1 *Introduction: Understanding the Links between Family Planning and HIV Prevention*

Intimate interventions are programs, policies, and organizational actions that aim to change sexual behavior in the name of the individual or collective good. This book examines two intimate interventions across sub-Saharan Africa and in Malawi, Nigeria, and Senegal: efforts to prevent pregnancy and efforts to prevent the heterosexual transmission of HIV. Existing research on the implementation and effectiveness of HIV prevention programs has failed to account for the prior history of family planning programs. By accounting for this history, we can better explain why some countries successfully prevent HIV and others do not. By recognizing the similarities between preventing pregnancy and preventing HIV, we are able to reach broader conclusions about why and how countries respond to health problems.

The book considers intimate interventions implemented in sub-Saharan Africa from the late 1970s onwards, focusing primarily on the 1980s and 1990s, the years prior to the mid-2000s when affordable treatment for HIV became widely available. This was a period of intensive action among donors, governments, and nongovernmental organizations (NGOs) to first prevent pregnancy, and then to prevent HIV. Significant numbers of sub-Saharan African governments began to implement family planning programs and adopt national population policies to slow population growth in the late 1970s. Soon thereafter, in the mid-1980s, most countries reported the first cases of AIDS, but the extent and nature of the response within countries varied. With both family planning and HIV programs, international actors played a significant role. The book thus follows the transfer of resources, discourses, and strategies associated with intimate interventions from the prevention of pregnancy to the prevention of HIV. In so doing, it shows that knowing the history of health interventions in a country increases our understanding of how and to what extent countries respond to new health threats. The conclusion addresses this last

point specifically, with a short examination of responses to high maternal mortality in Malawi, Nigeria, and Senegal.

There are two main reasons why research on responses to HIV has not taken into account the historical context. First, the vast majority of HIV research is biomedical, and the doctors and epidemiologists who lead prevention programs have little reason or training to examine how social relations and norms shape policy and programs. Social scientists seeking to find patterns in HIV transmission and responses across historical time and social space are a minority of those studying HIV (Adam 2011; Kippax and Holt 2009). Although a small group, they have made important contributions, particularly in emphasizing structural factors driving HIV transmission as well as resilience to HIV among communities and individuals, but even then, their attention has rarely been to history (Auerbach, Parkhurst, and Cáceres 2011; Blankenship, Bray, and Merson 2000; Gupta et al. 2008; Seeley et al. 2012). Second, scholars, policymakers, and activists alike have viewed AIDS as an exceptional health event, unlike anything seen in modern times (see discussions in Benton 2015; Foley and Hendrixson 2011; Forman 2011; Seckinelgin 2012; Smith and Whiteside 2010). This framing of AIDS initially helped activists and public health policymakers raise awareness and galvanize action to prevent HIV. But treating AIDS as an exceptional and unprecedented disease obscured how responses to it would come from actors – local activists, NGOs, state ministries of health, and donor agencies – that brought their experience from other public health programs with them. And, as I will show, many of these actors had familiarity with designing and implementing intimate interventions for family planning. Because heterosexual sex causes almost all pregnancy and most HIV transmission, both intimate interventions have aimed to affect the very same behavior, particularly in sub-Saharan Africa.

Making contraception available to all who desire it and preventing HIV are quite literally matters of life and death. High maternal mortality in sub-Saharan Africa stems from high fertility – women on average bear five children in their lifetimes – in the context of inadequate health systems, gender inequality, and other factors (Population Reference Bureau 2015). Maternal mortality accounts for 9 percent of deaths to women aged 15–49 globally, almost half of which occur in sub-Saharan Africa (Hogan et al. 2010; Sepúlveda and Murray 2014). Close to a quarter of maternal mortality globally could be prevented if

women wanting to avoid pregnancy but not using contraception did so, which averages approximately one quarter of married women in sub-Saharan African countries (Bradley et al. 2012; Singh, Darroch and Ashford 2014). While maternal mortality is a major preventable cause of death, so is HIV. HIV is the sixth-leading cause of death globally, and theoretically could be completely avoided through prevention (Lozano et al. 2012). HIV first emerged in Central Africa in the 1950s; today, slightly more than two thirds of those who are HIV-positive globally live in sub-Saharan Africa (Kaiser Family Foundation and UNAIDS 2016).

High fertility and high HIV prevalence have, among other factors, led to significant foreign aid commitments towards family planning and HIV programs. Donor expenditure for population assistance *not* including HIV and sexually transmitted infections was US$4.4 billion in 2012, the most recent data available (UNFPA 2014). In comparison, donor government disbursements for all AIDS activities in 2015 reached US$7.5 billion, and total investments in the global AIDS response in 2015 were estimated to be US$19 billion (Kaiser Family Foundation and UNAIDS 2016). That both unintended pregnancy and HIV are preventable in almost all cases, and yet thousands of deaths due to each occur every day, demands an explanation for why some countries have been more successful than others in providing contraception and HIV prevention services to their citizens. The volume of resources, both domestic and global, going towards addressing both issues only heightens the urgency.

Organized efforts to prevent pregnancy in developing countries have primarily taken the form of family planning programs designed to introduce and supply modern contraceptive techniques in order to reduce fertility, lower maternal mortality, and improve infant wellbeing. These efforts have also sought to change norms about family size among both women and men, promoting a small family with two or three children. Donor organizations have funded such programs, while African governments have managed and implemented them alongside local NGOs. In addition to family planning programs, in the 1980s and 1990s many sub-Saharan African governments also adopted population policies, explicit policies targeted at slowing population growth as well as altering other elements of population dynamics, such as mortality and migration.

HIV interventions have sought to prevent and treat HIV, while also caring for those affected by it. The chapters that follow focus primarily on HIV prevention because the parallels with pregnancy prevention are strongest, but do reference interventions to provide treatment that now has the capacity to greatly extend the lives of people who are HIV-positive, and can also help prevent HIV. HIV prevention programs have revolved around messages of abstinence, faithfulness to one partner, condom usage during sex (the "ABC" approach), and testing for the virus. Generally speaking, these programs have encouraged change in the number and/or type of sexual partners, as well as promoted the use of technology (condoms) during sex.

In the analysis of intimate interventions that follows, I refer frequently to the population and AIDS fields. A field consists of the set of individual and collective actors who interact with one another with a shared understanding of the purposes, relationships within, and rules of the field (Fligstein and McAdam 2011). The population field within a particular country thus subsumes all activities around pregnancy prevention and family planning and consists of all of the actors engaged in providing contraception and generating discourse about it: women and men using contraception; local and national organizations that participate in provision of and advocacy around reproductive health; the government, including relevant ministries such as health, finance, women, and youth, as well as legislators and executive leaders; multilateral, bilateral, and nongovernmental international organizations that provide aid and services; and religious institutions and their leaders. The AIDS field consists of a largely parallel, and often overlapping, set of actors that includes people living with HIV and those who care for them as well as global, national, and local organizations that participate in prevention, treatment, care, and advocacy around HIV/AIDS. The population and AIDS fields are "global assemblages," spanning different elements (actors, ideas, treaties, government structures, etc.) and the relationships among them across the global-local scale (Browner and Sargent 2011; Campbell, Cornish and Skovdal 2012; Ong and Collier 2005). Each field encompasses different social movements, some of which overlap, and which attend either directly or indirectly to the focal activity of the field. Actors within each field have differential capacities and ability to influence outcomes, which depend on their position in the field as well as their resources. For example, international donors have massive financial resources, which mean that

their opinions and desires carry great weight, but the programs funded by these resources may ultimately have no impact because the position of the donors is so culturally different than those of the people targeted by interventions. Fields cut across levels of analysis, containing both international and local organizations, with local organizations and actors often playing a mediating and interpretive role for the messages from international organizations (e.g., Browner and Sargent 2011; Ferguson 2006; Li 2007; Merry 2006).

Fields are not isolated entities, but are instead densely connected to one another. These connections span space, as well as time. Understanding how a new field emerges requires considering the fields that preceded it, and indeed, Fligstein and McAdam (2011: 12) note that "New [fields] are likely to emerge nearby existing [fields]. They are likely to be populated by existing groups who 'migrate' or by offshoots of existing groups." This book's emphasis on the linkages between population interventions and HIV interventions invites the investigation of how exactly the AIDS field globally as well as in individual sub-Saharan African countries grew out of extant fields, in particular the population field.

The fields involved in intimate interventions define the scope of relevant actors, purposes, relationships, and rules. With that understanding of fields as a backdrop, I draw from both the sociological and political science literature to develop a model that specifies transnational, political, sociocultural, and economic factors as driving the extent and contours of intimate interventions within countries. The chapters that follow combine cross-country statistical analysis of all sub-Saharan African countries with detailed case studies of Malawi, Nigeria, and Senegal, countries that vary in terms of their experiences with family planning and HIV programs. The statistical analysis facilitates making generalizable claims, while the case studies reveal mechanisms and nuances invisible to macro-level analyses.

The remainder of the introduction provides core background for the chapters that follow. First, I present an argument about the connections between family planning programs and HIV prevention interventions in order to motivate examination of pregnancy prevention within the context of understanding responses to HIV in sub-Saharan Africa. I then develop a model for why countries "do what they do" that structures both the cross-country statistical analysis as well as the individual case studies around transnational, political, sociocultural,

and economic factors. Following that, I explain the logic of case selection and introduce the three cases – Malawi, Nigeria, and Senegal – as well as details on data collection and analysis. I conclude with summaries of the book's remaining chapters.

Connecting Pregnancy Prevention to HIV Prevention

Pregnancy and HIV transmission in sub-Saharan Africa occur mostly through the same mechanism: sex between a man and a woman. The use of assisted reproductive technologies is extremely limited in sub-Saharan Africa, meaning almost all pregnancies occur through sexual intercourse, and the vast majority of the approximately 25 million women and men who are HIV-positive in sub-Saharan Africa acquired HIV through heterosexual intercourse (UNAIDS 2014). The remaining cases are the result of mother-to-child transmission during pregnancy, delivery, and breastfeeding;[1] homosexual male sex; injection drug use; or unsafe medical practices. In the sub-Saharan African context, then, any program to change the number of children people bear, or their risk for contracting HIV, almost certainly requires engaging in the intimate arena of sex. In this section, I note a number of similarities between these two types of intimate interventions, and also discuss some important ways in which pregnancy and HIV, and the prevention of each, differ. These similarities provide the basis for the argument that the experience donors, governments, and NGOs gained through family planning programs should be considered when studying responses to HIV. The argument does not, however, depend on family planning programs being successful. Family planning programs can influence HIV interventions regardless of whether they increased contraceptive prevalence or lowered fertility.

Family planning programs and HIV interventions both draw on the same resources: donors, country-level organizations, and human capital. Specifically, external nongovernmental and governmental organizations with deep pockets have strongly shaped the contours of both interventions. Within countries, the same federal ministries of health, women, and youth as well as many of the same local NGOs have been involved in both types of interventions. Across organizations at all levels, it is often the very same people who first

[1] Sometimes referred to as "vertical transmission."

worked on family planning who then came to work on HIV. For both intimate interventions there are "layers of local brokers who mediate between international donors and the poor villagers whose lives are seen as requiring transformation," facilitating the flow of money from a global to a local level (Swidler and Watkins 2017; Watkins and Swidler 2013: 212). Put in another way, both family planning and HIV interventions represent well "the global-to-local supply chain of interventions to improve the human condition" (Dionne 2012: 2475).

Intimate interventions introduce new ideas about the rationalities of sex, including sex for purposes other than procreation and the concomitant safe sex practices that prevent HIV and other sexually transmitted infections. The goal of family planning programs has been to lower fertility by limiting the overall number of births, as well as spacing them further apart, through the use of contraception. Contraception greatly reduces the risk of pregnancy and distances the risk of pregnancy from decisions about when to have sex and with whom. HIV prevention interventions have encouraged people to have "safe" sex, meaning avoiding sex with those believed to elevate the risk for HIV transmission, like extramarital partners, sex workers, or multiple partners. HIV prevention programs have also promoted condoms, particularly with partners deemed "risky," but even within relationships, adding a decision about condom use to any sexual interaction. Changing rationalities of sex, whether for family planning or HIV, takes time and so reductions in fertility and HIV transmission rarely occur rapidly (Cleland and Watkins 2006b; Merson et al. 2008).

Family planning programs and HIV interventions have both developed and then applied the same templates for action to wildly different cultural, demographic, and epidemiological settings, including the same technologies, logics, and target populations. Contraception is the primary technology of family planning programs, and sub-Saharan African programs have tended to emphasize long-lasting and female-controlled, hormonal forms (Zaba, Boerma and Marchant 1998). The main technology associated with HIV prevention has been the condom, but other technologies include the kits used to test for HIV and now even antiretroviral medication. Condoms can, of course, prevent both pregnancy and HIV. As one long-time observer of family planning and HIV programs put it, "What brings family

planning and HIV together is our old friend the condom."[2] As I describe in Chapter 3 on sub-Saharan Africa, while programmers have generally not promoted condoms as a means of family planning in the region, the associated social marketing programs that include condoms in their arsenal of technologies *have* been a link between intimate interventions.

Both family planning and HIV prevention have relied on the logic that the provision of information and technology will change the calculus of sexual decision making and facilitate implementation of those decisions. In fact, many family planning programmers assumed that supplying technology (pills, injections, and other contraceptive devices) would, in and of itself, lower desired family size and ultimately, fertility. Similarly, HIV programs have admonished people to use condoms and handed them out en masse, presuming that availability would increase use. In both cases, practitioners have been surprised that these templates have not produced the desired behavior change, even though such an outcome is predictable given the importance of context to program implementation and success (Pritchett and Woolcock 2004).

Both interventions have also disproportionately targeted women. With family planning, such a focus is because most contraceptive methods are female-controlled. But with HIV prevention in sub-Saharan Africa, intimate interventions have targeted women because women have more interactions with the health system, creating more opportunities to communicate behavior change messages and to test for HIV. Indeed, much of women's interaction with the health system is centered around fertility. In addition, HIV prevention programs have also targeted female sex workers, a group particularly at risk for HIV. Intervention programs have sought to arm these women with male condoms, regardless of their actual ability to negotiate condom use with clients. Such strategies have worked best in instances where there is regulation and monitoring of sex work, such as in Thailand and Senegal (Hearst and Chen 2004; Phoolcharoen 1998; Pisani 1999). In parallel, men have frequently been "blamed" for both high fertility and the transmission of HIV. Academics and policymakers have given great weight

[2] Expert 5 – see the "methods" section of this chapter for discussion of population experts interviewed for this book.

to male preferences for large families in explaining high fertility, and men's extramarital relationships in explaining the spread of HIV (see the thoughtful discussion and critique in Dodoo and Frost 2008; Greene and Biddlecom 2000).

Intimate interventions challenge the status quo regarding relationships between sex partners, between generations, and between citizens and the state. They intersect with the socially prescribed arena of sex and create moral reactions about appropriate behavior, and who even has the authority to define what counts as "appropriate." While sex within marriage is less contested than other forms of sex, even contraception within marriage raises questions: who has the right to manage an individual woman's fertility? Does she, her partner, her mother-in-law, her spiritual counselor? Sex *outside* of marriage raises moral objections across a wide variety of contexts as it more strongly disassociates sex from procreation and is often explicitly forbidden by religious and legal dictates. As a result, intimate interventions have high potential to invoke the approbation of a variety of social groups, requiring their proponents to go to great lengths to depoliticize them. Contraception has thus turned into "family planning," and HIV treatment has superseded HIV prevention. Such depoliticization has, I will show, complicated what might have otherwise been productive linkages between intimate interventions.

Intimate interventions, *par excellence*, broadcast, reflect, and reinforce biopower, or the management of the population through a variety of techniques and practices that act on individual bodies (Foucault 1978). Separated from directive state power in the form of force, biopower operates through the agents of the state – such as schools, hospitals, and public health programs – that train people to discipline themselves through engaging in appropriate behaviors. Sexuality is thus a dense transfer point for relations of power between the state and individual. From this perspective many authors have examined the state's intervention into reproductive life as well into sexuality more broadly in the name of HIV prevention (e.g., Ginsburg and Rapp 1991; Greenhalgh 2003; Kaler 2003; Newland 2001; Nguyen 2010; Pigg and Adams 2005; Richey 2004; Richey 2008; Thomas 2003). Programs and policies related to family planning and HIV deploy disciplinary tactics, including the close monitoring of populations "at risk" for pregnancy or HIV

transmission. Such monitoring requires the collection of detailed data from women of childbearing age, sex workers, and men who have sex with men,[3] thus bringing these populations under the gaze of the state. These are ultimately mechanisms of biopower, which tie individual sexual and reproductive behavior directly to national power (Gordon 1991).

Though preventing pregnancy and preventing HIV bear many similarities, becoming pregnant and becoming HIV-positive are nonetheless very different transitions with different outcomes. Thus policymakers and programmers addressing HIV, while at times building on the history of family planning, have also required new approaches. Pregnancy does not lead to death with the certainty that HIV did in the era before effective treatment and still does in many contexts where treatment is not readily accessible. As a result, much of the activism around HIV, particularly in the early years of the epidemic, centered on access to treatment and was spearheaded by organizations representing gay men in relatively wealthy countries. Pregnancy is not a disease, and in many instances is a celebrated state. Women's groups promoting reproductive health and rights have been the primary activists associated with pregnancy prevention. Although women can purchase, carry, and in theory demand that male sex partners use a condom, their technological ability to protect themselves from HIV is significantly less than with pregnancy. Trials of female-controlled microbicide gels that would kill the HIV virus have proven overwhelmingly disappointing (Karim, Baxter and Karim 2013) and female condoms cannot be used as clandestinely as can hormonal contraception, an intrauterine device, a cervical cap, or diaphragm. While these differences are important to remember, the similarities between pregnancy prevention and HIV prevention nonetheless motivate investigating how the history of family planning globally as well as within countries has shaped the HIV interventions that followed.

[3] "Men who have sex with men" is the term used in the public health field, preferred because it focuses on the behavior that puts individuals at risk for HIV, as opposed to terms like "gay" or "homosexual" that describe a sexual identity that many men are unlikely to espouse in the context of sub-Saharan Africa and elsewhere.