

**Provision and Use of Family
Planning in the Context of
HIV/AIDS in Zambia:
Perspectives of Providers,
Family Planning and
Antenatal Care Clients, and
HIV-Positive Women**

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARVs	Antiretroviral drugs
BCC	Behavior change communication
CBOH	Central Board of Health
CSO	Central Statistics Office
FGD	Focus group discussion
FHI	Family Health International
FP	Family planning
HIV	Human immunodeficiency virus
MCH	Maternal and child health
MOH	Ministry of Health
NGO	Nongovernmental organization
NZP+	Network of Zambian People Living with AIDS
PMTCT	Prevention of mother-to-child transmission
PPAZ	Planned Parenthood Association of Zambia
PRB	Population Reference Bureau
RH	Reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
ZDHS	Zambia Demographic Health Survey

Executive Summary

In the context of the HIV/AIDS pandemic, is there still a need for family planning? As government and donor resources in Africa shift increasingly to support AIDS programs, the answer to this question is crucial. The objective of this study was to document the status and trends in Zambia's family planning (FP) program in the context of high prevalence of HIV/AIDS. A similar study was conducted in Kenya.

This qualitative research study used focus group discussions (FGDs) to examine the views of 215 service providers, HIV-positive (HIV+) women, and FP/antenatal care (ANC) clients on the need for family planning within the context of the HIV epidemic. The study was conducted in Lusaka, Livingstone, Kitwe, and Kabwe in 2003.

Findings

Background of participants

Sixty-eight service providers between the ages of 30 and 45 were interviewed for this study, most of whom were midwives who had worked in the clinics for at least two years. Seventy-eight FP/ANC clients participated in this study, most of whom were married women between the ages of 30 and 45 who used the injectable and wanted to have more children. Most of the 68 HIV+ women who participated in this study were single or widowed, between the ages of 26 and 45, and did not want to have another child.

Demand for FP services

Discussions with providers, HIV+ women, and FP/ANC clients revealed that, due to the HIV/AIDS epidemic, more women were seeking FP services for fear of getting pregnant. The FP/ANC clients said they had the impression that more people were using FP services to avoid having HIV-infected children, and the HIV+ women wanted to avoid reinfection that would increase their viral load and leave behind orphans.

Accessibility and availability of FP services

Participants generally felt FP services were both accessible and available, and despite concerns for stigma and discrimination against HIV+ women and men, the study revealed that at no time was anyone denied services or discriminated against because of his or her HIV status.

Use of methods: condoms, other contraceptives, dual protection, and dual method use

Among women in the study who used contraceptives, the majority used the injectable. While decisions about contraceptive method use should be based on the need to prevent unwanted pregnancy as well as the need to prevent sexually transmitted infections (STIs) and HIV, study findings showed that women most commonly used the injectable because they did not want their husbands to know about their contraceptive use. This clandestine use clearly makes condom use difficult. The women considered men to be a major barrier to condom use, and they noted the great difficulty of convincing a man to use a condom.

Service providers reported that they faced an ethical dilemma if they advocated contraceptive methods that, while highly effective, put clients at increased risk of HIV. The term "dual method use" is new and

poses several challenges for the provision of FP/reproductive health (RH) services. The providers generally were not aware of Zambia's policy on dual method use.

Most of the HIV+ women and FP/ANC clients were not well informed about methods of contraception and knew little about dual protection or dual method use. This can be attributed to the service providers' inadequate knowledge and failure to counsel.

Integration of FP and HIV/AIDS services

This study showed that there is a clear trend toward the integration of maternal and child health (MCH), FP, and STI/HIV/AIDS services in Zambia, although many challenges remain to further integration. The service providers in this study tended to be dissatisfied with the delivery of family planning for HIV+ individuals, in part due to their own inadequate counseling skills. The providers said that HIV+ women should be provided with accurate, understandable information to enable them to make fully informed choices about their reproductive lives; however, they do not consider themselves adequately trained for that task. HIV+ women generally agreed with that assessment and were frustrated that they were not presented with contraceptive methods and information appropriate for their HIV status. HIV+ women also saw the need to have voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services fully integrated and provided with FP services.

Many of the service providers noted the need for more staff, given that more and more clients were attending the clinics in light of the HIV/AIDS crisis. The providers also noted the need for updated training on contraceptive methods and HIV/AIDS counseling.

Quality of FP services

Both FP/ANC clients and HIV+ women said they trusted the service providers to maintain confidentiality. FP/ANC clients tended to be satisfied with the counseling services offered at the clinic, but both FP/ANC clients and HIV+ women noted many myths and misconceptions about FP methods, some of which made them hesitant to use contraceptives.

Prevention of HIV transmission in the healthcare facility

Findings showed that all of the service providers were concerned about HIV transmission in the workplace. For the most part, basic precautions were taken, including using gloves and sharp boxes, but often when supplies ran out, clients had to buy their own gloves and syringes and were not seen without bringing supplies for providers to use unless it was an emergency. While Zambia does have guidelines on safe procedures and post-exposure prophylaxis, many providers were not aware of the guidelines.

Sustainability of FP services

Both FP/ANC clients and service providers emphasized the need for donors to provide supplies and contraceptives to ensure continuity in the use of FP services.

Suggestions for improving services

The HIV+ women suggested that FP services be promoted and provided by training HIV+ women as FP providers to reach out to their friends. FP/ANC clients stressed the need to improve FP services by including education at places of work on condom use. All three groups suggested that awareness

campaigns on family planning, HIV/AIDS, and VCT be conducted in the community through radio, TV, neighborhood health committees, and drama shows.

Recommendations

The following recommendations emerged from this study in Zambia:

Continuing support for family planning

- The government of Zambia and donor organizations should continue funding FP services. Demand for services is *increasing* rather than decreasing in the context of HIV.
- The government and donors should commit human, financial, and material resources (e.g., syringes, gloves, and contraceptives) to ensure contraceptive security and improve FP, ANC, and HIV/AIDS services.

Targeted integration of FP and HIV activities

- A broad range of contraceptives, including dual methods, should be available through various delivery routes. Clients are more likely to use contraceptives if they are presented with a choice of methods and services that are easily accessible. Contraceptive methods that are appropriate for HIV+ women must be available, and the women must be presented with up-to-date information.
- VCT and PMTCT should be incorporated into the counseling services of FP programs.
- VCT should be promoted so that people know their HIV status and can make decisions on RH issues accordingly.
- FP services at VCT centers should include provision of condoms and contraceptives by trained FP providers.
- The integration of FP and HIV/AIDS services should be taken into account when planning staffing levels, training, and clinic infrastructure. Adjustments to current staffing levels may need to be made to accommodate the growing number of current clients, as well as staff burnout and turnover.
- The availability of female-initiated methods of protection such as the female condom should be increased.

Training for providers

- Providers need training to improve interaction with clients and to update their clinical skills, counseling skills, and FP and HIV knowledge.

Using a variety of communication channels to provide information and behavior change communication (BCC)

- Education programs targeting men, women, and youth should use BCC strategies to teach about VCT, HIV, and FP methods. Television, radio, and drama programs should be used.

- Health programs should include counseling to help men and women improve their communication skills and involve men in FP programs.
- HIV+ women (and men) should be trained as counsellors and FP providers to reach out to others in the community that are dealing with the same issues.
- Male involvement should be promoted through media, workplace initiatives, and clinic outreach.

The aim of FP programs is to improve health status and help individuals and couples meet their reproductive intentions. The need for family planning still exists, especially in light of the growing HIV/AIDS epidemic. The government of Zambia and donors must recognize the continued need for expansion of FP programs that meet the needs of both HIV-positive and HIV-negative persons, and they need to commit the resources to make FP services available to all who need them.

Introduction

Background

Zambia, a landlocked country in Southern Africa, is divided into nine provinces and 72 districts. Of those provinces, only two, Lusaka and Copperbelt, are predominantly urban. According to the Central Statistics Office (CSO), in 2001, Zambia had a population of 10.3 million people with a life expectancy of 48 years. The total fertility rate in 2002 was 5.9 children per woman (Population Reference Bureau (PRB), 2003).

Family planning was first introduced in Zambia in 1972 by the Planned Parenthood Association of Zambia (PPAZ), whose primary objective was to motivate people to accept family planning and to procure contraceptives for the country. In 1982, the FP program was integrated into MCH services within the context of primary healthcare of the Ministry of Health (MOH). The government launched a population policy in 1989. Today, a full range of FP services are available throughout the country. The Central Board of Health (CBOH) (1997) reports that it is Zambian policy that FP services be made accessible to all people of reproductive age.

Over the past decade, Zambia has undergone an extensive health reform process, including a restructuring of the primary healthcare program. The health policy reform has demonstrated the government's commitment to improving the health of Zambians by increasing access to and acceptance of FP information and services.

FP services are currently offered at various government hospitals and by a number of nongovernmental organizations (NGOs) such as PPAZ, Family Life Movement of Zambia, Family Health Trust, and CARE International. Most providers of family planning are enrolled midwives, but also include registered nurses/midwives. Some of these service providers have received training in counseling, growth and monitoring, life-saving skills, and family planning, among other topics.

Since the introduction of FP services, the CSO (2001) reports that contraceptive use in Zambia has increased from 15 percent in 1992 to 26 percent in 1996 to 34 percent in 2001. Knowledge of contraceptive methods is almost universal in Zambia, with 98 percent of all women and men aware of at least one method of family planning.

HIV/AIDS remains a major concern in Zambia due to its high prevalence rates among both youth and adults. According to 2001 CSO data, HIV prevalence, which was estimated at 15.6 percent nationwide at the end of 2001, is twice as high in urban areas as in rural areas (23% and 11%, respectively). HIV prevalence is highest in Lusaka (22%), Copperbelt (20%), and Southern provinces (18%), and lowest in the Northern (8%) and North Western provinces (9%). Nationwide, HIV prevalence is higher among women than men (18% compared with 13%).

To reverse the HIV/AIDS epidemic, the government—through the National HIV/AIDS/STD/TB Council and with the support of donors—has implemented a number of programs to reduce the spread of HIV. Programs have focused on ensuring that individuals, families, and communities have correct and appropriate knowledge and information. A major focus of health interventions is BCC to stem the spread of the epidemic. According to the CSO (2001), general awareness of HIV/AIDS is high among men and women of reproductive age. Eighty-six percent of men and 78 percent of women know two or more effective ways to avoid contracting HIV.

Because methods that are currently available for reducing HIV transmission are male-controlled, prevention efforts for women are seriously compromised. Repeatedly, male resistance to condom use emerges as a major obstacle to interventions that seek to protect women. The CSO (2001) reports that current condom use has increased only from 3.5 percent of currently married women ages 15–49 in 1996 to 3.8 percent in 2001–2002. This is an issue that needs to be addressed, as condoms are the only method that offers protection against both STIs/HIV and pregnancy (although, the condom is more effective in preventing the transmission of HIV than in preventing pregnancy).

Despite the increase in contraceptive usage and knowledge, Zambia still has a high rate of natural increase of 2.2 percent in 2002 (PRB, 2003), and the maternal mortality rate, which remains high, has increased from 649 deaths per 100,000 births in 1996 to 729 deaths in 2001 (ZDHS 2001–2002). The mortality rate for children under five is also high, at 144 deaths per 1,000 births (UNFPA, 2003). As in other countries hit by the AIDS epidemic, Zambia has a growing number of AIDS orphans.

The goal of family planning is to provide services that help clients regulate their own fertility safely and effectively. Effective provision of FP services can help HIV+ women and couples meet their RH needs. Family planning can help HIV+ women and men avoid unwanted or unintended pregnancies and as a result reduce the risk of those infants contracting HIV. Limited access to FP services can result in unwanted pregnancies and high infant and maternal mortality rates, and further contributes to the HIV/AIDS epidemic.

This qualitative research, part of a multicountry study, was undertaken to investigate the status of family planning in the context of high HIV/AIDS prevalence. The primary objective was to assess the status of Zambia's FP program to identify trends that will help to improve FP services in light of Zambia's high HIV/AIDS prevalence.

Specific objectives of the study were the following:

- To gain insight into the quality of services and RH information available to FP users in Zambia.
- To examine FP practices and knowledge of FP providers and users, especially those living with HIV/AIDS.
- To explore people's opinions on how to improve FP services.

Methodology

Study design

This was a qualitative research study in which FGDs were conducted to collect information from service providers, FP/ANC clients, and HIV+ women.

Research setting

According to the HIV/AIDS/STD/TB National Council's HIV/AIDS/STD/TB framework (2000)—which incorporates social, cultural, and economic factors—Lusaka, Copperbelt, and Southern and Central provinces have been hard hit by HIV/AIDS. Within those provinces, the study was conducted in the following locations (see map):

1. Lusaka Province (Lusaka): Chipata Clinic, Chilenje Clinic, HIV/AIDS support group (YWCA)

2. Copperbelt Province (Kitwe): Buchi Clinic, Chimwemwe Clinic, HIV/AIDS support group (CHEP)
3. Southern Province (Livingstone): Maramba Clinic, Dambwa Clinic, HIV/AIDS support group (SEPO)
4. Central Province (Kabwe): Buchi Clinic, Chimwemwe Clinic, HIV/AIDS support group (DAPP)

Map of Zambia



Map of Zambia Courtesy of the General Libraries, University of Texas at Austin

Sample size

This study used purposive sampling in order to gain in-depth information about family planning and HIV/AIDS from respondents. Two FGDs were conducted in each city or town from the three groups: service providers, HIV+ women, and FP/ANC clients. Each focus group was composed of eight to 12 respondents (see Table 1). The clinics were selected from among all possible clinics using random sampling. HIV+ women were selected from those who expressed interest in the study at the drop-in centers included in the study.

Data collection instruments

An FGD guide was developed for the study by POLICY Project staff and was modified based on a pretest among FP/ANC clients in Livingstone. The FGDs were used to collect views about family planning and HIV/AIDS from service providers, FP/ANC clients, and women living with HIV/AIDS. The discussion topics covered issues relating to the following:

- Background of participants
- Demand for FP services
- Accessibility and availability of FP services
- Use of methods: condoms, other contraceptives, dual protection, and dual method use
- Integration of FP and HIV/AIDS services
- Quality of FP services
- Prevention of HIV transmission in the healthcare facility
- Sustainability of FP services
- Suggestions for improving services

The FGDs were conducted August 13–31, 2003, by the principal author, with the help of a scribe. Most of the FGDs were conducted in Chinyanja and Ichibemba (two of the most widely spoken local languages), and lasted from 45 minutes to one hour. The interviews were recorded using a portable tape recorder, transcribed, and then translated into English.

Ethical clearance

Ethical clearance to conduct the study was granted from the Ethics Committee of the University of Zambia. Permission was also sought from the CBOH and the Network of Zambian People Living with HIV/AIDS (NZP+). Participants were reassured that confidentiality would be maintained, and they were asked to sign a consent form. Participants were asked for permission to tape record each FGD to have an accurate account of each interview.

Data analysis

This report is based on the transcripts of the FGDs. The data were ordered in relation to the research questions, and structured analysis condensed and structured the mass of data to identify trends and patterns. Answers with similar characteristics or patterns were categorized together. Areas of strong agreement within each group were also identified. The analysis clearly illustrated comments and perceptions commonly held by all groups, or within particular subgroups. Comments that were made by one or a few respondents were also easily identifiable. In the report, the quotations included are taken verbatim from the FGD transcripts. Where used, these comments are shown in italics.

Table 1. FGD Details

Group	Number of Participants	City/Town	Province
Service providers	8	Livingstone	Southern
	8		
	10	Lusaka	Lusaka
	8		
	8	Kitwe	Copperbelt
	9		
	8	Kabwe	Central
	9		
FP/ANC clients pre- testing of FGD guide	8	Livingstone	Southern
FP/ANC clients	11		
	8	Lusaka	Lusaka
	8		
	9	Kitwe	Copperbelt
	8		
	8	Kabwe	Central
	10		
	8		
HIV+ women	8	Livingstone	Southern
	8		
	8	Lusaka	Lusaka
	8		
	10	Kitwe	Copperbelt
	11		
	8	Kabwe	Central
	8		

Findings

Background of Participants

Service providers

Eight focus groups were conducted with 68 service providers. The service providers were between ages 30 and 45; most were married, and most were Catholic. Most providers were enrolled midwives who had undergone a two-year course in general nursing and a one-year course in midwifery. Only one or two registered midwives were found in each clinic, and they were usually in charge of the clinic. Registered midwives have been trained for three years with an additional one-year diploma course in midwifery. With the introduction of health reform, there will soon be a cadre of registered nurses/midwives, but none were identified for this study. Most of the service providers in this study had worked in the clinics for at least two years. Most providers had taken a course in either psychosocial counseling or family planning, but not all of them were trained in both areas. The providers who had studied counseling took their last course in 2002, but the providers who studied family planning had not received updated training since 1997.

FP/ANC clients

Seventy-eight FP/ANC clients participated in FGDs for this study, including eight women who helped pretest the FGD guide. The FP/ANC clients were mostly married women between 30 and 45 years of age, and the majority of them had attained a primary level of education. Most of the respondents used injectable contraceptives. FP/ANC clients' use of family planning was related to education. A large number of the FP/ANC clients still wanted to have a child; the most any of the participants wanted to have was five children.

HIV+ women

Eight focus group discussions were held with 68 HIV+ women whose ages ranged from 26 to 45 years. The majority of the women were either single or widowed, and most of them belonged to the New Apostolic Faith. Through the study, it was determined that the respondents' religious denomination did not have much influence on their contraceptive use.

Most of the HIV+ women had received only a primary level of education, and only a few of them were using contraceptives. Among the HIV+ women in this study, there was a direct correlation between contraceptive use and education levels; women with lower levels of education were less likely to be using contraceptives. Almost all of the HIV+ women reported having one current sexual partner. None of the HIV+ women in the study wanted to have another child, indicating a need for family planning. Some of the HIV+ respondents received FP services at the nearest clinic and were using contraceptives, most commonly the injectable.

Demand for FP Services

When asked how the HIV/AIDS epidemic has affected men's and women's needs for FP services, providers, FP/ANC clients, and HIV+ women agreed that more men and women than ever before are using FP services.

A lot of women are coming for antenatal and family planning. (FP/ANC client)

Men have started coming for family planning with their wives. (provider)

More [male] youths are coming for condoms to protect themselves from impregnating their girlfriends and contracting STDs and HIV/AIDS. (provider)

The reasons the providers, FP/ANC clients, and HIV+ women gave for increased use of family planning were similar—particularly that pregnancy affects immunity and increases one’s chances of infection or further illness.

More women are attending family planning services. They believe that when you become pregnant, your immunity goes down and you end up with AIDS. (provider)

They are coming for family planning to avoid getting pregnant. Pregnancy lowers one’s immunity. (FP/ANC client)

A person who is HIV positive does not need to have children because if you conceive you worsen your immunity. (HIV+ woman)

Other respondents noted the need to have fewer children, particularly if they risk being orphaned. Several of the respondents were also concerned about the current state of the economy.

People are scared about dying so they try anything that can keep them longer to see their children grow and not leave them as street kids. (HIV+ woman)

More people are coming because it’s scary now to have more children as the economy is bad. We are failing to raise and send children to schools; feeding has become hard so it’s better to have a small family. (FP/ANC client)

Nowadays it’s better to have a limited number of children. (FP/ANC client)

I will not have AIDS. I do not want to have children who will end up to be orphans. (FP/ANC client)

We have been told that we are sick, so having any more children is out of question, so we can not help it but be on family planning. (HIV+ woman)

People are coming for family planning to avoid having children who are infected with HIV and leaving behind orphans. (FP/ANC client)

Some participants noted the need to protect themselves against infection.

I personally started coming to the clinic for family planning because I don’t trust my husband and I am scared of becoming infected. (FP/ANC client)

Family planning is important for protection against HIV. (HIV+ woman)

During antenatal clinics we are encouraged to know our status so that we start medication and the baby also put on medication when born. (FP/ANC client)

Discussions with the providers and HIV+ women revealed that some people avoid FP services for several reasons.

Men are shunning the service for fear of being associated with HIV/AIDS infection and subsequent testing. (provider)

Some men say that condom use does not offer sexual satisfaction. (provider)

Vaginal examination causes some to shun the service. (provider)

People say that family planning brings about illnesses like cancer. (HIV+ woman)

*People shun the service—they say some become pregnant even if they are on contraceptives.
(FP/ANC client)*

Some say contraceptives destroy the uterus. (FP/ANC client)

I think family planning promotes promiscuity—it promotes casual sex. (HIV+ woman)

Accessibility and Availability of FP Services

Despite concerns that HIV/AIDS has affected care-seeking behavior for fear of stigma and discrimination, the FP/ANC clients and HIV+ women in this study considered FP services to be available and accessible to them. Most of the communities in the study had clinics within walking distance. The research revealed that no HIV+ respondents were at any time denied FP services, despite concerns that HIV+ women could be discriminated against in service delivery settings. HIV+ women were asked whether the FP/RH information and services that they received were different because of their HIV status.

There is a difference. Those who have gone for counseling [training] treat us better and those who are not trained...they just tell us to wait. (HIV+ woman)

We are treated like any other person; we are always welcomed and whatever we discuss is left in the room. (HIV+ woman)

Use of Methods: Condoms, Other Contraceptives, Dual Protection, and Dual Method Use

This study found that most of the FP/ANC clients and HIV+ women who were using family planning were using the injectable. The Zambia Demographic Health Survey (ZDHS) (2001–2002) reports that injectable use has increased from 1 percent in 1996 to 4.5 percent in 2001–2002. The main reason given by respondents in this study for using the injectable was that they did not want their husbands to know that they were using contraception.

*Most men are against their wives using contraceptives, as they believe that they can be barren, so women choose the injection, which cannot be detected by their husbands.
(provider)*

My husband does not allow family planning so injectable is very alright for me because he doesn't know anything. (FP/ANC client)

In 1997, the MOH issued its first *National Family Planning in Reproductive Health Policy Framework, Guidelines and Strategies*, which states that the dual use method should be recommended to any client the service provider considers to be at risk for STIs or HIV/AIDS. In order to comply with the guidelines, the notion of dual protection through use of condoms (to prevent virus/disease transmission and to prevent pregnancy) or dual method use (use of a condom and another method of contraception) is important for providers and clients to understand. The study found that only a few of the service providers had heard about dual protection, commonly known as double protection.

Because of HIV infection, condom use is important to prevent pregnancy and infection. Unless if people are faithful—[it offers] double protection. (provider)

Furthermore, most providers were not aware of the guidelines. Almost all providers said that no policy or guidelines on dual method use and protection exist.

There is currently no policy on dual protection despite having knowledge on it. (provider)

Guidelines are not there, but we know about double protection, and we discuss it with our clients. (provider)

There are guidelines on this but they are not displayed. A lot needs to be done on dual protection. (provider)

In terms of policy we know nothing [about] guidelines. Somebody from the hospital told us she was going to bring them to us. (provider)

All women should be free to use the injectable as their method of contraception, but it is important that they understand fully that the injectable (like all modern methods of contraception) does not protect against HIV. One provider indicated that women are given this information.

It is mentioned to clients, for example, that the injectable only prevents pregnancy and not protection from HIV/AIDS. (provider)

The term “dual method use” poses several challenges for reproductive health services. Family Helath International (FHI) (2001) states that barrier methods such as diaphragms, cervical caps, and vaginal sponges may provide some protection against cervical infections when used with currently available spermicides. However, they are less effective in preventing HIV transmission because they cover the cervix but not the vaginal wall. This study found that some clients, especially those who were HIV+, were not discouraged from using nonbarrier methods like pills or IUDs.

It is said you cannot tell by looking if one is HIV positive, so it is difficult to tell what to do. If they are positive and they ask for a nonbarrier method you cannot stop them. That is their choice. I don't know what to do. (provider)

Discussions with FP/ANC clients revealed that they were mostly unfamiliar with the concepts of dual method use and dual protection.

I have not heard of dual method. (FP/ANC client)

I have not heard about it. (FP/ANC client)

I have only used a single method. (FP/ANC client)

Yes, we have been told by the nurses [to use] any family planning method plus a condom, especially if you don't trust your spouse or you suspect your health. (FP/ANC client)

Only a few of the HIV+ women in the study were familiar with the term, although comments from some HIV+ women indicate that they have been told primarily about condoms.

Condom use prevents re-infection. (HIV+ woman)

Once you use condoms you will have double protection; there is protection for both pregnancy and HIV/AIDS. (HIV+ woman)

You cannot think of having children once you are infected—condoms give double protection. (HIV+ woman)

We just need condoms—the best method. This is because if you miss a pill you get pregnant. (HIV+ woman)

When you are HIV+ you need condoms only; using contraceptives like the pill can transmit HIV infection, or the best method is to abstain. (HIV+ woman)

A few of the HIV+ women noted the need for dual method use.

Condoms are not 100 percent safe. Therefore, the need for another contraceptive. (HIV+ woman)

You cannot trust a man even when he is using a condom, so it is better to use two methods. (HIV+ woman)

In fact at the clinic, this reminds me, we are taught about double protection, to use a condom and another method, which is to protect ourselves from reinfection and prevention of pregnancy. (HIV+ woman)

We know that a condom can protect us from both disease and pregnancy. (HIV+ woman)

The study showed, however, that dual methods are rarely used. Women's reliance on the injectable is in part due to the inability of women to negotiate condom use with their partners, although it was encouraging to learn from service providers that more men and youths are coming for condoms. Traditionally, men have avoided FP services. It is understood (or at least assumed), however, that men are willing to use condoms only with nonregular partners and generally not with their wives.

Most clients are females, and they have no say over sex. Women are willing, but convincing husband on the use of condoms is difficult. (provider)

Many of the FP/ANC clients in the study expressed concerns over their husbands' objections to condom use.

My husband says ‘How can you eat a banana with its peels on and enjoy it?’ (FP/ANC client)

There is no sexual satisfaction. (FP/ANC client)

Our husbands only use condoms when the baby is still small, up to four months. Then they just stop, and it is up to the woman to go for family planning. (FP/ANC client)

Furthermore, respondents felt that condoms were only used in sexual relationships outside marriage and that husbands rejected condom use.

When I asked my husband to use condoms, he refused and said that you are my wife and not my girlfriend. (FP/ANC client)

When I took him condoms, he adamantly refused and said that I had started misbehaving, that’s why I wanted to use condoms. (FP/ANC client)

He says that [if he uses a condom] he feels like he is sleeping with a prostitute. (FP/ANC client)

Most of the FP/ANC clients did not know how or were unable to negotiate condom use with their husbands. It was generally agreed that it was still difficult to convince a man to use a condom, although one woman said:

I tell him to use a condom if I suspect he has a girlfriend. (FP/ANC client)

Condoms should be promoted not only as a method to use in outside relationships but as a means to protect the sexual and reproductive health of all people, including married couples. Condoms should be accessible and affordable to all. One service provider commented on the popularity of female condoms, when available.

Female condoms were also widely used by our clients, but now they’re out of stock so the option is male condom. (provider)

Efforts should therefore be made to ensure the availability of all forms of contraceptives, particularly barrier methods. FP/ANC clients suggested that men be included by inviting men to FP counseling so that they understand contraceptives, which would make it easier for women to negotiate condom use.

Integration of FP and HIV/AIDS Services

There is a clear trend toward the integration of FP and HIV/AIDS services, although providers are not always aware of the official sanction of integration. Nationally, the “supermarket approach” has been adopted in Zambia, in which services are provided in the same place at the same time, and clients are considered holistically rather than separated by function and body part. Clinic services, including family planning, antenatal care, and the children’s clinic are offered at the same time through an integrated delivery system. Nurses are rotated through the different departments every three to six months.

Several providers felt that although FP and HIV/AIDS services were not officially integrated, the separation was in name only.

The integration is already there though not official, but because of the supermarket method, everybody offers counseling and services together. (provider)

In principle, the integration has taken place though there is no [integration] policy currently. (provider)

That [integration of services] has already taken place except it's not official. (provider)

That is the practice—when people come for FP we also discuss HIV/AIDS. (provider)

The providers, FP/ANC clients, and HIV+ women supported the notion of integrated services, but each had reservations about its implementation. Providers worried about increased workload and lack of supplies, room, and equipment to provide all services.

This system is okay; all that is needed is to provide all the necessary supplies and equipment in each room in order to cater for all the services. (provider)

The supermarket method is putting more strain on nurses as there is need for more nurses, and there is a lot of waiting. The clinics are always overcrowded as there are specific days for specific activities so some go back without getting their services. (provider)

Support is needed, especially with infrastructure—the clinic needs extension—so that we can have activities in different rooms. Not crowded the way it is. (provider)

There is a shortage and lack of room. The clinic was built a long time ago when the population was small, now there is need for expansion of the place where the service is provided. (provider)

Some FP clients noted that they had to wait for the ANC clients to be served first. They said that integration comes with long waiting times and congestion in the clinics.

More attention is paid to antenatal mothers/clients. They are attended to first, and we are told to wait. (FP/ANC client)

Discussions with HIV+ women about integration revealed the need for FP and HIV/AIDS services to be integrated. Several women felt that VCT and PMTCT services should be integrated and provided together with FP services. They also had comments on other areas for improvement.

Family planning still has gaps in terms of incorporation of VCT and MTCT. (HIV+ woman)

Nurses to be trained as counselors. (HIV+ woman)

Train nurses in counseling and direct nurses in teaching the best methods of contraceptives for people living with HIV. (HIV+ woman)

Quality of FP Services

Privacy and confidentiality

Maintaining privacy and confidentiality is a key element of good quality counseling. The consequences of not ensuring privacy and confidentiality for a client, particularly an HIV+ client, in service delivery settings could include exposure to domestic violence, endangering her relationship with her partner and her community, as well as eroding her trust and future participation in the healthcare system. The FP/ANC clients and the HIV+ women in the study felt that their confidentiality was maintained; that clients were counseled in a separate room alone with the service provider, sometimes despite limited space in the clinic; that information shared with the service providers was not discussed elsewhere; and that names were not mentioned when examples were used.

Information provided

FP/ANC clients reported having access to contraceptive methods but differed on how much information and choice they were given.

As for me, the nurse brought the whole tray of contraceptives methods and explained to me even the side effects. (FP/ANC client)

I heard and had Norplant inserted at the clinic and they told me to go for follow up. (FP/ANC client)

I was told to choose between two methods of contraceptives. (FP/ANC client)

The FGDs revealed that the FP/ANC clients and HIV+ women had heard a lot of myths and misconceptions about contraceptive methods.

Some say family planning makes you to have a blood clot in the uterus, which will stop you from having children. (FP/ANC client)

If you take contraceptives for a long period of time, you end up with children with deformities. (FP/ANC client)

People fear to attend family planning. They say it brings side effects like cancer or a growth in the uterus. (HIV+ woman)¹

Despite the increased demand and consequent crowds in the clinic, FP/ANC clients were generally satisfied with the information they received on HIV/AIDS. This information was given freely during health education, and clients were free to ask questions. However, one client expressed a desire for more time for questions with the service providers, stating that there is not much time for “meaningful conversation” due to clinic crowding.

¹ Contraceptive use does not cause cancer, birth defects, blood clots in the uterus, or uterine deformities (Miller, Shane, and Murphy, 1999).

If it were possible, home visits by nurses should be welcomed, as this would give us enough time to ask questions and have meaningful discussions because at the clinic there is a lot of congestion. (FP/ANC client)

Counseling

In an integrated service setting, counseling for family planning and HIV/AIDS requires information on contraceptives and HIV and the interaction between the two, in addition to the skills needed to assess risk and discuss a positive HIV test when necessary. The study revealed that most of the providers felt inadequate in their counseling skills.

I have been long in the service, but I'm still not a trained counselor. (provider)

We all need to be trained counselors instead of calling other known counselors. (provider)

I am not a counselor so I need [training in] psychosocial counseling. (provider)

Some of us each time a client needs to be counseled, we look for nurses who are trained counselors to come and counsel the client. (provider)

Many service providers expressed dissatisfaction with their own delivery of FP services, stating that they needed updated information and training on new contraceptive methods.

I last went for a course in family planning in 1995. A lot has changed; there is need for more counselors due to an increase in the population. (provider)

All nurses should undergo training. What is done in midwifery is not enough—in comparison to family planning workshops. These focus on provision itself. (provider)

Overall, service providers reported feeling constrained in the advice they give by their own outdated knowledge, limited counseling skills, and the need to respect their client's privacy and freedom of choice.

We are not able to assess a client's status, but we feel we still have to respect a client's privacy and freedom of choice. (provider)

Most of the HIV+ respondents received their counseling on family planning at the family planning clinic. Information about PMTCT was given to them during ANC visits. The HIV+ women were generally satisfied with the length of counseling, if not with the information provided.

However, among the HIV+ women in this study, those who are hesitant to use contraceptives cite side effects and the lack of information on which methods are suitable for HIV+ women as the main fears that keep them from using contraceptive methods other than condoms. Some HIV+ women revealed that they were frustrated that they were not well informed about the methods of contraceptives to use.

I feel they do not have information on the safe methods of contraceptives. They know that I'm HIV positive but they do not tell me the methods suitable for me. (HIV+ woman)

We need more information on which methods are best for us in light of HIV/AIDS. (HIV+ woman)

This lack of information reflects the providers' inability to properly counsel clients due to their own inadequate knowledge and lack of training in counseling.

Interpersonal relations

Trust is an important factor in the relationship between the counsellor and the client. If the client trusts the information and advice given by the counsellor, there is a much greater chance that they will act on that information. Generally, the FP/ANC clients and the HIV+ women in the study had no complaints about their relationships with the staff and rated their relationships with providers as good.

Whatever we tell the service provider, we do not hear it from others, and they do not use our situations as references or examples. (FP/ANC client)

Waiting time

The primary complaint that FP/ANC clients had about the services they received was the long waiting times that they often experienced at the clinics, although some FP/ANC clients did report that service providers were readily available.

There is overcrowding in the clinic. (FP/ANC client)

They are ever busy. (FP/ANC client)

We wait for a long time in the queue. (FP/ANC client)

They take a long time before attending to us. (FP/ANC client)

Mostly we are attended to, though late because of the rising number of clients attending clinics these days. (FP/ANC client)

They talk to us when it is our turn and we get the required services. (FP/ANC client)

Staff shortages

As more and more clients attend FP clinics due to the HIV/AIDS epidemic, providers say they face an ever-increasing workload. Most programs struggle with staffing issues. Inadequate remuneration and burnout affect staff performance. Providers said that staff members are called upon to do more work due to shortage of staff for several reasons.

There is shortage of staff due to sickness among member of staff. (provider)

Some members of staff are on leave. (provider)

Others have left for greener pastures. (provider)

Some clients attending the clinics have also noticed the effects of increased staff workloads.

There is congestion at the clinics nowadays with very few numbers of nurses, so they are usually very tired such that they don't pay attention to us. (FP/ANC client)

An FHI study (2001) reported that in Lusaka in 1991–1992, HIV prevalence among midwives was 39 percent and among nurses was 44 percent. The providers in the FGDs indicated that some nurses and midwives had died from AIDS-related causes.

Prevention of HIV Transmission in the Healthcare Facility

Health workers are at risk of contracting HIV in the workplace. Although illnesses and deaths from HIV/AIDS were reported among service providers, it was not made public whether or not HIV was contracted through work. Illness and death among healthcare workers can worsen existing inefficiencies and capacity constraints. Providers take extra precautions when dealing with HIV+ clients.

We use gloves. (provider)

We also use disinfectants like Jik. (provider)

We no longer recap needles, instead we use sharp boxes for disposal. (provider)

If a client comes without gloves we tell them to buy or we use some from for emergency if she is in labor. (provider)

Hand washing. (provider)

In case of short supply, we ask our clients to buy items like gloves. (provider)

Discussions with service providers showed that they all worry about being exposed to HIV at work during procedures like IUD insertion, when they come into contact with vaginal secretions, and when working with needles.

Due to fear of contracting HIV, we shun some procedures. (provider)

Use of gloves—one lady had a bleeding wound, I was stranded because there were no gloves. Luckily, we used gloves from the laboratory, and this woman was RPR positive. (provider)

One provider noted that procedures are sometimes changed due to the lack of supplies.

In fact, without gloves no vaginal examinations are done. We just go straight to give them medicines. (provider)

This study found that guidelines and drugs for post-exposure prophylaxis following needle sticks and other possible exposure to HIV were not available in the clinics and that guidelines were not provided on safe procedures.

There are no drugs for nurses, only for patients—in fact, pregnant mothers and children at birth. (provider)

One provider noted a make-shift approach to addressing possible exposure.

Unfortunately there is nothing so far in this clinic. Usually what happens is that when you're pricked in case of needle prick, we just squeeze blood out. (provider)

Sustainability

The impact of HIV/AIDS is especially severe in the countries least equipped to deal with it. More than 90 percent of HIV+ people live in resource-constrained settings. The providers emphasized that there is a need for both political and donor support for family planning in the context of HIV. In most of the clinics in the study, FP services had been supported by CARE International, whose support had been withdrawn.

CARE International used to provide some of the materials for delivering of FP services, but it has so far pulled out. (provider)

UNICEF is still providing supplies, although that organization is about to hand over responsibility of material support back to the government. Right now there is little to no donor support in the delivery of FP services, and government resources are likely to be quickly consumed by the huge new needs of the HIV/AIDS epidemic.

This study found that inadequate supplies of basic items such as needles, syringes, and gloves continue to be a problem. Lack of such supplies constrains the ability of providers to provide quality FP services by limiting the range of methods they are willing to offer to clients. This lack of supplies has consequences for clients.

Sometimes when you do not have money for a syringe, you are sent home and you end up becoming pregnant. (FP/ANC client)

When the resources we have run out after the pulling out of donors, we will have a very big problem. (provider)

Suggestions for Improving FP Services in Light of HIV/AIDS

The providers, FP/ANC clients, and HIV+ women made a number of suggestions for improving the provision of FP services in light of the HIV/AIDS epidemic in Zambia, ranging from more information through the media; awareness campaigns in communities; increasing the involvement of men; providing services to adolescents; ensuring availability of condoms, other methods of contraception, and supplies; and promoting all methods of family planning.

Promoting media and community-based awareness campaigns

More health topics [including FP and RH] should be included in the programs on TV. (provider)

Family planning should be advertised through messages on the radio and in the clinics. (FP/ANC client)

More sensitization through the media would also help, except on the TV they should choose good time—especially when children have gone to sleep. (FP/ANC client)

Awareness campaigns should be conducted through neighborhood health committees. (provider)

Campaigns should be conducted in the community because some don't know family planning. (HIV+ woman)

I think people in the community should be sensitized about family planning in order to reach women who do not attend family planning. (HIV+ woman)

Sensitizing women in the community on HIV/AIDS. (HIV+ woman)

Media coverage should be stepped up, especially on FP. It's not enough. (provider)

Have drama shows in the community. (FP/ANC client)

I think the use of drama to reach people in the community. (HIV+ woman)

Providing community-based counseling

Nurses should come to homes to teach couples. (FP/ANC client)

The community should be told about FP through massive campaigns by nurses in order to bring awareness among people in the community. (HIV+ Woman)

HIV+ women in the community should be trained as family planning providers due to shortage of service providers. These will be able to reach all women and men in the community. (HIV+ woman)

Encouraging VCT

You need to go to the clinic for HIV counseling to know your HIV status—VCT. (HIV+ woman)

I think more people should be tested so that proper advice can be given on what type of method they should use because the majority don't know. (provider)

Involving men

Involve men in family planning because the issue involves both men and women. (provider)

Men should be involved in family planning. If possible, have them also have lessons on family planning methods and side effects. (FP/ANC client)

Men should be followed at their working places. (provider)

Men's involvement should be considered—women should be encouraged to come with their spouses to the clinic. (provider)

We should have our husbands also involved in FP services. (FP/ANC client)

Condoms should be introduced at places of work by sensitizing men. (FP/ANC client)

Reaching young people

I think there is need to develop services that can reach groups such as adolescents. (provider)

There should be more sensitization, especially among the youth. (FP/ANC client)

Family planning should be extended to schools—included in the school curriculum, though it would encourage promiscuity but they will be taught well at school. (provider)²

More information on HIV/AIDS and family planning

We need information on how to protect ourselves from HIV infection. (FP/ANC client)

Personally, [I think that] all methods should be promoted because when a women is pregnant her immunity goes down. (provider)

More counseling and education on methods of FP to HIV+ women, and men should be well taught. (HIV+ woman)

Ensuring availability of condoms, other methods of contraception, and supplies

There should be good condom supply to avoid infecting others. (HIV+ woman)

Contraceptives should be available. Condoms give double protection. (HIV+ woman)

Syringes and needles should not be in short supply. Sometimes you end up pregnant because of not getting the method of contraceptive on the scheduled date due to non-availability of syringes and needles. (HIV+ woman)

Meeting clients' RH needs

Physical examination should be done before giving contraceptives. This is important to identify health problems before giving the desired method of contraceptives. (HIV+ woman)

Intensive education should be given with thorough physical examination. Myths and misconceptions of methods of contraceptives should be clarified. (HIV+ woman)

Addressing organizational and infrastructural needs

I think more room should be made available—the old building is too small; we have more clients. (provider)

Family planning should be offered separately. It should not be mixed with antenatal. (provider)

The family planning programs at the clinics should be done separately and not with antenatal as clients need a lot of attention and explanations in order for them to make proper and informed choices. (provider)

Family planning clinics should be separated, because it's not the sick that come. (provider)

These findings suggest that there is continued need for BCC that is focused on reduction of risk and vulnerability. Successful BCC will ensure that there is national and community dialogue and promotion and provision of information and services. The findings also suggest a continued need for male involvement in family planning and community-based counseling (including through use of HIV+ peer educators). While physical exams are not strictly needed for most contraceptive methods, HIV+ women noted that they would like access to exams (which includes need for supplies to conduct them). There continues to be a need for female-controlled methods and counseling for men and women so that women have better ability to negotiate condom use.

Summary and Recommendations

Summary

Because of the bad economic situation in Zambia and because of fears that parents or their children may contract HIV, women are increasingly turning to FP services to avoid becoming pregnant. Most women, including HIV+ women, are convinced that using family planning and having smaller families provides health and economic benefits. HIV+ women in particular are concerned that pregnancy would cause deterioration in their health. FP/ANC clients and HIV+ women expressed the need for a choice of contraceptive methods because condoms are not 100 percent effective in protecting against pregnancy, STIs, and HIV reinfection.

The study found that while women perceived numerous benefits of family planning, they also were concerned about negative consequences, including side effects and their husband's disapproval, which could discourage them from taking control of their fertility. Women who are not using contraception but want to space or limit their births are said to have an unmet need for family planning. Unmet need for family planning among married women in Zambia was 27.4 percent in 2000–2001 (ZDHS). CSO (2001) reports that much of the unmet need for family planning results from women's fear of the health side effects associated with contraceptive methods, especially the pill and injectables. Although service providers said that more youths and men were coming to clinics for condom collection, FP/ANC clients and HIV+ women reported low acceptance of condom use among men. Other than abstaining from sex or having sex with a partner who has no other partner, consistent condom use is currently the only effective strategy to protect sexually active individuals from HIV transmission. There is an urgent need to increase the acceptance and user satisfaction of condoms and to make other methods of protection against HIV available.

Clients deserve FP programs that provide them with a variety of contraceptive choices that are explained to them through counseling with knowledgeable providers. Overall, all clients felt that their privacy and confidentiality were maintained. HIV+ women, unlike FP/ANC clients, expressed dissatisfaction with the counseling services they received. Women who are known to be HIV+ should have access to appropriate information and FP/RH services so that they can make informed decisions concerning contraception, continuation of a pregnancy, and prenatal practices to reduce mother-to-child transmission of HIV. All clients expressed concern about myths and misconceptions surrounding contraceptives. Faden et al. (1996) report that access to healthcare services and patient participation in ongoing care are important elements in reducing HIV-related morbidity and mortality. In addition, attempts to engage women in discussions concerning the health consequences of their reproductive decisions are predicated on the existence of a relationship between the woman and a healthcare provider.

With the increase in clients, space was an issue in some clinics. Findings from the study indicate that although many providers battled overcrowding, all FP/ANC clients and HIV+ women remained confident that their conversations with providers were not overheard and that confidentiality was maintained. Corburn (1997) suggests that service providers can still take the initiative of curtailing off one corner of the room for examination and counseling.

Suggestions for promoting FP services included the promotion of all methods; advertising in clinics, on radio, and on television; community awareness campaigns using theatre; reaching out to involve men and youth; and improving family planning and integrated services.

There is a clear trend toward the integration of MCH, FP, and HIV/AIDS services. Integration is regarded as an important criterion for improving the health of individuals and couples. As they agreed to do at the

1994 Conference on Population and Development in Cairo, the government of Zambia and donor agencies are faced with the challenge of providing appropriate and accessible means to enable couples to decide freely and responsibly on the number and timing of children they have and providing the means to do so, and to protect their reproductive health free of disease. Collaboration between the government and NGOs needs to be revisited to ensure increased accessibility and use of RH services.

Programs that offer high-quality services use training to motivate providers and build providers' counseling and interpersonal communication skills. More trained counsellors are needed to counsel effectively and provide accurate and complete information about the impact of HIV on RH issues. The CBOH (1997) puts emphasis on training for providers that includes counseling, communication, administration, technical, and managerial skills. Service providers must be able to discuss the connection between STIs/HIV and contraceptive use and the role condoms can play in preventing transmission, as the risk of infection is an important consideration in choosing a contraceptive. Clients who receive services from trained providers are more likely to accept and use contraception, report fewer and milder side effects, and return for regular visits.

The service providers in the study knew the precautions to take in order to protect against HIV transmission, but there were limited amounts of gloves (in case of needle sticks or other accidents in the workplace) and antiretroviral drugs (ARVs). In addition, the clinics in Zambia had no written guidelines on post-exposure prophylaxis and safe procedures. When gloves were in short supply, clients were told to buy them. Prevention programs should include the implementation of safe procedures and proper disposal receptacles for gloves and sharp objects. Addressing the problem of occupational risk may boost staff moral and improve the quality of client care.

Recommendations

The following recommendations emerged from this study in Zambia:

Continuing support for family planning

- The government of Zambia and donor organizations should continue funding FP services. Demand for services is *increasing* rather than decreasing in the context of HIV.
- The government and donors should commit human, financial, and material resources (e.g., syringes, gloves, and contraceptives) to ensure contraceptive security and improve FP, ANC, and HIV/AIDS services.

Targeted integration of FP and HIV activities

- A broad range of contraceptives, including dual methods, should be available through various delivery routes. Clients are more likely to use contraceptives if they are presented with a choice of methods and services that are easily accessible. Contraceptive methods that are appropriate for HIV+ women must be available, and the women must be presented with up-to-date information.
- VCT and PMTCT should be incorporated into the counseling services of FP programs.
- VCT should be promoted so that people know their HIV status and can make decisions on RH issues accordingly.

- FP services at VCT centres should include provision of condoms and contraceptives by trained FP providers.
- The integration of FP and HIV/AIDS services should be taken into account when planning staffing levels, training, and clinic infrastructure. Adjustments to current staffing levels may need to be made to accommodate the growing number of current clients, as well as staff burnout and turnover.
- The availability of female-initiated methods of protection such as the female condom should be increased.

Training for providers

- Providers need training to improve interaction with clients and to update their clinical skills, counseling skills, and FP and HIV knowledge.

Using a variety of communication channels to provide information and BCC

- Education programs targeting men, women, and youth should use BCC strategies to teach about VCT, HIV, and FP methods. Television, radio, and drama programs should be used.
- Health programs should include counseling to help men and women improve their communication skills and involve men in FP programs.
- HIV+ women (and men) should be trained as counsellors and FP providers to reach out to others in the community that are dealing with the same issues.
- Male involvement should be promoted through media, workplace initiatives, and clinic outreach.

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Appendix: Focus Group Discussion Guides

These guides were modified from the original focus group discussion guides after pretesting.

HIV+ WOMEN FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Introduce yourself: I'm a health worker and part of my responsibility includes assessing health needs through conducting research in order to provide information to policymakers, program planners, and NGOs, which will help to improve delivery of healthcare in the community. Today, the purpose of our visit is to discuss with you issues of family planning in light of HIV/AIDS.

BACKGROUND

Tell us about yourself: your first name, age, your marital status, and number of children. How many children do you still want to have? Do you have a boyfriend, how many sexual partners do have, have you ever had a broken relationship, why, what are your main concerns?
Where do you go for FP? Where do you go for counseling, are you using any contraceptives?

DEMAND FOR THE SERVICE

1. In general, how has the HIV/AIDS epidemic in this community affected men's and women's needs for FP services?
 - Are men and women shunning the services?
 - If yes, why?
 - Where do think men and women are getting information on FP from?
 - Do you feel welcome at a clinic and do you feel confidentiality can be maintained?
 - Are the FP services accessible and available in your area?
 - How is confidentiality and privacy maintained?
 - How is your relationship with staff at the clinic?
 - How did you find the information given to you?
2. Should FP be promoted and provided differently now, if at, in light of HIV/AIDS in your community? If so: How? Why?
 - How should FP be promoted in light of HIV/AIDS and why?
 - How should FP be provided in light of HIV/AIDS in your community and why?
3. Thinking specifically about HIV+ women and men, what are their needs for FP?
 - Which services do they need?
 - Why do you think they need the above services?
 - Is FP still considered a need among HIV + women and men in this community?
 - Do they see condoms as a method for preventing STIs and HIV/AIDS?
 - Do you think that HIV+ women and men currently need protection from HIV/ AIDS and not contraceptives?
 - Do HIV+ WOMEN and men feel more or less need for FP in light of their status?
4. Do you think that the FP information and services that you receive is different because of your HIV status?
 - If so, how?
 - How was the counseling done, for how long?

METHODS OF CONTRACEPTIVES

How are dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention) promoted at FP clinics?

- Were the above-mentioned methods explained to you and if so, how?

QUALITY OF SERVICE

5. What is the best way to reach HIV+ women and men with FP information and services?
6. Have you been to a VCT clinic or a center that provides PMTCT? If so what FP services, if any, were offered?
7. What FP services would you like to see available at a PMTCT or a VCT center?
8. Do you know anyone who has been denied access to services or treatment at a health clinic in this community or that serves this community because of their HIV status?
 - Give examples?
 - What types of services were denied?
 - How was the denial of access communicated?

SUSTAINABILITY

9. Are the supplies and equipment adequate?
10. Are there any NGOs working with the FP services in your area?
11. Do you think there is need for donor/political support?

INTERGRATION OF SERVICES

12. Which other services are provided apart from the FP services?
13. Should these services be integrated with FP and how?
14. Are there any other issues that you feel should be discussed in relation to FP in light to HIV/ AIDS?
15. What are the practical implications of the issues?
16. What are the practical alternatives?

Thank you for participating in the discussion.

SERVICE PROVIDER FOCUS GROUP DISCUSSION GUIDE

Introduce yourself: I am a health worker and part of my responsibility include assessing health needs and providing means on how best to improve the delivery of health services to the community. Today, the purpose of my visit is to discuss with you issues of family planning in light of HIV/ AIDS. This will enable program planners and policymakers to find suitable ways of how best to improve the delivery of FP services in Zambia in light of HIV/AIDS.

BACKGROUND

Tell us about yourself: your marital status and number of children. For how long have worked as a family health provider, the courses you have attended and briefly how the FP services are conducted in your clinic?

DEMAND FOR THE SERVICE

1. How has HIV/ AIDS epidemic in this community affected men and women's needs for FP services?
 - Are you seeing more men and women attended FP services?
 - What could be the reason for not using the services?
 - Which is the commonly used method of contraceptive?
 - Is their need to improve the service in terms of resources and counseling skills?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community?
 - Do you think the FP services should be conducted differently in light of HIV/AIDS?
 - Are there some inadequacies in the way FP services are conducted in light of HIV/AIDS?
 - How should family planning be provided in light of HIV/AIDS? (Separately).
 - Why do you think family planning should be promoted differently in light of HIV/AIDS?
 - Why do you think family planning should be provided differently in light of HIV/AIDS?

COUNSELING

3. Has the rising prevalence of HIV/AIDS in this area affected counseling for family planning your facilities? If so how?
 - Do you feel inadequate when counseling?
 - Do you need more counseling skills?
 - Do you have more people coming for counseling only?
 - Are you able to assess a client's risk status?
 - Do you face an ethical dilemma if you advocate contraceptive methods depending on the client's risk status?

METHODS OF CONTRACEPTIVES

4. Does the MOH/Clinic have a policy for promoting dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention)?
 - What is the practice at your clinic?
 - Do you have guidelines on the dual method use and protection?
 - Are clients discouraged from using nonbarrier methods (like pills or the IUD)?
 - How does the clinic staff go about discussing with clients of dual method use or dual protection?
 - Does the staff start by explaining the importance of dual method use or dual protection?

INFECTION PREVENTION

5. Does staff worry about being exposed to the possibility of HIV infection at work?
 - How do you think you can be exposed to HIV infection at work?
 - What have some staff reactions been to this worry about HIV?

- Are there any guidelines for post-exposure prophylaxis? If any what are they.
 - Are drugs for post-exposure prophylaxis available?
 - How do you protect yourself from being exposed to HIV infection?
6. Does staff take any extra precaution for treating clients in light of HIV/AIDS?
- If so, what precautions?
 - Is guidance provided on safe procedures?
 - Are there any barriers to taking extra precautions?

QUALITY OF SERVICE

7. Is staff called to do more at work due to HIV in this area?
- In what ways is staff called to do more work?
 - Are there more clients attending family planning?
8. Has the HIV/AIDS epidemic have any impact on the staffing levels in the clinics where you work?
- What about in the overall healthcare delivery system?
 - Are there any reports of illness and mortality among providers and staff in light to exposure to HIV infection? Examples?

INTERGRATION OF FP AND HIV/AIDS SERVICES

9. Do you feel that FP and HIV/AIDS services can be integrated at the clinic level?
- How should this be done?
 - What elements should be considered?
 - What types of training would be necessary for this to take place?
10. What other issue do you think should be discussed which are related to the topic of discussion?
11. What are the practical implications of the issues that have been discussed?
12. What are the practical alternatives that can be employed?

Thank you for your participation.

FP/ANC CLIENTS FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Introduce yourself: I am a health worker and part of my responsibility includes assessing health needs and providing means on how best to improve the delivery of health services to the community. Today the purpose of my visit is to discuss with you issues of family planning in light of HIV/AIDS.

This information will enable policymakers, program planners, and NGOs to find suitable ways of how best to improve the delivery of family planning services in Zambia in light of HIV/AIDS.

BACKGROUND

Can you tell us about yourself?

How old you are, what is your marital status, number of children, occupation, highest education level, religion?

How many sexual partners do you have?

Who makes the choice of family planning contraceptive you should use? Where do you go for FP? How long have you been attending the FP clinic? How is the attitude of the providers?

DEMAND FOR THE SERVICE

1. In general, how has the HIV/AIDS epidemic in the community affected men and women's needs for FP services?
 - Do you think the number of men and women attending the FP services increased?
 - Are they shunning the service due to fear of stigmatization?
 - Do you think they do no longer require the service for fear of having children who are HIV positive?
 - Do they have knowledge on HIV/AIDS and FP?
 - Are the services available and accessible?
 - Are you happy with the facility?
 - How are your needs and expectations met?
 - Is the information you are receiving adequate?
 - How is your relationship with the staff?
2. Should family planning be promoted in light of HIV/AIDS in your community? Give reasons why family planning should be promoted?
 - How should it be provided?
 - Who should provide the service?
 - Do women and men have any fears about using family planning or attending family planning clinics in light of HIV/AIDS in, your community?
 - If so, what are these fears?

USE/BEHAVIOR

3. How are dual method use (using a condom + another contraceptive) or dual protection (using a condom for both disease and pregnancy prevention) promoted at family planning clinics, if at all?
 - Have you ever heard of dual method use and dual protection?
 - How were they explained to your?
4. What barriers do women in your community have to using a condom (or a condom with another form of contraception) with each sex partner?
 - What are the barriers to condom use? Are there fewer barriers to using to condom with some partners than others?
 - What are the reasons for that difference?

- What are some of the negative responses of some partners when you ask them to use condoms?
- Why do you think some partners dislike the use of condoms?
- Do you think the low status of women and the tolerance of male promiscuity are factors that hinder women from negotiating the use of barrier methods?
- How would you convince your partner to use a condom?
- Is the ability to exercise choice united by a women's and partner's knowledge of HIV, cultural norms, regarding discussion of sexual matters?
- How would you react if your partner suggested not using a condom for sex?
- What could be done in your community to make it easier for women to use condoms?

QUALITY OF SERVICE

5. Do you think that the increase of HIV/AIDS in this area has affected the services available in the ANC/FP clinic?
 - Do you find staff readily available at the clinic?
 - Have the services improved in terms of counseling and how?
 - Do you sit for long hours before being attended to?
 - How is privacy assured?
 - Is confidentiality maintained?
 - Does the staff at the clinic discuss HIV/AIDS freely and do they attend to clients freely without fear of being infected?

SUSTAINABILITY

6. Are the supplies, medicine and contraceptives easily available at the clinic?
7. Do they need any political/donor support?
8. What other issues which are related to family planning in light to HIV/AIDS do you feel should be discussed.
9. What is the practical implication of these issues?
10. What are the practical alternatives of these issues?

Thank you for your participation.