Is Integration the Answer for Africa?

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Since the International Conference on Population and Development (ICPD) in 1994, much rhetoric and some action have been expended on the attempt to integrate family planning with services that manage sexually transmitted infections (STIs) and HIV/AIDS. For some regions in the developing world, integration may be both feasible and appropriate. In Sub-Saharan Africa, however, the effort to integrate services may not be successful and is subject to risks that should be considered carefully. Service programs in this area are severely challenged and fragile. Sub-Saharan Africa is the only major region in the world where the majority of countries have yet to show significant fertility declines and where the total fertility rate still has not decreased far below six lifetime births per woman.[1] It is also the region that is home to 70% of the people in the world who have HIV/AIDS;[2] indeed, half the world's total infected persons are among the 4% of the global population living in East and southern Africa.[3]

BACKGROUND

The ICPD Programme of Action favored service integration under the umbrella of reproductive health, not because such integration had been shown in practice to be the most effective approach, but because it strengthened the internal logic of the ICPD program. The program aimed at reducing the impersonal demographic emphasis on limiting family size by placing the stress on improving women's situation and by ensuring that contraceptive provision was encompassed within the broader provision of reproductive health services. The proposed arrangement would certainly extend to the identification and treatment of STIs, and it might also embrace HIV/AIDS programs and issues of sexual behavior. The provision of comprehensive services—including reproductive health care—under the umbrella of primary care, which the 1978 Alma Ata Declaration had made its aim, did not seem achievable, because poor countries in Sub-Saharan Africa and elsewhere could not afford a full range of adequate health services. Indeed, that is why specialized family planning, STI and HIV/AIDS programs partly supported by international donors came into existence. Technical aid and foundation programs followed the ICPD lead to find reasons for maintaining internal coherence in international endeavors. Furthermore, integration of services implied a unified direction, greater efficiency and a higher return on expenditure. In Sub-Saharan Africa, reality may differ from theory for reasons that can be understood only by looking at the history and nature of the programs concerned.

Family Planning

Family planning programs in Sub-Saharan Africa have slowly and painstakingly improved despite poverty, a rural production system that offers no advantages to the small family, governmental inefficiency and lack of dedication to low fertility, individual uncertainty about the wisdom of practicing contraception and male dominance in sexual decision-making. Some of these obstacles are beginning to give way, but the move to smaller families has been marked only in southern Africa, Kenya and Ghana.

Family planning services in Sub-Saharan Africa are clinic-based, probably in imitation of Asian programs that have achieved success because they mainly serve married women in couples who wish to call a halt to family-building. In Africa, the clinics mainly serve married women whose youngest child is old enough that the mother can respectably resume sexual relations. The service staff and their clients are almost all women, because sexual activity and contraception are not easily discussed across the gender line. Partly for the same reasons, most of the women want a contraceptive method that they can quietly control themselves and that can be reversed (thus avoiding spousal quarrels or marital dissolution). Most women choose hormonal methods: the pill or, somewhat less frequently, the injectable. The clients want good, quick and inconspicuous service. In contrast, in Brazil, Honduras and Jamaica, experimental International Planned Parenthood Federation (IPPF) programs provide integrated family planning and STI/HIV/AIDS services through "an exploration of [the client's] sexuality, relationships, life circumstances and other contextual issues...."[4] In Africa, family planning clients would most likely be happy to have STIs identified and treated, but very reluctant to have the infecting person traced or to be asked to take responsibility for urging their partners to use condoms.

The demand for contraception in Africa is not driven simply by the desire of married couples to control the size of their families. Although at least half of the demand is in fact from married women, most of them wish to use contraceptives to space births—a goal previously achieved by the practice of postpartum sexual abstinence. Another large part of the demand is from adolescents of both sexes and from adult males. These groups, however, do not wish to be seen attending clinics, and adolescents are unlikely to receive assistance, even though it is government policy that they should be served. This is why almost half of all contraceptive users in countries like Nigeria or Cameroon buy contraceptives at the market, although this method of pro-

curement is far from efficient. Many married women also prefer the anonymity of the market to the intrusions into privacy presented by clinic waiting rooms and the recording of names and other personal details by the staff. Lectures on AIDS and the offer of condoms for use with their partners might also be perceived as intrusions and would be resented by most African married women. Furthermore, poor women who sell sex to provide for their families usually know the risks and often have extramarital partners who are sufficiently familiar to them that they feel it impossible to insist on condom use.

Thus, there is a large market of contraceptive users in Africa that family planning programs barely touch. Such people will not be reached through existing government family planning programs. Adolescents, especially teenage girls who are at high risk of both pregnancy and HIV infection, probably could be reached with both advice and condom distribution through groups that are themselves organized and managed by adolescents. But many parents and churches, and most governments, are opposed to this approach. The answer may be to subsidize and assist the market sector in providing unquestioning and anonymous service, but this kind of service cannot be an effective vehicle for AIDS education.

AIDS PROGRAMS

So far, Africa has proved better at caring for people with AIDS—usually through the family—than at preventing HIV infection. Effective AIDS programs in Africa aim principally at reducing high-risk sexual relations and at providing condoms for use when such relations occur. The main targets have to be males, partly because they decide whether condoms are to be used or not, and adolescents—the very groups not served by family planning clinics.

The days of simple educational programs that explain how HIV is transmitted are over. Nearly every African who is likely to be infected knows that in the region, HIV is mainly transmitted by sexual relations. The messages must cover multiple angles, as suggested in the following examples:

- Safety lies in knowing how widespread the disease is and that HIV/AIDS is a sickness, not a sin or a cause of family shame. Hence, the infected should state their condition, relatives at funerals should be truthful about the cause of death and the media should identify in a sympathetic way well-known individuals who have died of the disease.
- Lives are precious and should not be thrown away carelessly, for death is the ultimate tragedy. Africans not infected with HIV now have the prospect of a reasonably long life.
- Sickness and death are not determined mostly by chance, and certainly not by witchcraft, but by individual determination to protect one's own health and life, as well as the health and lives of one's relatives.
- Men can control overwhelming urges to find a female partner for sex or, alternatively, if there is likely to be any risk, can use a condom to protect both partners.
- Nonspousal partners, no matter how affectionate, probably have other partners, and condom use is not insulting.
- Sex is enjoyable but should not be a route to death.
- Condoms are not evil, and using them is far safer than using nothing.

These are messages rather than factual education. They constitute a philosophy that centers on the primacy of valuing life and delaying death, and on being fully aware of surrounding dangers. Some of the content is somber and is not the unequivocally joyous message that family planning services should be delivering. Such a philosophy cannot be spread by service providers alone; to be effective, it must come from heads of state, state ministers, the media and the elite, and it must be repeated urgently and continuously. This is what an effective African campaign against HIV/AIDS looks like. It is no accident that the first high-prevalence country in Africa to experience a decline was Uganda, the only country where the head of state has provided such leadership.

Governments can also confront the disease by trying to break the chain of HIV infection. The instrument that should be used to break that chain is the condom, supplies of which can be made available in large quantities and, where desired, discreetly. Drivers and travelers, as well as the military and the police, are obviously groups in need. The most effective approach, which is the one taken in Thailand, would probably be to ensure the greatest possible use of condoms in commercial sex, especially the most purely commercial relations. There would have to be constant pressure to implement condom use, as there has been in Thailand. Evidence suggests that most African prostitutes would welcome such a system;[5] thus, the pressure would have to be on the clients and the owners of the premises used for commercial sex. Such pressure, together with powers of enforcement, implies a special government program rather than an additional responsibility for family planning programs, especially because one of the activities would be to oversee how the police force carries out its role.

The African situation is quite different from the Asian one. Poor women in South Asia rarely undertake part-time prostitution, but that may be because their societies would exact awful punishment. In Sub-Saharan Africa, there is a commercial element in many sexual relationships, and full-time prostitutes usually operate individually, by renting their own rooms rather than working as employees. Targeting relationships in the most commercial circumstances—those occurring in rented rooms in buildings where many rooms are rented for commercial sex, and those paid for on the spot—might have surprising success in reducing HIV transmission to the point where the epidemic begins to weaken.

THE CASE AGAINST INTEGRATION

It is significant that there has been so little broad programmatic action but so much writing suffused with abstract nouns since ICPD urged the integration of services.[6] Such a lack of progress is usually the sign, not of lack of resolve, but of unsoundness in the basic plan. There is no problem in expanding the reproductive health services provided at family planning clinics by adding the detection and treatment of STIs, except that the type of equipment and staff needed for the diagnosis of many cases of gon-

orrhea and most cases of chlamydia are not found in most African family planning clinics. Testing for HIV is different from testing for other STIs, for symptoms are not visible before symptomatic AIDS and, even then, they are not genital symptoms. Alternatively, family planning could be absorbed into community health services, as exemplified by South Africa's primary health care system, but this arrangement is beyond the means of most African countries.[7]

The central problem is that family planning and AIDS programs serve two different constituencies and needs in Africa. Family planning programs work mostly through clinics that serve married women, the majority of whom request only hormonal contraceptives. Clients who practice commercial sex are mostly involved in part-time relationships to feed their family and educate their children. They know the risks and are willing to take them to avoid destitution. Furthermore, they are unlikely to be able to persuade husbands or semicommercial, semipermanent partners to use condoms and, if given them by clinics, might well be punished for having them. Certainly, many married women are HIV-positive, but some have entered marriage in that state and not all the remainder were infected by their husbands.

The major focus of AIDS programs in Africa is men and unmarried young persons of both sexes. These individuals need to be protected in sexual relations that are rarely intended to cause pregnancy. However, these groups are almost never found at family planning clinics. In addition, most AIDS educators and condom suppliers are males. They have to speak a very different language from family planning clinic providers: Their main audience is young adult men, who can be assertive and intimidate many female family planning workers.

There are certain areas of mutual interest to both programs. First, both require politicians to speak out more often, but not to include both family planning and AIDS messages in the same speech. In addition, both should provide adolescents with reproductive health and AIDS knowledge, including the use of condoms and perhaps other contraceptives. But meeting the needs of adolescents will require a very different strategy from that currently used by either program; perhaps the needs of this group could most efficiently be met by a specialized, third program, probably utilizing adolescent organizations.

Sub-Saharan African family planning and AIDS programs have different structures, employ different kinds of staff and have distinct motivations and histories. They should not be sacrificed to conform to international donors' ideologies and unrealistic expectations of greater efficiency and cost savings. Richer countries may be able to integrate the two programs into comprehensive health services of a kind that most African countries cannot yet afford. In richer countries, too, the situation of poor women would not be so desperate and beyond their own control. In the end, the pursuit of integrated services in Africa is likely to do more harm than good, and the cost will be measured in lives and unwanted pregnancies, as well as money.

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