The Challenges of Integrating Family Planning and HIV Services:
An Analysis of Programmer and Policymaker Opinions in Malawi, Nigeria, and Senegal[1]

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Abstract: In sub-Saharan Africa, pregnancy and HIV are "transmitted" in primarily the same way: through unprotected, heterosexual sex. And in most African countries, there are more pregnancies than desired, and certainly too many new cases of HIV. These similarities alongside patterns of health care access and differential funding streams suggest that integrating family planning and HIV services should lead to better outcomes. But despite years of talk about the benefits to integration, it remains more rhetoric than reality. Why? Based on interviews I conducted with more than 90 people working for federal ministries, donor organizations, and local nongovernmental organizations in Malawi, Nigeria, and Senegal, I show that donor and government structures combined with overburdened primary health care providers are the primary obstacles to integration. I find, however, that in Malawi and Senegal, programmers are trying to use the distinctions between pregnancy and HIV prevention to benefit those they serve.

[1] Please note that I submitted this paper last year and it was accepted for a session, but I was unable to present it, and so it did not appear on the program.

Introduction

In sub-Saharan Africa, pregnancy and HIV are "transmitted" in primarily the same way: through unprotected, heterosexual sex. And in most African countries, there are more pregnancies than desired, and certainly too many new cases of HIV. These similarities combined with a number of other factors—ranging from the fact that women access the health sector most frequently because of pregnancy to the reality that the bulk of the population-related aid to African countries over the past ten years has been for HIV/AIDS—suggest that integrating family planning, reproductive health, and HIV services should lead to better outcomes for women, and men, across a number of dimensions. But despite years of talk about the benefits to integration, it remains more rhetoric than reality. Why does integration remain so elusive?

In this paper, I answer this question by considering the opinions of programmers and policymakers across three African countries—Malawi, Nigeria, and Senegal—on the topic of integrating family planning and HIV services. These opinions were expressed during in-depth interviews I conducted with more than 90 people working for federal ministries, donor organizations, and local nongovernmental organizations (NGOs) in 2009-2010 for a separate project examining the impact of family planning interventions on HIV interventions. The opinions of these particular individuals regarding integration of family planning HIV services are crucial as it is these people who will have to promote integration efforts to their ministers and funders (who control the overall structure of health systems) as well as to those below them (who actually implement health care).

The three countries present a range of family planning and HIV "experiences" that are broadly representative of sub-Saharan Africa. Senegal has had continued low HIV prevalence of less than 1%, but also continued low levels of contraceptive prevalence (10-15%) and high levels of unmet need (30%).[2] Nigeria has had moderate HIV prevalence of 3-5%, and similarly low levels of contraceptive prevalence to Senegal, although with a slightly lower level of unmet need (17%).[3] Malawi is a heavily impacted country with HIV prevalence of ~12%, but where recent rapid uptake of long-lasting hormonal methods has brought the contraceptive prevalence rate to 41%, despite continued high levels of unmet need (27%).[4]

Programmers in all three countries were aware of the potential benefits to integrating family planning and HIV services, and noted that in many cases services *were* integrated at the health center level because there was often only one person providing care, but they also described two main challenges to integration: (1) both donor and government structures for HIV have been kept separate from family planning; and (2) overburdened primary health care providers and facilities do not have the capacity to absorb new activities.

[2] Population Reference Bureau Data Finder. Accessed 6/3/11.
[3] Ibid.
[4] Ibid.

Background

Family planning and HIV services can be integrated in three primary ways (Adamchak et al. 2010): (1) family planning can be added to HIV counseling and testing in order to reach populations otherwise not accessing family planning (e.g., those who are young, male, or unmarried); (2) family planning can be added to HIV care and treatment in order to limit vertical transmission; and (3) HIV services can be added to family planning so as to increase the percentage of the population tested, and to reduce vertical transmission.

There has long been discussion of integrating services related to family planning and sexually transmitted infections, but these have often been accompanied by acknowledgement of the challenges. As Willard Cates wrote near the time of the emergence of HIV, "Rather than being natural bedfellows, the fields of STD and family planning are hardly even conversant companions" (Cates 1984: 317). Most of the focused discussion of integrating family planning and HIV services emerged around the time of the 1994 International Conference on Population and Development, which established reproductive health—requiring attention to the prevention of pregnancy, HIV, *and* STIs—as a development goal (Boonstra 2011). Shortly after, evidence emerged for the benefits of syndromic management of STIs as a means to combat HIV, further promoting the benefits to integration of HIV services with existing STI and reproductive health care (Walt, Lush and Ogden 2004). But even then, integration did not take off. Resistance stemmed at least in part from concerns that the "good" family planning should not be mixed with the "bad" HIV/AIDS (May et al. 1991), and that those who worked so hard for acceptance of family planning did not want to lose ground by associating with a stigmatized disease like AIDS (Zaba, Boerma and Marchant 1998).

The arrival of affordable HIV treatment and the massive foreign aid programs to fund it (the Global Fund in 2002 and the US President's Emergency Plan for AIDS Relief in 2003), along with evidence that syndromic management of STIs was *not* as effective as previously thought, pushed global emphasis from HIV prevention to treatment, and took support away from integrating services. In the past five years, however, renewed interest in integration of family planning and HIV services has developed as funding for HIV dwindles, and interest in family planning increases because of its ability to reduce vertical transmission of HIV and lower maternal mortality rates, both key Millennium Development Goals.

Data and Methods

As part of a larger project on the impact of pregnancy prevention interventions on later HIV prevention interventions, in 2009-10 I conducted semi-structured interviews with more than 90 programmers and policymakers working for federal ministries, donor organizations (multilateral, bilateral, and nongovernmental), and local NGOs in Malawi, Nigeria, and Senegal. My primary interest was to understand the historical linkages between pregnancy prevention efforts and HIV prevention, but many of my respondents provided a great deal of information about past and current efforts towards integration that I draw on for this article. The vast majority of respondents were nationals of the country in question, although a small handful of respondents (particularly in Malawi) were European or American. Respondents were split evenly between men and women, and had above-average levels of education for their

countries. After transcription, and translation into English in the case of the interviews from Senegal, I coded the interviews using QDAMiner, qualitative data analysis software. In the analysis below, quotes are identified by the first letter of the respondent's country (M, N, or S) and a unique number, as well as a description of the respondent's type of organization.

Analysis

I will first discuss reasons respondents gave for the historical lack of integration between family planning and HIV interventions, and then present the two key reasons for the current lack of integration: donor and bureaucratic structures, and overburdened health care providers. I conclude with some observations about ways that programmers may be drawing on the distinction between family planning and HIV prevention in order to benefit those they serve.

Respondents noted that historically it was difficult to integrate HIV and family planning because of the stigma associated with HIV. In one respondent's words, "In the imagination of the population, AIDS was a part of sex and prostitution."[5] More prosaically, someone else explained, "[HIV is] an infection, thought to be sexually acquired. It was a subject not to be discussed. And anybody with sexually transmitted infection, has a stigma to it . . . And we felt that it might affect the patronage, but we've since learned that it's not so."[6]

The fact that HIV was seen as a disease, unlike pregnancy, also made integration unlikely: people dying was different than people having multiple children. In Malawi, the only country of the three where significant numbers of people visibly died from AIDS, those deaths made it additionally challenging to discuss family planning. "It's a sensitive topic, family planning, in times of AIDS. I think there were even well-instructed people saying, 'Why should we care about family planning with our populations dying?'"[7]

Reasons cited for the current push for integration of family planning and HIV services included declines in funding for HIV, a perceived increased awareness that it was more efficient/productive to integrate services (with some acknowledgement that donors had been promoting the same argument), and the scale-up of prevention of mother-to-child transmission (PMTCT, also donor driven), which necessitated discussion of all four prongs of PMTCT, including family planning.

Many respondents noted that services were essentially integrated at the clinic level because clinics were so understaffed that the same person would provide family planning and HIV services, as well as immunizations, malaria care, antibiotics, etc. As one respondent from Malawi put it, "Whether it's on paper or not, we integrate family planning and HIV – you have to take advantage when you get people in [to the health center]."[8] But more so than not, respondents also observed that therefore it was too much to ask an overburdened clinic worker to take on yet one more obligation (either family planning or HIV). As a Nigerian working for a federal ministry explained, "Integration means that providers are given more work. Training for

[5] S11, national NGO.
[6] N38, national NGO.
[7] M36, bilateral organization.
[8] M20, international NGO.

all the extra things takes time, which is time away from the health post."[9] In Malawi, a respondent working for a federal ministry noted how particular topics could lose out:

> "On the ground, by default, [integration] is actually happening, because you don't have more than one service provider, and this poor service provider has to do everything. But we also find that, because of that, the family planning usually suffers, because she or he doesn't have time to go through the whole array of whatever products they have in terms of family planning, and it will either be the male condoms that will be given out or Depo. Because it's the quickest, and people are already well aware of it. So [integration] fails us in that way, because this person is overworked and they don't have the time to go through the whole salesperson approach."[10]

Respondents also raised the possibility that integration was not the best option for clients.

> "You've got a family planning clinic . . . and then you say, oh when she [the client] comes, oh, let's talk about HIV AIDS. And she's like . . . 'ugh, ok.' And then after that, 'Okay, would you like to test?' 'I came here for family planning!' So even the patients aren't very keen on integration in the first place, because it takes a fair amount of time."[11]

As a result of this reality, some organizations purposefully separate family planning and HIV services. As a respondent from a Senegalese NGO put it, "We introduce family planning and HIV at different times to clients because of confusion about condoms – are they for family planning or STIs? We don't want to mix the two – we want the women to stay on message."[12]

The second main challenge to integration of family planning and HIV services was the structure of donor and federal bureaucracy, which uniformly separated HIV and family planning into individual, vertical silos. In all three countries, the Ministry of Health is divided such that there are separate units/divisions for reproductive health (which includes maternal and child health) and for STIs. These divisions predate HIV, and when HIV emerged, it was placed with the STI division. In all three countries, there is also a national AIDS commission which is above the Ministry of Health. These divisions have created turf that interested individuals and bureaucracies defend, but also practical difficulties. In Dakar, the reproductive health unit is several blocks down busy Avenue Blaise Diagne from the HIV/STI unit. In Abuja and Lilongwe, the units are too far apart to easily walk between them. Respondents used words like "protectiveness" and "turf" to describe how integration might force one unit to have to give something up. As a respondent in Malawi explained, "Even when we are talking about PMTCT, and this is a pregnant woman, and the reproductive health unit says, 'The pregnant woman belongs to us.' But this pregnant woman has HIV and the HIV unit says, "We also have something to do with this woman.'"[13] A respondent working within the government in Nigeria noted, "Even in the division you find that people just know their own legs and hands. They don't know that others have also two legs and hands. Everybody is just on his own. But I think

[9] N46, federal ministry.
[10] M34, federal ministry/multilateral organization.
[11] N24, national NGO.
[12] S10, local NGO.
[13] M7, national NGO.

it's improving.[14] And as a Nigerian working for an international foundation gracefully described the issue, "It's easy to create things, but hard to take them away."[15]

Despite the turf battles, in both Malawi and Senegal (although not in Nigeria), there was evidence that efforts had been made to redistribute some of the HIV funding largesse from the HIV/STI units back to the reproductive health units.

In addition to government structures, respondents blamed donors' bureaucratic structures for directly influencing their own programs. "It's not just the government to blame," said a respondent from Senegal, "it's also the donors. It's much easier to integrate at an operational level. Donors are more supportive at that level."[16] When I asked why Malawi's reproductive health and HIV programming were separated, the response came back, "Because at the World Health Organization they are two separate departments. They don't talk to each other."[17] Respondents found it challenging to work with donors even when they were supportive of integration:

> "The funding is not integrated. But the donors want integration. But if you ask, okay, give us money for everything [to be integrated]... for instance, we are doing PMTCT. If we say, give us money for family planning, for prevention, for... we will not get it. Because the donors' own money is coded only for PMTCT, so you have to go and find some other person who can fund your family planning, to be able to do that."[18]

Thus government as well as donor structures challenged integration.

Thus while integration of family planning and HIV services is likely to remain challenging in all three countries (despite having very different family planning and HIV needs), in Malawi and Senegal there were efforts to take advantage of the distinctions between family planning and HIV prevention in order to improve health and wellbeing. In Malawi, many respondents spoke of a family planning condom rather than an HIV prevention condom in order to introduce condoms into marriage, a place of increasing HIV transmission.

> "I think the whole issue of promoting condoms, getting them used, has been greatly challenged by having it seen as an HIV prevention technique as opposed to family planning. I think if we had, and if we do, position condoms much more as a family planning method, even if a woman wants to use it for HIV prevention, you avoid all these dynamics about who's being unfaithful to whom, and she says 'Look, I don't want to get pregnant.' It's an immediate thing that everybody can appreciate. I think it's much easier to negotiate."[19]

> "Once we get in the family-planning condom, maybe condoms would be more acceptable. So that's the whole idea, it should be more acceptable because we would say, 'Okay, I use a pill, I use injectables." But it's not dual protection so even if you have that, but then also bring in something that is more acceptable to everybody because like here, most people

[14] N27, federal ministry.
[15] N37, international foundation.
[16] S14, international NGO.
[17] M11, multilateral organization.
[18] N39, international NGO.
[19] M27, international NGO.

> don't feel shy to say, 'Okay, I'm going to the clinic - I'm going to get my pills. I'm going to the clinic - I'm going to get my injection.' So we also wanted to be the same, 'I'm going to the clinic- I'm going to get myself the safe plan condom for my family planning.' So we're hoping that it's going to work.[20]

Similarly, but with a different population, in Senegal, there was some discussion of adolescents accessing condoms to supposedly protect from HIV, but really to prevent pregnancy. As one respondent explained, "Early pregnancy is a big deal culturally. The message on condoms has been appropriated by young women who want to protect against early, unwanted pregnancy."[21]

Conclusions

More so than not, the road to integration of family planning and HIV services will be challenging in the three very different countries examined in this paper. The primary obstacles are donor and governmental structures, as well as overburdened health care providers. Overcoming these obstacles would most likely offer benefits by "de-verticalizing" health programs more generally, but will require concerted effort by donors and governments. Branding condoms as family planning, and appropriating messages about condoms to help protect against pregnancy, are two strategies that creative individuals have deployed in order to make do with the current realities of unintegrated programming.

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[20] M30, national NGO.

[21] S19, university.