national HIV/STD and MCH/FP programmes had been cooperating on new policies for increasing attention to STDs through MCH/FP services. However, this process has not been well coordinated, resulting in large numbers of overlapping policies emanating from different health ministry departments. Developments in policy formulation have been hindered by inadequate allocation of responsibility between different programmes, a lack of communication between programme staff, i.e. those associated with child health care or family planning divisions, amongst others, and health system employees, i.e. individuals devoted to drug or finance management divisions etc., and limited organizational commitment to improving quality and equity. In Ghana, for example, FP management has remained separate despite advances in the integration of district systems. Similarly, in Kenya the provision of new drugs for the treatment of STDs has remained distinct

from existing logistics systems, and drugs have been packaged so as to exclude treating other infections.

At the service level there has also been a focus on adding less complex or less sensitive components of the comprehensive control of HIV/STDs to existing MCH/FP services, especially clinical care. In all three countries, for example, guidelines for syndromic management of STDs were more widely available than health promotion materials, and nurses were more likely to have been trained in clinical care than in counselling for HIV testing, condom promotion or partner notification. There is also evidence from these countries that, in respect of interactions between clients and providers in the area of MCH/FP, only around one-quarter of clients received any information about STDs or HIV and almost none underwent case detection procedures for STDs or received HIV care (*18*).

Problems with integration have been further exacerbated by the activities of external donors. The rhetoric of international policy meetings has not been reflected in project assistance at national level. Just as health ministries have adapted pre-existing health systems to the new agenda, so donors have added particular aspects of reproductive health to prior project activities, which have tended to promote vertical approaches in order to satisfy donor government needs for transparency in expenditure and reporting. Thus Ghana and Kenya, supported by the United States Agency for International Development (USAID) and the World Bank, respectively, have used vertical family planning logistical systems to distribute drugs for the treatment of STDs to primary care facilities. Similarly, UNICEF has supported the integration of screening of pregnant women for syphilis as part of its safe motherhood programme in Zambia but not other aspects of the comprehensive control of HIV/STDs.

In Ghana, Kenya, and Zambia both government and donor decision-makers have supported the international rhetoric on integration while being aware of the obstacles at national level. Defining and formulating appropriate policies has thus proved difficult. Operational definitions have been elusive because integration means different things at different types of facility and to different levels of administration. Furthermore, it depends on staff outside specific programmes to achieve functional integration. Reproductive health care, like primary care before it, has consequently been unable to provide clear guidelines on implementation. While there have been strong ethical and conceptual rationales for integration, pre-existing vertical management and separate service delivery have hindered efforts to translate concepts into practice.

South Africa: integrated and comprehensive?

In South Africa, the integration of HIV/STD services with MCH/FP has been occurring in political circumstances that differ from those in the other three countries considered here. Since 1994 there has been a strong commitment to providing comprehensive free primary care for all, in line with the Declaration of Alma-Ata. This commitment has been guided by a desire to improve equity in access to health care and to achieve gender equality and reproductive rights in accordance with the country's new constitution. The Ministry of Health has maintained separate programmes for HIV/STD control and MCH/FP, and has designated them as national health priorities. However, in contrast to the situations in the other countries studied, management of all financial, human resource and logistical systems has been fully integrated in the provinces, assisted by the relative independence of provincial decision-makers under the new federal system. Thus the role of national programmes has been to provide technical support for integrated implementation through horizontal management systems at the national, provincial and district levels. Similarly, service integration has been defined as a supermarket approach supported by an evolving system of district management teams; both HIV/STDs and MCH/FP are included in this broad package. This clear vision of what primary care should look like and how it should be managed differs markedly from what is seen elsewhere in sub-Saharan Africa. In particular, it includes services for all population groups rather than being limited to childbearing women and their offspring.

Defining the integration of reproductive health services has therefore not been an issue in South Africa, since integration has been a central element of the approach to primary care. Of course, there have been problems, and the staff of former health care structures have found it difficult to adapt to the new system. Most crucially, communication difficulties and consequent conflicts over the setting of priorities have arisen between, on the one hand, national and provincial managers of technical programmes for HIV/STDs and MCH/FP, and, on the other, provincial staff responsible for integrated implementation. Poor capacity for health system management has further limited the implementation of objectives, raising the temptation for the programmes to re-establish separate mechanisms for improving efficiency. At the service level, the provision of comprehensive care and, especially, free curative care, has stretched capacity at health facilities, making it difficult for providers to prioritize activities of particular public health importance. As elsewhere, they have focused on clinical services at the expense of health promotion and counselling.

Two main lessons can be drawn from the South African experience.

- Integration has been achieved through political and ideological commitment to the ideals of Alma-Ata rather than through compromised attempts to expand vertical programmes. Policy-makers concerned with reproductive health in other countries would thus do well to consider the

feasibility of their intentions, given the comparatively weak commitment to the ideals.

- The goals of controlling HIV/STDs or improving reproductive health are not necessarily going to be realized even where full integration has been achieved. Managers of fully integrated systems and generalist providers continue to need strong technical support in order to ensure a comprehensive package of care, including condom promotion for dual protection, case detection, and information on the prevention of HIV/STDs.

From primary care to reproductive health: concepts and politics

Much has been written since the International Conference on Population and Development concerning the gulf between reproductive health rhetoric and reality in low-income countries (*19–23*). In order to understand why the rhetoric of integration has been predominantly used, it is necessary to consider how it emerged in the early 1990s as a result of the convergence of four agendas: the need to improve the quality of family planning; the need to improve women's health, especially in their reproductive years; the rapid spread of HIV; and conceptual shifts in primary care.

The first two agendas have been strongly related: during the 1980s and 1990s, economists' concerns over population growth lessened partly because, in many low-income countries, fertility had fallen, and partly because of a lack of decisive evidence on the harmful consequences of increases in population. At the same time, women's rights activists pushed for a change in the rationale behind family planning programmes to shift the emphasis from controlling the number of children a woman bears to helping women achieve reproductive goals safely and effectively (*24*). The understanding of safe motherhood has improved alongside developments in family planning. In particular the need has been recognized for emergency obstetric services in addition to routine antenatal and postnatal care. In an attempt to respond to the concerns of both economists and women's groups, services designed to meet these needs have been introduced at the core of the reproductive health movement.

The third agenda has stemmed from the extremely rapid rise in HIV prevalence, especially in sub-Saharan Africa, and the associated high levels of infection with classical STDs. Policy-makers in low-income countries have become increasingly aware of the grave consequences that HIV can be expected to have on their economies if left unchecked. Although clients in the MCH/FP area, consisting largely of women, are generally less likely than others to spread infection through the population, governments have found it politically and logistically easier to provide services for these women than for men or sexually active single women. The vulnerability of women to sexually transmitted infection has also been highlighted by women's health advocates, who have pushed concerns about HIV/STDs to the forefront of reproductive health.

The fourth agenda relates to links between primary care and reproductive health care which, although similar in ideology, have emerged during periods when the political and economic contexts differed considerably. Since its origin in the 1960s and 1970s, primary health care has been guided by five principles: equitable distribution, community involvement, prevention, appropriate technology and a multisectoral approach (*25*). It has been grounded in a broad theory of development that rejected economic modernization as the only path to well-being and placed good health firmly at the centre of an economic growth/equity/productivity nexus.

Many of these concepts have reappeared in the Programme of Action of the International Conference on Population and Development (*26, 27),* chapter 8 of which starts with a discussion of primary health care. In Chapter 7 it is pointed out that, in order to improve reproductive health, governments have committed themselves to involve civil society, especially women's groups, in programme design, to focus on the prevention of reproductive ill-health, and to promote a multisectoral approach. However, while the reproductive health movement has reflected an unprecedented level of agreement among groups of women's health advocates around the world on the association between gender equity and health, these groups have generally been less concerned with the links between poverty and health (*22*). Similarly, whereas primary care has been grounded in the right to good health, reproductive health care has been based on the rights of women and men to safe and voluntary sex and reproduction (*28*).

The convergence of these agendas, rather than overwhelming evidence of public health effectiveness, has been the impetus behind the integration of HIV/STD and MCH/FP services. The convenience of the policy rhetoric reflects a careful balancing act between worthy but often competing objectives. There may have been other means to address the goals of controlling HIV/AIDS and improving reproductive health but none would have met the concerns of women's health advocates, public health professionals and economists. These international reproductive health actors, however, have taken little account of political, financial and managerial constraints on implementation in low-income countries. In particular, while MCH/FP programmes consist of simple, cost-effective preventive measures for women and their children, such as have been delivered for many years, activities for HIV/STD control involve other population groups, are sensitive, and have unconfirmed efficacy and costs, especially for women.

Conclusion: debunking the myths

The goal of integration represents a compromise that is difficult to achieve. It cannot solve HIV/STD or

reproductive health problems. The international community has emphasized integration instead of promoting comprehensive services, some of which could be provided through primary care but others of which could not. From the point of view of improving women's health it may be that, in many settings, issues other than HIV/STDs may be more important, including unsafe abortion, adolescent sexuality and gender inequality. From the standpoint of controlling HIV/STDs, policy-makers should pay more attention to variations in exposure to the risk of acquiring these conditions. The integration of services for HIV/STDs with those for MCH/FP, if done properly, can meet the needs of a population group that has not had access to such care. However, this group rarely includes the main infection transmitters — men and sexually active, unmarried women — none of whose needs can be addressed through MCH/FP services. Targeting these populations through separately provided and vertically managed services may be more appropriate.

Choices on the spending of limited resources are extremely difficult, but it should be noted that five years of rhetoric on integration have coincided with soaring HIV prevalence, continuing high maternal mortality, and a persisting unmet need for contraception in sub-Saharan Africa. One potential response to this apparent failure would be to intensify the vertical programme approach, which at least satisfies funders' accountability and monitoring requirements. Another might be to strengthen efforts to move towards the South African model of comprehensive primary care, with inclusion of both HIV/STD management and MCH/FP. A third, more likely, route is that of continuing negotiation and compromise between different powerful parties: this option could be more effective if accompanied by a raised awareness of international political agendas and a better allowance for constraints on implementation in low-income countries. ■

Acknowledgements

The study on which the present paper is based was funded by the Wellcome Trust (grant number 049341/Z/96/Z) and supported by the Population and Reproductive Health Programme of the United Kingdom Department for International Development. We thank our collaborators for their input: Joe Annan and Helen Dzikunu, JSA Consultants, Accra; Christine Mutungwa, formerly of the Planned Parenthood Association of Zambia; and Enos Njeru and John Njoka, Sociology Department, University of Nairobi, Nairobi, Kenya.

Résumé

L'intégration de la santé génésique : le mythe et l'idéologie

Depuis 1994, on préconise d'intégrer les services concernant le virus de l'immunodéficience humaine et les maladies sexuellement transmissibles (VIH/MST) aux soins de santé primaires dans le cadre de la santé génésique afin de faire face à deux grands problèmes de santé publique : la lutte contre la propagation du VIH et l'amélioration de la santé génésique des femmes en général. Or cette approche a peu de chance d'être couronnée de succès, car les soins de santé primaires dans lesquels les services VIH/MST doivent être intégrés et le contexte politique ne s'y prêtent pas. Depuis la Déclaration d'Alma-Ata en 1978, les soins de santé primaires complets ont progressivement cédé la place à des soins sélectifs en fonction des services qui sont jugés économiquement efficaces. De même, reconnaissant les difficultés financières des secteurs de la santé dans les pays à faible revenu, les avocats de la santé génésique se préoccupent de la rentabilité des services plutôt que de l'équité; cette évolution des idées n'est pas sans répercussion sur l'intégration des services.

Le présent article s'inspire d'une étude entreprise en 1997-1998 dans quatre pays d'Afrique subsaharienne traitant des problèmes qui se sont posés sur la façon de définir l'intégration des services VIH/MST et de formuler des politiques d'intégration appropriées. Une comparaison historique est effectuée entre les systèmes de santé du Ghana, du Kenya et de la Zambie, dominés par des programmes verticaux et la participation des donateurs, et le système sud-africain qui s'est engagé politiquement depuis 1994 à offrir un service de soins de santé primaires complets à l'ensemble de la population.

Les résultats montrent qu'à un stade précoce de l'approche des soins de santé primaires, l'évolution des idées de même que des dilemmes financiers et logistiques ont conduit à s'écarter des soins primaires complets pour préférer un ensemble de services déterminés fournis par un personnel infirmier spécialisé et privilégiant les soins de l'enfant, les soins prénatals et postnatals de la mère ou la planification familiale. Ainsi, les services du niveau primaire au Ghana, au Kenya et en Zambie ont été principalement utilisés par les femmes et leurs enfants. En outre, du fait de la spécialisation du personnel, la clientèle a dû s'adresser à des sources différentes ou à des endroits différents ou choisir différents jours pour satisfaire ses différents besoins de santé. Des services séparés ont été gérés par des systèmes verticaux distincts (programmes verticaux), souvent plus soucieux d'atteindre les objectifs de responsables politiques internationaux et nationaux que de répondre aux besoins communautaires. Lorsque les soins de santé primaires se limitaient à la santé maternelle et infantile et à la planification familiale, l'intégration a consisté à ajouter de nouvelles activités à ces services. Pour les programmes verticaux qui appuient ces services, l'intégration signifie une collaboration renforcée plutôt qu'une responsabilité commune. Ce compromis entre une théorie complète et une réalité sélective n'a pas changé grand-chose aux structures et

pratiques existantes, et les problèmes d'intégration ont en outre été exacerbés par les activités et les priorités des donateurs extérieurs.

A titre de comparaison, il y a deux leçons à tirer de l'exemple sud-africain. Tout d'abord, l'intégration résulte d'un engagement politique et idéologique en faveur des idéaux d'Alma-Ata plutôt que d'efforts fondés sur un compromis pour élargir des programmes verticaux. Ensuite, même lorsque l'intégration a été complète, les buts de la lutte contre le VIH/MST ou l'amélioration de la santé génésique ne seront pas nécessairement atteints.

La théorie de l'intégration a été largement utilisée dans les soins de santé génésique, malgré les données insuffisantes concernant la faisabilité, sur la base de la convergence de quatre facteurs :

– la nécessité d'améliorer la qualité de la planification familiale;
– la nécessité d'améliorer la santé de la femme, surtout de la femme en âge de procréer;
– la propagation rapide du VIH; et
– l'évolution des concepts des soins de santé primaires.

Il y aurait peut-être eu d'autres moyens d'atteindre les deux buts de la lutte contre le VIH/SIDA et de l'amélioration de la santé génésique, mais aucun n'aurait permis de tenir compte à la fois des préoccupations des milieux féministes, des professionnels de la santé publique et des économistes. Ces intervenants internationaux en matière de santé génésique n'ont guère pris en considération les contraintes politiques, financières et gestionnaires pratiques auxquelles se heurtent les pays à faible revenu. L'intégration a donc été à la fois un but de compromis et une solution difficile à appliquer; il est faux de croire qu'elle permettra de résoudre les problèmes mondiaux concernant le VIH et les MST ou la santé génésique.

Resumen

Integración de la salud reproductiva: mito e ideología

Desde 1994, se viene propugnando la integración de los servicios de lucha contra el virus de la inmunodeficiencia humana y las enfermedades de transmisión sexual (VIH/ETS) en la atención primaria, como parte de la salud reproductiva, a fin de abordar dos objetivos importantes de salud pública: combatir la propagación del VIH y mejorar la salud reproductiva general de la mujer. No obstante, es difícil que ese planteamiento prospere, pues ni la atención primaria, en la que deberían integrarse los servicios relacionados con el VIH y las ETS, ni el contexto político de dicha integración son adecuados para esa tarea. Desde la Declaración de Alma-Ata, en 1978, la atención primaria integral ha dado paso a una atención selectiva basada en lo que se consideraban paquetes de servicios eficientes desde un punto de vista económico. De igual modo, los defensores de la salud reproductiva han asumido las dificultades económicas de los sectores sanitarios en los países de bajos ingresos y se han centrado en la eficacia en función del costo, y no en la equidad de la prestación de servicios; estos cambios ideológicos han influido en la integración de los servicios.

El presente artículo, basado en un estudio realizado en 1997-1998 en cuatro países del África subsahariana, trata de los problemas que han surgido a la hora de definir la integración de los servicios relacionados con el VIH y las ETS y de formular las políticas necesarias para conseguirla. Se hace una comparación histórica entre los sistemas de salud de Ghana, Kenya y Zambia, en los que han predominado los programas verticales y la participación de donantes, y el de Sudáfrica a partir de 1994, que ha asumido el empeño político de facilitar servicios de atención primaria integral a toda su población.

Los resultados muestran que, en las primeras fases de la aplicación del enfoque de la atención primaria, los cambios ideológicos y los dilemas económicos y logísticos condujeron a abandonar la atención primaria integral y a seleccionar un conjunto de servicios atendidos por personal de enfermería especializado y centrados en la salud infantil, la atención prenatal y posnatal a las madres y la planificación familiar. Como resultado, los principales usuarios de los servicios de primer nivel en Ghana, Kenya y Zambia han sido las mujeres y sus hijos. Además, debido a la especialización del personal, los clientes han tenido que recibir atención de distintos proveedores, en distintos días o en diferentes lugares, para sus diversas necesidades sanitarias. Los distintos servicios se han gestionado a través de sistemas de administración peculiares, organizados de arriba abajo (programas verticales), que a menudo han demostrado estar más interesados por las metas de los responsables políticos internacionales y nacionales que por las necesidades comunitarias. Allí donde la atención primaria de salud se ha limitado a la atención maternoinfantil y la planificación familiar, la integración ha supuesto añadir nuevas actividades a esos servicios. Para los programas verticales que sostienen dichos servicios, la integración implica mayor colaboración en lugar de responsabilidad compartida. Este compromiso entre la retórica de la integración y una realidad selectiva no ha alterado demasiado las estructuras y los procesos existentes, y los problemas de integración se han visto exacerbados aún más por las actividades y las prioridades de los donantes externos.

En comparación, hay que sacar dos enseñanzas importantes del caso de Sudáfrica. Primero, la integración se ha conseguido gracias a la adhesión política e ideológica a los ideales de Alma-Ata, antes que pactando tentativas de ampliación de los programas verticales. En segundo lugar, incluso donde se ha logrado una integración plena, las metas de controlar el VIH y las ETS y de mejorar la salud reproductiva no siempre se alcanzan.

La retórica de la integración ha sido harto frecuente en el campo de la atención de salud reproductiva, pese a que no hay pruebas de su viabilidad, debido a la convergencia de cuatro circunstancias:

– la necesidad de mejorar la calidad de la planificación familiar;
– la necesidad de mejorar la salud de la mujer, especialmente durante sus años reproductivos;
– la rápida propagación del VIH; y
– los cambios conceptuales que se han producido en la esfera de la atención primaria.

Puede que hubiera otros medios para alcanzar las dos metas de controlar el VIH/SIDA y mejorar la salud reproductiva, pero ninguno habría podido responder al mismo tiempo a las preocupaciones de las feministas, los profesionales de la salud pública y los economistas. No obstante, esos actores de la salud reproductiva internacional no han tenido en cuenta las limitaciones políticas, económicas y administrativas para la puesta en práctica de los programas en los países de bajos ingresos. Así pues, la integración ha sido una meta de compromiso y difícil de aplicar; la creencia de que va a resolver los problemas mundiales en materia de VIH y ETS y de salud reproductiva es sólo un mito.

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