

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

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with contributions from:

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POLICY Project



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## Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral (therapy)
CBS	Central Bureau of Statistics
CDC	Center for Disease Control
CPR	Contraceptive prevalence rate
FGD	Focus group discussion
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IUD	Intrauterine device
KDHS	Kenya Demographic and Health Survey
MCH	Maternal and child health
MOH	Ministry of Health
NASCOP	National AIDS and STDs Control Program
NCPD	National Council for Population and Development
PLHA	Person living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PRB	Population Reference Bureau
RH	Reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
WOFAK	Women Fighting AIDS in Kenya

## **Executive Summary**

### **Background**

Kenya's family planning (FP) success has been overshadowed by the HIV/AIDS epidemic, which was declared a national crisis in 1999. Data from the 2003 Demographic and Health Survey in Kenya (KDHS) provide a cautionary tale of the unintended outcomes associated with the shift in attention of programs and resources from family planning primarily to HIV/AIDS. From a steady rise in contraceptive prevalence from 27 percent in 1989 to 39 percent in 1998, contraceptive prevalence stalled and remained at 39 percent in 2003. Yet, the surveys have consistently shown that many women report wanting to delay or limit future births but are not using any FP method.

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 of AIDS programs, the answer to this question is crucial. The purpose of this study was to explore how family planning is being implemented in Kenya in the context of high HIV prevalence. A similar study was conducted in Zambia. The specific objectives of the study were to

- Assess how the HIV/AIDS epidemic has affected needs for FP services and other HIV/AIDS-related services like voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT);
- Explore emerging FP and reproductive health (RH) needs in the context of high HIV/AIDS prevalence; and
- Provide lessons learned and make recommendations for improved FP and HIV/AIDS programs.

### **Methods**

Focus group discussions (FGDs) with service providers, FP/antenatal care (ANC) clients, and women living with HIV/AIDS (HIV+ women) were used to gather the views of these groups on family planning in light of HIV/AIDS.

To capture regional variations, nine FGDs were carried out in three regions (three per region). Kisumu District was selected for its high HIV/AIDS prevalence and low contraceptive prevalence rate (CPR), while the Nyeri District has the highest CPR in the country and an HIV prevalence rate of 11 percent. Inclusion of Nairobi District/Province gave an urban/rural comparison. The FGDs were conducted in Kikuyu, Kiswahili, and Luo in 2003. Each FGD had seven or eight participants, for a total of 71 participants.

### **Findings**

#### *Views of providers*

*Method use.* The providers discussed the promotion of dual method use. The providers agreed that their training requires them to counsel clients on all FP methods and that they should also counsel clients on the advantages of condom use to protect against the transmission of HIV. The providers agreed that the final choice of method(s) rested with the client, although providers should attempt to clear up misconceptions about FP methods, particularly as these misconceptions relate to HIV/AIDS. Some providers did express concern that clients may choose methods that are not the most appropriate for them, even after counseling.

The groups of service providers generally agreed that an increase in demand for barrier methods (mostly condoms) in the communities they served is likely to be a result of high HIV prevalence. In the Nairobi group, the providers concurred that clients had increased demand for dual methods. The group agreed that while in the past, married women with children never used to take condoms from the clinic, more were doing so now.

In Nyeri, respondents indicated that youth and men were the primary groups with an increased demand for condoms, while in Kisumu, an increased number of clients who are informed about their HIV status were seeking condoms. The providers noted seasonal variation in demand for condoms, especially during festival months like December. In Nyeri, where service providers considered that family planning was readily accepted by both women and men, women were increasingly seeking longer-term methods such as the injection.

The Kisumu group discussed two issues that were not raised in Nairobi or Nyeri. They discussed that clients might not be using family planning because they want to have children before they die or to replace children that have died. Kisumu has high HIV prevalence, thus this view is plausible. The group also raised the issue of wife inheritance, a cultural practice prevalent in Nyanza in which a woman is taken as a wife by the brother of her deceased husband. Women who were inherited but did not want more children and did not have the power to negotiate condom use usually adopted other methods of contraception, such as the pill.

*The need for integration.* All of the providers agreed that due to HIV/AIDS, FP services should be provided differently and that integration of FP/RH and HIV/AIDS services is long overdue. Providers noted that integrated services could enhance clients' privacy and ease of using services (or raise clients' curiosity about the benefits of new services) and save time for clients. An example discussed at length was clients' failure to follow through on HIV/AIDS services like PMTCT for fear of being tested or being seen near the separate rooms offering the services. The providers suggested that more counseling about integrating family planning and HIV/AIDS is needed, as are innovative ways to reach men and youth with FP services.

There was consensus among providers that while FP/RH should be integrated with HIV/AIDS services, some services such as VCT should continue to serve groups such as youth and men who do not visit maternal and child health (MCH) clinics. Providers see a need to train more service providers and counselors to deal with the increased workload because more time would be taken up counseling clients.

Those skeptical about integration expressed concern that the stigma of HIV/AIDS might affect the gains achieved in FP provision and counseling.

*Providers' need for training.* The providers unanimously agreed on the urgent need for thorough training on HIV/AIDS counseling and management and on FP provision. Providers emphasized the constant need for regular updates on various medical issues such as VCT, PMTCT, and new HIV/AIDS testing kits. They reported that there were few trained HIV/AIDS counselors and a need for many more.

*Increased workload.* Providers, especially in Kisumu, said that their workload had increased. In Kisumu, AIDS placed an increased burden on staff and accordingly increased their workload, and the government was not employing more staff to ease the workload. Sick leave among the staff has also increased the workload burden on others. Providers also perceived that HIV was bringing more clients to the clinics, in part because they wanted information and in part to get medical attention that might be related to being HIV positive, even if the clients did not know their status.



*Fear of exposure to HIV.* All of the service providers expressed worry about being exposed to HIV infection, although some said that if all measures of protection were provided in all facilities, such outcomes may be minimized. Providers said that guidelines and drugs for post-exposure prophylaxis are only available in big government hospitals, and smaller clinics/centers may not always have them. Despite the lack of availability of universal precaution guidelines and drugs for post-exposure prophylaxis, providers tried to take extra precautions, such as wearing two sets of gloves, proper disposal of syringes, and proper removal of gloves.

Providers explained that there are barriers to taking the precautions, including emergencies and/or lack of adequate equipment in some facilities. In Kisumu, providers highlighted the heavy workload as an impediment to taking extra precautions. However, other counterparts in Nairobi and Nyeri stated that workload could not interfere with precautions. Some providers said if they could not take adequate precautions, they would not do the work. On the issue of emergencies being a barrier to taking precautions, providers expressed the view that it depended on one's conscience and work ethic. For instance, one might be faced with a case of a mother in labor delivering before being admitted or taken to the ward, thus not having the chance to get gloves. Providers concurred that such situations are left to the individual, although generally they assist first and take precautions later since providers consider it their medical duty to attend to a client in need.

#### ***Views of FP/ANC clients and HIV+ women***

*Contraceptives and condoms.* The FP/ANC clients and HIV+ women perceived that the need for FP services had increased in their communities as a result of high HIV/AIDS prevalence. They agreed that they were informed and counseled on the benefits of all FP methods, including condoms, but that condoms were not generally promoted as the first method of choice for a contraceptive.

The HIV+ women agreed on the dual benefits of condoms—serving as a method to prevent infections and reinfections and as a family planning method to prevent pregnancy. Although not all of the HIV+ women understood the concept of dual method use, some were using a condom and another method of contraception. Among the ANC clients, some viewed condoms as a backup method and as a convenient method for preventing infections among youth and unmarried people.

It was clear that there was general discomfort with condoms, particularly for the married women because bringing up condom use tested a relationship by introducing questions of faithfulness and trust. All of the participants agreed that men, particularly married men, need information and education on condoms and HIV, including prevention messages and the critical role of condoms in preventing the spread of HIV.

All of the women wondered whether the female condom could be used clandestinely. Among the HIV+ women who knew about the female condom, its cost was the main barrier noted. Among the ANC clients, the main barrier to use was husbands finding out about it. The discussion surrounding the female condom was infused with much confusion, for example, whether it could be washed and reused.

*Need for more information.* The women's need for more information cannot be underestimated. There was a clear cry from all the participants for more information on a number of topics. For instance, there was a hunger among HIV+ women for knowledge on the best FP method(s) for them to use. The HIV+ women said that they did not receive different FP information because they did not disclose their status to the providers. They cited potential discrimination as a barrier to informing the FP providers and suggested that family planning for them should be provided through the support groups or by self-declared HIV+ service providers at the FP clinics.

*The need to reach men directly with safer sex messages.* Women agreed that men need to hear information directly from program staff on the benefits of condom use. The women agreed that the best way to reach men with information was not through their female partners or wives as this could lead to conflicts in relationships. Some women suggested that men would be reached through public *barazas* and seminars.

*Better promotion of PMTCT.* Both the HIV+ women and the ANC clients expressed the view that PMTCT was not being properly promoted. The women's groups agreed that all women should be informed so that they clearly understand the importance of PMTCT services in order to make informed decisions. Some of the HIV+ women wanted to know more about what PMTCT entailed so that they could weigh the options of having children.

*Improve quality of care.* Some women complained of poor quality care. Having experienced stigma and discrimination from the public, the HIV+ women were concerned about potential discrimination and fear from service providers (thus, they did not disclose their status). The HIV+ women also expressed concern about quality of care at the PMTCT sites. Some FP/ANC clients reported that providers, especially those working in public health facilities, deliberately withheld care and comfort toward them or exhibited a "don't care" attitude. The clients also complained of long delays at the clinics, which might hinder clients accessing services.

## **Policy Implications**

Kenya should be rightly proud of achievements made in its national FP program through the 1990s. This study reinforces the notion that women and men still need family planning, even as they need protection against disease. The 2003 KDHS has shown that the gains made in Kenya's FP program are threatened by a loss of focus and a loss of resources devoted to the program and to services that people want and need. Yet, providing family planning cannot follow a "business as usual" path. FP services must adapt to the realities of HIV/AIDS by integrating HIV-related counseling and services and reaching out to women, men, and young people through all possible channels.

The findings from this study shed light on the status of family planning in Kenya and point to policies and plans that should be strengthened or reoriented to support provision of family planning to meet the RH needs of individuals in countries hard hit by HIV/AIDS. Providers are burdened with increasing workloads and by uncertain access to precautions against infection in their work. Providers favor integration but need training in integrating counseling and services.

# Chapter 1. Introduction

## Background

In 1967, Kenya was the first sub-Saharan country to establish a national FP program. By the late 1980s, Kenya's program was heralded as an African success story, credited as contributing to reducing total fertility from approximately eight births per woman in 1978 to 4.4 in 2002 (World Bank, 1980; CBS, 1980; PRB, 2003). Kenya's FP success has been overshadowed by the HIV/AIDS epidemic, which the government declared a national crisis in 1999 and identified as "the single most important health challenge that Kenya has faced in its post-independence history...the only known health problem that has the potential to reverse the significant gains made in life expectancy and infant mortality" (Government of Kenya, 1996).

The Kenya government's objectives set in the National Population Policy for Sustainable Development were to reach a contraceptive prevalence rate of 43 percent, all methods combined, by 2002, 53 percent by 2005, and 62 percent by 2010 (NCPD, 1999). The National Reproductive Health Strategy stipulated that reducing unmet need required making quality and sustainable FP services available to all who need them (MOH, 1996).

Preliminary data from the 2003 KDHS, however, provides a cautionary tale of the unintended outcomes associated with the shift in programming attention and resources away from family planning and primarily to HIV/AIDS. From a steady rise in contraceptive prevalence from 27 percent in 1989 to 33 percent 1993 to 39 percent in 1998, contraceptive prevalence stalled and remained at 39 percent in 2003 (CBS et al., 2003). Yet, unmet need continues to exist. The KDHS has consistently shown that many women report wanting to delay or limit future births but are not using any family planning method. In 1998, this unmet need among married women stood at 23.9 percent (NCPD, 1999).

Since the first case of AIDS in 1984, it is estimated that 2.2 million Kenyans are infected with HIV/AIDS, while 1.5 million have already died (NASCO, 2001). An average of 200,000 new HIV cases are reported annually. Estimates of HIV prevalence in Kenya vary. National surveillance data suggest an adult HIV prevalence of 13.5 percent in 2002, with regional and rural-urban variations (NASCO, 2001). Prevalence in sentinel sites ranges from a low of 4 percent to a high of 35 percent. Data from the 2003 KDHS, one of the first sub-Saharan population-based HIV prevalence surveys, suggests that HIV prevalence rates may be somewhat lower, at 6.7 percent, ranging from 10 percent in urban areas to 6 percent in rural areas (CBS et al., 2003). Women tested HIV+ at almost twice the rate of men (8.7 % and 4.5%, respectively).

Whatever the prevalence rate, HIV is overwhelming the health system and has drawn the attention of the government and donors away from family planning and reproductive health, as well as many other health issues. The rapid increase in the number of people infected with HIV/AIDS presents a major challenge to Kenya's health system, particularly in the rural areas (MOH, 2000). While only 16–19 percent of Kenya's population live in urban areas, 56 percent of the health sector personnel work in those same areas (Obunga, 2002). The few resources, both human and financial, that are left to the rural areas are being overstretched. Shortages of drugs and patient care services, inadequate diagnostic capabilities at various levels, including blood screening equipment and its maintenance, overcrowding, irregular supply of the testing reagents, and high turnover of qualified health personnel are indications of a strained health sector.

AIDS-related illnesses are common among staff at district-level health facilities, leading to high rates of absenteeism (NASCO, 2001). HIV/AIDS has had a negative impact on the morale of the staff, especially health service providers, due to pressure of work and heavy workload with very few positive

results (MOH, 2000). The MOH 1999 Service Provision Assessment Survey indicated that personnel shortages were one of the main issues hampering health workers' job performance (MOH, 2000).

The government is the largest provider of healthcare, including FP/MCH services, operating 56 percent of all health facilities in the country and providing 60 percent of all healthcare services (MOH, 2000; NCPD, 1994; National Research Council, 1993). Out of the documented 4,339 health facilities in the country, 2,482 or 57.2 percent offer FP services (Obunga, 2002). An integrated FP/MCH service delivery approach remained the model of service delivery in Kenya from the 1970s until the mid 1990s, when the FP agenda was broadened to incorporate other aspects of reproductive health after the 1994 International Conference on Population and Development (ICPD). A situation analysis study in Kenya found that few links were made between family planning and STIs/HIV/AIDS (Miller et al., 1998).

The Kenya National Reproductive Health Strategy stresses the role of condoms for dual protection against pregnancy and HIV/AIDS. It states that HIV/AIDS raises maternal mortality and morbidity and that pregnancy hastens progression of HIV to AIDS in HIV+ women. As stated, "Due to this mutual interaction and the fact that both conditions, i.e., pregnancy and HIV infection, affect or are found in the same segments of the population, contraceptives that prevent both pregnancy and STDs/HIV, e.g., condoms, will take central role in both family planning and STDs/HIV prevention programs" (MOH, 1996). Condoms in Kenya are mainly accessed through government outlets. The socially marketed *Trust* condom account for 15 percent of all condoms used (Obunga, 2002). The government has published a Condom Policy and Strategy (2001–2005) to ensure adequate national supply of and access to condoms (MOH, 2001; 2000). This policy and strategy has also been used to increase public education and advocacy to create demand for condom use.

Condom use for family planning is generally low (NCPD, 1989; 1994; and 1999). According to the 1998 KDHS, only 1.3 percent of currently married women (and 1.8% of all women) reported condom use. The preliminary 2003 KDHS puts this figure even lower, at 1.2 percent (CBS, 2003). According to the 1998 KDHS (the latest survey for which these data are available), even among sexually active unmarried women, condom use is at 8 percent, trailing behind injection hormones (12.2%) and pills (10.7%).

## **Study Objectives**

The purpose of this multicountry study, implemented in 2003, was to explore how family planning is being implemented in high HIV prevalence countries, including Kenya. The specific objectives of the study were to

- Assess how the HIV/AIDS epidemic has affected needs for FP services and other HIV/AIDS-related services like VCT and PMTCT;
- Explore emerging FP/RH needs in the context of high HIV/AIDS prevalence; and
- Provide lessons learned and make recommendations for improved FP and HIV/AIDS programs.

## **Methodology**

FGDs were used to gather data for the study. Opinions from three groups, which included service providers, FP/ANC clients, and HIV+ women, were solicited using FGD guides specific to the three groups studied. The FGDs were conducted in May–July 2003.

### *Study sites*

To capture regional variations of contraceptive prevalence and HIV prevalence, the study covered three regions (see map on page 5). Kisumu District was selected to reflect the high HIV prevalence (28%) and low CPR (28%) in Nyanza Province. The Nyeri District selected in Central Province, meanwhile, has the highest CPR in the country (63% use of any modern method) (NCPD, 1998) and an HIV prevalence rate of 11 percent. Inclusion of Nairobi District/Province, which has a CPR of 46 percent and an HIV prevalence rate of 16 percent, gave an urban/rural comparison (NASCO, 2001).

In selecting these sites for the study, urban/rural and socioeconomic variations were also captured. Both Nyeri and Kisumu are rural districts, but Nyeri enjoys better socioeconomic conditions than Kisumu. Nairobi District/Province, on the other hand, is an urban district but with large pockets of poverty and poor socioeconomic conditions in informal settlement areas and slums.

### *Recruitment of participants*

Participants for the FGDs were recruited through local opinion leaders in the study sites. For the HIV+ women, the research team identified a social worker in each community who in turn introduced the researchers to HIV+ women. The snowballing method of recruitment was adopted to get the right number of eligible participants. In Kisumu, the research team used social workers from the Kisumu County Council and Center for Disease Control (CDC) while in Nairobi, the research team found social workers working with people living with HIV/AIDS (PLHAs), support groups, and home-based care to assist them in recruiting FGD participants. In Nairobi, the group was drawn from the support group, Women Fighting Aids in Kenya (WOFAK). The eight participants were receptive and willing to give their opinions. In Nyeri and Kisumu, the participants (eight each) were part of a support group from a home-based care program.

For the FP/ANC clients, the researchers visited various MCH/FP clinics and after speaking with the head health workers, talked to the clients individually, telling them about the study. The researchers obtained consent and arranged for a day to conduct the FGD.

Providers were recruited through a “seminar” method in which the researchers met with providers in the health facilities serving the study communities as a group to explain the purpose of the study. Nurses were recruited for the study after ensuring that they were working with FP/ANC departments in their health facility.

A total of 71 participants from three regions participated in the FGDs, as shown in Table 1.

**Table 1: FGD Participants**

<b>Group</b>	<b>Nairobi</b>	<b>Nyeri</b>	<b>Nyanza</b>	<b>Total</b>
Service providers	8	8	8	24
FP/ANC clients	7	8	8	23
HIV+ women	8	8	8	24
<b>Total Participants</b>	<b>23</b>	<b>24</b>	<b>24</b>	<b>71</b>

### ***Focus group guides***

An FGD guide was developed for the study by POLICY Project staff and was modified after pretesting with a group of nurses in rural Nairobi. The FGD guide was also modified slightly for each of the three subgroups: service providers, FP/ANC clients, and HIV+ women. The content in the three guides was similar but with some group-specific differences. Please see Appendix 1 for the English versions of all three FGD guides.

The FGDs were used to collect views about family planning and HIV/AIDS and covered issues relating to

- background of participants;
- demand for FP services;
- use of methods: condoms, other contraceptives, dual protection, and dual method use;
- integration of FP and HIV/AIDS services;
- quality of care;
- program and organizational issues; and
- suggestions for improving services.

For the purpose of this study, the three guides were translated into Kiswahili for HIV+ women and FP/ANC clients in Nairobi, Luo for participants in Kisumu District, and Kikuyu for those in the Nyeri District. For all three regions, the FGD guide for service providers was not translated, as it was expected that they all understood English.

### ***Training of research assistants***

In preparation for fieldwork, the facilitator hired a group of research assistants as trainers for moderators and scribes. Training took place in Nairobi, and the selected team consisted of two moderators and two scribes. One moderator and one scribe were Luo with good knowledge of the Luo language and Kiswahili. The other moderator and scribe were Kikuyus with a good understanding of Kikuyu and Kiswahili.

The facilitator carried out the training, which covered the purpose of the study, the importance of participants' consent and understanding the contribution to the discussions, and the specific roles that the moderator and scribe play in the FGD group dynamics. The importance of group facilitation and confidentiality was emphasized during training. The training also included the different groups of participants and how to recruit them. At the end of the training, selected research assistants were given copies of the training manual for reference in the field.

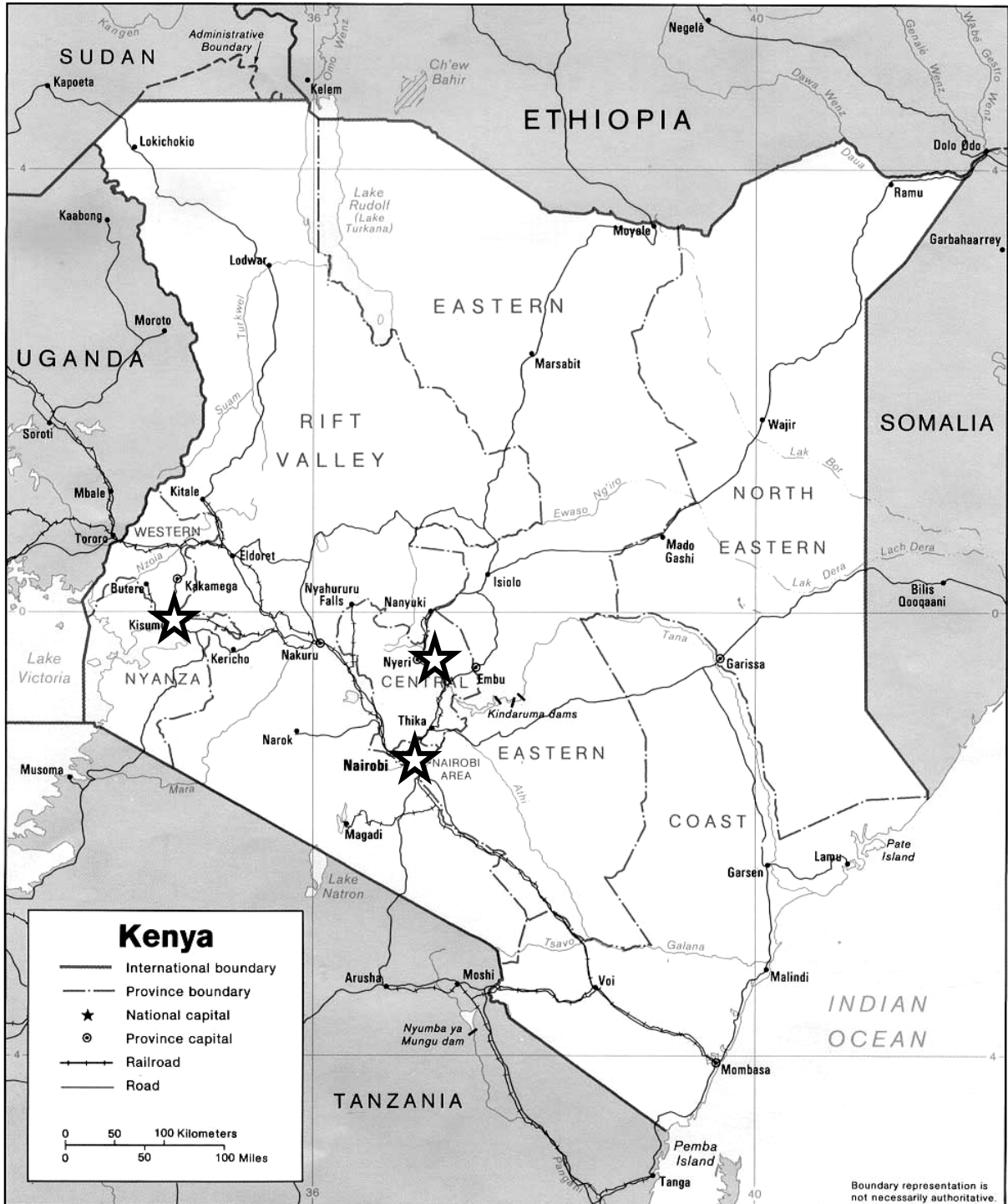
### ***Data analysis***

Data were collected using FGDs in the form of scribes' notes assisted by recorded tapes. In the field, the research team—the moderator, scribe, and facilitator—compiled summaries of each of the discussions. After completion of the fieldwork, the moderators and scribes transcribed and translated the recorded FGDs as accurately as possible. The research team discussed some of the phrases in local languages before they were translated into English.

The transcripts from the nine focus groups were then prepared for importation into NU\*DIST, a qualitative software program for coding and analysis. The research team then met and prepared the coding framework on the basis of the emerging themes from the data summaries.

A specialist in qualitative data analysis coded the documents based on the major theme framework and other emergent themes in close consultation with the research team, particularly the facilitator. These themes/nodes were used in preparation of this report.

## Map of Kenya



Map of Kenya Courtesy of the General Libraries, University of Texas at Austin Base B01061 (B00446) 1-88

## Chapter 2. Findings

The FGDs with service providers, FP/ANC clients, and HIV+ women touched on several issues pertaining to the need for family planning in the context of HIV, the linkage between FP programs and HIV/AIDS services, prevention and protection against the virus, fears and concerns about HIV/AIDS, condom use and barriers, and FP needs for people living with HIV/AIDS.

### Background of Participants

#### *Service providers*

Among the 24 service providers who participated in the study, the eight Nairobi service providers included males and females ages 20–30 years. With one exception, the service providers were single. All had received training in the University of Nairobi Nursing Program, and they were working on RH activities at the referral hospital or other health clinics. The Nyeri and Kisumu participants (eight from each location) were mainly married, ages 30–50 years, were trained in the Medical Training Colleges, and had practiced longer. The Nyeri providers were all women while the Kisumu group had two men in addition to the women. The participants served clients seeking RH services in MCH clinics, sexually transmitted infection (STI) clinics, and the Youth Clinic in Nyeri. The Youth Clinic is one-of-a-kind in the country, providing RH services to young people.

#### *FP/ANC clients*

Twenty-three FP/ANC clients were interviewed for this study—eight participants in Nairobi, eight in Nyeri, and seven in Kisumu. The participants' ages ranged from 18–40 years, and most of the women were married and had at least one child. All were attending ANC clinics, and most had visited FP/MCH clinics for services. While participants willingly contributed to discussions, the group initially lacked a common connection and limited their sharing until probed by the facilitator. However, once they warmed up and got comfortable, they freely discussed the questions addressed to them.

#### *HIV+ women*

Twenty-four HIV+ women between the ages of 24 and 60 participated in the Nairobi, Nyeri, and Kisumu FGDs. The women had known about their status for between one and 10 years and most were either widowed or single. Almost all of the HIV+ participants had at least one child and those who did not expressed the desire to have a child. Some had had children after learning about their HIV status.

### Demand for FP Services

Among all groups in the study, most participants agreed that there was an increased need for FP services, particularly condoms, due to high HIV prevalence in the Kenyan communities. Respondents generally felt that the need for family planning is greater and more people are using, interested in, or willing to use condoms. All participants in all groups, whether or not they agreed that the need for FP services was increasing, felt that FP needs had changed in light of the AIDS epidemic.

*The AIDS disease has made people use family planning services because if one is 'active' they can either fall pregnant or contract the disease; therefore, some who have HIV can use family planning to increase their days. (FP/ANC client, Kisumu)*



*Yes, [family planning] needs have changed because one of my neighbors, when tested and told she had the virus and the husband too, instead of going for family planning tablets/medicine or injections, they opted for condoms. On my side I don't have a husband; I am alone, and from the time I was tested and told I am sick, I stopped using family planning services. (HIV+ woman, Nyeri)*

*I would say HIV/AIDS has not affected family planning to such an alarming stage which we can think HIV has made our women not to go for family planning. (provider, Nyeri)*

*[HIV] has increased the needs for family planning services by men and women in the community... Now men and women from these communities have decided to come for family planning clinics, especially use of barrier methods such as condoms, so that as to protect themselves against conception, therefore planning the families at the same time protecting themselves against this killer disease. (provider, Nairobi)*

*I think basically condom is the one on high demand here because you can use these other methods for family planning but you have to protect yourself from HIV/AIDS. You find that maybe a mother can come for injectables but still has to get some condoms to protect her from HIV/AIDS. (provider, Nairobi)*

*Even the number of men as per now has increased compared to the men who were coming [for condoms] that time. (provider, Nairobi)*

Increasing HIV prevalence in Kenya's lake region has resulted in continued sickness and death. FP/ANC participants varied in their opinions on how HIV has affected the need for family planning in their region.

*AIDS has made many people seek family planning services so that even if they fall very sick, they can have a smaller number of children to take care of. (FP/ANC client, Kisumu)*

*Those who have AIDS may wish to have children but they will not manage because the children will die one after another. (FP/ANC client, Kisumu)*

*My opinion is that AIDS has reduced the number of people seeking family planning services because many people are sick and therefore feel that they should not use family planning services since this will increase their ailment. (FP/ANC client, Kisumu)*

In some societies, the practice of wife inheritance, in which a woman is taken as a wife by the brother of her deceased husband, is common in conformity with cultural norms. Among the Luos in Nyanza, inheritance of wives is widely practiced. This study found that there are times when women wanted to be inherited to conform to cultural norms but did not want more children in the newly formed marriage. These women did not, however, have the power to negotiate condom use, particularly during the "cleansing" ritual, which often can contribute to HIV transmission.<sup>1</sup> Women who were inherited therefore usually adopted other methods of contraception, such as the pill. Because of such rituals, the service providers in Kisumu noted increased need for family planning services.

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<sup>1</sup> A ritual cleanser, commonly a man of low social standing known as a *jater*, is paid to have sex with the widow in order to cleanse her of her husband's evil spirits. Condom use is rare as cleansing is not considered complete unless semen enters the widow and because women's inequality makes it difficult to demand condom use. For more information on this subject, see *Double Standards: Women's Property Rights Violations in Kenya* by Human Rights Watch, available at <http://www.hrw.org/reports/2003/kenya0303/>.

*Those who are coming for family planning mainly in our place are ladies ... most of them have husbands who have already died so they have inherited husbands<sup>2</sup> and they don't want to give birth...most of them come for family planning. Therefore, the number using family planning methods has increased. (provider, Kisumu)*

Service providers in Kisumu felt that awareness of one's HIV status had a significant impact on their decision to use family planning. In situations where clients knew their HIV status but chose not to use family planning, providers expressed that the clients wanted to have children before they died or to replace the dead ones.

*...When we assess our statistics we find that certain age group is fading out and replacement is not there. It has affected us in a manner that people feel, let us replace. (provider, Kisumu)*

An FP/ANC client noted that she thought HIV has reduced demand for family planning among HIV+ people.

*...In my opinion, it has reduced the use of family planning services because someone who has tested HIV positive knows they are going to die and consequently feel there is no need in using these services. (FP/ANC client, Kisumu)*

## **Use of Methods: Condoms, Dual Protection, and Dual Method Use**

### ***Male condom***

The importance of condom use was discussed in length in the groups. All three types of participants were clear that for PLHAs, the only way to minimize the spread of HIV is through abstinence for those who can manage, or through consistent use of condoms to avoid pregnancy and/or re-infection. Condom use was also mentioned as the best method for those at high risk of HIV infection and for youth. However, it was clear that expecting condom use among married couples is a huge challenge.

*The mothers tell us their husbands refused to use the condoms, so it's not a reliable method. I would not say it's very reliable [expressing personal experience with clients], because they will use one day and the following day they would say they don't want to use [condoms]. So I don't really think that I would trust any mother in using the condom for long. (provider, Nairobi)*

*...the only hindrance to women using the condom is men, so if they are taught together with the women they will accept. (FP/ANC client, Kisumu)*

*We know, but husbands cannot agree. They will cause fights. He will assume that 'you know where you go visiting [referring to suspicion of unfaithfulness]...' (FP/ANC client, Nairobi)*

*It is because I am married and my husband will not accept to use [the condom]. (chorus of agreement from the group) (FP/ANC client, Nyeri)*

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<sup>2</sup> Meaning that a husband has died and a brother has taken over the household of the deceased brother, including his widow.

Although the church was cited as a potential barrier to condom use, it was clear that after church service, individuals went their ways and made personal choices. At times, the personal choices may be contrary to the teaching of the church.

*Sometimes the church discourages people from using condoms, probably because they want to control immorality. But after church, people seem confused. (HIV+ woman, Nyeri)*

Discomfort and fear were also cited as barriers to condom use.

*If you look at the condom, it has some powder and some pores that affect the woman. This may cause itching and some sores on the woman. So women do not like the condom. I also fear it. (FP/ANC client, Kisumu)*

One FP/ANC client thought that some people did not use condoms specifically because they knew they were already HIV+, responding to a question about barriers to condom use this way:

*Some of the people are HIV+ and know they are going to die soon... [and] what the condom would have prevented, they have already contracted it. (FP/ANC client, Kisumu)*

Several suggestions were discussed on what can make women able to use condoms. The need for men to be more involved in acquisition of FP services, information, and education on the importance of FP methods for pregnancy protection and HIV prevention were on the forefront. FP/ANC clients thought that the best way to reach men with information was not through their female partners, as this might lead to conflicts in marriage, but more through public meetings with local chiefs and/or seminars planned for Sundays when the men are not busy working.

*... couples should be advised to use it when they are together. Sit down with the couple and tell them the benefits of using the condom. This should be done door-to-door. (FP/ANC client, Kisumu)*

*They [men] should be called for seminars, such as on Sundays when most are not working. (FP/ANC client, Nairobi)*

The women also said that the condoms currently are placed in exposed places where there is no privacy if one wished to collect some. They suggested that condoms should instead be provided door-to-door to avoid embarrassment and public involvement in one's lifestyle.

*...you see where they normally put them its difficult for you to pick the condom because it's put in the open. You even feel shy to pick them because people will see you and their immediate opinion is that this woman normally uses these things. (FP/ANC client, Kisumu)*

Observations that stood out touched on the increased need for FP services among youth and men in general. In Nyeri, where a one-of-a-kind Youth Reproductive Health Clinic was started in the late 1990s, it was agreed that the presence of the clinic has encouraged young people to seek FP/RH and HIV/AIDS services. The participants, particularly service providers, expressed that:

*We have observed that young people are really on the use of condoms because they know it protects from HIV. (provider, Nyeri)*

### **Female condom**

It was clear that women needed another method that could protect against both pregnancy and STIs/HIV that they could use that does not completely depend on their husbands. Some groups discussed the female condom as such a method. One participant said:

*I would talk about this other way in which women can prevent themselves getting pregnant using condoms. There is femidom [female condom], which has recently been introduced. Many people are not very comfortable with femidom. Women are saying it makes a lot of noise. If there was another way through which women can use to prevent pregnancy, that even if their partners have refused to use condoms, women would be happy. They would use it to prevent infection and pregnancy. (HIV+ woman, Nairobi)*

Some participants were interested in the female condom but had never seen one and did not know how female condoms were used. One participant asked the moderator of the FGD for more information.

*Yes, we have heard [about female condoms] but... I haven't seen one. (To moderator) Is it something he can't see or feel? (FP/ANC client, Nyeri)*

HIV+ women expressed the need for female condoms and the importance of making them available and accessible to people of all economic levels.

*Some have not even ever seen it [female condom]. The cheapest we can get is 50 shillings<sup>3</sup> and it goes for one round [of sex], and we are told one can wash it, but people here might not be able to clean it. So they only use it once, and you know 50 shillings for people like us is too expensive. (HIV+ woman, Nairobi)*

*...Now if this female condom is there, why are family planning providers not giving it for free? (HIV+ woman, Nairobi)*

Service providers confirmed that the female condom was not readily available and that when clients could afford female condoms, they were often reused.

*No, only samples because they [female condoms] are quite expensive. (provider, Nairobi)*

*Like for commercial sex workers, you find they have introduced the female condoms... When one is ready they ask, 'have you finished with it, go and wash' because the female condom is very expensive they cannot afford it. If one is about KShs. 150 and it's supposed to be used once. (provider, Kisumu)*

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<sup>3</sup> The cost of the female condom was much disputed. It was agreed that the cost of around Ksh. 250.00 without subsidy was too high. This cost was beyond the limit for almost all clients (HIV+ or otherwise). There were also feelings that the female condom was not being promoted strongly, and the clients wanted to know why.

### *Dual method use and dual protection*

One practice causing considerable conceptual difficulties, not only for providers but also for clients, is the need to use dual methods.<sup>4</sup> Only the condom protects against HIV transmission; however, the condom is not the most effective method of protecting against pregnancy. Furthermore, regular and consistent condom use, particularly by married couples, is uncommon. Hence, clients exposed to the risk of both pregnancy and HIV infection should be counseled on use of condoms and other methods of contraception so that they can make informed choices about what method or methods to use. HIV+ women who are concerned with protecting against infecting partners and, at the same time, need adequate contraception to avoid getting pregnant unintentionally (and thus reduce the potential of having an HIV-positive baby) should also be counseled on dual method use.

Generally, the service providers were not clearly informed on whether dual method use and dual protection were part of a government policy. However, they reported that their basic training required them to counsel clients on all FP methods and that due to HIV/AIDS, they also counsel clients on the advantages of using barrier methods, which people are also increasingly hearing about in other settings as the society struggles with efforts to curb the spread of HIV/AIDS.

*We can also advocate the clients to use two methods; for example, if someone is using pills, we give together with condoms; it's called dual method wherein with each method we use the condom so that we can protect against STIs and HIV/AIDS.* (provider, Nyeri)

*...I think that a condom is not a very reliable method of family planning. It has its own failure so most of the time we encourage it as a back-up method when you have the pill or something like that. So those other methods are usually more reliable than the condom, but you see the condom comes in because of the issue of sexually transmitted diseases and HIV/AIDS...* (provider, Nairobi)

*They [service providers] advise that there are pills, condoms, tubal ligation, and coil [IUD].* (FP/ANC client, Kisumu)

FP/ANC clients expressed that service providers usually counseled them on all possible benefits of all FP methods. Service providers and clients agreed that the clients made the final decision as to which method was right for them.

*I think all of them [methods] should be provided, so long as the mother has chosen the method herself; the family planning provider should just tell the mothers the truth that HIV/AIDS is there. I will give you this Norplant or these other pills but they will not protect you from HIV/AIDS. So you just offer the information if they want to choose the method maybe because they trust themselves or their spouses, then there is no problem.* (provider, Nairobi)

At times, service providers indicated that they get frustrated by this arrangement in cases where they do not think clients are making the best choice regarding prevention of pregnancy and HIV. In those cases, the providers can only hope their counseling helps.

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<sup>4</sup> USAID's 2003 Technical Guidance on Family Planning and HIV Integration subsumes dual method use under dual protection, which the agency defines as mutual monogamous partners practicing effective contraception, the practice of abstinence and/or the delay of sexual debut, correct and consistent condom use, and the use of an effective FP method along with correct and consistent condom use.

*...A client will come determined with what they want. The only thing that can affect the counseling to divert her from whatever she wanted will depend on how you examined her. (provider, Kisumu)*

*...I think when the HIV test is done at least it is helping now having data on how many [clients] are positive. So that at least you may know or be able to help that client to make another choice of method. Because they will come with a fixed mind that 'I want an IUD,' and in this case she may not need an IUD.<sup>5</sup> (provider, Nyeri)*

The groups of HIV+ women and FP/ANC clients expressed that while they may have heard about the dual methods for dual protection and prevention, the concepts had not been explicitly explained to them by their service providers.

*...the condom and family planning...they even taught me how to use the condom {after probe} both of them at a time. (FP/ANC client, Kisumu)*

*My counselor advised me to use condom and contraceptive to prevent pregnancy since this will weaken my immunity. (HIV+ woman, Nyeri)*

Most of the participants agreed that they were informed and counseled on all FP methods before making their choices, but several of the participants indicated that, at times, their choices were driven by information from their friends or spouses.

The Nairobi group of HIV+ women, however, were an exception. They all agreed there was a lack of adequate information on the subject from providers and expressed the need for more information and better counseling on dual method use and dual protection. One woman had suggestions for how to reach PLHAs with FP (and dual method/dual protection) information.

*Many should be educated, both in hospital, clinics, and even for those who have come up with support groups, they should all be educated. Brochures and pamphlets could also be produced. That information should also be made to reach men. (HIV+ woman, Nairobi)*

Some FP/ANC clients were informed about the subject but said that they were advised to use only one method at a time.

*They [providers] normally talk of only one, either the condom or the pill. (FP/ANC client, Kisumu)*

Overall, the subject of dual method use and dual protection needs thorough clarification so that clients can fully understand the ideas and apply them. There is also need for more information and better education and training in this area for the community, men, and service providers.

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<sup>5</sup> The WHO has updated the Medical Eligibility Criteria of the IUD for use with HIV+ women from a category 3 (Should not use. Theoretical risks usually outweigh the benefits) to a Category 2 (Can use. Advantages usually outweigh the risks). This information is available in the third edition of *Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use*. [www.who.int/reproductive-health/publications/MEC\\_3/index.htm](http://www.who.int/reproductive-health/publications/MEC_3/index.htm)

## Integration of FP and HIV/AIDS Services

The majority of service providers, FP/ANC clients, and HIV+ women supported the idea of integrating HIV/AIDS services with FP/MCH services. The benefits of integration mentioned included promoting privacy, saving time, and reducing stigma.

*You see even if it will not be in one room because it will depend on the setup of the facility you have, if it's integrated in that setup all the clients will be sitting together under one room but nobody will know am I here because I want to be tested for HIV or am I here because I want a family planning method. It will be conducive even to the public because that fear 'so and so will see me going near the VCT site,' will not be there. (provider, Nyeri)*

Participants felt that information on VCT and particularly PMTCT was lacking, and some hoped that integration of services could make PMTCT and VCT more accessible. HIV+ women and FP/ANC clients expressed that PMTCT was not being promoted properly but felt that it was important for women to understand how important these services were in order to make informed decisions. Participants also felt that VCT and PMTCT services should be made readily available to clients in less conspicuous, more private spaces.

*I also think that the VCT should be integrated even in MCH... [Now] it's somewhere separate, but it's a very bad place because everybody is seeing you while you are entering there, there is no privacy. (provider, Nyeri)*

*You see like today, we were told to go for testing in room No. 8 [referring to the VCT room] so as to protect the unborn child. But you see, its somewhere you are being seen and people are afraid. (FP/ANC client, Nairobi)*

The HIV+ women expressed the need for information on VCT and PMTCT so that they can make informed decisions about their own reproductive health and whether to have children.

*We would want more information, and that information should be targeted well because we are many. It should be flashed on billboards, because most victims do not know what to do. You can help those who do not know about re-infection, condoms; others are only using family planning and they do not know they can be infected. You should also advocate for VCT services in family planning clinics. (HIV+ woman, Nairobi)*

The few providers who did not favor integration feared that integration would actually increase stigma and reduce privacy.

*If all people realize that in a certain room when you enter they [the service providers] want to know your HIV/AIDS status, people will refuse entering that room so when one comes from family planning [the person] will not go to that room because of the stigma that room has. (provider, Kisumu)*

*Now because of the number of staff we have in our place, we have a shortage we cannot help, so we try to separate one room for the FP, the other room for the VCT, so after the person decides to be tested [they] will go directly to the VCT room... You try to dis-integrate the services, so most of them fear that if I go there I'll be told about HIV/AIDS, and I have a fear in myself and I don't want to know my status. (provider, Nyeri)*

*HIV counseling needs privacy, so you cannot have two staffs in the [same] room. The client will not feel ok. It is always good to tell the client to have HIV/AIDS tested, but you are not forced.* (provider, Kisumu)

Some providers were also concerned that integrating services (e.g., if VCT were only offered at places where family planning and reproductive health were offered) would make it even less likely that men would attend the clinics.

*We might have a problem [if we integrate services] because for one, if a man comes in such a facility, back in the mind he will know that people will know he is not coming for family planning, so the other alternative he is coming for VCT, and he doesn't want to be known that he is coming for that.* (provider, Nyeri)

*If [a man] comes to a clinic and finds that he is the only one, he will never come again.* (provider, Nairobi)

*The ego of the man doesn't want to be seen near women [in the clinic], and they don't want to be known they are using [condoms]; if you talk to most men, they will tell you they cannot use them, yet they are the ones who are using.* (provider, Nyeri)

One provider was concerned that integrating MCH/FP and HIV/AIDS services would increase his workload:

*Those working in family planning clinics already have a lot of work. Thus, including VCT will worsen the situation [workload].* (provider, Kisumu)

Overall, the sentiment on both workload and integration of FP and HIV/AIDS services was best expressed by this statement:

*We need staff. If there is enough staff, integration can happen. You can counsel a mother both on family planning and HIV/AIDS at the same time because she has the time and knows that in one place there are around 20 staff ... But with this [current] shortage it is not possible.* (provider, Nairobi)

Although there was much support among the participants for making VCT more available, some clients did not support integration of VCT with other services. When considering the integration of VCT and other services, factors to consider might include negative associations that some clients may have with the VCT clinics.

*Like me, I was not counseled, I took the test at an old age. After receiving the shocking news, you no longer think of going back to that place [where one was tested] again.* (HIV+ woman, Nyeri)

The FP/ANC clients, on the other hand, unanimously supported integrated services. They agreed that separation of FP and HIV/AIDS services kept them from patronizing all the services simultaneously. For example, although pregnant women were told that they should visit the PMTCT center, they feared possible consequences of being seen coming from the isolated room where PMTCT services are held and so did not attend the services. If PMTCT services were fully integrated, there would be no stigma



attached to going to a center where all services were offered in the same place at the same time. Clients would also receive better and more comprehensive care without fear.

## **Quality of Care**

One of the major concerns that emerged during the discussions with HIV+ women and FP/ANC clients was the level of quality of care that patients were receiving in light of the HIV/AIDS epidemic. They reported that at times they felt that providers deliberately withheld care and comfort. They complained of long delays and unclean facilities at the government clinics, which made them seek some services from private providers. They concurred, however, that private clinics are expensive and do not have all the services they usually need. As much as they would wish to stay away from government health facilities, they are forced by circumstance to revisit them. There was unanimous agreement that government facilities give a wide range of services in a One-Shop (integrated service) model and are more equipped and less expensive than private clinics. It is the quality of care that may hinder them from visiting most public health facilities. Many clients reported deterioration in interpersonal relationships between the health providers and clients. Some providers agreed that high HIV/AIDS prevalence might have an affect on care. Providers felt that fears of infection, overwork, and a lack of appropriate methods could contribute to less than adequate care.

*In fact, clients are not getting 100 percent services we are supposed to give...due to overwork.... Sometimes you are forced to use methods which are not the right method; you want to clear the queue. What the government wants is that all patients who reported to the hospital left the place when they were all attended so the quality is not their problem but the quantity. (provider, Kisumu)*

Some of the clients agreed that the care they received was not of high quality. Several participants reported poor relationships with service providers.

*I spent a day there waiting [for PMTCT] but there was nobody to attend me... you spend time [in the clinic] and they [the staff] don't care. (FP/ANC client, Nyeri)*

Factors relating to HIV/AIDS that may impede quality of care to clients may include providers' eroding motivation, high workload, working attitudes, and the necessities of making up for the constant illnesses of their co-workers. During this time when HIV/AIDS is a constant worry, providers' work performance may also be affected by the fear of exposure to HIV at the workplace and a lack of guidelines on post-exposure prophylaxis.

One HIV+ woman indicated that quality of care for PLHAs is not necessarily better in the private sector.

*Private institutions will serve you, but when you reach critical stage or at the peak of the disease, they refer you to public institutions. They attend you when strong but at the peak of the disease, they disown you. Another thing is that they take long to disclose to the patient that he/she is suffering from HIV/AIDS. (HIV+ woman Nyeri)*

## **Information provided**

FP/ANC clients reported that they receive information on family planning and HIV from various sources, including from service providers as well as from the radio and other forms of media, and they said they would like more information on the linkages between family planning and HIV/AIDS. The FP/ANC

clients also expressed frustration about receiving confusing information. They also received some incorrect information.

*You know once you do not use family planning you can give birth and this is where there is a problem. At times, they [service providers] say that you may be HIV positive but you do not have AIDS. They [service providers] should differentiate the HIV virus from AIDS. At [one service delivery site] they [service providers] tell some people that they can give birth while others give birth and children die. So, I do not know the difference. (FP/ANC client, Kisumu)*

The findings also showed that some clients were misinformed about contraceptives and HIV. Many clients believed myths about HIV transmission when receiving family planning services. For example, one FP/ANC client from Kisumu said:

*Look at something like the injectable, you know one can contract AIDS through injections. At the same time these 'AIDS people' [here referring to personnel] say that if you have AIDS you should be releasing some blood through menstruation every month because this cleans up the system. This is one explanation they give why men die faster than women.<sup>6</sup> Men do not release any of their blood. However, when you use injectable, you do not see your periods for even one year, so all the blood is in your body. This means they should promote these services differently. (FP/ANC client, Kisumu)*

Some providers agreed that clients believed myths about contraceptives and HIV and that these myths may lead to a distrust of contraceptive methods. The providers said that they worked to dispel these myths.

*Some clients have heard rumors that condoms have the HIV virus inside. We discourage the rumors by telling them if you use them wrongly you can also be infected, maybe like using one condom throughout the night—it's wrong. Some people got HIV by using condoms wrongly; then they start blaming the method. (provider, Kisumu)*

The FP/ANC clients expressed the need for more information/education not only for themselves but also for their husbands and for service providers. They felt that their husbands needed more education on the importance of family planning for protection against both pregnancy and HIV/AIDS transmission. The mothers in the FGDs expressed the need for more information specific to the increased risk of HIV/AIDS infection and benefits of programs like PMTCT, and better training for providers on these issues. Some of the FP/ANC clients thought the providers were not well educated:

*Most of the time you find student nurses who do not seem to know a lot. You find that you are even better[educated] than them. (FP/ANC client, Nyeri)*

Some HIV+ women said they were advised strongly by service providers not to get pregnant, or to have abortions if they were pregnant and HIV+.

*I was told never to give birth again. I was asked why I got pregnant when having the HIV virus. I was told if I give birth, I will have a lot of problems and will die. That time there was no counseling. You were being told things and the nurse was like she was just insulting you. It's like you had committed a big crime. (HIV+ woman, Nairobi)*

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<sup>6</sup> This is a myth. There is no evidence that menstruation contributes to the lifespan of HIV+ women.

*I was pregnant; after they tested me and confirmed I had HIV, they told me to abort, but I refused. But unfortunately the baby later died. (HIV+ woman, Nairobi)*

*According to the counseling we get from this place, if you do not go for family planning, you will get pregnant, and there is no need of getting a baby because your immunity will decline and maybe your baby will be positive, so the trauma increases. We are not taught about VCT. (The woman was actually referring to PMTCT) (HIV+ woman, Nyeri)*

The HIV+ women were unanimous on the urgent need for more and appropriate information on FP methods.

*Do research, and tell us the appropriate and good family planning method for HIV+ people. Can we use Depo? What if I am HIV+ and three months pregnant, what am I supposed to do? What works and what doesn't? (HIV+ woman, Nairobi)*

The HIV+ women wanted to know more about HIV/AIDS, appropriate FP methods, and how they could improve their well being. They had overcome the fear of knowing their status, and now they needed information to take care of their health and live with the virus. With more information and better counseling, the HIV+ women would be able to make their own informed decisions about childbearing.

### ***Counseling***

Providers and clients agreed that the HIV/AIDS epidemic has changed the mode of FP delivery and counseling, warranting the need for many questions, including marital status and HIV/AIDS status, to be asked, unlike in the past. Counseling HIV+ mothers about breastfeeding and other related information takes more time than is generally allocated per visit. Along with the HIV epidemic, the number of HIV+ mothers is growing, and time and staff needed for this type of counseling must be taken into account.

*When we used to go for family planning services, they were not many questions asked like are you married. You could only be checked, for example, for blood and advised on the best methods for you, and if after use there are side effects it's changed to another. Today, they ask whether one is married, have you taken HIV test, why you want family planning. They then check you and recommend the best family planning. (HIV+ woman, Nyeri)*

*First is counseling, like now if you give birth you cannot breastfeed or you breastfeed for two to three months. Otherwise you use other sources of milk. So one is told all that. (HIV+ woman, Nairobi)*

*... with counseling, it's something which can take 40–45 minutes. It's not something that can take 10 minutes. Even to give a method it needs 45 minutes to one hour. So there should be more counselors in the room as well as family planners. (provider, Kisumu)*

One provider also noted that general counseling and education on HIV/AIDS also took up a large amount of time.

*When they come to you, you must start from scratch explaining everything, transmission and all that, because they do not know. At the end of the day you end up spending more than an hour with one client and others are waiting. It's lunch time but you can't go. (provider, Nairobi)*

All groups agreed overwhelmingly that more FP and HIV/AIDS counseling was needed. Training on HIV/AIDS counseling and FP provision was highlighted by the service providers as an important and urgent requirement to successfully implement an integrated service delivery model. Providers also mentioned needing regular updates on medical issues such as VCT, PMTCT, and new HIV/AIDS testing kits. In general, providers reported that there were few trained HIV/AIDS counselors, and it was important to have holistic training where one counselor would be able to serve both HIV/AIDS and family planning.

*I think it can be integrated by first training the service providers and integrating the HIV counseling in the training. You see, when they are being trained, it's not integrated. That component is not there. If you would put it there so as when they are leaving class, they know they are going to do family planning as well as HIV counseling. So that when they go to the field they will be better counselors and they will counsel all way round and serve the clients at once instead of telling the client to go to the other place for HIV counseling. (provider, Nyeri)*

The groups concurred on the urgent need for more HIV/AIDS-specific training, counseling, and updates to meet the overflow of demand for services due to high HIV/AIDS prevalence. Providers felt inadequately trained to provide integrated counseling services.

*In counseling, unless you have gone for the training on counseling people with HIV/AIDS, your sessions will not affect people living with HIV/AIDS because you probably have no idea on how to counsel on HIV/AIDS. (provider, Kisumu)*

*First we need to be trained on counseling of HIV—some of us don't know, and secondly, we need to be trained on testing if we need to test these clients under one roof, and in that when the client goes out she is comfortable. We also need to be trained on how to test so that when she comes we do the counseling you do the testing so as when she leaves you have completed everything. (provider, Nyeri)*

*I also feel each staff in the clinic should be updated on every issue which comes up which relates to HIV/AIDS. So updates should be there. (provider, Nyeri)*

*We need counseling services—staff to go for a short course in counseling specifically for HIV/AIDS. Maybe you did counseling [in school], but this time we want to be specific... so that you receive a certificate [in] counseling for HIV patients. (provider, Nairobi)*

One provider noted the need for training on youth-related RH issues.

*And even updates on reproductive health as a whole because it falls on that category and even your health because we are having a group called youth, and they are the ones who are really suffering. So we need to train our staff on how to handle the young people. (provider, Nyeri)*

### ***Interpersonal relations***

FP/ANC clients, particularly in Nyeri, felt that service providers should strive to be more sensitive to clients' needs and treat them with respect. The participants particularly felt that more effort was needed on the part of providers in government health facilities.

*Staff is adequate but do not take their work seriously. For example, a patient comes from far, and after seeing the doctor/nurse you are told to come tomorrow because there are no gloves... Sometimes we doubt if it's really lack of gloves. We find [that] they are not willing to work. (FP/ANC client, Nyeri)*

*The staff have a 'don't care' attitude. (FP/ANC client, Nyeri)*

*Some services offered here are not available in other clinics. So you find yourself back to this [government facility] because of those services missing in other clinics. Otherwise, one would not come back. (FP/ANC client, Nyeri)*

HIV+ women from all regions indicated that discrimination by providers impinged on the quality of care they received. Though the discrimination they experienced was not limited to healthcare provision, the HIV+ women expressed much disdain toward the system and felt forgotten and unwanted.

*They treat you like an outcast. (HIV+ woman, Nyeri)*

*I think health workers should change their attitude [towards HIV+ clients]. Perhaps even them they are infected it's only that they have not been tested.... They should be retrained. (HIV+ woman, Nairobi)*

*The staff at the family planning is very rude, they despise those who have AIDS. Once you go there, you leave the place very desperate because they do not counsel you on how to live with AIDS. (HIV+ woman, Kisumu)*

*I might be waiting at the reception on the bench, and I will have told the provider that I am pregnant but I have the HIV virus. She or he will be going in talk to a colleague; they will come together look at me ... Go in again talk to others... they look at you... You will know that they do not want to treat you. (HIV+ woman, Nairobi)*

Providers in Nairobi reacted with embarrassed laughter when they heard some statements from HIV+ women on poor quality of care. One service provider responded:

*The mere fact that HIV came, it should not dehumanize people. It should not lower our dignity... You still consider human beings as human, of course, you will still die and go to heaven. It doesn't matter which disease, one day we shall find ourselves there. So you have to...try and put yourself into their shoes. (provider, Nairobi)*

Not only does this sort of stigma and discrimination keep clients from disclosing their status to their providers and possibly receiving treatments that are not necessarily the best for them (e.g., not taking advantage of PMTCT programs), thus continuing the circle of silence, but it also may keep clients from seeking services at all.

The topic of stigma and discrimination led to a lively discussion among the HIV+ women, who discussed how they were treated not only in the health system but more broadly by the government and society. See Appendix 2 for further comments from the HIV+ women on the extent to which they face stigma and discrimination in their lives.

Participants living in Nairobi did, however, cite some institutions as having gone out of the way to treat PLHAs well.

*The most important drug to us is love... When I come to your clinic how do you treat me? In fact, we have one counselor here...who is very good. When you see him even if he has not treated you, you are cured... Even if you have rashes all over the body, the way he talks to you, treats you, you feel better. So you see our first medicine for us is love. The service providers should know that. (HIV+ woman, Nairobi)*

## **Program and Organizational Issues**

### ***Staff shortages***

Perception of increased workload due to high HIV/AIDS prevalence varied across regions. In Kisumu, consistent with the documented high HIV prevalence, service providers concurred that the healthcare workload was more than they could handle, to the extent that it compromised the quality of care that they were able to provide. Some of the factors the providers mentioned as indicators of their heavy workload included not having enough time to counsel clients, long queues, inadequately trained counselors, and staffing shortages.

*I think it [workload] has been affected because counselors are also overworked, such that you cannot have time with one client for a longer time and then the queue is long... counselors should be trained and then this counseling should be everywhere, i.e., churches, any social place so that the target group can be tapped anywhere not only in hospitals. (provider, Kisumu)*

*It [workload] has increased, staffs die, they are not replaced; there is an acute shortage. You might find yourself alone in the ward with seventy patients in the ward. (provider, Kisumu)*

*Shortage is always there; in the Ministry of Health staff are never enough, so even that now staff are dying because of the disease, so we are really having shortage. And also the government is not employing the people who are being trained; and some are retiring, some are dying and others are going to private practice, greener pastures, others are going abroad. (provider, Nyeri)*

*You see they say when you are not infected you are affected, the staff who are working there they are still be relatives of those who are sick. In this case if you have a very sick person, maybe you have asked for some time to go and take him to the hospital, others are dying. You are going off to bury your brother or whoever so at the end of it all they are so many people who are going off. The number of people who are on duty at a particular time is affected because of the epidemic. (provider, Nyeri)*

It must be noted, however, that this view of the providers' workload was not shared by clients who were asked about staffing levels. FP/ANC clients in Kisumu believed that there is less demand now than in the past for FP services and that there are more than enough staff to handle the workload.

*I think people [clients] have reduced because in the past there were very long queues, but now, if I may estimate using all the time we have spent in this discussion, there would only have been less than ten people attended at the clinic. (FP/ANC client, Kisumu)*

*The workers are nowadays just idling; there are no clients to serve. (FP/ANC client, Kisumu)*

The Kisumu FP/ANC clients felt that the quality of care that they received had improved because of the lowered number of clients.

*Nowadays they are very receptive as compared to the past... they sit down and talk to you, listen to your problem, and they are in no hurry. You see in the past they were teaching us in a group, but nowadays they talk to you one by one. (FP/ANC client, Kisumu)*

### ***Prevention of HIV transmission in the healthcare facility***

Service providers unanimously worried about being exposed to HIV/AIDS in the workplace, regardless of their region. Despite this fear, service providers indicated that they did the best they could to cater to the needs of clients.

*Sometimes you get a client [who] has wounds all over the body, he's almost collapsing; before you run and get the gloves, you will find the client down, so you say to be ethical let me just help and then I will rush and wash my hands. (provider, Nairobi)*

*The workload [is a barrier to taking precautions], like when I am the only nurse in labor ward on night or in stitching room for a casualty. I am exhausted and am to attend to these people as they come. In the process, I find I have pricked myself already, but I don't know the status of this person I am stitching as a casualty. (provider, Kisumu)*

It was clear from the service providers that while guidelines and drugs for post-exposure prophylaxis are available, access to both is limited mainly to the large government health facilities. Generally, smaller clinics and health centers do not have them. Providers indicated that they had to rely on precaution measures rather than post-exposure treatment to help them avoid HIV transmission.

Use of extra precautions elicited much discussion among the groups of service providers. It was evident that providers take extra precautions like wearing two sets of gloves, properly disposing of syringes, and properly removing gloves, whether guidelines are available or not. But unlike the case with post-exposure prophylaxis, guidelines on extra precautions were available in most health facilities regardless of size and resources.

*Yes, [the guidelines] are there. In fact they are posted on the walls in most of the rooms where you are dealing with the client. What to do with this. If dealing with the sharp [equipment] you put them in the sharps. (provider, Nairobi)*

Barriers to taking extra precautions included emergencies and/or lack of adequate equipment in some facilities. In Kisumu, providers cited heavy workload as an impediment to taking extra precautions. The Nairobi providers, however, felt strongly that workload could not interfere with their taking precautions. They expressed that if workload posed as a threat to taking extra precautions, it was better that work was left undone. The Nyeri providers' responses fell between those of their colleagues from Kisumu and Nairobi: they expressed that they would not allow their workload to keep them from taking the necessary precautions, but they might try to speed along the process if they had many clients waiting.

*I think the workload also affects because sometimes maybe you are supposed to decontaminate something and you have so many clients on queue, sometimes you don't spend the 10 minutes, you do it faster so that you can get the instruments for other clients. (provider, Nyeri)*

On the issue of emergencies being a barrier to taking precautions, providers expressed the view that it depends on one's conscience and work ethic. For instance, one might be faced with a case of a mother in labor delivering before being admitted or taken to the ward, and thus not having the chance to get gloves. In such a case, the providers concurred that it would be unethical not to attend to the patient.

*Sometimes there arises emergencies, especially in places like labor ward. You find a mother is in the stage of giving birth and the baby is almost out. You have no gloves anywhere near, you feel tempted to just get that baby and assist because the baby can get out of breath or something like that. (provider, Nairobi)*

Another provider emphasized the unpredictability of emergencies and the need for providers to care for their patients, regardless of their own fears.

*There was an emergency where a mother whose child was about to die, the person who was available had to do something fast, and at the end of the day blood was splashed all over her face but she ended up saving a life. (provider, Nairobi)*

Providers also discussed that they had to act rationally in making some of their choices.

*If you do not have cuts on your hands and here is somebody who is almost dying, you may decide to risk. (provider, Nairobi)*

A comment expressed by service providers suggests that clients go out of their way to provide needed supplies so that their quality of care is not compromised.

*Also you get in some clinics where mothers have been conditioned to come with a pair [of gloves] in case of need. If they come and are told the gloves are out of stock, they usually have their pairs. They [clients] even come with a syringe. (provider, Nairobi)*

## **Suggestions for Improving Services**

Participants in the study had many suggestions for improving FP and HIV/AIDS services, including other ways of promoting family planning, providing more information on HIV/AIDS family planning, providing counseling through the community, encouraging VCT and PMTCT, involving men in FP/HIV/AIDS counseling, ensuring the availability of condoms and other supplies, and providing antiretroviral (ARV) drugs through government assistance.

### ***Promoting family planning differently***

All groups agreed that promoting and providing FP counseling services should be done differently. HIV must be incorporated into counseling, and clients need accurate information and high quality counseling in order to make informed choices about protecting themselves from diseases and unintended pregnancy. Clients must be assured that they will not contract HIV through use of the injectable or the IUD. FP/ANC clients in Nyeri particularly were worried about contracting HIV through the needle used to provide the injectable contraceptive.<sup>7</sup>

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<sup>7</sup> Data indicate that this concern may be widespread, at least in Central Province, where Nyeri is located. Although use of the injectable as a contraceptive method increased among married women throughout Kenya according to the 2003 KDHS, from 11.8 percent in 1998 to 13.8 percent in 2003, injectable use fell slightly in Central Province from



*Since needles are endangered, if it's not sterilized properly and was used on an HIV/AIDS patient, if used on another patient, it can transmit HIV/AIDS. (FP/ANC client, Nyeri)*

*Yes, we are afraid of acquiring infections through injectables or needles. (FP/ANC client, Nyeri)*

However, this was not the case with the FP/ANC clients in Nairobi. The FP/ANC clients in Nairobi, unlike in Nyeri, expressed general satisfaction and no fear with the care given in the clinics.

*I feel like nowadays people understand what cleanliness is. Again syringes are opened as you watch, or you buy them if they are not available there. (FP/ANC clients, Nairobi)*

### ***Providing more information on HIV/AIDS and family planning***

There was general consensus that more information on family planning and HIV/AIDS was urgently needed in communities. The HIV+ women especially expressed the need for more information/education and reported that the best way to reach them would be through their support groups or having a self-declared HIV+ service provider in health facilities. People reported that they were lacking information on many topics, especially HIV/AIDS.

*You know, it's just that people do not have information... They should be informed on the risks involved, so that when one is doing something, one knows that this will hurt me... That information has not reached most people. If you talk to people about HIV, they tell you they do not know where to start or end. (HIV+ woman, Nairobi)*

*We would like to know more on how to protect ourselves from AIDS. (FP/ANC client, Nyeri)*

Some of the service providers agreed that people needed more information on HIV/AIDS, especially when choosing a contraceptive method.

*No, it should not also be criteria for family planning that because you are either positive or negative, that's when one [service provider] can give a method. But even as we give them [contraceptives], I think it is important for them [clients] to be given the knowledge on HIV/AIDS so as they choose the method, at least one knows that this method is more prone to giving me more problems if I am using it and I don't know my status ... If I am positive I may not use method 1, 2, or 3. So I think that information should be given to the client. (provider, Nyeri)*

*We discuss all the FP methods, and these barrier methods happen to be FP methods... you say in particular a condom will prevent you from getting pregnant and also from getting STI. That's how you get to be helped with the dual methods because you tell the mother, 'If you choose the pill, you should know one thing, it will not protect you from getting STIs.' If she chooses to use the condom plus the pill that's ok, but if she does not want to use the two, we have got no right forcing her. All you tell her is that yes you can*

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22.6 percent in 1998 to 21.6 percent in 2003. Injectable use increased in Nairobi, from 10.8 percent in 1998 to 14.8 percent in 2003 (CBS et al., 2003).

*use the pill alone, but remember you can still get infected with HIV/AIDS or any other STIs so you go think about it then you can choose to use the barrier method also. (provider, Nairobi)*

*During your counseling as you finish giving her all the choices and methods, you also emphasize on the dual method because of the benefit she will get such that even if you have taken the Depo or an IUD or whatever you are going to use, because of the problem we are having today of HIV/AIDS, if you cannot trust your husband, it is better for you to go and talk about a condom to your spouse, and we encourage that way. (provider, Nyeri)*

Other comments on the need for more information included the following:

*If possible, I would advocate for natural family planning, that is, they educate people more on natural family planning method. (FP/ANC client, Nyeri)*

*They should be taught on ways through which they can stay faithfully as husband and wife even if they are not using family planning methods. (HIV+ women, Nairobi)*

### ***Providing community-based counseling***

Door-to-door promotion, especially for condoms, was discussed as a preferable method of promotion because one would feel comfortable asking for condoms.

*They should have door to door campaigns... You know there are people who hear the side effects from their friends who use them [family planning methods], they therefore decide not to use them due to their effects. All this time they are just giving birth [having more children]. (FP/ANC client, Kisumu)*

Several HIV+ women felt that PLHAs should be trained as counselors and healthcare workers.

*Now that the health workers don't want to treat us or touch us why doesn't the government remit us and we will serve the people with AIDS. (HIV+ woman, Nairobi)*

*If you could train some of us we can readily serve people. Like me, I have been volunteering here at [the support group] center for a long time. (HIV+ woman, Nairobi)*

Several participants felt that prostitutes in particular were at risk of both becoming HIV+ and transmitting HIV. One woman suggested that there should be education on family planning and HIV/AIDS provided through outreach for prostitutes and that condoms should be distributed in the places they work.

*Condoms should be provided in lodgings; [prostitutes] get a place where they can put them or put them in the rooms. Commercial sex workers should be educated, and condoms be distributed. (HIV+ woman, Nyeri)*

### ***Encouraging VCT and PMTCT***

Among HIV+ women who had no living husband, the discussions also revealed that some were opting for abstinence, thus stopping the use of FP services. However, for those who expressed such choices, they expressed the need for FP services for others.

*...since one reason for marriage is sexual intimacy, and if you decide to marry, then you say no to it [sex], you break your marriage. So I suggest that people should continue using family planning methods but first be tested so that your type of virus can be identified [either as] type A or type B<sup>8</sup> so that you know the family planning method to use. So that you are not affected psychologically. (HIV+ woman, Nyeri)*

Some clients felt that PMTCT counseling and services should be improved at the local level.

*They told us, when labor comes, they refer you to Kenyatta Hospital because they do not have those drugs. We were told the mother takes two tablets of these drugs and the newborn is also given these drugs. (FP/ANC client, Nairobi)*

*I have heard of PMTCT, where one gets baby and is told not to breastfeed the baby but we have [to] know where [the services are available]. (HIV+ woman, Nyeri)*

One participant felt that counseling on PMTCT should be required for all pregnant women.

*I would suggest that instead of leaving it [PMTCT counseling] as voluntary, it should be made a must for any pregnant woman. They should stress the usefulness of this knowledge. (FP/ANC client, Nyeri)*

### ***Involving men***

It was mentioned repeatedly that it was often difficult, yet urgently necessary, to reach men with FP and HIV/AIDS information and services. Respondents had several comments on the importance of educating and counseling men, as well as suggestions on how to reach them.

*The only hindrance to women using the condom is men, so if they are taught together with the women they will accept. (FP/ANC client, Kisumu)*

*The men will only use condoms if all other methods of family planning are banned, and it's only the condom which is left. This way the men will be encouraged and they will see that it's only the condom they can use to plan their families. (FP/ANC client, Kisumu)*

*Men should also be educated. Because the first time one is told they have HIV, one cannot believe that sex with another partner can lead to re-infection. So the best thing is for both partners to talk and agree that they should not have a child so that they can live longer. (HIV+ woman, Nairobi)*

*The government should increase the intensity [of promotion of FP services] because we in the past knew how to manage ourselves because one may have had two or three wives and would not stay in the house in which a wife had give birth. So, if the government increases the intensity of promoting, the people will use the services. (HIV+ woman, Kisumu)*

*...because you get something like the condom, you get it's only around 60 percent of men who know how to use a condom to prevent something like HIV. There are so many who*

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<sup>8</sup> Types A and B refer to HIV-1 and HIV-2. The type of HIV has no effect on the contraceptive methods that HIV+ women can or should use.

*will fumble around with the condom, and they sort of contaminate it, maybe with their secretions, maybe transmit the same to the mate, or maybe you get the same secretion from the mate to the man and vice versa. (provider, Nairobi)*

*Basically, the number of men [visiting antenatal clinics] is less but...we can use something like outreach services. May be we can go and distribute the condoms... (provider, Nairobi)*

### **Ensuring availability of supplies and commodities**

Participants commented on the need to make condoms available and mentioned that certain supplies were often lacking in some clinics. Providers commented on the high volume of condoms needed in some of their clinics.

*This young man will come with his bag and ask, 'Sister, I need some condoms.' 'How many do you want?' '400 or 600.' 'What for?' You see, those question don't exist; you just give what he wants... Then he comes the following day, you can get some initiative of asking, 'Where did you take the ones that I gave you yesterday?' Then he will tell you he is working with a hotel and there is a lot of activities so all of them are gone; that's why he has come for some more, because of the discos. (provider, Nyeri)*

*But if you dish out condoms, like to the society, they get finished so fast. (provider, Nairobi)*

Some providers said that they often were not given enough disinfectant to sterilize their equipment properly.

*Generally there is worry everywhere because even the Jik we are given is not enough; you find you are given five liters to last for one week in one room. (provider, Nyeri)*

*We are supposed to be given full [strength disinfectant, but] we dilute so that you can use those instruments. Sometimes it's very little so you can't risk touching them without anything to decontaminate. (provider, Nairobi)*

Another provider said that gloves, in addition to disinfectant, were often in short supply, and that these shortages kept him from taking the necessary safety precautions to prevent HIV transmission.

*When you have very little Jik to use for a long time, and maybe at times you need to use sterile gloves but you don't have them, so this hinders you from doing the right thing. You know the right thing, but you can't do it. (provider, Nyeri)*

Some providers were concerned about the possibility of transmitting HIV from one patient to another due to insufficient supplies in emergency situations.

*You find there are few instruments; mothers who come to deliver are many... These instruments you had used some seconds ago on that patient and you had started sterilizing and maybe it was the only one remaining, you cannot allow this patient to die, you'll be sacked. So you use the instruments [on another patient]. (provider, Kisumu)*

Lack of supplies often jeopardize safe practices. At times, service providers compromised their work ethics not because they were not informed but because they lacked the necessary tools to do what they

knew was right. It is therefore critical that provision of supplies in a timely manner is ensured to better serve clients and sustain the safety of providers.

### ***Providing ARVs through government assistance***

The HIV+ women noted the need for the government to provide them care to help them live longer.

*The government should help provide drugs to HIV/AIDS patients, take care of them since it's a misfortune that befell them. Hospitals to provide identification letters so that HIV/AIDS victims can access treatment easily. When we die and leave our dependants, the government has a big burden of looking after them. This is contributing to the down fall of our economy, but when taking care of us, our life span increases, we are able to work and take care of our siblings. (HIV+ woman, Nyeri)*

*Prices of ARV medicines should be reduced. (HIV+ woman, Nyeri)*

*You know we have been given months which you can pick drugs at the hospitals. Once your quota is over, you cannot buy the drugs because they are expensive and are not available in the chemists. Our request is for the drugs to be distributed widely. (HIV+ woman, Kisumu)*

*We have heard that there are drugs that slow down the disease. We want to know whether it's available to all class of people. We are eagerly waiting. (HIV+ woman, Nyeri)*

Providers also asked for government assistance in the form of health insurance that would cover ARV treatment for them should they acquire HIV through their work.

*I remember there was a time when amniotic fluid dropped into my eyes. There was no way I could protect my eyes, so we would ask the government to give an insurance policy. We should have a good medical cover so that in case of anything [like contracting HIV through work] you are well taken care of. (provider, Kisumu)*

One provider said that their employer would provide partial post-exposure prophylaxis in the event of possible HIV exposure but would not cover the full cost of the treatment course.

*There is one staff who pricked herself in theatre, and she was given 14 tablets [of ARVs] and she was supposed to buy the rest for herself. (provider, Nyeri)*

Another provider said that the risk allowance they received was too little to cover even antimalarials, much less ARVs.

*I received a prick from my used VCT needle. I had to go through post-exposure prophylaxis, am finishing my tablets tomorrow. I had to have all the investigations done on me initially, and post the drugs I will have to be tested again. The risk allowance we are given is very little—KShs. 900—you can't even buy antimalarials. (provider, Kisumu)*

## Chapter 3. Summary and Recommendations

### Summary

Provision of FP services can help clients attain their RH goals, prevent unwanted pregnancy, lower infant and maternal mortality, and allow couples to serve as more productive members of society. In Kenya, as in many other developing countries, many births to women are unplanned, so family planning can help women, including HIV+ women, avoid unwanted or unintended pregnancies. At the family level, family planning empowers HIV+ couples to freely decide on limiting subsequent births. For the society, expanding FP programs in high HIV/AIDS prevalence countries helps reduce the burden on health services that are already overwhelmed and unable to meet the needs of the current population. Yet evidence suggests that as countries, particularly in Africa, are focusing resources on stemming the spread of HIV/AIDS, the attention to FP programs is waning.

This study of service providers, FP/ANC clients, and HIV+ women in three regions in Kenya explored how family planning has been affected by the high HIV/AIDS prevalence rates in Kenya and documents the emerging needs of family planning in light of the epidemic. This study is timely in light of the 2003 KDHS preliminary results showing no increase in contraceptive prevalence between 1998 and 2003 and a slight rise in the total fertility rate from 4.7 percent (during the years 1995–1997) to 4.9 percent (during the years 2000–2002).

Most participants in the three groups perceived that the HIV epidemic has increased the demand for family planning, while a few believe the need for family planning to have remained the same or even declined somewhat. While many people are using family planning for fear of passing HIV to their children, the desire among HIV+ women in the study to have children was strong.

Among all the groups there was a general understanding of how HIV/AIDS has had an impact on FP provision and what is needed in this era of HIV/AIDS. The threat of HIV/AIDS was clear to most of the participants, though some people tried to ignore the danger. All groups agreed on the need for intensive counseling, education, and community-awareness campaigns.

The majority of participants noted that family planning must be provided differently in light of HIV. Counseling for family planning can no longer simply focus on preventing unintended pregnancy among married women and couples but must include discussion of disease prevention and the methods to do so. In that light, most providers expressed the need for additional training to provide the comprehensive counseling that clients need to make fully informed decisions on pregnancy and disease prevention. It was evident in the FGDs that providers, FP/ANC clients, and HIV+ women alike have much misinformation about contraceptive methods as they relate to HIV. For example, some participants believed that HIV+ women live longer than HIV+ men because they menstruate; condoms contain the HIV virus; condoms are powdered and cause sores; promoting family planning encourages the spread of HIV; and HIV can be contracted through injectable contraceptives.

Participants, particularly the HIV+ women, suggested the FP programs need to disseminate information on preventing pregnancy and infection to the community through various media and through community-based and peer counseling. The HIV+ women suggested using other PLHAs to provide peer education to community members. In addition to individual counseling, discussions revealed the overwhelming unmet community awareness need, not only for FP and HIV/AIDS counseling but also awareness-building on PMTCT and breastfeeding for HIV+ mothers. All groups stressed that programs absolutely must include men directly—through providers, community leaders, and the media—rather than reaching women and expecting them to pass information to their partners.

Dual protection and dual method use caused conceptual difficulties for clients and providers alike. Providers were sometimes hesitant to recommend contraceptives other than barrier methods for clients they thought could be at risk of contracting HIV, yet most clients, particularly married women, reported that their husbands refused to use condoms. Furthermore, condoms had traditionally been considered more of a backup method rather than a first line method of contraception. Other than abstaining from sex or limiting sex to uninfected partners both of whom have 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 available other methods of protection against HIV (e.g., the female condom and, when they are available, microbicides).

Most participants supported the integration of HIV/AIDS and FP/RH/MCH services to lessen stigma, increase privacy, and save time for both clients and providers. To provide integrated services, providers said they would need updated training and steady stocks of supplies, such as gloves. Some providers noted a need for more staff to ease overwork and said that more staff may need to be hired.

Family planning can play a crucial role in preventing vertical transmission of HIV from mother to child through the prevention of unintended pregnancy among HIV+ women. An added advantage is that in situations where HIV/AIDS services are offered at special clinics that may be prone to stigma, offering those services at FP/MCH clinics might reduce that stigma. It is likely that integration might attract more service seekers in such clinics. However, programs must be aware that linking HIV/AIDS and FP services will not be sufficient for reaching men.

The findings of this study show the growing needs of PLHAs. One important element for PLHAs that cannot be ignored is that improved access to information and testing is leading to more PLHAs living longer. This will increase the challenges of support and care as well as prolonged need for FP/RH services, in addition to interventions to mitigate poverty. HIV+ women felt badly treated by service providers. Reducing stigma and discrimination among HIV+ women seeking services should be implemented immediately in the FP program in Kenya.

Kenya should be rightly proud of achievements made in its national FP program through the 1990s. This study reinforces that women and men still need family planning, even as they need protection against disease. The 2003 preliminary KDHS has shown that the gains made in Kenya's FP program are threatened by a loss of focus and resources devoted to the program and to services that people want and need. Yet, providing family planning cannot follow a business as usual path. Provision of family planning must adapt to the realities of HIV/AIDS by integrating HIV-related counseling and services and reaching out to women, men, and young people through all possible channels.

## **Recommendations**

### ***Promote family planning differently in light of HIV/AIDS***

- The findings on these issues show a consensus agreement among the groups that family planning should be provided differently to incorporate HIV/AIDS and also to cater to the needs of those who are HIV positive. Family planning needs in the era of HIV/AIDS require innovative promotions and provision and should reach out to PLHAs, men, and youth. In the context of HIV prevalence, FP services should be promoted, provided, and counseled differently.

- Women need access to methods they can control (like female condoms) as well as methods they can use without their husband's knowledge that protect against HIV/STIs and pregnancy (microbicides, when they are available).
- HIV+ women and FP/ANC clients want more and better information on family planning and condom use, and they want programs to reach their partners and husbands directly.
- New approaches and methods of FP services need to be promoted, for example, door-to-door provision of condoms and other contraceptives.

***Integrate aspects of FP and HIV/AIDS services***

- Integration of FP/RH and HIV/AIDS services needs to be taken seriously. There is urgent need to study the pros and cons of the model and put a pilot study in place. Given the sensitivity of HIV/AIDS, several models would need to be adopted and studied.

***Reach men with integrated messages on reducing unintended pregnancy and disease transmission***

- Male-specific education on the importance of FP methods like condom use should be emphasized, particularly to minimize barriers to condom use among married couples. Innovative interventions to reach men need to be developed and implemented. Examples could include intensive seminars targeting men to educate them on the dual benefits of FP and HIV/AIDS services, mobile outreach clinics, and training more male service providers.

***Use a variety of communication channels to provide information and behavior change communication***

- People need more information on HIV/AIDS and on the need for family planning as part of prevention and care services. All forms of media—radio, TV, print, community-based— should be used to increase knowledge and promote behavior change.
- Public campaigns are needed to promote new methods like the female condom and reduce fear of HIV/AIDS.
- Public campaigns on the benefits of VCT and PMTCT are necessary. Clinics offering these services should be distributed proportionately in rural and urban locales.
- Clients and communities need more thorough and accurate information on FP methods and HIV/AIDS to avoid misinformation and being misled by rumors and myths.
- Providers and clients need more information on dual method use and dual protection. Official policies on dual methods/protection should be available in all clinics.
- Men need to be targeted directly through the media regarding safer sex.

***Provide support for HIV+ clients to reduce stigma and discrimination in the healthcare setting***

- HIV+ clients need support in the form of patient support centers, HIV+ staff members, or clinics designated for PLHAs to reduce stigma and discrimination and be responsive to HIV+ clients' needs.



### ***Train PLHAs to become service providers themselves***

- HIV+ women expressed the need for having FP providers who are HIV+ or who, at the very least, had been trained in HIV/AIDS counseling, so that they could show sensitivity to their needs. If possible, HIV+ volunteers from local support groups could be trained to assist in the provision and promotion of FP services.

### ***Provide PMTCT/VCT services at the FP/ANC clinics to reduce stigma***

- PMTCT should be incorporated properly into ANC services to avoid clients skipping the treatment due to fear or stigma. Clients should be educated thoroughly in order to understand the benefits of PMTCT and make them more likely to use the services.

### ***Train providers to be able to counsel on FP and HIV***

- Providers need more training on counseling and updated information in order to provide integrated services. Providers also need training to raise their sensitivity to avoid discrimination against PLHAs.
- Because of heavy workload, especially in regions with high HIV/AIDS prevalence, there is a need to train more counselors. More service providers would reduce the time that clients must wait to be attended to.

### ***Provide support for the practice of universal precautions in health settings***

- Providers expressed worry about being exposed to HIV infection and noted that if all measures of protection were provided in all facilities (including at the local level rather than only in big hospitals), HIV exposure would be minimized. Lack of supplies hampered providers' ability to protect themselves in both routine healthcare (e.g., IUD insertion, normal delivery) and in emergencies (e.g., emergency obstetric care).

### ***Provide ARVs for PLHAs and health insurance for service providers***

- HIV+ women noted the need for the government to provide them with ARVs to improve their health and help them live longer. Providers were concerned about their health insurance coverage, including ARVs, should they contract HIV through their work. Providing ARVs at an affordable rate to PLHAs and health insurance that includes providing ARVs to service providers would improve the quality of life for Kenyans who are hardest hit by the HIV epidemic.

### ***Meet other needs of PLHAs***

- In addition to providing more compassionate services in healthcare settings, the government should implement policies and/or guidelines to support and protect those most affected by HIV/AIDS, including orphans and widows. The government and/or interested stakeholders should come up with income-generating approaches for PLHAs and their families. This might give hope and ways to alleviate poverty.

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## **Appendix 1. Focus Group Discussion Guide**

### **Instructions to interviewer:**

It is your job to facilitate the discussion. It is not your job to concentrate on recording information. That is the scribe's role. Explain how the focus group interview will work—in particular stress the confidentiality aspects. Check whether anyone requires clarification. Explain that you will be leading the focus group and that your colleague will be recording what is said. Ask permission to tape record the session.

Encourage all the participants—try to draw anyone who is quieter into the discussion. Make it clear that they should feel free to ask questions, too.

Try to end on an up beat!

### **Instructions to scribe:**

Tape record the session. Also, take notes to record the group's discussions in as much detail as possible, so that we get a sense of the range of views expressed. Always record WHO made WHICH comments. Record as much verbatim as possible in the notes to cross check with the tape-recorded version.

Before you leave, ensure that you have all the details necessary to complete the focus group write-up cover sheet.

### **Introduction and consent:**

Introduce the focus group and get verbal consent on tape from all the participants in the group, and explain the issues around confidentiality.

In the process of obtaining verbal consent, make it clear that

- Everything they tell you will be completely confidential—although their views may be contained in any reports that will be written, nobody outside of the group will know who has said what, and their names will not be used.
- Encourage them to interrupt with anything they think is important.
- Get permission to take notes and record the proceedings.

NB: please use the focus group questions below as a guide, but use your own initiative to prompt and further explore the group's responses.

## Service Provider Focus Group Discussion

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. Has the rising prevalence of HIV/AIDS in these areas affected counseling for family planning in your facilities? If so, how?
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)?

Probe: What is the practice at your clinic? Are clients discouraged from using non-barrier methods (like pills or the IUD)

Probe: How does the clinic staff go about discussion with clients of dual method use or dual protection?

5. Do staff worry about being exposed to the possibility of HIV infection at work?  
What have some staff reactions been to this worry about HIV? Are there any guidelines for post-exposure prophylaxis? Are drugs for post-exposure prophylaxis available?
6. Do staff take any extra precautions 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?
7. Are staff called to do more at work due to HIV in this area? In what ways are staff called to do more work?
8. Has the HIV/AIDS epidemic had any impact on the staffing levels in the clinics where you work? What about in the overall health care delivery system?  
(Prompt: illness and mortality among providers and staff)
9. Do you feel that family planning and HIV/AIDS services can be integrated at the clinic level? How? What elements?

Give the group space to raise any other issues that they feel are relevant. Explore with the group what the practical implications of the issues are and what the practical alternatives are.

**Thank the group for participating in the group discussion. Provide tea/soda and biscuits.**

## FP/ANC Clients Focus Group Discussion

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. 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 those fears?
4. 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?
5. What barriers do women in your community have to using a condom (or a condom with another form of contraception) with each sex partner? Are there fewer barriers to using a condom with some partners than with others? What are the reasons for that difference?
6. What could be done in your community to make it easier for women to use condoms?
7. Where do they usually obtain FP services and what changes they have experienced in receiving FP services?
8. Have you been to a VCT clinic or a center that provides PMTCT. If so, what FP services, if any, were offered? (Prompt for FP counseling)
9. What FP services would you like to see available at a MTCT or a VCT center?
10. Do you think that the increase of HIV/AIDS in this area has affected the services available in the antenatal/FP clinic? If so, how? (Prompt: fewer staff, staff less willing to provide services for fear of HIV/AIDS, fewer supplies and medicine or contraceptives available).

Give the group space to raise any other issues that they feel are relevant. Explore with the group what the practical implications of the issues are and what the practical alternatives are.

**Thank the group for participating in the group discussion. Provide tea/soda and biscuits.**

## HIV+ Women Focus Group Discussion

1. In general, how has the HIV/AIDS epidemic in this community affected men and women's needs for family planning services?
2. Should family planning be promoted and provided differently now, if at all, in light of HIV/AIDS in your community? If so: How? Why?
3. Thinking specifically about HIV + women and men, what are their needs for family planning?

Probe: Is family planning still considered a need among HIV + women and men in this community?

Probe: Do HIV + women and men feel more or less need for family planning in light of their status?

4. Do you think that the family planning information and services that you receive is different because of your HIV status? Is so, how?
5. 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?
6. What is the best way to reach HIV + women and men with family planning information and services?
7. Have you been to a VCT clinic or a center that provides PMTCT. If so, what FP services, if any, were offered? (Prompt for FP counseling)?
8. What FP services would you like to see available at a MTCT or a VCT center?
9. 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?

Probe: What types of services were denied?

Probe: How was the denial of access communicated?

Give the group space to raise any other issues that they feel are relevant. Explore with the group what the practical implications of the issues are and what the practical alternatives are.

**Thank the group for participating in the group discussion. Provide tea/soda and biscuits.**

## Appendix 2. HIV+ Women's Views on Stigma and Discrimination

The remarks from HIV+ women show the extent to which they feel discriminated against by providers and by the government and society. They expressed their feelings of being discriminated against and stigmatized in such strong words as “like you are a lesser person,” “outcast,” “despised,” and “unloved”. In an era when nearly everyone is aware of HIV/AIDS and its implications, the extent of continued stigmatization against PLHAs, particularly by service providers, is worrisome.

*Once you enter Ward 4, that's the end of you. Secondly, they do not bathe you unless a relative does it; food, once placed on the table, nobody cares whether you eat it or not. Hence, people are dying faster than they would if taken care of. (HIV+ woman, Nyeri)*

*Even a barber in my neighborhood refused to shave me because they had seen me coming out of this WOFAK Center. So there is still a lot of discrimination. I think one should not disclose their status so that one can get these services. Again this might lead to more people getting infected. We do not know what to do. (HIV+ woman, Nairobi)*

Poverty was also noted by HIV+ participants as a contributing factor in the spread of HIV/AIDS.

*Because of poverty, the disease is spreading in chains from parents to children. We were watching a movie...first born girl child was left responsible and when she goes out looking for money, she also falls victim of HIV/AIDS. So poverty has to be eliminated if we are going to curb this. Loans should be provided which will help in running business and will stop sex abuse as a source of income. (HIV+ woman, Nyeri)*

The cycle of poverty continues even after knowing one's HIV/AIDS status.

*You know I have gone to the VCT and am positive. Apart from this, I have children going to school. However, Kibaki helped us by providing free education.<sup>9</sup> But our life is not easy. We have to feed our children and clothe them. That is why we ask if the government can provide means for us, provide help to us. Okay, it's good we are provided with drugs, but what else do they provide? If there is no food, you cannot live because the drugs are so powerful you can collapse any time and your neighbor will confirm the rumor you have AIDS. You see our situation. So what help can you provide us? God loves us very much, people who do not have AIDS die and leave us kicking [i.e., that HIV-negative people may at times die due to other causes before HIV-positive people]. (HIV+ woman, Kisumu)*

*Poverty is the main enemy to AIDS patient because if you do not have the basic needs, you get mental breakdown. (HIV+ woman, Nyeri)*

*The commercial sex workers are infecting many people. For instance [suppose] I am a commercial sex worker, my child has been sent home to collect school fees. I get this man with a lot of money, he does not want to use a condom. I sleep with him, he gets the disease, and tomorrow he is with another woman. You see poverty is a main factor in the spread of AIDS. (HIV+ woman, Nyeri)*

The HIV+ women unanimously expressed the need for the government initiating assistance interventions in order for other stakeholders to follow.

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<sup>9</sup> President Mwai Kibaki abolished school fees in January 2003.



*The government should support the different groups of the HIV/AIDS victims so that other people can join these groups and help campaign against HIV/AIDS. (HIV+ woman, Nyeri)*

HIV+ women expressed the need to be protected by the government.<sup>10</sup> The groups noted that AIDS discrimination is twice as bad for women as it is for men. The worst happens if one's husband dies and the wife is left to provide for the family. The participants concurred that, at times, if the extended family knows the husband died of an AIDS-related disease, they often will destabilize the wife and children. The following quote summarizes the general feeling expressed about discrimination toward married women living with HIV/AIDS.

*Government to intervene, in the cases of widows who are always denied their right to own property left by their husbands; they are chased away from their homes and end up in the streets... Now that you are alone, you surrender and move out of that home. You are sick, you do not know where to go. (HIV+ woman, Nyeri)*

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<sup>10</sup> Many of the HIV+ women in the study were also members of support groups like WOFAK. It was evident that for the HIV+ women, affiliation with support groups gave members hope and inspiration. For some, the support groups created a feeling of family identity. In the group, they received unconditional support and love that was usually limited elsewhere because of their status.