Reaching People Living with HIV with Family Planning Services through an Integrated FP/TB/HIV Program in Mwase-Lundazi, Eastern Province, Zambia

Christina Wegs, CARE USA
Jennifer Kuzara, CARE USA
Jane Alaii, FHI 360
Geeta Nanda, FHI 360
Theresa Hwang, CARE USA
Philemon Cheeba, CARE Zambia
Bamikale Feyistan, FHI 360

Abstract

This study assessed the effects of an integrated FP/HIV program in Mwase Zonal Rural Health Center Zone (RHC), Eastern Province, Zambia. The program strengthened family planning screening and referral systems within the Mwase RHC (from VCT, outpatient and ARV clinics to family planning services offered within MCH.) Trained community volunteers facilitated a series of social and behavior change (SBCC) communication activities designed to address barriers to family planning, including FP myths/misconceptions, gender roles and community norms about ideal family size. Data were collected at baseline, midline and endline using service records, community-based surveys and focus group discussions. Study participants included HIV-infected and non-infected persons randomly selected from VCT and ART registers at Mwase RHC. Results indicate that both acceptance and use of family planning increased over the life of the project. Use of a modern family planning by women increased from 43% at baseline to 54% at endline. Inter-survey comparisons indicate that approval of family planning by women increased over the course of the project, for both female respondents overall (p=.021) and for HIV-positive female respondents (p=.038). Male approval for FP remained fairly constant across the three surveys, but larger proportions of women at endline reported that their husband or partner approved of FP than at baseline (p=.016); this change was more notable among HIV-negative female respondents (p=.049) than HIV-positive respondents (p = .094.) Inter-survey analyses also suggest that perceived norms of ideal family size shifted downwards for both male and female respondents: at endline, 47.7% of women and 54.6% of men reported the community's ideal family size included 6 or more children (vs. 67% of women and 66.2% of men at baseline.)

Background

Healthy timing and spacing of births help ensure the health and well-being of all women and infants, regardless of their HIV-status.[1] For HIV-positive women who do not wish to become pregnant or have more children, access to family planning not only prevents unwanted pregnancies but can prevent maternal-to-child transmission of HIV. In Africa, it is estimated that 160,000 HIV-positive births could be averted each if all women who wished to avoid pregnancy had access to contraceptive services.[2] Despite this great need, family planning is often not integrated or very poorly linked to HIV services[3] and there are few well-evaluated models for effectively providing SRH services to people at risk for and living with HIV.[4]

Limited availability and access to FP information and services at the community level and from health clinics can be significant barriers to family planning. Myths and misconceptions about family planning can also be important barriers to the uptake of FP services.[5] At both the community and clinic levels, stigma and discrimination regarding the rights of

[1] Kate J Kerber, Joseph E de Graft-Johnson, Zulfi qar A Bhutta, Pius Okong, Ann Starrs, Joy E Lawn. 2007. Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet; 370: 1358–69

[2] Reynolds HW, Janowitz B, Wilcher R and Cates W. 2008. Contraception to prevent HIV-positive births: current contribution and potential cost-savings in PEPFAR countries. Sex Transm Infect, 84 (Supplement II): ii: 49-53.

[3] Wilcher R and Cates W. (No date.) AIDStar. Spotlight on prevention: The astonishing neglect of an HIV-prevention strategy: The value of integrating family planning and HIV services.

[4] Brickley, Deborah Bain , Almers, Lucy , Kennedy, Caitlin E. , Spaulding, Alicen B. , Mirjahangir, Joy Kennedy, Gail E. , Packel, Laura , Osborne, Kevin , Mbizvo, Michael and Collins, Lynn. 2011 .Sexual and reproductive health services for people living with HIV: a systematic review, AIDS Care, 23: 3, 303 — 314

[5] Adair, T. 2007. Desire for Children and Unmet Need for Contraception among HIV-Positive Women in Lesotho; Macro International

PLHIV to manage their own fertility limits access to family planning services.[6] Gender-related bias also limits the effectiveness of many family planning services. FP services are often geared solely towards women, leaving men without an easily accessible option for accessing FP services and information.[7] Social and cultural barriers also limit the acceptability and utilization of family planning. Gender norms may limit women's ability to make autonomous decisions about their fertility, including community norms about gender roles and inequitable power dynamics in couples.[8] Community norms around ideal family size may limit the ability of couples to delay and space births or limit the number of children they have. Taboos about premaritial sex may limit the ability of young, unmarried men and women to access family planning. People living with HIV may not have disclosed their HIV status to their family and/or may want no more children but feel pressured to continue having children.[9] All of these considerations highlight the importance of developing nuanced and contextually-appropriate interventions aimed at the underlying factors that influence FP decision-making, and the need for FP communications programs that reach both men and women as well as PLHIV.

HIV and Family Planning in Eastern Province, Zambia

Zambia is one of the countries in Africa worst hit by the HIV/AIDS epidemic: HIV prevalence is estimated at 14.3% nationally and at 10.3% in the Eastern Province. Nationally, HIV prevalence is higher among women (16.1%) than men (12.3%.)[10] Efforts to reduce transmission through aversion of unwanted births (a major component of new infections) are curtailed by unmet need for contraception[11] which is still relatively high in Zambia. According to the 2007 ZDHS, only one third (33%) of married women were using a modern method of family planning and unmet need for contraception was estimated at about 27% (28% of currently married women in rural areas and 23% of their counterparts in urban areas.) In the Eastern Province -where this program was implemented - unmet need for family planning among people of reproductive age was estimated at 24% in 2007. The 2007 ZDHS further revealed that many young people were not hearing FP messages in the media - 58% of men and 64% of women age 15-19 had not heard about FP on the radio, television or in newspapers. [10]

While almost all the health centers in the Lundazi district offer FP services, there have been reports of frequent stock-outs, during which FP commodities were not available from the national Medical Stores or when there were delays in the supply chain from Medical Stores to districts. (Unfortunately, the project team did not have any control over supplies of commodities during the project.)

Mwase RHC, the focal project implementation center, provides a range of FP services, including counseling and distribution of methods. The clinic supplies contraceptives to community based distributors (CBDs), trained volunteers who provide FP counseling and methods to community members. CBDs are authorized to provide only two methods of FP - condoms and oral contraceptives (OCPs). Although CBDs can distribute both male and female condoms, they generally distribute male condoms, as female condoms are stocked only intermittently at Mwase RHC. When female condoms are available, stocks are limited and quickly depleted. The CBDs are trained to refer any clients they encounter in the community who are interested in a method other than OCPs or condoms to Mwase RHC.

Key Project Strategies

This project was implemented in the Mwase Zonal Rural Health Center (Mwase RHC) catchment area in Lundazi District, Eastern Province, Zambia. The project included two complementary sets of interventions. In order to improve access to family planning at the Mwase RHC, the team established a family planning screening and referral system from the VCT, outpatient department and ARV clinic to the MCH department (where family planning services are provided.) The project team also implemented a series of social and behavior change (SBCC) communication strategies at the community level to increase demand for FP and reduce barriers to FP use.

---

[6] Shalini Bharat A. Vaishali Sharma Mahendra. 2007. Meeting the Sexual and Reproductive Health Needs of People Living with HIV:Challenges for Health Care Providers. Reproductive Health Matters. 15 (29 Supplement):1–3

[7] Karin Ringheim and Charlotte Feldman-Jacobs 2009. Engaging Men for Gender Equality and Improved Reproductive Health. Population Reference Bureau.

[8] Gupta GR. 2000: *Gender, sexuality and HIV/AIDS: The what, the why and the how*. Plenary address at the XII International AIDS Conference, Durban, South Africa, 9-14 July

[9] ACQUIRE. 2007. Integrating Family Planning with Antiretroviral Therapy Services in Uganda.

[10] Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007.*Calverton, Maryland, USA: CSO and Macro International Inc.

[11] Defined as percent of married women who want to delay their next birth or stop child bearing entirely but are not using contraception, as measured in the 2007 ZDHS survey

Under the family planning referral system, clinic workers in three units of the Mwase RHC - the outpatient department (OPD), anti-retroviral therapy (ART) clinic and the laboratory - were trained to ask clients about their interest in family planning. Interested patients were then referred to the family planning section and provided with a referral slip. Screening and referral services were provided to both HIV-infected and non-infected clients.

The first phase of SBCC included participatory dialogues facilitated by volunteers from neighborhood health committees (NHC), who were trained using the CARE *Social Analysis and Action* (SAA) approach. Using tools and participatory learning activities from *SAA*, these volunteers facilitated recurring community dialogues within neighbourhood health committee meetings in order to initiate critical reflection about gender roles, power relations between men and women, sexuality, HIV, family planning and other social/cultural factors that influence family planning including community perceptions about ideal family size. A total of 57 community SAA dialogues were facilitated by these volunteers between February and December 2010.

During the second phase of SBCC activities, this cadre of facilitators integrated a field-tested SBCC tool into their community dialogues. The tool - originally developed by FHI360 (then AED) and CARE in the Democratic Republic of Congo - was tested in and adapted to the Zambian context, using contextually appropriate images and messages (including information to address myths and concerns about family planning revealed through qualitative research in Mwase-Lundazi.) The tool consisted of a set of picture cards that follow the journey of a young couple making family planning decisions together, and highlight the experience of an older couple who has achieved their desired family size and are using a long-acting contraceptive method. The picture cards include simple discussion points for facilitators to help guide discussions about the benefits of birth spacing and provided accurate information about modern family planning methods. During this second phase, dialogues were complemented by community theatre performances about topics related to FP. SBCC facilitators were also trained to conduct one-on-one meetings with interested FP clients. A total of 144 Community FP dialogues (using these SBCC using picture codes) were facilitated by community volunteers between late January and early June 2011.

Study Objectives and Study Design

The main objective of the FP/HIV integration study was to determine the effects of implementing contextually appropriate, community-based communications strategies for FP uptake and the social norms that influence it, particularly among PLHIV. The study also examined the effect of strengthening family planning screening and referral systems within the Mwase RH (from outpatient and ARV clinics to family planning services offering within MCH.) Outcomes of interest included acceptance of FP, FP uptake, and changes in the underlying social norms[12] that influence FP behaviors.

Data on family planning use, attitudes and beliefs about family planning, and attitudes and beliefs about social and gender norms was obtained through community-based, representative KAPC surveys and focus group discussions (FGD) completed at baseline, midline and endline. Data was also obtained from family planning service records at Mwase RHC.[13]

Study participants included HIV-positive and HIV-negative men and women of reproductive age (18-49). It was not feasible to collect blood at the household level to verify HIV status. Therefore the HIV-infected and non-infected individuals were selected through the following processes:[14]

1. The ART register at the Mwase rural health center (RHC) was the sampling frame for the HIV infected individuals aged 18-49. Separate lists of male and female patients within the age range were generated from the register. From the male list, about 50 males were randomly selected and from the female list about 50 females were randomly selected.[15]

[12] C-Change/USAID define social and gender norms as "the social expectations about how men and women should behave due to the fact that they are men and women" (C-Change: "Gender Equality," http://c-changeprogram.org/focus-areas/gender-equality). For the purposes of this report, social norms are not limited to those related to gender, and may include other expectations around individuals' behaviors as related to marriage, fertility, etc., though within these norms there are often gender-specific behavioral expectations.

[13] Unfortunately, due to irregular supply of FP commodities which sometimes led to stock-outs of these commodities, the quantities of commodities reported to have been distributed did not exactly reflect the demands for these commodities and so service statistic about family planning use were not included in our final analysis.

[14] Individuals who have never been tested for HIV are excluded from this study.

[15] The number selected was informed by the size of the sampling frame. Unfortunately we were not able to locate all the respondents selected for interviews.

2. The VCT register at the Mwase RHC was the sampling frame for the HIV non-infected individuals aged 18-49. From the register, separate lists of male and female clients with non-reactive HIV test results in the three months[16] before the survey were generated. From the male list, about 70 males were randomly selected and from the female list about 70 females were randomly selected.

3. The addresses of selected individuals (both HIV-infected and non-infected) were compiled to enable research assistants visit and interview them at home. The HIV status of selected individuals was not known to anybody other than the senior researchers and clinic staff involved in sample selection.

Key highlights of Results:

a. Fertility intention and ideal family size:

At endline, a smaller proportion of female respondents were unsure of their fertility desires than at baseline, and more reported wanting no more children. Throughout the project, respondents continued to report perceptions of community family size norms that were higher than their personal family size ideals, indicating that these community norms are a possible inhibitor to individuals limiting their family size and using family planning. Qualitative data indicated that women in particular were sensitive to perceptions of community pressures and expectations related to child-bearing.

However, inter-survey analyses indicated that perceived norms of ideal family size have shifted downwards for both male and female respondents: at endline, 47.7% of women and 54.6% of men reported the community's ideal family size included 6 or more children (vs. 67% of women and 66.2% of men at baseline.).

b. Use of family planning

Over the life of the project, female use of modern methods of FP increased. By endline, over half of women in the survey sample were using a modern family planning method, increasing from 43% at baseline to 54% at endline.

Table 1. Proportion of respondents currently using any modern method of contraception

	Baseline (%)	n	Endline (%)	n
Total Men	**52.1**	**71**	**44.7**	**94**
HIV-Positive Men	63.0	27	70.4	27
HIV-Negative Men	45.5	44	34.3	67
Total Women	**42.9**	**84**	**54.1**	**74**
HIV-Positive Women	43.9	41	57.7	26
HIV-Negative Women	41.9	43	52.1	48

Overall, current use of contraceptives fell among all men (52.1% at baseline vs. 44.7% at endline.) However, current use of contraceptives did increase among HIV-positive men, from 63% at baseline to 70.4% at endline. It is notable that, at endine, more than twice as many HIV-positive men were currently using contraception, than were HIV-negative men (70.4% vs. 34.3%), a difference that probably reflects higher condom use among HIV-positive respondents.

Condoms, injectables, and oral contraceptive pills (OCPs) were the contraceptive methods most commonly used by the population, while long-term and permanent methods were reported rarely, if at all. Condom use was notably higher among HIV-positive men and women than among their HIV-negative counterparts. Among all men using contraception at endline, 51.9% of HIV-positive men were using male condoms vs. 14.9% of HIV-negative men. Among all women using contraception at endline, 46.2% of HIV-positive women were using male condoms, compared to 10.4% of HIV-negative women.

[16] The initial plan was to limit the sample to respondents who were found to be non-reactive within the three months preceding the survey. However, because there were not enough individuals to sample from, we had to extend it to six months before the survey.

c. Sources of family planning

Among males who reported using a contraceptive method at the time of the survey, the percentage who obtained contraceptives from the government health center (Mwase RHC) increased between the baseline and the endline for the overall sample (though increases were not significant by HIV status).

At endline, there was also an increase in the proportion of female respondents who had been to a health clinic in the previous 12 months and had discussed FP with a health worker.

By the endline, the percentage of people who obtained a method of modern family planning from a community health worker increased for all groups. Because some community-based heath workers served as facilitators for the community-based SBCC interventions, the intervention may have increased CHW visibility and/or credibility among community members and thus contributed to an increase in community members seeking family planning from CHWs.

d. Acceptance of the use of family planning:

Approval for use of family planning was high among all groups from the beginning of the project and was not notably different by sex or HIV-status. However, inter-survey comparisons indicated that female approval for FP significantly increased over the course of the project, for female respondents overall (p=.021) and for HIV-positive female respondents (p=.038). Male approval for FP was fairly constant across the three surveys.

Table 2. Proportion of respondents who approve of FP use

	Baseline (%)	n	Endline (%)	n
Total Men	**88.8**	**80**	**83.3**	**102**
HIV-Positive Men	87.9	33	81.3	32
HIV-Negative Men	89.4	47	85.7	70
Total Women	**80.4**	**102**	**92.6**	**94**
HIV-Positive Women	76.9	52	94.3	35
HIV-Negative Women	84.0	50	91.5	59

Significantly more women in the endline sample reported that their husband or partner approved of FP, as compared to baseline female respondents (p=.016); this change was more notable among HIV-negative female respondents (.049) than HIV-positive respondents (p = .094.)

Approval for use of family planning by recently married couples, however, remained very low among all groups, at both endline and baseline.

Table 3. Proportion of respondents who approved of FP use for young married couples

	Baseline (%)	n	Endline (%)	n
Total Men	**22.5**	**80**	**15.7**	**102**
HIV-Positive Men	27.3	33	25.0	32
HIV-Negative Men	19.1	47	11.4	70
Total Women	**25.5**	**102**	**20.2**	**94**
HIV-Positive Women	32.7	52	14.3	35
HIV-Negative Women	18.0	50	23.7	59

Qualitative data collected through the project provide some insights into beliefs and norms about fertility and child-bearing, including the strong expectation that young couples should have a child early in marriage. Many community members expressed the belief that the primary purpose of marriage is to bear children. One female focus-group respondent said, “A home does not have real meaning if there are no children in it.” Another male respondent said, “The

family and community expect you to have children. In fact, [a woman who does not want to have children] will not be respected by the community because children bring respect to their parents." Young unmarried couples' use of FP also seems to be contentious in the community, with some participants associating unmarried girls' use of FP with promiscuity and/or prostitution.

Despite strong community expectations that young couples have children early in marriage, the proportion of male respondents who believed that it was up to a couple to decide how long they should wait to have a child after marriage increased between the baseline and the endline (from 22.5 percent to 35.3 percent). The increase was particularly notable among HIV-positive respondents: HIV-positive respondents who indicated that newly married couples should be able to decide how long to delay childbearing doubled between the baseline and endline (from 24.2 percent to 50.0 percent). Changes were nearly significant for the male population overall (p=.051) and were significant among HIV-positive male respondents (p=.010). Reconciling these various themes in the quantitative and qualitative data, it may be that while community members were aware of norms that expect couples to bear children (and to do so early on in their marriage in order to give the marriage meaning), there is a possibility that norms are shifting to allow some space for birth delay by young couples.

Higher proportions of both male and female endline respondents rejected the idea that a woman who uses FP will be unfaithful that did respondents in the baseline, possibly suggesting changes in the prevailing perception that use of contraceptives promote promiscuity.

e. Comfort discussing family planning and HIV

At the endline, both men and women reported increased comfort with discussing family planning and HIV with their partners.

At endline, 97% of men felt comfortable discussing family planning with their partners (vs. 91% at baseline.) Similarly, 98% of men at endline felt comfortable discussing HIV with their partners (vs. 95% at baseline.)

Among women, significantly more women (irrespective of HIV status) felt more comfortable discussing HIV with their partners (92% at endline vs. 85% at baseline.) Proportions of women who felt comfortable discussing FP with their partners were high at endline (89%) but this was not a notable from baseline (86%).

f. Program reach and exposure to SBCC interventions

At endline, almost three times as many female respondents reported visits by a health worker to discuss FP than female respondents at baseline; increases were significant for the female sample overall and for HIV-positive as well as HIV-negative sub-samples. Higher proportions also said they had been visited by a health worker to discuss HIV, though increases were only significant for HIV-negative respondents and the sample overall. Endline male sample also reported attending more meetings where FP was discussed than baseline male respondents.

g. Gender norms/attitudes and beliefs about gender

Endline data from both survey and focus groups suggested a shift in some attitudes and beliefs related to gender. Women reported more equitable attitudes and beliefs about gender at endline than at baseline, as measured using a scale adapted from the Gender Equitable Men (GEM)[17] scale. However, this change was not statistically significant (p = .072.)

Strongly held norms around shared decision-making in couples were confirmed through FGD, where FGD of both men and women of different ages indicated they engaged in joint decision-making around family planning and childbirth. Importantly, however, qualitative data—supported by survey data on gender relations—also suggested that men had final

[17] Pulerwitz, J, and G Barker. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale. Men and Masculinities 10:322-338

decision-making authority in the household, including making final decisions about family planning. In addition, qualitative data suggest that couples' decisions about family planning are highly influenced by community norms and that women are especially sensitive to family and community expectations about fertility.

Interestingly, at endline significantly more women indicated that it is woman's responsibility to avoid getting pregnant. At baseline, 22.5% of women disagreed with the statement "that it is a woman's responsibility to avoid getting pregnant," where only 7.4% disagreed at endline. This may reflect a greater sense of control over fertility among women, instead of gender-inequitable views of responsibility for fertility.

h. Limitations

Despite promising findings, there are several key limitations that should be considered when evaluating the findings from this study. The social and behavior change strategies (SBCC) were suspended or slowed down at several points in the project. A key component of the SBCC strategy—the community family planning discussion guide—was introduced very late in the project (February 2011), allowing for less than five months of use before the project endline in June 2011. Thus, it is very difficult to assess the added value of this SBCC tool.

There were also some key differences in the characteristics of the baseline and endline samples which must be noted when interpreting apparent differences in reported outcomes between baseline and endline surveys. The endline female sample was characterized by higher rates of school attendance and earlier age at marriage compared to the baseline female sample. Both male and female respondents in the endline survey reported higher rates of exposure to TV compared to baseline respondents. Female endline respondents also reported higher rates of exposure to radio.