Study of the Integration of Family Planning and VCT/PMTCT/ART Programs in Uganda

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EXECUTIVE SUMMARY

Background

HIV/AIDS and Fertility in Uganda

Uganda has had laudable success in reducing HIV prevalence in the country and is still focused on strengthening and scaling up prevention, treatment and care, and support efforts. Currently, over 1 million people are estimated to have received HIV counseling and testing, over 500,000 HIV-positive individuals are receiving palliative care and over 60,000 are receiving antiretroviral therapy (ART).[1] Access to services has increased as service delivery sites have expanded into rural areas. With a prevalence rate that appears to have stalled at around 7 percent and new infections continuing to occur among those of reproductive age, the epidemic still requires policy and program attention.

At the same time, Uganda's total fertility rate of 7.0 children per woman is one of the highest in the world. Over 1.4 million women in Uganda report wanting to delay pregnancy, space their children, or stop childbearing altogether, but are not currently using any contraceptive method. High HIV prevalence, coupled with high fertility and limited access to family planning (FP) and prevention of mother-to-child transmission (PMTCT) services, implies that many children are born to HIV-positive parents. Unintended pregnancies and births often have serious consequences for the health and welfare of mothers and their families as well as economic implications for society.

An estimated 80 percent of HIV cases are transmitted sexually and an additional 10 percent are transmitted from mothers to children perinatally or during breastfeeding. Women and men have a need for protection against both unintended pregnancy and HIV infection, yet programs to address these two issues have typically been developed, implemented, and administered separately. Integration of family planning with voluntary counseling and testing (VCT), PMTCT, and ART services is preferred by clients and also has the potential for being more cost-efficient.

Study Description and Methods

The Study for Integration of FP and VCT, PMTCT, and ART Programs in Uganda was carried out between October 2004 and February 2005 to assess the national policy environment regarding the possibility of providing FP services in VCT, PMTCT, and ART settings and to identify existing barriers to and successes of the integration of FP in these services. The specific objectives were to

- Gain a clear understanding of the national policy environment regarding the provision of family planning in the context of VCT, PMTCT, and ART programs—from the perspective of national HIV/AIDS and FP policymakers and implementers;
- Identify existing FP information and services in VCT, PMTCT, and ART programs and services;
- Determine clients' desires for family planning within the context of VCT, PMTCT, and ART services;
- Identify operational barriers, gaps, and constraints affecting the provision of family planning in VCT, PMTCT, and ART service delivery sites; and
- Make recommendations for integrating FP in VCT, PMTCT, and ART programs and services.

The study covered two urban sites (Kampala and Jinja) and two rural sites (Mbale and Mbarara). Each of these sites provided some or all of the four services being studied. The districts in which these sites are

[1] In the report, ART is also defined as antiretroviral treatment.

located host the largest PMTCT and ART programs in Uganda. Data were collected using a combination of quantitative and qualitative methods. The study population included six national level policymakers; four program directors; 18 center or unit managers of HIV/AIDS and FP services; and 16 providers of VCT, ART, and PMTCT counseling. One hundred eighty-three HIV-positive clients participated in focus group discussions (FGDs) and exit polls—107 were involved in 14 focus group discussions and 76 participated in exit polls.

Findings

Policy Development

Often with civil society organizations paving the way, Uganda has responded rapidly to the HIV epidemic through the development of various policies and guidelines to support delivery of HIV/AIDS services, including VCT, PMTCT, and ART. These policies and guidelines are developed through consultation and consensus with a broad range of stakeholders. There are considerable differences in the degree to which these policies address family planning.

- The national VCT policy currently under review is the most comprehensive in addressing family planning. The National Policy Guidelines for VCT highlight the importance of assessing clients' needs for family planning and other services.
- Existing PMTCT policies only partially address family planning but are undergoing revision to strengthen the FP component.
- ART policies and guidelines do not address family planning primarily because of the pressing need to expand and consolidate ART services and achieve treatment goals.
- Conversely, HIV/AIDS issues and services—particularly VCT and PMTCT—are addressed in the National Policy Guidelines and Service Standards for Reproductive Health that govern the delivery of FP services.

Program Structure

Implementation of integrated services remains a challenge. Under the public healthcare system, FP and VCT services are vertical and nonintegrated—HIV/AIDS is under the Ministry of Health (MOH) HIV/AIDS Control Program (within the Communicable Diseases unit) while family planning falls within the MOH's Reproductive Health Division. Under the current structure, the Reproductive Health Division is solely responsible for any FP services or information provided at HIV/AIDS service sites.

Policy and Program Implementation

At the implementation level, translation of policies into practice varies greatly across HIV/AIDS services. The major VCT provider in Uganda, the AIDS Information Center (AIC), reported that family planning is an integral component of their services. Indeed, FP service integration is more evident in VCT and PMTCT settings where counseling; provision of contraceptive methods other than condoms; and information, education, and communication (IEC) materials are available in varying degrees. Though staff at ART sites provide counseling and condoms, these condoms are promoted primarily to prevent HIV infection and re-infection as opposed to unintended pregnancy.

In settings where family planning has been integrated into HIV/AIDS services, FP information and a limited range of nonsurgical contraceptives are made available to clients, and service providers have been trained in FP service delivery and referrals for specialized FP services. In fact, most counselors in each of the HIV/AIDS settings had received at least some kind of FP training in counseling and contraceptive

methods. However, the formal referral systems and mechanisms are weak or nonexistent and coordination remains problematic because of the vertical management of FP/reproductive health (RH), VCT, and PMTCT programs.

Perceived Need for Family Planning among HIV-positive Clients

Overwhelmingly, the people living with HIV/AIDS (PLHAs) participating in the study reported a need for family planning based on their perception of the social and health implications of HIV-positive people having children. There was almost universal but superficial knowledge of family planning. Generally, clients are unsatisfied with the limited range of FP services currently offered in HIV/AIDS service settings, and PLHAs are reluctant to access FP services outside the HIV/AIDS centers because they fear stigma and discrimination.

Most of the PLHAs expressed desire for integrated HIV/AIDS and FP services, preferring to receive FP services at the same places they receive HIV-related services and from providers who already know much about their personal lives and appreciate the wide range of problems clients face when trying to access other suitable FP methods. Providers noted that they often urge HIV-positive clients to limit their sexual activity to avoid deterioration of their health. However, many clients misconstrue this to mean that they should not be having sex because they are HIV positive and consequently do not ask for family planning.

Despite 45 percent of the HIV-positive women and men who participated in the exit interviews saying that they had been sexually active during the past six months, most providers said that uptake of contraceptives—other than condoms—is low at their centers. While they felt at risk for unintended pregnancy, few PLHAs were using any effective method of contraception. Low use of contraceptives may be attributable to several barriers, including actual and perceived side effects and the efficacy of some FP methods, a limited range of methods available in HIV/AIDS settings, male dominance over sexual decisionmaking, and nondisclosure of serostatus to sexual partners. At the same time, providers' attitudes toward use of non-condom methods of family planning may discourage use of contraception among PLHAs who want to space or limit childbearing. Some providers fear that adding FP services will result in increased sexual activity and more pregnancies among HIV-positive clients—a fear shared by some PLHAs who believe that HIV-positive women should not have more children, planned or unplanned. It should be noted that most PLHAs argued that they, like HIV-negative people, have the right to decide whether or not to have children.

Most policymakers recognized that integrated services would also save time and money and would reduce the duplication of services. Clients noted that since they often spend the whole day in HIV/AIDS centers, they have little time to go elsewhere to access additional services. Additionally, most women felt that the integration of services would assist them in changing the negative attitudes of their husbands toward family planning since they could attend FP counseling sessions together.

Although their attitudes toward integration were mostly positive, some policymakers, program directors, and service providers expressed concerns about the effect of integration in view of limited resources—particularly staff and supplies—and thus, the effect on quality of HIV/AIDS services if stretched to include even more services. In addition, some providers felt that introducing full scale FP services for the entire public could lead to these organizations losing their original vision and engaging in wasteful competition with specialized FP providers.

Recommendations

This study generated a number of recommendations.

- Policymakers should be sensitized to the desire among HIV-positive women and men for access to contraception to help them have the number of children they want. Sensitization can take the form of policy briefs outlining specific findings, targeted meetings with policymakers, and advocacy by PLHA groups.

- Policy on and implementation of HIV/AIDS and FP services need to be harmonized to enhance joint planning and inter-service coordination to take advantage of synergies among the programs. Harmonization does not necessarily imply a transfer of resources from one program to another—for example, integrated services could be implemented by the HIV/AIDS program with technical input and support from the FP/RH program.

- With vertical public health programs for HIV and family planning, even if policies are integrated, the programs and services must be linked or integrated, which requires attention to policy implementation to surmount the current organization of programs that are under different lines of authority in the Ministry of Health (MOH). For example, harmonized (and greatly strengthened) logistics systems would help avoid stockouts, which were reported to be a huge issue, particularly in the public sector's provision of FP and HIV services. Human resource allocations should be jointly determined. The FP division's plan to appoint a focal point for PMTCT is laudable. Such focal points should be appointed across the programs to help ensure integration. A coordination unit could be established to supervise the integration process.

- Initiating family planning as an integral component of ART services during scale up will be easier than adding it after the policies, guidelines, and protocols have been firmly established. The ART policy was found most lacking in addressing FP concerns, despite the need for FP integration expressed by ART clients. Policymakers should quickly address this gap and provide adequate guidance to service providers on FP provision for HIV-positive clients. Adding family planning to the ART policy would include components of training, supervision, and logistics management; which contraceptive methods would be provided at the ART sites and which would be provided through referral (e.g., sterilization); and what counseling would include.

- Currently, ART providers, most of whom have received training from The AIDS Support Organization (TASO), take it upon themselves to provide FP counseling. But there is no system to ensure that these counselors—and providers in other HIV service settings—have the most current FP information. Counseling training can be further integrated and strengthened, with standard guidelines from MOH.

- Despite the nearly universal knowledge of family planning among PLHAs, many still hold a number of misconceptions about contraceptive methods. There is a need to develop targeted messages specifically addressing these misconceptions.

- Provision of family planning appears to be passive in HIV settings. In some VCT settings, clients receive information only if they ask for it. Provision of information and methods should be more proactive by providers, backed up by guidelines and protocols.

- Systems for referrals are currently informal. Feedback systems could be established so that providers know if clients they give referrals to actually seek and receive the services.

- Given the current constraints in coverage, staffing, range of FP services, and space in HIV/AIDS settings, it is likely that HIV/AIDS facilities will continue referring clients who require invasive contraceptive methods to specialized FP clinics. Consequently, FP providers need to be sensitized

to serving HIV-positive clients without judgment. HIV-positive clients should not feel that they are being discouraged from having sex or using contraception.

- Data on fertility preferences suggest that female PLHAs are likely to come under pressure from their male spouses to produce more children—since males generally prefer larger numbers of children. Programs should pay closer attention to sensitizing men to the need for and the benefits of family planning. At the same time, there is a need to increase women's access to female controlled methods.

These issues clearly pose significant programming challenges that have to be delicately addressed to improve use of FP services by PLHAs. As Uganda intensifies its efforts in fighting HIV/AIDS, integration of FP and other reproductive health services in HIV/AIDS settings is of critical strategic importance to the prevention of further transmission of HIV and to optimizing the quality of life for those infected and affected.

ABBREVIATIONS

AIC	AIDS Information Center
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
FGD	focus group discussion
FP	family planning
FPAU	Family Planning Association of Uganda
HIV	human immunodeficiency virus
IDI	in-depth interviews
IEC	information, education, and communication
JCRC	Joint Clinical Research Centre
MISR	Makerere Institute of Social Research
MOFPED	Ministry of Finance, Planning, and Economic Development
MOH	Ministry of Health
NGO	nongovernmental organization
NOPA	National Overarching Policy on AIDS
PEAP	Poverty Eradication Action Plan
PLHA	person living with HIV or AIDS
PMTCT	prevention of mother-to-child transmission
RH	reproductive health
RHA	reproductive health attendant
SPSS	Statistical Package for the Social Sciences
STD	sexually transmitted disease
STI	sexually transmitted infection
TASO	The AIDS Support Organization
TB	tuberculosis
TFR	total fertility rate
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNCST	Uganda National Council of Science and Technology
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

1.0 BACKGROUND TO THE STUDY

1.1 Country Context

Uganda is a sub-Saharan African country of 25 million people. Close to 90 percent of these people live in rural areas and engage in peasant subsistence agriculture (UBOS, 2002). The country remains among the 20 poorest countries in the world. Despite investments in social and economic infrastructure since the mid-1980s, the proportion of people living below the poverty line (living on less than $1 a day) increased from 35 percent in 2000 to 38 percent in 2004 (MOFPED, 2005).

The government is working to improve healthcare. Health sector funding has increased to 13 percent of the total national budget (MOFPED, 2005). Supply of drugs and other essential commodities has also improved especially with the adoption of the pull requisition system that entails a demand driven approach to forecasting and procurement of drugs and other supplies. To increase access to care, health services have been decentralized through a layered system of health units, ranging from national referral hospitals, regional referral hospitals, district hospitals, and health sub-districts to lower-level health centers IIIs and IIs at sub-county and parish levels, respectively. The government, with support from donors, has substantially improved the quality of physical infrastructure for health service delivery. Four hundred new parish health center IIs have been built and 180 similar health centers have been upgraded to level III and equipped to provide maternity services. Out-patient attendance in all public facilities rose from 9.3 million new cases in 2000 to 17.7 million in 2003 (MOFPED, 2005).

However, the health sector still has glaring gaps in quality and reliability of services. Infant mortality stands at 89 per 1,000; the maternal mortality ratio is 505 per 100,000; 39 percent of children less than five years of age are stunted; and only 37 percent of eligible children complete the full immunization cycle. The total fertility rate (TFR) has stagnated at an average of seven children per woman despite evidence of a strong desire for better-spaced and smaller families among both women and men (UBOS and ORC/Macro, 2001). There is a shortage of human resources; weak logistics systems for the procurement and distribution of drugs, supplies, and equipment; and inadequate physical infrastructure to absorb the soaring numbers of people seeking services.

1.2 Status of the HIV/AIDS Epidemic

Uganda has sustained an early and impressive response to the HIV/AIDS epidemic as the first sub-Saharan African country to record a consistent decline in HIV prevalence. Today, awareness about HIV/AIDS is near universal. With government and donor support, access to HIV/AIDS prevention, care, and treatment has increased dramatically. Currently, 1 million people are estimated to have received HIV counseling and testing, and over 45,000 are receiving treatment; these numbers are projected to double as the bilateral and multilateral funding programs are consolidated (MOH, 2005c).

While Uganda's adult HIV prevalence rate of 6 percent in 2004 reflects a laudable decline from over 20 percent in 1992, it conceals major variations in prevalence between urban and rural areas, males and females, and different regions of the country. HIV prevalence is highest among women of reproductive age (UNAIDS, 2004). Prevalence is much higher in urban than rural areas, with urban residents twice as likely to be infected with HIV. Data from longitudinal and cohort-based studies in Uganda indicate that new infections continue to occur among sexually active individuals. It appears that while great strides have been made to stem the tide of the AIDS epidemic in Uganda, the cost in dollars and resources associated with AIDS care and treatment continues to overburden an already stretched healthcare sector.

1.3 Status of Family Planning Services

Unlike the gains made in reducing HIV/AIDS prevalence, Uganda has not had much success with family planning. The TFR is among the world's highest at seven children per woman, and contributes to the rising rate of poverty and maternal and infant mortality across the country. In addition, high fertility has resulted in a predominantly young population. Fifty two percent of the entire population is below 15 years of age, creating a high dependency ratio that has mounted pressure on the working population and stretched the government's capacity to provide high-quality, basic social services (UBOS and ORC/Macro, 2001).

According to the 2000–2001 Uganda Demographic Health Survey, the mean ideal number of children was reported to be five. This implies that women, on average, are having two more children than desired, pointing to a huge unmet need for family planning. Although the use of modern contraception among married women has increased from 7.8 percent in 1995 to 18.2 percent in 2001, the unmet need for family planning also increased from 29 percent to 35 percent over the same period (UBOS and ORC/Macro, 2001).

A lack of or limited access to FP services and information remains a major barrier to improved contraceptive use for a large portion of the population (GOU and UNFPA, 2001). The social norm and expectation of early and frequent childbearing and preference for large family size is encouraged by the strong desire to sustain lineage and the increased chances that some children will survive. The belief that children provide old-age security has contributed to poor use of and access to FP services.

A lack of accurate information also plays a key role in limiting contraceptive use. Only 23 percent of currently married women report using contraception. Misconceptions about family planning and the affect of contraceptives on women's health, future fertility, and birth outcomes were cited as main reasons for nonuse (UBOS and ORC/Macro, 2001).

At the policy level, while many health policymakers and national planners support FP/RH services, some political leaders argue that Uganda's population is too small given the country's resources and that population pressure will stimulate the creativity and innovation required to harness these resources. As a result, reducing unmet need for family planning has not featured prominently in Uganda's budget and strategic priorities, despite being a component of key national development strategies, such as the Poverty Eradication Action Plan (PEAP).

1.4 Case for Integration of FP and HIV/AIDS Services

As noted by Askew and Berer (2003), because the vast majority of HIV cases are transmitted sexually (80%) or as a result of MTCT (10%) and because unintended pregnancy is a real concern among HIV-positive women, the integration of FP and HIV/AIDS services is crucial. Integrating FP with VCT, PMTCT, and ART services can provide individuals with multiple access points to FP services. Most men and women are infected with HIV early in their reproductive lives. Providing integrated services would not only provide the means to reduce risk of infection and re-infection, but would also help to prevent unintended pregnancies among HIV-positive individuals. HIV-positive people would be able to determine if, when, and how they would choose to have children, leaving fewer children orphaned.

Women and girls are highly vulnerable to both unintended pregnancies and HIV infection in large part because of their low socioeconomic status, inadequate access to education, and limited control over their reproductive and sexual lives. For HIV-positive women and girls in particular, family planning is extremely important to their health and survival and is a crucial component of the PMTCT effort. According to the Ministry of Health's National Family Planning Advocacy Strategy, 2005–2010, over 1.4

million women in Uganda would like to delay pregnancy, space their children, or stop childbearing altogether but are not currently using any contraceptive method (MOH, 2005a). The rapid scale up of HIV/AIDS services including access to VCT, PMTCT, and ART services creates excellent opportunities for integrated service delivery settings and increased access to FP/RH services.

Several arguments have been made for the benefits of integrated services—the most important being that clients want services in environments they find most acceptable. HIV-positive clients may prefer to receive contraceptive care in settings where they receive HIV-related services. PMTCT programs are generally linked to antenatal clinics, which offer optimal environments for delivery of FP services. Furthermore, in VCT settings, counseling related to HIV infection and sexual activity could also address unwanted pregnancy since unprotected sex can result in both unintended pregnancy and HIV infection. VCT settings also offer service environments to provide condoms and other contraceptive methods. A review of studies of women infected with HIV found that while around 70 percent are sexually active, effective contraceptive use is variable and unplanned pregnancy is frequently reported (Magalhaes et al., 2002). ART settings have the facilities to provide contraceptive care for clients who do not want to get pregnant (Shelton and Peterson, 2004). Another argument for the benefit of integration is that it has the potential to be cost-efficient by combining services and saving providers' and clients' time.

1.5 Forms of Integration

Integration can take place at multiple levels (Hardee and Yount, 1995). At the policy level, policies that are formulated to direct the delivery of services provide the rationale and guidelines on mainstreaming appropriate elements of family planning into HIV/AIDS services and vice versa. At the service delivery level, integration may take various forms. It may entail training providers in multiple skills to enable them to deliver all the services within the same facility or a "one stop" center where FP and HIV/AIDS services are offered by the same provider through different units within the same premises. On the other hand, integration may entail a network of providers linked by a well-developed and monitored referral system.

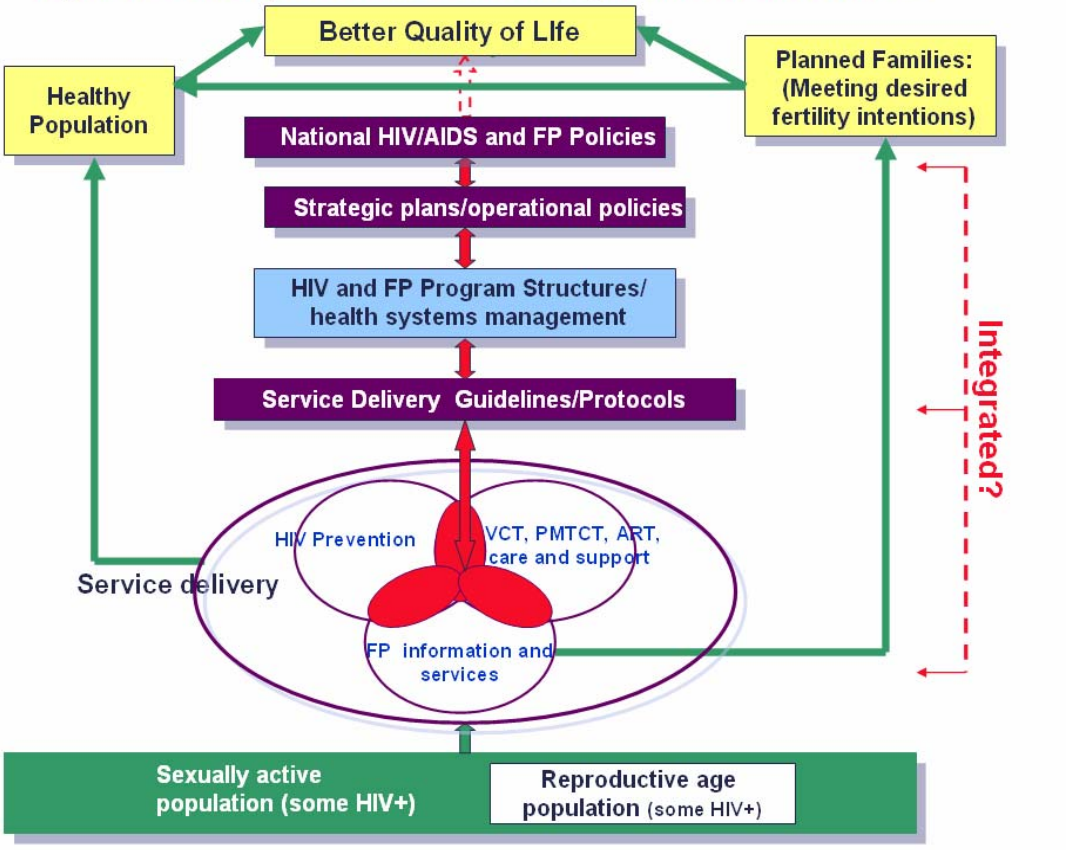
This study, carried out between October 2004 and March 2005 by the Makerere Institute of Social Research (MISR) and the POLICY Project, sought to assess the national policy environment for and realities, challenges, and level of integration of FP services into VCT, PMTCT, and ART services. The specific objectives were to

- Gain a clear understanding of the national policy environment regarding the provision of family planning in the context of VCT, PMTCT, and ART programs—from the perspective of national HIV/AIDS and FP policymakers and implementers;
- Identify existing FP information and services in VCT centers, PMTCT, and ART programs and services;
- Determine clients' desires for family planning within the context of VCT, PMTCT, ART services;
- Identify operational barriers, gaps, and constraints affecting the provision of family planning in VCT, PMTCT, and ART service delivery sites; and
- Make recommendations for integrating FP in VCT, PMTCT, and ART programs and services.

The conceptual framework guiding the project is shown in Figure 1.1. According to the framework, both FP and HIV/AIDS services target the sexually active population—most of them in the reproductive age and some of whom are HIV positive. Without integration, FP services would only address reproductive health issues, while discrete HIV/AIDS services would similarly only address HIV/AIDS concerns. However, the target population has both FP and HIV/AIDS needs; therefore, integration of these services would more efficiently and cost-effectively address those needs, leading to better-planned families, a

healthier population, and an overall better quality of life. Consequently, effective integration of services is only viewed in the realm of appropriate and supportive policies, guidelines, and protocols at national and service delivery levels.

Figure 1.1. Conceptual Framework For Integration of FP with HIV/AIDS



2.0 METHODOLOGY

2.1 Study Design and Sample Selection

For this study, integration of FP and VCT, PMTCT, and ART services refers to facility-based and spatial integration. Facility integration refers to sites at which both FP and the relevant HIV services (VCT, PMTCT, and ART) are available and offered at the same time by the same provider or referred to another provider within the same premises. In contrast, spatial integration refers to a formal network of providers linked by a consciously developed and monitored referral system. This study assessed integration of FP into VCT, PTMTC, and ART services from both the spatial and facility-based perspectives.

As illustrated in the conceptual framework (Figure 1.1), this study assessed integration from the perspectives of policy development and implementation, program organization, and service delivery and use. The study was conducted among national policymakers, directors, program managers, and providers of VCT, ART, PMTCT, and FP services as well as clients using these services.

Organizations covered by the study were selected from two urban sites (Kampala and Jinja) and two rural sites (Mbala and Mbarara) based on the availability of VCT, PMTCT, ART, and FP services. Besides having the four services, the sites host the largest branches of AIC and TASO, Uganda's main providers of voluntary counseling and testing.

These sites are in the districts that were the first to be accredited to provide PMTCT and ART services and host the largest PMTCT and ART programs in Uganda. Together these four districts have a total population of 3,432,457, which is 14 percent of the national population (UBOS, 2002). HIV prevalence in these sites is estimated at 10 percent for Kampala, 7.4 percent for Jinja, 11 percent for Mbarara, and 5.6 percent for Mbale—compared to the national average of seven percent (MOH, 2002).

Table 2.1 presents the urban and rural facilities where the study was based. The TASO and AIC facilities that provide VCT services are private, while the facilities providing PMTCT and ART services are public.

Table 2.1: VCT, ART, PMTCT, and FP Sites Covered by the Study

Services	Urban Sites		Rural Sites	
	Kampala	Jinja	Mbarara	Mbale
VCT	TASO Mulago	AIC Jinja TASO Jinja	TASO Mbarara	AIC Mbale TASO Mbale
PMTCT	Mulago Hospital	Jinja Regional Referral Hospital	Mbarara Regional Referral Hospital	Mbale Regional Referral Hospital
ART	Infectious Diseases Institute, Mulago Hospital	Jinja Regional Referral Hospital	Mbarara Regional Referral Hospital	Mbale Regional Referral Hospital
FP	Maternal & Child Health Unit – Mulago Hospital	FP Association of Uganda Clinic	FP Association of Uganda Clinic	Maternal & Child Health Unit –Mbale Hospital

2.2 Data Collection

The data for this study came from an extensive document review; in-depth and semi-structured interviews with policymakers, program managers, and providers; and client exit polls and FGDs with HIV-positive clients.

Document Review

The study involved an extensive review of research and publications looking at the integration of FP and HIV/AIDS services; available VCT, ART, PMTCT, and FP policy documents; and annual and mid-term strategic plans of key VCT, ART, PMTCT, and FP implementing organizations. Information from these documents was used to complement findings from the primary sources. Documents reviewed are presented in the reference section of this report.

In-depth Interviews

In-depth interviews (IDIs) were conducted with national policymakers and VCT, PMTCT, ART, and FP program directors and managers. Interviews with policymakers helped to provide insight into the Ugandan policy environment in which FP and HIV/AIDS services are delivered as well as recommendations on how to best address constraints and challenges to integration. Policymakers also provided perspectives on the plausibility and rationale for integration of FP into VCT, PMTCT, and ART services.

Interviews with program directors and center managers yielded qualitative data on the realities of delivering integrated FP and HIV/AIDS services. They also provided their perspectives and perceptions on the effect of integration on the quality and quantity of services; the challenges, advantages, and disadvantages of offering integrated services; and recommendations on integrated delivery of FP and VCT, PMTCT, and ART services in settings where services were not yet integrated.

Semi-Structured Interviews

Semi-structured interviews on the delivery of integrated services were conducted with counselors in VCT, PMTCT, ART, and FP sites. Data were collected on many aspects, including provider training, use of the training, the available protocols, the counselors' experiences and perceptions, and recommendations for enhancing delivery of integrated services. A summary of the interviews with policymakers, program directors, center managers, and counselors can be found in Table 2.2.

Exit Polls

At the study sites, 76 exit interviews were conducted among HIV-positive clients who had received VCT and ART services. The exit interviews relating to voluntary counseling and testing were conducted at TASO only to ensure that those exiting the service had received post-test counseling and had thus received the entire VCT protocol and, for ethical reasons, that they had had some time to adjust to the results of their test. Exit polls were not conducted in PMTCT settings because it was not possible to isolate clients, as PMTCT services are delivered within general antenatal care clinics.

Generally, every third person exiting the facility was asked to participate, while making an effort to ensure the representation of men and women of various ages. Service providers, particularly counselors and nurses, helped to inform clients about the possibility of participating in the interviews.

The exit poll interviews enabled the team to collect data on FP information and issues discussed during the VCT and ART sessions, on services received, and on clients' views on how best to provide FP information and services in these settings. In addition, client views on the importance of delivering FP in VCT and ART settings, future contraceptive plans after getting exposed to FP information, and their satisfaction with integrated services were assessed.

Table 2.2: Summary of In-Depth and Semi-Structured Interviews Conducted

Services	Designation	Urban sites		Rural Sites	
		Kampala	**Jinja**	**Mbarara**	**Mbale**
National HIV/AIDS Policymakers		Manager, AIDS/STI Control Program in the Ministry of Health Director, Policy and Research, Uganda AIDS Commission			
VCT	Policymaker	National VCT Coordinator			
	Program directors	Director, AIC Director , TASO			
	Center managers	Manager , TASO Mulago	Manager TASO Jinja Manager AIC Jinja	Manager TASO Mbarara	Manager TASO Mbale Manager AIC Mbale
	Counselors	2 counselors at TASO Mulago	1 TASO counselor 1 AIC counselor	2 counselors at TASO Mbarara	1 TASO counselor 1 AIC counselor
PMTCT	Policymaker	National VCT Coordinator			
	Center managers	In-Charge PMTCT Mulago Hospital	In-Charge PMTCT Jinja Hospital	In-Charge PMTCT Mbarara Hospital	In-Charge PMTCT Mbale Hospital
	Counselors	1 PMTCT counselor	1 PMTCT counselor	1 PMTCT counselor	1 PMTCT counselor
ART	Policymaker	National ART Coordinator			
	Program directors	Deputy Director Joint Clinical Research Center			
	Center managers	In-Charge ART Mulago Hospital	In-Charge ART Jinja Hospital	In-Charge ART Mbarara Hospital	In-Charge ART Mbale Hospital
	Counselors	1 ART counselor	1 ART counselor	1 ART counselor	1 ART counselor
FP	Policymaker	Acting Commissioner Reproductive Health, Ministry of Health			
	Program director	Director, FPAU			
	Unit mangers	In-Charge Maternal and Child Health Mulago Hospital	Clinic Manager, FPAU	Clinic Manager, FPAU	In-Charge Maternal and Child Health Mbale Hospital

Focus Group Discussions

FGDs were conducted among HIV-positive males and females receiving VCT and ART services, as well as HIV-positive pregnant mothers currently enrolled in PMTCT programs. These participants were contacted through the organizations where they receive their respective services, with the help of service providers at various centers. The selection of FGD participants was based on individual willingness to participate in the study, length of exposure to services, and individuals' openness about their HIV-positive status. In total, 107 people participated in 14 focus group discussions (each with 4–10 participants).

The discussions were used to assess clients' knowledge, attitudes, and practices toward family planning and integrated information and services; perceptions of risk for unintended pregnancy; actual and

perceived impact of integrating FP into VCT, PMTCT, and ART services; barriers to contraceptive use; and preferences for various FP methods. Suggestions to improve the delivery of FP information and services in VCT, PMTCT, and ART settings were also assessed. Table 2.3 presents a summary of the discussions conducted at the study sites.

Table 2.3: Summary of FGDs Conducted in the Study Sites

Service	Urban Sites		Rural Sites	
	Kampala	Jinja	Mbarara	Mbale
VCT	1 male, 1 female at TASO Mulago	1 male, 1 female at TASO Jinja	1 male, 1 female at TASO Mbarara	1 male, 1 female at TASO Mbale
PMTCT	1 at Mulago Hospital		1 at Mbarara Hospital	
ART	1 male, 1 female at the Infectious Diseases Institute, Mulago Hospital		1 male, 1 female at the ARV Clinic of Mbarara Hospital	

2.3 Organization of the Study

Technical Oversight to the Study

Technical oversight to the study was provided at various levels. At the international level, Karen Hardee, POLICY Project Director of Research, designed the study and offered significant input into the revision of the study protocol, the data collection tools, and the draft report. A technical review committee, composed of Ugandans with extensive experience in behavioral research and delivery of HIV/AIDS services, was formed to provide technical guidance for the study. This committee included Drs. Alex Countinho, Romano Adupa, and Paul Waibale and played a central role in offering ethical oversight, refining the study protocol, reviewing data collection instruments, and guiding in the preparation of the study report.

Training of Research Team

The data collection team was trained at MISR over a two-week period. The training included orientation of the team on data collection techniques and provided a context of HIV/AIDS in Uganda, particularly with regard to VCT, ART, and PMTCT. To ensure that team members had baseline knowledge of family planning and HIV/AIDS, the training curriculum included VCT, ART, PMTCT and FP information. The training also covered the basic concepts of research, objectives of the study, the interviewer's role, identification and selection of respondents, techniques of interviewing, problem solving during the interviews, and recording of responses (see Appendix 1 for the survey instrument).

Instrument Pre-testing

The FGD, exit poll, and semi-structured and in-depth interview instruments were pre-tested at a TASO branch in Entebbe—which provides VCT and ART services—to determine their suitability for collecting the required data. The results from the pre-test were used to refine the instruments and to enhance the data collection skills of the research assistants. Following the revisions, the FGD and exit poll instruments were translated into four local languages—Luganda, Runyankore, Lusoga, and Lumasaba—that are dominantly spoken in the selected study sites of Kampala, Mbarara, Jinja, and Mbale, respectively.

Execution of the Field Work

Each study site had a team of two field researchers to conduct focus group discussions, in-depth interviews, and exit polls. At the end of each day, the teams would report their day's activities to the principal investigator or his representative. The principal investigators examined all of the data collected to ensure that it was accurate and that there was adequate participation of the target respondents.

Data Processing

Data were returned to the MISR offices in Kampala for processing. The principal investigators cross-checked all the data received for completeness and accuracy. Content analysis was used to analyze qualitative data on the basis of emerging themes and sub-themes in line with the study objectives. Descriptive summaries and quotes were used. Trend analysis of the FGDs and IDIs for each topic was useful in identifying the major issues for each of the study themes and sub-themes. It also facilitated comparisons and contrasts of participants' views within and among the different study sites by gender, location, and age. Quantitative data from the exit poll interviews were entered and analyzed using the SPSS software. Frequencies and a few bi-variate analyses were also carried out.

Ethical Considerations

Uganda's national policy on research binds researchers to the protection of the human and biological subjects involved in the studies they undertake. The Uganda National Council of Science and Technology (UNCST) is the body responsible for research clearance in the country and it includes an AIDS Research Committee. MISR has been compliant with the research policy and the UNCST procedures for research review and approval. While the intention of this study was to elicit information to improve HIV and FP services, the study was sensitive to the fact that HIV/AIDS, sexual activity, and contraceptive use are delicate issues. The confidentiality and integrity of all individuals who participated in the study was observed. All participants, including policymakers and directors, were asked for verbal voluntary consent before being enrolled in the study. Notwithstanding declining stigma and the high degree of openness of people living with HIV/AIDS, interviews with policymakers, program directors, and program managers were held in their offices. Interviews with providers were conducted in counseling rooms. Focus group discussions were held in quiet rooms at the respective facilities. For the exit poll interviews that were conducted outside facilities, care was taken to ensure that the interviews were private. Unless volunteered, participants' names were not required and hence views expressed cannot be traced to any participant.

Study Limitations

Although care was taken to include urban and rural sites in which the services were all provided, this study should not be considered representative of all of Uganda. It did not cover all providers of the four services; for example, the VCT services covered in the study were private sector services offered by AIC and TASO. Furthermore, the study only captured the voices of people who actually accessed the HIV/AIDS or FP services. It also focused entirely on HIV-positive clients and, thus, did not capture the voices of clients who were not HIV-positive. Finally, note that it was not possible, due to ethical reasons, to include client voices at AIC VCT facilities (see Exit Polls under Section 2.2 for an explanation); therefore, information on services at AIC came only from providers.

3.0 VCT, ART, PMTCT, AND FP POLICY ENVIRONMENT

This chapter presents an analysis of the environment in Uganda regarding the policymaking process, existing HIV/AIDS and FP policies, and the extent of FP integration into VCT, PMTCT, and ART at the policy level. Also assessed is the extent to which FP policies address HIV/AIDS issues. Relevant data for this chapter came from interviews with policymakers and national directors of VCT, PMTCT, ART, and FP programs; and policy documents relating to VCT, PMTCT, ART, and FP services.

3.1 The Policymaking Process

The government of Uganda bears responsibility for developing national policies and guidelines, as well as monitoring implementation and compliance to these policies. Most of the health sector policies have been developed under the supervision of the Ministry of Health (MOH), which has the mandate to provide policy and guidance for healthcare. In most cases, initiation of a policy follows the identification of a need, which may be related to a new activity or an ongoing activity that requires more policy guidance or revision of an existing policy.

The MOH may establish a technical committee or commission a consultancy to formulate a draft policy. Through workshops and meetings, stakeholders are invited to provide input and eventually reach final consensus on the draft, which is then sent to the minister for approval. Once approved, the draft is presented to the cabinet. In addition to ensuring that policies address locally identified needs, efforts are made to ensure that policies are consistent with international standards, such as those defined by the World Health Organization (WHO), the United Nations Program on HIV/AIDS, the United Nations Population Fund, and other international bodies.

Once the cabinet has endorsed the draft, it becomes a national policy and is then ready for wide-scale dissemination. It should be noted that, even after being approved, the policy remains a living document and is amenable to revisions as necessary to better address the needs of the citizenry. For example, the National Overarching Policy on AIDS (NOPA) was developed in 1992, revised in 1995, and again revised in 2002. Similarly, the National Policy Guidelines for HIV Voluntary Counseling and Testing, formulated in 2003, are currently undergoing revision to address newly emerging issues, such as the transformation of HIV testing from a voluntary to a routine diagnostic and clinical service.

The process of drafting HIV/AIDS and RH policies in Uganda was reported to be participatory, involving wide-scale consultations among various stakeholders. The main stakeholders in policymaking include civil society organizations, such as AIC and TASO for HIV/AIDS and the Family Planning Association of Uganda (FPAU) for FP/RH; public sector institutions; donor agencies; PLHAs; private, for-profit organizations; local government leaders; and traditional health practitioners. It is interesting to note that in the fast pace of HIV/AIDS programming in Uganda, civil society stakeholders have often been the catalysts for developing policies.

Overall, the major focus has been to ensure that policies are tailored to the local situations, are simple to comprehend and implement, and address the actual needs of the target population. Regardless of whether the policy is for VCT, ART, PMTCT, or RH programs, the development process is the same. Until recently, there has been little interface between policymakers and stakeholders involved in HIV/AIDS and FP/RH policymaking.

The HIV/AIDS policy environment in Uganda has been dynamic; in situations where interventions such as ART are new, implementing organizations have created their own organizational policies ahead of national policies. For instance, the AIC and the Joint Clinical Research Centre (JCRC) pioneered VCT

and ART delivery in Uganda, respectively. In such situations, these organizations had to formulate their own organizational policies to guide service delivery, because services were offered before the national VCT and ART policies were developed.

> *Government policies are sometimes slow, yet you have people who are dying. So in some instances we develop our own guidelines.*
> ~ TASO official

Implementation of VCT, ART, and PMTCT policies is supported by various protocols and guidelines to ensure that services are of uniform quality across the country. The process of formulating protocols and guidelines is equally participatory. It differs from policy development in that guidelines are normally drafted by teams of technical personnel composed of representatives from the various stakeholder groups and do not need cabinet approval.

3.2 Existing HIV/AIDS Policies

Uganda's HIV/AIDS response has been participatory and multisectoral, involving government, nongovernmental organizations (NGOs), faith-based organizations, community-based organizations, and private individuals. The multiplicity of HIV/AIDS interventions necessitated coordination to ensure that services are consistent across providers and a minimum standard of quality is maintained. The government has tried to move rapidly in drafting policies and guidelines to support implementation of HIV/AIDS activities including VCT, ART, and PMTCT services, but as mentioned previously, some NGOs have had to move even faster with their own organizational policies and guidelines for service delivery.

At the national level, the following policies have been developed to guide delivery of HIV/AIDS services:

- Uganda National Policy for HIV Counseling and Testing, June 2005
- Antiretroviral Treatment Policy for Uganda, June 2003
- National Antiretroviral Treatment and Care Guidelines for Adults and Children, November 2003
- National Guidelines for Implementation of Antiretroviral Therapy, October 2003
- National Condom Policy and Strategy, May 2003
- Policy for Reduction of the Mother-to-Child HIV Transmission in Uganda, July 2001
- National Strategic Framework for Expansion of HIV/AIDS Care and Support in Uganda, February 2002
- The Revised National Strategic Framework for HIV/AIDS Activities in Uganda, 2004
- National Policy Guidelines for Cortrimoxazole Prophylaxis for PLHA, April 2005

These policies and guidelines feed into the NOPA, which provides the overall policy and planning framework for HIV/AIDS in Uganda. Within the framework of the NOPA, the five-year Revised National Strategic Framework for HIV/AIDS Activities in Uganda, 2003/04–2005/06, has been developed as a strategic guide for all HIV/AIDS interventions in the country. Additional policies have been developed to support interventions in specific areas such as the National Orphans and other Vulnerable Children Policy and the National Policy on HIV/AIDS in the Work Place.

At the implementation level, organizations adapt national policies and guidelines to fit with their operating structure and resources. For instance, the private VCT and ART organizations covered by the study have established guidelines and protocols to guide service delivery and to ensure that they deliver consistent and high-quality services across their various branches in the country. In the public sector, the VCT, ART, and PMTCT providers follow the standard national guidelines. In both cases, these guidelines are consistent with the national policies governing the respective services.

3.3 Existing FP Policies

> *You cannot take family planning as an isolated component; it is an element of Reproductive Health. So it is the Ministry of Health National Reproductive Health Policy that guides us.*
> ~ Senior official, FPAU

FP services in Uganda are guided by the overarching National Reproductive Health Policy (2001). According to this policy, the key objective of family planning is to provide information and services that enable individuals and couples to decide freely and responsibly how often and how many children to have. Family planning is also one of the six components of the minimum reproductive health package as defined by the MOH. To make the National Reproductive Health Policy operational, the National Policy Guidelines and Service Standards for Reproductive Health have been designed to support delivery of and ensure a standard of quality for RH services.

Uganda developed a National Family Planning Advocacy Strategy in 2005, which includes a section on integration. One priority is to review the policies related to HIV/AIDS (including VCT, PMTCT, and ART) and other relevant health sectors in order to integrate FP into those policies.

Family planning is also highlighted in Uganda's PEAP, with the goal of improving health outcomes and increasing people's ability to plan the size of their families as key strategies for reducing poverty. The PEAP notes that large families can be a powerful force in generating and perpetuating poverty, especially where land is in limited supply or where the family is paying for education. The plan further states that over the next five years, the government will ensure that FP services are accessible to anyone who needs them.

3.4 Integration of FP in HIV/AIDS Policies

FP Integration within VCT Policies

At the national policy level, integration of tuberculosis (TB), FP, sexually transmitted infections (STIs), ART, and PMTCT into VCT is addressed as a key component of the new National Policy Guidelines for HIV Counseling and Testing, which is currently under wide stakeholder review. A leading expert from the Population Secretariat in Kenya was brought in to facilitate the development of this policy.

The guidelines call upon providers to assess the client's need for various services and to provide these services or refer clients to where the services can be obtained. The policy also recommends that VCT be integrated into TB, FP, and STI settings and that providers should offer VCT on-site or refer clients to specialized VCT centers. The VCT Policy and Guidelines clearly articulate the need for creating a referral system within and across VCT, FP, STI, and TB services and for establishing the mechanisms of obtaining feedback.

In addition, integration of FP into VCT has been addressed through the training of service providers. The VCT counselors' curriculum has components of family planning, as well as other RH issues. However, implementation of integrated VCT services remains a challenge. Under the public healthcare system; FP and VCT services are vertical and nonintegrated—HIV/AIDS is under the HIV/AIDS Control Program (which is under the Communicable Diseases unit) while family planning is under the Reproductive Health Division. Under the current structure, supply of FP inputs in VCT sites is the responsibility of the Reproductive Health Division, with no responsibility assumed by the HIV/AIDS program. Because these two units are not coordinated, stockouts of FP commodities are common in VCT sites.

Integration of Family Planning into PMTCT Policies

Family planning is partially integrated into PMTCT policies—addressed as one of the "additional" interventions within the National PMTCT Policy to reduce mother-to-child transmission of HIV. PMTCT services are delivered within the MOH's maternal and child health departments, which already include family planning as an integral service. However, emphasis is put on condom use as a method of dual protection against unintended pregnancy as well as STIs, including HIV. Other contraceptive methods do not appear to be a priority or are not emphasized within PMTCT programs as stated in the PMTCT Policy:

> "Whereas some methods of family planning, such as hormonal contraceptives and intrauterine devices, are very effective in preventing pregnancy, they do not provide any protection against HIV transmission. Clients of family planning should be screened for STIs and appropriately managed. The use of barrier methods, such as condoms, is highly recommended for prevention of HIV and other STIs. This message needs to be emphasized in FP counseling, and the Ministry of Health reaffirms this policy in prevention of mother-to-child transmission of HIV." ~MOH, 2005b

Policymakers involved in PMTCT realize the crucial role that family planning can play in strengthening PMTCT services and consolidating its objectives. As a result, the PMTCT policy is being revised to strengthen the FP component. However, the lack of coordination in the delivery of FP and PMTCT services poses a serious challenge to effective integration of FP into PMTCT. Although actual delivery of PMTCT services takes place in antenatal clinics, which are units under the Reproductive Health Department, PMTCT is financed and managed through the AIDS Control Program. Because the services are managed separately, it is unclear who is responsible for coordinating integrated services. For example, PMTCT managers strongly believe that increasing access to FP services within PMTCT settings is the responsibility of the Reproductive Health Division, which is responsible for this service in the overall healthcare system.

> *If talking about family planning, we are talking, but if it is implementing, we are not implementing. We only added counseling and testing to the existing antenatal services. We take no responsibility for FP. I am not mandated to do that.*
>
> ~ Senior official, MOH

The Reproductive Health Division aims to provide FP services to all people who need them, regardless of one's HIV status. However, given the weaknesses in the health sector, interruptions in services due to stockouts of contraceptives are not uncommon. Currently, the PMTCT program is not mandated to ensure FP supplies in antenatal clinics where PMTCT is provided. Better coordination between the AIDS Control Program and the RH Division would help to address these supply interruptions and ensure consistent and reliable FP services, especially for HIV-positive mothers. In fact, the Reproductive Health Division noted that a focal point for PMTCT will be added to the RH department staff.

Integration of Family Planning into ART Policies

> *My mandate doesn't include family planning. We deal with people who are sick. We don't go to family planning.*
>
> ~ Senior official, JCRC

There was consensus among policymakers that the integration of FP and ART services has not been given proper attention because there has been a push to expand and coordinate ART services in the country. Interviews with ART managers and directors revealed that it was not clear to them how and why family planning should be integrated into ART settings. The only FP method recognized was a condom, but even then, condoms are given for prevention of re-infection but not for family planning. The first National Antiretroviral Treatment Policy was formulated in 2003, with a focus on strategies for expanding access, streamlining quality assurance, addressing institutional and

coordination issues, and creating and strengthening logistical and regulatory systems related to ART. FP integration is neither addressed in this policy nor in the National Guidelines for Implementation of Antiretroviral Therapy.

Integration of HIV/AIDS Concerns in FP Policies

This study also assessed the extent to which HIV/AIDS issues particularly related to VCT, ART, and PMTCT were integrated within FP policies. The national RH policy includes a chapter on integration with STI/HIV/AIDS, with the goal of integrating the management of STI/HIV/AIDS into all RH services and strengthening existing strategies to reduce mother-to-child transmission. Promotion of strong, integrated FP information and services in all health sectors is one of the key objectives of the National Policy Guidelines and Service Standards for Reproductive Health. In addition, while the condom is outlined as a barrier contraceptive method, the policy impresses upon providers to emphasize its use in HIV prevention, especially in couples where one or both partners are HIV positive. The policy further outlines screening and management of HIV/AIDS as well as voluntary counseling and testing as critical components of safe motherhood, especially during pre-conception and antenatal care (MOH, 2001). National FP managers and directors reported that FP programs are a logical place to add HIV/AIDS prevention and care components, given that these programs serve a large number of people at risk.

In summary, Uganda still maintains and supports an open policy to HIV/AIDS prevention, care, and treatment. This openness allows greater opportunities for innovation and adaptation of interventions to address emerging needs. The policymakers recognize the need to include family planning and general reproductive health components within the crucial HIV/AIDS interventions of VCT, PMTCT, and ART. Efforts made to integrate FP services together with PMTCT and VCT services are laudable, but constraints to these initiatives such as weak coordination between the three programs cannot be overlooked. With regard to ART, most of the policy and program focus appears to be on expanding access and improving quality of services, and it may not be realistic to envisage a move toward integration of family planning into ART services in the near future.

4.0 INTEGRATION OF FP AND HIV/AIDS SERVICES

This chapter presents an analysis of the extent to which family planning has been integrated in VCT, PMTCT, and ART services and vice versa. It highlights the achievements, benefits and challenges, procedures followed, and methodologies and future plans of delivering integrated services. This chapter is based primarily on interviews with program directors and providers, with some information from policymakers.

4.1 Existing FP, VCT, PMTCT, and ART Services

The analysis of coverage for VCT, PMTCT, ART, and FP services by providers is limited to TASO, the AIC, JCRC, and the MOH, which are the major players in supporting the national roll-out plan for these services. These are the same organizations that were covered in the study. TASO and AIC are both considered VCT organizations in that both provide voluntary HIV counseling.[2]

VCT Services and Coverage

VCT services are widespread in the whole country. There are over 400 centers across the country, with a minimum of three sites in every district (with the exception of Bushenyi District, which has a total of 19 sites). A home-based approach to delivery of counseling and testing is being piloted in the Bushenyi District, with the objective of providing access to services for all eligible individuals in the district by June 2006.

AIC initiated VCT services in Uganda and remains the leading private organization delivering these services. Currently, the AIC operates in 40 of 56 districts of Uganda, with activities focusing on community mobilization, pre-test counseling, HIV testing, post-test counseling, and transitional care to help individuals cope with test results. AIC delivers its services through eight directly managed branches in the Kampala, Jinja, Mbale, Soroti, Lira, Arua, Mbarara, and Kabale districts. In addition, AIC supports VCT services through indirect sites, which include public and faith-based health units around the main branches. These indirect sites receive technical assistance from AIC, particularly in the area of training counselors and laboratory staff, supplying HIV test kits, and providing routine quality assurance oversight.

TASO was also the first organization to provide HIV/AIDS care in Uganda. Its primary focus is on the provision of ongoing psychosocial support and treatment of opportunistic infections, both of which are critically needed to support individuals and their families to live positively with HIV/AIDS. TASO also offers social support programs, such as care for orphans and vulnerable children; food supplements; and skills training and grants for initiating community-based activities for economic survival. Recently, TASO introduced ART services with the objective of addressing the holistic needs of its clients. Currently, TASO services are located in the districts of Rukungiri, Mbarara, Masaka, Kampala, Wakiso, Jinja, Tororo, Mbale, Soroti, and Gulu. These services are offered in centers that also offer technical assistance to a minimum of three districts around them. In addition, TASO extends its services to thousands of individuals in peripheral communities through an outreach program that provides services at strategic sites in rural areas on designated dates. Both TASO and AIC reported that they also provide FP services and treatment of STIs as integral components of their programs.

[2] TASO provides ongoing, post-test counseling to people living with HIV/AIDS. AIC provides HIV/AIDS counseling and testing, with a transitional post-test club to support individuals coping with their test results. Those in need of ongoing care are referred to HIV/AIDS care organizations, mainly TASO.

ART Services and Coverage

The ART program in Uganda currently covers national referral hospitals, regional hospitals, and district and NGO hospitals. Under the national roll-out plan, all health center IVs will be covered by the end of 2006. Currently, there are 143 sites accredited by the MOH to offer ART in Uganda—of which 116 units are delivering services. The target was to provide ART to 60,000 people in Uganda by the end of 2005 (MOH, 2003a). Uganda is also working toward achieving the WHO "three-by-five" goal of 3 million people on treatment by the end of 2005. Through a well coordinated ART program and with the support of donors and private and faith-based organizations, Uganda hit its target of 60,000 in June 2005.[3] The MOH is now poised to ensure that treatment is accessible to every eligible Ugandan by 2007.

PMTCT Services and Coverage

In every district of Uganda, there is a PMTCT center based in the district hospital and PMTCT services are offered at health center IVs and IIIs. In districts that do not have hospitals, such as Kalangala and Kamuli, PMTCT services are offered at health center IVs and IIIs. According to the PMTCT roll-out plan, the government plans to have services established in all health center IVs across the country by the end of 2005, with the ultimate goal of reaching all health center IIIs.

The PMTCT sites were reported to provide medical treatment, antenatal health education, and PMTCT services. The medical services include care for the baby, detection of danger signs during pregnancy, management of STIs, diet during pregnancy, vaccination against tetanus, treatment of minor ailments, and general check up of the pregnant mothers. Those coming for the first time receive pre-test counseling, and HIV and STI testing is given to any woman who consents. Women who are diagnosed with HIV are counseled and introduced to PMTCT services. Those who opt for them are enrolled and offered ongoing psychosocial support services in which topics of family planning, infant feeding and disclosure, HIV-positive living, and use of condoms to avoid HIV re-infection are discussed.

FP Services and Coverage

According to the MOH's Reproductive Health Division officials, FP services are supposed to be provided in all health units that have a midwife. However, this is currently not the case because of limited funding and human resources. The National FP Advocacy Strategy (2005–2010) indicates that at district hospital and health center IV levels, few providers are trained and equipped to offer long-term and permanent methods of contraception. For example, 75 percent of health center IVs do not have anaesthetic officers, and 30 percent of health center IIIs and 69 percent of health center IIs do not have qualified midwives or comprehensive nurses (MOH, 2005a).

Private providers, mainly the FPAU and Marie Stopes Uganda, were reported to have greatly complemented government efforts in delivering FP services. Currently, FPAU has 29 centers located throughout the country and 15 FP clinics that also support outreach services. FPAU provides FP counseling and contraceptives, antenatal and postnatal care, STI diagnosis and management, adolescent reproductive health services, HIV/AIDS prevention services, and postabortion care. Table 3.1 presents the contraceptive methods available in the FP service sites covered by the study.

[3] In a press release (The New Vision, Newspaper, Monday, July 18, 2005), the MOH officially announced that they have hit the target of 60,000 people on ART halfway in 2005.

Table 3.1: Provision of Contraceptive Methods at the Visited Facilities

Contraceptive Methods	FPAU- Mbale	FPU-Mulago	FPAU-Mbarara	FPAU-Iganga
Female sterilization/ Tubal ligation	✓	✓	-	-
Male sterilization/Vasectomy	✓	✓	-	-
Pill	✓	✓	✓	✓
Intrauterine device/Coil	✓	✓	✓	✓
Injections/Depo-provera	✓	✓	✓	✓
Implants	✓	✓	✓	✓
Male condom	✓	✓	✓	✓
Female condom	✓	✓	✓	✓
Diaphragm	✓	✓	-	✓
Foam/Jelly	✓	✓	✓	✓
Emergency contraception	✓	✓	-	✓
Withdrawal	-	-	-	✓
Calendar methods	-	-	-	✓

Source: Semi-structured interviews with service providers.

4.2 Level of Integration of FP into VCT, PMTCT, and ART Services

The center managers and counselors at ART, PMTCT, and VCT sites were asked the extent to which family planning is addressed in their services, mechanisms, guidelines, and protocols used to support their delivery of integrated services. They were also asked about the effect that integrated service delivery has had on their facilities and how they plan to address or include FP in VCT, PMTCT, and ART settings.

Internal Service Delivery Mechanisms

At the VCT sites visited, both of which are run by civil society organizations, providers reported that family planning was offered as an integral component of their services to address the holistic needs of their clients. The FP services offered included counseling and provision of nonsurgical contraceptives (condoms and to a limited extent pills and injectables).

In TASO, orientation to FP services is initially provided through the general health talks given to its clientele as they wait to see providers. The health talks cover a wide range of topics related to general health, HIV/AIDS prevention, hygiene, nutrition, strategies for coping with HIV/AIDS infection, treatment seeking behavior for STIs, and family planning. The FP information offered at this stage aims to encourage clients to engage in detailed discussions with counselors. These individual counseling sessions cover specific FP issues and detailed information on the need for, benefits of, and types of available contraceptives. The counselor assesses the client's risk for HIV re-infection and unintended pregnancy and develops a risk reduction plan. Condoms are provided if a client expresses interest in them. If a client prefers pills or injections, he/she is referred to the medical unit within the same premises. The medical personnel review the clients' medical, gynecological, and surgical history and discuss the contraceptive options available and their advantages and disadvantages. For example, if a client decides to change his/her chosen method of contraception because of potential side effects discussed with provider, the client is referred back to the counselor for counseling.

Interviews with TASO service providers revealed that provision of FP services during the ongoing counseling sessions is always prompted by the client. If clients do not ask any FP-related questions during the counseling sessions, no FP issues are discussed because the counseling agenda is always driven by the clients' needs. In taking this approach, there is a risk that clients who may have needs for family planning but are not able to raise them during counseling may not receive sufficient information and guidance.

At AIC, clients are introduced to family planning during the HIV/AIDS counseling sessions. During these sessions, FP needs and pregnancy risk are assessed. If the client shows interest in FP services, he/she is

sent to the reproductive health attendant (RHA) within the same premises for further counseling and more FP information. The RHA answers questions and concerns raised by the client on family planning and also prescribes the appropriate contraceptives, such as condoms or pills. However, methods such as injections that require specialized skills are prescribed by the medical counselor.

Providers at AIC and TASO noted that clients who choose to take contraceptives receive ongoing counseling and monitoring to ensure that they adhere to the prescription protocols and that any negative effects on their health are identified and addressed. When side effects of FP methods are identified by clinicians, clients are sent back for further counseling before the adoption of an alternative method.

VCT providers were asked whether there are any written guidelines and protocols directing the delivery of FP services. Guidelines are general rules and regulations governing service delivery and stipulate the roles and responsibilities of providers. Protocols provide explicit steps and a course of action to follow in the delivery of services. Both guidelines and protocols are used to standardize the quality of services across different providers and settings.

At TASO, there are no specifically written guidelines and protocols to follow while delivering FP services; however, family planning is included as a component of the general counseling guidelines, which counselors follow while delivering HIV/AIDS counseling. TASO has two comprehensive forms, the Medical Visit Summary Form and the Counseling Form, which include a variety of issues that providers should address during counseling and medical sessions with clients. At the end of each session, providers are required to complete the forms by ticking the issues that were addressed. Family planning is indicated as one of the issues on both forms.

> *We have guidelines on counseling in general but not specifically family planning. We are supposed to demonstrate to them how condoms are used. The guidelines are not written down.*
> ~ Counselor, TASO

AIC has a specific FP client form that is completed for each client seeking FP services. Client history and FP services offered are recorded. The form is used for registration and the assessment of FP clients.

In PMTCT settings, orientation to FP services is given to all mothers as a routine component of general antenatal and postnatal care. All mothers receive FP counseling, covering the available contraception methods, benefits, and possible side effects. This information is given through the general health talks to both the old and new clients, including the men who come with their wives. Because most of the clients in PMTCT settings are already pregnant women, providers said that the scope of FP services is limited to counseling and provision of condoms to avoid HIV re-infection and STIs; however, the provision of FP information and counseling is emphasized to enable mothers to make appropriate contraceptive decisions in the future.

PMTCT counselors provide FP information and noninvasive contraceptives, also known as “supply” methods of contraception, such as pills and condoms. Clients who prefer “clinical” methods (referred to in Uganda as body-invasive methods) like the coil (intrauterine device), injectables, and permanent methods, such as tubal ligation and vasectomy, are referred to specialized FP providers who may be located within the same hospitals or a distance away. In one PMTCT site, the counselors reported that sometimes they are able to accompany clients to the FP clinic. After the client has received services, the counselor completes the FP section on the client’s card that is returned to the PMTCT unit.

There are no written guidelines and protocols for the delivery of FP services in the PMTCT settings studied. However, there is a generic form for postnatal services that gives guidance to providers on what issues to address with mothers seeking postnatal care. This form has an FP section that is meant to help

providers assess the need for contraception. For mothers who are not yet using contraception, providers are required to counsel and help them start appropriate contraception methods.

Despite the views of policymakers that family planning has not been integrated into ART services, the ART providers, particularly counselors, reported that they provide FP counseling, condoms, and referrals. Like in VCT and PMTCT settings, clients are introduced to family planning through the general health talks. The FP needs and concerns of individual clients are addressed by counselors during the ART counseling sessions. Clients who need contraceptives other than condoms are referred to the FP unit in the hospital or other appropriate sources. The only contraceptive method provided in ART sites was a condom, but even then, clients are encouraged to use condoms mainly to prevent re-infection rather than for FP purposes.

But on the whole, family planning is not in our work. Remember I did not talk about it when you asked me about the services we give to our clients. I would say, yes, family planning is not an integral part of our services.

~ Counselor, ART

My mandate doesn't include family planning. We deal with people who are already sick. Our counselors may be better placed to talk about family planning. They tell the patients how to control their parenthood, when and where, but it is not in the policy.

~ Senior official, JCRC

Provision of FP services in ART settings hinges on the counselors' initiatives and skills to assess the need for family planning among clients and provide the appropriate support. Although counselors do attempt to provide limited FP services to those who need them, discussions with ART managers and directors reveal that, based on the training they have received, FP is not among the services that ART providers are expected or required to offer. Table 3.2 shows the contraceptive methods provided in VCT, PMTCT, and ART facilities. Condoms are available in all facilities, with the pills and injectables available in fewer than half of the centers.

Table 3.2: Contraceptives Provided at VCT, PMTCT, and ART Facilities

	VCT				PMTCT				ART			
FP Method	**TASO Mulago**	**TASO Mbarar**	**AIC Mbale**	**AIC Jinja**	**Mulago Hospital**	**Mbale Hospital**	**Jinja Hospital**	**Mbarara Hospital**	**Mulago Hospital**	**Mbale Hospital**	**Jinja Hospital**	**Mbarara Hospital**
Tubal ligation												
Vasectomy												
Pill		✓	✓	✓		✓		✓				
Intrauterine device/Coil												
Injections		✓	✓	✓				✓				
Implants												
Male condom	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Female condom												
Diaphragm												
Foam/Jelly												
Emergency contraception												
Calendar method				✓								

Source: Semi-structured interviews with service providers and in-depth interviews with center managers.

There were no guidelines or protocols developed to support delivery of FP services in ART settings. The ART Client Assessment Form includes family planning, but only to establish whether clients are using contraception so that the provider prescribes the appropriate drug combination that will not interact with the contraceptive method.

External Linkages and Referrals

VCT service providers reported that clients who need contraceptive methods not offered at the VCT facilities are referred to specialized FP facilities, mainly referral hospitals and the FPAU. Specific referral forms have been created for this purpose. However, referral coordination between VCT facilities and the specialized FP providers is still weak and to a large extent not formal. For example, in all of the sites visited, providers reported that there is no formal follow-up mechanism to ensure that clients who are referred for FP services make it to the facilities and actually receive the services.

> *This is a regional referral hospital where ideally everything should be there. When we refer clients on humanitarian grounds, we cannot document it or have a mechanism for follow-up because officially we are not supposed to refer [since we are the facility to which clients are referred].*
>
> ~ Counselor, PMTCT

All of the PMTCT sites visited were providing services in regional referral hospitals. By implication, these hospitals are expected to have the full range of FP services and are not supposed to refer clients to any other hospital other than the other national referral hospitals. However, providers reported that often there are stockouts of contraceptives. In these situations, clients are told that they need to obtain contraceptives from other sources. These referrals are informal and undocumented with no mechanism of following up with clients.

In ART settings, the condom is the only contraceptive that is provided; therefore, clients who need other methods are referred to FP organizations, with a medical form (Form 5). There is no mechanism to ensure that they get the FP services they are referred for. However, a few service providers reported follow-up discussions with clients to determine what FP services were provided to the client. There is also a monthly follow-up with clients who are accessing FP services to ensure that the contraceptive method is compatible with their ART regimen. In one ART site, clients are required to present their respective FP referral forms so that providers can assess the contraceptive choices made and advise them accordingly.

> *You know this is one of the challenges we have. If a client is not grateful and doesn't come back, it is hard to know whether they received the referred services. This is because some of them think we have ignored them and sent them away from our services. Sometime back we used to call the referral places to ensure that clients got the services but we no longer do so, and escorting clients is only done for those who have TB.*
>
> ~ Counselor, AIC
>
> *The only mechanism we have is an oral feedback from the clients. We don't have documents to follow. It is difficult to ascertain that these clients have accessed the services referred for.*
>
> ~ Counselor, TASO

Availability of IEC Materials on FP within VCT, PMTCT, and ART Settings

Service providers were asked about what IEC materials on family planning were available at their facilities to raise awareness of the need for family planning among clients.

In VCT facilities, the most common IEC materials were charts, brochures, and pamphlets. Besides print materials, AIC sites also had videos, demonstration materials, and drama groups that present plays and songs depicting the need for family planning in communities.

At PMTCT sites, the most used IEC material was a video that is shown in the waiting hall where mothers gather for services; however, it was reported that the video is used to provide information on a wide range of maternal and child health issues—not only FP. There were also charts, pamphlets, and demonstration materials available.

FP-related IEC materials were available in only two ART sites in Jinja (charts and pamphlets) and Mbale (video).

Provider Training

Ideally, effective delivery of integrated services requires that VCT, PMTCT, and ART providers are trained in skills that allow them to competently handle FP needs in their settings. Service providers were asked about what aspect of family planning and contraceptive methods they had been trained on.

Fourteen of the 16 VCT, PMTCT, and ART counselors reported receiving training in FP counseling and education, provision of both prescriptive and nonprescriptive contraceptives, and referrals. However, there were wide variations across all the three services (VCT, PMTCT, and ART) regarding the contraceptives covered by the training; some of the counselors had been trained on all methods of contraception, while others had been trained in a few commonly used contraceptives (particularly the pill and injectables).

Service providers reported that FP training has made it easy to introduce and handle FP issues with their clients. They are able to provide adequate and accurate information to their clients, assess their FP needs, discuss side effects, and provide the appropriate contraceptive methods.

Special Considerations for Addressing FP Needs for Adolescents

VCT, PMTCT, and ART service providers were asked how they assist adolescents in accessing FP services.

AIC was the only site where special provisions had been made to provide services for youth and adolescents. Saturdays have been specifically designated for serving youth. On these days, youth are introduced to a variety of sexual reproductive health issues including family planning. PMTCT and ART providers reported that no special provisions were made for youth, because most of their clients are adults.

Future Plans to Consolidate or Initiate Integration of FP into VCT, PMTCT, and ART Services

VCT, ART, and PMTCT policymakers and service providers were asked what plans they had for strengthening delivery of family planning within VCT, ART, and PMTCT settings. In sites where family planning had not been integrated, they were asked how they planned to do so.

Both TASO and AIC reported having plans to step up public awareness on family planning within VCT settings through radio programs and drama activities. These campaigns will aim to increase knowledge, change the attitude of the public toward family planning, and increase the use of FP services. TASO also had plans to have designated staff to talk about FP issues during the outreach programs.

Both organizations plan to strengthen the referral system by conducting follow-up to ensure that clients access and receive the services they are referred for. However, they had no intentions of delivering the full spectrum of FP services in VCT centers. There are also plans to provide annual updates on family planning for counselors and medical personnel to ensure their awareness of emerging FP issues and challenges.

TASO officials reported that they are currently collecting data on the use of contraceptives, particularly injectables and pills, to make an informed decision on the future provision of these methods. It was

reported that if the figures are found to be significant enough to justify continued delivery, plans will be made to strengthen the services and increase use. However, if the demand remains low, TASO may shift its focus to FP information and condom distribution, and refer clients to FP service providers, such as the FPAU for additional services.

Interviews with VCT policymakers did not reveal any tangible plans to consolidate the integration of FP and VCT services, although this is well-articulated in the revised National Policy Guidelines for HIV Counseling and Testing.

Interviews with PMTCT providers and managers in the Jinja and Mbale hospitals revealed plans to equip their staff with improved client handling approaches and better skills in delivery of FP and PMTCT. On the other hand, Mbarara and Mulago PMTCT centers did not report any specific future plans to improve integration of FP and PMTCT services. However, the Mbarara center was developing plans to improve its procurement system to ensure that necessary supplies for PMTCT and FP services are in place.

At the national level, interviews with the PMTCT program managers revealed that plans are underway to strengthen the integration of PMTCT with FP services. It was reported that the PMTCT policy has already been reviewed to facilitate the delivery of a comprehensive package of integrated FP and PMTCT services. This package is being piloted in two health center IVs in the Soroti and Mpigi districts.

We don't have it really (the plan to integrate FP into ART). We want to integrate Anti-Retroviral Therapy with PMTCT services and PMTCT with family planning.

~ Senior official, MOH

ART officials at three of the four ART sites reported that there were no future plans to integrate FP with ART services. They said that it is not something that they had even thought about. At each of these sites, officials contend that there are specialized FP units within the hospitals, and therefore, it is easier to refer clients to these and other relevant units rather than incorporating family planning into their services.

At the fourth ART center, plans were under way to integrate PMTCT and FP with ART services. A resource person had already been put in place to oversee the integration of these services, and a meeting with officials from the AIC, TASO, and the FP unit of the hospital had been scheduled to discuss this initiative.

At the national level, policymakers shared the same views as those presented by the majority of ART officials.

4.3 Integration of HIV/AIDS in FP Services

Internal HIV/AIDS Service Delivery Mechanisms

To get a balanced insight into the current realities and challenges of integrating FP services into VCT, PMTCT, and ART services, it was necessary also to assess the current efforts being made to address HIV/AIDS in FP settings. FP service providers were asked if any HIV/AIDS-related services were being provided along with FP services, and if so, what services were being provided and how. It was reported that HIV/AIDS services, particularly VCT and PMTCT, are emphasized in the delivery of FP services. Prevention of HIV/AIDS, particularly risks of pregnancy for women with HIV, is included in the basic FP messages provided to all FP clients.

The service providers reported that the most common HIV/AIDS-related services provided were pre-test counseling, HIV testing, post-test counseling, and PMTCT counseling. HIV/AIDS-related issues, particularly surrounding VCT and PMTCT, are introduced to clients in the FP sessions. If a client

expresses a need for HIV/AIDS services, providers either offer the services or refer clients to other specialized HIV/AIDS service organizations. Many of the established FP sites were reported to be offering VCT.

FPAU, which is a leading private provider of FP services in Uganda, offers a more holistic package of RH services that includes FP counseling, antenatal and postnatal care, STI diagnosis and management, HIV prevention, diagnosis of reproductive cancers, postabortion care services and general counseling on gender issues, and interventions to address the negative social and cultural factors that influence sexual reproductive health. FPAU also runs a program on PMTCT but refers mothers to hospitals to access ART services to prevent vertical transmission.

FP service providers were asked whether there were any written guidelines and protocols to help them in delivery of HIV/AIDS services. They reported that there are no guidelines or protocols specifically written for HIV/AIDS service delivery in FP settings. However, the FPAU units had MOH VCT protocols that detail the mandatory three tier HIV testing algorithm. The units also had VCT Client Cards, which are used to assess sexual behavior, HIV/AIDS risk, and contraceptive usage among clients. In addition, copies of a "Guide to Establishing Voluntary Counseling and Testing Services for HIV," developed by Family Health International with the support of USAID, are also available and being used in all the FPAU units visited.

External Linkages and Referrals

FP service providers reported having specific referral forms for referring clients to HIV/AIDS services that are not offered at their units. FPAU service providers network with other organizations providing HIV/AIDS services, particularly TASO and AIC. For example, they refer clients who need HIV/AIDS care and support or home-based care to TASO. Service providers stated that although such external linkages have not been formalized, both TASO and AIC generate reports showing the clients referred from FPAU units, which help in the follow-up on referred clients. On the other hand, government FP units based within the referral hospitals are not supposed to refer their clients to other providers except to the national referral hospitals; therefore, external referrals are informal and are not tracked.

Availability of IEC Materials on HIV/AIDS within FP Settings

FP service providers were asked what IEC materials on HIV/AIDS were available at their facilities to promote HIV/AIDS awareness among their clients and to enhance delivery of integrated FP and HIV/AIDS services. All FP service providers interviewed reported having a variety of IEC materials, particularly charts and pamphlets. FPAU units also had videos, drama groups, and demonstration materials on HIV/AIDS.

Provider Training in HIV/AIDS Service Delivery

FP service providers were asked whether they had received any training in HIV/AIDS issues to enable them to effectively deliver integrated FP and HIV/AIDS services. FP providers reported being trained on VCT and HIV/AIDS-related stigma. FP facilities have been equipped with HIV-testing equipment and supplies, and laboratory staff have been trained in HIV-testing technologies. All the providers interviewed had received HIV/AIDS training in pre- and post-test counseling and psychosocial support counseling. Most of them had also received training in PMTCT counseling. Only one out of the four interviewed had training in clinical management of opportunistic infections. They reported that this training had helped them to provide accurate information and adequate care to their clients.

To share information and complement other HIV prevention programs, FP providers have also stepped up their engagement in national HIV/AIDS forums. For instance, the FPAU is actively participating in the development of the new National Policy for HIV Counseling and Testing.

> *We don't have it really (the plan to integrate FP into ART). We want to integrate antiretroviral therapy with PMTCT services and PMTCT with FP.*
>
> ~ Senior official, MOH

Special Considerations for Addressing FP Needs for Adolescents

The FPAU units reported establishing special arrangements to assist adolescents and youth in accessing FP services. Youth centers have been established where a full range of RH services are offered. Some of the activities in the centers include peer education, counseling, IEC services, and HIV prevention education. Outreach activities targeting schools and communities where youth congregate include family planning and HIV prevention information. Recreational activities such as sports, debates, and dramas are organized purposely to occupy the youth and divert their attention from risky behavior. Through these activities, youth are also exposed to information on a range of RH issues. Youth who are eligible for and require contraceptives also receive them.

In summary, the analysis above shows that efforts to fully integrate HIV/AIDS into FP services appear to be more advanced than vice versa. Efforts for integrated delivery of services were more evident in VCT and PMTCT and less in ART settings—both at policy and service delivery levels.

Provider training in multiple HIV/AIDS and FP skills is a driving force to the current efforts and level of integrated service delivery. For example, even in situations where policy guidance is lacking, trained providers have on their own initiative, and within the limits of the resources available, provided FP and HIV/AIDS services to clients who need them.

5.0 CLIENT KNOWLEDGE AND USE OF FP IN HIV/AIDS SETTINGS

This chapter presents the socioeconomic profile of PLHAs receiving HIV/AIDS services at PMTCT, VCT, and ART centers and their level of knowledge, use of, and satisfaction with FP information and services in HIV/AIDS settings. Additional comments made by clients regarding HIV services specifically (not related to family planning) are included in Appendix 2. These comments are related to staffing shortages in health facilities, access to HIV services, implications of ART availability, protection of discordant couples, and poverty among PLHAs.

5.1 Profile of Clients Accessing HIV/AIDS Services

Table 5.1 gives the socio-demographic profile of 63 women and 44 men living with HIV/AIDS who participated in focus group discussions at the various HIV/AIDS facilities. The findings show that the majority of these clients are within the reproductive age (83 percent are 45 years and below) and most of them are either widowed (52 percent) or married (42 percent). Most of the clients have low levels of education. Fifty-two percent had not gone beyond primary school. The majority are low-income earners engaged in peasant farming and petty trade, while others are unemployed. One in every six clients reported that they did not have any source of income because they were too weak to work, could not find a job, or were economically dependant on their husbands.

Even me, I have a young bride at home, a girl of 21 years old but she insisted that she wanted to produce; that she can't die without a child. At first I refused, I said no. When I refused she wanted to divorce, then I did it live without a condom and she conceived but unfortunately, it became a miscarriage, then I did it again and as I talk now, she is pregnant.

~ Male FGD for VCT clients, TASO

However, the data shows that there are substantial gender differences in the demographic characteristics of PLHAs accessing HIV/AIDS services at the different study facilities. Most women had attained only primary education, while the majority of men had attained secondary education. Regarding age, the female clients were generally much younger than their male counterparts. Most importantly, however, the majority of the male clients (75 percent and 63 percent of the VCT and ART clients, respectively) reported that they were married/cohabiting compared to only 10 percent and 21 percent of the VCT and ART female clients. On the other hand, unlike men, the majority of women (86 percent and 75 percent of VCT and ART female clients, respectively) were widows. This significant difference in marital status seems to suggest that, unlike the women, most of the male PLHAs whose wives may have died have actually remarried. This increases the risk of re-infection, bearing HIV-infected children, and producing more children that they may not financially be able to care for.

Table 5.1: Socioeconomic Characteristics of FGD Participants

Client's Marital Status	Type of Service					Total (n=107)
	VCT		ART		PMTCT	
	Sex of Client		Sex of Client		Sex of Client	
	Male (n = 28)	Female (n = 29)	Male (n = 16)	Female (n = 24)	Female (n = 10)	
	Col %	Col %	Col %	Col %	Col %	Col %
Single/Never married	4	3		4	10	4
Married/Cohabiting	75	10	63	21	60	42
Widowed	21	86	38	75	10	52
Separated/Divorced					20	2
TOTAL	100	100	100	100	100	100
Client's Level of Education						
Never		3	6	4	10	4
Primary	36	66	25	50	60	48
Secondary	32	28	50	42	20	35
Tertiary	32	3	19	4	10	14
TOTAL	100	100	100	100	100	100
Client's Age						
25 and below			6	4	40	6
26–35	32	41	13	67	50	41
36–45	43	45	38	29	10	36
Above 45	25	14	44			17
TOTAL	100	100	100	100	100	100
Client's Occupation						
None/Unemployed	14	14	13	8	20	13
Housewife				4	30	4
Peasant farmer	25	17	38	46	20	29
Self-employed (Petty Trade)	18	38	25	21	10	24
Casual laborer	7					2
Civil Servant	7		6			3
Self-employed (Tailor/Mason/Mechanic, etc.)	11	14	19	13	10	13
Teacher/Nurse	11	3		4		5
Volunteer/Peer educator	7	10		4		6
Employee (Non-civil Servant)		3			10	2
TOTAL	100	100	100	100	100	100

Source: Focus group discussions.

5.2 Clients' Knowledge of Family Planning

Clients accessing any of the HIV/AIDS services had sufficient knowledge of family planning. Although varying definitions of family planning were given by the FGD participants, they generally had a common understanding of the concept and understood the economic and health ramifications of not using FP services. Perhaps the most comprehensive description came from the male VCT discussion participants of TASO-Mbarara:

"FP is producing the number of children a person can care for in terms of providing for their education and feeding and clothing, because if a person produces 10 children and that person has a small piece of land, he cannot give them enough food and he will be overburdened; he will be 'loaded' with caring for those children especially if he has HIV/AIDS. Family planning means having children when one wants them like after every five years to help the mother stay healthy; otherwise the children will suffer from kwashiorkor [severe malnutrition]. Lack of family planning means having children when one is renting (a house) and fails to feed them yet he continues producing more children because producing is sweet."

There are problems and misconceptions associated with use of certain FP methods. For example one may bleed seriously when one uses methods like the pills or the injections.
~ Male FGD for VCT clients

Results from the exit polls also show that there is near universal knowledge of family planning among PLHAs receiving HIV/AIDS services at the various centers. Table 5.2 shows that about 95 percent of the exit poll clients were knowledgeable about family planning and could mention at least two correct FP methods. There was, however, some gender differences in the types of methods mentioned.[4] The majority of women mentioned the pill (88 percent), injectables (73 percent), and the male condom (63 percent) as the FP methods they knew, while most men mentioned the male condom (88 percent) and the pill (67 percent). Only 39 percent of the men mentioned injectables. The results in Table 5.2 show that knowledge of modern methods—such as the female condom, diaphragm, foam/jellies, and emergency contraception—was low.

If a man has AIDS and is physically weak, he cannot use a condom because his penis is too weak to erect; it keeps falling down and the condom falls off.
~ Female FGD for VCT clients

The findings imply that PLHAs' knowledge of family planning is limited to only a few methods. However, the majority of these methods may not be recommended for this population because of their HIV status and misconceptions about certain FP methods. For example, it was repeatedly mentioned that most female PLHAs are unable to use injectables because they tend to be anemic, while many others should not use pills because of their side effects, particularly when one is on ART. It was also reported that some male PLHAs may not be in a position to put on a condom during sexual intercourse because they cannot attain full erection due to the long duration of their illness. Some women reported that they felt uncomfortable using the male condoms because they feel pain during sexual intercourse due to the weakened vaginal linings. FGD participants also cited common fears and myths about the condom, including that the condom contains the HIV virus; its lubricants cause cancer; and that it reduces "sweetness" during sexual intercourse. Women also fear that the condom may easily get stuck inside of them during sexual intercourse.

Some of our husbands say we are already dead and also say they don't enjoy sex with condoms. It is therefore good to go for family planning and use other methods like pills or injections to avoid unwanted pregnancies.
~ Female FGD for VCT clients

While the male condom is an effective FP method and reduces the risk of HIV infection and re-infection, it puts women in a vulnerable position because condom use is often determined by the male partner—many of whom were reported to detest its use for various reasons. Alcohol use and nondisclosure of serostatus were cited as additional reasons for not using a condom.

Based on the fears and negative attitudes expressed by FGD participants, it is reasonable to conclude that a lack of access and insufficient exposure to a variety of other practical FP options increases PLHAs' risk for unintended pregnancy and STIs. Increasing access to female-controlled methods, such as pills and injections, seem to be a viable FP alternative for PLHAs, especially in situations where male partners refuse to use condoms.

[4] Question was asked without prompting for FP methods.

Table 5.2: Knowledge of Family Planning and FP Methods among PLHAs

	Type of Service				Total (n=76)
	ART		VCT		
	Sex of Client		Sex of Client		
	Male (n = 13)	Female (n = 17)	Male (n = 21)	Female (n = 25)	
	Col %	Col %	Col %	Col %	Col %
Respondents who know family planning	**100**	**100**	**95**	**96**	**97**
FP Methods mentioned as known by respondents (*multiple responses possible)*					
Female sterilization	8	12	15	21	15
Male sterilization	8	6	20	4	10
Pill	69	88	65	88	78
IUD/Coil	8	12	25	8	14
Injections	46	53	35	88	58
Implants	15	12	10	13	12
Male Condom	85	59	90	67	74
Female Condom	-	-	10	4	4
Periodic Abstinence	-	-	19	8	8
Number of methods mentioned					
None	-	-	5	4	3
One	-	-	10	4	4
Two or more	100	100	86	92	93
Total	**100**	**100**	**100**	**100**	**100**

Source: Exit poll interviews.

Note: The tables that present data on exit polls cover only VCT and ART clients since this study covered HIV-positive clients. It was not possible to isolate PMTCT clients exiting a facility since PMTCT services are provided within the general ANC clinics. Totals may sum to over 100 because of rounding.

5.3 Client Utilization of Family Planning and the Service Gaps

Extent of Use

Almost half (45 percent) of the PLHAs receiving HIV/AIDS services at the various centers reported that they were sexually active. This percentage is likely to be higher because some PLHAs do not disclose sexual activity for fear of being discouraged by counselors. Since most PLHAs interviewed were of reproductive age, they are at a high risk for unintended pregnancies.

Clients of VCT and ART services who indicated that either they had had sex in the last six months or they felt at risk of getting an unintended pregnancy were asked what actions they had taken to reduce that risk. Eight out of 10 (83 percent) reported using a FP method—most of whom (63 percent) were using male condoms. Despite HIV/AIDS centers providing free but limited FP services (mainly condoms), one in six (17 percent) of the sexually

The only thing I can tell you is that young people are not open. They go to private clinics to obtain FP services. This is because they tell us that they are not having sexual intercourse but we see them in private clinics where services are commercialized.

~ Counselor, VCT

active or at-risk respondents had not taken any action to protect themselves against unintended pregnancies (see Table 5.3). This may be attributed to the negative attitudes, barriers, and misconceptions regarding contraception.

Among condom users, there was a wide variation on contraception use between VCT and ART clients. Eighty-six percent of male and 67 percent of female ART clients reported using condoms, as compared to 58 percent of male and 56 percent of female VCT clients. This difference may be associated with the fear that ART may be discontinued for women who become pregnant or with the emphasis placed on condom use to reduce re-infection in order to enhance ART outcomes.

Table 5.3: Actions Taken by PLHAs to Avoid Unintended Pregnancies

FP methods being used by respondents who are sexually active or who feel are at risk of getting an unwanted pregnancy (multiple responses possible)	Type of Service				Total (n =41)
	ART		VCT		
	Sex of Client		Sex of Client		
	Male (n = 7)	Female (n = 6)	Male (n = 12)	Female (n = 16)	
	Col %	Col %	Col %	Col %	Col %
None	14	17	17	19	17
Pill	14	-	8	6	7
Injections	-	-	-	19	7
Male condom	86	67	58	56	63
Female condom	-	-	8	-	2
Periodic abstinence	-	17	17	13	12
Other	-	-	8	13	7

Source: Exit poll interviews.

VCT, ART, and PMTCT service providers were also asked whether many of their clients are interested in accessing FP services. Within VCT settings, there were differences in opinions regarding client interest in accessing family planning. In TASO centers, 75 percent of the service providers interviewed believed that many of their clients were interested in family planning, although some of them, particularly the young ones, do not reveal so. On the other hand, all AIC service providers interviewed reported that few of their clients are interested in family planning, and even then, many of them did not use the prescribed FP methods consistently. Clients' interest in obtaining FP services from TASO and AIC varies perhaps due to the nature of services and clients served. While TASO provides ongoing care to individuals with a confirmed HIV diagnosis, AIC serves clients who are young, sexually active, and largely HIV-negative. Most of these clients come to AIC when they are already receiving FP services from elsewhere.

There have been some problems convincing staunch Catholics to use condoms yet this is the only method that prevents both HIV re-infection and unwanted pregnancies.

~ Counselor, ART

They are few people who can pick condoms from the pharmacy. When we are counseling them, those who pick condoms tell us that they are facing problems at home that the men (husbands) are refusing to use condoms. There is a category of people who need and want to use condoms but fear to pick them. There are other people who if you put condoms in their homes, they would use them; their problem is being seen picking condoms.

~ ART service provider

The majority of ART service providers reported that most of their clients are not interested in FP services. The service providers attributed resistance toward condom use and family planning among their clients to religious beliefs, negative attitudes and beliefs toward condoms and family planning, and client

nondisclosure of sexual activity to the counselor. However, service providers at the ART center in Mbarara reported that many of their clients are interested in family planning. They, however, added that most clients are initially not interested in family planning, but through the routine health talks, they become interested—particularly once their health improves.

Within PMTCT settings, opinions were divided among service providers. However, all providers reported that while the women would prefer to use condoms to avoid HIV re-infection and possible side effects of other contraceptive methods, the men do not want to use condoms. As a result, some women do not use any FP method, while others secretly use other contraceptive methods.

Sources of FP Methods Currently Used by Clients

My husband sometimes buys one packet of condoms for us to use. If he doesn't have money, we play sex without a condom. …Men are inconsistent in using these methods. Today, he might use a condom and the other day he refuses.
~ FGD for PMTCT clients

Results from the exit polls show that 51 percent of all clients have received FP information and services from their respective HIV/AIDS centers. Among those currently using family planning, 39 percent get FP devices from these centers (see Table **5.4**). Those who are unable to use the methods provided by the HIV/AIDS centers or for some reason could not access FP devices at the centers go to other health units or buy from shops/pharmacies. This was found most often among male ART clients and sexually active female clients. Although condoms are provided free at the HIV/AIDS centers, some PLHAs do not disclose that they are sexually active, and therefore, cannot access condoms from the ART centers. In addition, stockouts of contraceptives necessitate clients to search for supplies elsewhere.

Yesterday, I wanted to get an injection for family planning. When I reached the FP Clinic, they told me that it is now a month since the drugs for FP injections got finished. I was sent to Mbarara Hospital but I did not have 1,000/= [Ugandan shillings] to buy the drugs from the pharmacy.
~Female FGD for VCT clients

In addition, some women look for FP services elsewhere because they find the methods provided at HIV/AIDS centers unsuitable for them. This includes women with sexual partners who refuse or are unable to use condoms. However, many PLHAs are uncomfortable seeking the services elsewhere, especially if it involves spending money; and therefore, they do not access FP services and put themselves at increased risk for unintended pregnancies and STIs.

Table 5.4: Sources of FP Information and Services Used by PLHAs

Ever received FP information and services from this facility	Type of Service				Total (n=76)
	VCT		ART		
	Sex of Client		Sex of Client		
	Male (n = 13)	Female (n = 17)	Male (n = 21)	Female (n = 25)	
	Col %	Col %	Col %	Col %	Col %
Yes	54	47	57	48	51
No	46	53	43	52	49
Total	100	100	100	100	100
Source of FP methods currently used[5] *(multiple responses possible)*	**(n=6)**	**(n=4)**	**(n=8)**	**(n=10)**	**(N=28)**
This facility	71	17	50	25	39
Another health unit	43	17	17	19	22
FP clinic	-	17	-	6	5
From shop/pharmacy	43	33	8	25	24

Source: Exit poll interviews.

5.4 Satisfaction with Existing Services

> *Service providers should give condoms to all clients rather wait for them to ask. This is because clients usually shy away before the counselors for fear of being accused as being highly sexually active.*
>
> ~ Male FGD for VCT clients

In general, there was wide dissatisfaction among the PLHAs about the limited range of FP services most of the HIV/AIDS centers were offering. Condoms and FP counseling remained the most prominent services offered at most HIV/AIDS facilities. The problem of the limited range of FP services mostly affected VCT and ART facilities because PMTCT services are provided in antenatal clinics within hospitals. PMTCT clients who need additional FP services are simply referred to the FP clinics within the same setting. Likewise, VCT and ART units situated within hospitals also tended to refer their clients to the hospital FP units for any specialized FP services. Although such FP clinics are reported to offer a wider range of FP services, they sometimes lack the necessary supplies and may not help clients at their hour of need. Furthermore, as indicated earlier, most PLHAs felt they are not properly handled in such public facilities and prefer to obtain all the services in their respective HIV/AIDS centers.

> *The first and biggest challenge (of integration) is to find out why we have low demand for FP services. I am saying this because we give information, provide condoms but our clients still get pregnant.*
>
> ~Counselor, VCT

According to FGD participants at VCT and ART centers, FP concerns are not given adequate attention during FP sessions—attributed to the large volume of clients and the prioritization of ART issues over family planning. Clients at both ART and VCT centers reported usually spending a whole day at the centers to receive all the required services. Some ART clients felt that family planning was not a priority at ART facilities and that the condoms were given to PLHAs for prevention of HIV re-infection rather than for FP purposes. Some also felt that ART service providers are not confident enough to discuss FP issues in detail and, therefore, refer clients to FP clinics when they are asked to provide more information.

[5] Natural and permanent methods are excluded since the table presents data on sources of FP information and services.

FGD participants noted that FP services were offered when requested by the client or based on the provider's assessment. Because some clients do not disclose their sexual activity to their service providers, their assessment may be inaccurate and, therefore, clients do not receive adequate FP services. Some FGD participants do not ask for a sufficient amount of condoms because they are encouraged by providers to limit their sexual activity to preserve their health.

In summary, there was near universal knowledge of family planning among PLHAs—although knowledge of methods was limited to condoms, pills, and injectables. Many sexually active clients felt at risk of unintended pregnancy and a third of them were either not using any contraceptives or were relying on traditional FP methods such as periodic abstinence. There were wide variations between sexes with regard to fertility preferences, with men preferring more children than women. The gender differences in the ideal number of children preferred among respondents also indicate that female PLHAs are likely to come under pressure from their male spouses to produce more children. Non-use of contraceptives by PLHAs who feel they are at risk of unintended pregnancy could be linked to poor accessibility to FP services or the barriers that have been highlighted above. These issues clearly point to the need to improve accessibility and the range of FP services for PLHAs to enable those who wish to have more children to make informed fertility choices and minimize the risk for unintended pregnancies.

PLHAs would prefer a wider range of services to be available in HIV/AIDS centers. The limited range of available FP options increases vulnerability to unintended pregnancies. Furthermore, reliance on the provider's assessment or the client's initiative to demand FP services may be unproductive since the provider may fail to make the correct assessment of the FP needs or the client may feel nervous or shy about mentioning FP needs to a provider who may not condone sexual activity among HIV-positive clients.

6.0 PERCEPTIONS OF THE NEED FOR FP AND INTEGRATED SERVICES

This chapter presents the perceptions of the need for and importance of delivering FP services in VCT, PMTCT, and ART settings from the perspectives of clients, service providers, and policymakers. It also illustrates providers' experiences of delivering integrated FP and HIV/AIDS services.

6.1 Clients' Perceptions of the Need for Family planning among PLHAs

Findings from all the FGDs reveal a general consensus among female and male participants about the need for family planning among PLHAs. A number of socioeconomic and health-related reasons were proposed as to why it is essential for PLHAs to receive FP services. Men and women both noted the following socioeconomic reasons:

- PLHAs are very concerned about how their children will be cared for if they die.
- Most PLHAs are unable to cater to their basic needs and those of their families because of poor health, which does not enable them to be as productive as they should.
- To stay healthy and fend off opportunistic infections, PLHAs have to spend beyond their means on nutrition and medical care, which leaves little or no income to take care of other family needs.
- Due to poverty, mothers with HIV are often forced to breastfeed their babies because they cannot afford to buy milk and other food supplements for their babies, which increases the risk of mother-to-child transmission.
- PLHAs may have a shorter time to live and having fewer children lessens the burden on society, which has to take of the orphans left behind.

The health-related reasons cited included the following:

- (The inaccurate belief that) pregnancies reduce the immunity of the mother and make her much more vulnerable to opportunistic infections, which puts her life and that of the baby at great risk.
- Although PMTCT services are now available, there is no guarantee that the child would be HIV-negative.
- PMTCT services are only available in a few selected centers (hospitals), which are not readily accessible to the majority of expectant mothers.
- (The inaccurate belief that) HIV/AIDS destroys a woman's vaginal linings and when she gives birth, these linings get severely damaged and torn, which further affects her health.
- An HIV-positive woman whose immune system is severely compromised may have a more difficult labor and delivery, putting both her life and the life of the baby in jeopardy.
- If a woman gets pregnant while on ART, medical providers may discontinue or change the regimen during the first trimester because of the potential risk to the developing fetus; the impact of this change on the mother's health is unknown.
- The misconception that unprotected sex between a partner on ART and one who is not yet on ART can cause an "underdose" of ART to the partner not yet on treatment, which could cause drug resistance in that person.

Results of the exit polls also supported the FGD findings that PLHAs had a need for family planning. Most respondents (88 percent of the female and 61 percent of the male ART clients and 68 percent of the female and 58 percent of the male VCT clients) indicated that the ideal number of children they would want to have is the number they already had or fewer. In addition, 45 percent of PLHAs reported being

sexually active in the past six months; of these, 52 percent of the females and 23 percent of the males reported that they (or their partners) were at risk of unintended pregnancy.

Table 6.1: Child Preferences and Risk of Unintended Pregnancies

Characteristic	Type of Service				Total (n=76)
	ART		VCT		
	Sex of Client		Sex of Client		
	Male (n = 13)	Female (n = 17)	Male (n = 21)	Female (n = 25)	
	Col %	Col %	Col %	Col %	Col %
Number of children*					
1–2	8	18	24	24	20
3–4	46	47	19	20	30
5–7	39	24	19	36	29
8 or more	8	12	38	20	21
Total	100	100	100	100	100
Ideal number of children desired					
None				4	1
1–2	15	6	5	8	8
3–4	46	47	57	32	45
5–7	8	35	19	44	29
8 or more	31	12	19	12	17
Total	100	100	100	100	100
Difference between number born and ideal number desired					
Ideal number is less than those already born	46	41	29	36	37
Ideal number is the same as those already born	15	47	29	32	32
Ideal number is higher than those already born	39	12	43	32	32
Total	100	100	100	100	100
Have you had sexual intercourse last six months?					
Yes	46	29	52	48	45
No	54	71	48	52	55
Total	100	100	100	100	100
Do you think you are at risk of getting an unintended pregnancy?					
Yes	8	18	24	44	26
No	92	82	76	56	74
Total	100	100	100	100	100

*All respondents had at least one child.
Source: Exit poll interviews.
Note: Totals may sum to over 100 because of rounding.

Men are so rigid. They like producing children even at the age of 90 years.
~ Female FGD for VCT clients

However, there was some disagreement regarding the appropriateness of family planning as a program targeting PLHAs. Among PLHAs who felt that HIV-positive people should not have children, there was concern that promoting family planning may encourage PLHAs to have more children and would undermine or replace the consistent use of the condom. According to this group of clients, only condoms should be promoted.

Others argued that PLHAs, like HIV-negative people, have the right to decide whether to have more children or not. They felt that PMTCT services reduced the risk of perinatal transmission enough to allow for HIV-positive people to have children.

6.2 Service Providers' Perceptions of the Need for FP among PLHAs

All the VCT, PMTCT, ART, and FP service providers interviewed felt that PLHAs had an urgent need for FP services:

"Socially and psychologically, the way we live, we tend to have many children. But persons living with AIDS are not able to work and produce food or provide care for the children. Even those who are employed are chased from their jobs when they become weak and incapacitated. They sack them because of absenteeism from work. In line with this they may not care for the children, and after death the number of orphans becomes higher and sometimes the orphans are left under the care of people who may be themselves infected and unable to work. Then there is also a bigger possibility that they will pass on the infection to the children." ~ Counselor, VCT

"Some men insist that they want children despite the fact that their wives are HIV positive. Some women say that their husbands don't want to use FP methods, and their husbands don't come for counseling."

~ Counselor, VCT

6.3 Perceptions toward Integration of FP and HIV/AIDS Services

Clients' Perceptions toward Integration of FP and HIV/AIDS Services

Results from FGDs and exit poll interviews show that there was near universal agreement of PLHAs in support of integrating FP and VCT, PMTCT, and ART services and programs (see Table 6.2). PLHAs are much more comfortable receiving services at their respective HIV/AIDS centers because they are familiar with and confide in the service providers. They also felt that integrated services reduced the incidence of stigma that they face when accessing FP services elsewhere.

Respondents felt that integrated services would save time and money spent obtaining FP services elsewhere. Furthermore, female VCT clients in a number of FGDs pointed out that full integration of the FP and HIV/AIDS services would assist them in changing their partners' negative attitudes toward family planning.

…The health workers in the hospital discriminate against us when they know you are from TASO. When a TASO client goes to Mbarara Hospital, the health workers there take you as a gone case. They say: Don't you have drugs at TASO? Do not squeeze (inconvenience) our patients.

~ Female FGD for VCT clients

Obtaining FP services from here would save us from the embarrassment we face when we go to FP clinics outside TASO. You know service providers in such places ask us very funny questions like 'you are young, why do you go for this FP?' And since you fear to disclose your status, you don't answer.

~ Female FGD for VCT clients, Jinja

Table 6.2: Need for Integration of FP with HIV/AIDS Services

Whether FP services should be provided together with ART/VCT services	Type of Service				Total (n=75)
	ART		VCT		
	Sex of Client		Sex of Client		
	Male (n = 13)	Female (n = 17)	Male (n = 20)	Female (n = 25)	
	Col %	Col %	Col %	Col %	Col %
Yes	92	88	100	96	95
No	8	12	-	4	5
Total	100	100	100	100	100

Source: Exit poll interviews.

Policymakers' and Service Providers' Perceptions toward Integration of FP and HIV/AIDS Services

Among policymakers, managers, and counselors interviewed, there was general agreement that HIV/AIDS prevention, care, and treatment is needed to address family planning and reproductive health to minimize further spread of HIV and to optimize the quality of life for PLHAs and their families. Policymakers and program directors also noted that provision of FP and HIV/AIDS services would be cost-effective and time-efficient for health providers and clients. Nonintegrated services promotes the duplication of services at different facilities. As a result, the access and quality of services are compromised.

In summary, both policymakers and service providers appreciated that HIV/AIDS services need to incorporate FP/RH services to reduce the incidence of HIV transmission and optimize services for PLHAs. Among clients, there was equally near-universal agreement in support of integrating FP services with the three (PMTCT, ART, and VCT) HIV/AIDS services. However, providers reported that uptake of FP methods other than condoms at these facilities is low. This low uptake, perceived by providers as a lack of interest in family planning, may be attributable to several barriers, including the actual and perceived side effects and efficacy of some FP methods; the limited range of methods available in HIV/AIDS settings; male dominance over sexual decisions; and difficulties associated with disclosure of sero-status to spouses. Furthermore, providers give the impression that HIV-positive people should not be having sex or additional children, so clients are caught in a dilemma; they feel that they cannot ask for contraceptives as that implies that they are sexually active.

We used to refer clients to Mulago hospital say for Depo-Provera; you would be very lucky that the people would actually reach those places. We carried out a study on TB but found out that less than 50 percent of the client would actually go there.

~ Senior official, AIC

Given that a good number of VCT clients are sexually active and most of them, especially women, would like to have children, they need to get knowledge as to when they can get children and what FP methods to use if they are going to continue to be sexually active.

~ Senior official, MOH

I see this area as an emerging issue for prioritization. In less than a year, I think it is going to be a priority.

~ Senior official, UAC

7.0 IMPLICATIONS AND BARRIERS TO DELIVERING FP AND HIV/AIDS SERVICES

This chapter presents implications of delivering FP services in VCT, PMTCT, and ART settings from the perspective of policymakers, service providers, and clients. Both integrated and nonintegrated settings were evaluated; therefore, the findings reflect both real experiences and perceptions of what it is needed to effectively deliver integrated FP and VCT, PMTCT, and ART services. This chapter also highlights the existing and perceived barriers of delivering integrated services.

7.1 Policy Implications

As was mentioned earlier, most policymakers see family planning as a crucial and integral component of holistic HIV/AIDS prevention and care. They feel that integration would optimize facility resources, space, and personnel and is the most effective approach to scaling up access to FP services, particularly for PLHAs.

> *I went to one health centre which had only three staff members. One had gone to attend a workshop, another one had not reported on duty. There was only one health worker who was trying to do immunization and general healthcare. She had to handle immunization, which she thought was a priority. So, with such understaffing, areas like immunization take priority over other issues like family planning.*
>
> ~ Senior official, MOH

Staffing shortages and worker burnout are major challenges facing the healthcare sector. For some time now, as part of the World Bank/International Monetary Fund-supported public sector reform strategy, in an effort to limit public spending, there has been a hiring freeze, leaving the public service sector largely understaffed. The existing staff, particularly those engaged in direct service delivery, feel overworked and unmotivated and, therefore, unwilling and unable to take on extra responsibilities, such as FP counseling. Similarly, another study found that inadequate staffing, poor remuneration, and weak logistics systems were key challenges to effective integration of VCT into FP, TB, and STI settings (Kalibala, 2002).

As was mentioned earlier, the activities and resources of FP, VCT, PMTCT, and ART services are discrete with little or no crossover with other services under the same department or ministry. For example, the study findings show that within the MOH, family planning is managed under the Reproductive Health Unit, while HIV/AIDS falls under the Communicable Diseases Unit. Despite the overlapping goals between these two activities, they are not linked strategically and run as parallel services. This lack of coordination is compounded by inequity in the distribution of resources among the different service sectors. For instance, HIV/AIDS activities are well-funded, while FP services are under-funded.

> *Sexual Reproductive Health is the one mandated to provide family planning. If I go to a health unit and find no FP supplies, I cannot carry Depo-Provera there. I only take HIV/AIDS supplies.*
>
> ~ Senior official, MOH
>
> *FP is not a disease. Integrating it with illnesses will result in less concentration being given to family planning. For instance, the average counseling session in VCT settings is 30 minutes. One cannot use this time to exhaust all it takes to educate a client on family planning."*
>
> ~ Senior official, MOH

Effective integration of FP into VCT, PMTCT, and ART services also requires a new approach to service delivery—the "one stop shop" design; the approach provides all inclusive services in one place and requires training providers and planners to provide multiple services and to develop their skill set to address a variety of healthcare issues.

7.2 Implications for Service Delivery

As indicated earlier, PMTCT providers and clients as well as policymakers were generally supportive of integrating FP into PMTCT services because it would allow clients to seek services more openly, choose the optimal FP method, and increase FP acceptability and adherence.

> *We don't get enough time with each client because we aim to serve everybody, but we don't exhaust everything they need or want.*
>
> ~ PMTCT counselor
>
> *Maybe we will bore our clients because our sessions will be very long. Teaching about PMTCT and you add on FP teaching and counseling? Clients will become bored and many of them come from very far.*
>
> ~ PMTCT counselor

However, PMTCT providers advised that inadequate staffing, space, and supplies made it difficult to address FP and PMTCT issues in a single counseling session. Service providers were concerned that full integration of FP into PMTCT services might make the counseling sessions unnecessarily long and perhaps boring, particularly for those who do not need FP services. Some of the providers were also worried that clients would feel overwhelmed and become confused. They also felt that frequent stockouts of required FP supplies would frustrate clients.

> *You see here we get clients who come when they are very weak. After gaining weight and good health due to ART, they become sexually active again, so they come and ask how they can avoid pregnancies. In fact, more than 70 percent of our clients are interested in family planning.*
>
> ~ Counselor, ART
>
> *They just continue getting pregnant anyhow. When FP services are fully available here, we will be able to sensitize them about the issue.*
>
> ~ Service provider, ART

ART providers acknowledged that family planning is becoming a crucial intervention in HIV/AIDS prevention, especially as access to ART increases. They noted that as ART clients regain their health, they are becoming sexually active again; therefore, family planning is essential to reducing the number of clients getting pregnant and the risk of HIV transmission.

However, no integration has taken place in ART settings beyond the provision of condoms. Providers were concerned that the increased workload would negatively affect the quality of services.

Similar to the PMTCT providers, ART staff did not think that there was enough time to provide FP and ART services in a single session. They felt that because ART is a new service and clients and their caretakers are still adjusting to the new drugs, the introduction of FP information and devices was likely to confuse them and impact negatively on treatment adherence. In addition, ART providers also expressed fear that with the current misunderstanding of FP objectives, clients who want to have children may be discouraged from accessing ART services. Some ART service providers believed that integration also requires a revision in the newly ratified ART policy and guidelines from the MOH.

> *Even with the few things we are offering without FP, we are leaving offices late in the night. If the number of people at present overwhelms us, what will happen if FP is added on?*
>
> ~ Counselor, ART
>
> *It will also need a change in policy of ART to include FP. There is need to develop a work plan from the Ministry of Health that includes the integration of the two services.*
>
> ~ Counselor, ART

Both AIC and TASO, the organizations that provide VCT services covered by this study, have made significant efforts to integrate family planning into their

services. However, the scope of these services is still limited to nonsurgical contraception and referrals to specialized FP providers. Both organizations reported that integration of FP into VCT services is feasible and that the cost of integrating has been minimal.

By adding the services, I think we reach out to the people who would not come for the services and the marginal cost is very small compared to the results.

~ Senior official, AIC

Financially, family planning is a small component, so cost is not a big problem. It is just training and capacity building that are needed.

~VCT official, TASO

When you talk about abstinence, condom use and then introduce family planning, clients tend to get confused. This is why integrating family planning has been a challenge to both our clients and staff like the counselors.

~ Counselor, VCT

However, despite the availability of services, use is still very low. Most of the clients, especially those who are HIV positive, report no sexual activity, while those who are HIV negative either do not use FP services or access services from other sources.

Providers also reported that although they provide FP services, there is a fear that promotion of other FP methods, besides a condom, may have a negative affect on the use of condoms. They argued that promotion of FP methods such as pills, coils, or injectables may increase the risk of HIV transmission among HIV-positive clients who were otherwise using condoms. In addition, providers reported that discussion of family planning tends to confuse clients, since some FP methods and strategies are also used to reduce risk of HIV transmission.

Again, the volume of case loads and time allotted for counseling sessions were cited as challenges in delivering family planning in VCT settings. It was reported that, on average, each counselor meets with 30 to 50 clients per day, and as a result, sessions are hurried, affecting the quality and impact of counseling.

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7.3 Barriers to Use of Integrated FP and HIV/AIDS Services

Clients also cited understaffing, a high volume of case loads, and long waiting times for services as barriers to HIV/AIDS service delivery. FGD participants in each of the HIV/AIDS services settings felt that that integration of FP with HIV/AIDS services would worsen the already bad situation.

Some PLHAs felt that introducing FP services into HIV/AIDS services is tantamount to telling PLHAs to go and produce more children, which contradicts previous messages they received from their providers discouraging sexual activity and unprotected sex; while others felt that promotion of family planning in HIV/AIDS facilities was to discourage PLHAs from having children, which may deter some from accessing services.

Fear of disclosure and side effects and misconceptions about FP strategies discourage PLHAs from accessing FP services. FGD participants reported that because some clients have not disclosed their serostatus to their partners, they do not use FP methods for fear of revealing that they are HIV positive. Additionally, possible health-related side effects of various FP methods are a major source of anxiety among PLHAs; some expressed concern that using FP methods may result in further deterioration of their health.

Other women fear that family planning causes them boils in the womb and that injectables cause overbleeding during menstruation and high blood pressure. There is fear that if a woman uses FP methods, she can spend three years without menstruation periods. Family planning is feared because women say it kills the desire for sex, it reduces vaginal fluids and if you play sex with a man who has given you his money and finds you dry he can beat you up.

~ Female FGD for VCT clients

Although the level of general awareness about family planning was high among PLHAs, there were a number of misconceptions cited regarding reasons for not accessing FP services. In one FGD, a participant reported that one of the major reasons why men fear a vasectomy is because the surgical operation involves opening up the ribs, which would lead to the deterioration of one's health. In another FGD, it was reported that some FP methods made sex less enjoyable and caused cancer.

In summary, policymakers and VCT, ART, and PMTCT service providers realize the need to scale up access to FP services for people affected by HIV/AIDS and acknowledge that integrating family planning into existing HIV/AIDS services is the most cost-effective and sustainable way to effectively integrate these services. The staffing capacity of health units and motivation of the available manpower remain crucial to any transition into an integrated approach to service delivery. While integration has improved access and use of services, it has stretched the already limited resources of provider organizations, particularly physical infrastructure and staff. This has resulted in extended counseling and medical sessions and ultimately long waiting hours for clients. Integration has also raised client expectations for a full range of FP services. However, the providers, particularly those offering VCT, are averse to the introduction of comprehensive FP services, arguing that this may affect the quality of their core services.

8.0 CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

With an HIV prevalence rate of 7 percent, a total fertility rate of seven per woman, and an unmet need of 34.6 percent, Uganda has a need of HIV/AIDS prevention, care, and treatment, as well as a continued need for FP services. This study evaluated the need for, experiences with, and challenges facing the integration of services from the perspectives of the client, policymaker, and program planner.

The national response to the HIV epidemic in Uganda has come from both the private and public sectors. To coordinate the diversity of responses and to ensure a minimum level of quality of services, many policies and guidelines have been developed to provide guidance. These policies and guidelines feed into and support the National Overarching Policy on AIDS (NOPA), which is the overarching policy and planning framework for HIV/AIDS in Uganda. With regard to FP service delivery, services are guided by the National Reproductive Health Policy, which is the overarching framework for policy and planning for reproductive health, including family planning.

Given the high prevalence of HIV and the high fertility rate in Uganda, policymakers and program managers and staff recognize the need to include FP/RH components within the main HIV/AIDS interventions of VCT and PMTCT and, to some extent, ART. However, the extent to which HIV/AIDS policies address FP issues currently varies across these services. For instance, both the VCT policy currently under review and the PMTCT policy that is being revised address family planning; however, the existing ART policy does not address family planning. From the FP perspective, integration with HIV/AIDS services is addressed in the National Reproductive Health Policy and its companion, the National Policy Guidelines and Service Standards for Reproductive Health, and in the National Family Planning Advocacy Strategy.

At the service delivery level, integration of FP concerns in a HIV/AIDS setting is equally varied across HIV/AIDS services. Family planning is an integral component of VCT services and is also evident in PMTCT settings, although the focus is on provision of FP information and a limited range of nonsurgical contraceptives, particularly condoms. Within the ART setting, family planning is only minimally addressed. There are no formal referral or feedback mechanisms in place in any of the HIV/AIDS service settings.

Most counselors in VCT, PMTCT, and ART facilities had received some level of FP training in counseling and contraceptive methods. ART counselors found FP training to be particularly useful to the extent that even in ART settings where there were no policies to support integration, counselors were able to provide some FP information to clients on their own initiative. However, the absence of protocols and guidelines regarding FP services within the HIV/AIDS setting is challenging for direct service providers.

Knowledge of and agreement about the need for family planning was high among PLHAs for both economic and health reasons. PLHAs preferred to receive these services from providers who know them and their status. The majority of PLHAs accessing PMTCT, VCT, and ART services are sexually active and, therefore, need FP services and information. However, providers tended to advise clients to reduce sexual activity in order to avoid pregnancy and maintain their health. Forty-five percent of the HIV-positive women and men who participated in the exit interviews reported that they had been sexually active during the past six months; however, most providers said that uptake of contraceptives is low at their centers. Service providers may be underestimating the need for FP services among their HIV-positive clients because the clients do not feel comfortable discussing their sexual activity with their provider.

Findings from FGDs with clients indicate several factors that likely contribute to low use of FP methods among HIV-positive clients, including actual and perceived side effects, misgivings about the efficacy of some FP methods, the limited range of methods available in HIV/AIDS settings, male dominance over sexual decisionmaking, and nondisclosure of serostatus and sexual activity.

A considerable proportion of sexually active clients felt at risk for unintended pregnancy, yet a third of them were either not taking any contraceptives or were relying on traditional FP methods such as periodic abstinence. There was a wide variation between sexes regarding fertility preferences, with men preferring more children than women. The gender differences in the ideal number of children among respondents also indicate that HIV-positive women are likely to come under pressure from their male partners to have more children. Nonuse of contraceptives by PLHAs who did not want any more children highlight the need to improve access to and the range of FP services for PLHAs to make informed fertility choices and minimize the risk for unintended pregnancies.

PLHAs did not all agree on the appropriateness of family planning as a program targeting PLHAs and whether PLHAs should have children at all—planned or unplanned. Some PLHAs feared that promoting FP services among PLHAs might undermine efforts to mitigate the health and economic effect of HIV/AIDS on the infected and affected. Others argued for the rights of PLHAs to have children. The views of providers and PLHAs have programming implications for future efforts to expand delivery of FP services in HIV/AIDS settings. In fact, this could partly account for the low use of FP services other than condoms and the reluctance of clients to broach FP issues in their sessions with providers.

Clients expressed a desire for a wider range of services at HIV/AIDS centers. They also noted that FP services are only offered when requested by the client or as a result of a provider's assessment of client needs. The limited range of available FP options and stockouts increases vulnerability to unintended pregnancies. Furthermore, reliance on the provider's assessment or the client's initiative to demand FP services may be unproductive when the provider fails to make the correct assessment of the FP needs or the client does not feel comfortable initiating a discussion about FP needs to a provider whose preferred option for the client is abstinence.

Misconceptions and misinformation surrounding family planning among PLHAs may also hinder use of FP services. Some respondents felt that family planning was a means of controlling the fertility of HIV-positive people. In addition, clients were unsure of the scope of FP services to expect from VCT, PMTCT, and ART facilities. It was not clear to both clients and providers whether the services target entire communities or only those seeking VCT, ART, and PMTCT services. It appears the latter is the most acceptable to both PLHAs and providers—given that VCT, ART, and PMTCT organizations need to remain committed to their mandates and clientele.

Nevertheless, PLHAs overwhelmingly supported the integration of FP within HIV/AIDS services settings. They felt that it would save time and money, allow clients to seek services from providers they already knew, and support women to change the negative attitudes of their male partners toward family planning. Policymakers and providers were also supportive of integration as a means to cut costs and reduce duplication of services.

However, providers, policymakers, and clients cited limited resources—particularly qualified personnel, space, and supplies—as a major barrier to integrating FP into HIV/AIDS services. ART providers were particularly wary that integration of FP into ART services may be disruptive given that ART is a new service. On the other hand, both TASO and AIC, who are the major providers of VCT services in the country, have demonstrated—to an extent—that integration is feasible and that the cost of doing so is marginal. Hence, the current reluctance by public service providers toward embracing the concept of

integration may be largely due to the fear of the unknown, the current lack of coordination between national HIV/AIDS and FP programs at all levels, and variations in sources and amount of funding available for different programs. For integration to succeed, all these issues need to be carefully addressed, as they are likely to cause tension and resistance to any attempts made toward integration.

8.2 Recommendations

- Policymakers should be sensitized to the desire among HIV-positive women and men for access to contraception to help them have the number of children they want.

- Policy on and implementation of HIV/AIDS and FP services need to be harmonized to enhance joint planning and inter-service coordination to take advantage of synergies among the programs.

- With vertical public health programs for HIV and family planning, even if policies are integrated, the programs and services must be linked or integrated, which requires attention to policy implementation to surmount the current organization of programs that are under different lines of authority in the MOH. For example, harmonized (and greatly strengthened) logistics systems would help avoid stockouts, which were reported to be a huge issue, particularly in the public sector provision of FP and HIV services. Human resource allocations should be jointly determined. The FP division's plan to appoint a focal point for PMTCT is laudable. Such focal points should be appointed across the programs to help ensure integration. A coordination unit could be established to supervise the integration process.

- The ART policy was found most lacking in addressing FP concerns, despite the need for FP integration expressed by ART clients. Policymakers should quickly address this gap and provide adequate guidance to service providers on FP provision for HIV-positive clients.

- Currently, ART providers, most of whom have received training from TASO, take it upon themselves to provide FP counseling; however, there is no system to ensure that these counselors—and providers in other HIV service settings—have the most current information on FP use among HIV-positive clients. Counseling training can be further integrated and strengthened, with standard guidelines from MOH.

- Despite the near universal knowledge of family planning among PLHAs, many still hold several misconceptions about contraceptive methods. There is a need to develop targeted messages specifically addressing these misconceptions.

- Provision of FP services appears to be passive in HIV settings. In some VCT settings, clients receive information only if they ask for it. Provision of information and methods should be more proactive by providers, backed up by guidelines and protocols.

- Systems for referral are currently informal. Feedback systems could be established so that providers know if clients who receive referrals actually seek the services.

- Given the current constraints in coverage, staffing, range of FP services, and space in HIV/AIDS settings, it is likely that HIV/AIDS facilities will continue referring clients who require body-invasive contraceptive methods (clinical methods such as the intrauterine device and male and female sterilization) to specialized FP clinics. Consequently, FP providers need to be sensitized to serving HIV-positive clients without judgment. HIV-positive clients should not feel that they are being discouraged from having sex or using contraception.

- Data on fertility preferences suggest that female PLHAs are likely to come under pressure from their male partners to produce more children—since males generally prefer larger numbers of children. Programs should pay closer attention to sensitizing men to the need for and the benefits of family planning and to meeting their needs. At the same time, there is a need to increase women's access to female controlled methods.

APPENDIX 1: Data Collection Instruments

Category of Respondent/Informant	Title of Instrument
Policymakers	Policymakers Questionnaire
	PMTCT National Coordinator Questionnaire
	VCT National Coordinator Questionnaire
	ART National Coordinator Questionnaire
	ART Program Director Questionnaire
	FP Program Director Questionnaire
	VCT Program Directors Questionnaire
Service Providers	VCT Center Managers Structured Questionnaire
	PMTCT Center Managers Structured Questionnaire
	ART Center Managers Structured Questionnaire
	PMTCT Service Providers Questionnaire
	ART Service Providers Questionnaire
	VCT Service Providers Questionnaire
	FP Service Providers Questionnaire
Clients	VCT Exit Polls Questionnaire
	ART Exit Polls Questionnaire
	ART FGD Checklist
	PMTCT FGD Checklist
	VCT FGD Checklist

APPENDIX 2: Emerging HIV/AIDS Issues and Challenges

This chapter highlights some of the important issues and challenges that are not necessarily related to the integration of FP with HIV/AIDS services but emerged out of the discussions held with the clients of PMTCT, VCT, and ART services. These issues are of strategic significance to the delivery of improved HIV/AIDS services, especially in the area of care and treatment.

Staffing in HIV/AIDS Facilities

Whereas the issue of staffing was discussed earlier on, it is important to highlight its significance to the quality of care. While understaffing and high client load were found to be major problems in each study site, their impact on the quality of care is most severe in government facilities. In the Mbarara Hospital, for example, expectant mothers in the PMTCT program reported that some of them did not know why they were given nevirapine and some had not been counseled on safe infant feeding practices. This indicates that some PMTCT programs are not providing basic information and services to HIV-positive women to help reduce the risk of transmitting HIV to their children.

> *The doctors are always not available when a woman wants to test for HIV/AIDS. We also lack HIV/AIDS counseling; sometimes a person even fails to meet health workers. We lack sensitization; some mothers don't even know whether they should breastfeed or not.*
>
> ~ FGD for PMTCT clients

Access to HIV/AIDS Services

Access to HIV/AIDS services still poses a major challenge and may be most acute for those in need of ART. Some clients of the Infectious Diseases Center (IDC) in Mulago reported to be traveling from areas as far away as Kiboga (130 kms away from the center), as much as every two weeks, in order to access ART services. Many clients advised that they have difficulty covering their travel expenses and have to endure thirst and hunger as they wait for up to two days to be served.

> *Our children are born with HIV/AIDS, you can see that your child is sick, some even have symptoms for AIDS but there are no services for them at TASO. …So when we get drugs from TASO, we share with them.*
>
> ~ Female FGD for VCT clients

ART access issues within households has created a moral dilemma for many ART clients who are forced to choose whether to take the medication as prescribed or share it with family members who are also in need but do not have access to ART. Since many clients choose the latter, these individuals are unable to optimize their treatment and risk developing drug resistance.

Implications of Availability of HIV/AIDS Drugs

Availability and access to proper treatment and care services has improved the health and extended the lives of many PLHAs. Nevertheless, this has both negative and positive social consequences. Availability of services, such as PMTCT services, allows PLHAs who wish to have children to do so; however, these parents may not live long enough or remain healthy enough to support their children, and as a result, eventually add to the country's orphan and poverty problem. Access to ART may also lead to complacency around safer sex and result in people engaging in unsafe sexual activity.

Meeting these challenges requires the continuous engagement of the population in terms of sensitization, so that those already infected continue living positively while the non-infected remain mindful to avoid infection.

Protection of Discordant Couples

Interviews with VCT officials revealed that about 15 percent of couples receiving VCT services at AIC centers are sero-discordant. At the same time, there are many PMTCT and VCT clients who have never disclosed their HIV status to their sexual partners, which puts their partners at a high risk of getting infected. In addition, some male PLHAs deliberately refuse to use condoms or abstain from having sex with their wives who are still HIV-negative, even when they know and have been warned by HIV/AIDS counselors that continuous exposure to the virus increases the likelihood of their partner contracting the virus.

> *I have been handling a couple from Kabale; the man is HIV-positive, the woman is negative but the man has refused to use condoms. We have counseled him day after day but he has refused.*
>
> ~ Counselor, ART

Poverty among PLHAs

Poverty was repeatedly mentioned as a major problem among PLHAs. Many PLHAs cannot afford to buy themselves the nutritious foods they need to stay healthy let alone send their children to school. In fact, some of the PLHAs who had regained their health after receiving ART were very worried because they had regained their appetite but had nothing to eat.

TASO has taken some steps to address the situation by extending loans and providing food baskets to some of its clients. However, only a small fraction of those in need are receiving these benefits. The government needs to assess the TASO approach with the aim of replicating it countrywide.

> *For us here, we need financial assistance to help us cater for transport. Some of our colleagues, on top of being already weak physically, are not working and come from far away places like Kiboga. They cannot find money for transport and food in order for them to come here for treatment. Me, I came here today at 9:00 a.m and right now it is 4:00 p.m. and I have not had anything to eat yet doctors say I have to feed well. But how can I achieve that when I only have money for transport? If I use it to eat, I will have no transport back yet I am taking very strong drugs that require frequent eating.*
>
> ~ Female FGD for ART clients

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