Addressing Unmet Need for Contraception among HIV-Positive Women: A Qualitative Study of the Arise Project in Uganda

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May 2014
This document was produced under *Arise—Enhancing HIV Prevention for At-Risk-Populations*, under subagreement number CID: 1450-08862-SUB, through financial support provided by the Canadian Government through Foreign Affairs, Trade and Development Canada, and via financial and technical support provided by PATH. *Arise* implements innovative HIV prevention initiatives for vulnerable communities, with a focus on determining cost-effectiveness through rigorous evaluations.
Pathfinder Research and Evaluation Working Paper Series

The purpose of the Working Paper Series is to disseminate work in progress by Pathfinder International staff on critical issues of population, reproductive health, and development.

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**Acknowledgements**

This study was conducted under *Arise*—Enhancing HIV Prevention for At-Risk-Populations. *Arise* implements innovative HIV prevention initiatives for vulnerable communities with a focus on determining cost-effectiveness through rigorous evaluations.

The authors acknowledge and thank the study participants - the women, men, community service providers and facility providers in Teso and Langi districts for their dedication. Thanks also to NACWOLA Project Officers for mobilizing the respondents for this study and to Pathfinder Uganda staff for logistical planning. Thanks to Ibou Thior and Elizabeth King of PATH who provided input into the study design and reviewed the final report. Special thanks to Patricia David, Laura Subramanian, Bram Brooks and Alden Nouga of Pathfinder International, for their extensive review of the report. Last but not least, many thanks to Emma Morse, who finalized the text and formatted the report.
Table of Contents

Abbreviations ........................................................................................................................................... 1

Executive Summary .................................................................................................................................... 2

Section 1: Introduction and Background .................................................................................................. 6
  1.1 Introduction ......................................................................................................................................... 6
  1.2 Purpose of the qualitative study ........................................................................................................ 6
  1.3 Objectives .......................................................................................................................................... 6
  1.4 Study Questions ............................................................................................................................... 7

Section 2: Approach and Methodology .................................................................................................... 8
  2.1 Study Design ..................................................................................................................................... 8
  2.2 Study Sites ....................................................................................................................................... 8
  2.3 Study Team ..................................................................................................................................... 8
  2.4 Sampling Strategies .......................................................................................................................... 8
  2.5 Data Collection Methods ................................................................................................................ 9
  2.6 Data Management and Analysis ..................................................................................................... 10
  2.7 Ethical Considerations ..................................................................................................................... 10

Section 3: Findings .................................................................................................................................... 11
  3.1 Participants Background Characteristics ....................................................................................... 11
  3.2 Fertility Intentions and Decision-Making among Clients and their Partners .................................. 11
  3.3 Current Family Planning Use .......................................................................................................... 13
  3.4 Communication and Decision Making about Use of Contraception ............................................. 16
  3.5 Condom Use ................................................................................................................................... 17
  3.6 Dual method Use ............................................................................................................................ 19
  3.7 Counseling .................................................................................................................................... 20
  3.8 Male Perspectives of Arise Interventions ........................................................................................ 22
  3.9 Adopting New Behaviors ............................................................................................................... 25
  3.10 Acceptability of the Arise Intervention .......................................................................................... 28
  3.11 Barriers to the Arise Interventions ............................................................................................... 32

Section 4. Conclusions .............................................................................................................................. 37

References .................................................................................................................................................. 45
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CSA</td>
<td>Community Support Agent</td>
</tr>
<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
</tr>
<tr>
<td>FDIC</td>
<td>Field data Identification Codes</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>ICDM</td>
<td>Integrated Community Dialogue Meetings</td>
</tr>
<tr>
<td>IUD</td>
<td>IntraUterine Device</td>
</tr>
<tr>
<td>NACWOLA</td>
<td>National Community of Women Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
</tr>
<tr>
<td>PNC</td>
<td>Post-Natal Care</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>THETA</td>
<td>Traditional and Modern Health Practitioners Together Against AIDS and other Diseases</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing for HIV</td>
</tr>
<tr>
<td>VHT</td>
<td>Village Health Team</td>
</tr>
</tbody>
</table>
Executive Summary

From 2011-2014, Pathfinder International with funding from the Department of Foreign Affairs, Trade and Development (DFATD), through PATH, implemented the *Arise—Enhancing HIV Prevention for At-Risk-Populations* Project to integrate Family Planning (FP) into HIV prevention and care services at clinic and community levels in 11 districts of northern and eastern Uganda. The main goal of *Arise* was to address the unmet need for contraception among women living with HIV in order to prevent HIV infections through averted pregnancies. The specific objectives of *Arise* included: (1) increase access to and use of FP by women and couples living with HIV; (2) increase use of dual methods by women living with HIV and their partners; and (3) increase demand for integrated FP/HIV Services.

*Arise* supported facility health workers and community support agents (CSAs) to provide individual and couples counseling for FP and support HIV-positive women in their decision-making around childbearing and fertility intentions. The project also helped ensure availability of FP methods at facilities, and engaged beneficiaries through community-based interventions.

This report presents the findings from a qualitative study conducted in January 2014 in Lango and Teso regions of Uganda among *Arise* Project beneficiaries and service providers. The purpose of the study was to elicit in-depth perspectives and experiences about the effectiveness of *Arise* interventions and suggest ways for improving future interventions in the target districts. The qualitative study findings were intended to complement quantitative data from *Arise* baseline and endline surveys conducted in 2011 and 2013, respectively. The study objectives were:

1. To understand what works for couples in terms of negotiating, trying, and adopting behaviors that are promoted through the intervention—both in terms of provider approaches and individual actions;
2. To obtain men’s perspectives on this intervention, which is targeted to their partners;
3. To assess the acceptability of the intervention from the provider perspective;
4. To understand how the community mobilization component of the project functioned, particularly in terms of engaging the eligible population of women living with HIV and their partners.

The study methodology included key informant interviews with 8 service providers at facilities and 12 community service agents, and in-depth interviews with 40 HIV-positive female clients and 20 male partners who had been exposed to the intervention.

The following are the key findings and recommendations from the study.

Effectiveness of project interventions in influencing couples’ adoption of new behaviors

Overall, the study findings indicate that *Arise* was successful in influencing adoption of new behaviors. While some women and their partners had used FP in the past, most initiated FP after interacting with a health worker or CSA during an Antenatal Care (ANC) visit, child immunization day, home visit, or community dialogue/meeting. Others switched to more effective modern methods after learning about these methods from health workers or CSAs. Despite the adoption of new behaviors among most clients and their partners, the findings show that some never adopted new behaviors due to a number of reasons including negative perceptions of FP, influence from other community members, unfounded myths about the possible effects of contraceptives, and clients’ fear of their male partners. Some clients and their partners observed that targeting only People Living with HIV and AIDS (PLHIV) with project interventions increased social stigma towards them and suggested that future project activities should include other community members to prevent such stigmatization.
Key messages

- Counseling by health workers and CSAs contributed to the clients’ decision to use contraception.
- Commodity stock-outs and male partner opposition to condoms affect a client’s ability to consistently use dual methods.
- Ongoing discussion with clients was a key factor in adoption of new behaviors, as clients were often skeptical at first but their attitudes changed over time.
- Correction of misconceptions about family planning methods and the availability of family planning methods at health facilities were crucial in motivating clients’ adoption of contraceptives and dual method use.
- Targeting only PLHIV with project interventions may have increased social stigma towards them and suggests that future project activities should include other community members to prevent such stigmatization.

Acceptability of project interventions among men

- Men were perceived by all study participants as key decision-makers in respect to family planning and reproductive health, highlighting the importance of engaging them in project interventions. In general, male partners were supportive of project interventions and expressed positive opinions about their partners’ involvement in project activities. Men appreciated the project’s role in encouraging adoption of new behaviors such as contraceptive/dual method use, joint intra-household planning, and reduction of alcohol consumption. Reproductive health issues were seen as the domain of women, which was a key constraint to male participation in the project. Some men objected to the project’s primary focus on women and the high proportion of female CSAs. There appeared to be a disconnect between men’s expressed reasons for lack of participation in the project (busy work schedules, lack of monetary incentives, stigma, long waiting time at health facilities) and women’s and providers’ perceptions of why men did not participate (laziness, lack of interest/support for their partners).

Key Messages

- Successful adoption of reproductive health behaviors requires strong male involvement and participation.
- Understanding male perspectives of interventions targeted to them and potential hindrances to their participation may lead to more effective programming and results.

Providers’ perspectives of project interventions

In general, health workers, case managers and CSAs expressed positive opinions about the project’s integration of FP into HIV services. Integration was perceived to have improved efficiency because FP, maternal and child health and HIV services were provided at the same location. Providers observed that couple FP counseling had improved communication between couples on FP and other health issues. Providers had integrated FP counseling in almost all critical activities in the realm of maternal and child health including out-patient department (OPD), antenatal care (ANC), post-natal care (PNC), immunization, and ART clinics. This may help explain the quantitative survey findings of increased proportions of women receiving family planning from an HIV site (from 69% at baseline to 80.7% at endline). Health workers appreciated the training provided by the project on integrating FP
and HIV services, though felt that they needed additional training on method provision (particularly long-acting methods) since some had no prior training or skills in this area.

Key Messages

- The ready availability of FP methods at the health center was crucial in motivating clients’ adoption of contraceptive methods (including dual method use).
- Inadequate staff and skill gaps were a major barrier to FP uptake. The project stimulated significant demand for family planning and HIV & AIDS services at the facility level, but recruitment of health workers did not keep pace.

**Effectiveness of community mobilization components of the project**

At the community level, home visits, community dialogue meetings, mini-FP outreaches and camp fires (of a limited number) were the primary interventions used to reach project beneficiaries. Community dialogues were reported to have provoked discussions and provided an important platform to dispel myths associated with some FP methods (for example, men’s belief that vasectomy causes impotence). Some beneficiaries were concerned about the use of illustrations and condom demonstrations in community dialogues, particularly in the presence of close kinsmen and in mixed groups of men and women. Others felt that the approach used to educate communities about FP methods (specifically male condoms) was not as effective as it could have been, because the project did not implement adequate audience segmentation based on sex and age. For example, the project tended to include all community members (even children) in community dialogues.

Key Messages:

- The selection of CSAs from the local community who were living with HIV themselves was an effective strategy in reaching HIV-positive women.
- Personal testimonies by CSAs about experiences, challenges and solutions were very helpful in building trust and encouraging women to seek integrated services at facilities.
- Home visits were instrumental in engaging couples and facilitating male involvement in FP and HIV services, since the CSAs conducted home visits to ascertain why the male partners did not escort their partners to the health facility.
- Use of culturally appropriate HIV and family planning behavior change communication strategies that take into account gender roles, needs, and concerns of men and women is essential.

**Recommendations**

Based on the findings from the *Arise* qualitative study, several recommendations are offered for future service provision and community interventions.

Service provision:

- There is need to enhance capacity of health workers in providing long-acting family planning methods to people living with HIV and AIDS through organized trainings tailored to health worker needs. A systematic training assessment of health workers would be helpful in order to organize FP/HIV integration training focusing on long-acting FP methods. Trainees should induct and mentor other health workers at their respective health units in providing similar services. This approach will minimize instances whereby clients go unattended in the event that those trained are not present.
• Health systems challenges affecting Uganda’s health facilities need to be factored in the planning of FP/HIV integration. Particular attention should be given to constraints in human resources, medicines and health supplies and how future interventions can better account for these issues.

• Strengthening the management of FP side effects will need to be addressed in future activities given that this was a key reason clients discontinued FP methods or did not adopt them in the first place. The stock outs for pills/medicines for management of side effects should be reduced or eliminated.

Community interventions:

• Innovative male involvement strategies in FP and sexual and reproductive health (SRH) services need to be developed. Use of drama, peer education, testimonies from men living with HIV, satisfied male users, and using male village and health trainers (VHTs) and CSA have been suggested by study participants as possible strategies that Pathfinder and partners may want to consider for their programs. Strategies addressing HIV-related stigma among men should be accorded high priority.

• Given that the CSA strategy has attained a high level of acceptability, there is need to strengthen their visibility and effectiveness through deploying at least two CSAs per sub-county. There is also need to consider recruiting more male CSAs whom men can identify with during community dialogue meetings and home visits. Moreover, since VHTs are mobilizing clients for HIV services, working with the VHTs to promote integrated FP services could help reduce the workload of CSAs. In selecting VHTs to work with, priority should be given to those that live with HIV and are willing to disclose their sero-status, as the study findings indicated that this made the CSAs easy to relate to and identify with.

• There is a need to consider gender-specific outreach activities where target group members will not feel uncomfortable or constrained by the presence of others. Additionally, community dialogues should target participants by age so that young mothers do not fear asking FP questions in the presence of older participants, some of whom may be their mothers-in-law.

• Design of future project activities and materials should not contribute to stigma. The good intention of providing white jerry cans to HIV-positive clients had the unanticipated effect of contributing to stigma at the community and household level.

• Some women were using FP without the knowledge of their male partners because they feared negative reprisal such as domestic violence. The project should ensure that the messages communicated during community mobilization and community dialogue meetings address the gender imbalances in communication, power relations and access to resources that affect women’s decision making.
Section 1: Introduction and Background

1.1 Introduction

This is a report from the qualitative study of Arise conducted by Pathfinder International in Lango and Teso regions of Uganda in January 2014. The report is organized into the following sections: 1) Introduction and background; 2) Study rationale; 3) Study design 4) Findings; 5) Conclusions; and 6) Recommendations.

For the past three years, Pathfinder International, Uganda, with funding from the Department of Foreign Affairs, Trade and Development (DFATD), through PATH, has been working with health facilities and the National Community of Women Living with HIV/AIDS (NACWOLA) to implement Arise, which aims to integrate family planning (FP) into HIV prevention and care services in 11 districts of northern and eastern Uganda (Kaberamaido, Amolatar, Dokolo, Lira, Apac, Katakwi, Amuria, Oyam, Gulu, Pader and Amuru) with a total population of about 3.6 million people. Northern Uganda is a post-conflict, underserved area where FP has not traditionally been offered in PMTCT or ART services. The main goal of Arise was to address the unmet need for contraception among women living with HIV in order to prevent HIV infections through averted pregnancies. The specific objectives of Arise included: (1) increase access to and use of FP by women and couples living with HIV; (2) increase use of dual methods by women living with HIV and their partners; and (3) increase demand for integrated FP/HIV services. The target population for Arise was women living with HIV and their partners. The project supported facility health workers and community support agents (CSAs) to provide individual and couples counseling for FP and support HIV-positive women in their decision-making around childbearing and fertility intentions. The project also helped ensure availability of FP methods at facilities, and engaged beneficiaries through community-based interventions.

In 2011 and 2013 respectively, Pathfinder conducted baseline and endline surveys to assess key project outcomes among the Arise project target population. However, these study findings lacked context on people's experiences, perceptions and opinions about the integration of family planning in HIV prevention and care services. To fill this gap, a qualitative study was conducted to contextualize, add depth, detail, and nuance to the quantitative survey findings.

1.2 Purpose of the qualitative study

The purpose of the qualitative study was to elicit in-depth and detailed perspectives, experiences, and perceptions of project clients, their partners, and service providers (both facility-based and community-based) about the effectiveness of Arise interventions and strategies, and suggest ways for improving future interventions in the target districts.

1.3 Objectives

The specific objectives of the study were:

1. To understand what works for couples in terms of negotiating, trying, and adopting behaviors that are promoted through the intervention—both in terms of provider approaches and individual actions;
2. To obtain men's perspectives on this intervention, which is targeted to their partners;
3. To assess the acceptability of the intervention from the provider perspective;
4. To understand how the community mobilization component of the project functioned, particularly in terms of engaging the eligible population of women living with HIV and their partners.
1.4 **Study Questions**

The study had two central questions and 16 sub-questions as indicated below:

Central questions

1. What aspects of the intervention did providers, clients, and partners find most effective in addressing unmet need for contraception among HIV-positive women as a strategy to prevent HIV infection through averting unintended pregnancies and through increased dual method use?

2. What aspects of the intervention did providers, clients, and partners find most effective in expanding the reach of services targeted to women with children less than two years, and to engage male partners of HIV-positive women in family planning?

Sub-questions

1. What strategies did providers/CSAs employ to encourage clients to try or adopt new behaviors?
2. What strategies did providers/CSAs feel were most/least helpful in encouraging clients to try new behaviors? Under what circumstances are these strategies helpful or not helpful?
3. What strategies did providers/CSAs feel were most/least helpful in encouraging clients to try to adopt promoted behaviors?
4. What challenges did providers face at the clinic level in promoting the key behaviors?
5. What information, if any that providers or CSAs provided did clients feel helped them to negotiate behaviors that were promoted by *Arise* (contraceptive use, dual method use)?
6. What led clients to try new behaviors? If clients did not try new behaviors, why not?
7. How did the woman’s partner affect her willingness to try new behaviors?
8. How did the woman’s partner affect her ability to adopt new behaviors?
9. What support provided by providers or CSAs helped clients to adopt new behaviors?
10. What was men’s experience of the intervention?
11. What was the response of male partners to the project interventions?
12. What was the response of male partners to the behaviors that were promoted?
13. What health systems and community-level factors impede or facilitate the integration of FP in HIV services?
14. What are the positive effects of integration of FP in HIV services on coverage and utilization of both FP and HIV services?
15. What health / equity benefits resulted from integration of FP in HIV services?
16. What are the unintended consequences of the intervention?
Section 2: Approach and Methodology

2.1 Study Design

The qualitative study employed an exploratory design utilizing both phenomenological and grounded theory approaches to qualitative inquiry (Creswell 2013). Creswell (2013, p.148) noted that a phenomenological approach to qualitative research targets involved “multiple individuals who have experienced the phenomenon” while the grounded theory approach to inquiry targets “multiple individuals who have responded to an action or participated in a process about a central phenomenon”. Therefore, the study utilized both approaches of qualitative inquiry to explore perspectives of female HIV clients that benefited from the integration of family planning and HIV services, their partners, and service providers.

2.2 Study Sites

The study was conducted in Lira and Dokolo districts of Lango region (Northern Uganda), and Katakwi district in Teso region (northeastern Uganda). Participants were selected from areas surrounding four health units: Ogur Health Centre IV (Lira district, Lango region), Agwata Health Centre III (Dokolo district, Lango region), Toroma Health Centre IV (Katakwi district, Teso region) and Kapujan Health Centre III (Katakwi district, Teso). The health units were selected based on their performance in relation to Arise interventions, that is, the best performing (i.e., Ogur HC IV and Toroma HC IV) and the least performing health facilities (Agwata HC III and Kapujan HC III) was based on service statistics.

2.3 Study Team

The study team was led by two senior researchers, with experience in conducting qualitative studies in the study regions and other parts of Uganda. Each study region had six research assistants (4 females, 2 males) who were proficient in the local language and had prior experience in conducting qualitative studies in the study districts. The team also had one female supervisor.

2.4 Sampling Strategies

A combination of criterion and maximum variation purposeful sampling strategies was used to select the study participants. Criterion sampling was used to select an initial group of 72 study participants: 40 female HIV-positive clients, 20 male partners of the female HIV clients, and 12 trained service providers that met the eligibility criteria outlined below. Although the community support agents (CSAs) had mobilized more male partners, the study team selected only those whose female partners agreed that they should be interviewed.

Study participants selection criteria

- HIV-positive female clients who received both HIV and FP counseling and services by CSAs
- HIV-positive female clients who received both HIV and FP counseling and services at the facility
- Male partners whose participating female partners had agreed that they should be interviewed.
- Facility-based providers who were trained by Arise on integration of family planning and HIV
- Community support agents who were trained by Arise on integration of family planning and HIV
Community support agents (CSAs) who led the community-based activities, counseled, and referred women and their partners for the *Arise* project services were asked to mobilize all women that they counseled. Additionally, they were requested to ask the women whether it was okay to interview their partners. Furthermore, case managers that worked with health workers to organize and support clients at the health facility were requested to mobilize clients that they reached at the facility level who may not have interfaced with the CSAs. The role of CSAs and case managers was to mobilize project clients and their partners and provide support and guidance to the study team.

After identifying individuals who met the selection criteria above and were willing to participate in the study, the study team used maximum variation purposeful sampling to select 72 participants with diverse features: HIV sero-discordance and using single method or dual method of family planning. Patton (2002) emphasized that maximum variation is valuable in isolating and documenting exceptional or diverse characteristics that may be present in a sample.

### Table 1: Category and number of participants by region and health facility

<table>
<thead>
<tr>
<th>Participant’s category</th>
<th>Lango region</th>
<th>Teso Region</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ogur HC IV</td>
<td>Agwata HC III</td>
<td>Toroma HC IV</td>
</tr>
<tr>
<td>Female Clients</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Male Partners</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Health workers</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Community support agents</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>

#### 2.5 Data Collection Methods

In-depth interviews, key informant interviews, and document reviews were used to collect data for the study. Key informant interviews were conducted with service providers at facility and community levels. In-depth interviews were conducted with HIV-positive female clients and selected male partners of the female HIV clients that received both HIV and FP counseling and services. Interview guides were developed for the in-depth individual interviews and the key informant interviews, using open-ended questions and probes to facilitate exploration of ideas and generation of rich personal narratives and perspectives. The questions were based on the study objectives and insights gained from the review of project reports and previous project studies (i.e. baseline survey, endline survey, and modeling study). Basic demographic information (age, sex, number of children, etc.) were also collected from each study participant. The interview guides were translated into Langi and Ateso languages and pre-tested at two non-study sites in the study regions prior to the commencement of fieldwork.

The research team comprised 12 research assistants in teams of two (interviewer and note taker) with oversight from two field supervisors. Training and pre-test for the data collection team was conducted from Jan 19-22, 2014, followed by revision of the tools. The pre-testing enabled the study team to test the sampling procedures and familiarize themselves with the study questions and how participants understood and perceived them. After the pre-test, the study team met for a day to share lessons learned and revise the tools to ensure alignment with the study objectives and comprehension by respondents.

Data collection was conducted over a period of 4 days from [January 27-30, 2014, in Lango and in Teso simultaneously. During fieldwork, the study team met every evening for one hour to debrief and assess what went well or did not go well. They also reflected on the emerging issues and deliberated.
on questions that were not clearly understood by study participants. The debrief sessions provided opportunities to further revise the study guides in order to make them more responsive to the study objectives. They were also helpful in enabling the study team to identify and reflect on the emerging themes, especially those that warranted follow-up and deeper analysis.

2.6 Data Management and Analysis

This study yielded data from primary and secondary sources. Audio recordings were transcribed and simultaneously translated from local languages to English. Field notes were expanded to generate data transcripts that were scrutinized and organized into descriptive themes through continuous comparison. The notes were read thoroughly by multiple study team members to develop a priori codes and identify emerging themes. Coding helped to classify responses into meaningful categories in order to identify essential patterns. The transcribed notes were entered into Atlas ti version 5 software for analysis. Data were organized into themes derived from the key study thematic areas as well as other key emerging issues from the data. Some verbatim quotes were extracted from the transcripts and inserted directly into the report. The quotes were selected based on their testimonial value and relevance to the study themes, objectives, and regions. Content analysis was then carried out to draw implications of the data and what they mean in relation to the study context and objectives.

2.7 Ethical Considerations

The study was approved by the Committees on Human Research Ethics at PATH, Makerere University School of Public Health, and the Uganda National Council of Science and Technology. Informed consent was obtained from all participants. All participants were informed of the purpose of the study, what their participation entailed and the risks and benefits of participating in the study. For male partners, consent was obtained twice: from the female partner and the male himself. This was done to ensure that only the male partners who knew the sero-status of their female partner were interviewed. Before the interviews, a field data identification code (FDIC) was assigned to each study participant to protect their identity and avoid having any personal identifiers on the interview transcripts. Similarly, all materials associated with the interviewee were assigned the same FDIC. All interviews were audio recorded with the consent of participants, labeled with the FDIC of each interviewee, typed, and stored under a password-protected file. All participants were informed of their right to refuse to participate in the study without any consequences, and the right to refuse to answer any question during the interview process.
Section 3: Findings

3.1 Participant Background Characteristics

This section briefly summarizes the key background characteristics of the three categories of study participants: female HIV clients, male partners, health workers, and CSAs.

3.1.1 Female Clients

Out of the 40 female clients, the average age of female HIV-positive participants was 33 years, with a range from 20 to 46. The average number of children per female participant was 3.7 and 4 in Lango and Teso respectively. All of the women had been diagnosed with HIV more than 12 months preceding the study and 70% in both regions were diagnosed before Arise began in 2010. Nearly all women in both districts had children before being diagnosed with HIV (range of 2-4 children), and most decided to have more children after their diagnosis (range of 1-5 additional children). Nine women (2 in Lango, 7 in Teso) were in discordant relationships in which they were positive while their male partners were not; 30 women had HIV-positive partners (18 in Lango, 12 in Teso); and one woman in Teso did not know her partner’s sero-status.

3.1.2 Male Partners

In contrast to the female clients, out of the 40 male partners a minority of male partners (one in Lango, three in Teso) had tested for HIV before Arise began in 2010. Seven men (4 in Lango, 3 in Teso) did not specify when they tested for HIV, and eight men (4 in Lango, 4 in Teso) were diagnosed during the Arise project period of 2011 to 2013. The male partners indicated that Arise interventions influenced their decision to test for HIV, mainly because the female partners encouraged them to test for HIV and seek FP/HIV services. As noted above, the majority of men had children prior to their female partner’s HIV diagnosis, and decided to have additional children after the diagnosis. All nine HIV-negative male partners in the discordant relationships noted above were included in the sample (2 in Lango, 7 in Teso); the other 11 men were in concordant relationships.

3.1.3 Service Providers

The eight health workers interviewed for the study included 4 midwives (1 at each of the sites), 1 male nurse at Toroma HCIV, 1 female nurse at Kapujan HCIII, 1 psychiatric nurse at Ogur HCIV, and 1 senior clinical officer at Agwata health center III. While the rest of the health workers had spent more than three years at the study health facilities, the midwife and senior clinical officer at Agwata had only been there for 9 and 4 months respectively. All four of the CSAs who were interviewed had participated in the project for three years.

3.2 Fertility Intentions and Decision-Making among Clients and their Partners

As noted above, the majority of HIV-positive women (85% of clients in Lango region and 100% in Teso region) made the decision to have children after the HIV diagnosis. The main drivers of childbearing decisions after HIV diagnosis included fear of giving birth to an infected person, fear of child caring costs, preference for girl or boy child, pressure from new partner to bear him a child, getting playmate for the existing child, and confidence from knowing that access to PMTCT services can prevent mother to child transmission of HIV. There was no difference by region in respect to having children after diagnosis as majority of the female clients and their partners decided to have other children after the diagnosis.
Clients went through numerous thought processes and actions, including seeking counseling and consulting others before deciding whether or not to have other children, as the quote below illustrates:

[After the HIV diagnosis in 2005], we went and consulted the doctor and informed him that we wanted to have children. The doctors advised us to check the immunity (CD4) before having a baby. When we tested for CD4, we found that we were okay. We then made the decision to have two more children. We currently have four children [and opted for tubal ligation in 2013] (33-year old male partner in a concordant relationship, Toroma, Katakwi district).

The decision to have children after receiving an HIV diagnosis was based in large part on current family size and fertility intentions. Those without a child still wanted to have one or two children. Women with one child wanted to have another so that the existing child has a playmate, as one 24-year old mother of two children in Katakwi district pointed out: “I thought that let me produce only two children and then finish. I wanted to have two children so that the first child is not bored, has a sibling to play with.” Others with a child of one sex wanted to try for a child of a different sex. Although there was a general preference for boys, some mothers with boys desired to have girls as the 35-year old mother of eight children in Katakwi district narrated, “...then I gave birth to one more, but that one was a boy but I wanted to have a girl child”. For some women in new relationships, the new partners wanted to have children which compelled them to give birth to another child after diagnosis:

I had decided not to have more children, but my new husband told me that I should at least produce one child with him (36-year female, Toroma HC IV, Amuria District, who gave birth to her third child after the HIV diagnosis).

For some couples, knowing that programs on prevention of mother-to-child transmission of HIV could reduce the risk of having HIV-positive children diminished their fears, and gave them hope and confidence to achieve their fertility intentions:

Well, my thought was that I should retain the number of children I had, but we got counseled and they told us about the support they give to pregnant women to prevent the HIV virus from passing on to the child during the time of birth and also during breast feeding (40-year old male, Dokolo District, who had 2 additional children after HIV diagnosis)

I feared because I thought I would give birth to an HIV-positive child but with continuous counseling I realized I could give birth to an HIV-negative child. But my husband didn’t think so …. When I try to tell him about family planning, he doesn’t care so if I give birth, it is because I want to (34 year-old mother of 4 children, Lira District, who gave birth to her fourth child after the diagnosis).

Some women initially decided not to have more children after receiving their HIV diagnosis, but then their fertility intentions changed. For example, one female client who lost her first husband to AIDS did not initially want more children but then changed her mind after re-marrying:

When I lost my first husband, I said there was no way I was going to cater for these two children if I continue reproducing. I stayed free for two years before I got married again. The thought that ran through my mind was that it is difficult to look after many children when you are HIV-positive, you can run out of money and fail to cater for them. Secondly, giving birth makes someone grow old. And also the body immunity system can be low all the time... (36-
Among those who decided not to have more children, a primary reason was the fear of transmitting the HIV infection to their children. For example, a 35-year-old woman with four children noted that she began using contraceptive pills after her HIV diagnosis:

> When I was diagnosed with HIV, I thought that we should not have more children because I feared giving birth to an infected child. Luckily, my husband also agreed and suggested that we enroll on ART [and begin using pills] (35-year old mother of four children, Ogor, Lira district, Lango region).

Others did not want to have more children but opted for family planning when it was too late. One 38-year old mother of 5 five children in Dokolo District, who gave birth to two (2) other children after the HIV diagnosis, recounted: “I thought I wouldn’t give birth again but just realized I was pregnant. By the time I thought of going for family planning contraceptives, I was again pregnant”.

### 3.3 Current Family Planning Use

#### 3.3.1 Type of contraceptive methods used

The study findings show that among the women interviewed in both Lango and Teso regions, Injectaplan (Depo Provera) and implants were the most commonly used family planning (FP) methods. Condoms, intrauterine Devices (IUD), pills, and periodic abstinence (safe days) were the least used methods. These findings are similar to those of the quantitative endline survey, which showed that many women use injectables (22.6%) and implants (18.2%). The endline survey further showed an increase in the proportion of women using injectables (i.e., from 16.2% to 22.6 %) and implants (i.e., from 9.7% to 18.2%). Regional variations in the use of certain FP methods were observed. For example, whereas no participant in Lango region mentioned using tubal ligation, six participants cited using it in Teso region. More participants in Teso region than in Lango region reported using male condoms as the only family planning method. Non-use of female condoms was attributed mainly to limited knowledge and confidence in using them. Condom use was mostly associated with preventing sexually transmitted infections and reinfection with HIV. Except in the case of tubal ligation (TL), there were no significant differences in family planning methods being used by clients in the high and low-performing health units. The reported high number of clients using TL in Toroma is understandable because as a Health Centre level IV, it has the staff and infrastructure that can provide such a service. The family planning choices among female clients are summarized in Table 2 (below).
Table 2: Family planning method being used

<table>
<thead>
<tr>
<th>Family Planning method</th>
<th>Lango region</th>
<th></th>
<th>Teso Region</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ogur HC IV</td>
<td>Agwata HC III</td>
<td>Toroma HC IV</td>
<td>Kapujan HC III</td>
</tr>
<tr>
<td>Condom only</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Condom and periodic abstinence (safe days)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Injectaplan (Depo Provera)</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Implant</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Intrauterine Device (IUD)</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Pills</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Dual method Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Method (FP only)</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Dual Method (FP &amp; Condom)*</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

*One client in Toroma who is currently using tubal ligation used to practice dual methods before the death of her husband in 2010.

The findings show that before the Arise project started, some beneficiaries were already accessing family planning and HIV services from government health facilities. However, these were being provided as standalone interventions. Two NGOs were reported to be providing FP services: Marie Stopes and THETA, with the former mainly providing long-term methods (i.e., IUDs, implants, tubal ligation) while the latter provides information and creates demand for family planning services. Arise interventions therefore built on these earlier FP services but focused mainly on short-acting methods such as injectables, pills, and condoms. Some study participants noted that the project’s focus on short-acting methods limited their choices and opportunity to access permanent and long-term methods.

If it were possible Pathfinder should help us bring permanent methods of family planning here because some of the women here don’t wish to give birth again, they should bring us the long-term methods because others may prefer those ones since we have different interest. (36-year female, Ogur Health centre, Lira district)

Some study participants had difficulties in specifying from whom they had received services because to them, all providers (i.e., THETA, Marie Stopes, and Arise project staff) seemed similar. Nonetheless, the Arise intervention was perceived to be unique because of its emphasis on the integration of family planning and HIV services and the use of CSAs. As reported below, in some instances, beneficiaries reported not being clear about who was providing particular services.

It was difficult for me to differentiate between a VHT counselor and these other group because there are many people who conduct counseling in the community …..talked about many things and we get counseling from many people and they are similar (31-year old female, Agwata Dokolo)

3.3.2 Factors influencing the choice of family planning method

The choice of family planning methods used by project beneficiaries was based on several factors ranging from personal experiences with previous methods, recommendation by satisfied users, peer
influence, perceived side-effects, access and availability of the family planning method, and cost of the method, among others. Some clients reported to have switched FP methods because of the bad experience they had gone through after using some FP methods in the past such as unexpected pregnancies, irregular menstrual cycle, body itches, among others. Such experiences discouraged beneficiaries from using some FP methods in favor of others. These cases were common across the two study regions. Some clients abandoned other methods in favor of Injectaplan, reflecting its appropriateness and suitability to their needs.

I first used DEPO while I was breastfeeding but it made me bleed twice a month for 2 weeks, so I decided to abandon it. Then I decided to use the 5-year implant (37-year HIV-positive woman, Toroma HC IV, Amuria District)

We had been using the calendar method but I ended up conceiving and bearing all my children. Then we started withdrawal method but my husband got tired of this method so we decided to come to the health center. Since then we started using condoms (35-year old female, Ogur Lira)

We chose to use injectaplan because when my wife gave birth to our first-born child she used pills but they did not work so well on her. They disturbed her; she was not having regular periods, and felt pain around her pelvic area. When we consulted a doctor he advised us to choose between injectaplan and tubal ligation. We chose injectaplan. (HIV-negative male, 36 years, Kapujan, Katakwi district).

Although some clients reported being initially discouraged from using some FP methods based on their perceived negative effects, they later on used them. This also influenced pregnancy decisions of some clients in order to have children before resorting to FP methods as one case below shows;

Now I started using injectaplan to prevent pregnancy although people discouraged me about it that they said injectaplan I would get complication and might not give birth again, then I decided to first give birth to my daughter before using it so that in case of anything I will have had all my children (37-year old HIV-positive female, Agwata Dokolo).

Furthermore, there were some methods that clients feared to use due to the perceived difficulties in using them, for example the moon beads. Although these were not methods primarily provided by Arise, problems in their use made some clients to seek alternative FP methods offered by the project.

Moon beads are very scarce and you should be able to count them well but if you have a bad husband he can push the black bead either ahead or behind and you will fail to count properly and you conceive again (37-year-old HIV-positive female, Agwata, Lira)

They counseled us on how to use moon beads but people here don’t like it because they can easily forget to count the beads well, then when you have sex you can conceive if you miscounted it but IUDs and implants are good because they stay on your body until when they expire (36-year-old HIV-positive female, Ogur Lira))

Condoms are good and easy to use, it’s only down side is it’s not always available (50-year old male, Agwata Health Centre III, Dokolo District).

Other factors that affected FP choices included the apparent costs and time involved in terms of travel to the health center.
I was shown moon beads, injectaplan and pills but I chose implants because it lasts for 3 years but injectaplan is for every 3 months. This meant that I had to travel to the health center every 3 months (36-year-old HIV-positive female, Ogur Health Centre IV (Health Centre CIV, Lira district).

I am using injectaplan. I like the method because it reduces sexual desires so you don’t need to have sex every day, prevents pregnancy, if you are on injectaplan it remains until three months without any worries of becoming pregnant, when you want to use it again you come back and they inject you again (35-year-old HIV-positive female, Lira/Ogur).

These perspectives demonstrate that communities have different perceptions and preferences about family planning methods. These perceptions point to the need for counseling and provision of detailed information about the benefits and side effects of family planning methods. Participants revealed that counseling is not only valuable in dispelling the myths and misconceptions about FP but also in allowing couples to ask questions and discuss their fears.

With contraceptives some people prefer a certain method to the other. It all depends on how information given by the counselors (HIV-positive female, 36 years, Lira district, Ogur Health Centre IV). I think we liked the things the counselors said about BTL (bilateral tubal ligation). That is why we chose this method (28-year-old HIV-positive female, Katakwi).

3.4 Communication and Decision Making about Use of Contraception

This study also sought to understand how decisions about family planning are made between the clients and their partners- individually or jointly. It also sought to understand the nature and quality of couples’ communication about family planning. The findings show that despite the traditional power and control over decision-making by men, choices on FP methods were mainly agreed upon jointly. By agreeing on a particular FP method, clients and their partners were mainly concerned with making good preparations for the children they had without excessive financial and physical strain. The quotes below provide a glimpse into some of the reasons why women discussed and communicated with their partners about contraception. Notably, several women mentioned the possibility of domestic violence if they chose to use contraception without consulting their partner.

I came up with the suggestion about a permanent method of family planning. She had fears especially about the side effects of the permanent method (tubal ligation), but I told her that health workers assure people that this method has no side effect, and above all it is performed by qualified medical personnel (43-year-old male Ogur Health Centre IV, Lira District).

We first sat down and we asked ourselves how we could be able to raise the children that we had produced already and we agreed that we should use the injection and the condoms at the same time; yes this is what we agreed (29-year-old male Kapujan health centre III, Amuria District).

We had to decide together because if I had not told him and I went to use contraceptives on my own and he got to know later it would have resulted in domestic violence (36-year-old HIV-positive female Ogur, Lira district).

Despite the generally good communication evident between the couples, there were some cases in which conflict arose between the client and her partner on the choice of FP method.
When I started family planning, my partner and I started to fight; besides I also started bleeding and experienced no change in spite of medication. So I decided to stop (40-year-old HIV-positive female, Toroma HC IV, Katakwi District).

My partner was not around but when he returned, he was angry that I allowed the CSA to talk to me about FP in his absence. But I told him, I have committed no wrong because what she has shared was what I told him about. (40-year-old HIV-positive female, Toroma HC IV, Katakwi District).

It was also evident from the findings that most clients and their partners initiated family planning after interacting with a health worker or CSA either during an ANC visit, child immunization day, home visit, or community dialogue/meeting. This, therefore, signifies the critical role played by staff in motivating project beneficiaries to make decisions on appropriate FP method as noted in the extracts from the interviews below.

It is when Betty (CSA) came to our community and talked to us about family planning at one of the community meetings that I attended that I decided to take on the IUD (28-year old HIV-positive female, Ogur Health Centre IV, Lira district).

I knew these methods before I decided with my wife to take on the IUDs. Although I knew about them, I did not use them; it is after the CSA visited my home and talked to us that we decided to the IUD (43-year male, Ogur Health Centre IV, Lira district).

After we were counseled by the CSA I accompanied my wife to the health center where we got more counseling on family planning. She is now using injectaplan (36-year old HIV-positive male, Kapujan, Katakwi).

Regardless of whether clients and their partners had used some form of FP methods in the past, it appears that Arise helped couples to take action in choosing contraceptive methods that met their needs. There were no significant differences in how participants in high and low-performing health facilities communicated and made decisions about using or not using family planning services. This may be so because the study only targeted FP service users who may not possess diametrically divergent views.

3.5 Condom Use

The findings show that male condoms were a common method in both Teso and Lango regions although they were more pronounced in Teso region. It was reported as being a common method mainly because of its easy application as well as availability to clients and their partners. The study participants revealed that they used condoms to prevent conception, HIV infection and reinfection. In terms of experiences and perceptions, the following extracts support condom usage.

I don’t use condom but I know condoms also prevents pregnancy. It also helps in a way that if you are on family planning and you don’t use condom, a man or woman might get infected in case one partner is negative so condoms helps. Using condom is good because I might be on injectaplan and it expires, if I am not using condom I can get pregnant but if I am using condom I will not get pregnant (35-year-old HIV-positive female, Ogur/Lira)
I like using condoms because they prevent HIV. I am HIV-negative yet my wife is HIV-positive; the only way we can have sex without me acquiring HIV is by using a condom. (21-year old HIV-negative male, Kapujan, Katakwi district).

We use condoms just to prevent reinfections. Failure to use condom may lead to a reduction of CD4 count because too much unprotected sex is not good for people who are positive, as you acquire other infections that can lead to early death. (34-year-old HIV-positive female, Agwata)

The uptake of female condoms was said to be negligible, and participants expressed disinterest in their usage. Study participants related that they were more familiar with male condoms than female condoms. Though some participants mentioned being sensitized and shown female condoms, others had no knowledge. They cited lack of knowledge on how to use them, myths and misconceptions surrounding female condoms, and their unavailability at the health facilities as the major barriers to their use. The negative attitude and apathy towards female condoms is clear in the expressions below.

I hate female condoms because they can enter into you and fail to come out if not properly used...then they will have to take you for an operation to remove. (35-year female, Lira/Ogur)

...female condoms help in family planning but the disadvantage of female condoms, I hear people saying that it can disappear in you (36-year-old HIV-positive female, Ogur Health Centre IV Lira)

I don't know how to use the female condoms so I have never used them (30-year-old HIV-positive female, Ogur, Lira)

I use male condoms; I have never seen the female condom. (HIV-positive male, 25 years, Ogur, Lira)

Beside the barriers cited above, the approach used to educate communities about male condoms was said to have limitations that preclude would-be users from understanding how they can be used. Some participants observed that CSAs and health workers had discussed condoms during community dialogues and ART days. The mixing of males and females during the sensitization was regarded to be culturally inappropriate and thus a barrier to genuine discussions. Some participants pointed out that many people including in-laws and some children attended such dialogues, which made it difficult for participants to ask sensitive sex-related questions fearing that they will scandalize the in-laws and children that were present. Besides, the use of dildos to illustrate how to use condoms was said to have made some women shy to the extent that they looked away when such demonstrations were being made. As a result, some of them reportedly did not fully grasp the intended messages.

Likewise, the use of female CSAs as community dialogue facilitators was perceived by most men to be culturally inappropriate especially on matters of sexuality. Both Lango and Teso regions have a strong male dominated culture; in this context, female CSAs educating men about sexual matters was regarded by some as an abuse of the cultural norms and practices of the area. Consequently, some males did not participate in project activities while those that attended had reservations that limited their learning.

Besides the constraints mentioned above, participants revealed that misconceptions about male and female condoms exist, which impacts their demand and utilization in the communities.
These male/female condoms have their oil, I have heard people say that this oil causes itching around one’s penis/ vagina. (HIV-negative male, 21 years, Kapujan, Katakwi district)

In some cases, women’s use of condoms was constrained by their partners’ negative attitude and resistance to their usage. There was also a belief that circumcision negates the need for condoms, which reflects an apparent information gap that should be addressed during counseling of clients and their partners.

My husband never liked family planning and he never allowed us to use condom but he understood the importance after the FP counseling and also HIV/AIDS counseling (28-year old, female, Ogur Health Centre, Lira District)

I am not using condoms because my husband said he is circumcised. (31-year old, HIV-positive female, Agwata Health Centre)

The above findings suggest that community dialogues should be segregated by gender and age. Moreover, children should not be allowed to participate in such dialogues given the sensitive nature of the issues discussed. They also call for using culturally appropriate HIV and family planning behavior change communication strategies that take into account gender roles, needs, and concerns of men and women. Moreover, future interventions should address men’s negative attitudes about condoms and the misconceptions related to circumcision and HIV prevention.

### 3.6 Dual method Use

In addition to encouraging HIV-positive women and their partners to use contraceptives, Arise educated them about the value of concurrently using them with condoms to offer added protection against HIV reinfection and transmission. The message to use dual methods was part of the counseling process in Arise interventions. As indicated in Table 3 above, 26 female clients (14 in Lango region and 12 in Teso region) reported using dual methods, that is, they use another modern family planning method concurrently with the condom. Discussions with clients and their partners revealed that they were knowledgeable about the benefits associated with dual method as evident in their expressions below.

Family planning with condom use helps prevent reinfections, which are a result of unprotected sex. For us each time we need to have sex, we use condoms. (34-year old HIV-positive female, Agwata)

I use both methods at the same time. It is because the health worker during counseling told us to use both methods one is for preventing pregnancy and the other is for HIV (35-year old HIV-positive female, Ogur Lira).

My wife uses tubal ligation, and I use condoms. According to the information we got from health workers, using both methods not only prevent pregnancy but also prevents me from re-infecting my wife and her from re-infecting me. (43-year old Male, Ogur Health Centre, Lira)

The above quotes indicate that Arise sensitized clients and their partners about the importance of dual method use, as 65% of female clients reported using dual methods with their partners to prevent HIV reinfection and unwanted pregnancies. These findings are consistent with those of the Arise endline study, which showed an increase in dual method use among clients from 44% at baseline to 51% at endline. However, providers observed that there instances reported in which men resisted using the dual method.
Many really don’t see any reason why they should adopt this dual method. The man says they are already positive, why use a condom and then for the woman they say her libido has already gone down (Toroma HC IV, Katakwi District).

Some men take you badly that you are the one spoiling their wives by teaching them how to use condoms (CSA, Toroma HC IV, Katakwi district).

Although I advise those living with HIV to use condoms such that they don’t spread diseases like syphilis, it is the discordant couples that readily accept using condoms. Others may use both condoms and FP but not regularly as the discordant couples do. (CSA Kapujan, Katakwi).

Another challenge to dual method use was consistent use of condoms, which was reported to be limited among some couples. This was partly attributed to stock out of condoms at the health facilities as noted by a health worker at Toroma HC IV: “The challenge is that condoms get finished because there is high demand for them from clients and youth who participate in the Youth corner here in this place.” Other factors affecting consistent condom use were reported to include: sexual pleasure, meaning sex feels better without condom; the perception that they were already infected with HIV, meaning that there is no need to take precautions, the need to have children; and the belief that when one is circumcised, one does not need to use condoms. The above factors were mainly isolated and there was no major variation in responses by location, sex or contraceptive use.

These findings suggest that the use of dual methods still faces challenges, including beliefs about decreased sexual pleasure associated with condoms and misperceptions about the protective effect of circumcision. Future projects should therefore develop strategies for educating women and their partners about the value of dual protection and also provide accurate information about circumcision and HIV prevention. One strategy that may be considered is using satisfied users to give personal testimonies, since many study participants found this approach helpful in providing users’ experiences, which facilitate informed decision-making. Minimizing condom stock-outs can also help in ensuring regular use of condoms alongside modern family planning methods. Some study participants noted that apart from the CSAs; village health team (VHT) members were helpful in mobilizing communities and providing HIV services as pointed out in the quotes below. Therefore, VHTs as well as CSAs can be used to distribute condoms, thus making them available and accessible to clients. This will not only increase access to condoms but also reduce the workload for the few CSAs.

To reach women with children below two years, we visit them at home. We also work through VHTs. We get those mothers from the register. Then we get a VHT of that village and tell them to bring the children here for testing. (Midwife, Toroma HC IV, Katakwi District)

The persons from whom I received counseling were the VHT as well as the health workers at the health centre. (33-year-old HIV-positive female, Dokolo District)

I get the condoms at the health center. I also get them through VHT. (24-year old woman living with HIV, Kapujan, Katakwi district)

3.7 Counseling

Counseling was an integral activity of Arise undertaken at the facility and community levels by the CSAs and health staff. It was aimed at increasing the use of contraceptives and dual methods. The findings show that counseling was organized mainly at two levels- group and couple levels. Some
study participants particularly appreciated the approach counselors used as having enabled them to make appropriate reproductive health choices.

The approach used during the counseling session was good, they would ask us questions and then we would also ask questions. It was very participatory and after my first counseling session at the health facility, I was able to talk to my husband about family planning, which I could not have done before. (HIV-positive Female 28, lira, Ogur)

I like counseling a lot because at first I feared to open up but she really encouraged me to speak freely; I was counseled twice or three times that is when I also accepted to go and start taking the ARVs. The counselor was also not rude and had humility in dealing with me until I accepted (25-year old male Ogur Health Centre IV, Lira District)

I am glad the counseling they provided influenced my decision to use family planning which has bettered my life. (36-male Agwata Health Centre III, Lira District)

Other clients noted that the information gained from counseling sessions was not only helpful in making appropriate reproductive health choices but also in helping them in other aspects of life. These clients could even recall key messages they learnt and how they had influenced their lives as shown below.

During counseling they told us that people living with HIV should take on their treatment seriously and also women who give birth always will get weak. They said that alcohol when you are on ARVs is very dangerous because you can forget about treatment and also drinking is not good with drugs. (35-year old HIV-positive female Ogur/Lira)

In counseling they said that we should not have sex frequently but rather reduce on our sexual desires and use family planning to control birth. They also told us that we should not worry much because HIV doesn’t kill so long us we follow our treatment and feeding ourselves well (31-year old female, Agwata Dokolo)

Besides the counseling approach and FP/HIV information accessed through counseling, some participants noted that the counseling also improved communication with their partners, which improved family life.

The counseling helped me so much that I was able to learn how to communicate with my husband in the home (35-year female, Ogur/Lira)

Counseling by CSAs creating strong families between men and women, levels of violence has gone down and if a man is found battering his wife because she is on contraceptive, then the community will view him as a stupid man. Counseling is making most men love their wives (31-year old female, Agwata Dokolo)

3.7.1 Couples counseling

Counseling clients together with their partners was appreciated for having increased men’s participation in project activities and support for partners on issues of reproductive health. It also enhanced information sharing, joint discussions and couple’s communication. This is clear in the expressions below. The reported improvements in information sharing, joint discussions, and couple’s communication as a result of couples counseling may help explain the reported increase in the percentage of women who knew their partner’s HIV status from 76.3% in the baseline survey to 81.3%
in the *endline* survey. It is possible that as couple’s communication improved, men were able to disclose their sero-status to their spouses.

*Couple counseling is good because the husband is more receptive than when I am counseled alone. When I went alone, he rejected the information but when we went together he was receptive* (28-year old HIV-positive female, Toroma HC IV, Amuria District)

*The difference was when I went alone, I wondered how I would deliver the information I received to him and that is why I went up to the health worker so they can talk with both of us* (35-year old HIV-positive female Ogur/Lira)

*When we went with my husband, we were talked to and he liked the message so he picked interest and told me that I should also join and start using contraceptives so we can space our children. We had Marie Stopes here in the community and they provided us the services but later when they left, after three month we spoke with Milly (one of the CSA) and we started receiving contraceptive at the health facility here* (31-year old HIV-positive female, Agwata Dokolo).

Despite the positive experiences expressed by participants on counseling, concerns were mainly raised about the general exclusion of men in the community and lack of privacy especially during group discussions.

*What I didn’t like about counseling is that they mobilize women and most of them did not inform their husbands to come for the counseling and we had very few men* (35-year old HIV-positive female Ogur/Lira).

The findings in Sections 3.7 and 3.7.1 indicate that counseling is not only valuable in helping individuals and couples make decisions about HIV and FP services, but also improves couple’s communication and family life in general. However, to be useful, counseling should be done on a one-on-one basis as opposed to groups. This suggests that future interventions should emphasize individualized counseling when promoting integrated HIV and FP services and not group counseling. Given the space limitations at most health facilities in the study sites, CSAs and VHTs can be empowered with basic counseling skills so that they can provide individualized counseling during home visits. If and when resources allow, counseling rooms could be constructed to aid individualized counseling.

### 3.8 Male Perspectives of Arise Interventions

Responses and experiences of male partners to the project interventions

Analysis of men’s responses showed that most of them were supportive of project interventions, although a few men expressed skepticism and dissatisfaction with the project’s primary focus on women. Generally, men appreciated the project’s contribution to adoption of new behaviors such as contraceptive and dual method use, joint intra-household planning, and reduction of alcohol consumption. Although some of these were not direct objectives of the project, they were attributed to project interventions. This is clearly reflected in some of the observations below.

*The project has changed me because before I used to drink alcohol a lot but since I received the counseling I stopped drinking alcohol and even my wife no longer drinks alcohol* (42-year old male partner, Dokolo district).
The counseling I got convinced me to re-start using condoms. This was based on what they told me that if I continue having sex with my wife without using condom I would contract other diseases or new strains of HIV (43-year old male partner, Dokolo district)

Men were particularly satisfied with individual and couple counseling because of the detailed information provided about family planning methods as well as the opportunity for free expression and communication with their partners. They also appreciated the ready availability of CSAs and health workers to address their concerns and needs.

I like the counseling services more than all the other services because it’s given for free at all times and the CSA’s and health workers are always available especially on ART days (47-year old male partner, Lira district).

What I liked about that counseling was that there are some kinds of information that was difficult to tell my wife but these people said it openly (Male partner, Ogur Health Centre IV, Lira District)

Despite men’s positive views and experiences with project activities, particularly counseling services, they had reservations about some aspects of the project, for example, the inappropriate timing of community dialogue meetings, inadequate health workers at the health centers and absence of privacy during group counseling sessions, and limited information about the side effects of family planning, among others.

One thing I didn’t like about community dialogue meetings was the inappropriate time they organize them, which was not so favorable to us. It made attendance to be very low (43-year old male partner, Dokolo district).

I wish one-to-one counseling sessions are introduced for HIV patients, this is better than the group counseling provided on ART clinic days where there is no privacy at all. We lineup outside where everyone identifies you (47-year old male partner, Lira district).

There are some health workers here if you come to them and say you want to know more about family planning, you may find the health worker is busy doing his/her work talking to pregnant women, there are many patients seated waiting too and she is also clerking them, they will tell you that today we don’t have time we have many patients, you go and come back another time (43-year old male partner, Dokolo district).

Men’s response to partner’s participation in project interventions

The findings show that men were generally positive about their spouse’s involvement in project activities, as evidenced by their support and encouragement of their partners to adopt family planning methods and use condoms. Some men even used other community members to convince their partners to participate in project activities. Men’s positive perceptions were mainly influenced by two factors- persuasion and joint discussions with their partners and anticipated indirect benefits of their participation in project activities. Their positive responses are evident in the following expressions.

My wife was reluctant to participate in the project but I told the church pastor who convinced her to attend (25-year old HIV-negative male partner, Lira district).
He didn’t want me to use family planning since I had never had any complications during childbirth, he still wanted more children but later on as .... he agreed that we stop at 5 children (34-year old female HIV client, Dokolo district).

We discussed at home and agreed to use condoms before trying other methods. When we finally came to the health center, the counselor gave us a choice of FP methods then decided to try using IUD (37-year old male partner, Lira district).

A few men were unhappy with their spouses’ participation in the project, mainly due to factors such as men’s apathy and relegation of reproductive issues to women, busy schedules and absence of monetary incentives in the project, among others. This is evident in the expressions of the women, health facility staff and some men.

Whenever I tell my husband that we go to the hospital for counseling he often declines saying he has other things to do. The men are not interested on FP issues and even though the men escort the women to the facility they don’t bother to join the meetings. Men are not interested in the discussions (37-year old HIV-positive female, Katakwi district).

Male involvement is still a challenge because their attitudes, perceptions, and practices are negative. They view participation in family planning services as women’s responsibilities. Moreover, they believe that coming to clinics wastes time and many believe they can use that time to make money and socialize with friends as they enjoy alcohol (34-year old male partner, Dokolo district).

Constraints to men’s participation in Arise project activities

There were some barriers that particularly constrained men’s participation in project activities; for example, some men reported missing out on community dialogue meetings because of other commitments such as businesses and employment in other districts. However, other respondents attributed men’s lack of participation to laziness, alcohol, and the misinterpretation of possible outcomes from participating in project activities.

I haven’t attended any dialogue meetings with Pathfinder or NACWOLA. I travel a lot due to the nature of my work so I really can’t find time to attend those activities (47- year old male partner, Lira district)

At individual level, it is laziness and some of them are stubborn. At the community level, some of them are drunkards and some men say we (HIV-positive people) are already dead (28- year old HIV-positive female, Dokolo district).

Some men think that if they participate their wives will begin having love affairs outside marriage. At community level, some men aren’t interested; they say my wife has only one child and we need more. Some fear being diagnosed with HIV. It all depends on the decision made between a man and his wife. (31-year old HIV-positive female, Dokolo district)

I think these men lack knowledge on the importance of being counseled as a couple. You hear them say that family planning is a woman’s thing, (Midwife, Ogur health Centre, Lira District)

Most of the above constraints to male participation were from the perspective of women and health workers. Apart from pointing out their busy schedules and dislike for long waiting time at health facilities, some men suggested that interventions like Arise should pay them whenever they participate
in activities. However, as one 43-year old participant from Ogur, Lira district noted, male participation in HIV activities is encumbered by HIV-related stigma and discrimination, “I think fear of being recognized as HIV-positive and stigma in the community prevents men from coming out in big numbers.” Stigma and long waiting time at health facilities may be the major barriers.

Because men were perceived by all study participants as key decision-makers in respect to family planning, health, and economic matters, their participation cannot be over emphasized. Although many men had excuses to avoid getting involved in FP, when mobilized and counseled on FP it helped in creating opportunities for their partners and health workers to engage them on FP decisions. Thus men may sound apathetic and reluctant to participate in FP, but when programs effectively engage them through community dialogues, couple and one-on-one counseling sessions on FP they tend to be supportive. Some of the strategies that can be used to influence and increase their participation may include drama, peer education, and testimonies from other men living with HIV as the voices below suggest.

What I normally do is to tell as many people as possible about my status, I have noticed that this encourages many men to feel free and attend such activities. Therefore using peers living with HIV might convince more men to participate in such activities. (43-year old male partner Ogur HC IV, Lira)

Organizations should use music and drama. Men like entertainment. For example, some time ago they organized a group that plays drama. In the drama they covered many issues including showing someone who is sick with HIV looking for marriage disguising like a rich person and wanting to marry a young girl. In this drama they showed things that are happening in our society. Some men were touched by this drama. But the most important thing is that this kind of drama attracted many people, including men. In the process they learnt something. (43-year old male, Dokolo district)

As suggested by some of the men interviewed, involving men as CSAs and VHTs may not only encourage them to participate in HIV activities but also challenge them to play leadership roles in HIV interventions at the community level. Through the examples of such men, more and more men may be encouraged to participate in FP and HIV activities. Finally, as noted by a midwife at Ogur HC IV, Lira district, involving VHTs in mobilizing men can increase their participation in HIV and FP interventions.

When you go to the community we have VHTs who mobilize the community and that is really the time that we get to involve the men in the services and of course you find that they come with wives; so again you will give them the counseling as a group and then those who need the service or more information you will move aside with them and talk to them, so you find that it’s easier to get them as a couple in the outreaches than at the health facilities.

3.9 Adopting New Behaviors

What led clients to try new behaviours?

One of the objectives of this study was to assess the acceptability of the intervention from the provider perspective, particularly what led to successes or failures in clients’ adoption of new behaviors (most notably contraceptive use).

From the perspective of health service providers, information provided was very instrumental in enhancing adoption of new behaviors. People living with HIV, and discordant couples, were particularly
pointed out as having been active in adoption of the promoted behaviors because of the implications for their health.

*What is helping them to adapt to these new behaviors is the knowledge that is being given to them to demystify the misconceptions they hold about FP* (Female Health worker Agwata Health Centre III, Dokolo District)

*Those who are adopting these new behaviors are those on HIV drugs because they understand fully and the consequences of not taking it up. And they also keep getting constant information* (Female health worker, Ogur Health Centre IV, Lira District)

*Most of them who come to us for counseling as couples are discordant; you get the woman who is HIV-negative and the man is positive or the other way around, so we educate them on mother-to-child transmission and then we counsel them on prevention of STIs and other infections so we are emphasizing condom use as a dual method* (Midwife, Ogur health Centre, Lira District)

Availability of the FP methods being promoted by the project was also reportedly a success factor for client adoption of new behaviors. For example promoting condom use relied mainly on their availability at the health centers. According to health officials at Ogur health center in Lira District, maintaining a regular supply of condoms was an incentive for adoption of other methods.

*Usually when we learn that there are men who have come for the service, we don’t make them to wait for long because for the men they don’t sit like the women, you will have to give them the service and they go* (Midwife, Ogur health Centre, Lira District).

The adoption of contraceptives and dual method use by clients and their partners was also facilitated by the anticipated/realized benefits at individual and family levels such as increasing longevity, providing better care to children and living a better life. This was reinforced by the good counseling conducted by the project staff pointing out at these benefits of integration. Quotes from clients highlight the success of counseling in promoting new behaviors:

*The method (pills and condom) is so good that I have rested enough from having young babies all the time and have been able to raise them, I have also been able to work and raise some money for paying fees for my children and I don’t get so stressed over taking care of the children.* (35-year old HIV-positive female, Ogur Lira)

*I decided to adopt using these methods because they support each other in family planning because when they inject a woman, she does not get pregnant and also the condoms helps in doing the same during the time of sexual intercourse.* (29-year old male Kapujan health center III, Amuria District).

*After the counseling my opinion changed and I told my wife that if our life was to be comfortable, I should accept what I was told about family planning because it will solve some of our problems. Basically that’s why I accepted what I was told during the counseling.* (47-year old male, Ogur Health Centre IV, Lira District)

*My husband wanted more children but after family planning counseling he is more than willing and he has appreciated the program so much and we decided that I can use it and stop having more children so we can be able to plan for the ones we have. My husband never liked family*
planning and he never allowed us to use condom but he understood the importance after the counseling and also HIV and AIDs counseling. (HIV-positive female, Agwata Dokolo district)

The above quotes show that when community members anticipate positive benefits from the integration, their response to such programs can be positive. It also depends on the strategy used in implementing the project activities. The client’s and their partners’ reference to counseling as the basis of their adoption of behaviors reflects the appropriateness and effectiveness of the counseling activities.

Why did clients not try new behaviours?

Despite the adoption of new behaviours among most clients and their partners, the findings show that some never adopted new behaviours. This happened for a number of reasons including negative perceptions of FP, influence from other community members, unfounded myths about the possible effects of contraceptives, and clients’ fear of their male partners. These views were mainly evident from the perspectives of health workers and men.

Some men ask that, “when they go for vasectomy, won’t it affect their manhood?” I then tell them that it doesn’t work that way. I just tell them that they just cut the part that can make the woman pregnant but not their manhood. (Health worker, Lira District/Ogur Health Centre IV)

The most affecting factor is men’s response to the dual method use. Most men do not want the use of condoms simply because they think women who use condoms are prostitutes (Female Health worker, Agwata Health Centre III, Dokolo District).

Most clients ask us that we hear family planning methods make you give birth to abnormal children, then why do I have to join this family planning if they can make me give birth to abnormal children? (Female health worker, Agwata Health Centre III, Dokolo District).

For us men our fear is that if you come people will perform vasectomy on you and for us men we cannot allow that they do such a thing on you, at least women if only women do it (laughs) because if they cut you tubes it will reach a moment when the woman needs a child and problems start, she will need a child but you will not do anything and that’s why we men cannot accept (30-year old male, Ogur Health Centre IV, Lira District)

I spoke to someone who said that she heard that these methods cause a lot of bleeding ad that she will never go on any family planning method. She will keep giving birth to children. The men tell me that that they can never go for vasectomy because it reduces their manhood. (37-year old female, Ogur Health Centre IV, Lira District)

The above quotes show that adoption of new behaviours depends on clear information about family planning as well as culturally appropriate project interventions. For example it seems that some men perceived the project in terms of vasectomy which scared them and their wives because it was perceived to be at variance with their cultural norms and masculinity ideas. Despite the efforts by service providers in clarifying myths about use of family planning, it is apparent that some clients still had fears of such myths. As evident some clients were discouraged by others hence the need for more community sensitisations before and during project interventions.
3.10 Acceptability of the Arise Intervention

The findings reveal that both men and women generally supported the integrated services in Arise. Some were particularly receptive to integration after learning that it would not stop them from bearing more children in case they wished to do so. Women were particularly very supportive in integration through their efforts in bringing their partners to the health facility.

Strategies used to encourage clients’ adoption of new behaviours

The findings show that service providers employed a number of strategies and techniques to access and encourage clients and their partners to adopt promoted behaviours of contraceptives and dual methods use. Home visits, integrated community dialogue meetings, mini-FP outreaches, and campfires were primarily used to reach project beneficiaries. Community dialogue meetings were instrumental in reaching out to clients. These were conducted to target clients that could not easily visit health facilities such as men in their entertainment/drinking places. From the perspectives of providers/CSAs, home visits were most useful to clients that were sensitive to stigma and lived at a great distance from health units. Community dialogues provoked discussions and provided platform to dispel myths associated with some FP methods. They also helped to bring men into project activities that are often viewed as the domain of women. Service providers also used existing service delivery systems to access the clients and their partners.

*We normally get mothers who come for young child counseling (YCC) and at the maternity unit. YCC works best because the mothers attend, last time we were giving mosquito nets so mothers getting DPT3 were present (Female health worker, Dokolo district).*

*Most times we get women when they bring children for immunization, then when they come for treatment in the hospital especially when they bring the child and when they come for refills. Sometimes you start monitoring someone when they become pregnant for those who are positive and for some when they are in the wards when they are admitted. Others may be through information in churches (Male health worker, Katakwi district).*

Besides the strategies used in accessing clients, providers employed a number of techniques to encourage clients and their partners to adopt promoted behaviours. These techniques were aimed at enabling clients to make informed decisions about their reproductive health. Among the techniques used include; simple explanations and friendly approach, use of self-reference examples, use of illustrations, among others.

Use of simple explanations and illustrations

One of the techniques used by CSAs and facility staff was to use simple explanations about the promoted behaviors. This was significant in view of literacy limitations especially at the community level. Specifically, they used simple experiences that clearly brought the message and opened up choices for the clients and their partners to decide.

*They drew comparisons with a single plate of food being shared by five people; they then asked if the people could get satisfied. This was meant to paint a picture of our families with many children and limited resources, they would then ask us to make a choice of the type of families we wanted to have. (35-year old male Ogur Health Centre IV, Lira District)*

In addition, the use of visual illustrations such as dildos (for condoms) and charts during information was instrumental in reducing fears associated with use of some family planning methods and helped to elicit more participation of the clients and their partners. Use of illustrations was also mentioned by
health workers as an important tool during their training to help them comprehend the FP methods. This is evident in the expressions below.

They showed us pictures of IUDs and they said you could use it for 10 to 12 years. They said breastfeeding could prevent pregnancy, condoms, injectaplan and implants. I admired these methods and decided to use injectaplan; other people admired and started using the methods they provided (36-year old HIV-positive female, Dokolo district).

Their work was really practical and appropriate for learning about FP methods. Physical illustrations helped those with impaired visual and to experience how the methods are used (40-year old male partner, Dokolo district).

Something that I saw was so unique to me was the female condom because I personally had never seen the female condom but I just saw it from the training, they demonstrated how they use this female condom to us during the training and I was able to get the knowledge and give it to the people and some of them even took up the method (Midwife, Ogur health Centre, Lira District).

Use of appropriate counseling approach

The findings revealed that clients and their male partners were impressed by the approaches used by the CSAs and health staff during the counseling sessions. Specifically, counselors were reported to be happy, welcoming and supportive and hence able to motivate clients to adopt new behaviors as promoted by the project. The openness and participatory nature of counseling sessions was a success factor in client’s adoption of new behaviors after seeking clarity about their questions and queries.

I liked it because the way they counsel people is so lovely and they really teach people well and in a good way with a good and loving heart. Even what they are telling you is something you can do, not very difficult complicated methods and most of them were method which were friendly for people to use. (43-year old male, Ogur Health Centre IV, Lira District).

The counselors were free; they encouraged us to express ourselves (36-year old male partner, Lira district).

Couples counseling was reported to have been instrumental in improving communication about FP and HIV at the family level. It helped to improve communication between the men and women particularly on aspects of HIV/AIDS and family planning and hence often led to joint decision making. This overcame the challenge in which women access information from health centers but find difficulties in passing it to their spouses. Couple’s counseling therefore encouraged both men and women in adopting the promoted behaviors.

A key counseling concern of clients and their partners was the group counseling held at the facility level. Such a strategy reportedly compromised privacy and constrained smooth group discussions.

We also have a challenge of privacy in our facility, so we don’t have those private rooms for counseling .. this room is for EPI ...the owners are coming in anytime to keep their vaccines and the room that you saw over there is our room for night duty. These are the rooms we improvise for counseling (37-year old female, /Ogur Health Centre IV, Lira District).

I don’t like the group counseling it should be done in private; this is one of the reasons why men don’t attend its due to stigma (25-year old, male Ogur Health Centre IV, Lira District).
Use of life experiences

A key technique that influenced clients was the CSA’s use of themselves as living examples in integrating FP and HIV & AIDS services. As persons living with HIV, CSA’s experience and testimonies were a strong motivational force in raising clients’ hope that life can continue even after contracting HIV, and that use of contraceptive methods can help achieve fertility intentions. Their sameness to clients in this regard also helped in building trust as a key factor in behavioral change communication. This is evident in clients’ expressions below.

*The fact that they (CSAs) draw examples from their own experiences as HIV-positive women using family planning is very good and encourages us (30-year old HIV-positive female, Lira district).*

*She (CSA) used herself as an example. She said that since her husband died and left her infected she has lived and raised her children. She also showed us charts about family planning and couples living with HIV (38-year old HIV-positive female, Dokolo district).*

*The counseling was very useful because she was telling me that you know for us who are living with the virus it would be good to have families that we can be able to manage well with less stress, she said that we should not exceed the number of children that we are willing to produce (29-year old male Kapujan health centre III, Amuria District)*

Provision of detailed information

Access to information is a key driver for behavioral change. The findings show that service providers availed clients with timely, detailed and consistent information about new behaviors. They particularly emphasized the advantages, types of family planning and availability of support in case of adverse effects. Additional information was also provided to clients about other issues such as personal hygiene, alcohol drinking and smoking and their potential effects on health. Such information helped to widen choices for clients and addressed fears about some of the FP methods that were promoted by the project and its partners. This is evident in the words of the clients below:

*She (CSA) really emphasized drug adherence; (29-year old male Kapujan health center III, Amuria District)*

*They told us that people living with HIV should take on their treatment seriously; alcohol drinking is very dangerous when you are on ARVs; that if you have HIV you shouldn’t smoke; and advised us on good feeding (37-year old HIV-positive female, Agwata Dokolo)*

*During counseling they talked about personal hygiene that you should always keep clean where you are living, bathing all the time, they also talked about cervical cancer which affects women so much and we should also be very careful about it, they told us not to engage so much in sexual activities even with our own partners (35-year old HIV-positive female, Ogur Lira)*

Use of CSA members from the community

By selecting CSAs from the community, the project made an appropriate strategy in enabling clients to access information and services without fear. Since CSAs are from the local community, they were reportedly approachable, understanding and responsive to the needs and concerns of their clients.
Besides providing information, they were also involved in distributing pills and condoms hence increasing access and utilization of services at the community level. CSAs were valuable in mobilizing people, providing door-to-door services, and reminding clients about their appointments for ART, pills and other FP methods.

> What I liked most was the way they advised us, to love ourselves because we still have a lot of time to live. About CSA’s in the community, I think they are very hard working and they counsel basing on their own experiences as people living with HIV. (43-year old male, Ogur Health Centre IV, Lira District)

Continuous engagement with clients

The health service providers also promoted behavioral change through persistence in their talk about the promoted behaviors. Over time, this helped in encouraging clients to try out the FP methods. Aware that behavioral change takes time, CSAs always continued talking about such issues until some clients are encouraged to change.

> We don’t get tired of talking to our clients; we always keep talking to them. Some of them accept but others wait till they have conceived, after conceiving or after delivering is when they will be themselves and just come say, okay now am ready (Female health provider, Katakwi district).

> Some did not know anything about FP but when we kept talking to them, they became aware and got information. They stay in the villages; they do not know about family planning as well as where to get them and what we keep telling them makes them have the knowledge on Family planning. (Lira District/Ogur Health Centre IV)

> You have to keep giving them the information because you can’t force them because each time you get them when they are getting other services from the clinic/facility and We give them the information each time they come and its upon them to decide we can’t force them to take up a method when they have not accepted (Midwife, Ogur health Centre, Lira District)

Promoting disclosure of HIV status and couples accessing services together

Another approach that was valuable in increasing access to and utilization of FP methods and HIV treatment services was encouraging disclosure of HIV status and seeking of services as a couple. Both CSA and facility-based providers noted that if and when a person discloses his or her HIV status to spouse and children, it creates a platform for discussion on FP and HIV treatment. Additionally, it creates opportunities for care and support as narrated by a CSA in Dokolo district, “I also tell them about the need to disclose to their partners or their children because when they fall sick or become weak, they may need someone to come and pick their medicines at the health center.”

Community outreach clinics and use of village health teams (VHTs)

Providers and beneficiaries alike noted that community outreach clinics and VHTs were useful in mobilizing communities, especially men for HIV and FP services. The quote below from a midwife at Ogur HC IV illustrates the role of outreach services.

> When we go for the outreaches, this is when the male clients come very many and they have that time to ask questions that they feel that they need to ask a health worker. They are free to ask any thing about family planning and the misconceptions about the methods of family and
we iron out the misconceptions very well. But when they come to the health facility they might be sick, they might have come for other services and so they might be having a divided mind and they might not pay attention to what you are telling them. And they may not ask you many questions as they do when you go for the outreaches.

Health workers in Teso and Lango region noted that beyond asking questions about FP during outreach clinics, some men and women would make decisions to use family planning and dual method. Such decisions may not be on the same day but another time when they have had time to discuss FP options with the partner.

Perceptions of most helpful strategies in encouraging adoption of new behaviours

From the perspective of service providers, continuous talking with clients was a key success factor in adoption of new behaviors. This practice was based on the assumption that clients were usually skeptical at the beginning, but over time their attitudes towards interventions change. The health service providers promoted new behaviors through correction of misconceptions about some family planning methods. For example, some men reportedly held a belief that if they underwent vasectomy they would become impotent. This helped in encouraging clients to try out the FP methods.

The ready availability of family planning methods at the health center was also crucial in motivating clients’ adoption of contraceptives and dual methods. Stock-outs of some provisions of family planning methods reportedly discouraged users and resulted in the abandonment of their intended family planning choices.

Perceptions of least helpful strategies in encouraging adoption of new behaviours

Despite the successes in the adoption of new behaviors, some clients and their partners observed that targeting only PLHIV for FP increased social stigma towards them. There were a number of ways through which other community members reportedly could tell that the targeted clients were PLHIV. For example, the white jerry cans that were given out became a symbol of members with HIV. There was therefore a suggestion that project activities would have included other community members so as to prevent such stigmatization.

Most clients of Pathfinder or NACWOLA are complaining because of the white jerricans that they give out. It is making people differentiate them when we go to fetch water like for us men we don’t go for water but even carrying it on your bicycle while riding makes people fear. People are saying that jerry can should be of different and mixed colors. People segregate us based on the jerry cans. So please forward our complaint because it’s making our life difficult (43-year old male, Ogur Health Centre IV, Lira District).

3.11 Barriers to the Arise Interventions

The process of implementing Arise project involved some barriers/challenges that constrained the attainment of project objectives. The findings show that these barriers were faced at different levels including; clients, their male partners, community and facility levels.

Challenges faced by clients

The challenges faced by clients were mainly related to their relationship with their male partners. This was evident in the way they referred to some men as constraining their decisions on behaviors being promoted.
Whenever I tell my husband that we go to the hospital for counseling he declines saying he has other things to do. The men are not interested on FP issues and even though the men escort the women to the facility they don’t bother to join the meetings. The men are not interested in the discussions (37-year old HIV-positive female, Katakwi district).

While most women readily embraced contraceptives and HIV methods, some of them were skeptical about the outcomes of family planning methods. For example there were concerns that permanent family planning methods could cause problems in their marriages or limit their future reproductive choices in case their current marriages break up. Whereas this fear was particular to permanent methods, they apparently extended to other short-acting methods.

I feared going for a permanent method since we don’t know what can happen in future, when couples separate a woman get another man who may also want to have children again (38-year old Female HIV client, Lira district).

Challenges related to male partners

There were some barriers that particularly constrained men’s participation in project activities, for example, some men reported missing out on community dialogue meetings because of other family commitments such as businesses and employment in other districts. However, other respondents denied such male allegations and attributed non-male participation to laziness, alcohol, and the misinterpretation of possible outcomes from participating in project activities.

The men are not concerned about family planning because it’s you as a woman who is concerned about family planning because there are many problems you face but the men .... for them they go drinking; it is you whom the children disturb. I don’t fear talking to my partner but it’s the drinking that prevents their participations (28-year old HIV-positive female, Toroma HC IV, Amuria District)

You know there are men who depend on the test that their partners have got and they think that their status is the same already with that of their wives and yet that may not be the case. And others are not so courageous that if they hear about their status they can drink poison and commit suicide or die. So that makes them not to for HIV testing. (40 year old male, Ogur Health Centre IV, Lira District)

It would be better they train male CSA’s so that they can speak to the men, because when the female CSA’s come to talk to them at home, they get onto their bicycles and go away saying those are women’s issues. But if it is a male CSA, the man will fear to leave his wife alone with the man, so he will be forced to stay back and listen in what the male CSA gas to say. (24-year old female, Kapujan Health Centre iii, Katakwi District)

Generally, the findings suggest that successful adoption of behaviors requires strong involvement of men. It is also apparent that the community is concerned about the lack of strong male participation. This perception of men may be anchored in the strong cultural beliefs about men’s superiority and their relegation of reproductive issues to women. It is therefore important to consider this limitation in future project interventions.
Challenges to providers at community level

Health service providers faced a number of challenges at the community level in trying to promote behavioral change. These challenges include cultural beliefs that families should have large numbers of children, the wide geographical coverage that CSAs provide services to, and men’s relegation of reproductive health to women.

*Men think giving birth is an issue for women, it is not important to them, they don’t mind having many children. Some believe that having many children shows that you are rich. Some men engage in drinking alcohol and some refuse stubbornly (38-year old HIV client, Dokolo district)*

*This area is too wide so it is hard to go to all the areas, to an extent that some people even forget who you are because we take long before you go back. Some of them, their homes are too far that you cannot do follow-ups. If you are alone, it becomes difficult (CSA, Lira district)*

From the debriefing sessions, it was revealed a 24-year female client in Kapujan Health Centre III, Katakwi District) had been told by her partner that “Women are meant to produce children because the cows given to her family as bride price are producing so the woman should also produce because it's not family planning that married her”. This example highlights some of the cultural barriers experienced in the community and how they prevent adoption of contraceptive and dual methods use.

Another challenge was related to the conflict of family planning choices between the men and their partners. While some women desired to undergo permanent family planning methods, men usually opposed this. To avoid problems in their marriages, women often avoided such methods or attempted to adopt them secretly. This reflects disagreement among partners on some pertinent reproductive issues and calls for more sensitization and counseling.

*The use of the long term methods was poorly received. You counsel them as couple but when they go back home, the woman comes back wanting the method when the husband has not yet accepted. They don’t discuss it at home that which method should we take. A woman will come alone in need of a method of her choice. (Female Health worker Agwata Health Centre III, Dokolo District)*

*I remember one couple in which the woman was pregnant and had some medical problem. I told her to join family planning so that she rests. But she told me that she had to deliver more children because her husband was only born alone, so she had to bear many children so as to compensate for few people in the family. (Female Health worker Agwata Health Centre III, Dokolo District)*

*The challenges I face are that, the man thinks that it is the woman who has brought all the problems and the virus, so they want to chase the woman away. Some men say that since they are sick, they should just commit suicide and leave their women behind. (Lira District/Ogur Health Centre IV)*

Challenges to providers at facility level

There were a number of challenges reported at the facility level that affected the integration activities of *Arise*, stifling the promotion of key behaviors. These challenges mainly related to inadequate staff and skill gaps, as well as regular stock outs of supplies and failure of the CD4 count machine. These problems were evident from the perspectives of health workers, CSAs and project beneficiaries.
Human resource-related challenges

The project stimulated tremendous demand for family planning and HIV & AIDS services at the facility level. Unfortunately, the high client demand for the services (family planning and ART) overwhelmed providers, leading to delayed services and complaints from the clients. This demand and supply gap was exacerbated by the low number of facility staff that had been trained by Pathfinder in family planning methods. The impact of these constraints on clients is reflected in the perspectives of both facility staff and clients.

Our theater (surgical) is not yet working, there are clients who want to stop having children permanently but since the theatre is not working we wait for the Marie Stopes people to come and they usually come once in a month or once in two months and by trying to wait for these people to come you will find that some clients again will conceive and so they still continue to wait for the TL (Midwife, Ogur health Centre, Lira District).

Sometimes there are few health workers and yet they have a lot of work to do for many clients. (CSA, Lira district).

When you come in the morning, you can go back at 2pm because the staff are few and people end up returning home very late. When they go back late, they get frustrated and refuse to come back (20-year old, female with an HIV-negative husband, Ogur, Lira district).

The main challenge is when the Pathfinder staff are not there, the other health workers don’t want to work; they say that they do not have any knowledge on the work of Pathfinder. When the staffs are not there, the health workers at the Health Centre refuse to attend to our clients. They have to wait for the other people and then they shall receive service. (Lira District/Ogur Health Centre IV)

One of the challenges that I am faced with in this facility is the heavy workload or one person which limits quality care to the patient because I am the only one to manage the maternal problems in the unit attending to the mother in labor, attending to those who come with malaria, somebody comes for abortion needs you and these other person who has come for family planning also needs you, so you find when the ward is full and all of them need your service... (Female health worker, Ogur Health Centre)

It is evident that from both that client and provider perspectives, inadequate staffing at the facility level was a key point of concern. Another observation was that whenever the trained staffs were not at the health facility for whatever reasons, the full impact of supply and demand for services would be felt. This often frustrated clients and negatively affected the pursuit of project objectives. In order to address this gap, some health officials have taken initiative to train other staff members so as to help them. Nonetheless, the workload for the facility remains too high satisfactorily address the situation.

... in the maternity ward, I have trained another three to help in family planning but our training is now on job because the workload is so big and we are not all always around at the same time. (Female health worker, Ogur Health Centre IV, Lira District)

Apart from their insufficient number, there were also skills and knowledge gaps among facility staff in relation to applying some family planning methods. This was mainly in relation to providing long-term and permanent methods such as IUDs, implants and vasectomy. As a result, facility staff could not
meet all the FP needs of clients and had to refer them to other health centers/hospitals. With the distances and costs involved, some clients would often abandon their quest for such services.

*They should train me and give me more information on the female condoms because I do not understand it properly (CSA, Lira district).*

*I need skills in use of IUDs because the two of us when we had that training, we were not trained on IUD insertion (Female health worker, Katakwi).*

Stock outs of drugs, testing kits and condoms

With the high demand for FP and HIV and AIDS services, some facilities often experienced stock outs of drugs, testing kits and condoms. This did not only frustrate clients and facility providers but also negatively impacted community confidence in the project and pursuit of project objectives. The machine providing CD4 measurements was reported to have problems hence stalling the screening process for HIV.

*There is constant shortage of drugs at the Health centre not on ART drugs but also other drugs too (47-year old male partner, Lira district).*

*At this health Centre, sometimes the testing kits get finished. Then with the family planning methods, specifically vasectomy, we do not have it at the health Centre, so sometimes we refer people to Lira Referral Hospital, for the condoms, they are readily available. (Midwife, Ogur Health Centre IV, Lira District)*

*There is a time when we run short of testing kits, if they can also get those testing kits for us Then ARVs, I think they have been there but sometimes there maybe stock outs in Toroma HC IV, Amuria District)*

*The health facility is small and there is limited space for the people to sit so you find that people are congested and the PHAs are squeezing with other patients and also those who are not patients are in the same area (29-year old male, Kapujan health center III, Amuria District)*

Amidst the above challenges, providers seemed to have little or no choice on how to handle them. In apparent resignation one of the providers observed the following: *I do not have a voice and there is nothing much that I can do. I sometimes tell the people of Pathfinder that for you if you are not around, we really suffer a lot. But there is nothing they can do (Ogur Health Centre IV, Lira District)*
Section 4. Conclusions

The above findings indicate that Arise utilized several approaches to increase access to and utilization of integrated family planning and HIV services in the target communities in northern and northeastern Uganda. These included integrated community dialogue meetings, couple’s counseling, campfires, music and drama, mini-FP outreaches during ART clinic days, integration of FP awareness, and education in other health facility activities—nutrition and immunization days, pediatric ward admissions, Early Infant Diagnosis (EID) days, and Out-Patient Department (OPD) health education sessions. Table 3 summarizes the key aspects of Arise that providers, women living with HIV, and male partners perceived in addressing unmet need for contraception among HIV-positive women and expanding the reach of FP services. Overall, provision of detailed information about the benefits and side effects of short-term, long-term, and permanent family planning (FP) methods during these activities, coupled with integration of FP counseling in HIV and other health services as well as the availability of FP supplies, were helpful in facilitating decision-making and adoption of FP methods.
<table>
<thead>
<tr>
<th>Study Question(s)</th>
<th>Women Living with HIV (WLHIV)</th>
<th>Male Partners of WLHIV</th>
<th>Health Facility Providers</th>
<th>Community-based Providers (CSAs)</th>
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<tr>
<td>What aspects of the intervention did providers, clients, and partners find most effective in addressing unmet need for contraception among HIV-POSITIVE women?</td>
<td>*Integration of FP in HIV services, which reduced costs and time spent seeking services</td>
<td>*Couple counseling, which facilitated joint decision-making</td>
<td>*Integration of FP in HIV services—PMTCT &amp; ART</td>
<td>*Home visits, which provided opportunities for one-on-one counseling on FP</td>
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<td>* Availability of relatively reliable FP supplies and providers at participating facilities</td>
<td>*One-on-one counseling, which minimized HIV-related stigma &amp; allowed couples to ask individualized FP-related questions</td>
<td>*Availability and stability of FP supplies</td>
<td>* Access to and availability of FP supplies at participating</td>
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<td>* Couple counseling, which facilitated discussion of couple-specific concerns &amp; joint decision-making</td>
<td>*Home visit by CSAs which allowed couples to ask individualized questions and discuss fears about FP</td>
<td>*Working with CSAs that are not only familiar with community context but also living with HIV to mobilize, engage with clients, and provided on-going counseling and FP information to clients</td>
<td>* Use of satisfied FP users and CSAs whom clients could identify with because they also live with HIV</td>
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<td>* Use of satisfied users (couples) to speak about the benefits and side effects of FP methods</td>
<td>* CSAs accompanying clients to the clinic &amp; helping them negotiate clinic procedures/processes thus saving them waiting time</td>
<td>* Providing FP information using simple explanations &amp; illustrations</td>
<td>* Encouraging disclosure of HIV status and seeking of services as a couple.</td>
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<td>* Positive attitudes of both facility and community based providers during counseling sessions</td>
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<td>*Mini-FP outreaches that provided information and counseling opportunities during ART days</td>
<td>*Mini-FP outreaches that provided information and counseling opportunities during ART days</td>
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<td></td>
<td>* Use of personal testimonies/life experiences by CSAs</td>
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<td></td>
<td>* Provision of detailed information on FP—benefits, side effects, when &amp; where to seek help in case of side effects</td>
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<td>What aspects of the intervention did providers, clients, and partners find most effective in expanding the reach of services targeted to women with children less than two years, and to engage male partners of HIV-POSITIVE women in family planning?</td>
<td>*Provision of FP information during integrated community dialogue meetings</td>
<td>*One-on-one counseling, which minimized HIV-related stigma &amp; allowed couples to ask individualized FP-related questions</td>
<td>*Continuous Provision of information on FP and dual method use during ART days, PMTCT, maternal and child-related services—ANC, immunization days, Nutrition days, EID sessions, &amp; pediatric admissions.</td>
<td>*Home visits and community dialogues which created awareness about the availability of FP services</td>
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Opinions and experiences from a range of study participants revealed that integrating behavioral change communication messages on FP into existing maternal and child health activities worked well in facilitating clients to try out and adopt new FP behaviors. These activities include counseling and sensitizing clients during ANC, immunization, child clinics (targeting children for immunization, EID, nutrition, and child care) and when children are admitted in the pediatric ward.

**Separation of male and female groups**

Findings also indicate that talking to men and women separately, especially in the initial FP counseling sessions, works well in helping to allay their fears and deal with misconceptions about FP and HIV services. It helped particularly in building the confidence of men to support their partners in seeking FP services and the couple in trying out and adopting new methods. Couple counseling about FP and HIV services during activities such as ART and ANC days was perceived as a useful strategy in getting particularly men’s participation and commitment to try out and adopt new FP behaviors. It was noted that men prefer to know the intentions of their partners to use FP before the actual use of FP commences. This helps to remove suspicions and to have a candid discussion about FP between the couple and the service providers. Additionally, findings show that holding mixed gender community dialogue meetings may be counterproductive because it constrains men and women’s freedom in openly expressing their gender-specific concerns. This further underscores the importance of targeting community dialogue meetings for men and women separately for better results in adopting FP behavior.

**Integrated approach perceived to have positive outcomes**

Ongoing FP and HIV integration counseling, education and follow up provided in collaboration with CSAs and case managers was identified by health workers and clients to have been instrumental in motivating the clients to try and adopt new FP services. Similarly, user-friendly couple counseling through ANC, PNC, and home visits conducted by CSAs was perceived by clients as valuable in getting men and women to embrace project activities. Home visits were perceived by clients and CSAs to offer privacy and to create a safe space and adequate time for CSAs and case managers to provide tailored FP and HIV/AIDS counseling to a couple at home. Given that CSAs and clients are all HIV-positive, this worked well in facilitating shared personal experiences in relation to trying and adopting new FP methods by clients. Clients could identify with and relate to CSAs as peers. Using case studies and testimonies from CSAs (as satisfied users) to give personal experiences shared during home visits, support group meetings and one-on-one counseling was perceived by most study participants to have been crucial in facilitating the adoption of new FP behaviors. These findings are consistent with those of the endline survey which revealed that women who had received information from a support group had higher odds of having demand for family planning and were also more likely to be using contraception than women who had not received information from a support group.

Overall, a combination of integrating FP and maternal and child health services, including HIV and AIDS services and employing home visits by CSAs and community dialogue sessions, was perceived to contribute to the success of the project, especially in influencing the adoption of new FP behaviors among people living with HIV and AIDS.

**Behavior change communication activities**

Behavior change communication (BCC) methods and messages employed by *Arise* and its partners were perceived to be community and context sensitive. Male clients reported that the messages were easy to understand; clients and community members identified with them and perceived them to be aligned to the realities of relationships between men and women in the community. However, mixed
gender groups were not well received at the community level and men preferred counselors who were males.

Community dialogues were perceived to have provoked discussions and provided platforms to dispel myths associated with some FP methods through sensitization of the community members. This was perceived to have created an enabling environment for adopting new FP behaviors at the family and community level. They also helped to bring men into project activities that they had hitherto viewed as a domain of women. Community dialogues targeting men in their entertainment/drinking places were viewed to have worked well but there were some concerns that this isolated men who do not drink alcohol.

Access to information is perceived as a key driver for behavioral change. The findings show that the project service providers availed clients with timely, detailed and consistent information about new behaviors. They particularly emphasized the advantages, types of family planning and availability of support in case of adverse effects.

**Linking information to service availability**

The ready availability of family planning methods at the health center was also crucial in motivating clients’ adoption of contraceptives and dual methods. Stock outs of some provisions of family planning methods reportedly discouraged users and made them more likely to abandon their intended family planning choices.

**Positive perceptions of interventions**

Counseling by CSAs and health workers was perceived to have facilitated improved couple’s communication. The messages from the project promoting the value of talking and working together to plan for the future of the children were reported to have been effective in promoting couple’s communication. It was noted that prior to the project, men planned alone and rarely engaged women in discussions about children. *Arise* interventions were perceived by male partners to have contributed to facilitating men to try out and adopt new FP behavior especially in respect to using condoms, facilitating discussions among couples and joint planning about FP, as well as the general future welfare of their children.

Clients liked the counseling approach used by services providers; however, they did not like group counseling at the facility level because it compromises their privacy and does not provide opportunities to discuss individual concerns.

The findings show that men were generally positive about their spouse’s involvement in project activities. This is clearly evident in the way they supported and encouraged their partners to adopt different family planning methods and condom use. Men’s positive responses were mainly influenced by two factors: (1) persuasion and joint discussions with their partners and (2) anticipated indirect benefits of their participation in project activities. Although there were some men who were reluctant to support their spouse’s participation, these were mainly isolated cases. Such cases were attributed not to the project *per se*, but rather to other factors such as men’s apathy and perception that reproductive health issues are women’s domain.
Negative perceptions of interventions

Overall, men seemed to perceive family planning services as an issue of women. FP was conceived as a feminine issue that was rather of secondary importance to men. This may be attributed to the cultural context that generally perceives reproductive health issues including FP as a domain for women.

Similarly, findings revealed that some men perceived it as an opportunity cost for them (men) to attend activities such as ANC, PNC and ART days that are critical for FP/HIV service integration. Men seemed to consider going to health centers as a burden and a waste of time that they could have committed to commercial activities. Some men also had a myth that FP was tied to promoting vasectomy. Some shunned going for FP counseling and services under the conviction that they could be subjected to vasectomy when they still wanted to have children. This is also linked to the fact that vasectomy is still less popular in the study communities and those who undergo vasectomy may be stigmatized and labeled as “not men enough” (less masculine) because they can no longer impregnate a woman.

Acceptability of the intervention from the provider perspective

It was clear from discussions with service providers that the focus of Arise was strengthening integration of FP and HIV services. The providers, ranging from health workers, case managers, and CSAs generally had a positive attitude towards the project interventions. These interventions included facilitating integration of FP and HIV services, mobilization and education of community members, ongoing support to clients through CSAs and facilitating referrals. Providers generally appreciated the fact that integration of FP and HIV services facilitates prevention of HIV infection and reinfection. Health workers and case managers reported that the prescription of dual methods of FP had become a common practice at the health facilities. The providers also observed that couple FP counseling had improved communication between couples on FP and other health issues. It had also provided an opportunity for health workers to interact with the couples and emphasize importance of male involvement in FP and other services. It was noted that case managers and in some cases CSAs were instrumental in helping health workers to identify couples and provide them with timely FP and HIV services. One major indicator of acceptability of integration by health providers at the facility level was that they had integrated FP counseling in almost all critical activities in the realm of maternal and child health including OPD, ANC, PNC, immunization, and ART clinics. Integration was also perceived to have improved efficiency because FP, maternal and child health and HIV services were provided at the same location. The integration of FP counseling in maternal and child health as well as HIV and AIDS services may explain the quantitative evaluation findings that reported an increase in the number of clients that received family planning from an HIV service from 69% at baseline to 80.7% at endline.

Health workers also appreciated the training provided by Arise on integrating FP and HIV services. They also appreciated the practice of the project to intervene when there were stock outs due to delays in delivery of requisite supplies by the National Medical Stores. Despite the positive aspects of the project, health workers noted several challenges:

- Findings indicate that initially, there was an assumption that providers were already trained in FP-HIV integration, particularly in administering FP for both the short and long term methods. Therefore the project focused on organizing refresher trainings. Although these worked well for health workers who were already trained, they were perceived by health workers, case managers and some CSAs as not adequate for those that were not trained prior to the start of the project. In this respect, discussions with some health workers indicated that some of their peers (health workers) lacked confidence in providing particularly the long-term methods (e.g. IUDs and implants). This suggests that there was limited training on long-term and permanent
methods such as IUDs, implants and tubal ligation. In addition, it was observed that the project trained few health workers at the target health units. When those trained are not present, those that were not trained do not provide services.

- The other challenge was related to the health systems challenges related to gaps in human resources. Although the clientele in need for FP services was perceived by health workers to have increased as a result of activities at the facility and community level that increased clientele demand, the number of health workers was reported not to have increased at the same pace. It was also observed that although some of the facilities benefited from the recent recruitment of health workers, staffing gaps, especially in the areas of FP service providers, remained. Similarly, it was also noted that the CSA-client ratio is a challenge. Only one CSA was in charge of providing services to wide areas (sometimes an entire sub-county). This was perceived as unrealistic. Although CSAs received bicycles, the distances were too far given that the CSAs were PLHIV.

- Side effects of FP methods are quite common and present a challenge to FP use.

- It was also noted that there is limited, or no feedback, on how Arise is performing. Arise collects project data but does not provide feedback to health workers. There seemed to be a gap between health worker and Pathfinder/NACWOLA staff as a health worker in Kapujan observed:

  *Maybe the other thing is, if they can, they should give us reports on our performance. I don’t know whether they normally gauge the performance, whether it is possible. Because they normally come for facility reports and the rest, is it possible for them to give us a performance report at the end of the year? Giving us feedback on how we have been performing can help us to improve.*

**Performance of the community mobilization component of the project**

Overall, it was noted that the community mobilization was effective in reaching out to women living with HIV. The study revealed that many of the CSAs were PLHIV and therefore easily identified themselves and were able to engage with women living with HIV. During their interactions with these women, they shared experiences, challenges and solutions that enabled women to better appreciate the FP and HIV services that were provided at the health facilities. More so, the continuous follow up visits conducted by the CSAs encouraged more women to access services at the health facilities. Community dialogues were effective in providing information on available services and where people in need of FP and HIV services can get them. Information on the ART, HIV, EID, and immunization clinic days was shared during the dialogues sessions. CSAs, who are satisfied users of FP, were accustomed to sharing their experience about the FP methods that they were using; their stories encouraged many women and their partners to ask for FP services.

Home visits were particularly perceived as instrumental in engaging clients as couples and facilitating male involvement in FP and HIV services. CSAs followed up with HIV-positive women who visited the health facilities without their partners. The CSAs conducted home visits to ascertain why the male partners did not escort their partners to the health facility. During these sessions, CSAs shared the importance of partners making decisions related to family planning uptake together. This encouraged some men to visit the health facilities with their partners. Campfires were also recognized as an important fact of engaging men. However, these were perceived to have isolated those who do not drink.

**Arise**, which has been implemented for three years, can be viewed as a successful project in which the interventions and approaches have been well received and embraced at both the health facility and community level. The strategy of using multiple interventions and actors at various levels (health facility, community and household level) was instrumental in motivating adoption of new behaviors
and creating an enabling environment to facilitate use of FP and integration of FP into HIV and AIDS services. Although there are players such as Marie Stopes and THETA that were reported to promote FP in the project region, the high association of motivation to use FP as a result of exposure to Arise project-specific interventions, such as home visits by CSAs, couple's counseling by CSAs and health providers, community dialogue meetings and support groups coupled with integration of FP in HIV and AIDS services, suggests that Arise contributed to the number of clients that adopted FP behavior as reported in the qualitative study and endline survey.

**Recommendations**

Based on the findings from the Arise qualitative study, several recommendations are offered for future service provision and community interventions.

**Service provision:**

- There is need to enhance capacity of health workers in providing long-acting family planning methods to people living with HIV and AIDS through organized trainings tailored to health worker needs. A systematic training assessment of health workers would be helpful in order to organize FP/HIV integration training focusing on long-acting FP methods. Trainees should induct and mentor other health workers at their respective health units in providing similar services. This approach will minimize instances whereby clients go unattended in the event that those trained are not present.

- Health systems challenges affecting Uganda’s health facilities need to be factored into the planning of FP/HIV integration. Particular attention should be given to constraints in human resources, medicines and health supplies and how future interventions can better account for these issues.

- Strengthening the management of FP side effects will need to be addressed in future activities given that this was a key reason clients discontinued FP methods or did not adopt them in the first place. The stock outs for medicines for management of side effects should be reduced or eliminated.

**Community interventions:**

- Innovative male involvement strategies in FP and sexual and reproductive health (SRH) services need to be developed. Use of drama, peer education, testimonies from men living with HIV, satisfied male users, and using male VHTs and CSAs have been suggested by study participants as possible strategies that Pathfinder and partners may want to consider for their programs. Strategies addressing HIV-related stigma among men should be accorded high priority.

- Given that the CSA strategy has attained a high level of acceptability, there is need to strengthen their visibility and effectiveness through deploying at least two CSAs per sub-county. There is also need to consider recruiting more male CSAs whom men can identify with during community dialogue meetings and home visits. Moreover, since VHTs are mobilizing clients for HIV services, working with the VHTs to promote integrated FP services could help reduce the workload of CSAs. In selecting VHTs to work with, priority should be given to those that live with HIV and are willing to disclose their sero-status, as the study findings indicated that this made the CSAs easy to relate to and identify with.
• There is a need to consider gender-specific outreach activities where target group members will not feel uncomfortable or constrained by the presence of others. Additionally, community dialogues should target participants by age so that young mothers do not fear asking FP questions in the presence of older participants, some of whom may be their mothers-in-law.

• Design of future project activities and materials should not contribute to stigma. The good intention of providing white jerry cans to HIV-positive clients had the unanticipated effect of contributing to stigma at the community and household level.

• Some women were using FP without the knowledge of their male partners because they feared negative reprisal such as domestic violence. The project should ensure that the messages communicated during community mobilization and community dialogue meetings address the gender imbalances in communication, power relations and access to resources that affect women’s decision making.
References


