

THE IMPACT OF PEER EDUCATION ON FAMILY PLANNING UPTAKE IN LUSAKA  
HIV CLINICS: A GENDER PERSPECTIVE

By

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A dissertation submitted to the University of Zambia in Partial fulfillment of the requirements of  
the degree of Master of Arts in Gender Studies

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DECLARATION

I, Namakau Nyambe, declare that this dissertation:

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## ABSTRACT

This study aimed to determine the impact of peer educators on family planning usage in Lusaka HIV clinics from a gender perspective. This was achieved by examining the perceptions of ART clients on the quality of family planning in the TIDES supported clinics and clinics that were not supported by TIDES. Two sets of clinics were compared to see the difference in perceptions; determining the gendered trends among ART clients on contraceptives after the introduction of peer education and by assessing the gendered processes through which peer education impacts on family planning.

This study used both qualitative and quantitative research methods to examine the views of 80 HIV + individuals who are on ART, 40 from clinics that were supported by TIDES and 40 from two randomly picked control site i.e clinics that were not supported by TIDES; 9 nurses, 6 from the TIDES supported clinics and 3 from the control sites and 7 peer educators from the TIDES sites. Maximum variation purposive sampling was used to select the sample. The target population consisted of HIV+ women and men, nurses and peer educators. Data collection tools included the use of questionnaires administered to the ART clients, 4 in-depth interviews with nurses and 2 with peer educators. Quantitatively, the study will use tables, graphs, and the computer based social science statistical package (SPSS).

The study findings show that peer education had an average effect on the uptake of family planning. The peer educators were able to reach both men and women with family planning information. They taught women the importance of decision making when it comes to family planning. The counseling given by the peer educators seemed to be appreciated by the ART clients in the TIDES supported sites. Even though they seemed to have gotten the information and knowledge on family planning and double protection, family planning use in all 16 TIDES sites did not change much. Many of the counseled clients still opted to use condoms as family planning, because that was their preferred method or because of the myths and misconceptions surrounding HIV and family planning they could not accept any method.

More men should be employed as peer counselor to enhance male involvement in family planning issues. Women should be informed that they have the right to make a decision when it comes to family planning. The family planning and HIV care integration should continue.

## **DEDICATION**

I dedicate this work to all the HIV positive women that I worked with during my research and all the CIDRZ peer educators and the entire TIDES/ Family planning team.

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## ABBREVIATIONS

ADS	-	Automatic Directive System
ART	-	Antiretroviral Therapy

ARV	-	Anti - Retroviral Drugs
CBRHA	-	Community Based Reproductive Health Agents
CIDRZ	-	Center for infectious Disease Research Zambia
DSP	-	Drug Stop Project
FCI	-	Family Care International
FP	-	Family Planning
FPI	-	Family Planning International
HIV	-	Human Immune Virus
HST	-	Health Systems Trust
IGWG	-	Interagency Gender Working Group
IUCD	-	Intrauterine Contraceptive Devise
M2M	-	Mother2Mother
MCH	-	Maternal Child Health
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organization
PEPFAR	-	President's Emergency Plan for AIDS Relief
PLWHA	-	People Living With HIV/AIDS
PMTCT	-	Prevention of Mother To Child Transmission
RH	-	Reproductive Health
SFH	-	Society for Family Health
STI	-	Sexually Transmitted infections
TB	-	Tuberculosis
UNFPA	-	United Nations Population Fund
VCT	-	Voluntary Counseling and Testing

WHO	-	World Health Organization
ZDHS	-	Zambia Demographic Health Survey

# CHAPTER ONE

## Introduction

### 1.1 Background

Reproductive health remains an important part of general health and should be available to all individuals. Reproductive health is a state of complete physical, mental, and social well being relating to the functions and processes of the reproductive system. It entails that people have the opportunity to lead a satisfying and safe sex life along with the capability to reproduce when desired. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility which are not illegal (Family Planning International (FPI), 1995).

Family planning is a very important component of reproductive health and should be made available to every individual. It saves the lives of women and children and improves the quality of life for all. Using family planning saves women's lives and health by allowing them to avoid unwanted and poorly timed pregnancies and saves children's lives by allowing parents to delay and adequately space births. The use of family planning helps to empower women by allowing them to decide the number and spacing of their children, which in turn provides them with increased opportunities for participation in educational, economic, and social activities. Measures to improve women's health, coupled with access to family planning and other key reproductive health services are likely to result in the most rapid improvements in health and wellbeing. (Policy framework strategies, guidelines, 1997)

Zambia is facing a very important reproductive health problem brought about by the high prevalence of HIV infections. The Zambian Government has established incentives such as Voluntary Counseling and Testing Centers (VCT) and Antiretroviral Therapy Centers (ART). VCT service was established in 1999 and expanded rapidly opening 46 sites by 2001, 101 sites by 2003, and 1,776 sites by April 2004. This has translated into 386,000 VCT visits between October 1999 and May 2003, over 266,000 HIV tests administered. In 2002, the government decided to make ART available to its citizens at no cost at all. This was in line with the specific objectives of the national HIV/AIDS/STI/TB intervention strategic plan. Lusaka alone is home to

a large scale public HIV care program that has provided free ART services to 75,000 HIV + Zambians since 2004 (CIDRZ Database).

Reproductive health, in particular family planning, has not been given adequate attention in Zambia. Family planning is not accessed by many people, especially PLWHA, for various reasons. Issues of gender equity and imbalance have a big role to play in the low uptake of family planning, staff shortages in many health centers play a major role in the inaccessibility of family planning commodities leading to a poor health worker to patient ratio causing some services to be neglected. For instance, most health workers say that family planning cannot kill any one as it is not a disease, so health care providers in the maternal child health (MCH) clinics would rather give priority to antenatal visits, PMTCT, and post natal visits. To curb this shortage, MOH and its collaborating partners have deployed peer educators to assist in providing the clients with family planning information and in some cases services. They are allowed to give short term family planning methods such as pills, condoms and injectables. There is evidence that not all PLWHA are accessing family planning. The low usage of family planning specifically in HIV clinics can be attributed to a lot of factors.

### **1.1.1 Health Service Related Factors**

The shortage of medical staff in clinics plays a major part in this ordeal. As alluded to earlier, the few medical staff in the clinics have a heavy workload and limited time to spend on counseling the ART clients on other significant issues such as family planning.

Most of the service providers are untrained and cannot give adequate and appropriate counseling to the HIV patients. For instance, they do not give the patients appropriate contraceptives such as hormonal contraceptives because the clinicians are not familiar with the method and these types of contraceptives are not usually supplied in the clinics. Hardy and Bradley (2004) also revealed that most of the providers had inadequate counseling skills. Many service providers expressed dissatisfaction with their own delivery of FP services, stating that they need updated information and training on new contraceptive methods. Hardy and Bradley (2004) showed that overall, service providers felt constrained in the advice they give by their own outdated knowledge, limited counseling skills, and the need to respect their client's privacy and freedom of choice. There is also a lack of family planning methods that are recommended for PLWHA. In some

cases, the methods could be available but the service providers are not trained on how to administer them to the clients.

The HIV+ patients also expect confidentiality from the service providers, Bradley and Hardee (2004) reported that for this reason the HIV+ women suggested that FP services be promoted and provided by training HIV+ women as FP providers to reach out to their friends.

### **1.1.2 Community Related Factors**

The study by Bradley and Honestor (2004) revealed that most people living with HIV do not want to access family planning because of many myths and misconceptions about FP methods. The myths and misconceptions made them hesitant to use contraceptives because they may believe that they cannot get pregnant because of HIV infection. Clear information about contraceptive methods is essential for women and their partners to make informed choices.

Many people, including providers, incorrectly assume that individuals with HIV will not be interested in or involved in sexual relationships. They may also believe that people with HIV should not have children. As a result of these biases, women are often denied the information and services that they need to prevent pregnancy, plan a safe pregnancy, and prevent mother-to-child transmission of HIV. In support of this the WHO and UNFPA 2006 made the following statement: “Because of the stigma and discrimination so often attached to HIV, it is particularly important that health service providers be able to protect the reproductive rights of women living with HIV. These rights include having access to sexual and reproductive health services and sexuality education, being able to choose a partner, deciding whether to be sexually active or not and deciding freely and responsibly the number, spacing and timing of their children. Women also have the right to make these decisions free of discrimination, coercion and violence Provider biases combined with a client’s fear of stigma and discrimination may limit access to family planning services(Banda, Honestor and Bradley, Sarah, 2004).

### **1.1.3 Economic Factors**

Some of the patients do not use family planning due to economic factors. Depo provera and noristerat, which are injection based conceptive methods, are typically too expensive for most individuals to afford because they cost K30, 000. In most of the health centers, if a client does not have the money they are sent back home without a proper contraceptive and may be at risk

for unwanted pregnancies. Most of the health centers are located very far from the rural areas and hence the people have to travel long distances to get there and most of the people cannot afford to pay for transport and end up not accessing health services.

#### **1.1.4 House Hold Factors**

Gender issues often affect decisions about contraception and STI/HIV prevention. Partner opposition is one of the most common reasons women cite for not beginning or continuing to use contraception. It is important to involve men in decision-making whenever possible because reproductive health decisions are more likely to be implemented when they are made jointly by both partners. The family size and the family duties that follow also contribute to the women not being able to access family planning. Most women who have large families have more responsibilities and are usually occupied with household chores and economic activities to fend for their families. International initiatives to achieve reproductive health (RH) outcomes such as reducing unintended pregnancy, stopping the spread of HIV/AIDS, and improving maternal health are increasingly recognizing that these outcomes are affected by gender, or the roles that are commonly assumed to apply to women and men. This includes the roles that affect intimate and sexual relationships. Governments worldwide are working to achieve the Millennium Development Goals, including Goal 3: *to promote gender equality and empower women*. Most international donor agencies have embraced the idea that RH policies and programs should support women's empowerment and gender equity, and have included this in their goals and strategies. For example, the United States Agency for International Development (USAID) has long required that gender issues both the potential effect of gender on proposed objectives and the impact of results on gender relations be addressed within its projects, including health programs. USAID provides guidance on gender through its Automatic Directive System (ADS). Since 1997, the Interagency Gender Working Group (IGWG), funded by USAID, has supported development of evidence-based materials and training for the implementation of programs that integrate gender into RH programs. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which is a key component of the Global Health Initiative, has provided technical assistance and guidance for the integration of gender into HIV prevention, treatment, and care programs, including the implementation of five PEPFAR gender strategies (What you need to know about the Global Health Initiative and Family Planning HIV/AIDS Integration).

The United Nations (UN) and the World Health Organization (WHO) have encouraged “gender mainstreaming” for the last decade. The Global Fund to Fight AIDS, Tuberculosis, and Malaria is developing a gender strategy that promotes increased attention to gender in country grants and within the organization itself. The World Bank adopted a gender and development mainstreaming strategy in 2001 and issued a revised Operational Policy and Bank Procedures statement in 2003. More recently, through the Gender Action Plan, it created a guiding framework to advance women’s economic empowerment in order to promote shared growth and MDG3. Many other bilateral and multilateral organizations also support policies and programs that promote gender equality. UNFPA’s State of the World Population 2008 Report states that “Gender equality is a human right. In all cultures there are pressures towards and against women’s empowerment and gender equality.” (Elisabeth Rottach, Sidney Ruth Schuler and Karen Hardee, 2009)

Numerous gender-related barriers that contribute to unintended pregnancy have been identified, some at the institutional and policy level, and others at the levels of the family and community. Fertility control has often been seen as women’s domain, and women are often construed as targets of family planning (FP) programs rather than beneficiaries of reproductive health care. As a result, programs have been slow to engage men and address gender-based inequities. Men’s power over women in the household also has implications for contraceptive use and reducing unintended pregnancies. Women are often in a weak position in negotiating the timing and circumstances of sexual intercourse. The perception that women are responsible for FP may mean that women without their own sources of income are unable to use family planning services unless they are free of charge. Women are often blamed for unplanned pregnancies even though men often play important roles in regulating women’s access to RH services through control of finances, women’s mobility, means of transportation, and health care decisions.

Women in some settings would rather undergo abortions than risk repeated conflicts with their husbands over contraceptive use. Women are disadvantaged by unequal power relations outside the home as well as within it. Gender power imbalances in client-provider relationships often are exacerbated by disparities in social status and education, which are likely to be greater when the client is female and the provider is male. This may encourage providers to behave in an authoritarian fashion that often results in compliance and passivity from their clients. Regardless

of the sex of the provider, female clients often fail to ask questions or voice concerns that may affect the success of their family planning use. Additionally, gender norms may discourage women, especially young women, from appearing to know or acquiring knowledge about sexual matters or suggesting contraceptive use. At the same time, the social construction of masculinity may contribute to male risk-taking in the form of unprotected sex and expectations to prove sexual potency (Elisabeth Rottach, Sidney Ruth Schuler and Karen Hardee, 2009).

## **1.2 Statement of the Problem**

Family planning has attracted the attention from both developed and developing countries. The main discussions drawn from the Cairo 1994 conference stated that, “The aim of family planning programmes must be to enable couples and individuals to decide freely and responsibly make available a full range of safe and effective methods”. Most women in rural areas are not utilizing these services and this could rise from different factors. Firstly, the possibility that their male partners do not allow them to use contraceptives due to various misconceptions around family planning in the community. Secondly, the fact that, in most African societies, men are still the decision makers at home, women do not have control over their sexual reproductive rights including utilisation of family planning services. The absence of men in family planning services has been evidenced as one of the reasons which affects the general utilisation of family planning contraceptives among PLWHA. It is worth mentioning here that gender issues affect both the HIV positive and HIV negative people the same way in terms of family planning usage (UN, 2010).

With the overwhelming numbers of ART clients in the face of few medical staff, namely doctors and nurses, the ministry of health and its collaborating partner, CIDRZ have introduced a back up strategy of incorporating within the mainstream peer educators. The worldwide trend towards integrating family planning into ART services is most likely to make the challenge of shortage of medical staff more eminent as provision of integrated health services requires more time and more staff. With this background, the extent to which peer education has gone to help improve the uptake of family planning through incorporating within the main stream gender equity and equality, has not been assessed or fully understood. It is this lack of thorough assessment of the impact of peer educators on the uptake of family planning by being gender sensitive that this investigation seeks to address. Put as a question, the statement of the problem is: What is the

impact of peer education on family planning uptake in Lusaka HIV clinics from a gender perspective?

### 1.3 Research Questions, Objectives, Tools and Analysis

#### 1.3.1 Main Question

What is the impact of peer education on family planning uptake among ART clients in Lusaka HIV clinics ‘A Gender Perspective’?

Research questions	Research objectives	Population and sampling	Tool	Analysis
What are the perceptions of ART clients on the quality of family planning in TIDES supported ART clinics and non TIDES supported clinics?	To compare the perceptions of ART clients on the quality of family planning in the two sites - TIDES supported and non TIDES supported clinics.	ART clients randomly selected	Questionnaire for ART clients	Descriptive analysis
What are the gendered trends of family planning uptake in TIDES supported ART clinics and non TIDES support ART clinics?	To document the gendered trends of family planning uptake in TIDES supported ART clinics and non TIDES support ART clinics?	Peer Educators selected using Purposive Maximum variation sampling and ART clients	Questionnaire for ART clients and In-depth Interviews with peer educators	Framework analysis
What gendered strategies are in place to enhance family planning uptake?	To describe the processes that are used to enhance family planning uptake.	Peer educators and Nurses selected using Purposive Maximum variation sampling	In-depth interviews with peer educators and Questionnaires for ART clients	Framework analysis

#### 1.4 Significance of Study

This study was considered significant in that it would provide valuable information on whether or not the use of peer counseling helped improve the uptake of family planning by Lusaka HIV patients from a gender perspective. The information generated might be useful to health services providers in designing health promotion messages relating to family planning services. The information might also be useful for advocacy by to gender-based NGOs seeking to promote favourable gender relations at family and community level.

## **1.5 Theoretical Framework**

This study was informed by the Gender in Development (GAD) approach which identifies power imbalances between men and women as determinants in the allocation of gender roles which have implications on decision-making (Reeves and Baden, 2000). The Gender in Development (GAD) approach provides opportunity for men and women to equally participate in and benefit from a given facility or service. Arising from this approach the study sought to test the view that decisions regarding family planning uptake in the clinics under investigation were made by men as heads of households and not women as direct bearers of reproductive roles. It was envisaged that the benefits of family planning uptake could be maximized if both men and women were involved in decision-making as equal partners.

## **CHAPTER TWO**

### **Literature Review**

#### **2.1 What is TIDES?**

It is important the background to the TIDES project is understood as this work is a comparison of TIDES supported clinics and Non-TIDES supported clinics. The word TIDES does not

necessarily stand for anything. It is a foundation that financially supports organizations that promote the integration of family planning and ART services in Southern Africa. In Zambia, CIDRZ together with the Ministry of Health was the first organization to pioneer the integration of family planning and ART services. In the effort to increase the number of HIV treatment patients accessing family planning services, CIDRZ had proposed two core activities: to integrate family planning counseling and referrals into routine HIV drug adherence counseling provided by peer counselors, and to ensure family planning clinic staff are able to provide appropriate services for HIV-positive patients. The organization sought to achieve this through the use of peer educators rather than clinicians. In Zambia, Doctors and nurses are in extremely short supply. They face an ever increasing demand for care and have little time to spend counseling patients. The frequent adherence counseling sessions provided a platform for frequent family planning counseling and the ability to ask about continued contraceptive use. The TIDES project was carried out in 16 Lusaka District Health Management Team (DHMT) clinics.

Its objectives included;

1. To develop a comprehensive FP educational and counseling message
2. To integrate FP counseling and referrals to FP services into routine HIV counseling and care
3. To enhance FP service provision in LDHMT clinics
4. To increase uptake of modern FP methods among HIV-infected women and men in Lusaka HIV care and treatment clinics

To increase access to FP services, the Tides FP project has established two core activities: Integrated FP education and counseling provided in Lusaka HIV clinic and training and mentoring for FP clinical staff to ensure provision of appropriate services for HIV-infected women and men. It aimed to achieve this through improved education and awareness through video programming in HIV clinics. 106 peer educators were trained to deliver an integrated FP counseling message at HIV clinic visits through the use of FP job aids. 52 nurses were trained in counseling and provision FP services, including: Short-term methods such as Condoms, OCPs, injectables, Long-term methods like Levonorgestrel implant, IUD and Permanent methods (counseling only). There was also on-going mentoring and support for clinical staff.

The project also put in an effort to make the work environment for the nurses and peer educators more comfortable by renovating the family planning rooms and providing new furniture as well as equipment and supplies needed to administer family planning methods (Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011).

## **2.2 Family planning for PLWHA Background**

Every individual has the right to family planning services and information including vulnerable people such as HIV positive people who are at risk of not having access to such services. It is argued that the demand for FP among HIV+ people is high. HIV+ women who are seeking FP because they did not want to fall pregnant or they did not want to get re-infected as this would increase their viral load and leave behind orphaned children. Growing evidence suggests that HIV-positive women and men lack adequate access to reproductive health (RH) services, including FP and HIV services. At best, they are offered interventions for the prevention of mother-to-child transmission (PMTCT) of HIV without attention to their broader RH needs. However, because many PLWHA are sexually active, they are faced with the same issues as HIV-negative men and women regarding the numbers, timing, and spacing of their children along with the need for comprehensive, safe, and quality FP services. Health workers generally lack the knowledge and skills to support PLWHA to make free and informed FP choices. They are even less equipped to address the additional issues related to introducing FP to persons receiving antiretroviral therapy (ART) (Banda, Honestor and Bradley, Sarah, 2004).

## **2.3 Limitations of Current Family Planning Services for Meeting Needs of PLWHA**

According to the CIDRZ database, less than a third of patients getting HIV care in Lusaka report using contraception at time of enrollment into ART; which is lower than the contraception use level reported in the general population (ZDHS). The CIDRZ database of more than 150,000 HIV patients indicates that the pregnancy rate for female patients who report contraceptive use at enrollment is similar to that for women not using contraception at enrollment. This suggests that patients may discontinue contraception after enrollment, although it is not yet known whether HIV patients continue contraceptive use over time. With only 2% of patients reporting a pregnancy after enrollment, it is suspected that the true number of pregnancies is under-reported. ART service providers indicate a perception that patients become more sexually active over time

in the ART program as their health improves. Also during that time, patients express increased interest in understanding how ongoing treatment will impact their options to become pregnant.

There is currently no specialized counseling to address these issues, and patients are not currently asked about contraceptive use after the enrollment visit. If patients seek family planning on their own within the family planning clinic, they may find that nurses have not been trained to give oral contraceptive pills to women on ART and other methods, such as injectable or implantable hormones, are unavailable. Nurses tend to give easy to administer methods like pills, condoms and injectables because they do not take up much time and they do not need much counseling. Generally, most people do not know reproductive rights exist or that they have the right to choose any method that they desire. They are often cut off from accessing family planning methods as a result of myths and misconceptions going round in their communities. For instance, several years ago, there was a misconception that Depo provera had HIV. Most women believe that when you have IUCD, you can still fall pregnant and the baby would be born with the IUCD in its hand. The frequent stock outs of family planning commodities in most health centers in the country is also one of the major limitations this happens due to poor forecasting and untimely ordering by the health center staff and at national level by national strategic planners. In the HIV clinics, lack of health personnel is the reason why most people do not have access to family planning. In the forms used in ART clinics, , there is a section where the client is asked about their family planning use. However, there is not much counseling on this. This is mainly because there is usually very few staff in the ART clinic attending to over 200 clients in a day. This results in inadequate time to spend counseling the clients. HIV clinical care in Zambia is currently provided by Ministry of Health (MOH) nurses and clinical officers. CIDRZ, which is one of the main NGOs providing ART services in the country, has opted to use peer counselors or educators through a task shifting programme(Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011).

#### **2.4Integration of Family planning and HIV services**

Lately, there has been a worldwide trend towards the integration of family planning and ART. In the United States of America for example, major HIV and AIDS funding initiative, the President's Emergency Plan for AIDS Relief (PEPFAR) is undergoing significant change. HIV/AIDS prevention, care and treatment remain the focus of PEPFAR, yet the Global Health

Initiative (GHI) mandates that PEPFAR along with the rest of the U.S. government's global health portfolio take a more holistic approach to meeting individuals' primary and preventive health care needs, especially for women and girls, with family planning/reproductive health chief among those.

U.S. law and policy does not prohibit, restrict or otherwise discourage integration of reproductive and maternal health with HIV/AIDS. The favorable policy environment for family planning/reproductive health and maternal-child health in the U.S. and globally and the reality of budget constraints, make it imperative that U.S. based and local NGOs ensure health efforts are integrated, linked and sustainable to deliver services and maximize positive health outcomes. "As a component of the Global Health Initiative," the strategy states, "PEPFAR will be carefully and purposefully integrated with other health and development programmes. PEPFAR is working to implement women-centered care, and to ensure that its services are gender-equitable." (Anne Eckman, Blakley Huntley and Anita Bhuyan, 2004, p. 24)

## **2.5 Use of peer education in FP/ART Integration**

Peer education has been used because it is cost effective, accessible to all, promotes behavior change, is a good mode of communication, and curbs the health staff shortage. Recently, CIDRZ has pioneered an effort to integrate family planning with ART. About 102 peer educators who currently offer ART adherence counseling services have been trained to counsel on family planning. A lot of pilot studies have been carried out on the use of peer education in transmitting family planning information to PLWHA inside and outside the HIV clinics (Elizabeth Stringer, MD., Carla Chibwesa, MD. Christine Matoba, 2011). For Instance, Society for Family Health Nigeria, PSI, and USAID carried out a study entitled "Youths as effective role models in integrated HIV and Family planning programme in rural community. Lessons learnt from a youth FP/HIV intervention in Nwaorieubi, imo state, Nigeria." The goal of the project was to reduce the incidence of new HIV infections and mitigate the impact of HIV and AIDS. The objective of the programme was to reduce HIV prevalence and unplanned pregnancy rates among youths of age 15 – 24 years, increasing the number of PLWHA receiving care and support. The project also sought to create awareness on FP/HIV, and share correct information on myths and misconceptions about family planning methods. Due to the worldwide shortage of

staff, the main intervention strategy employed in this research involved the use of peer educators. Forty male and female youths were selected and trained as peer educators for one year on both HIV and Family planning. The PEs were supported to hold monthly PE sessions using specially designed manuals, interpersonal communication, community drama, role play and board games. The result of the study showed that the youths were able to design and implement integrated programmes aimed at reducing risky sexual behavior and improving the adoption of FP methods. There was improved knowledge on the different methods of pregnancy prevention especially on the importance of condom as dual protection method. The programme resulted in an increase in basic knowledge on HIV prevention and unwanted pregnancies. Peer educators served as role models in initiating and implementing behavior change activities in the community(www.SFHNigeria.org, 2010).

A similar study was conducted to find out if the delivery of integrated family planning and HIV/AIDS services influenced community based workers' client loads. The community-based reproductive health agents (CBRHAs) who are mostly volunteers trained to give information of reproductive health to their communities; it was argued could increase community knowledge of and offer immediate access to reproductive health services, including HIV/AIDS. Due to growing interest in integration of family planning and HIV services in Ethiopia, it was important to examine whether CBRHAs are efficiently offering both service types. This study used survey data collected from Ethiopian CBRHAs and examined associations between agents' demographic, personality and work-related characteristics and their capacity to provide integrated services and have high client volumes. Nearly half of CBRHAs in the sample offered integrated services, but this was not jointly associated with increased productivity. Personality traits and work experience were more strongly associated with agents' capacity to provide integrated services than demographic characteristics, while agents' gender and work-related characteristics were significantly associated with increased likelihood of serving more clients. (F:\Integration with HIV-AIDS updates Elements of Family Planning Success.mht, 2011)

## **2.6 Gender and Family Planning**

Gender equity refers to fairness and justice in the distribution of responsibilities and benefits between men and women. It recognizes that men and women have different needs and power and that these differences should be identified and addressed in a manner that adjusts the imbalance

between the sexes. Traditional gender norms of femininity may limit women's access to information as well as their ability to control how and when they should engage in sexual relations. Many traditional cultures expect women to be innocent, subservient, and modest. Norms that equate female sexual knowledge with promiscuity also affect women's ability to talk openly with health providers about intimate sexual issues. Both married and unmarried women who visit clinics for contraceptives may be stigmatized as promiscuous or "too independent," creating a social and psychological barrier that prevents them from making their own reproductive choices. In some traditional cultures, a woman's status is defined and a husband's virility is confirmed by her fertility. Cultural beliefs that place such importance on procreation affect a woman's ability to use or request that her husband use contraception. Many cultures' prevailing myths and misconceptions about the use of modern contraceptives put psychological pressure on women who want contraception. Many of the myths imply that use of modern contraceptives may make women and men sterile and cause sexual dysfunction and deformities in a woman's children. To help women and their partners make informed choices about the method best suited to them, the myths and misconceptions need to be addressed in their gender and cultural context (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Traditional norms of masculinity may limit a man's or his partner's use of family planning services. It has always been assumed that men are indifferent or even opposed to family planning programs, but men also face stigma and discrimination that arise from pre-constructed "masculine" gender roles. Male partners often face negative reactions from other men and family members when they attempt to become involved in women's or children's health. Many men also believe sexual myths about family planning, for example, that a vasectomy will affect their ability to function sexually, when in fact a vasectomy is safe, has few side effects, and has a low annual pregnancy rate of less than 1 percent (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Power inequalities in relationships between men and women, especially related to control of decisionmaking power, economic resources, time, and mobility, also affect women's access to services and their ability to use family planning. Men play an important role in regulating women's access to healthcare. A woman's perception of her husband's attitude toward

family planning may strongly influence whether she uses contraception. In addition, as a consequence of the gender and community norms discussed above, women may also have limited personal and financial resources and mobility within their communities. These barriers may significantly hinder a woman from leaving the household and accessing family planning services. Many women may be afraid to raise the issue of contraception for fear that their partners may respond violently. In some cultures, husbands may react negatively to family planning programs because they feel that protection against pregnancy will encourage their wives to be unfaithful (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Women's decisions about family planning may also reflect pressures from family members to use a particular method or not to use any method. When women have little autonomy, their husbands, mothers-in-law, or other family members often make family planning decisions for them. Family planning clinicians have historically assumed an authoritarian role and expect the client to be passive. Providers' failure to demonstrate psychosocial support and gender sensitivity may inhibit women from obtaining correct information about risks, benefits, side effects, and correct use, which is crucial to ensuring the initiation or continuation of family planning (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Gender discrimination and inequities currently limit women's and men's access to confidential family planning services, the ability of women to negotiate the use of family planning for themselves, and effective use of contraceptive methods. Confidential information about the full range of family planning and reproductive health services should be available to all individuals throughout their lives. By addressing the gender dynamics that hinder access to and use of family planning services, services can promote improved reproductive health. Women's autonomy and decision making can be reinforced and appropriate male participation can be promoted by how services are offered as well as which services are available. These efforts will help women exercise their reproductive rights more freely and assist men in playing a more constructive role in their own reproductive health and that of their partners. Promotion of gender equity is widely acknowledged as important for improving reproductive health programs (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Promoting gender equity, fairness and justice in responsibilities and access to benefits to women, men, girls, and boys is a major goal for RH programs. Therefore programs can operationalize the concept of gender perspective when delivering family planning and reproductive health services([www.popcouncil.org/frontiers](http://www.popcouncil.org/frontiers)). This can be done throughengaging men in safeguarding reproductive health.

Joint counseling of women attending ANC services and their partners can lead to improved couple communication and reproductive health benefits.In many developing countries, men are the major decision-makers on reproductive health but are poorly informed about or engaged in services to support partner health. The frontiers legacy document further reports that in India and South Africa, couples were offered joint, individual, or same-sex group counseling sessions during antenatal care visits. Men demonstrate great interest in learning more about partners' needs, but the intervention had very different results in the two settings. In A study carried out in New Delhi, participating couples were married and members of the husband's employer-provided government health insurance scheme. When men were offered joint counseling sessions at the dispensary, twice as many husbands (28%) attended sessions when not offered. Couples reported more communication on family planning (84% versus 64%, respectively) and more joint decision-making on the issue (91% versus 71%). Moreover, this model led to significantly higher levels of postpartum contraception compared with couples in which women received regular ANC. These results have led to this model being scaled up from the original three dispensaries to all 30 facilities in the insurance scheme. In urban and rural clinics of KwaZulu Natal, South Africa, implementing joint counseling was challenging. Fewer than 10 percent of pregnant women were married and only one quarter lived with partners. One-third of couples invited did attend joint counseling, communication was reported to improve, and male partners were more likely to give support in pregnancy complications; however, postpartum family planning and overall risk behavior did not change ([www.popcouncil.org/frontiers](http://www.popcouncil.org/frontiers)) .

Integrating RH services for males into female-focused primary health care clinics increases number of both male and female clients and reduces cost per client. Findings from Bangladesh show the monthly average of male clients per clinic nearly tripled, from 131 to 345, and

women's use of any service increased from average of 425 to 693 per clinic per month . These improved and integrated services have been successfully scaled up to 40 additional clinics, with similar increases in utilization by both men and women ([www.popcouncil.org/frontiers](http://www.popcouncil.org/frontiers)).

Numerous studies show recruiting men for community-based family planning services is feasible and effective. Studies in Cameroon, Ghana, Kenya, and Mali showed communities readily accept male CBD agents. Moreover, comparing condom sales by male and female agents showed men sold twice (Peru) or almost three times (Kenya) as many condoms as women. Studies in Latin America and Africa show male and female CBD agents can be equally productive overall in providing couple-years of([www.popcouncil.org/frontiers](http://www.popcouncil.org/frontiers)).

Gender norms often support high fertility, influencing the timing of marriage and childbearing, and aspirations regarding family size and sex composition. FP programs and services have often selectively accommodated rather than challenged prevailing gender norms by targeting FP toward women and have reinforced the idea that reproduction and family welfare are women's responsibilities. Beyond limiting the reach of FP services, gender inequality and the norms surrounding masculinity, femininity, and male-female relationships can impede the healthy timing and spacing of pregnancies. For example, men might be willing to accept women's contraceptive use but unwilling to bear the costs and perceived risks of FP, as has been documented in Bangladesh . In many African settings, fathering children is a sign of virility and status. In many parts of the world, dominating women by pushing them to have unprotected sex is considered an acceptable way of asserting male power and demonstrating manhood and male rights over women. In some settings, women have reported that bringing up the issue of condom use can result in violence. A synthesis of case studies supported by WHO points to a number of gender-related constraints that female youth, in particular, face in exercising choice regarding sexual relationships, accessing sexual and reproductive health information, and using contraceptive methods. These include gender-based double standards, fear of losing a partner, and fear of disclosure(Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

Gender norms can have a positive influence on RH as well. For example, programs have emphasized the norm of men as providers for their families, encouraging them to consider the economic costs of children in the context of rising aspirations for education and consumer goods. Operations research studies have shown success in involving men in maternity care and increasing spousal communication about family size and FP. The findings showed near universal agreement among women and men users and non-users about the norms related to men's and women's roles in the family and society. Men were characterized as being the head of the household, the provider for the family, able to have sex and satisfy a woman, able to have children, and able to participate in society. As head of the household, a man was responsible for providing for the family financially, including providing money for clothing, food, education for children, and health care. Men's position as head of the household was also described in terms of dominance in decision-making, e.g., "...in charge in each and every decision. What makes me a good man is to have the first and last word on issues like having children. A man is the sole decision-maker, and it doesn't matter whether the woman has her views or not, she has to wait for the man to give the last word" (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009)

In addition to being able to satisfy their wives sexually, men were expected to be able to start a family soon after being married. Many participants said that a man who could not have children was still a man, but not a "complete man." However, only a very small minority of male participants said they wanted large families or that a large family would bring them prestige. Money spent on one's family was seen as an investment whereas outside relationships were seen as a drain on family resources and for personal pleasure only. Men were described as wanting and having a right to both love and sex on demand from their wives. Some participants said a real or ideal man did not have sex outside marriage, but many also said that men needed more than one woman to be sexually satisfied. According to one woman, it is all right for a man to have an affair as long as he does not flaunt it: "He can do it in secret so that his wife doesn't find out, and that shows that he respects his marriage" (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009)

A woman in Tanzanian society was characterized as the supporter of the husband, a caretaker of the family, and a bearer of children. A woman's ability to bear children was linked very closely to the definition of a woman. One male participant said that a woman who could not have children "... would not be described as a woman. She would be a human being but not a woman because I did not get married to her so that we can look at each other. I married her so that we can have a family and that is by getting children." Most participants said that a woman should stick to one man, but some, even men, felt that it was understandable that a woman who was neglected emotionally, physically or economically might take another lover. Like men, women were described as needing love. As men were the main decision-makers in the family, women were expected to support their husbands' decisions. It was considered disrespectful for a woman to disagree with and disobey her husband, though it was generally said to be acceptable for her to provide advice and state her opinion during the decision-making process: "She has...the right to be listened to when she advises on anything that affects the family." In contrast to the almost invariant responses regarding men as heads of the family and main decision-makers, nearly all participants said that gender roles were changing. They spoke about the economic roles that women were increasingly taking on as a result of women's education and hard economic times.

When asked about recent changes, participants voiced more liberal views about the roles women can play in the family and society. Participants drew contrasts to earlier expectations of women. Whereas then it was the norm for women to stay home and receive money from the husband for food and clothing, it was now becoming more and more acceptable, and even expected, for a woman to do some kind of work to contribute financially to the family. One female participant stated, "Long ago, women used to stay at home and wait for their husbands to do everything, even to buy them underwear, but now women have come out so strongly and they are doing all that men can do in order for them to get some money." Another said, "Previously women used to rely on men, but now a man will not marry a woman who is jobless" (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

In the study mentioned above, a male non-user described a conversation he had with his wife, in which he told her that he wanted four children: "She did not question me nor ask the reason why. She told me that I'm the one who makes the decisions and that she cannot decide anything for

me.” A male user said that telling his wife to use contraceptives “was a command, not a request. I told her that it was a must for us to use it.” Another male user said, “I do involve her [in decisions] because when I want to have a child, I tell her and she agrees. But she can’t tell me that we should stop having more children because I am the one to make that decision.” One urban woman was afraid to raise the subject at all: “For example, if I made myself out as knowing too much and started talking about family planning, I would definitely get a beating. That is why I choose to remain silent.” Women rarely initiated contraceptive use on their own, without the husband’s consent. A female non-user stated, “If he ever finds out that I’m using any type of family planning method, then my marriage would be in trouble. He refuses because he says that I might never be able to deliver again and that is why I’ve decided to take his advice. I’m not going to use any kind of family planning method just in case he discovers it and this brings problems in our relationship.” A large minority of the female non-users said they wanted to use modern contraceptives but did not because their husbands did not allow it.

In several other cases, men imposed contraceptive use on their wives rather than blocked its use. Many of the men had made misinformed decisions about contraception, as it is not normative for men to seek information from sources such as health clinics. Three out of the 11 male non-users directly stated that they did not have enough information on contraceptives to make an informed decision, but that did not stop them from deciding that neither they nor their wives would use them, for fear of side effects. Four women acknowledged that they had initiated contraceptive use without their husbands’ involvement or consent. One was switching methods from condoms to pills, and a second began using pills after visiting a health clinic and then discussed this with her husband. The remaining two did so in secret, fearing serious conflict, including violence or divorce if they openly went against their husbands’ wishes. We suspect the actual the number might have been higher. One woman began using contraceptives secretly after having marital problems. Her husband had threatened to divorce her, and she did not want to be pregnant if that happened. So she decided to protect herself by using injections: “... I got scared of getting pregnant at that time when there are problems. So I decided to use injectable contraceptives until the problem was over. Because it reached a point that he threatened to get a divorce, so what would have happened if he divorced me while I was pregnant?” (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

The consequences for women using FP methods in secret were described as very severe. Both men and women, users and non-users, said that if a woman was caught using contraceptives secretly a husband would warn, beat, or divorce her. Most believed that a decision like that should not be made without involving the husband, and that if the husband refused, his decision should be obeyed. Many also said that using contraceptives secretly would create mistrust and cause a husband to think his wife is doing other things in secret, such as having an affair. A man in a Dar es Salaam focus group described his own experience: “My wife was using the pill in secret and it took me a very long time to find out. It was after not having a baby for a long time that I discovered it. To be honest, I kicked her out of the house. ... It was very hard.” Speaking hypothetically, another man said, “I think the marriage would end because (it would mean) she was not faithful.” A woman in a Dar es Salaam focus group said, “If he discovers it, you will see that your bags have been thrown out and your divorce papers are on the table. If he discovers it at night, then the beatings will start, and at 5:00 in the morning you will be kicked out”(Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009)

## **2.7 Gendered trends of family planning**

Studies show that women and men tend to use specific contraceptive methods for instance a study was carried out in Malito examine the situation of women in Mali who use modern contraceptive methods and compares this to the situation of women who do not, in order to understand how and why women take action to use family planning and what method of family planning to use. The research sought to discover if certain elements in social and family relationships influence the decision to use family planning or not. In Mali, as in many other West African countries, rates of contraceptive use have remained very low. To compare women who use family planning to those who do not, this study explored a number of themes: women’s experiences growing up, their participation in the choice of a husband, creating a family of their own, their knowledge of contraception, their fertility preferences, their access to services, their preferences for different types of services, and their socioeconomic status in the household. The study explored the relative importance of elements that affect the use of modern family planning methods from the perspectives of married women, married men, and service providers who offer family planning methods. The major portion of the research was dedicated to interviews with

women and analysis of their testimonies. Since Malian women who do use modern contraceptive methods are the exceptions, it is important to determine if their circumstances differ from those who have never used contraception, or have used it in the past but are no longer doing so. By examining the social and family context of women in these varying situations and the perspectives of women and men with regard to these issues, this study shows how women evaluate their own situation with regard to spacing the births of their children (International Conference on Family Planning Research and Best Practices, 2009).

The techniques of data collection included In-depth interviews with married women, discussion groups with triads of married men, brief interviews with individual service providers, both professional and volunteers. Three regions of Mali were chosen for data collection: Bamako, the capital city; Koulikoro, east of Bamako, and Ségou, still further east of Bamako. In Bamako two neighborhoods in one commune and two in another commune were selected; in Ségou and Koulikoro, four sites were selected in each region, making a total of 12 sites. In each site selected, six women were interviewed and a discussion was held with a group of three men. In each region two health care facilities that provided family planning services were identified. Health service providers were interviewed at these facilities. In the sites selected that had active community-based volunteers (CBV) attached to the facilities, the volunteers were also interviewed. They were asked to state which methods were popular. Among the short-term methods that providers mentioned, two emerged as the most popular for women wishing to avoid or space pregnancy: the pill and injectables. Long-term methods are available in about half of the facilities. In all cases, providers of contraceptive methods said clients preferred injectables over pills or other methods, because injectables are easier to hide from their husband if they are using contraception clandestinely, or that they often forget to take the pill on a daily basis, whereas injectables only require a visit to the facility every three months. The *relais* (as CBVs are called in francophone West Africa) talked about the problems they had in increasing and improving their services. They said they were still hampered by a lack of communication with the health facilities and program directors (International Conference on Family Planning Research and Best Practices, 2009).

The study findings show that both women and men understand the benefits of longer birth intervals for their own health and the health of their children. However, both women and

men seems slow to apply the knowledge they articulated to their personal situations. The gap between family planning knowledge and its practice could be narrowed by well-trained counselors who can provide a range of modern methods of contraception. Just as women's individual needs in regard to birth spacing shifts over time, the preference for one contraceptive method over another and the families' financial situation may also change, and the demand for family planning services can change as well. This study examines levels and trends in contraceptive switching, contraceptive failure, and abandonment of contraception while still in need of pregnancy prevention. Data come from the two most recent Demographic and Health Surveys in Armenia, Bangladesh, Colombia, the Dominican Republic, Egypt, Indonesia, Kenya, and Zimbabwe. Results show that contraceptive discontinuation in the first year of use is common (18 to 63 percent across countries), and that the majority of these discontinuations are among women who are still in need of contraception: between 12 and 47 percent of women stop using contraception within one year even though they do not want to become pregnant. We found discontinuation to be strongly associated with the type of contraceptive method used. Additionally, age, parity, education, partner's desired fertility, community-level contraceptive prevalence, and the region in which women live were all associated with contraceptive switching, failure, or discontinuing while still in need of contraception. In summary, rates of contraceptive discontinuation, even among women who want to avoid pregnancy, remain high and are increasing in some countries where family planning efforts have decreased. This contraceptive discontinuation study, along with future research in this area, can help policymakers and program managers track family planning progress and refocus efforts to meet the goal of reproductive health for all (International Conference on Family Planning Research and Best Practices, 2009).

A study was carried out in Brazil which as a country has registered a relatively low HIV prevalence rate at 0.61%. Brazil has an open HIV/AIDS prevention strategy characterized by a vibrant mass media campaign, and treatment strategy whereby ART is offered at no cost through the public health system. Contraceptive use remains an issue of concern among HIV-positive women in Rio De Janeiro where 6.9 pregnancies/100 women occurred between 1999 and 2003 among HIV-positive women on ART. The last National Household Survey found the use of condoms low and the explanation was that partners still trust each other to be safe. Women are

the most affected by HIV in Brazil. Nearly all women use contraceptives because they find condom difficult to negotiate. Pills are rarely used because mothers say they forget to take them routinely as prescribed. Based this background information, a qualitative study was conducted in by Oswaldo Cruz Foundation among HIV-positive women between 18-40 years of age to determine factors for contraceptive choice and discontinuation. All the respondents at least had one child. The majority of women preferred oral contraceptives and injectables, but these were not readily available. The male condom is key because of its dual purpose as FP method and HIV prevention tool but women complained of the difficulty to negotiate condom use, which normally results into domestic violence. Women who practiced sterilization later regretted when they found out they can't have children with their new partners. The study concluded that that HIV status has some impact on women's choice and discontinuation of contraceptive use but it is not the key factor. It is necessary to have comprehensive counseling package for women on ART to enable them make informed decisions. A wide of FP methods should be made available to give women a variety from where to choose. There is need for mass education about condom use and other FP methods with emphasis on rights and responsibilities (International Conference on Family Planning Research and Best Practices, 2009).

A qualitative study coordinated by Colombia University was carried out in Kenya in the Kericho District with objectives to determine the impact of gender on contraceptive utilization among PLWHA in Kenya and to assess the level of integration of FP/SRH and HIV/AIDS services. The study was part of an international study conducted in three countries: Kenya, Brazil and South Africa. Data was collected using a questionnaire about ART usage, fertility history, fertility desires and contraceptive usage. Focus Group Discussions were organized to obtain in-depth information about the subject. Data was coded and using grounded theory was put in themes to determine the factors. it was noted that people had inaccurate information about fertility and timing pregnancies and medically inaccurate beliefs. In terms of gender roles, men tended to refuse the use of condom on the claim that it reduces pleasure. Regarding HIV diagnosis, women became assertive. For example some refused to be inherited after their husband's death. The themes generated on contraceptive choice some participants indicated that contraceptives reduce libido, menstrual changes lead to method discontinuation, noted that male participation in decision making about use of contraception is crucial. Limitations of the study included a potential

bias because most respondents were widows and because focus group discussions were limited on themes. In order to reduce bias, female health workers were used to collect data (International Conference on Family Planning Research and Best Practices, 2009).

In Indonesia, a study was carried out to determine the rates of discontinuation of family planning methods. In this study the results showed that the highest discontinuation rates occur for condoms and vaginal use methods. Most of the condom/vaginal segments end with 19 months of use. On the other hand the discontinuation rates for implants and IUDs are very low with median duration of use more than 36 months. The most commonly used method injectables, has a fairly low discontinuation rate and a fairly high median duration of use (36 to 45 months). Contraceptive pills and traditional methods both show high 24 months discontinuation rates. In terms of trend in contraceptive prevalence, according to the 1997 Indonesia demographic health survey, the most popular methods are injectables (21%), contraceptive pills (15%) and IUDs (8%). Other methods such as condoms, implants and intravaginal methods are not widely used (3%) (Fathona, 2000).

## **2.8 What is Peer Education?**

There are many working definitions for peer education. The Oxford Thesaurus defines peer education as a popular concept that implies an approach, a communication channel, a methodology, a philosophy and a strategy. Peer education is a strategy, tool or communication channel used by people who share similar ages, backgrounds and interests to communicate messages. She further argues that, while it can be for a variety of age groups and populations for various goals, peer education has widely been used as one approach in behavior change communication components of pregnancy, STI and HIV prevention programmes. In summation, peer education involves the training and use of individuals from the target group to educate and support their peers (Truong, 2008).

### **2.8.1 Peer education as a communication tool**

Peer education is often used as a means of communicating messages to the community, especially in societies where people find it difficult to obtain clear and correct information on issues that concern them such as sexuality, reproductive health, HIV and AIDS and STIs. This happens for many reasons, which include social cultural norms, economic deprivation, or lack

of access to information. Although information is typically available, it may be given in a manner that is judgmental, or non-adapted to the people's values, viewpoints and lifestyle. Peer education is one way of dealing with these issues as it is a dialogue between equals and involves members of a particular group educating others of the same group. (<http://gateway.nlm.nih.gov>) Research also explores how the perceived similarity with peer educators makes peer led interventions feel more informative and satisfying than other provisions. In a review of research, a range of factors was identified which was associated with young people's satisfaction including being able to relate well to peer leaders, perceiving them as credible sources of information, feeling relaxed during lessons, describing them as fun, appreciating not being lectured at, and understanding young people's problems better than teachers.

### **2.8.2 Uses of Peer education**

Peer educators are usually effective and credible communicators who have inside knowledge of the intended audience. They use appropriate language or terminology as well as non – verbal gestures to allow their peers to feel comfortable when talking about issues; this has led to the use of peer education being used in many areas of public health. It is a widely utilized HIV – prevention strategy that is accepted and valued by both program audiences and stakeholders. It has been used mostly in the area of HIV and AIDS due to the sensitivity of the disease and also due to the justifications for the use of peer education. It has been used greatly in the fight against HIV and AIDS for instance, in the prevention of mother to child transmission (PMTCT), Family Planning, behavior change, and anti-retroviral therapy (Mead, 2006).

### **2.8.3 Identification**

Peer educators and program beneficiaries can mutually be identified with each other as individuals and as members of a specific socio-cultural reality. Because of this identification, peer educators make strong role models for promoting the adoption of HIV- preventive behaviors. Peer educators are people living with HIV and AIDS working in an HIV and AIDS programme such as ART clinics. They typically work as adherence counselors with PLWHA who have started lifelong ART therapy. It's easy for both parties to share experiences during the counseling session (Truong, 2008).

A good example which portrays the issue of people identifying themselves with the peers is a peer education program called mather2mother which was introduced in South Africa's Kwazulu

Natal. In this program, HIV positive women who recently delivered healthy babies are identified, trained, and returned to maternity wards and clinics as mentor mothers. Mentor mothers educate new mothers and support them as they confront decisions that mean the difference between illness and health. When a woman arrives for her first antenatal visit, she is paired with a mentor mother. This Mentor Mother performs an assessment to determine what the client understands about HIV and its ramifications for her health, her child's health, and her life. If the client desires, her Mentor Mother will accompany her to her medical appointments and aid the woman in completing referral appointments. Additionally, the Mentor Mothers lead group meetings and discussions with all the participating women in the program so that the women benefit from the support of others. The Mentor Mother also acts as an advocate in the labor wards ensure that the mother receives appropriate PMTCT interventions during delivery(<http://www.m2m.org/>).

Mothers2mothers (m2m) was developed in response to perceived medical and social needs to keep mothers in care after delivery. To address these factors, m2m also answers questions women may have after delivery and addresses needs with regard to feeding, accessing family health care, and adjusting to life in the community as a woman and mother living with HIV. M2m acknowledges the physical and emotional challenges of the postpartum period. Mothers2mothers also utilizes the seasoned skills and talents of Mentor Mothers to provide community education and outreach on topics related to reproductive health, especially HIV/AIDS. Site coordinators and Mentor Mothers regularly travel to clients' homes and/or invite family members to a mothers2mothers location in order to provide education and support to women who are disclosing their HIV status. In addition, m2m adapts to rural health care settings where women who are unable to travel to the nearest health care facility for antenatal clinic visits and/or delivery play an integral role in promoting ARV therapy adherence. M2m positively impacts efforts to prevent the transmission of HIV from pregnant women to their babies (PMTCT) according to an important public health study focusing on key indicators for the PMTCT programs. In a study conducted by Horizons/Population Council and Health Systems Trust (HST), an independent South African research organization, PMTCT care substantially improved at sites after m2m services were introduced. Overall, they found that m2m's programs have a considerable impact on key factors involved in preventing mother-to-child transmission of HIV:

1. Increasing the number of women who received the drugs to prevent transmission to infants
2. Increasing the number of infants receiving the drug to prevent transmission of HIV
3. Helping women to disclose their HIV status to their partners and families
4. Improving women's knowledge about how HIV can be transmitted from mothers to infants during pregnancy and breastfeeding
5. Increasing the number of women who chose an exclusive infant feeding method which reduces transmission risk Helping women feel that they were better able to help themselves, care for their infants and live positively
6. Increasing the number of women who received a CD4 test during pregnancy to make sure that the appropriate PMTCT drugs were given
7. Improving the use of family planning after pregnancy
8. Encouraging more women to discuss the importance of faithfulness and safer sex with their partners (<http://www.m2m.org/>).

#### **2.8.4 Behavior change**

When messages are communicated, change is likely to be affected. One view explains that peer education is based on behavioral theory, which asserts that people make changes not because of scientific evidence or testimony but because of the subjective judgment of close, trusted peers who have themselves adopted changes and who act as persuasive role models for change. When people have identified themselves with others who have shared negative experiences and can see positive outcomes and changes in them, it is encouraging to know that they too can have a positive outcome and change of behavior (Truong, 2008).

A good instance in which peer education was used to induce behavior change can be cited from Stanley et al (2008) where they explain that since 2000, peer-mediated interventions among female sex workers (FSW) in Mombasa Kenya have promoted behavioral change through improving knowledge, attitudes and awareness of HIV serostatus, and aimed to prevent HIV and other sexually transmitted infection (STI) by facilitating early STI treatment. Impact of these

interventions was evaluated among those who attended peer education and at the FSW population level. A pre-intervention survey in 2000, recruited 503 FSW using snowball sampling. Thereafter, peer educators provided STI/HIV education, condoms, and facilitated HIV testing, treatment and care services. In 2005, data was collected using identical survey methods and compared results with historical controls and FSW who had not received peer interventions. The findings over five years showed that sex work became predominately a full-time activity and the mean number of sexual partners increased (2.8 versus 4.9/week;  $P < 0.001$ ). Consistent condom use with clients increased from 28.8% (145/503) to 70.4% (356/506;  $P < 0.001$ ) as well as the likelihood of refusing clients who were unwilling to use condoms (OR = 4.9, 95%CI = 3.7–6.6). FSW who received peer interventions (28.7%, 145/506), had more consistent condom use with clients compared with unexposed FSW (86.2% versus 64.0%; AOR = 3.6, 95%CI = 2.1–6.1). These differences were larger among FSW with greater peer-intervention exposure. HIV prevalence was 25% (17/69) in FSW attending  $\geq 4$  peer-education sessions, compared with 34% (25/73) in those attending 1–3 sessions ( $P = 0.21$ ). Overall HIV prevalence was 30.6 (151/493) in 2000 and 33.3% (166/498) in 2005 ( $P = 0.36$ )(Stanley Luchters et al, 2008).

### **2.8.5 Access**

Peer educators have physical and socio-cultural access to intended audiences in their natural environments without being conspicuous. This is particularly true when working with hard-to-reach populations such as sex workers, injecting drug users, and prison inmates because physical access to such populations can be difficult as shown by the Mombasa study. Key informants also stated that peers have access to populations that have historically been stigmatized. Jenny Truong (2008) argues that the use of peer educators can access hard to reach groups if they have a similar profile. A study was carried out to show the efficacy of peer education in relation to “hidden populations.” They looked at drug use among adolescents in a town called Manly-Warringah. Typically during the adolescence is period, peers tend to have more influence than authority figures such as parents and teachers and can model positive patterns of behavior, which endure into adult hood. The overall intention of the DSP was to provide young people living in the Warringah area, with the tools for the survival of possible experimental and recreational drug use during adolescence through to adulthood. In order to reach as wide a cross section of young people, thirty – seven (13 – 19 year olds), were trained to be DSP peer educators. These peer

educators were provided 40 hours of intensive training about drug information as well as in decision making, confidence building, communication and listening skills, rapport, and team building strategies(Bleeker, 2001).

In the DSP project, the overall role of the peer educator was to pass on information to their friends through casual conversations. This process was referred to as a drug information “hit”. All peer educators involved in the study were asked to make at least 20 hits over the duration of the project. At the end of the project, an evaluation revealed that the project was successful at reaching a wide cross section of young people who would typically not have received exposure to this type of drug information. A process evaluation of the project revealed that the DSP performed better than originally anticipated by recording at least 3 times more “hits” than expected. Approximately 2,300 “hits” were recorded over the life of the project(Bleeker, 2001).

#### **2.8.6 Cost Effectiveness**

Peer education is also a cost effective intervention strategy because its use of volunteers makes it inexpensive to implement and/or expand. Peer education is said to be more cost effective than other methods. Peer education involves the use of non professional teachers who talk to, work with and motivate their peers. Peer education can take place on a street corner, at a social club, in a bar, on school grounds, in a home, in a church, at a bus station, in a factory, on a farm or any other place where people feel comfortable. There is hardly any need to worry about location for peer education activities or payment. It’s up to an individual institution to decide whether to give the peer educators a token of appreciation or not(Truong, 2008).

#### **2.9 The Role of Peer Education in Meeting the FP Needs of PLWHA**

Peer education has been used because it is cost effective, accessible to all, promotes behavior change, is a good mode of communication, and curbs the health staff shortage. Recently, CIDRZ has pioneered an effort to integrate family planning with ART. About 102 peer educators who currently offer ART adherence counseling services have been trained to counsel on family planning. A lot of pilot studies have been carried out on the use of peer education in transmitting family planning information to PLWHA inside and outside the HIV clinics(Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011).

Society for Family Health Nigeria, PSI, and USAID carried out a study entitled “Youths as effective role models in integrated HIV and Family planning programme in rural community – Lessons learnt from a youth FP/HIV intervention in Nwaorieubi, imo state, Nigeria.” The goal of the project was to reduce the incidence of new HIV infections and mitigate the impact of HIV and AIDS. The objective of the programme was to reduce HIV prevalence and unplanned pregnancy rates among youths of age *15 – 24 years*, increasing the number of PLWHA receiving care and support. The project also sought to create awareness on FP/HIV, and share correct information on myths and misconceptions about family planning methods. Due to the worldwide shortage of staff, the main intervention strategy employed in this research involved the use of peer educators. Forty male and female youths were selected and trained as peer educators for one year on both HIV and Family planning. The PEs were supported to hold monthly PE sessions using specially designed manuals, interpersonal communication, community drama, role play and board games. The result of the study showed that the youths were able to design and implement integrated programmes aimed at reducing risky sexual behavior and improving the adoption of FP methods. There was improved knowledge on the different methods of pregnancy prevention especially on the importance of condom as dual protection method. The programme resulted in an increase in basic knowledge on HIV prevention and unwanted pregnancies. Peer educators served as role models in initiating and implementing behavior change activities in the community ([www.SFHNigeria.org](http://www.SFHNigeria.org)).

A similar study was conducted to find out if the delivery of integrated family planning and HIV/AIDS services influenced community based workers’ client loads. The community-based reproductive health agents (CBRHAs) who are mostly volunteers trained to give information of reproductive health to their communities; it was argued could increase community knowledge of and offer immediate access to reproductive health services, including HIV/AIDS. Due to growing interest in integration of family planning and HIV services in Ethiopia, it was important to examine whether CBRHAs are efficiently offering both service types. This study used survey data collected from Ethiopian CBRHAs and examined associations between agents’ demographic, personality and work-related characteristics and their capacity to provide integrated services and have high client volumes. Nearly half of CBRHAs in the sample offered integrated services, but this was not jointly associated with increased productivity. Personality traits and work experience were more strongly associated with agents’ capacity to provide

integrated services than demographic characteristics, while agents' gender and work-related characteristics were significantly associated with increased likelihood of serving more clients. (F:\Integration with HIV-AIDS updates Elements of Family Planning Success.mht)

In the integration of family planning and ART launched by CIDRZ, the peer educators counsel the clients on family planning each time they come for a clinic visit. The clients are taught about the benefits of family planning and are educated about the various types of family planning available in the health facility as well as their side effects. They clients are told that they have the right to choose which ever method they prefer. If they are interested in obtaining a family planning method that day, they are taken to the family planning clinic within the same health facility(Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011).

## **2.10 Sustaining Family Planning Uptake among PLWHA**

Sustaining client demand and utilization for family planning among PLWHA entails ensuring that FP commodities are in supply in the health centers at all times. Maintaining demand requires the myths and misconceptions relating to family planning use to be dispelled. This is accomplished by intensifying community sensitizations of RH rights with a focus on family planning, continuing one on one counseling in the adherence counseling rooms, and encouraging. Because of the wide application of peer education, AIDSCAP sponsored a study of 21 peer education and HIV/AIDS prevention and care projects in 10 countries in Africa, Asia, Latin America, and the Caribbean. The research was conducted with 223 project managers, peer educators, and peer beneficiaries from programmes that reached a variety of population groups including factory workers, university students, commercial sex workers, men who have sex with men, and farmers. The objectives of the study were “to examine peer-education strategies in AIDCSAP supported projects and clarify their definition and scope, to identify and describe factors that are essential to sustainable peer education, and to establish a set of guidelines and standards by which to design future projects using peer education”. Study findings documented the need for: initial and reinforcement training; ongoing follow-up, support, and supervision; clearly understood expectations of the peer educator’s role; and continued incentives and motivation techniques. Findings also suggested the need for HIV/AIDS peer educators to broaden their base to other related health fields such as family planning and care for people living with HIV/AIDS. The final output of the review was a handbook of guidelines from which

future peer education programmes can be designed, entitled *How to Create an Effective Peer Education Project* (Donna Flanagan and Hally Mahler, 2006).

A comprehensive and participatory assessment of HIV/AIDS peer education programmes was recently conducted in several clusters (regional HIV/AIDS NGO networks) in Tanzania. The results of this assessment signaled a series of programmatic recommendations, including: (1) further enhancement of community involvement and ownership in order to facilitate programme continuity and sustainability; (2) ongoing capacity-building, such as continuing supervision and follow-up with peer educators to ensure programme quality; (3) capitalizing on and using the knowledge, creativity, and energy of peer educators in programme planning; (4) extension of the reach of peer education by conducting more training of trainers and peer educator training in other geographical areas; (5) provision of both non-monetary (e.g. bicycles, T-shirts, materials) and financial incentives (e.g. access to credit and compensation for expenses) to motivate peer educators; and (6) integration of reproductive health and other topical areas, as identified by communities, into the scope of peer educators (Donna Flanagan and Hally Mahler, 2006).

## **2.11 Conclusion**

Though several studies showed peer-educators can effectively deliver many interventions, additional evidence is needed on the impact of outreach and peer-networks in diverse settings, and sustainability over longer periods of time (UNFPA 2002). The shift from the use of medical staff to peer educators calls for the need to hear the perspectives of the ART clients on this change or shift. A lot of funding has gone into recruitment and training of the peer educators but an evaluation that shows the effectiveness of these programmes is necessary to enable new funding to ensure the continuity of this programme. For potential funders, this research will demonstrate that the peer educators' programme has undergone a robust evaluation process that has established that the programme has very important impacts upon programme participants' well-being. There is also need to aid in terms of incentives for both the ART clients and the clinic staff to extenuate benefits and reduce negative aspects of the programme. The aim of this research therefore was to establish impact of peer educators on the use of family planning among PLWHA in the ART centers.

## **CHAPTER THREE**

### **Methodology**

#### **3.1 Research Design**

This study used the descriptive case study design. The case study design helped give a detailed profile of the respondents as far as their experience pertaining to family planning services in the ART clinic is concerned (<http://www.nedarc.org>). Data was obtained from 80 HIV positive people. Data was collected in two weeks. The questionnaires were administered to the patients as they came for their drug refill at the ART clinic. The questionnaires were administered by research assistants after adherence counseling. The in-depth interviews were conducted in the first week of data collection.

### **3.2 Study Sites**

The study was conducted in 4 ART clinics in Lusaka, 2 of which were control sites. These included Kanyama, Matero Reference, Bwafwano and Chazanga ART clinics. Bwafwano and Chazanga clinics were the control sites. The study sites were randomly selected from the 16 possible CIDRZ supported ART clinics. The control sites were also randomly picked from among the ART clinics that were not supported by TIDES Family planning.

### **3.3 Study Population**

The study targeted both women and men in the age range of 18 – 50, who are ART clients. It also included peer educators and nurses.

### **3.4. Study Sample**

The study targeted 80 ART clients 20 from each site. In- depth Interviews were held with 4 peer educators from Matero Reference and 3 from Kanyama ART clinics. In-depth interviews were held with 2 nurses from chazanga, 2 from Bwafwano, 4 from Chawama and 2 from Matero Reference.

### **3.5. Sampling Techniques**

The ART clients were selected using purposive selection. A total of 80 men and women were selected from the appointment register. Basically, the first 20 clients were picked. The nurses and the peer educators were selected using purposive maximum variation sampling. Denscombe, (1998) indicates that with purposive sampling, the sample is ‘hand-picked’ for the research, and is based on institutions where the researcher already knows about the specific people and events. The study sites were picked using simple random sampling (Descombe, 1998). Maximum variation sampling, also known as heterogeneous sampling, is a purposive sampling technique used to capture a wide range of perspectives relating to the phenomenon that you are interested in studying; that is, maximum variation is sampling is a search for variation in perspective, ranging from those conditions that are viewed to be typical through to those that are more extreme in nature. By conditions, what is meant is the units (i.e people, cases/organizations, events, pieces of data) that are of interest to the researcher. These units may exhibit a wide range of attributes, behaviors, experiences, incidents, qualities, situations and so forth. The basic

principle of maximum variation sampling is to gain greater insights into a phenomenon by looking at it from all angles. This can often help the researcher to identify common themes that are evident across the sample([www.dissertation.laerd.com/articles/purposive-sampling-an-overview.php](http://www.dissertation.laerd.com/articles/purposive-sampling-an-overview.php), 2010)

### **3.6 Data Collection Instruments**

The study used triangulation in data collection by involving the use of questionnaires and in-depth interviews. Triangulation in data collection is the involving of two or more methods in the study, and it can help explain more fully the richness and complexity of data (silverman., 1997). This can be done by studying practices from more than one angle using multiple methods of data collection, and each method can reveal different aspects of empirical facts within the same site. The purpose of the in-depth interview was to tease out some of the finer details of the peer educators' and nurses' experiences.

### **3.7 Pre-testing of research Instruments**

The pilot in-depth interviews with the nurses and peer educators were conducted with the nurses and peer educators from Kabwata MCH and Kalingalinga ART clinics respectively. The clinics were chosen because they have similar characteristics with the four clinics under study and also because it was convenient for the researcher to carry out the pilot there as they were her duty stations. Ten ART clients who are in the age range of 18 – 50 (5 men and 5 women), 2 service providers and 4 peer educators were sampled in order to determine the effectiveness of the research instruments. The respondents were assured of the confidentiality of their answers.

As a result of the pilot, Areas of flaw in the data collection tools were cleared. Some questions were deleted or rephrased. The format of the questionnaire was also changed and the questions were divided into sections depending on the topic.

Data was collected by 4 people. The researcher and 3 research assistants. The researcher sensitized the research assistants on the objectives, ethical considerations and how to administer the consent form. All the in-depth interviews were conducted by the researcher while the questionnaires were administered by the research assistants.

### **3.8 In-depth Interviews**

In depth Interviews were used in collecting data from the peer educators and the family planning nurses. In the two control sites, the in depth interviews consisted of less than 4 nurses. There were no interviews with peer educators in the control sites because there are no peer educators; the nurses do all the work.

The respondents who participated in the in-depth interviews were selected using purposive maximum variation sampling. A total of six (6) in depth interviews were conducted, four (4) with the nurses from both the control and study sites and two (2) with the peer educators. The in depth interviews with the nurses at the study sites were held in the offices while the interviews with the nurse from the control sites were held in the counseling rooms. The nurse at one of the control sites was working during the interview as she was the only nurse at the site and she could not afford to put the work on hold. All the nurses who participated in the interviews were women. The interviews with the peer educators included both men and women. In total, there were 4 men and 3 women.

The interview team included the moderator in this case the researcher and one research assistant who operated the digital recorder. The recorder was played back after the interviews to transcribe into notes. Permission to record the discussion was sought from the participants before the discussion and was granted in most cases except at one of the sites where the nurses were not comfortable with being recorded so hand written notes had to be taken during the discussion.

### **3.9 Permission to carry out Research and informed consent**

Consent was sought from the CIDRZ training director to carry out the study under CIDRZ and permission was granted. Consent was obtained from all the participants by way of signing a consent form. The consents and the questionnaires were translated into Nyanja and Bemba languages. All information was confidential and this was made known to the participants. The study does not use any names. The participants were told about the benefits and risks of being in the study if any. The clients' participation in the study was completely voluntary and they could decide to leave the study at any time.

### **3.10 Data Analysis**

This study involved the use of quantitative methods. The study included the use of quantitative methods to show the distinction in terms of gender, in the uptake of family planning in HIV clinics. Furthermore, a comparison is made between the control and case sites. Data was collected by questionnaires from the ART clients and all questions were close ended questions with optional answers provided. The responses were coded and entered onto the statistical package for social sciences (SPSS) computer soft ware for analysis. All the data was coded into categorical variables. For instance, age was categorized into seven (7) groups (15-20; 21-25; 26-30; 31-35; 36-40; 41-45). Processing of the data included descriptive analysis implying the running of frequencies to show how some variables were distributed in percentages.

### **3.11 Challenges Encountered During Research**

The initial plan was to have focus discussions (FDGs) with the nurses and peer educators. This proved difficult because the numbers of the peer educators and nurses were below the minimum number of FDG participants which is recommended in research. As a result of that, in depth interviews were held. The peer educators and nurses had a very heavy work load. So getting them off work was difficult. Getting the peer educators from their work to participate in the interviews meant that the clients stayed in the queue a bit longer because there was no one to attend to them and they complained about this. Similarly administering the questionnaires to the clients during the adherence counseling meant that the client stayed in the counseling room longer than usual. This caused some unrest among the other clients in the queue who were waiting to be attended to.

## **CHAPTER FOUR**

### **Presentation of Findings**

This chapter presents the findings of the survey in line with the overriding research objectives and research questions and the overall objective being the impact of peer education on family planning uptake in Lusaka HIV clinics. Under this objective, specific objectives will be presented. The quantitative survey findings in this study were collected using questionnaires. The results of the questionnaire survey are indicated below.

## 4.1 General Information

### 4.1.1 Age distribution all sites

In the questionnaire, participants were asked to state their age. On analysis, the results showed that the majority of the participants (24) were in the age range of 36 – 40.19 were in the age range of 31- 35, 16 in the age range of 26-30, 12 in the age range of 41-45, 7 in the age range of 21-25 and 2 between the ages of 15 and 20 years.

**Table1: Respondents' Age Range**

Age	Frequency	%
15-20	2	2.5
21-25	7	8.75
26-30	16	20
31-35	19	23.75
36-40	24	30
41-45	12	15
Total	80	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.1.2 Marital Status

The study population consisted of 51 married participants, 6 singles and 5 divorced.

**Table 2: Marital Status of Respondents**

Marital Status	Frequency	%
Married	51	63.75
Single	6	7.5
divorced	5	6.25
widowed	18	22.5
Total	80	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.1.3 Level of Education

The survey showed that 47 of the participants had attained high school education, 29 were at primary school level, 2 had reached college and 2 had attained high school education.

**Table 3: Respondents, Level of Education**

Level of Education	Frequency	%
Primary	29	36.25
High School	47	58.75
College	2	2.5
University	2	2.5
Total	80	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.1.4 Religion

Participants were asked to choose what religion they belonged to. The results showed that majority (74) of the participants belonged to Christianity while 2 indicated other.

**Table 4: Religion**

Religion	Frequency
Christianity	78
Other	2
Total	80

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.1.5 Last Pregnancy Planned

67 respondents said that their last pregnancy was planned while 8 said that their last pregnancy was not planned. There was a missing value of 5.

**Table 5: Was Last Pregnancy Planned**

Was your Last Pregnancy Planned all	
Response	Frequency
Yes	67
No	8
Total	77
Missing Value	5
Total	80

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.1.6 Effect of HV on Family Planning Use

49 respondents said that HIV has got an effect on family planning use while 2 said that it did not have an effect on family planning.

**Table 6: Effect of HIV on FP Use**

HIV Effect on FP use	
Response	Frequency
Yes	49
No	29
Total	78
Missing System	2
Total	80

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.1.7 Promotion of Family Planning

74 out the 80 respondents said that family planning should be promoted while 6 said that it should not be promoted.

**Table 7: Promotion of Family Planning**

FP Promotion	
Response	Frequency
Yes	74
No	6
Total	80

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.1.8 HIV and AIDS Affects Family Planning Needs

Of the 80 respondents, 64 said that HIV and AIDS affected family planning needs while 16 respondents said HIV and AIDS does not affect family planning needs.

**Table 8: HIV and AIDS affects FP Needs**

HIV and AIDS affects FP needs	
Response	Frequency
Yes	64
No	16
Total	80

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

## 4.2 Gendered trends of family planning uptake in TIDES supported ART clinics and non TIDES support ART clinics?

### 4.2.1 Reason Given for Not Using Family Planning

The control sites recorded more people (4) who reported not using a family planning because their partner did not allow them compared to the case sites which recorded only 2 with the same reason. 4 respondents from the case sites indicated that they did not use family planning because they wanted a child while 2 respondents from the control site gave the same reason.

**Table 9: Reasons given by respondents for not Using Family Planning**

Reasons for Not Taking Family Planning	Case Sites		Control Sites	
	No	%	No	%
I want a child	4	10	2	5
partner does not allow	2	5	4	10
Others	4	10	2	5
Missing Value	30	75	32	80
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.2.2 Family Planning Knowledge levels

The table below shows the difference in knowledge of family planning methods between the control and case sites.

**Table 10: Difference in the commonly known Family planning methods between the case and control sites**

Commonly Known Family Planning Methods In the Case and Control Sites	Case Sites		Control Sites	
	No	%	No	%
Condoms	4	10	17	50
IUD	1	2.5		
OCP	7	17.5	16	40
Injectables	5	12.5	2	5
Condoms, OCP,IUD, Jadelle	17	42.5		
Missing Value	6	15	2	5

Total	40	100	40	100
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Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

At the case sites, 4 of the people said that they know of condoms only as a family planning method, 1 said they know IUD, 7 indicated that they know OCP, 17 indicated that they knew of more than one family planning which included OCP, Condoms, IUD and Jadelle. In the control sites, 17 of the respondents knew condoms only as family planning method. 16 knew OCPs, 2 indicated that they knew other forms of family planning. No one indicated that they knew more than one family planning method.

#### 4.2.3 Current Family planning use

The respondents were also asked to state if they were currently using any family planning.

A comparison of case and control sites showed that 26 of the respondents from the case sites said that they were currently using family planning, 28 from the control sites said that they were currently using family planning. 14 respondents from the case sites indicated that they were not on any family planning method while 10 from the control sites said that they were not on any family planning method. Five people from the control sites did not respond to this question (table 12).

**Table 11: Participants who are currently using Family planning methods**

Participants Who Are Currently Using Family Planning	Case Sites		Control Sites	
	No	%	No	%
Yes	26	65	28	70
No	14	35	10	25
Missing Value			2	5
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.2.4 Changes in Clients' Family Planning Use

In the case sites, 36 of the respondents said that peer education has caused their family planning use to change. 3 said that their family planning use did not change.

**Table 12: Changes in the use of family planning due to peer education**

Changes in Use of Family Planning	Case sites	
	No	%

Yes	36	90
No	3	7.5
Missing Value	1	2.5
Total	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.2.5 Stigma in the Clinics

In the control sites, 6 respondents said that they have experienced stigma at the clinic while 32 said that they had not experienced stigma at the clinic. In the case sites, 3 said that they had not experienced any stigma at the clinic while 37 respondents said that they had experienced stigma at the clinic.

**Table 13: Stigma in the Clinics**

	Case Sites	Control Sites
	Frequency	Frequency
Yes	6	3
No	32	37
Total	38	40
Missing Value	2	
Total	40	40

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.3 Perceptions of ART clients on the quality of family planning in the two sites - TIDES supported and non TIDES supported clinics

#### 4.3.1 Accessibility of Family Planning Services

The respondents were asked to rank the extent of accessibility of family planning in their clinic, using an ordinal scale of: poor, fair, good and very good. At the case sites, 3 respondents said the accessibility of family planning services was fair, 31 said that the accessibility was good while 5 said that the accessibility was very good. Findings from the control sites, on the other hand

revealed that 22 of the respondents perceive the accessibility of family planning to be very good, 14 said that accessibility is good and 4 indicated that accessibility is fair.

**Table 14: Accessibility of Family Planning services**

Accessibility of Family Planning Services	Case Sites		Control Sites	
	No	%	No	%
Fair	3	7.5	4	10
Good	31	77.5	14	35
Very Good	5	12.5	22	55
Missing Value	1	2.5		
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.3.2 Extent of Satisfaction with Family Planning Services

The respondents were asked if they were happy with the current services offered at the FP clinic. 38 of the respondents from the case sites said that they were happy with the family planning services offered at the clinic. 50% respondents did not give an answer. All the 40 respondents from the control sites indicated that they were happy with the family planning services being offered at their clinic.

**Table 15: Participants satisfied with family planning clinic**

Participants Satisfied with Family Planning Clinic	Case Sites		Control Sites	
	No	%	No	%
Yes	38	95	40	100
Missing Value	2	5		
Total	40	100		

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.3.3 Quality of Family Planning Counseling

Asked to describe the quality of counseling offered by the counselors, 29 of the respondents from the case sites described the quality of counseling as good, 6 said the counseling was very good, 2 said that the counseling was fair and 1 of the respondents rated the quality of counseling as poor. 22 of the respondents from the control sites said that the quality of counseling that they received was very good and 16 described the quality of counseling as good (Table 17).

**Table 16: Quality of family planning counseling**

Quality of Family Planning Counseling	Case Sites		Control Sites	
	No	%	No	%
Poor	1	2.5		
Fair	2	5		
Good	29	72.5	16	40
Very Good	6	15	22	55
Missing Value	2	5	2	5
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.3.4 Waiting Time at the Clinic

The survey showed that in the control sites, 14 of the respondents said that they do not wait long hours, 12 said yes they wait long hours before being attended to at the family planning clinic and 10 said they wait long hours sometimes. More of the respondents, 19 from the case sites indicated that they sometimes waited long hours before being attended to at the family planning clinic. 10 respondents said they don't wait long hours and 7 admitted that they wait long hours at the clinic.

**Table 17: Difference in length of waiting time between case and control sites**

Waits for a long time at the ART and Family Planning Clinics	Case Sites		Control Sites	
	No	%	No	%
Yes	7	17.5	12	30
No	10	25	14	35
Sometimes	19	47.5	10	25
Missing Value	4	10	4	10
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.3.5 Improvement in accessibility since inception of peer education in Family planning

All the respondents 40 from the two case sites indicated that family planning services had become easy to access since the introduction of peer intervention in family planning.

## 4.4 Processes that are used to enhance family planning uptake

### 4.4.1 Family planning Decision making

The table below illustrates that only 2 of the respondents at the case sites reported that the nurse made the choice of family planning for them and 6 respondents from the control sites said that their choice of family planning was made by the nurse. Eight respondents from the case sites indicated that their partners decided what method they should use while 12 from the control sites said that their partner makes the decision for them. 26 respondents from the case sites reported that they made their own family planning choice compared to 18 from the control sites. In the case sites, no respondent indicated that the peer educators made the family choice for them.

**Table 18: Person responsible for participant's choice of family planning method**

Person Responsible for Family Planning Method Choice	Case Sites		Control Sites	
	No	%	No	%
Nurse	2	5	6	15
Peer Educators				
My Partner	8	20	12	30
Myself	26	65	18	45
Other	2	5	2	5
Missing Value	2	5	2	5
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

### 4.4.2 Difference in FP counseling between PE and Nurses

The respondents were asked if there was any difference between the family counseling provided by the Peer educators and the nurses. 37 of the respondents from the case sites said yes and 3 said no. at the control sites 14 said yes and 24 said no there was no difference. This is illustrated in the table below.

**Table 19: Difference between Family Planning counseling provided by Peer Educators and that provided by Nurses**

There is a difference between Family Planning counseling provided by Peer Educators and that provided by Nurses	Case Sites		Control Sites	
	No	%	No	%
Yes	37	92.5	14	35

No	3	7.5	24	60
			2	5
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.4.3 Clients' Source of Family Planning Information

The source of information on family planning among the respondents is illustrated below:

**Table 20: Source of family planning information**

Source of Information on Family Planning	Case Sites		Control Sites	
	Frequency	%	Frequency	%
Clinic	38	95	36	90
Community	2	5	2	5
Missing Value			2	5
Total			40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

From the control sites, 36 of respondents said that they got the family planning information from the clinics compared to 38 from the case sites 2 from both the sites got the information from the community. The number of people who got family planning information from the clinic in the control sites is almost the same as in the case sites.

#### 4.4.4 Peer Educators' level of family planning knowledge

Most of the respondents (38) from case sites indicated that the peer educators' knowledge on family planning was adequate while 1 said that the peer educators, knowledge was not adequate. A comparison with the control sites will not be done as far as peer educators' knowledge is concerned because in the control sites it is the nurses who do the adherence counseling and the clients goes to the family planning clinic on their own if they wanted family planning services.

**Table 21: Peer Educators have Adequate Knowledge on Family Planning**

Peer Educators have Adequate Knowledge on Family Planning	Case Sites	
	No	%
Yes	38	95
No	1	2.5

Missing Value	1	2.5
Total	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.4.5 Adequacy of Family Planning Information Received

The table below shows a comparison in the results between the sites. 40 of the respondents from the case sites said that the family planning information from the peer educators was adequate while 34 of the respondents from the control sites said that the information was adequate and 6 said the information they were receiving was not adequate.

**Table 22: Family Planning Information Received is Adequate**

Family Planning Information Received is Adequate	Case Sites		Control Sites	
	No	%	No	%
Yes	40	100	34	85
No			6	15
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.4.6 Relationship with Clinic Staff

The participants were asked to describe their relationship with the clinic staff. They were given 4 options which included poor, fair, good or very good. As illustrated in the table below, 2 of the respondents from the case sites rated their relationship with the clinic staff as fair, 34 said their relationship was good and 4 said that their relationship was very good. On the other hand, 10 of the respondents from the control sites said that the relationship with the clinic staff was very good, 28 indicated that their relationship was good and 2 described their relationship as fair.

**Table 23: Participants' Relationship with clinic staff**

Participants' Relationship with Clinic Staff	Case Sites		Control Sites	
	No	%	No	%
Fair	2	5	2	5
Good	34	85	28	70

Very Good	4	10	10	25
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

#### 4.4.7 Teaching Aids

The table below shows some results from the survey comparing teaching aids used in the case and control sites.

**Table 24: Teaching Aids Used By Peer Educators**

Teaching Aids Used By Peer Educators	Case Sites		Control Sites	
	No	%	No	%
Nothing	1	2.5	4	10
Flip Charts	22	55	6	15
Brochures			28	70
TV	17	42.5		
Missing Value			2	5
Total	40	100	40	100

Source: *The Impact of Peer Education on Family Planning Uptake in Lusaka HIV clinics Survey data*

In the case sites, 1 respondent said nothing was used to teach them on family planning, 22 said that a flipchart was used to teach them on family planning and 17 said that they were taught using TV. At the control sites 4 respondents said that nothing was used to teach them, 6 said a flipchart was used, and 28 said that they were given a brochure.

#### 4.5. In-depth Interviews with the Peer Educators

Two in-depth interviews were held with peer educators in the two case sites. The initial plan was to hold 4 (four) focus group discussions with peer educators from both the control and case sites. There were no peer educators at one of the control sites while at the other site, they had only one peer educator whose role was to follow up on ART clients.

##### 4.5.1 Changes in Clients' Uptake of Family planning

Asked if the ART clients' family planning behavior had changed since they started doing the family planning counseling, the peer educators at both sites said that there was an improvement and that a lot of the clients are now using dual protection. According to the peer educators at site

two, this was as a result of the family planning counseling skill that they had acquired from CIDRZ.

#### **4.5.2 Family Planning Counseling Procedure**

The peer educators were asked to explain the counseling procedure, both sites gave the same response. They said that the peer educators explained the type of family planning methods to the client and if the client was interested in a method they were escorted to MCH to get the method. It was revealed that the peer educators offered family planning counseling to all clients who are of child bearing age. The peer educators explained that the information given to the clients included benefits of family planning and prevention of re-infection. The peer educators at both sites stated that they used a flip chart as a teaching aid. The peer educators at site two also reported that they also make use of health talks to teach people on family planning. The peer educators reported that the time spent on counseling depends on how fast a client understands. Site one peer educators reported that they counsel about 30 clients each. Site two said that number of clients counseled by each peer educator ranges from 5 to 15 clients per day.

#### **4.5.3 Peer Education and gender in Family Planning Counseling**

The peer educators reported that they counsel both men and women on family planning. When asked how their experience in counseling men has been, they explained that some men accept family planning while others do not. They were also asked if they had experienced a situation where a woman refused to take family planning because her husband does not allow. The peer educators at site one said they do but that it is very rare while site two peer educators said that the women do not necessarily say so but they would just say that they want to consult their husbands first before they can accept any family planning method. The peer educators said that in such cases they would explain the benefits of family planning to women who refuse to accept family planning because their husbands do not allow.

## **4.6 In-depth Interviews with the Nurses**

Four in-depth interviews with Service providers were held; two with the case sites and two with the control sites. The survey had targeted family planning nurses. In the case sites the FDGs comprised of family planning nurses. At one of the control sites, there was no family planning nurse as there is no family planning offered in the clinic so the discussion was held with two ART nurses. At the other control site, the group included two ART nurse and one of them also did family planning in the clinic.

### **4.6.1 Integration of Family Planning and ART services**

The nurses were asked to explain what they think about integrating family planning into ART services and they also asked to discuss the effect of HIV and AIDS on family planning needs of women and men. In response, the nurses from the case sites said that it is a good idea because very few women who are HIV positive access family planning. They added that some ARVs cause fertility so the women from the ART clinic needed family planning more. At one of the control sites, the nurses agreed that family planning should be part of ART in order to help ART clients and also to help them to maintain their status. They also added that the integration gives an opportunity to advise the ART clients on the best time to get pregnant. The nurses in the case sites were asked to explain what they know about TIDES and if they see more client coming or family planning. At both case sites, the nurses said that TIDES was a project that was looking into integrating family planning and ART services. They said that the integration was a good idea because it gives an opportunity for HIV positive women to access family planning. They said that HIV positive people want to space their children as well so there are more people coming for family planning services now than before the inception of TIDES. They added that HIV positive people needed to be on family planning to enable their CD4 to increase.

### **4.6.2 Peer educators' involvement in Family planning in the ART clinic**

The nurses were asked what they think about the peer educators' involvement in family planning. The nurses at the case sites said that the peer educators were helping in educating women from the ART clinic on family planning and that they made sure that the clients received their family planning method. They said that

peer education is effective as the peer educators are always in contact with the clients. The nurses said that the peer educators should also go out into the community and sensitize women on family planning. They also added that peer education is effective because the peer educators make the nurses' work easier and that the clients come to the family planning clinic already counseled on the methods and they have already chosen the method. All they do is counsel them more on the method that they have chosen. They added that they would like the peer educators to help more in filling out the family planning cards and also register the clients in the family planning register. At one of the control sites, the nurse said that there is only one peer educator in the clinic because the clinic is small. She added that peer educators' involvement could be very helpful because the health sector is always understaffed especially in the ART clinic. She explained that peer educators do a lot of work such as filling and they could also do adherence if properly counseled. At the other control site, it was reported that there was no peer educator but just a community liaison person whose main role was to follow up on ART clients. They added that they would rather do the counseling of the clients because peer educators do not understand the importance of adherence counseling.

## **CHAPTER FIVE**

### **Discussion of Findings**

## **5.1 Introduction**

This chapter discusses the research findings in line with the overriding research objectives and research questions and the overall objective being the impact of peer education on family planning uptake in Lusaka HIV clinics. Under this objective, specific objectives will be discussed.

## **5.2 Perceptions of ART clients on quality of family planning services offered in the case sites and control sites**

### **5.2.1 Stigma in the clinic**

As already mentioned, many traditional cultures expect women to be innocent, subservient, and modest. Norms that equate female sexual knowledge with promiscuity also affect women's ability to talk openly with health providers about intimate sexual issues. Both married and unmarried women who visit clinics for contraceptives may be stigmatized as promiscuous or "too independent," creating a social and psychological barrier that prevents them from making their own reproductive choices. In some traditional cultures, a woman's status is defined and a husband's virility is confirmed by her fertility. Cultural beliefs that place such importance on procreation affect a woman's ability to use or request that her husband use contraception. Many cultures' prevailing myths and misconceptions about the use of modern contraceptives put psychological pressure on women who want contraception (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009). Contrary to that concept, the findings in this study showed different results however. Most of the respondents from both the sites (32 from the case sites and 37 from the control sites), when asked if they experienced stigma at the clinics said that they have never experienced stigma in the clinic.

### **5.2.2 Quality of Family Planning Counseling**

Results from the survey showed that 6 of the respondents from the case sites said that the quality of family planning was very good. They were asked to rate the family planning counseling from very good, good, fair and poor. In comparison, 22 of the respondent from the control sites rated the quality of family planning counseling as very good. During the interviews with the nurses and peer educators, it was discovered that in the case sites the counseling was done by the peer educators while in the control sites it was done by the nurses. This could mean that the quality of counseling given by the nurses is better than the quality of the counseling which is given by the

peer educators. The issue of quality of the services can never be over emphasized. This is why it is argued that in the governmental organizations and the reproductive health NGOs, the emphasis is on quality and access (Anne Eckman, Blakley Huntley and Anita Bhuyan, 2004).

### **5.2.3 Waiting time at the clinic**

The results of the survey show that more of the participants from the control sites (12) waited for long hours at the clinic before being attended to compared to the participants from the case sites (7). The flow of clients in the TIDES supported sites was quite systematic. According to Elizabeth Stringer et al, the client was counseled on adherence first then on family planning and if they were interested in any method, they were escorted to the family planning clinic where they were fast tracked. They did not have to join the queue of other women there. So that could account for the few people in the case sites who said that they do not wait for long hours (Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011). 14 of the respondents from the control sites said that they do not wait long hours compared to 10 from the case sites. On observation, the counseling sessions at the case sites were longer than the ones in the control sites. The introduction of family planning counseling in clinics meant that the clients would have to stay a bit longer in the counseling room and that coupled with the time that the client spent at the family planning clinic.

### **5.2.4 Improvement in accessibility of family planning**

All the respondents from the case sites said that there was an improvement in accessibility of family planning since the inception of peer education. This could have been as a result of the systems that the TIDES project put in place such as the order of client flow as mentioned in the paragraph above and the availability of family planning methods at all times. Elizabeth Stringer et al explains that the TIDES project made sure that all the methods and equipment needed for family planning administering were available at all times and the nurses in the case sites were all trained on how to give all the methods (Elizabeth Stringer, MD., Carla Chibwasha, MD. Christine Matoba, 2011).

### **5.2.5 Family planning Decision making**

In the case sites, 26 of the respondents made their choice of family planning themselves compared to 18 in the control sites. In the case sites, 8 respondents said that their husbands made the decision for them compared to 12 respondents from the control sites. Just like in the DPS

study mentioned in the literature review (page 30) were peer educators were provided 40 hours of intensive training about drug information as well as in decision making, Elizabeth Stringer et al (2011) explains that the peer educators in the TIDES supported sites were taught to always educate the clients on their right to decide which family planning method they want to take and when to take it. In this sense Schuler et al (2009) clearly explains that power inequalities in relationships between men and women, especially related to control of decision making power, economic resources, time, and mobility, also affect women's access to services and their ability to use family planning. Sita Fathona (2000) sites a Sabla provider in India/UP as having said, *"If we are talking about the pills then it is the women's decisions, for condoms men decide, and for copper T [IUD] and sterilization, it is the whole family's decision."*

In the in-depth interviews, the peer educators were also asked if they had experienced a situation in which a woman refused to take family planning because her husband does not allow. The peer educators at case site 1 said they do but that is very rare while at case site 2 the peer educators said that the women do not necessarily say so but they would just say that they want to consult their husbands first before they can accept any family planning method. The peer educators said that in such cases they would explain the benefits of family planning to women who refuse to accept family planning because their husbands do not allow.

In the literature review (page 23) an example is given on a male non-user who described a conversation he had with his wife, in which he told her that he wanted four children: "She did not question me nor ask the reason why. She told me that I'm the one who makes the decisions and that she cannot decide anything for me." A male user said that telling his wife to use contraceptives "was a command, not a request. I told her that it was a must for us to use it." Another male user said, "I do involve her in decisions because when I want to have a child, I tell her and she agrees. But she can't tell me that we should stop having more children because I am the one to make that decision." One urban woman was afraid to raise the subject at all: "For example, if I made myself out as knowing too much and started talking about family planning, I would definitely get a beating. That is why I choose to remain silent." Women rarely initiated contraceptive use on their own, without the husband's consent. A female non-user stated, "If he ever finds out that I'm using any type of family planning method, then my marriage would be in

trouble. He refuses because he says that I might never be able to deliver again and that is why I've decided to take his advice. I'm not going to use any kind of family planning method just in case he discovers it and this brings problems in our relationship." A large minority of the female non-users said they wanted to use modern contraceptives but did not because their husbands did not allow it. In several other cases, men imposed contraceptive use on their wives rather than blocked its use. Generally, men are considered dominant in decision making in the three countries, although women are becoming more involved, particularly if they are educated. Men's opinions on number of children tend to hold sway, although some women take the initiative to decide on their own, which has implications for couple communication and choice of methods. In India, the extended families and particularly mothers-in-law are closely involved in decisions on childbearing and family planning use.

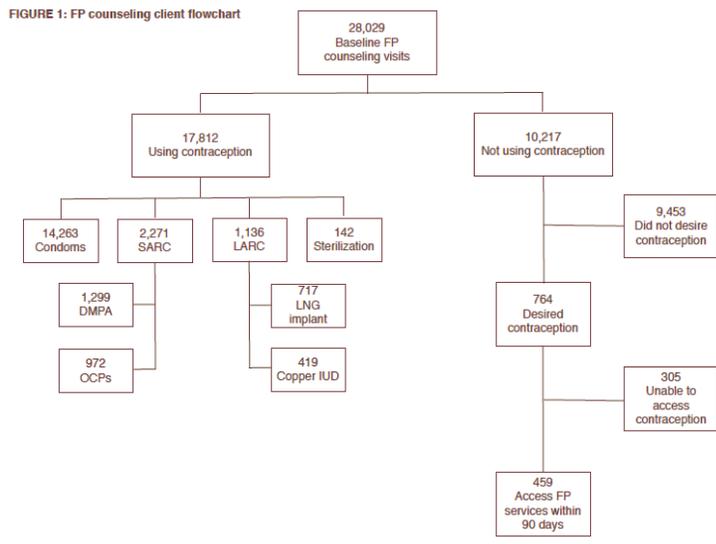
### **5.3 Impact of peer educators' skills on the uptake of family planning**

The findings from the survey reveal that the respondents from the case sites said that they had noted a difference in the family planning information given by the peer educators. This shows that the peer educators' family planning knowledge had an effect on clients and they felt the effect. Majority of the respondents from the case sites noticed a difference in the family planning counseling provided by the peer educators. On observation, the family planning counseling that was provided to ART clients before TIDES was introduced was limited to a few questions such as; "are you on any family planning method?" and "what family planning method are you using?" these questions appear on the adherence counseling form which is used to fill out clients information during adherence counseling. It was very rare to find any thorough counseling being done on family planning.

### **5.4 Gendered trends in family planning Uptake**

Data obtained from the TIDES data base shows that peer education had a generally average impact in terms of improving the levels of uptake of family planning use in HIV clinics and by women in particular. The data base showed that between November 2009 and November 2010, CIDRZ peer educators counseled a total of 69,636 HIV-infected men and women about family planning options. During this time period there were 28,029 new clients seen by peer educators.

At the time of their initial counseling session, 17,812 (64%) HIV-infected individuals reported use of a modern family planning method. Among these individuals, the most commonly reported contraceptive method was condoms (14,263). This best illustrated in the figure below which was created using statistics from the TIDES database.



The results from the questionnaires also indicates that though the clients were counseled on different types of family planning, most of them preferred to use condoms only. The most known family planning method in all the sites, according to the survey was condoms in both the case and control sites. As far as other family planning methods are concerned, the case sites recorded a high number of people who said that they knew more than one type of family which included condoms, OCP, IUD and jabelle. This could be attributed to the fact that the peer educators counseled them on all the family planning methods (Elizabeth Stringer et al).

In the study carried out by Sita Fathona (2000), providers of contraceptive methods said women preferred injectables over pills or other methods, because injectables are easier to hide from their husband if they are using contraception clandestinely, or that they often forget to take the pill on a daily basis, whereas injectables only require a visit to the facility every three months.

### **5.5 Gendered Processes through which peer education impacts on family planning**

The peer educators at both sites stated that they used a flip chart as a teaching aid. The peer educators at case site 2 (two) also reported that they also make use of health talks to teach people

on family planning. The peer educators reported that the time spent on counseling depends on how fast a client understands. The teaching aids contained pictures of family planning methods and this helped in educating the women who were mostly not very educated i.e majority attained high school according to the results from the survey.

In the in depth interviews, the peer educators were asked to explain the counseling procedure, both sites gave the same response. They said that the peer educators explained the type of family planning methods to the client and if the client was interested in a method they were escorted to MCH to get the method. It was revealed that the peer educators offered family planning counseling to all clients who are of child bearing age. This included even school going girls and thereby ruling out the issue of stigma which as mentioned above is one of the reasons why most women do not access family planning.

According to the TIDES project reports, the project trained 104 peer educators in August 2009, equipping them with medically accurate and up-to-date information on a range of barrier methods, short- and long-term reversible contraception, as well as options for permanent sterilization. The TIDES team went round the clinics every week to monitor the peer educators and the nurses and offer advice where it was needed. This helped to ensure that the peer educators were making use of their counseling skills as they were closely observed during each monitoring visit and hence ensuring that clients are provided with quality counseling services. As has been discussed already, compromised quality leads to the low uptake of family planning among women. Schuler et al (2009) gives an example to this effect where a comprehensive and participatory assessment of HIV/AIDS peer education programmes was recently conducted in several clusters (regional HIV/AIDS NGO networks) in Tanzania. The results of this assessment signaled a series of programmatic recommendations, including: (1) further enhancement of community involvement and ownership in order to facilitate programme continuity and sustainability; (2) ongoing capacity-building, such as continuing supervision and follow-up with peer educators to ensure programme quality.

Considering the dominant position that men have over women, it is unlikely that a man can listen to a female counselor. The fact that the peer educators in the TIDES project included both men and women meant that men would also counsel their fellow men. This is also a strategy being

used by many programmes to promote gender in family planning. In support of this it is argued that numerous studies show recruiting men for community based family planning services is feasible and effective. Studies in Cameroon, Ghana, Kenya, and Mali are cited as having showed that communities readily accept male CBD agents. Moreover, comparing condom sales by male and female agents showed men sold twice (Peru) or almost three times (Kenya) as many condoms as women. Studies in Latin America and Africa show male and female CBD agents can be equally productive overall in providing couple years of protection.

It is argued that traditional norms of masculinity may limit a man's or his partner's use of family planning services. It has always been assumed that men are indifferent or even opposed to family planning programs, but men also face stigma and discrimination that arise from pre-constructed "masculine" gender roles. Male partners often face negative reactions from other men and family members when they attempt to become involved in women's or children's health. Joint counseling of women attending ANC services and their partners can lead to improved couple communication and reproductive health benefits. In many developing countries, men are the major decision-makers on reproductive health but are poorly informed about or engaged in services to support partner health. The frontiers legacy document further reports that in India and South Africa, couples were offered joint, individual, or same-sex group counseling sessions during antenatal care visits. Men demonstrate great interest in learning more about partners' needs ([www.popcouncil.org/frontiers](http://www.popcouncil.org/frontiers)).

On the other hand the use of men as counselors could be negative. Schuler et al (2009) argues that women are disadvantaged by unequal power relations outside the home as well as within it. Gender power imbalances in client-provider relationships often are exacerbated by disparities in social status and education, which are likely to be greater when the client is female and the provider is male. This may encourage providers to behave in an authoritarian fashion that often results in compliance and passivity from their clients. Regardless of the sex of the provider, female clients often fail to ask questions or voice concerns that may affect the success of their family planning use. FP programs and services have often selectively accommodated rather than challenged prevailing gender norms by targeting FP toward women and have reinforced the idea that reproduction and family welfare are women's responsibilities. Beyond limiting the reach of

FP services, gender inequality and the norms surrounding masculinity, femininity, and male-female relationships can impede the healthy timing and spacing of pregnancies. For example, men might be willing to accept women's contraceptive use but unwilling to bear the costs and perceived risks of FP, as has been documented in Bangladesh (Sidney Ruth Schuler, Elisabeth Rottach, MA, and Peninah Mukiri, MBA, 2009).

## **CHAPTER SIX**

### **Conclusion and Recommendations**

#### **6.1 Conclusion**

The peer educators do most of the counseling in most ART clinics, therefore equipping them with family planning information giving skills is a good way of reaching PLWHA who can also be classified as “hard to reach people” this is so because PLWHA tend to shy away from such services for fear that their status will be known. The peer educators in the clinics are HIV positive individuals who volunteer to counsel other HIV+ individuals. They are living examples

to other HIV + people. ART clients are likely to be more open about their status to the peer counselors as opposed to the MCH nurses.

The introduction of peer education helped in reducing the work load for both the family planning nurses and the ART nurses. In the in depth interviews, the nurses were asked if they thought that the introduction of peer educators was useful. The nurses in the TIDES supported clinics stated that the time that they spent on counseling the clients on family planning had reduced as the clients already had the knowledge which they got from the counseling done by the peer educators. They also reported that at times, the peer educators assisted the nurses with tasks such as getting the weight of the client, checking the clients' blood pressure and also filling out the clients' information in the clients' family planning card. All the nurse had to do was to administer the family planning method. This could help reduce the time spent at the clinic by the women and hereby facilitate an increase in access to family planning. At one of the control sites, the nurse said that the introduction of peer education was not a good idea as the peer educators do not understand the concept of counseling and they do not give thorough counseling. The nurse further added that their role should be more of following up on clients, giving health talks and filing and not counseling on adherence and family planning. The nurses at the case sites said that the peer educators were helping in educating women on family planning and that they made sure that the clients received their family planning method. They said that peer education is effective as the peer educators are always in contact with the clients.

## **6.2 Recommendations**

### **6.2.1 Peer Educators' impact on gender in family planning access in the ART clinic**

The peer educators played an important role in providing intensive family planning counseling to both men and women. In most cases, couples are counseled separately due to the fact that they have different appointment dates at the ART clinic. In this case it is difficult to tell if the men are really involved in family planning life despite having received all the information from the peer educators. I would recommend that the peer educators be trained on couples counseling so they are able to counsel both partners at the same time and help them make a decision that they both will be comfortable with.

### **6.2.2 Gendered Trends of family planning uptake**

One can give as much information as possible, but if people are not willing to change, the information can have no effect. Only a year of family planning counseling was not enough to bring about the desired change. Persistence in giving out family planning information could gradually bring about the desired change over time. Both the clients and peer educators could also find the counseling time too long especially that adherence and family planning counseling was done separately. The family planning counseling that is already a component of adherence counseling should be enhanced i.e more information should be added so that there is only one counseling session. There should be more effort put in dispelling myths and misconceptions as this is the reason why women and men are inclined to one type of method which is condoms and these do not offer 100% protection from HIV and pregnancy especially when used on their own.

Involvement of men should be encouraged. The reason why most women use certain kinds of family planning like Implants and intravaginal methods is because they are afraid of their partners. With such methods, one can easily hide from the partner as shown in the results of the survey, there are women who refused to take family planning because their partners did not allow them.

### **6.2.3 Perceptions of ART clients on quality of family planning services offered in the case sites and control sites**

The respondents from the case sites all seemed happy with the quality of family planning offered to them. This was because of the fast track policy in those sites, family planning methods were readily available and the family planning clinics were open all the days of the week. more peer educators should be employed so that there is division of work i.e. other peer educators' sole responsibility should be to take the client to the family planning clinic, carry out the vital e.g. take their temperature, blood pressure and test them for pregnancy and then hand them over to the nurse and follow up on them later to make sure that they received the family planning method and they are happy. One peer educator cannot manage to do all that as well as adherence counseling. The health facilities should improve on their ordering logistics so that there is never a short supply of family planning commodities in the facility. That was the case before and a few months after TIDES was introduced. More peer educators should be employed as the ART clients relate more to them. They are a living example of their own situation.

#### 6.2.4 Gendered Processes through which peer education impacts on family planning uptake

To help increase the number of people on family planning in the ART clinic, the peer educators should be trained on how to give easy to administer family planning methods such as injectables and OCPs. This would reduce the work load of the family planning nurses who are already overwhelmed with work. As the results from the research show, some of the clients were not able to get their method even if they were interested because they were not attended to when they went to the family planning clinic to get their method.

More male peer educators should be employed. It is more effective for a male peer educator to counsel and male client on family planning. This will help bring about the much desired male involvement in family planning.

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**TITLE OF THE RESEARCH:**

A study on the Impact of Peer Educators on The Usage of Family Planning in Lusaka HIV clinics

Appendix 1  
English Consent Form

## **INTRODUCTION**

I am Namakau Nyambe a student at the University of Zambia in the school of HSS – Gender Studies Department pursuing a Master of Arts in Gender Studies. am conducting a research on the Impact of Peer Educators on Family Planning Usage in Lusaka HIV clinics.

This is a consent form which gives you information about this study. You are free to ask questions about this study at any time. If you agree to take part in this study, you will be asked to sign consent form. You will be offered a copy of the consent form to keep.

## **WHY IS THIS STUDY BEING DONE?**

The purpose of this study is to see whether peer educators can help improve the usage of family planning in HIV clinics. Another purpose of this study is to determine whether peer educators can be used as clinician extenders in the light of the shortage of staff prevalent in the country.

## **WHAT DO I HAVE TO DO IF I AM IN THIS STUDY?**

For ART clients, If you decide to join this study, you will be given a questionnaire to complete and return when you come for you next clinical visit.

If you are a Nurse you will be interviewed.

If you are a Peer educator you will be required to attend a focused group discussion. You will be informed of the date, time and venue.

To be enrolled in the study you are required to provide information about where you live so that you can be contacted you in case you cannot manage to return the questionnaire on the required time.

By signing this consent you are agreeing to allow us to use this information.

## **ARE THERE BENEFITS TO TAKING PART IN THIS STUDY?**

If you participate in this study, there may be a direct benefit to you, but no guarantee can be made. It is also possible that you may receive no benefit from being in this study..

Information learned from this study may help in the improvement of family planning services being offered to People Living With HIV.

**WHAT ABOUT CONFIDENTIALITY?**

The study will not use your name. You are not obliged to put on the questionnaire or to mention your name during our interactions.

**WHAT HAPPENS IF I AM INJURED?**

It is unlikely that you will be injured as a result of taking part in this study.

**WHAT IS MY RIGHT AS A VOLUNTEER IN A RESEARCH STUDY?**

Taking part in this study is completely voluntary. You may choose not to take part in this study or leave this study at any time. You will be treated the same no matter what you decide.

**SIGNIFICANT NEW FINDINGS**

We will tell you about new information from this study that may affect welfare, or willingness to stay in this study. If you want the results of the study.

**LEGAL RIGHTS:**

You will not be giving up or waiving any of your legal rights by signing this consent form.

**WHAT DO I DO IF I HAVE QUESTIONS OR PROBLEMS?**

For questions about this study contact:

Namakau Nyambe

Principal Investigator

P.O BOX 3020

Lusaka, Zambia

Mobile: 0966 679245

E-mail: [nyamben2002@yahoo.com](mailto:nyamben2002@yahoo.com)

**SIGNATURE PAGE:**

If you have read this consent form (or had it explained to you), all your questions have been answered and you agree to take part in this study, please sign your name or make your thumbprint below. You should also be aware that the Research Ethics Committee of the University of Zambia has approved the study, which is there to protect you

_____	_____	_____
Participant's Name (print)	Participant's Signature or Thumbprint	Date <i>(Leave blank if participant is illiterate)</i>
_____	_____	_____
Witness's Name <i>(As appropriate)</i> (print)	Witness's Signature or Thumbprint	Date
_____	_____	_____
Study Staff Conducting Consent Discussion (print)	Study Staff Signature	Date

*The witness name, signature and date are required on this form only when the consenting participant is illiterate/not able to read.*

## Appendix 2

### Nyanja version consent Form

CHIYAMBI

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**TITLE OF THE RESEARCH:**

A study on the Impact of Peer Educators on The Usage of Family Planning in Lusaka HIV clinics

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Ine ndine Namakau Nyambe wophunzira pa University of Zambia mu sukulu ya HSS – Gender Studies Department amene ndifuna nikatenge Master of Arts mu Gender Studies. Ndikuchita kufufuza pa zotulukapo za Ophunzitsa Anzao pa kusebenzesa chilezi (Family Planning) mu ma kiliniki ya ma ARVs mu Lusaka.

Ichi ndi chi pepala cha chivomerezo chimene chikupatsani nkhani za pa maphunziro. Muli omasuka kufunsa mafunso pa za maphunziro pa nthawi ili yonse. Ngati muzavomera kutengamo mbali mu maphunziro aya, muzapemphedwa kusaina chi pepala cha chivomerezo. muzapatsidwa kope ya chi pepala kuti mukasunge.

#### KODI NDI CHIFUKWA CHIYANI MAPHUNZIRO AKUCHITIDWA?

Cholinga cha maphunziro ndi kuona ngati Ophunzitsa Anzao angathe kuthandiza kukhonza kasebenzsedwe ka chilezi mu ma kiliniki ya HIV. Cholinga china cha maphunziro aya ndi kupeza ngati Ophunzitsa Anzao angathe kusebenzsedwa monga othandizira ogwira nchito mu kiliniki pa nthawi ya kuchepekera kwa anchito mu kiliniki imene ili vuto mu dziko lino.

#### KODI NDI CHIYANI CHIMENE NDINGACHITE NGATI NDILI MU MAPHUNZIRO?

Kwa otengamo mbali mu mankhwala yama ARVs: Ngati mwasankha kulowa mu maphunziro aya, muzapatsidwa chi pepala cha mafunso kuti muyankhe ndi kuchibweza pamene muzabwera ku ulendo wanu wosatira wa ku kiliniki.

Ngati ndinu a Dokota a Manxhwala, muzafunsidwa mafunso.

Ngati ndinu Opatsa Thandizo, muzafunikira kupezekapo pa kukambisirana kwa kagulu. Muzauzidwa za tsiku, nthawi ndi malo.

Kuti mulowe, muzafunika kupatsa nkhani za kumene mukhala kotero kuti tingathe kuonana naimwe/kutuma foni ngati simungakwanitse kubweretsa chi pepala cha mafunsano pa nthawi yofunika. Mwakusaina ichi chivomerezo mukuvomera kutilola kusebenzesa nkhani izi.

#### KODI KULI MAPHINDU OTENGAMO MBALI MU MAPHUNZIRO?

Ngati mwatengamo mbali mu maphunziro aya, mwina kungakhale phindu yoloza kwa inu, koma kulibe chisimikizo chimene tingakupatseni. N’chothekanso kuti mwina simungalandire phindu.

Nkhani zophunziridwa kuchoka mu maphunziro aya mwina ingathandize mu kukhonza kwa thandizo ya chilezi imene imapatsidwa kwa anthu amene ali ndi HIV.

#### NANGA BWANJI ZA CHISINSI?

Maphunziro sazasebenzesa dzina lanu. Simukakamizidwa kuika pa chi pepala kapena kuchula dzina lanu pa nthawi ya makambisirano athu.

#### KODI NDI CHIYANI CHIZACHITIKA NGATI NAZICHITA?

Sichioneka kuti mungazichite chifukwa cha kutengamo mbali mu maphunziro.

#### KODI NDI UFULU WANGA WOTANI CHIFUKWA CHOTENGAMO MBALI MU MAPHUNZIRO?

Kutengamo mbali mu maphunziro aya ndi kozifunira kotheratu. Mungasankhe kusatengamo mbali mu maphunziro kapena kuchoka mu maphunziro pa nthawi ili yonse. Muzachitidwa chimodzi modzi muli monse mwamene muzasankhira.

#### ZOPEZEKA ZATSOPANO ZOFUNIKA

Tizakuuzani pa za nkhani zatsopano kuchoka mu maphunziro aya zimene mwina zingakhuze umoyo wanu, kapena kufunisitsa kwanu kukhala mu maphunziro aya kapena ngati mufuna zotulukamo za maphunziro.

#### UFULU WA LAMULO

Simuzataya kapena kusingha ufulu wanu uli wonse walamulo mwa kusaina ichi chipepala cha chivomerezo.

**KODI NDINGACHITE CHIYANI NGATI NDILI NDI MAFUNSO KAPENA MAVUTO?**

Ngati muli ndi mafunso pa za maphunziro aya, onanani ndi a:

Namakau Nyambe

Principal Investigator

P.O BOX 3020

Lusaka, Zambia

Mobile: 0966 679245

E-mail: nyamben2002@yahoo.com

**KUSAINA:**

Ngati mwawerenga ichi chipepala cha chivomerezo (kapena chafotokozedwa kwa inu), mafunso onse ayankhidwa ndipo mwavomera kutengamo mbali mu maphunziro aya, chonde sainani dzina lanu kapena ikani chizindikiro cha chala chanu pansi. Muyenera kuziwanso kuti a bungwe la Biomedical Research Ethics Committee ya University of Zambia anavomereza maphunziro aya, imene ilipo kuti ikutetezeni.

_____	_____	_____
Dzina la Otengamo mbali (Sindikizani) <i>wotengamo</i>	Kusaina kwa otengamo mbali kapena chala chanu	Tsiku <i>(Siyani posalembangati mbali siwophunzira)</i>

_____	_____	_____
Dzina la Mboni (Sindikizani) <i>(Monga kuyenera)</i>	Kusaina kwa Mboni kapena chala chanu	Tsiku

_____	_____	_____
Wanchito za Maphunziro amene achita kukambisana kwa Chivomerezo (Sindikizani)	Kusaina kwa Wanchito za Maphunziro	Tsiku

*Dzina la mboni, kusaina ndi tsiku ndizofunika pa chipepala ichi chabe ngati otengamo mbali siwophunzira/sakwanitsa kuwerenga.*

## Appendix 3

### FOCUS GROUP DISCUSSION FOR PEER EDUCATORS

1. Introduction
  2. Explain the purpose of the study
  3. Get verbal consent
  4. Assure the participants of confidentiality
  5. Conduct the interview
  6. Thank the respondent for their participation
1. Give us some background information about yourselves?
    - How long have you been peer educators?
    - What motivated you to become peer educators?
    - What kinds of professional training do have?
    - Are you trained in family planning counseling?
  2. What are the concerns among ART clients regarding family planning services offered to them?
    - What sorts of questions do they ask?
    - How have ART clients' family planning behavior been affected?
    - How has peer education impacted on family planning among ART clients?
  3. Can you discuss the family planning counseling procedure?
    - What is the age range for family planning counseling?
    - What information do you give the clients?
    - What learning aids to you use when counseling?
    - How much time do you spend counseling each ART client on family planning?
    - How many ART clients do you counsel on family planning in a day?
    - What challenges do you face in performing your roles as far as family planning is concerned?

4. Do you counsel both men on family planning?

- Does male involvement play a role in the uptake of family planning?
- What has been your experience in counseling men on family planning?
- Do women refuse to accept family planning because of their partners?
- What advice do you give them?
- Do you feel you have enough FP counseling skills?

5. What motivates you to do your job?

- Are there enough peer educators in your clinic?
- Are peer educators resigning more often?
- Why are the peer educators leaving their jobs
- What can be done to keep you from resigning?

**THANK YOU FOR YOUR PARTICIPATION**

## Appendix 4

### INDEPTH INTERVIEW GUIDE FOR SERVICE PROVIDERS

#### **INSTRUCTIONS**

1. Introduction
2. Explain the purpose of the study
3. Get verbal consent
4. Assure the respondents of confidentiality
5. Conduct the interview
6. Thank the participants for their participation

#### **BACKGROUND**

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

#### **INTERVIEW GUIDE**

1. We would like to find out your opinion on family planning.
  - What is family planning?
  - What are the benefits of family planning?
  - Who should access family planning?
2. We would like to know your opinion about TIDES family planning
  - What do you understand about the TIDES family planning project?
  - How do you feel about integrating family planning into ART?
  - How has HIV/ AIDS epidemic in this community affected men and women's needs for FP services?
  - Since the inception of TIDES in your clinic, do you see more PLWHA coming for family planning than before?

3. We would like to find out how you feel about the family planning training that you received from TIDES family planning
  - Do you think the training is useful?
  - Are you able to insert the long term methods i.e jadelle and IUD?
  - Are you able to give the FP clients especially the people coming from ART, adequate information on FP methods?
  - Are there areas where you would need further skills upgrading?
4. We would like to find out from you the procedure for counseling and providing FP to ART clients.
  - How can you tell that the client has been referred from ART?
  - Is the counseling that you give PLWHA different from the counseling that you give to HIV negative people?
  - What FP information do you give PLWHA?
  - What has been the trend in the uptake of FP among PLWHA?
  - How would you explain these trends?
  - Do you manage to attend to all the ART clients that come to your clinic?
  - Are you able to provide the ART clients with the desired counseling and method at any given time?
  - Under which circumstances are you not able to provide FP methods?
5. Please tell us what you would like to be done to improve your work environment.
  - What is your idea of a perfect family planning clinic?
  - What should be done to the ordering logistics system in order to ensure availability of FP methods in the health facility?
6. We would like to find out what you think about the peer educators involvement in family planning.
  - How have the peer educators impacted on FP uptake among PLWHA?
  - Is the use of peer education in a health facility effective?
  - What other areas would you require the assistance of the peer educators?
  - What changes would you propose to improve on Peer education?

Appendix 5

QUESTIONNAIRE TO BE ADMINISTERED TO ART CLIENTS – English Version  
**THE IMPACT OF PEER EDUCATION ON FAMILY PLANNING UPTAKE IN  
LUSAKA HIV CLINICS**

**Section 1: RESPONDENT'S BACKGROUND**

1. Sex:            Male/female

2. Age \_\_\_\_\_

3. Marital status:            Married/Single/Divorced/widowed

3. How many children do you have? \_\_\_\_\_

4. When did you have your last pregnancy? \_\_\_\_\_

5. Was your last pregnancy planning?

Yes           

No           

6. What is your occupation \_\_\_\_\_

7. What is your highest level of education?

High school

College

University

Other specify \_\_\_\_\_

8. What is your religion?

Islam           

Hindu           

Christianity

Other specify \_\_\_\_\_

9. Have you ever used family planning?

Yes

No

10. What type(s) of family planning methods do you know?

Condoms

Intra-uterine Devise

Jadelle

Oral contraceptive pill

Tubaligation

Vasectomy

Other specify \_\_\_\_\_

11. Are you on any family planning method?

Yes

No

12. If yes to Q8, which family planning method are you using?

Condoms

Intra-uterine Devise

Jadelle

Oral contraceptive pill

Tubaligation

Vasectomy

Other specify \_\_\_\_\_

13. How did you learn about the family planning method?

At the clinic

In the community

Radio/ TV

Read about it

Other Specify \_\_\_\_\_

14. If no to Q8, why are you not on any method?

I have side effects

I want a Child

My partner does not allow

Lack of FP information

Other \_\_\_\_\_

15. Who makes the choice of family planning contraceptive you should use?

The Nurse

The peer educators

My partner

Myself

Other \_\_\_\_\_

## Section 2: DEMAND FOR THE SERVICE

1. Has the HIV/AIDS epidemic in the community affected men and women's needs for FP services?

Yes

No

2. How would you rate the accessibility of FP services and methods in the clinic?

Poor

Fair

Good

Very Good

3. Are you happy with the FP clinic?

Yes

No

4. Is the FP information you are receiving adequate?

Yes

No

5. How is your relationship with the ART and FP staff?

Poor

Fair

Good

Very Good

6. Have you ever experienced stigma at the FP clinic?

Yes

No

7. Should family planning be promoted in light of HIV/AIDS in your community?

Yes

No

**Section 3. QUALITY OF SERVICE (FEMALES ONLY)**

1. Has the increase of HIV/AIDS in this area affected the services available in the ART/FP clinic?

Yes

No

2. Do you find staff readily available at the clinic?

Yes

No

Sometimes

3. How is the counseling offered by the nurses?

Poor

Fair

Good

Very Good

4. Do you sit for long hours before being attended to?

Yes

No

Sometimes

5. Is confidentiality maintained?

Yes

No

Sometimes

6. How is the attitude of the providers?

Poor

Good

Very Good

Excellent

Section 4: COUNSELERS

1. Who would you rather attends to you when you go for ART/FP counseling?

Peer educators

Nurses

Other \_\_\_\_\_

2. Have you heard of the TIDES family planning project?

Yes

No

3. Have you noticed any change in the FP counseling provided by the peer educators?

Yes

No

4. Do you appreciate the changes?

Yes

No

5. Since the peer educators started doing intensive FP counseling, has your family planning use changed?

Yes

No

6. Do they have adequate knowledge concerning Family planning?

Yes

No

7. Is it easier now for you to access family planning methods and information?

Yes

No

8. What teaching aids do they use to give family planning information?

Nothing

Flipcharts

Brochures

Other \_\_\_\_\_

**THANK YOU FOR YOUR PARTICIPATION**

Appendix 6

Questionnaire to be administered to ART clients – Nyanja Version

**THE IMPACT OF PEER EDUCATION ON FAMILY PLANNING UPTAKE IN  
LUSAKA HIV CLINICS**

**Section 1: NKHANI ZA WOYANKHA MAFUNSO**

1. Sex:           Mwamuna/mkazi

2. Zaka \_\_\_\_\_

3. Umoyo wa chikwati:           Okwatiw(r)a/Mbeta/Osuzulidwa/Ofedwa

3. Kodi ndi ana angati amene muli nao? \_\_\_\_\_

4. Kodi mugwira nchito bwanji? \_\_\_\_\_

5. Kodi munaphunzira kufika pati?

Pulaimale           

Sukulu ya pamwamba

Koleji               

University           

Zina longosolani \_\_\_\_\_

6. Kodi mulowa chipembezo chiti?

Chislam           

Chihindu           

Chikhristu           

Zina longosolani \_\_\_\_\_

7. Kodi ndi njira yotani(zotani) ya chilezi imene mudziwa?

Makondomu           

Choika mu chisa (IUD

cha nyeleti (Jadelle)   

Cha mapilusi yakumw

Cha kuvalisa

Chakudula (Vasectomy)

Zina longosolani \_\_\_\_\_

8. Kodi munasebenzesapo chilezi?

Inde

Iyai

9. Kodi pa nthawi zino mumasebenzesa njira ya chilezi chili chonse?

Inde

Iyai

10. Ngati ndi inde kufunso la 8, kodi ndi njira ya chilezi iti imene mumasebenzesa pa nthawi zino?

Makondomu

Choika mu chisa (IUD)

cha nyeleti (Jadelle)

Cha mapilusi yakumw

Cha kuvalisa

Chakudula (Vasectomy)

Zina longosolani \_\_\_\_\_

11. Kodi munaphunzira bwanji pa za njira ya chilezi?

Pa kiliniki

Mu komboni

Pa wailesi/ TV

Kuwerenga pa zimenezi

Zina longosolani \_\_\_\_\_

12. Ngati ndi iyai kufunso la 8, kodi n'chifukwa chiyani simuli pa njira ya chilezi ili yonse?

Nimakhala ndi zotulukamo za a

Ndifuna mwana

Bwenzi langa savomereza

Ndilibe nkhani za pa chilezi

Zina \_\_\_\_\_

13. Kodi ndani amene amapanga chosankha cha chilezi chimene muyenera kusebenzesa?

A Nesi

Ophunzitsa anzao

Bwenzi langa

Nekha

Zina \_\_\_\_\_

## Section 2: KUFUNIKA KWA THANDIZO YA CHILEZI

1. Kodi matenda ya HIV/AIDS mukomboni yakhuza kufunika kwa thandizo ya chilezi mwa azibambo ndi azimai?

Inde

Iyai

2. Kodi mungapime bwanji kupeza thandizo ya chilezi mu kiliniki?

N'koipisitsa

N'kwabwinoko

N'kwabwino

N'kwabwinokwambir

3. Kodi ndinu okondwera ndi kiliniki ya chilezi?

Inde

Iyai

4. Kodi nkhani za pa chilezi zimene mumalandira ndizokwanira?

Inde

Iyai

5. Kodi kumverana kwanu kuli bwanji ndi anchito za ma ARVs ndi a chilezi?

N'koipisitsa

N'kwabwinoko

N'kwabwino

N'kwabwinokwambiri

6. Kodi munakumanapo ndi zokupatulani pa kiliniki ya chilezi?

Inde

Iyai

7. Kodi chilezi chiyenera kuchikambapo makamaka poona HIV/AIDS mu komboni?

Inde

Iyai

**Section 3. MUTUNDU WA THANDIZO (AZIMAI CHABE)**

1. Kodi HIV/AIDS mu dera ili yakhuza kasebenzesedwe kama ARVs/Chilezi mu kiliniki?

Inde

Iyai

2. Kodi mumapeza kuti anchito amapezeka pa kiliniki?

Inde

Iyai

Nthawi zina

3. Kodi mungapime bwanji kuyenera kwa kanseling'i imene imapatsidwa ndi anchito?

N'koipisitsa

N'kwabwinoko

N'kwabwino

N'kwabwinokwambiri

4. Kodi mumayembekeza kwa maola ambiri akalibe kumuonani?

Inde

Iyai

Nthawi zina

5. Kodi chisinsi chimakhalapo?

Inde

Iyai

Nthawi zina

6. Kodi ndi khalidwe la bwanji limene opatsa thandizo ali nalo?

N'labwinoko

N'labwino

N'labwinokwambiri

N'labwinokoposa

Kodi ndikangati pamene mumapatsidwa chosankha chanu cha njira ya chilezi

Nthawi zonse

Nthawi zina

Kambiri

Kulibe

#### Section 4: AKANSELA

1. Kodi ndani amene mungakonde kuti akutangateni pamene mwayenda kukanseling'i ya ma ARVsT/Chilezi?

Othandiza anzao

Ma nesi

Zina \_\_\_\_\_

2. Kodi munamverako za chilezi cha purojekiti ya TIDES?

Inde

Iyai

3. Kodi kuliko kusiyana mu njira ya kanseling'i ya chilezi yopatsidwa ndi ophunzitsa anzaondi anchito ena?

Inde

Iyai

Ni kuchinja kwa bwaji kumene mwaonapo?

4. Kodi mumayamikira kuchinja uku?

Inde

Iyai

5. Kuchokera pamene ophunzitsa anzao anayamba kuchita kanseling'i mwamphamvu, kodi kusebenzesa chilezi chanu kwachinja?

Inde

Iyai

6. Kodi ali ndi chiziwitso chokwanira cha pa chilezi?

Inde

Iyai

7. Kodi tsopano ndichopepuka kwa inu kutenga njira za chilezi ndi nkhani?

Inde

Iyai

8. Kodi ndi zophunzira zothandiza ziti zimene amasebenzesa popatsa nkhani za pa chilezi?

Kulibe

Mabuku ovununkula

Mabroshua

Zina \_\_\_\_\_

**ZIKOMO PA KUTENGAMO MBALI KWANU**

Appendix 7

QUESTIONNAIRE TO BE ADMINISTERED TO ART CLIENTS – Bemba Version  
THE IMPACT OF PEER EDUCATION ON FAMILY PLANNING UPTAKE IN  
LUSAKA HIV CLINICS

Icipande 1: IFYA PALI ABALE ASUKA

1. Umwanakashi/umwaume
2. Imyaka \_\_\_\_\_
3. Ifyacupo: Baliupwa/taupaupwa/balikanana/balifwilwa
3. Mwakwata abana banga? \_\_\_\_\_
4. Mubomba incite nshi? \_\_\_\_\_
5. Masambililo nshi ayakalamba wafikapo?  
Pulaimali   
Sekondale   
Koleji   
Isukulu likalamba/yunivesitu   
Limbi, londololeni \_\_\_\_\_
6. Mupeepa kwiisa?  
abaIslamumu   
abaHindu   
Bakilistyani   
Kumbi, landeni \_\_\_\_\_
7. Ninshila nshi mwasishiba iyakwimika ubufyashi?  
Imipila (kondomu)   
Ukukaka ubufyashi   
Jadelle

Amapilushi yakunwa cila mweshi

Tubaligation

Ukukaka inshila yabufyashi yamwaume (Vasector)

Imbi, landeni \_\_\_\_\_

8. Mwalibomfyapo inshila ya family planning?

Ee

Ine

9. Bushe mulebomfya inshila ili yonse iya family planning method? Low salary

Ee

Ine

10. Nga mwasumina pa 8, ninshila nshi mulebomfya?

Imipila (kondomu)

Ukukaka ubufyashi

Jadelle

Amapilushi yakunwa cila mweshi

Tubaligation

Ukukaka inshila yabufyashi yamwaume (Vasector)

Imbi, landeni \_\_\_\_\_

11. mwaishibe shani pali iyi inshila ya family planning?

Ku kiliniki

Kuncende njikalilako

Pacilimba/pa TV

Nalibelengele po

Kumbi, landeni \_\_\_\_\_

12. Nga awe kulipusho8, mulundunshi tamulebomfya inshila ili li lyonse?

Fila ndwalika

Ndefwaya umwana

Umunandi tasuminisha

Takwaba ilyashi lyapa family palining

Fimbi \_\_\_\_\_

13. Nina upingula inshila ya family planning mufwile ukubomfya?

Banasi

Ba peer educator

Abalume/abakashi

Nimwine

Bambi \_\_\_\_\_

## Icipande 2: UKUFWAYA KWA MIBOMBELE YA FAMILY PLANNING

1. Bushe ubulwele bwa HIV/AIDS mukomyuniti bwali cinja imifwaile yafya family planning kubanakashi na baume?

Ee

Awe

2. Bushe kuti mwapima shani ukangwa kwa fya family planning mu kiliniki?

Kubi

Kwabafye bwino

Kusuma

Kusuma sana

3. Bushe mwalisekelamo na kilinki ya family planning?

Ee

Awe

4. Bushe ilyshi pali famlly planning mulepoka lingi?

Ee

Awe

5. Mulomfwana shani nababomfi ba ART na family planning?

Kubi

Kwabafye bwino

Kusuma

Kusuma sana

6. Bushe mwalitala sekwapo kale ku family planning kiliniki?

Ee

Awe

7. Bushe family planning ifwile ukutwala pamulu muncende yenu ukukonka nefyo ubulwele bwa HIV/AIDS buli?

Ee

Awe

### Icipande 3. UBUSUMA BWA MIBOMBELE (ABANAKASHIFYE)

1. Bushe HIV/AIDS muno muncende yacita finshi mumibombelo ya ART/nafamily planning mu kilinki iyi?

Ee

Awe

2. Bushe mulasanga abancito ekobali lyonse ku kiliniki?

Ee

Awe

Limbi

3. Bushe kuti mwapima shani imibombele isuma iya kaselin'gi kubabomfi?

Kubi

Kwabafye bwino

Kusuma

Kusuma sana

4. Bushe mulalolela inshita itali sana pakuminmona?

Ee

Awe

Limolimo

5. Bushe inkama ilasungwa?

Ee

Awe

Limolimo

6. Bushe imibele ya bamimona yabashani?

Ibi

Isuma

Isuma sana

Yaliwamisha

Bamipela imiku iinga inshila ya kwiminika ubufyashi intu mulefwaya?

Lyonse

Limlimo

Kabilikabili

Takwaba

Icipande 4: BAKANSELA

1. Nibanani mungafwaya ukumimona nga mwaya ku kaselin'gi ya ART/ family?

Ba peer educator

banasi

Bambi \_\_\_\_\_

2. Bushe mwalyumfwapo kale plojekiti ya family planning iyaba TIDES?

Ee

Awe

3. Bushe kwaliba ubupusana munshila bacita kaselin'gi ba peer educator na babombi?

Ee

Awe

Bupusana nshi mwamona?

4. Bushe mwalitemwa ubu bupusano?

Ee

Awe

5. Ukutampila inshita ba peer educator baamba ukukoselesha kanselin'gi ya family planning, bushe ifyakusalapo po pa family planning fyalicinja?

Ee

Awe

6. Bushe balishiba ifingi pafya Family planning?

Ee

Awe

7. Bushe calyanguka nombamba kuli imwe ukusanga inshila ya family planning ne lyashi?

Ee

Awe

8. Babomfya fintu nshi ifyakwafwilisha ukusambilila lintu bapela ilyashi lya family planning in?

Takuli

Ama pikica (Flipcharts)

Ututabo (Brochures)

Fimbi \_\_\_\_\_

**TWATOTELA PAKUSENDAKO ULUBALI**