

**Providers' views on family planning service delivery to HIV+ women
in Mozambique ***

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Abstract

This study explores challenges and obstacles in providing effective family planning services to HIV+ women as seen by staff of maternal and child health (MCH) clinics. It uses data from a survey of service providers carried out in late 2008-early 2009 in 53 MCH clinics in southern Mozambique. The surveyed providers report that practical, financial, and social barriers make it difficult for HIV+ clients to follow protocols to prevent mother-to-child transmission of the virus. Likewise, staff are skeptical of their seropositive clients' ability to comply with the recommendations to stop having children and to use condom consistently to prevent pregnancy and re-infection, citing family and social constraints as well as women's and their partners' distrust of the clinics. Although integration of HIV and sexual and reproductive health services is advancing in Mozambique, service providers do not feel that they can effectively influence the behaviors and outcomes of HIV+ women.

Keywords: Systems integration; family planning services; reproductive health services; vertical transmission; Mozambique

Introduction

Despite the many successes of the international family planning movement, unintended birth rates remain high in much of sub-Saharan Africa (Bongaarts 2006). The goal of preventing unintended pregnancies has become even more urgent as the HIV/AIDS epidemic has spread in the region. Reducing unplanned conceptions can decrease the number of children born HIV positive. In addition, limiting unintended fertility reduces the risk of negative pregnancy outcomes for HIV+ women and of negative consequences for their health and the health and well-being of their children.

The growing number of HIV+ women in need of contraception has also made the provision of family planning services more difficult. In recommending contraceptive methods, service providers must balance the importance of condoms in preventing infection and reinfection with their relatively lower (compared to hormonal methods) contraceptive efficacy. Attitudes toward childbearing among HIV+ women, and by extension the acceptability of contraception among HIV+ women, are unstable, with the high social importance placed on childbearing conflicting with the stigma still cast on people living with AIDS (e.g., Cooper et al. 2006). The changing medical context of HIV testing and treatment further complicates the provision of family planning services. Voluntary counseling and testing (VCT) programs have become more widely available, which allows women to know their HIV status. Recently developed regimens for the prevention of mother-to-child transmission (PMTCT) lower the likelihood of vertical transmission, and highly active antiretroviral therapy (HAART) can transform AIDS into a chronic condition. In theory, these technologies make pregnancy and childbirth for HIV+ women possible with minimal risk to mother and child, but in practice there are considerable logistical,

financial, and cultural barriers to their full implementation.

In this article we consider these barriers from the perspective of service providers in maternal and child health (MCH) clinics in Mozambique, a country with high prevalence of HIV infection and large-scale rollout of PMTCT and HAART programs. We focus on both logistical and socio-cultural challenges that must be navigated in meeting the family planning needs of HIV+ women, as revealed through a survey administered to MCH clinic staff in southern Mozambique. In Mozambique as elsewhere in sub-Saharan Africa, MCH clinics are the main health care facilities in many rural areas. As a result, HIV testing and care are introduced primarily through integration with existing sexual and reproductive health services. Such integration potentially allows for more comprehensive care, makes more efficient use of both financial and human capital, and increases access to care for women whose primary interaction with the health system is through antenatal clinics (Askew and Berer 2003; Orner et al. 2003; Shelton 1999). However, integration of multiple programs under one institutional roof can also strain limited resources and contribute to overwork among staff, which is passed on to clients in the form of increased waiting time and decreased quality of care (Caldwell and Caldwell 2006; Foreit, Hardee, and Agarwal 2002; Maharaj and Cleland 2005; Mayhew 2000; Medley and Sweat 2008; Teasdale et al. 2008).

Our focus here is on how the challenges of providing family planning services in this context are interpreted by the care providers. Given the high HIV prevalence levels in southern Mozambique, providing treatment and counseling to HIV+ women has been a de-facto component of clinic workloads for decades, but not an explicitly labeled or defined task. The recent development of rapid and readily available HIV testing, regimes for the prevention of vertical transmission, and official policies for the management of seropositive women has

formalized the requirement to provide specialized care for HIV+ women. Prevention and treatment protocols are developed at the national and even international level, but implemented by local clinic staff. These “street level bureaucrats” (Lipsky 1980) make decisions about how to allocate limited resources and how to translate official recommendations into locally comprehensible advice – decisions shaped by their social position and cultural outlook as well as their personal agendas and individual capabilities. Previous research has demonstrated the importance of these factors for understanding the provision of family planning services (Kaler and Watkins 2001; Richey 2008), the implementation of health care reform (Walker and Gilson 2004), and the reception of breastfeeding advice for HIV+ women (Buskens and Jaffe 2008). We apply this approach to understand family planning service provision during the rollout of VCT and PMTCT services as it is occurring.

Setting

The fieldwork for this study was carried out in Gaza province of southern Mozambique. Fertility in Gaza, as elsewhere in Mozambique, remains high: according to the most recent Demographic and Health Survey (DHS), conducted in 2003, the total fertility rate in Gaza was 5.4 children per woman. Virtually all DHS respondents in the province reported knowing at least one modern method of contraception. About 15% of women of reproductive age were using some form of modern contraception, primarily hormonal methods, and more than three quarters of non-users reported planning future use. Still, desired family size is high (median of 4.3 children), and contraception is used largely for spacing at low parities (Instituto Nacional de Estatística 2005).

The mainstay of Gaza’s economy is subsistence agriculture. However, low soil productivity,

frequent droughts and occasional yet devastating floods render agricultural yields unpredictable. Partly due to the precariousness of agricultural production and partly because of Gaza's proximity to South Africa, the region's economic engine, the province has historically experienced large-scale male labor out-migration, directed primarily toward Mozambique's more prosperous neighbor. The prolonged absence of men affects both the dynamics of couple relationships and family and social structures more broadly. As in other similar settings, massive labor migration has also likely contributed to very high HIV levels. Thus in Gaza province, estimated adult HIV prevalence rose from 19% in 2001 to 27% in 2007, the highest level of all of Mozambique's provinces (Ministry of Health of Mozambique 2008). Despite the high estimated prevalence, the coverage of VCT services (recently re-branded as "Counseling, Testing, and Health" services) until two years ago remained low. In a representative survey of married women aged 18-40 that we conducted in July 2006 in Gaza's rural areas, over 95 percent of parous respondents reported having at least one antenatal consultation before their last births, but less than one-fifth of them had ever been tested for HIV (80 percent of those ever tested were tested at antenatal consultations).

Virtually all maternal and child health care in Gaza is provided by state-run MCH clinics, which offer their services free of charge. Some of these clinics provide VCT/PMTCT/HAART services; where available, HIV testing and treatment, including all antiretroviral drugs, are also fully free. Larger clinics, primarily located in district centers, have several nurses on their staff with specialized duties (e.g., first antenatal consultations, subsequent consultations, delivery, post-partum care and family planning counseling). Rural clinics usually have just one nurse who offers the entire range of sexual and reproductive health services and often also provides all general health care in the area. Neither urban nor rural clinics typically have a permanent

physician on staff.

In 2008, we conducted a series of in-depth interviews with staff of selected clinics in one district in Gaza. These interviews illustrate the basic conditions of integration of HIV counseling and treatment into MCH clinics. Staff workload has grown, with no additional hiring or salary adjustment to reflect changing duties; staff training in complex PMTCT regimes and infant feeding recommendations is limited and sporadic. In most clinics, the schedule for PMTCT treatments (checkups, pickup of medication, etc.) is not coordinated with standard antenatal visit schedules, resulting in increased travel burdens for HIV+ pregnant women and increased service requirements for clinic staff. In many clinics, staff have responded to the added complexity of services for HIV+ women by creating a situation of what in an earlier analysis we called “integrated segregation,” where HIV+ women are scheduled on different days and treated according to separate protocol from HIV- women (Authors 2009). In this article, we focus on the provision of family planning services for HIV+ women within this new and still imperfectly integrated system.

Data and Method

The data used in this article were collected in late 2008 and early 2009 through a survey conducted with administrators and nurses of all MCH clinics (N=53) in four of the eleven districts of Gaza province. Units surveyed included both urban and rural clinics; some units already offered HIV services (VCT, PMTCT, HAART), some units planned to start offering services soon, and others had no plans for specific services to diagnose and treat HIV+ women. Topics covered in the survey included the administrative structure of the clinic, the services provided, advice and recommendation given, and perceived barriers to client compliance. Both

closed and open-ended questions were asked; the survey protocol is available on request from the authors. The survey is an extension of the earlier mentioned qualitative investigation conducted by the authors in 2008 with clinic staff and community activists at selected clinics of one of the districts (Authors 2009) and is part of a larger longitudinal project on migration, HIV, and reproductive behavior.

Findings presented below are based largely on responses to the open-ended survey questions. Rather than presenting the distribution of responses in this relatively small sample, we summarize the main themes that emerged from the survey regarding family planning service provision to HIV+ women that are critical to understanding the institutional contexts shaping reproductive and contraceptive decision-making among HIV+ women. We focus in particular on the major obstacles to effective care as perceived by the clinic staff. Therefore the views and opinions presented in this article come from clinic staff rather than from clients. Of course, staff perceptions of the constraints faced by women may not align with women's own perceptions of the social context and barriers to care. But the observations of clinic staff are reflective of the clinic environment and their interactions with clients, two factors that help determine the health care options presented to women and how they choose among those options.

Results

Of the 53 clinics surveyed, 30 provide HIV testing services. 26 clinics offer PMTCT regimens; HAART regimens are available at 10 clinics. Specialized counseling is provided for HIV+ women at some facilities where HIV diagnosis and treatment are not available (N=10); some respondents in clinics without testing facilities report that the lack of direct information on women's serostatus limits their ability to provide effective counseling. Other clinics without

treatment capacity refer HIV+ clients for counseling to nearby clinics with testing facilities (N=3; in all three cases the nearby clinics were larger urban clinics). Only 10 clinics provide neither specialized counseling nor formal referrals for HIV+ women.

At clinics where specific family planning advice is provided to HIV+ women, virtually all recommend that HIV+ women stop childbearing. For the most part, this recommendation does not depend on the woman's parity – women with few children as well as women with many children are counseled not to have more. Respondents explained their advice with reference to the stresses placed by pregnancy on both women's immune system and their overall physical health. Respondents also reported counseling clients to avoid pregnancy in order to prevent reinfection and increasing viral load (our field observations suggest that staff typically thought about "re-infection" in terms of increasing viral load rather than of its correct scientific meaning of infection with a different strain of HIV). Clinic staff recommend that women use condoms consistently. However, respondents were generally pessimistic about their clients' ability to follow these recommendations. Staff at most clinics recommend two methods of contraception – usually Depo-Provera or pills in addition to condoms – often explicitly noting that they recommend two methods in hopes that women will then use at least one consistently.

This pessimism with regards to contraceptive compliance for HIV+ women contrasts with staff feelings of competence in the provision of contraception to HIV- women. Although barriers to use persist – fear of side effects, family resistance – most clinic staff report that they and their clients are able to successfully navigate these barriers to contraceptive use. Clinics have the resources to address clients' needs – they rarely report contraceptive stockouts – and the contraceptive technology fits well into women's lives. The variety of free hormonal methods available allows clinic staff flexibility to adjust to women's experiences of side effects. Depo-

Provera, in particular, is seen as well-suited to women's desires to use contraception without their husbands' knowledge.

A few respondents allowed that low-parity seropositive women might want more children, especially if their children were in poor health, and suggested that these women should wait until they were in stable health, consult with doctors before deciding to become pregnant, and give birth in a facility that provides full PMTCT services. However, this advice appears largely as secondary, to be considered only if the primary advice to stop having children is not accepted. Overall, the growing availability of PMTCT services does not appear to have changed the perspective of clinic staff on the advisability of childbearing for HIV+ women.

The as-yet limited availability of treatment makes it difficult to fully incorporate PMTCT in counseling HIV+ women. PMTCT is not offered at every clinic, and staff recognize that it is expensive and time-consuming for women to travel to facilities where it is offered. Even where PMTCT is available, limited resources make implementation a challenge. Many clinics lack electricity, water, space, and food for women delivering at the facility. As a result, women choose or are compelled to give birth at home, which is a major obstacle in carrying out PMTCT regimes. In addition, the uneven distribution of staff and resources across clinics, as well as the expense and inconvenience of transport, lead women to seek care from multiple clinics. For instance, women may get tested for HIV at one clinic, receive antenatal care from another facility, and get contraceptives from a third. The discontinuity of care makes it difficult for service providers to follow up with individual women's needs and to fully integrate care.

Although clinic staff are insistent in their recommendations to HIV+ women to stop childbearing indefinitely, they are skeptical about the ability of their clients to actually prevent new pregnancies. The frequent interruption of care due to infrastructural and logistical barriers is

only one reason for that the skepticism. Social and cultural constraints stemming from women's subordination within family kin networks were seen by survey respondents as even more powerful barriers to compliance with the advice of clinic staff regarding family planning in general and advice for HIV+ women more specifically.

Thus our respondents describe women as pressured to have more children by husbands and mothers-in-law. Our respondents portrayed men as primary obstacles both for the provision of contraception and for HIV testing and PMTCT. Some men, respondents said, are active opponents of the clinics' agenda, insisting that women continue childbearing and refusing to use condoms. Respondents also described men as passive resisters to integrated care – the husbands of seropositive women do not get tested or attend family planning consultations even when encouraged to do so. Clinic staff admitted additionally that husbands do not come to consultations because women do not inform them about available HIV testing and counseling services, often out of fear of provoking husbands' anger and even physical violence. Limited time and money for travel may also explain their lack of involvement. For the many men working as migrants in South Africa or in other parts of Mozambique, physical distance is a major constraint preventing them from being tested or attending consultations along with their wives. To the extent that women need to ask husbands' permission to get tested or to be treated, men's migration also constrains women's access to services by limiting women's ability to discuss these matters with their husbands.

In households where husbands are away, clinic staff report that mothers-in-law take on the role of surveillance of women's sexual behavior. Mothers-in-law are opposed to women's use of contraception in part because they suspect that their daughters-in-law use family planning to protect themselves during non-marital sexual relationships. According to respondents, older

women also distrust modern contraceptive methods and believe that women should be able to control child spacing through abstinence and long breastfeeding, as the mothers-in-law themselves did. It is possible that the older women are more opposed to family planning and the clinics than their sons would be if they were present, and thus that men's absence due to migration slows the acceptance of new reproductive technologies and behaviors.

Some of the barriers described by staff as preventing HIV+ women from following their advice are common to all women seeking contraception. The problems are compounded for HIV+ women in part because of the requirement to use male condoms (female condoms are barely known), which are widely disliked and distrusted. Unlike hormonal methods, which can be used without informing husbands, condoms require consent and cooperation from men. In addition, while HIV- women are generally seeking to delay the next birth, HIV+ women are recommended to stop childbearing altogether. This long-term decision, again, requires men's knowledge and agreement to carry out. Our respondents note that many women are afraid to disclose their HIV status to their family for fear that they will be abused or abandoned. Because they keep their test results secret, women are not able to obtain their husbands' support in stopping childbearing. The need to hide their serostatus also constrains women's ability to follow infant feeding guidelines (e.g. early weaning).

In describing the barriers arising from their clients' subordinate positions in the household, survey respondents were sympathetic to the problems faced. Yet they also highlight women's own resistance and reluctance to stop childbearing. More so than any other domain, reproductive counseling for HIV+ women elicited reports of client mistrust and opposition from our respondents. Respondents consistently report that HIV+ women did not follow their advice not to get pregnant because they did not believe that they were truly infected – and, by extension,

that they did not believe or value any of the advice they got from the clinic. Staff believed that women were able to surmount practical and financial obstacles to receiving care when they thought it was important. For instance, they said that women reliably brought their children to the clinic to get vaccinated, even though it was expensive and difficult to travel to the clinics. Women's inability to follow HIV-specific recommendations was therefore interpreted as a deliberate disregard for the recommendations and for the staff themselves.

Discussion and Conclusion

While family planning services have been offered by government clinics for decades, HIV as a treatable medical condition is still relatively new, and the testing and treatment offered for HIV have only been offered at the clinics for a few years at the most (and much less in many clinics). Our survey of clinic staff indicates that staff have not yet established a way of working with clients within the constraints posed by economic, practical, and social conditions. In contrast to their generally positive feelings about the provision of contraception, clinic staff have little confidence in their capacity to alter the behavior or the reproductive outcomes of HIV+ women. HIV+ women are seen as more difficult because their needs are greater: they must use condoms, they must stop childbearing, and they must follow complex PMTCT regimes if they become pregnant. HIV+ women's perceived resistance to staff advice due to ignorance, distrust, or fear of disclosure of serostatus further strengthen the expectation of compliance failure.

Whether because of this perceived opposition, because of their assessment of the practical impediments to following PMTCT regimes, or because of their own distrust of the relatively new medical technology, our respondents consistently left PMTCT out of their recommendations for their clients. Their main goal was for their HIV+ clients to stop having children. They persisted

in counseling their clients according to this goal, despite their clear understanding that stopping reproduction may be neither feasible nor desirable for most women. In this sense, new medication regimes have not been fully “integrated” into the repertoire of practical strategies for coping with HIV.

Ideally, integrated care would mean that medical providers offer care and advice that clients are able to follow. The practical barriers – both economic and sociocultural – to achieving this goal are compounded by the newness of the task. Neither clients nor staff have developed a conception of HIV as a chronic condition; they are unsure whether HIV+ women should be encouraged to live a normal life, including children, or advised to protect their own health, even at the cost of stopping reproduction. The development of a collective understanding of the role of HIV in social relationships is further hindered by high levels of labor migration, which limit communication between husbands and wives, and by the social isolation of clinic staff, who are mostly transplants from urban areas. Previous research suggests that support groups and local activists can play important roles in bridging the social worlds of the clinics and rural communities (Authors 2009). These informal actors facilitate communication between clinic staff and clients by helping to reconcile the antinatalist messages of the health sector and the pronatalist pressures from seropositive women’s sociocultural environments. They therefore not only transfer knowledge between providers and recipients of services, but also can lead to the production of new socially and culturally grounded – and more effective – models for care and counseling.

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