Mainstreaming HIV and AIDS Prevention into Family Planning Programmes at the Grassroots: ARFH Experience

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Background: Over time, as HIV and other STIs have increasingly affected the general population, including women and youth, it has become evident that they cannot be addressed in isolation from other health and social concerns. However, HIV and STI prevention efforts have ignored the natural and programmatic links with family planning in spite of the advantages FP organizations have in addressing disease prevention. Integrating HIV and STI prevention into their prophylactic activities presents multiple challenges. Rather than simply adding on activities, programmes must re-think the way services are provided - creating a broad sexual and reproductive health approach.

Description: The Association for Reproductive and Family Health (ARFH), with support from UNFPA, has embarked on the process of integrating HIV prevention with FP programmes in five Nigerian States shifting from the conventional emphasis on family planning alone. The process involves Capacity Building, Advocacy, Service Provision, Male Involvement, Behaviour Change Communication, Community Mobilisation and Outreach activities, Monitoring, Supervision and Evaluation.

A participatory strategic planning process on HIV and STIs, sexuality and program integration, development of the FP counseling training curriculum that introduces an integrated sexual and reproductive health approach to counseling involved Staff of local government areas (LGA) based at the project sites and Staff of partner NGOs carrying out oversight function. Technical assistance was provided from ARFH staff on a quarterly basis.

Community involvement is considered an important element of most health and development programmes. Local knowledge can inform programme design when community members are involved from the beginning, and community action extends the reach and scope of interventions. Consequently, the project trained Community Based Delivery (CBD) agents to mobilize and provide information and services to their

community members. A fifth of the agents were male who received additional skills in male involvement promotion.

Results: In all the 5 project states, one out of every 10 respondents had ever had unintended pregnancies. Over one third of the respondents were currently using a family planning method as at the time of midterm evaluation, and at least 20% obtained the currently used methods from the CBD agents. The rate of condom use at the midterm evaluation was about 16% in all project states compared with the national rate of 3.4 for all women (National population Commission and ORC, 2004). This is encouraging, considering the prophylactic function of condom as a barrier method.

CBD agents constitute a very effective source of information on family planning services in the rural communities. Virtually all (97%) CBD agent had been involved in community mobilization. As part of significant efforts made on the project, male advocates had been involved in awareness creation, involvement of men in project activities and advocacy visits to community leaders and LGA authorities.

Conclusions: Although many individuals within the organisation have long recognised HIV and STIs as important issues that need to be addressed, actually doing so is not a simple process. However, change can be achieved with efforts to analyse shifting roles of an organization as the world changes, and through giving people the knowledge, skills and tools to address HIV and STIs at the grassroots. ARFH has begun this ongoing process and at midterm of the project, the result is encouraging.