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Voices of Female Youths Living with HIV/AIDS on their Experiences regarding access and Utilisation of Contraceptives: A case of Kawempe Division Kampala City, Uganda.

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Abstract

Title: Voices of Female Youths Living with HIV/AIDS on their Experiences regarding access and Utilisation of Contraceptives: A case of Kawempe Division Kampala City, Uganda.

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Key words: HIV/AIDS, contraception, access to contraceptives, utilisation of contraceptives, experiences of FYLWHA.

This study aimed at documenting experiences of FYLWHA regarding their access and utilisation of contraceptives with reference to Kawempe division of Kampala city-Uganda. Basically the study was guided by three objectives i.e. to find out the sources of contraceptives for FYLHA in Kawempe division, to examine the factors for and against access and utilisation of contraceptives by FYLWHA and to come up with recommendations on how to enhance access and use of contraceptives in Kawempe division. Research questions that helped generate information for the study were as follow; how do FYLWHA access contraceptives/ information on contraceptives? Do national policy provisions on reproductive health care manifest into real services at lower/ community level? Which are the strength/ facilitating factors for FYLWHA in consumption of contraceptives? Which are the barriers and how do they hinder FYLWHA from consuming contraceptives? How does stigma affect the access and utilisation of contraceptives by FYLWHA? What motivates the health seeking behaviour of FYLWHA for contraception? How does gender influence contraceptive use by FYLWHA?

A case study design was used in collaboration with the qualitative approach. Methods of data collection that were employed under this approach included; semi-structured Individual interviews, Focus Group Discussions and a few relevant Participatory Rural Appraisal (PRA) tools. The gathered material was analysed under the blue prints of Narrative analysis, qualitative content analysis in combination with thematic analysis. The study's theoretical framework was composed of four theories including the health belief model, the social interaction theory, the gender based perspective and the stigmatisation theory.

Among other things, study results indicated that the public hospitals, private clinics and NGOs are the major sources of contraceptives but for some reasons, FYLWHA mainly buy their own pills from private clinics compared to other sources. Major facilitating factors for contraceptive use were; education and sensitisation, availability of most contraceptives on market, free contraceptives and Privacy and confidentiality assurance. Barriers to contraception use were multi-dimensional in nature i.e. institutional, cultural, religious, economical, misconception and health related.

It can be concluded therefore that experiences of FYLWHA while accessing and using contraceptives are not very different from what any other youth is likely to experience save for some unique health related weakness triggered by some contraceptives and also the influence of stigma. This therefore clearly shows that like any other young people in their most productive milestone of life, FYLWHA possess contraceptive needs that need to be met and all duty bearers need to ensure that they play their role to ensure this need and right is fulfilled especially by eliminating all social, cultural, economic, religious, and institutional barriers that hinder the access and use of contraceptives.

List of Contents

Abstract ii

List of Contents iii

Acknowledgement vi

List of Acronyms vii

CHARPTER ONE 1

1.0 Introduction and Study Background 1

1.1 Introduction 1

1.2 Study Background 1

1.2 Problem Statement 2

1.3 Objectives of the Study 3

1.3.1 Major Objective 3

1.3.2 Specific Objectives 3

1.4 Research Questions 3

1.5 Scope of the Study 3

1.5.1 Geographical Scope 3

1.5.2 Content Scope 4

1.5.3 Time Scope 4

1.6 Significance of the Study 4

1.7 Operational Definition of Key Concepts 4

1.7.1 Youth 4

1.7.2 Contraception 5

CHARPTER TWO 6

2.0 Literature Review/ Knowledge Basis 6

2.1 Introduction 6

2.2 Access to Contraceptives 6

2.3 Utilisation of Contraceptives 8

CHAPTER THREE 12

3.0 Theoretical/Analytical Framework 12

3.1 The Stigmatization Theory 12

3.2 Health Belief Model 13

3.3 Gender Based Perspective 13

3.4 Social Interaction Theory 14
CHAPTER FOUR 15
4.0 Methodology 15
4.1 Introduction 15
4.2 Study Area 15
4.3 Study Population 15
4.4 Study Design 15
4.5 Sample Size and Sampling Techniques 16
4.5.1 Sample Size 16
4.5.2 Sampling Techniques 16
4.5.3 Reflection on the Study Sample 16
4.6 Data Collection Methods and Techniques 17
4.6.1 Individual Interviews 17
4.6.2 Focus Group Discussions 17
4.6.3 Participatory Rural Appraisal Technics (PRATs) 18
4.7 Data Analysis Methods 19
4.7.1 Narrative Analysis 19
4.7.2 Qualitative Content Analysis 19
4.8 Ethical Considerations 20
4.8.1 Informed Consent (Transparency and Self-determination) 20
4.8.2 Respect 21
4.8.3 Confidentiality and Autonomy 21
4.8.4 Non-judgementality 21
CHAPTER FIVE 22
5.0 Findings and Analysis 22
5.1 Introduction and Respondents' Profile 22
5.2 Providers of Contraceptives for FYLWHA 23
5.3 Major Contraceptives Used by FYLWHA 26
5.3.1 Injectable 26
5.3.2 Oral Pills 27
5.3.3 Condoms 27
5.4 Facilitating Factors for Contraception 27
5.4.1 Education and Sensitisation 28
5.4.2 Availability of Most Contraceptives on Market 28

5.4.3 Privacy/Confidentiality 28
5.5 Contraceptives as a Right 29
5.6 Diagnosis for Contraception 29
5.7 Motivation for Contraception Use 30
5.7.1 Relief from Burden of Child Care 30
5.7.2 Source of Power 30
5.7.3 To Stay in School 31
5.8 The Condom Dilemma 31
5.9 Disclosure and Partner Protection from HIV/AIDS and other STIs 33
5.10 Barriers to Contraception Use 34
5.10.1 Institutional Factors 34
5.10.2 Cultural Factors 34
5.10.3 Religious Factors 34
5.10.4 Economic Factors 34
5.10.5 Misconceptions 35
5.10.6 Health Related Factors 35
5.11 Theorising the Findings 36
5.11.1 Health Belief Model 36
5.11.2 The Social Interaction Theory 38
5.11.3 The Gender Based Perspective 39
5.11.4 Stigmatisation Theory 41
CHAPTER SIX 43
6.1 Summary and Conclusions 43
6.2 Areas for Further Research 44
6.3 Recommendations to Public Health Facilities and other Development Partners in the area of Reproductive Health Services, Specifically Contraceptives 45
CHAPTER SEVEN 47
7.1 References 47
Appendices 50

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List of Acronyms

UBOS	Uganda Bureau of Statistics
HIV/AIDS	Human Immune Viral/ Acquired Immune Deficiency Syndrome
PMTCT	Prevention of Mother to Child Transmission and recently
EMTCT	Elimination of Mother to Child Transmission.
FYLWHA	Female Youths Living With HIV/AIDS
CSO	Civil Society Organisations
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation
PRB	Population Reference Bureau
ABC	Abstinence Being faithful and Condom Use
MoGLSD	Ministry of Gender Labour and Social Development
COP	Oral contraceptive, both combined
POP	Progesterone Only Pills
PRAT	Participatory Rural Appraisal Tools

CHARPTER ONE

1.0 Introduction and Study Background

1.1 Introduction

This is a masters degree report based on a study that was conducted in Uganda focusing on the voices of female youths living with HIV/AIDS on their experiences regarding access and utilisation of contraceptives. In this degree report, the text has been arranged under several chapters and these include; introduction and study background, literature review/knowledge basis, theoretical Framework, methodology, study findings and summery and conclusions.

1.2 Study Background

Reproductive health care in Uganda is a right to all and the state has a mandate to ensure that this right is realised by all. As echoed in the Uganda National Policy Guidelines and Service Standards for Reproductive health Services, all couples and individuals have the right to decide freely and responsibly the number, spacing and timing of their children. Chapter 3 of the same policy talks about family planning and contraceptive service delivery and its two key goals are to increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs contraception; and to promote strong integrated family planning information and services in all health sectors and levels.

According to WHO 2012, modern contraceptive utilization has globally increased in the recent past – from 54% in 1990 to 57% in 2012. However, the estimates in Africa remain persistently low at 23% and 24%, respectively. The estimates among countries in the Sub-Saharan region are much lower than the aforementioned figures. A 2013 WHO study also revealed that over 222 million women in developing countries who want to space or prevent child bearing but lack access to modern contraceptive methods. This has been attributed to among other factors shortfalls in health infrastructure and transportation facilities.

In relation to the above, contraceptive use among young people in Uganda is still low, this is first of all justified by the increasing fertility rate among young people which is currently at about 6.2 percent according to the population secretariat (2014). According to the Uganda-Population Reference Bureau (PRB) 2014, more than 220 million women in developing countries have an unmet need for Family Planning and the need is likely to be much higher in reality. It adds that contraceptive needs can fluctuate due to shifts in fertility desires that occur in response to changing life circumstances. In Uganda, about one in three women of reproductive age reported having an unmet need of contraceptives which translates into approximately 1.6 million women (ibid).

In relation to the above, PRB (2014) came up with four top reasons why most women are not using family planning, and these include fear of side effects, postpartum reasons, opposition to use by husband and lastly infrequent sex is considered less risky. In other research, some of the obstacles to contraception use include; misconceptions and fears related to contraception, gender power relations, socio-cultural expectations and contradictions, short term planning and health service barriers (Nalwadda et *al.*, 2010).

This is rather worrying because limited contraception use especially condoms not only increases the level of unwanted pregnancies and induced abortions but also increases the spread of HIV/AIDS and other sexually transmitted diseases and this is a big threat to the health of these young people and the nation at large due to the likely economic implications resulting from a weakening labour force.

At least 95 per cent of all new infections of HIV/AIDS occur in less developed countries and sub-Saharan Africa is the hardest hit region (Advocates for Youths, 2008). Sub-saharan Africa has the highest prevalence and incidence of HIV-1 infection in the world (Muyindike et *al.,* 2012). She also states that women of reproductive age account for 60 percent of all adult infections and 75 percent of infections are among people 15–24 years old. More to that, sub-saharan Africa also has high fertility rates with an estimated 14 million unintended pregnancies annually (IBID).

According to the Uganda HIV and AIDS Sero-Behavioural Survey (2006), it is estimated that one million Ugandans live with HIV, of whom 130,000 are children under 14 years.
The number of people living with HIV is higher in urban areas (10.1% prevalence) than rural areas (5.7%); it is also higher among women (7.5%) than men (5.0%). Women are particularly affected by the epidemic in Uganda, representing 59% of those infected with HIV/AIDS in the country (UNAIDS, 2008). Also, from age 15 to 39, women have higher HIV prevalence than their male counterpart (Uganda Aids Indicator Survey, 2011)

1.2 Problem Statement

Uganda has one of the youngest population in the world whereby 78 percent of the population is below 30 years (UBOS, 2014) and most rapidly growing population in the world with a high total fertility rate of 6.2 (Population Secretariat, 2014). There is a high fertility rate among young people aged 15-24 years and this is a huge public health concern in Uganda due to the increasing unwanted pregnancies, unsafe induced abortions and associated high morbidity and mortality among young women that has been attributed to low contraceptive use (Nalwadda et *al.*, 2010)

The government of Uganda and other Civil Society Organisations (CSOs) have for long been trying to fight the spread of HIV through several programs including among others the ABC-Abstinence, Being faithful to one partner and using a Condom campaign, PMTCT-Prevention of Mother to Child Transmission and recently EMTCT-Elimination of Mother to Child Transmission. Other efforts have been towards mass education such as sensitisation campaigns in schools and using social media for the general public on issues like use of contraceptives for safe sex and birth control.

However, little visible effort has been put on understanding the social, economic and cultural environment under which contraceptives are consumed. This could be one of the reasons why issues like, unwanted pregnancies, abortions and the HIV incidence continues to raise even with the many different existing programs by different stakeholder. This dilemma is further confirmed by recent 2014 HIV and AIDS Uganda Country Progress Report which indicates that HIV prevalence in the general population in Uganda has increased from 6.4% in 2004/5 to 7.3% by 2011, this tallies with the 2013 HIV estimates which show that HIV prevalence stabilised around 7.4% in 2012/2013. This increase in HIV prevalence has frustrated both Government and Civil Society's efforts towards the fight against HIV/AIDS in Uganda. Perhaps it's because most of their measures tend towards medical solutions to the epidemic.

This research therefore, sought to investigate, document and establish an understanding of the social cultural and economic issues surrounding the access to and utilisation of contraceptives by Female Youths living with HIV/AIDS in Uganda using Kawempe division as a case study and this was expected to come from their various experiences shared. The study only focused on FYLWHA given that they are likely to be in a more vulnerable position than other youths especially because they face a double tragedy i.e. one; of dealing with HIV/AIDS and; two, of accessing and utilising contraceptives given their social, economic and cultural position in African society that is usually due to ongoing marginalisation, stigmatisation, low education and thus low economic and decision making power. Therefore, it is worth investigating how this social, economic and cultural disadvantage and vulnerability plays out and affects the access and consumption of contraceptives by FYLWHA.

In addition to the above, FYLWHA unlike other youths face health related challenges that necessitate them to not only have protected sex but also control child birth as much as possible given that issues like new STIs, unplanned pregnancies and abortions are likely to affect hem more severely than other youths.

1.3 Objectives of the Study

1.3.1 Major Objective

To document experiences of female youths living with HIV/AIDS (FYLWHA) in accessing and utilising contraceptives, a case of Kawempe division in Kampala City, Uganda.

1.3.2 Specific Objectives

1. To find out the sources of contraceptives for FYLHA in Kawempe division.
2. To examine the factors for and against contraception access and utilisation by FYLWHA in Kawempe division.
3. To come up with recommendations on how to enhance the access and use of contraceptives in Kawempe division.

1.4 Research Questions

1. How do policy provisions on reproductive health care manifest into real services at lower/ community level?
2. How do FYLWHA access contraceptives/ information on contraceptives?
3. What are the major contraceptives used by FYLWHA?
4. Which are the facilitating factors for FYLWHA in consumption of contraceptives?
5. Which are the barriers? And how do they hinder FYLWHA from consuming contraceptives?
6. How stigma does affects the access and utilisation of contraceptives by FYLWHA?
7. What motivates the health seeking behaviour (contraception) of FYLWHA?
8. How does gender influence contraceptive use by FYLWHA?

1.5 Scope of the Study

1.5.1 Geographical Scope

The study was conducted in Kampala-the capital city of Uganda. Specifically Kawempe – one of the divisions in Kampala city was the study area. Several reasons were considered for the selection of this study area and one of them was the existence of several institutions both state and non- state based which offer contraception services to Youths Living with HIV/AIDS and the general public in this area.

The other reason was that Kawempe division has a higher rate of people living with HIV/AIDS compared to other divisions in Kampala City and more to that, 39% of its population lives in slums (UBOS, 2002). These include; Bwaise, Mulago and Makerere Kivulu among others. Most FYLWHA who live in slum areas are usually more vulnerable given the poor socio-economic condition that characterise most slums in Uganda and elsewhere in the world.

1.5.2 Content Scope

Content ways, the study focused on the experiences of female youths living with HIV/AIDS regarding access and use of contraceptives.

1.5.3 Time Scope

The study period ranged from January to June 2016. This was in line with the university schedule and it was also sufficient time for the researcher to undertake the study.

More to that, the study only targeted respondents who had been using contraceptives for the last one year. This was for the purpose of enabling the researcher to only interview those FYLWHA who possessed some experiences with the use of contraceptives.

1.6 Significance of the Study

The study aimed at documenting the experiences of female youths living with HIV/AIDS regarding access and utilisation of contraceptives. Such information further pointed out social, economic, cultural, institutional and religious factors that influence access and utilisation of contraceptives by female youths living with HIV/AIDS hence generation of vital knowledge with a more subjective view. Such is important baseline information that can guide various development partners including the state on designing of new interventions as well as boosting the already existing ones to better address arising issues.

The final report on the study will act as an eye opener for both state and non-state actors on the commonly used contraceptives and those that are not commonly used as well as echoing the reasons. Such information is expected to alert providers of contraceptives with feedback on which contraceptives are favoured most and what needs to be improved with those that are less favoured.

Barriers to access and utilisation of contraceptives will be highlighted as well and this provides evidence and vital information to service providers so as to improve where necessary.

Lastly, the study results are expected to highlight the pros and cons of various contraceptive methods according to the respondents' experiences and perceptions. Such information could be useful for other potential contraceptive users especially fellow female youths as it provides a basis for decision making on what contraceptives to go for and which service providers to reach out to.

1.7 Operational Definition of Key Concepts

1.7.1 Youth

The National Youth Policy defines youths as all young persons; female and male aged 12 to 3 0 years. This is aperiod of great emotional, physical and psychological changes that require s ocietal support for a safe passage from adolescent to full adulthood (MoGLSD, 2001).

However, according to the UN, for statistical consistency across regions, defines ‘youth’, as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States. All UN statistics on youth are based on this definition, as illustrated by the annual yearbooks of statistics published by the United Nations system on demography, education, employment and health.

It is also key to note that most cultures in Uganda socially determine who a youth is based on physical characteristics i.e. body shape, weight, height and physical strength among other things.

1.7.2 Contraception

Refers to modern and traditional birth control methods. Besides birth control, some of the methods can be used as a mechanism to control spread of HIV/AIDS.

The 2001 Uganda National Policy Guideline and service standards for Reproductive health services differentiates the several types of contraceptives as follows;

1.7.2.1 Prescriptive methods

- Oral contraceptive, both combined (COP), Progesterone Only Pills (POP), Levonorestrel Progesterone only emergency contraceptive pills;
- Injectable e.g. Depo Provera and Noristerat
- Implants e.g. Norplant; Or intra-uterine contraceptives:
- Copper T 380 A
- Multiload; Or permanent contraceptives:
- tuballigation;

1.7.2.2 Non prescriptive methods

- Natural family planning methods (fertility awareness);
- Barrier methods e.g. condoms (both female and male), spermicidal foam and jelly, foaming tablets, and diaphragm;
- Locational amenorrhea (breast feeding).

CHARPTER TWO

2.0 Literature Review/ Knowledge Basis

2.1 Introduction

This chapter talks about the previous research that has been conducted specifically that which is in relation to the study. Various sources of information have been consulted and among these are, articles, books, government policies and reports, organisational websites and organisational documents among others. Such sources enabled the researcher to get a clear picture on the study area both at national and international levels. HIV/AIDS and contraception being an evolving subject, new research and knowledge is being generated and for that matter, the researcher reviewed more journals and research reports than books so as to interact more with recent and up to date knowledge on the subject. In addition to that, journal articles were most preferred because most discussions on contraception were of the current context.

Knowing that contraception is quite a wide topic, while reviewing previous research, the researcher limited herself only to information that was specifically talking about contraceptives but especially among young women. This enabled the researcher to intensively review relevant literature specific to the study area. Also, the researcher was left with sufficient time to undertake other study tusks so as to stay on schedule.

Several search words that were used especially online include; global statistics on contraception, contraceptive use among female youths in Uganda, access to contraceptives by female youths living with HIV/AIDS in Uganda, access to contraceptives in Uganda today, contraceptive use in Uganda today, HIV status in Uganda, Stigmatisation theory, Ugandan Youth Policy, marginalisation theory, gender based theories, social interaction theory and theories on Contraception.

Through the online library of Gothenburg University and some other data bases like google scholar, it was possible to access some E- Journals, articles and books that were very helpful in establishing the relevance for this study. Several links were used as search engines which among others were; http://www.ub.gu.se/, Social Sciences Citation Index, ScienceDirect Freedom Collection 2011, https://www.guttmacher.org/pubs/journals/, http://www.who.int/mediacentre/factsheets/fs35, http://www.who.int/topic/millenium development goals/ maternal health/en/index.html, https://www.guttmacher.org/media/nr/2013/02/07/index.html.

Based on mainly two themes i.e. *access to*, and *utilisation of contraceptives by FYLWHA* it was possible to adequately review other related literature that was relevant for the study and they sufficiently brought out a picture on the existing status quo of the issues.

2.2 Access to Contraceptives

Access to contraceptives among women in Uganda is still a critical challenge and different literature clearly shows this. In a report published by the Guttmarcher Institute in 2013, it is stated that one in three sexually active women in Uganda, both married and unmarried, want to avoid pregnancy, but are not using a method of contraception—one of the highest recorded levels of unmet need for contraceptives in Sub-Saharan Africa. Furthermore, in a previous report by the same institution that

analyses data from Uganda's 2011 Demographic Health Survey (DHS) and other recent research, the report, *Unintended Pregnancy and Abortion in Uganda,* which was released by Guttmacher and the *Centre for Health, Human Rights and Development* (CEHURD), identifies critical gaps in reproductive health care and recommends steps urgently needed to reduce Uganda's high levels of unintended pregnancy and to improve maternal health.

The report further denotes that on average, Ugandan women give birth to nearly two more children than they want (6.2 vs. 4.5 birth rate). Only 26% of married women and 38% of unmarried women in the country use a modern method, and more than half of all pregnancies are unintended. This epidemic of unintended pregnancy takes a devastating toll on women, families and communities; it leads to nearly 700,000 unplanned births a year and extremely high levels of unsafe abortion, maternal morbidity and illness. Approximately 26% of all maternal deaths are attributed to unsafe abortion, and for every woman who dies many more are injured.

Uganda has the highest unmet need for contraception in East Africa, but lacks the resources to address the problem (Malinga and Ford, 2009). They farther state that According to Dr Moses Muwonge, the national reproductive health commodity security coordinator at Uganda's Ministry of Health, 41% of women in Uganda have an unmet need for contraception. Rates in neighbouring countries Kenya and Tanzania stand at 25% and 22% respectively. Rwanda has a rate 38%, while Ethiopia's is 34%. This therefore implies that there are many young women in Uganda who are unable to access contraceptives however much they are willing to use them hence at the same time accounting for the estimated 3.2% annual population growth rate according to Uganda Bureau of Statistics.

As revealed in the above literature, limited access to contraceptive use for young people results into diverse effects. The situation is likely to be more worrying if it is young people living with HIV/AIDS that are faced with limited access to contraceptives. This is so because due to their health status, issues of unplanned pregnancies, unsafe abortion and risks of other infections are likely to affect them severely both medically and socially compared to other youths. Therefore, there is need for reliable sources of contraceptive for all to avoid quite a number of uncertainties. However, how then can this be a reality if it is still impossible for all the married women to access contraceptives as they would have wished to?

Access to contraceptives is even made more complicated by other different barriers such socially constructed limitations and ignorance for example, in a recent research carried out in Senegal, young women in urban Senegal are restricted by service providers from accessing certain contraceptives (pills and injectable) basing on factors like age and marital status (Lardoux et *al.* 2014). They further add in their findings that the acceptable age to use these contraceptives is 18 and above and should preferably be married. The writers in their recommendation emphasise that training and education programs for health providers should aim to remove unnecessary barriers to contraceptive access.

It appears indeed ironic that such factors like age and marital status can be used as a yard stick to determine consumers of contraceptives, this from an individual point of view might not only deny several young women of their right to health but is also likely to lead to more devastating problems i.e. unwanted pregnancies, abortion and death in the worst scenario. In agreement with Lardoux et *al.* (2014), it is necessary to remove all barriers to contraceptive use especially for those groups of people with contraceptive needs. With or without

permission to access contraceptives, it is most likely that young people will continue to engage in sexuality as long as the need is present.

It is also important to note that the availability of different contraceptive options not only facilitates their access but also increases their demand and thus breaking barriers that limit their use. According to Skile 2015, in Malawi, product availability in the local service environment plays a critical role in women's demand for and use of contraceptive methods. And therefore, access to services was an important predictor of injectable use. In agreement with Skile, product availability is such a key determinant of its access that even when the rest of the factors say; economical and socio- cultural among others are favourable, it still becomes difficult to access contraceptives if un available especially on market.

Having said that, it is important to further understand the level and nature of utilisation of contraceptives where access is possible.

2.3 Utilisation of Contraceptives

Recent global trends indicate that modern contraceptive utilization has increased from 54% in 1990 to 57% in 2012 (WHO 2012). The estimates in Africa however remain persistently low at 23% and 24%, respectively and that the estimates among countries in the Sub-Saharan region are much lower than the aforementioned figures.

In Uganda for example, research indicates that there has been an upward trend in modern contraceptive use by women from 11.6% in 1995 to 32.1% in 2011. This shows that progress has been made in this regard (Andi et.*al,* 2011). It is important however to understand how this trend reveals between the rural and the urban divide, the 2006 Uganda Demographic Health Survey notes that the use of contraceptives is more than twice as high in urban areas when compared to the rural areas (UBOS and Macro International, 2006). Different factors facilitate this divergence between the rural and the urban. As noted earlier by Lerdoux et *al.* (2014) there exists barriers to contraceptive access by women and it is important in the same vein to understand some of the factors that limit the utilisation of the same.

Andi et *al.* (2011) suggest that socio-economic and demographic characteristics of women impact directly on modern contraceptive use. That such factors include religion, marital status, wealth index, current work status, education, age and number of children. These characteristics are further compounded by societal beliefs, perceptions and other negative cultural aspects and norms against women especially in Africa. A report by the Inter-agency coalition on AIDS and development 2006, further notes that women are negatively affected by gender based inequalities and the power imbalance that increases their vulnerability to sexual exploitations. Whereas it might seem obvious that such factors directly impact the use of contraceptives, it is imperative to establish how they actually cause the impact. This study on experiences of FYLWHA therefore aimed at bringing out such accounts in the respondents subjective words and perception.

Looking at religion for example, the use of condoms as a method of birth control and HIV prevention is generally is generally argued against by those who belong to Catholicism as a religion and Muslims. In a study by Reproductive Health Uganda 2015, religion has great influence on the utilisation of some contraceptives with fewer Muslims using condoms than Catholics. Given that this was a quantitative study, not much explanation was provided as to why that is the case. This is why therefore, a qualitative study ought to be undertaken to

generate detailed information in the respondents' own words on such issues for instance how different religion influences utilisation of certain contraceptives and why.

Musalia (2005) points out that adoption and utilisation of contraceptives in Kenya is due to influence from family members given that they are the ones who bear the burden of child raising. That family is therefore on the fore front of encouraging adjustment in behaviour contrary to previous findings which denote that kin networks are conservative and against innovative fertility behaviour. This study therefore sought to find out if the case was similar in Uganda. The research did not come across any previous research that seemed to say the same regarding the role of family members influence specifically on contraceptive use. However anecdotal information shows that extended families especially in rural areas have a lot of influence on women fertility. This was therefore given attention during data collection and analysis to establish such aspects and their relationship.

From the above, it is clearly evident that factors with in the environment greatly impact and influence the utilisation of contraceptives. However, it is important to note that individuals have hidden resources within themselves that can provide motivation for utilisation. Pearson (2006) argues that indeed self-efficacy is the key determinant. That sense of personal control is an important means of empowerment for young people in making sexual choices. That people who have a high sense of personal control believe that they can master and shape their own life and therefore adolescents who believe in the efficacy of their own actions may be more likely to abstain from sex or to use condoms than those who do not. This points out the strength with in an individual's personal resources and how that can influence adoption of certain behaviour and not necessarily being influenced by the external environment. In comparison with the previous paragraph therefore, the study sought to establish whether FYLWHA are influenced by external factor to use contraceptives or whether it is out of their individual efforts and decision to use contraceptives or both.

It has also been argued widely argued that modern contraceptives have devastating side effects on women and others claiming that they lead to infertility. Schwartz and Gabelnick (2002) confirm some of these fears by noting that while many women are motivated to avoid unwanted pregnancy, difficulties in using methods consistently, varying side effects and a wide range of failure rates may create obstacles to contraceptive use. For example, many women find it challenging to take a pill every day, and some find it a nuisance to use a chemical or mechanical barrier method at every act of intercourse. However, they add that cost may deter some women from using effective methods. This study too investigated whether the above mentioned factors influence the consumption of contraceptives by the study respondents. Special attention was given to the respondents' subjective feelings and views on the subject matter.

In a another study about women empowerment and choice of contraceptive method by Mai Do and Kurimoto (2012), it was found out that there is a relationship between women empowerment and contraceptive use. For instance the study found that among Egyptian women, having freedom of movement, having at least some control in household matters and budget decisions, and being involved in family planning decision making were all positively related to current use of contraceptives. This points to the fact that education as a tool of empowerment is critical in determining contraceptive use since through education, women can be provided with skills in sexual communication and safe sexual practices.

Women empowerment is indeed an important step towards freeing women from all sorts of injustices and discrimination. However it is vital not to always generalise the implications of

certain phenomenon on all women. One thing that is realistic is that due to the persistent categorisation and classifications under which society places women with varying characteristics, there is a high likelihood that even with ongoing women empowerment some women still face several injustices, discrimination and stigma for instance young women living with HIV/AIDS. In agreement with the former, such injustices are likely to influence their use of contraceptives.

It is therefore relevant to establish the subjective views of particular groups of women with common characteristics on what empowerment means for them unlike approaching the relationship between empowerment and contraception from a general perspective. This study was there more specific so as to establish the experiences of FYLWHA while accessing and utilising contraceptives.

2.3.1 Condom Use

During the study, the researcher took critical interest in condom use since it is a known effective method in the prevention of the spread of HIV and other STIs but also an efficient method of birth control. It was important to investigate the different power relations that facilitate and influence the effective use of this method. Given their HIV status, it was interesting to understand the value FYLWHA attach to condom use either as for prevention of the spread of HIV and other STIs or for birth control. It was therefore important to review literature available on condom use as a contraceptive method.

Although condom use is central to the prevention of STDs, including HIV among sexually active populations (Najjumba et *al.,* 2014), there is still low condom use in Uganda and the main reasons for non-condom use in Uganda among others are; condom unavailability, followed by objection by partners due to personal dislike of condoms (ibid).

In agreement with the former, Relief web (2013) states that condoms are not always available in Uganda, that for instance, Uganda requires 240 million condoms annually but the public sectors procures just half of that and for some years, condoms are as few as 80 million only. This study therefore among other things sought to establish the experiences of FYLWHA around condom use. It was therefore important to investigate whether condom access was an issue for the study respondents. More to that, it was also important to investigate about their spouses and sexual partners given that condom use is not usually a one person decision compared to other types of contraceptives.

The challenges around condom access are not only limited to Uganda. In some parts of Ghana for example condom use was said to be rare and associated with infidelity. That men perceive condoms as reducing sexual sensitivity and they are unlikely to remain with a partner who insists on condom use (Ankomah, 1998 cited in Najjumba et *al.,* 2014). This and several other accounts have been posed for non-condom use. It is not clear however whether the same claims still count especially in a situation where one of the couples or both have HIV/AIDs? Do they still go ahead and compromise their safety for the sake of more sexual sensitivity? Are the couples usually in the know of each other's HIV status or not? These and other several questions were the focus of this research. This not only provided information on the status quo of condom use by FYLWHA but also that of their male counterparts.

Conclusive reflection

From a general point of view, it turned out that not much research has been undertaken about the study topic locally. Much of the existing literature has mainly focussed on family

planning in general and not contraceptive use by female youths living with HIV/AIDS. This makes it more relevant and necessary to conduct such a study. In addition, most of the reviewed literature seemed to concentrate more on modern contraception, this study however approached contraception from a non-biased point of view such that while collecting, analysing and presenting data, , attention was given to both modern and traditional contraception methods.

CHAPTER THREE

3.0 Theoretical/Analytical Framework

Given the dynamic nature of contraceptive use, and for this research the uniqueness of targeted participants (FYLWHA), no single theory was found to be able to satisfactorily paint a true picture of the key dimensions that the research sought to study. As such, to provide an extensive explanation on the key research questions, this study is anchored on four theoretical perspectives. The theories applied take into consideration societal perceptions and attitude towards contraception and HIV that usually result into stigma (the stigmatisation theory), the study also borrows a leaf from the Health Belief Model to clearly understand the medical aspect as related to the study, the applied theories also take into consideration the gender aspect given the fact that the targeted participants were of a specific sex i.e. Female Youths Living with HIV/AIDS (the gender based perspective) and finally the social interaction theory that seeks to track the influence of social relationships and their meaning to individuals and groups on matters of contraception use. The theories are further discussed below.

3.1 The Stigmatization Theory

Goffman (1963: 3) defined stigma as ‘an attribute which is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed’. He adds that society labels an individual or group as deviant basing on several issues i.e. mental health, HIV/AIDS and abortion among other things. In addition to that, he looks at stigma as the situation of the individual who is disqualified from a full social acceptance and any attribute that is deeply discrediting. He notes further that the individual must be concerned for what others think about him and his or her situation and must also clearly understand the social constructions which he/she fails to conform to.

From the above attributes stigma as explained by Gofman is both a psychological and a sociological phenomenon. Psychological because it affects the way individuals think about themselves in relation to their environment and sociological because it determines how they relate with other in society depending on how others perceive and relate with them.

The idea of stigma being defined as both psychological and sociological is further complemented in the view of Deacon et *al* (2005) who points out that stigma as an ideology that identifies and links biological disease to negatively defined behaviour. In this case individuals find themselves in positions where there is a lot of bias and prejudice attached to them and this is likely to influence the way they live their life and the choices they make.

In the case of the current research, stigma directly relates to the circumstances under which FYLWHA find themselves while accessing and using contraceptives. They come across two unique situations; one is the fact that they are HIV positive and how society interprets that and two, that they need to seek for different contraceptive services from different providers whose perception and attitude they can neither predict nor control. Based on this theory, it is interesting investigate whether Female Youths living with HIV/AIDS in Kampala think that society has labelled them defiantly and how that is influencing or likely to influence their extent of access and utilisation of contraceptives.

3.2 Health Belief Model

In the view of Rosenstock et *al*. (1994) the HBM has been used to explain the adoption of single preventative behaviours, such as vaccination and screening, broader healthy lifestyle adoption illness prevention and sick-role behaviours.
The HBM provides an opportunity to explore how health-care provider behaviour can influence patient perceptions of patient safety and the likelihood of patient involvement in patient safety behaviours. That individuals will take action to prevent illness if they believe they are susceptible, if the consequences of the illness are severe and if the benefits of action outweigh the costs.

Over the past 60 years, the HBM has evolved to include six constructs: (i) perceived susceptibility; which looks at the varying feelings that individuals have regarding their personal vulnerability to a condition. This dimension is subjective in nature. (ii) perceived severity; feelings concerning the seriousness of contracting an illness and this varies from person to person. (iii) perceived benefits; beliefs regarding the effectiveness of the various actions available in reducing the disease threat for example a sufficiently threatened individual would not be expected to accept the recommended health action unless it is perceived as feasible. (iv) Perceived barriers; the potential negative aspect of a particular health action which may act as an impingement to undertaking the recommended behaviour. (v) Cues to action; and (vi) self-efficacy influences patient perceptions of patient safety and the likelihood of patient involvement in patient safety behaviours.

The HBM helps to explain how patient perceptions of benefits, barriers, threat and self-efficacy influence their involvement in both factual and challenging patient safety practices. The theory continues to emphasise the role of self-efficacy. That self-efficacy is an important factor in enabling patients to assess barriers and benefits of their involvement in health safety strategies.

Borrowing the self-efficacy dimension, it is important to find out how FYLWHA approach matters of contraception use and what influences them to settle for particular contraceptives. Special consideration was given to the aspect of self-efficacy i.e. confidence in one's ability to undertake a specific behaviour. This was helpful while analysing facilitating factors and some of the individual level facilitating factors for FYLWHA while accessing and utilising contraceptives.

3.3 Gender Based Perspective

Gupta (2000) defines gender as to the socially learned male and female behaviours that shape the opportunities that one is offered in life, the roles one may play and the kinds of relationships that one has. The gender aspect therefore, is critical for this study given the socially constructed differences that exist between men and women from place to place in a given time. In a report by the Inter-Agency coalition on AIDS and Development- ICAD (2006), it is noted that as a result of societal roles, women and girls face a number of unique challenges that affect their ability to protect themselves from HIV/AIDS and its overwhelming effects. The report further mentions that this vulnerability is further enhanced by their limited access to health services some because of household obligations, limited mobility or insufficient funds and this affects proper management of HIV.

In terms of access and actual utilisation of contraception, women and girls are less empowered in actual decision making on matters of sex compared to their male counterparts. For example negotiating condom use can be very difficult. In agreement with this statement, ICAD (2006) points out that women in the sex work industry find it difficult to negotiate condom use with their clients who refuse to use condoms since they are able to find other sex workers who are willing to engage in condom free sex.

Similarly, (Luker, 1996) agrees with the former when he emphasises that norms of appropriate femininity limit women's sexual desire and agency, thus hindering their ability to initiate discussions about sex or contraception with their partners. This in the end ultimately increases their vulnerability.
Pearson (2006) notes that young women do experience sexual desires and pleasurable sexual experiences, but cultural beliefs about women's sexuality deny them sexual subjectivity, and this influences their individual encounters. She adds that Adolescents' sexual decision making is shaped by normative ideas about appropriate sexual roles for women and men; consequently, the motivation and ability to engage in safer sex may be different for adolescent girls and boys.

This research was therefore guided by such gender based claims to investigate the role of gender plays as FYLWHA try to access and utilise contraceptives. Given that the study was conducted in a highly gender biased community just like many other communities in Uganda with influence from social, cultural and religious factors, application of the gender based perspective brought out some of the gender related aspect.

3.4 Social Interaction Theory

Musalia (2005) suggests that People do not usually act in isolated ways; rather their behaviour follows a fairly predictable pattern conditioned by the relationship they have with others with whom they regularly interact. This is in agreement with Lin (2001) that such ties with others are critical in understanding whether an individual receives models for and encouragement for carrying out a given behaviour or not and that it is through the resources embedded in social networks that individuals attach meaning to their situations and are able to determine an appropriate course of action.
In argument for this theory, Musalia (2005) states that it overcomes the limitation of both individual- and structural-based theories because it appreciates the interpersonal connections that may influence a person's behaviour. He adds that decisions to limit one's family size do not occur in a vacuum. They are made within a context. It is through the "community" represented by social networks that people assess whether the change in behaviour being undertaken is acceptable or not.

This study sought to investigate the influence of social networks on the FYLWHA's decisions to use contraceptives. It was anticipated that FYLWHA are likely to be part of several networks both formal and informal. However what the researcher was not sure of, was whether such networks do influence their decision to use contraceptives. In addition to that, the study sought to establish whether the influence is negative or positive.

CHAPTER FOUR

4.0 Methodology

4.1 Introduction

In this chapter the researcher focuses on the methodology that guided the study. Specific issues that are being tackled include; the area of study, the study population, the study design, the sample size and sampling techniques, the data collection methods, data analysis and the ethical considerations for the study. These are further explained below.

4.2 Study Area

The study was conducted in Kawempe division in Kampala city- Uganda. Kawempe is one of the five divisions that make up Kampala city with an estimated population of 304,733, living in 22 parishes and it is a densely populated area with 39% of its population living in slums (UBOS, 2002). The researcher was interested in an area with such characteristics so as to know the experiences of FYLWHA while accessing contraceptives in such a place.

4.3 Study Population

The study population constituted of female youths living with HIV/AIDS and only females were targeted because they make up more than half of the population i.e. 56% in the age bracket of 13 and 24 years (ibid). In addition to that, here is Uganda it is generally known that options for contraceptives for females tend to be more than those for males and therefore female youths are likely to have varying experiences regarding access and use of contraceptives compared to male youths.

It should also be noted that females in Uganda and elsewhere in the world have for long been disadvantaged by society and this has sometimes perpetuated their level of vulnerability. The situation is likely to get worsened for females living with HIV/AIDS due to the underlying discrimination and stigma. It is due to such and other reasons therefore that the researcher offered special consideration to female youths living with HIV/AIDS so as to document their experiences while accessing and using contraceptives.

4.4 Study Design

The study was entirely qualitative in nature because the researcher believes that qualitative methods are the most appropriate at exploring peoples' feelings, perceptions, attitudes and experiences. In addition, the study employed a case study design basic case study entails the detailed and intensive analysis of a single case (Bryman 2012, p. 66). Such a design was the most suitable because it offers an in-depth understanding of phenomenon being studied and therefore, the researcher was able to intensively and specifically examine and generate in-depth information on the experiences FYLWHA while accessing and using contraceptives. In agreement with Bryman (2012), the case study design enabled the researcher to apply unstructured interviews for the generation of adequate information.

The study does not claim that the study findings can be generalised on a similar study population however it is possible and more likely that other groups of people with similar

characteristics like those of the study population possess similar experiences of access and utilisation of contraceptives either here in Uganda or elsewhere in the world

4.5 Sample Size and Sampling Techniques

4.5.1 Sample Size

The study worked with 19 respondents in general. Of these, 6 constituted the first FGD and 7 were in the second FDG. 4 were individual interviewees and 2 were key informant interview. (See table 1). To ensure uniformity of participants' characteristics, all respondents were female youths living with HIV/AIDS unlike the key informants. The researcher did not conduct more interviews than these because by the last interviews, not much new information was coming up. The other reason was to do with time and the researcher did not have plenty of time to dig deeper into the interviewing phase or hold more interviews because the little time had to be well balanced to undertake all the other tusks one time i.e. data analysis and presentation

4.5.2 Sampling Techniques

The study only employed non-random sampling because it was an entirely qualitative study. Purposive sampling was used to select study respondents. This involved choosing respondents on the basis of their relevance to the research questions (Bryman, 2004). The researcher specifically selected respondents with experience and knowledge on the study topic hence Female Youths Living with HIV/AIDS who had been using contraceptives for at least the last one year.

Practically, the researcher was able to find the respondents by working in collaboration with a non-governmental organisation called Reproductive Health Uganda (RHU). This organisation undertakes various outreach programs in the area of sexual reproductive health and it was possible to mobiles Female Youth Living with HIV/AIDS both those still in school and those out of school.

4.5.3 Reflection on the Study Sample

Initially, the researcher targeted study respondents basing on three major characteristics i.e. youths, who are females and those living with HIV/AIDS. After the study it was realised that more characteristics had merged and some of these included the fact that most respondents were unmarried but had partners and some even had more than one partner, in addition to that, all out of school FYLWHA were employed in the informal sector which is largely characterised low and unstable income and had all been using contraceptives for the last one year.

The fact that the respondents selected were of particular nature i.e. HIV/AIDS could have influenced the results of the study especially in as far as condom use is concerned for instance in as far as the decision to use or not to use condoms vary between FYLWHA and a different study population especially those without HIV/AIDS. The researcher also suspects that the respondents only use the contraceptives that are relatively cheap i.e. three months injections and oral pills due to their inadequate income and finally it is possible that most respondents and their partners were not open about each other's HIV status because they were not married.

4.6 Data Collection Methods and Techniques

The study employed qualitative data collection methods, these included; in-depth interviews, Focus Group Discussion and Key informant interviews. The study complemented these with some Participatory Rural Appraisal Techniques (PRA), these included; the Resource Net Map, Matrix Ranking and chapatti/ Venn diagram. Below is a full account of how and why each was used.

4.6.1 Individual Interviews

6 individual Interviews that are semi structured in nature were conducted with some FYLWHA and Key informants. The researcher conducted in-depth interviews with FYLWHA and was guided by a semi- structured interview guide which had just a few close ended questions and more open ended questions to enable the respondents tell their story in their own way. Still under individual interviews, Key Informant Interviews were conducted with a health worker and an official from Reproductive Health Uganda- an organisations working with FYLWHA in the broad area of reproductive health. A key informant interview guide that is semi-structured in nature was used. Key informant interviews were helpful in generating expert knowledge on the topic of study. The researcher was also able to validate some of the information from the primary respondents.

The interview process is not only good for its flexibility but also due to the emphasis on the interviewees' own frames, explanations and understanding of events, patterns and forms of behaviour (Bryman 2012, p.471). This way, FYLWHA are likely to give their individual point of view and share their individual experiences about access and utilisation of contraceptives.

Document Review method was also used by the researcher. This was more helpful in the establishment of the status quo in terms of what other researchers have already written about the study subject. For example the researcher applied this method when coming up with a concrete background of the study as well as the literature review chapter.

4.6.2 Focus Group Discussions

This is one of the methods that was used to collect data. With this method, the researcher interviewed a group of FYLWHA; 6 in the first group and 7 in the second FGD. The discussion was specifically around the topic of access and utilisation of contraceptives and Focus Group Discussion guide with unstructured questions was used by the moderator to guide the conversations so as to avoid deviations from the major topic.

Bryman (2012, p. 503) suggests that Focus Group Discussions enable the researcher to develop an understanding about why people feel the way they feel and also that participants are able to bring to the fore issues in relation to a topic that they deem to be important and significant as well as make meaning out of it. He also adds that Focus Group Interviews may have a further role in allowing views of highly marginalised women to surface. It is due to such related accounts that FYLWHA were able to freely share their views and experiences regarding access and utilisation of contraceptives.

As anticipated by the researcher, FGDs were not only time consuming but there also manifested scenarios whereby some members' opinions seemed to be over shadowed by other speakers' opinions. The researcher however tried to be as keen as possible to ensure that at least all FGD participants had an opportunity to make their point. The other strategy that merged helpful was the application of some PRA i.e. Venn diagrams, matrix ranking and

Process Net Map techniques which allowed all participants to engage in thorough discussion amongst themselves as well as deeply analysing and prioritising issues to finally come to a common ground that they all were comfortable with.

In addition to the above, As the group moderator, the researcher tried to ensure maximum self-awareness and to avoid her own bias from interrupting the discussions since this could have greatly affect the rapport or even hinder respondents from opening up thus compromising the quality of information.

In agreement with Bryman (2012, p.517), where he stresses that Focus Group Discussions are not only difficult to organise but can also generate data that is difficult to analyse. In this same vein, organising a Focus Group Discussions with FYLWHA was a bit complicated at first given that the study population was supposed to obtain particular similar characteristics i.e. female youths living with HIV/AIDS and this necessitated the researcher to come up with appropriate solutions. One of the major concerns of the researcher was the issue of class because if not well considered and planned for, this can easily bias the social atmosphere of respondents and hinder them from freely sharing their views. Smithson (2000, p.103) also agrees that there could exist a likelihood of group dynamics obscuring some of the more controversial perspectives.

In addressing the above issue, the researcher held two separate FGDs and these were organised based on characteristics of respondents. Even when class is such a wide aspect that involves various issues, the researcher decided to classify the FYLWHA in terms of those that were still in school and those that were already out of school. Hence the first FDG was comprised of in-school FYLWHA and the second FGD was made up of out of school FYLWHA who had dropped out of school due to early pregnancy and lack of school funds. By doing this, the researcher realised that respondents in the two separate FGDs somehow share several things in common and found it easy to freely share their experiences while accessing and using contraceptives. Respondents actually ended up sharing issues that one would regard as most personal and difficult to share.

4.6.3 Participatory Rural Appraisal Technics (PRATs)

Participatory Rural Appraisal technic or methods were used for data collection as well. These were purposely meant to complement the Focus Group Discussion Method and that is why they were basically applied during the focus group discussions that were held. The researcher only applied a few PRATs that were necessary to generate the required data. These included; Venn or Chapatti diagram, Resource Net Map, and Matrix Ranking. Their meaning and how they were applied have been further discussed below.

4.6.3.1 Venn or Chappati Diagram

Narayanasamy (2009) defines a Venn or chappati diagram as a visual depiction of key institutions, organisations and individuals and their relationship with the local community or other groups. He adds that in using this tool, circles of different sizes are prepared and that the size of the circle indicates the degree of importance attached to an organisation by the community. That big circle represents ’most important’ organisations and smaller circle represents ’less important’ organisations as perceived by the participants. He further emphasises that in doing so, the researcher ought to probe for participants’ reasons for perceiving an organisation as ’important’ or ’not important and just it is vital not to allow just a few participants to dominate the process but rather to encourage everyone to fully participate.

Venn or chappati diagram technique was applied during FGDs that were help with FYLWHA. The main purpose of using it was for participants to collectively discuss and agree on who the major providers of contraceptive are in their community. However much the tool seemed to take a lot of time, it helped stimulate discussion amongst participants and it was possible for everyone to participate in the process of assess which organisations were most important and which were less important.

4.6.3.2 Matrix Ranking

This is a tool that can be used to stimulate discussions among people whenever choices are to be made and that it not only makes the decision making process transparent but also helps in the a achievement of a better clarity on the existing perceptions about the advantages and disadvantages of various possible solutions (ibid). The tool was applied during FGDs when the group needed to rank providers of contraceptives and it resulted into a transparent process that was owned by every participant given that they were part and parcel of it.

4.6.3.3 Process Net map

Process net map is one of the aspects of social mapping which involves not only naming actors but also tracking the entire process of given phenomenon from the start up to the end. The researcher employed this method which aided FYLWHA to track the contraception access and use process from when they first decide to take on a particular type of contraceptives up to when they finally become users. Among other advantages, this tool enable participants to bring out particular case scenarios, to also systematically recall events as well as identify barriers and how they are overcome while taking into perspective key players' motive. Like any other PRA tools, it was time consuming and required a lot of concertation by participants of the FGD which was a bit tiring.

4.7 Data Analysis Methods

To analyse the gathered material, qualitative data analysis approaches were employed. These included; narrative analysis, qualitative content analysis and thematic analysis.

4.7.1 Narrative Analysis

This method was specifically essential in analysing the case stories and the in-depth interviews that that were conducted with some of the FYLWHA. Riessman (2000 p. 4) puts it that narrative analysis is appropriate for studies on social movement, political change and macro level phenomena. She further denotes that narrative analysis allows for systematic study of personal experience and meaning (p. 24). This method was therefore suitable for such a study that sought to generate and document experiences of FYLWHA in accessing and utilising contraceptives. More to that, respondents of the study were able to share their own detailed story and experiences in their own words and perspective.

4.7.2 Qualitative Content Analysis

Drisko and Maschi (2015) are convinced that Qualitative content Analysis is much similar to what most researchers vaguely label as 'thematic analysis. Mayring (2010) cited by (ibid) describes qualitative content analysis as a set of techniques for the systematic analysis of texts of many kinds, addressing not only manifest content but also the themes and core ideas found in texts as primary content. She also adds that Contextual information and latent content are included in qualitative content analysis and that most importantly the model allows for exploring the complexity of communications in ways that may not be possible through quantitative analysis. For its vitality as claimed by various writers, qualitative content analysis was applied to analyse study findings and it was very helpful in 'digging out' not

only manifest text but also other themes and core ideas that communicated the various experiences of FYLWHA while accessing and using contraceptives.

Thematic analysis not being very different from qualitative content analysis was employed during data analysis as well given its merits. The researcher took note of key cross cutting themes that manifested from the gathered data and these were further interrogated to sufficiently bring out the experiences of FYLWHA while accessing and using contraceptives.

Open coding was done whereby codes were text/generated from the responses of the study population while paying attention to both verbal and non-verbal communication. This allowed data collection and data analysis to be undertaken simultaneously and flexibly in order to capture context and nuance (Drisko & Maschi, 2015). In addition to that, the researcher repetitively read through the text as well as listening to the audio recording several times to come up with cross cutting themes that guided reporting of the study findings.

The researcher believes that a combination of qualitative content analysis/thematic analysis together with narrative analysis should be able to lead to well-structured and elaborative experiences of FYLWHA on access and utilisation of contraceptives.

4.8 Ethical Considerations

The research purpose, content, methods, analysis and outcomes ought to abide by ethical principles and practices (Cohen et *al.* 2007). This entire study was as well guided by particular ethical guidelines especially during the process of data collection, analysis and writing/reporting. The major purpose of considering these particular ethical issues was to minimize and fully eliminate the likely risks and harm to study participants as a result of the research process. The ethical concerns that the researcher addressed are farther explained below.

4.8.1 Informed Consent (Transparency and Self-determination)

The researcher ensured that participants were well informed about the study a head of any interviews, this was for the purpose of ensuring that respondents had a clear understanding of the study and also to ensure that their participation in the study was highly voluntary. Respondents were also assured that even after consenting, they still had a right to adjourn during the interviews if they felt like unable to proceed. More to that, participants were given the opportunity to decide whether to be interviewed as individuals or as a pair of their choice or in a group.

A consent form was prepared by the researcher and this obtained all the necessary information about the study for respondents to be aware of before consenting. Two copies were signed by both the respondents and the researcher and each party retain a copy of the consent form.

In addition to the above, before the start of each interview, the researcher sought permission from all respondents whether to use an audio recorder during the interviews or not. Specific consent forms were prepared for respondents to sign as proof that they authorized the researcher to audio record the interviews.

This entire consenting process created not only clarity but also a conducive environment for both parties given that they were both very aware of the research and its purpose without any other expectations and mistrust. It was also a nice way of gaining entry.

4.8.2 Respect

Respect of all study participants was highly ensured. This was addressed in several ways, for example; the researcher tried as much as possible to ensure respect for privacy of respondents and some of the ways to achieve this were by use of appropriate language and respect of time. The researcher also tried to ensure a lot of self-awareness and reflection to avoid personal bias and preconceived idea from interfering with the views of the respondents. This was done both during the data collection and analysis levels.

4.8.3 Confidentiality and Autonomy

Knowing that the study area was quite a sensitive one, the researcher ensured that all study respondents were assured and re-assured of confidentiality both before FGDs and individual interviews were conducted. It had been anticipated earlier on by the researcher that the issue of contraceptive use by youths is likely to be a private one and in addition to that, the youths being targeted were those living with HIV/AIDs. These therefore were sufficient justifications that required consideration.

Confidentiality was also assured by making sure that the information both in written and audio form was kept safe and only used for the purpose of the research as promised to the respondents.

Anonymity was also ensured for all respondents both during analysis and report writing. To avoid using their real names, respondents were arranged in order of the first to the last i.e. first respondent, second respondent etc. and it is this order that was used to refer to particular respondents whenever there was need to quote their very words.

In addition id seeking permission from respondents to use cameras and audio recorders, the researcher also ensured that all the gathered material was only used for the research purpose and nothing else.

4.8.4 Non-judgementality

As mentioned earlier on, the researcher was much aware that the study involved quite sensitive issues i.e. HIV/AIDS and contraception among young women and therefore, there was a high likelihood that respondents could easily feel stigmatized and judged if one was not very careful. Judgementality could have result from misuse of language and sometimes uncoordinated body language. In addition to that, by wrongly paraphrasing the respondent's views, researchers sometimes end up changing the original meaning of the views of respondents and this could make them feel judged. The researcher therefore took maximum care to ensure that such is avoided given that it could have even biased respondents and hindered them from opening up.

CHAPTER FIVE

5.0 Findings and Analysis

5.1 Introduction and Respondents' Profile

This chapter presents the findings and analysis of the study. The findings were derived from 2 Focus Group Discussions, 4 individual interviews and 2 key informant interviews. Because of the likely varied experiences with contraceptive use among different categories of youths, one of the FGDs targeted the out of school FYLWHA while the second FDG focused on the in school FYLWHA specifically those in higher institutions of learning. This was also done in order to try and give a platform to FYLWHA that come from different socio economic setups. All participants of the individual interviews and FGDs were FYLWHA who had been using contraceptives for at least the last one year. On a whole, the youngest respondent interviewed was 18years and the eldest was 28 years. More to that, those that were not in school were unmarried but with kids and partners.

One key informant works in the family planning department in the national Referral hospital and the other works with a non-governmental organization known as Reproductive Health Uganda which is a key actor in the provision of contraceptive services in the study area of Kawempe division. The major purpose of interviewing key informants was to validate some of the technical information mentioned by the primary respondents and to get a general picture of the contraception situation at the moment. The table below clearly describes the respondents of the study.

Table 1: A Table Showing Respondents' Profile

Respondent category	Age	Occupation	Type of interview
1st FYLWHA	23	Commercial Sex worker	In-depth interview
2nd FYLWHA	22	Hair dresser	In-depth interview
3rd FYLWHA	18	Waitress in a food kiosk	In-depth interview
4th FYLWHA	28	Community mobiliser of Female Youths on behalf of RHU	In-depth interview
1st FGD with 6 respondents	18-28	In school FYLWHA	Focus Group Discussion
2nd FDG with 7 respondents	18-28	Out of school FYLWHA	Focus Group Discussion
1st Key			Key Informant

Informant		Worker in department of family planning at government hospital	Interview
2nd Key Informant		Worker at Reproductive Health Uganda- an NGO	Key Informant Interview

Data analysis was an on-going process both during and after data collection mainly for qualitative content analysis and thematic analysis. The researcher listened to and transcribed the interviews. With continuous reading of the text again and again, codes were attached to the data and themes derived.

Also, as narrative analysis allows for respondents to share their experiences in details, the researcher noted verbatim findings from in-depth interview which was helpful in bringing out respondents' subjective experiences as said.

While talking to FYLWHA and from analysing the findings, several themes were generated which represent the various experiences that FYLWHA go through while accessing and using contraceptives. Some of the themes are directly from the findings whereas others are a reflection of the theoretical framework. The study findings have therefore been presented in the order of these themes. Below is a more elaborative discussion on the study findings.

5.2 Providers of Contraceptives for FYLWHA

Varying sources of contraceptives for FYLWHA in Kawempe division were found out and these range from public, private to non-profit making organisations. It also turned out that FYLWHA access contraceptives form any of the former depending on the then factors for instance availability, financial implications and project time frame especially for the non-profit sector.

From an in-depth interview with the first respondent, she noted that she commonly uses pills and that she often buys them from private clinics save for some times when they are freely supplied in the community by some non-governmental organisations. Not different from the first respondent, the second respondent who uses the injection method that lasts for three months mentioned that due to the absence of contraceptives in most government hospital, she most of the time has no option but to pay for the injection contraception in private clinics and pharmacies. In her own words, the second respondent had the following to say;

> *Government hospitals are also supposed to offer pills but the challenge is that every time you go to collect pills you find when they are out of stock and then you are told to go and buy from external sources i.e. clinics and pharmacies. "* said the second individual respondent.

On a whole, from comparing responses of all the four individual interviewees, major sources of contraceptives that emerged are government hospitals, private clinics and pharmacies, and Non-governmental organisations.

In addition to the above, views from focus group discussions concur with those from individual interviews regarding who the major providers of contraceptives are. The researcher applied a PRA tool known as a Process Net Map to map out the major actors in the provision of contraceptives. With the aid of stationary i.e. a flip chart, mark pens and stickers, the respondents in the focus group were all able to participate in mapping out who the actors are and what they do.

With the application of another PRA tool known as matrix ranking, the researcher asked respondents to go ahead and rank the actors in the provision of contraceptives while taking note of the attribute for each. This process enables group respondents to discuss amongst themselves and collectively come to a conclusion of their choice. The table below illustrates who the major actors are and the attributes that were attached to each of them according to views from the first FGD.

A table showing major actors/ providers of Contraceptives, attributes for each and Ranking

Major actors in provision of contraceptives	**Attribute/Justification**	**Ranking**
Public Hospitals	• Contraceptives are free of charge • Clients are diagnosed before provided with contraceptives • Although most of the time contraceptives are out of stock • Clients are not usually treated with respect • Discriminates clients based on age most of the time	**3**
Private sector (clinics and Pharmacies)	• Contraceptives are always available when ever needed • Easy to access because there are many clinics and pharmacies all over • Customer care is good, client are treated with respect • Although it is expensive/ costly • And sometimes clients are not diagnosed before being provided with contraceptives • Sometimes discriminates clients based on age	**1**
Non-Governmental Organisations	• Contraceptives are provided for free • NGOs bring contraceptives to the community lower level • Sustainability is not obvious. • Do not discriminate clients based	**2**

	on age	

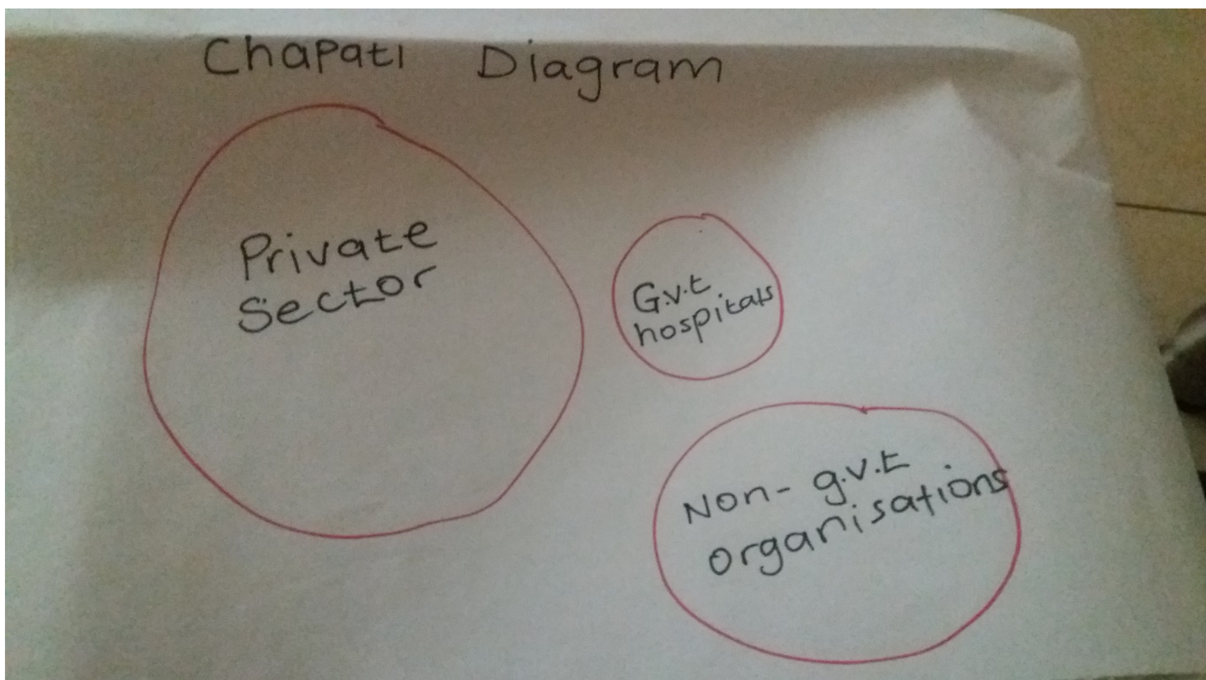
From the above table, it is evident that the major source of contraceptives for FYLWHA is the private sectors followed by the NGOs and then the public sector.

Views from the second FGD were closely similar to those of the fist FGD. Public hospitals were still ranked the least and some of the arguments among others include; inadequate contraceptive at the health centre facilities, corruption, poor customer care and time consuming. One of the respondents said the following;

> *I only have one child and I use pills contraceptives very consistently so that I do not produce another child yet. Initially I used to get my pills from mulago- the main public referral hospital but after sometime I got discouraged due to the inconvenience I go through. Most of the health workers there are corrupt, they ask people to pay for services that are supposed to be free like contraceptives. I expect that as a Ugandan citizen I am entitled to free health services but unfortunately this is not the case….. So I resorted to buying my own pills from the private clinics although it is expensive and sometimes limiting.* (Respondent 4 of the second FGD)

When asked to explain the ratting with the aid of a chapatti diagram tool, below is a picture what respondents from the second FGD came up with.

A Picture of a Chapatti Diagram Indicating Major Providers of Contraceptives to FYLWHA



It is evident therefore that government/public hospitals are least preferred whereas the private sector is of high preference and the NGOs fall somewhere in the middle. This is due to the respective justifications earlier on discussed. Important to note however is the fact that high preference for the private sector contraceptive provider comes with cost implications and that

access to contraceptives is only guaranteed by the ability of the FYLWA to continuously afford them. For some FYLWA, it was indicated that it is sometimes not possible to consistently use contraceptives especially when they are in an economic crisis. This also implies that for some other FYLWHA who are unemployed and are completely unable to earn a living, chances are high that they are likely not to access contraceptives at all even when they are willing to use them.

It is not surprising therefore that respondents are not satisfied with the services of the public health sector given that the same has been mentioned by some previous research. For example, UNFPA (2012) attribute low level of contraception use in Uganda to factors like shortfalls in health infrastructure and transport facilities among others.

In addition to the above, Andi et *al.* (2014) believe that the high unmet need for family planning in the Uganda (34%) worsens the issue of unwanted pregnancies particularly among the adolescents hence an increasing total fertility rate.

5.3 Major Contraceptives Used by FYLWHA

Major contraceptives said to be used by FYLWHA in kawempe include injectable oral pills, in plants and condoms. Different FYLWHA have tried the different methods for all the time they have been using contraceptives especially in the last one year and different attributes were attached to different contraceptive methods used. Only modern contraceptives were being used and none of the respondents had been using traditional contraceptives with the claim that traditional methods can only be successful with a supportive and willing partner.

5.3.1 Injectable

The injectable method is preferred for several reasons one being the time factor i.e. that one is able to have an injection that keeps them free from pregnancy for a maximum of three months without having to worry. It was emphasised that pregnancy is something that FYLWHA cannot risk given the implication it can have on their health. One of the young ladies said;
"*When I tested HIV positive about two years back, the health worker and the councillor told me that it would be safe for me not to conceive again because that would make me more weak and that I could even risk dying*". 3rd Individual Respondent.

One of the participants in the second FGD said;
"…I have not yet made up my mind on which man to settle with yet although I am seeing more that one at the time and all seem to have the potential…the injection keeps me safe from pregnancy until I am sure.--- but some go ahead and apply a condom sometimes." Respondent from the Second FDG.

Second was the affordability factor whereby FYLWHA said that this method is relatively cheap even when accessing from private providers for example it was said that an injection goes for about 3000 Ugandan shillings which is about 1US dollar and that this according to them is fairly cheap as long as one has a stable source of income. FYLWHA however mentioned that being employed in the informal sector sometimes had direct implications to contraception use given that they are not assured of constant income and this sometimes hinders them from using contraceptives due to absence of sufficient income.

Last but not least was the privacy factor whereby FYLWHA using this method believe that it is possible for them to use it without their husbands knowing that they are on contraceptives especially those whose partners are against contraceptives for various reasons.

On the other hand, respondents expressed their distress and disappointment with injectable saying that just like any other contraceptives, injections have deadly side effects some of which are being experienced by a number of FYLWHA. Some of the mentioned side effects included, obesity, high blood pressure, over bleeding during menstruation period and poor appetite among other things.

5.3.2 Oral Pills

This was another commonly used contraceptives method and at least all respondents use it or have used it before. The method is said to be effective only if properly used and that the beauty with it is that it one can be used only when needed and discontinued easily. In addition to that, pills were said to be readily available mainly on market and fairly cheap although when not used consistently one could have to buys a new dose and that makes them expensive at times.

Oral pills were also said to be most preferred among in-school FYLWHA given that only need to use contraceptives occasionally. The method was however discredited for its multiple side effects which most FYLWHA said are unbearable and that if not for the limiting options, they would have discontinued them.

5.3.3 Condoms

Respondents were more familiar to male condoms than female condoms, actually none of them had ever used a female condom a part from only knowing that it exists. Main reasons for female condom unpopularity were unavailability on the market and the fear of using it wrongly which is likely to cause it to slip into the female's uterus hence leading to further complications. Skile (2015) holds the a similar account that product unavailability limits its access whereby she gives an example of low injectable use in some local communities in Malawi that lead to low access and use of the contraceptive. Similarly therefore, unpopularity of the female condoms on the market in Uganda definitely limits its access and use.

More to the above, respondents mentioned that they rarely use male condoms as well due to a number of factors. One of the reasons given was that, unlike the previously mentioned contraceptives, condom contraceptives are controlled by men and it is entirely their responsibility to apply condom. Some FYLWHA however stressed that it is okay to suggest to their partners to use condoms only that such an act is usually perceived differently by some partners and could result into negative reputations for FYLWHA.

This dilemma regarding low condom use even among FYLWHA has been further addressed in details in a later chapter.

5.4 Facilitating Factors for Contraception

While seeking to understand the experiences of FYLWHA as they access and use contraceptives, the study inquired on the existing facilitating factors for contraceptive use. For clarity purposes to avoid any ambiguities, facilitating factors were explained by the researcher as those enabling conditions that make it possible for people to access and use contraceptives. Respondents were therefore asked to share those conditions or factors in their own perspective and these included; education and sensitisation, availability of most

contraceptives on market, free contraceptives and privacy/confidentiality. Respondents' voices on these factors are further shared below.

5.4.1 Education and Sensitisation

Respondents acknowledged that currently there is a lot of education and sensitisation campaigns on contraception being conducted and that unlike before, they now have basic knowledge what contraceptive are and how beneficial they can be . The government in collaboration with other development partners including NGOs and media are increasingly sensitising the population on matters of contraceptive use to reduce unwanted pregnancies.
The key informants agreed with this point saying that due to the increasing HIV rate and fertility, the public is always being sensitised on the need to use contraceptives especially condoms which are well known for reducing risks of both unwanted pregnancies and sexually transmitted diseases. They further noted however that sensitisation is not as effective as necessary due to limiting public funds and that in addition to that it is affected by certain barriers that are deeply rooted in peoples' cultures and religions continue to hinder consistent contraceptive use.

5.4.2 Availability of Most Contraceptives on Market

It was mentioned that unlike before, it is now possible to access most contraceptives in private clinics and pharmacies. This was attributed to the expanding informal sector in Uganda whereby most people are engaging in business and as a result, many have invested in clinics and pharmacies hence increasing the supply of contraceptives among other products.
In addition, respondents mentioned that the private sector is complemented by NGOs and public hospitals which sometimes delivers free contraceptives to people and this is said to have reduced contraceptive access challenges. Views from the second FGD are echoed below;

"*Some years back I used to line up for hours for contraceptives at the main public hospital but now I can just walk into any private clinic and buy them in just minutes*". Third respondent

"*I can access contraceptives any time I need them as long as I have money…. Even the variety has increased in terms of quality.--what you can afford is what you buy."* Second respondent

5.4.3 Privacy/Confidentiality

This was said to be one of the major factors that has made it possible for FYLWHA to continuously use contraceptives. Respondents mentioned that some contraceptives especially injectable and in-plants are possible to use without the knowledge of their partners and for most respondents, it was emphasised that this reduces the likely domestic violence that used to result from use of contraceptive. One FYLWHA said;

> *My current partner and at the same time the father of my child has never appreciated contraceptives…he always told me never to use them for their deadly side effects, but from the time I conceived my first child who I was not prepared to have yet, I decided to use contraceptives without his knowledge. Now I use an injection, I am safe from unwanted pregnancy and he can never find out.* Individual Respondent 3.

Another respondent during an FGD with in-school YLWHA had the following to say;

> *My parents are very dedicated Catholics and do not support the use of contraceptives, but my boyfriend and I decided that I use oral pills to avoid early pregnancy--- my parents have no clue that I use pills and whenever I am home for holidays I am very careful. Sometimes I use an injection. --once in a while we use a condom.* Respondent 5 from the first FGD

Related to a study conducted by PRB (2014), low contraception use by women was due to opposition to use contraceptives by their husbands or partners. Presence of contraceptives that are not easily noticed by partners therefore make it possible for more women to use whether with or without their partners' consent.

5.5 Contraceptives as a Right

On a whole, respondents indicated that health care is a right and all Ugandans are entitled to this right. It was however emphasised that apart from the government stating that people have the right to health, inadequate measures have been undertaken to ensure that this right is fully enjoyed.

Respondent 1 of the second FGD said, "*Here in our community the government through its various representatives tries to distribute some types of contraceptives but not everyone is able to get because they are usually inadequate"*

> Respondent 4 said," *I still don't understand why the health right is not highly prioritised in this country. First of all it is not easy to find free contraceptives in most public health centres.....*

One of the key informants further confirmed that FYLWHA like any other Ugandan have a right to health within which access and utilisation of contraceptives is embedded. He acknowledge the existing gaps within public health centres and blamed the ineffectiveness on limiting funds and corruption. Some of his views are echoed below

> *All Ugandans including the FYLWHA have a right to health. The government is doing all it can to ensure that this right is enjoyed however we should not forget that there is a lot to be done at the same time while under limited resources. That is why government health centres work with various health focused NGO which can help bridge the gap.* KI- worker at family planning unit of pubic hospital.

5.6 Diagnosis for Contraception

FYLWHA shared that sometimes contraceptives are provided to them without first undergoing diagnosis. They further explained that the public health facilities rarely have the technology and time to do the diagnosis for clients whereas the private clinics and pharmacies charge highly for the service, so FYLWHA end up only prioritising the purchase of contraceptives without undergoing diagnosis first given that they have insufficient money to pay for both diagnosis and contraceptives.

The second individual respondent also said

> *Yes it is true that the government sometimes provides free contraceptives but the problem is that they only give us contraceptives without diagnosing us first and I think it is not a good practice because some of our bodies react to the contraceptives but we go ahead and use them since we have no alternative. .*

Views from the first FGD say; “*even when providers of contraceptives are aware of the importance of diagnosing someone before providing them with the relevant contraceptives, they rarely do it.*” R6 Fist FGD

With reference to the above claims, one can already trace the genesis of some of the side effects that most of the FYLWHA tend to complain about, it is very likely that most of them are using contraceptives that their bodies cannot adopt and this is the case simply because diagnosis is not always done before prescribing or offering one contraceptives. This can actually lead to more devastating effect.

5.7 Motivation for Contraception Use

Respondents were requested to share their views on what motivates them to contraceptives. Three major motivations for contraception use were shared i.e. relief from the burden of child care, source of power and to stay in school. These are further discussed below.

5.7.1 Relief from Burden of Child Care

FYLWHA believe that contraception use spares them from the burden of child care given that they are able to avoid unwanted pregnancies. They mentioned that child care is not only expensive but also robes women of the time to be productive and to earn a living. One of the respondents explained that because of contraceptives she is able to provide the best care to her one child unlike if she had more than one. In her own words she said,

> *When I use contraceptives, I am assured of spacing my children and therefore I can also be free to do my work to earn a living especially because these days life is so expensive. Using contraceptives has also helped me to plan for my child. It becomes easier to provide my child with all the basic necessities of life because of now there is no immediate competitor. You know these days, men do not want to take care of their children and you see the law is not very strict on men especially when you are not a legally married couple. So as a woman you ought to plan for your child.* Third Individual Respondent.

5.7.2 Source of Power

Contraception use was regarded as a source of power for FYLWHA. That from experience, most of the sexual relationships they have had before tend to be ended suddenly by their partners whenever they come to learn that the person they are dating is HIV positive. The most unfortunate part is that they sometimes the couple already has a child or two by the time they end the relationship and that most men turn their back and never bother to provide any child care. However with the use of contraceptives, the FYLWHA believe that they feel like they are in control and it is not possible to conceive unless they have wished so themselves.

> *One of the respondents from the second FGD said, ” even though I am living an HIV positive life, I feel empowered because of contraceptives, I know that no one can take advantage of me….silence. I mean that no man can influence me to have unwanted pregnancies if I have not decided.* R2 second FGD

Another respondent from the first interview had this to say,

“ I am able to stay focussed in school and get good grades even when I have a boyfriend because I trust that I cannot become pregnant as long as I take my pills correctly” R4 first FGD

The first individual respondent also added her voice to the above and said,

> *Like I earlier on mentioned that I work as a prostitute, it could have been so difficult for me to sustain my services if I am not using contraceptives. Most of my clients don't care whether I am safe or not. By the way counsellors tell us that if we avoid getting pregnant our health stays stronger for longer. So with contraceptives I feel empowered, I feel safe and in charge....* Smiles. First Individual Respondent

5.7.3 To Stay in School

The in school FYLWHA shared that the key motivation for using contraceptives is for them to be able to stay in and be able to compete school. That with use of contraceptives they get relief from the pressure that would arise. One of them said,

" *some of us use contraceptives because we are not yet legally married. Like myself, I am still in school, so I cannot afford to have children now... laughers".* R2 First FGD.

In school FYLWHA also emphasised that becoming pregnant while still in school would not only be a disappointment to their caregivers but would also be a violation of school rules and regulations so they ought to use contraceptives to stay even though most of their parents do not approve their use of contraceptives.

5.8 The Condom Dilemma

The commonly used contraceptives as mentioned by respondents are oral pills, injections, in-plants and male condoms. FYLWHA however further shared that unlike the other types of contraceptives, condoms are only used out of their male partner's initiative because it is highly considered as the role of men to buy and use condoms. FYLWHA also expressed that it is something "shameful" to even propose use of a condom to their male partners because of the misconceptions that tend to arise. A probe from the researcher on this matter generated several views some of which are shared below;

"*…… it becomes difficult for me to ask my partner to use a condom even when I am sure it is the right thing to do.... It is him to decide whether we can use it or not*" 3rd Individual Respondent

> *I once told my former partner that it is good we use condoms every time we are to have sex but I think he felt offended. He sent me a text message after some days saying that he suspects I have HIV and that's why I proposed the use of condoms…………he even ended the relationship*---- 2nd Individual Respondent

From the above expressions, one can clearly find a trace of male dominance over female influencing the contraception use. This dominance might not be directly imposed on women by men but it is as a result of the pre-conceived ideas about what males or females ought to do or not and these tend to be deeply rooted in one's social, cultural and religious beliefs and values. Connel (1985) also states that condom use is a male-controlled activity over which women have limited control. Related to this, Mehra, Olof Östergren, Ekman and Agardh (2014) agree that there is a synergetic effect between being a female and low condom efficacy with inconsistent condom use.

In other research, it also come out clearly that there is an exciting gap when it comes to condom use by young people for instance the national AIDS indicator survey 2012, showed that only 36.2 percent of women and 52.9 percent of men between 20 and 24 used a condom during their last sexual intercourse in the past twelve months and among those who had more than two sexual partners in the last 12 months, only 23.4 percent of women and 30 percent of men reported using a condom during their last intercourse. The research (ibid.) also revealed that majority of young Ugandans lack comprehensive knowledge about HIV i.e. just 39 percent of men and women aged 15 to 24 have all the facts on how HIV is spread and how it can be prevented. This perhaps accounts for the rise in HIV prevalence from 6.4 percent to 7.3 percent over the past five years. (HIV and AIDS Uganda Progress Report, 2014).

It is therefore not surprising that some of the FYLWHA together with their partners do not attach as much value to condom use as they should have been doing due to several perpetuating issues that are highly patriarchal influence. Such tendencies create a big gap in the fight of the HIV pandemic that ought to be bridged given that many other people including youths stand a risk of contracting HIV.

The other main reason forwarded for minimal condom use was the access challenge. FYLWHA say female condoms are unpopular on market and expensive yet at the same time it is embarrassing to buy male condoms for their partners and that this leaves them with no option but to let their partners take the responsibility although not all partners ensure consistency of condom use. Some of the respondents said the following;

"In our society it is more awkward for a woman to buy condoms from any shop than it is for a man…... sometimes it is not easy for men too." (Individual Respondent 3)

"People would think I am a prostitute if I just walked into a shop or clinic and asked for a condom, so I would rather not." Individual Respondent 4

Minimal condom use can also be linked to low economic empowerment, this can be looked at in two dimensions; one of the dimensions is in terms of affordability whereby FYLWHA and the partners not being able to sometimes buy condoms and the second dimension where by sex without a condom is paid for highly especially for commercial sex. One of the respondent said,

> *As a commercial sex worker, I earn more money when I let my clients have sex with me without a condom than when they use one. I know it is risky for my clients and myself but I also need the extra money…. Silence. ……..any way I cannot be sure whether they are safe or not. May be they already have HIV too and that is why they do not care.* (Individual Respondent One)

It should be noted however that unprotected sexual intercourse not only increase risks on contracting HIV/AIDS but other sexually transmitted disease as well. So where as all sexual partners of FYLWHA are not safe, the former are neither safe from various sexually transmitted diseases that could actually further weaken their health. It would be unfair though to for one to take the entire blame on FYLWHA for not using condom especially if they are being hindered by economic constrains. I think that such a gap should highly attract government and third sector interventions to increase the supply of condoms for everyone's access.

5.9 Disclosure and Partner Protection from HIV/AIDS and other STIs

Respondents views on the issue of partner protection were sought to establish whether it is a subject they regard as important or not. To generate information on this subject, respondents were first of all asked whether their partners are aware that they (FYLWHA) are HIV positive, and secondly what they were doing to ensure that they do not transmit the disease to their partners in case they were still safe.

It unfortunately turned out that FYLWHA are more afraid of becoming pregnant than infecting their sexual partners with HIV/AIDS and themselves with STIs. This has in a way shaped the types of contraceptives that FYLWHA use for instance, they all commonly use oral pills, injections and in plants compared to condoms which are well known for protection from contraction of HIV and other sexually transmitted diseases.

Justifications stated by FYLWHA for not using a condom as mentioned earlier on do not only display waves of low income and gender based suppression but also further highlight the presence of stigma faced by FYLWHA which greatly hinders them from disclosing their HIV status hence increasing chances of new HIV infections. FYLWHA are afraid that by disclosing that they are HIV positive, not only will their partners leave them but the larger community will as well discriminate them especially at work place. So they end up sacrificing their partners' safety for their own stability. However, FYLWHA were very hesitant about defining this as selfishness because they believe that their partners might as well not be that safe given that they also never disclose their HIV status and therefore the two parties are both not warm of each other's' status.

In agreement with the above claims, Rodkjaer, Sodemann, Ostergaard and Lomborg (2011) denotes that Decision making concerning disclosure is shaped by factors specific to the individual as well as factors specific to the environment and that sharing about HIV status could provoke anxiety and cause perceived threats to one's personal wellbeing because HIV is still associated with stigma and prejudice. Important to note however is the fact that not only does stigma negatively affect the wellbeing of FYLWHA but also can have serious negative implications for the community members that are perpetrating it given that FYLWHA are cause to keep their status secret from not only the larger community but also to the closest family members and therefore all these stand a chance contracting the virus.

One can therefore imagine the kind of dilemma that such a situation is likely to turn into. Partner disclosure is such a major ingredient and a key starting point in avoiding further spread of HIV/AIDs. In this case however, it seems rather difficult given that partner communication on the subject of HIV/AIDs and condom use is being over shadowed by the waves of gender inequality and stigmatisation. This therefore, puts both the current and future safety of the community against HIV/AIDs at jeopardy and that is why some writers i.e. Mehra et *al.* (2014) propose that gender power relations should be addressed in policies and interventions aiming at increasing condom use among young people in sub-Sahara settings. (ibid) also believe that programs can be designed with interventions strategies that focus on interactive and participatory youth friendly activities that could improve their interpersonal communication and condom use negotiation skills with their partners.

5.10 Barriers to Contraception Use

The study uncovered several barriers to contraception use, these are multi-dimensional and are founded on various factors which among others include; institutional, cultural, religious, economical, mis-conceptional and health related factors.

5.10.1 Institutional Factors

Low contraception use was blamed on several institutional constraints. This was said to be the case for both state and non-state institutions. State based institutions were accused of not being well equipped when it comes to addressing the contraceptive need. Most state or public hospitals were said have insufficient contraceptive technologies and methods readily available. Respondents also mentioned that it is not obvious for one to be diagnosed prior to receiving contraceptives due to the absence of such technology and sometimes low motivation of health officials.

Non- state organisations especially those that are not for profit were said to be fairly effective compared to the former due to their implementation strategy which usually tries to reach out for the most vulnerable groups. Some of these organisations even bring contraceptives and helpful information to the community level. However it was emphasised that most of such organisations operate on project basis and usually the projects only run for short period of time hence making the services less reliable and less sustainable. Depending on the implementation strategy, this could imply that when the project time frame is over, FYLWHA are unable to continue accessing contraceptives and this is highly unsustainable and less empowering.

5.10.2 Cultural Factors

There still exists cultural beliefs and misconceptions that pose serious barriers to contraception use. For example youths who are still in school and living with their parents use contraceptives secretly without the knowledge of their parents given that society regards such an act as prostitution.

More to the above, males still assume a lot of control over the condom contraceptive whereby females have less condom efficacy and would rather not push for condom use in case their partners are not interested due to the likely repercussions. This is further perpetuated by the fact that there is still female dependency on the male partners for a living i.e. the patriarchal type of relationship where by the husband possesses more power and control.

5.10.3 Religious Factors

Religion was said to be very influential when it comes to peoples’ choices on the subject of contraception. Certain religions especially Catholicism were said to be against modern contraceptives and the church highly advises its members against the use of modern contraceptives. Respondents mentioned that sometimes they just go against the church position but this leaves them with a guilty conscious.

5.10.4 Economic Factors

The cost of contraceptives was said to be a serious barrier to their use, like mentioned earlier on, most public hospitals never have adequate contraceptives for the entire population and in that case people are left with no option but to purchase from the market and this is said to be costly for FYLWHA because of two major reasons, one being that they are unable to use the best quality contraceptives because they are usually more expensive and two, they cannot be

assured of getting the contraceptives whenever they need them due to their unstable sources of income.

"*Contraceptives are expensive to buy so I only use when I have money and when I am out of money I am unable to……."* Individual Respondent 1

> "*Due to poverty, it is expensive to buy contraceptive. The best alternative would have been getting them free of charge from government hospitals, however most government hospitals no longer offer free contraceptives. They always give excuses that they are out of stock*". Individual Respondent 3

5.10.5 Misconceptions

The society at large hold several preconceived ideas and beliefs towards contraceptives and these tend to pose a huge barrier to contraception use. Respondents for example mentioned that there is a common belief among the community members that when one uses contraceptives, they stand higher chances of becoming barren and that this is one of the reasons most men are not comfortable with their wives using contraceptives. ¨

It was pointed out that currently there is a rumour running a round that male circumcision reduces chances of contracting HIV/AIDs. It is believed that this could be one of the reasons most partners of FYLWHA are reluctant to using a condom as long as they have been circumcised.

Respondents also shared that contraceptives represent a new error of colonisation whereby they believe that the idea was birthed in the western world which is still the sole manufacture of most contraceptives and that the intention is to reduce the numbers of the black race which respondents considered as a threat to most developing countries like Uganda.

"*Some people tell us scaring information that contraceptives cause cancer, so it becomes so discouraging for us to consistently use contraceptives*." (Said R4)

"*Contraceptives like condoms cannot be trusted a hundred percent*." (Said R7)

"*I think it is also important to have a partner that is trust worthy if you want to use condom contraceptives because untrustworthy partners can intentionally damage the condom and that threatens someone's safety from unwanted pregnancies and diseases*."(Said R6)

5.10.6 Health Related Factors

These factors were largely associated with side effects that result from use of given contraceptives. Respondents mentioned that given that they are HIV positive, their body immunity is usually low that and most contraceptives tend to enhance general body weakness. There are several health related challenges which they claim only appeared after adopting the contraceptives that they are using. Among others, the several health challenges are over bleeding during menstruation, obesity, dizziness, low appetite, and body weakness.

"--- I have also developed challenges like high blood pressure since I started using contraceptives and Sometimes I miss my periods"). Individual Respondent 1

> *"Some contraceptive methods are very discouraging due to the negative side effects they cause. For example a friend of mine was once using the coil (IUD) method however when she later grew fat, it became impossible to remove it*

from her uterus and she instead had to undergo surgery for it to be removed. – I can never use such a method" individual respondent 2

5.11 Theorising the Findings

Integrating theory with study findings would have suited the current study being a qualitative one in nature, however to extensively integrate the different theories used in the study with the study findings, a separate discussion was created for this purpose. This was specifically done given that the current study presents different socio-economic as well as health related perspectives which the different theories used try to address. The theories in perspective are; the health belief model, the social interaction theory, the gender based perspectives and the stigmatisation theory. These were mainly considered so as to further interpret and analyse study findings.

5.11.1 Health Belief Model

Elements of the health belief model were found to be relevant for this study. For example, from the interview with the first and second respondent, it was emphasised that as FYLWHA, they were the very first resource with in themselves and that in the first place it is themselves who finally make the choice to begin using contraceptives. Respondent 2 also said that she is the first point of contact before anyone else and that the positive energy with in herself is the major driver of what should or should not happen in her sexual reproductive life depending on the anticipated outcomes. This is therefore in agreement with Rosenstock et *al* (1994) of the Health Belief Model when they state that individuals will take action to prevent illness if they believe they are susceptible, if the consequences of the illness are severe and if the benefits of action outweigh the costs. Although contraception use is not necessarily an illness issue, the idea of susceptibility and benefits of action echoed in the views of the respondents clearly match with the model. This is further enhanced by the idea of preventive behaviour adopted by patients as developed in the model.

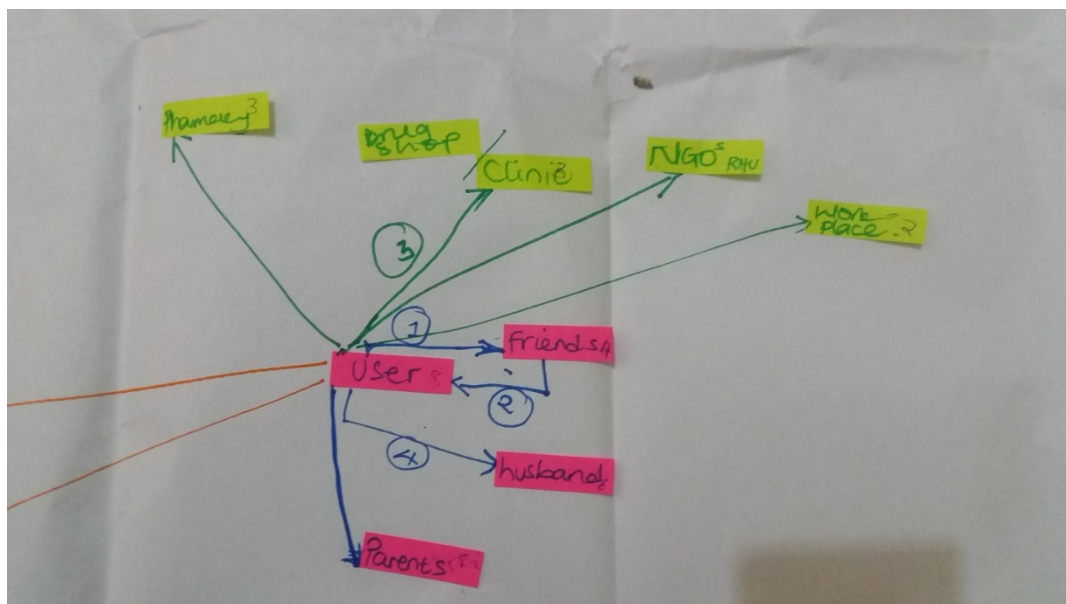
Views from both the first and second FGD also largely conquer with the self-efficacy aspect of the Health Belief Model. A PRA tool known as Resource Net Map was again used and this time the aim was to track the entire process of using contraception i.e. from when the decision to use contraception, the then influencing factors until the final step of consuming contraceptives. With the aid of a flip chart, mark pens and stick notes, the FGD respondents were able to jointly map out the entire process while taking note of the key parties.

Views from the first FGD showed that the process is initiated by the contraceptive user herself by deciding to avoid the risk of becoming pregnant or contracting sexually transmitted diseases. That this can be followed by consulting with friends which contraceptive options are good based on their experience. Whereas respondents in the second FDG mentioned that the next step is then to buy contraceptives from private clinics, the first FGD stated that NGOs are the most preferred priority since contraceptives are free of charge and there is no discrimination based on age. Not forgetting that the first FGD was composed of in-school FYLWHA, it is perhaps due to their position as students that they prefer free contraceptives from NGOs instead of having to purchase them from the private clinics.

Most importantly also is the fact that the NGO that provides contraceptives to in school FYLWHA known as RHU-Uganda highly operates on a non-discrimination policy according to the second key informant (worker with RHU-Uganda). However, respondents of the first FGD still concluded that NGOs are not always readily available but only visit schools once in a while hence leaving in school FYLWHA with no option but to go to private clinics most of the time.

It is vivid therefore that individual FYLWHA are the first point of contact and are themselves the major driving force behind contraception use. This portrays a trail of self-efficacy within the FYLWHA. The ability of FYLWHA to seek for knowledge and information on best contraceptive options and where to acquire them is itself a reflection of motivation and positive energy from within. This tends to agree with Rosenstock et *al.* (1994) that individuals will take action to prevent illness if they believe they are susceptible, if the consequences of the illness are severe and if the benefits of action outweigh the costs. The picture below shows views of the second FGD regarding the entire process of contraception use indicating all the involved parties and how significant their role is.

A picture of a process Net Map Indicating parties that influence contraception use by FYLWHA



From the picture above, respondents explain that, it is themselves as users of contraceptives that are at the centre of controlling their own contraceptive use. They believe that without individual or self-efficacy, it would be much difficult for them to effectively adopt contraceptive use. That the external environment in terms of friends, family and various

institutions indeed play a vital role that cannot be underestimated however it still comes back to the individual FYLWHA who opens up and allows to be influenced.

The researcher was much interested in why the husbands or partners of FYLWHA are place in the fourth position which seemed too far. On probing, respondents said that their partners are rarely concerned about whether their women are using contraceptives or not. One of them said,

> *I think my partner is not even interested in knowing about the contraceptives I use… silence. Mmmh… by the way he might not be aware that I am even HIV positive, you see most men believe that it is the lady's responsibility to use contraceptives and they even don't bother.* R5 Second FGD.´

Another respondent said,
"*My man only wants to know that we are safe from having babies and that's all, how I do it does not matter. He says I can ably fulfil that responsibility*". R1 second FGD.

Important to note is that however much respondents emphasised that they poses self-efficacy, it turns out that it is only true when it comes to access and utilisation of other contraceptives unlike condoms. Respondents shared that to a large extent, it is their partners who decide whether to use condoms or not and as already shared, FYLWHA cannot do much about it due to several reasons that are gender, religious and cultural based. This low condom efficacy among FYLWHA tends to fall crossroads with the Health Belief Model.

It is vital to note therefore, that the health belief model cannot sufficiently provide explanation for the different tendencies and experiences as shared by respondents, this is mainly because it focuses more on providing medical explanations relating to individual behaviours. This is why terms such as patient, illness, vaccination and treatment among others are most employed. Thus due to these deficiencies among others it necessitated consideration of other theoretical perspective to interpret study findings

5.11.2 The Social Interaction Theory

Findings from the study revealed that there is an influence of social networks on the FYLWHA while accessing and using contraceptives and it was as well realised that the influence is both positive and negatives. Views from both the first and second FGDs showed that friends play a crucial role in contraceptive use. They are thought to be the easiest party to consult on issues of contraceptive access and the likely best options available. Besides friends, it was also mentioned that family especially parents are a source of knowledge on contraceptive use. However it should be noted that findings indicated that it is commonly the out of school FYLWHA who find it easy to consult with parents on contraceptive use unlike the in school FYLWHA. This however does not entirely mean that the in school FYLWHA are not influenced by family, there seems to be an existing influence from family although it is rather indirect. One of the individual respondent had the following to say regarding this matter.
"*I sometimes use contraceptives to avoid pregnancy because I don't want to ruin the reputation of my family, my parents would never forgive me if I became pregnant while still in school.*" (4th Individual Respondent)

Also, one of the respondent from the second FGD is quoted to have said the following, "*in this community we have a group called "Tusitukire wamu" project and it often teaches us on*

issues of safe abortion and contraception use. It is very influential in the lives of most female youths".

These views therefore further conquer with Lin (2001) who suggests that social ties with others are critical in understanding whether an individual receives models for and encouragement for carrying out a given behaviour or not. That it is through the resources embedded in social networks that individuals attach meaning to their situations and are able to determine an appropriate course of action. Furthermore, the views are also in line with Musalia (2005) who notes that behaviours adopted by individuals do not happen in isolation of the social environment, meaning therefore that significant others such as family members and friends, have an influence on choices that people make.

Specifically on motivation for contraception use, decisions to limit one's family size do not occur in a vacuum. They are made within a context. It is through the "community" represented by social networks that people assess whether the change in behaviour being undertaken is acceptable or not (ibid).

When compared, the social interaction model as propounded by Lin (2001) so much emphasises the social environment around an individual having the greatest influence in terms of decision making especially on whether to use or not to use contraceptives as well as the best options to adopt. On the other hand, the health belief model contends that it is largely dependent on the individual self to make such decisions. It is however important to note that whether social environment has influence over the individual or not, the decision to use contraceptives lies entirely with the individual.

Important to note for this study on contraceptive use by FYLWHA is that when it came to condom use as a form of contraception, it was found that respondents showed both the lack of self-power and social power due to the limited control they poses as young women over condom use by their partners. This 'powerlessness' was attributed to the existing socially constructed gender relations in their society. It was therefore important to examine how the gender perspective influences contraceptive use and access.

5.11.3 The Gender Based Perspective

Regarding the gender aspect, respondents mentioned that the reason they are using contraceptives is because they are "women". That sometimes the decision to use contraceptives is made simply because if she does not use contraceptives, her spouse is not willing to take the responsibility and therefore, at the end of it all she is not safe. In addition to that, respondents also shared that their spouses and other sexual partners tend to assume much control around issues of sexuality and that the FYLWHA are put in a weaker decision making position.

FYLWHA also feel that the mind behind introduction of contraceptives was itself gender biased in a way. This was mainly attributed to the issue that most of the readily available contraceptive methods only target women.

In the second FGD, respondents emphasised that most of the available contraceptives only target women and not men, they further expressed their distress that even most of the contraception campaigns and advertisements tend to only emphasise the role of women than men, a position which was said to be promoting gender based discrimination. Respondent one's views regarding the gender aspect are as follows;

> *Most of the time I have to be responsible for using contraceptives because my partner does not mind. I am the one who always have to be careful. You see*

> *the issue is that we have different experiences for example it is us women who go through a lot of suffering with child bearing and upbringing so if you do not ensure that you are safe from unwanted pregnancies, no one else will do it on your behalf.* (First Individual Respondent)

In addition to that, respondent two said that

> *Contraceptive use is thought to be for women only and that is why most of the readily available methods only target women for example pills and injections. This even causes men to have excuses for not using contraception.* Second Individual Respondent

It is therefore evident that contraception use is highly gender biased and that the society largely puts that burden on the females.it puts them in a position that makes them in charge of ensuring that they are safe from unwanted pregnancies and sexually transmitted diseases which ideally is meant to be a joint effort by both partners. This leaves the males with all the freedom not to commit to using contraceptives since it is looked at as a responsibility of females. This is in agreement with Pearson (2006) who states that adolescents' sexual decision making is shaped by normative ideas about appropriate sexual roles for women and men; consequently, the motivation and ability to engage in safer sex may be different for adolescent girls and boys.

From a another perspective on gender, special attention was given to the male condom contraceptive given that it is one of the most popular male contraceptive which they can as well take responsibility to ensure safety of their partners and themselves from HIV and other sexually transmitted diseases. It was revealed however that unlike the other contraceptives, male condom use is highly controlled by the male partners and it is at their will that condoms can or cannot be used during sexual intercourse. Like Kurimoto (2012) suggests, there is a relationship between women empowerment and contraceptive use, it was confirmed in this study as well that there is still a gap in empowerment of FYLWHA and this is having a direct implication on how and what contraceptives they can use. FYLWHA seem to have low socio-economic empowerment hence the reason they have low condom efficacy and demand because in one way or the other they still depend of their partners for their survival given the job insecurity and unemployment they continue to go through.

As shared previously, it was found out that most of the interviewed FYLWHA rarely use condom contraceptives mainly because they have limited decision making power when it comes to asking their partners to use one. This therefore leave them with only the option of using the other types of contraceptives that they have more control over and unfortunately these options unlike condoms only protect FYLWHA from unwanted pregnancies and not sexually transmitted diseases and infections like STIs and HIV/AIDS.

Gender inequality is such a multi-dimensional problem that is hazardous to any society at a given point in time. It is more of a means to various ends that unfortunately are negative for young women living with HIV as seen in this study. This is because of the power dimensions it creates that tend to benefit a single party (males) compared to the other party (female). When it comes to contraceptive use, such power dimension and control is not only a violations of several rights of women but also has a high likelihood of perpetuating several adversities that are a threat to the lives of the victims as well as their dependants. FYLWHA and any other youths at large face such adversities because they were hindered from condom use when they needed to and these could manifest into health, economic and social related adversities.

5.11.4 Stigmatisation Theory

There were mixed reactions on the subject of stigma during the study. Whereas a section those interviewed believed that stigma was not a major issue in the area of contraceptive use, others contended that they still face negative attitude and reactions towards them especially when they offer information regarding their HIV status so as to acquire the most appropriate contraceptive given their status. Indeed this agrees with Deacon et *al* (2005) that individuals find themselves in positions where there is a lot of bias and prejudice attached to them and this is likely to influence the way they live their life and the choices they make.

When respondents were asked whether they thought society holds certain negative perceptions and attitudes towards them due to their status of HIV/AIDS and whether such negative treatment affects their access and utilisation of contraception in any way.

Respondents shared that it is not common these days for them as FYLWHA to feel stigmatised unlike before. In the second FGD respondents pointed out that actually society is doing all it can to eliminate stigma especially through several awareness raising campaigns. This was mainly attributed to the presence of ARVs that have been helpful in boosting the health of People Living with HIV/AIDs (PLWHA). Respondent 1 said that it is no longer easy to identify that someone is suffering from HIV/AIDs because as long as one is on ARVs they tend to look healthy and strong enough unlike before.

> *These days the law on discrimination of people based on HIV/AIDS is serious and that is why most employers cannot risk to discriminate employees living with HIV/AIDS. It is also not easy to tell that I have HIV/AIDS by merely looking at my physical appearance, can't you see I am as health as any other beautiful female youths... (Laughter's). So in that case the outside world may not be able to know my secret a part from close friends and relatives but those are usually understanding.*

On the other side of the coin, it was found out that stigmatisation is commonly perpetuated by the very closest relatives of the PLWHA. This was forwarded as one of the reasons most FYLWHA still find it difficult to disclose their HIV status to their spouses and other sexual partners because the experience they have had before was not the best whereby disclosure brings about stigmatisation and sometimes causes break ups in relationships.

Furthermore, it was mentioned by the second respondent that there are times when she feels like her life is influenced by a lot of bias from the environment around her. She mentioned that at her work place she is a hair dresser but most of the time clients especially those who have a clue about her status prefer to be handled by other hair dressers and that this makes her feel discriminated.

It can therefore be put that stigmatisation both from within and from the external environment is detrimental and 'a parasite' not only to an individual but also to the perpetuators and the entire society at large. When FYLWHA hesitate to disclose their HIV/AIDS status due to the likely repercussions, there is a higher risk that this concealed information and health status can in the end negatively affect close relatives and especially sexual partners.

For this study therefore, no single theoretical perspectives among those selected could satisfactorily provide a holistic explanation of the study area. This is because of the dynamic nature of the study area and the need to provide a more comprehensive and multidimensional understanding of the experiences of FYLWHA while accessing and using contraceptives.

Although seen as a reproductive health issue, contraceptive use to FYLWHA came with new socioeconomic and gender related challenges. Therefore, the use of different theories was seen to bring out an all-round perspective of this phenomenon.

CHAPTER SIX

6.1 Summary and Conclusions

This chapter presents summary and conclusions of the study. It further points out some of the issues that the researcher thinks can not only be considered for further research but can also be considered by the government of Uganda through its respective departments especially the health departments as well as other development partners especially NGOs focussing on issues of Sexual Reproductive to improve contraceptive service delivery in Kawempe division and elsewhere in the country where conditions are similar.

The major objective of the study was to document Experiences of Female Youths living with HIV/AIDS (FYLWHA) in accessing and using contraceptives a case of Kawempe division in Kampala City and this was further broken down into three specific objectives i.e.; to find out the sources of contraceptives for FYLHA in Kawempe division, to establish factors for and against access and use of contraceptives by FYLWHA in Kawempe division and to come up with a way forward on how to further improve the situation.

From the study findings, it was revealed that FYLWHA are aware of their right to health which is indeed true given that the government of Uganda is a signatory to the 1948 Universal Declaration of Human Rights and the right to health is catered for through the Uganda Health Policy. However, the FYLWHA also emphasised that besides being entitled to the right to health, they have not yet witnessed significant efforts by especially by the state to ensure that their right to contraception use id fully enjoyed. This was attributed to the lack of sufficient contraceptives in most public health facilities. They therefore regarded this as a gap that ought to be dealt with.

Findings also showed that the major sources of contraceptives for FYLWHA are the private clinics and pharmacies, public hospitals and Non- Governmental Organisations. In terms of consistent and quick access to contraceptives, the private clinics and pharmacies were ranked number one, followed by the NGOs and then the public hospitals. FYLWHA however further explained that Private clinics and pharmacies are the most expensive but remain the only alternatives given that NGOs work on a limited timeframe and public hospitals are out of stock of contraceptives most of the time.

It also came out clearly that the commonly used contraceptives by FYLWHA are oral pills, injectable and condoms although condoms are rarely used due to several reasons i.e. limited access and other gender, religious and cultural related factors. The major hindering factor however was gender related given that female condoms are not available and yet male condoms can only be bought by men and not women according to FYLWHA. Therefore, it was said that it is usually the role of men to use condoms and yet they are most of the time reluctant and hesitant to use them.

Disclosure of FYLWHA about their HIV status is minimal due to stigma and marginalisation that tend to come along with disclosure especially to close relatives and the general community at large. So the FYLWHA keep their status as a secret and neither are they aware of their partners, status.

Additionally, major key motivating factors for contraception use by FYLWHA are; relief from child care, source of power and to enable them stay in school especially those that are in school. It is unfortunate however that all motivating factors seem to be mainly in favour of

the FYLWHA and not their sexual partners. This signals inevitably threats not only to the sexual partners of FYLWHA but to themselves as well given that such motivating factors are likely to drive FYLWHA into the use of any other contraceptives unlike condoms given that control of sexually transmitted infections does not seem to be coming out as one of the major motivating factors.

Study findings tend to agree with self-efficacy aspect of the health belief model whereby, FYLWHA believe that as individuals they play a key role in access and utilisation of contraceptives and that without their determination, it would be difficult for other external parties to influence them. On the other hand however, FYLWHA, have low efficacy when it comes to the condom contraceptive. Their male partners control how and when a condom can be used.

In addition to that however, FYKWHA also acknowledged the important role played by the external factors especially the social networks that they are part of. For example they mentioned that friends and family especially parents and sometimes partners play an influential role that cannot be underestimated. That the influence could be indirect inform of ideas and lived experiences that they share, this is just in line with the social interaction theory that says social ties with others are critical in understanding whether an individual receives models for and encouragement for carrying out a given behaviour or not and that it is through the resources embedded in social networks that individuals attach meaning to their situations and are able to determine an appropriate course of action (Lin, 2001).

Regarding the Gender question, FYLWHA feel that contraception access and use does not happen on a levelled ground. From experiences shared, it is said that contraception use is highly regarded as a responsibility of the women and that it is very rare for men to take the initiative of not only using them but also discussing about them with their partners (the FYLWHA).This status quo was blamed on the providers of contraceptives who to the large extent target women than men and on the existing cultural bias and prejudice that people still hold towards the roles that should be undertaken by women and men.

It can be concluded therefore that experiences of FYLWHA while accessing and using contraceptives are not very different from what any other youth is likely to experience save for some unique health related weakness triggered by some contraceptives and also the influence of stigma. This therefore clearly shows that like any other young people in their most productive milestone of life, FYLWHA possess contraceptive needs that need to be met and all duty bearers need to ensure that they play their role to ensure this need and right is fulfilled especially by eliminating all social, cultural, economic, religious, and institutional barriers that hinder the access and use of contraceptives.

6.2 Areas for Further Research

There is need to conduct an in-depth study on the subject of condom use. This could focus on both male and female condom use to further establish the subjective justifications for low condom use and efficacy to inform future interventions and development projects in this area.

It would be interesting to conduct a similar research focusing on the experiences of FYLWHA but this time using mixed methods. Unlike qualitative methods alone, quantitative methods would perhaps target more respondents while focusing not only on views but numbers as well.

There is also need to conduct a study on socio economic livelihood for PYLWHA specifically those who are out of school. This would generate plenty of rich data on what out of school FYLWHA do for survival, the type of work they engage in and how best they can be supported to live a much better and fulfilling life.

Lastly further research on contraceptives with less health related side effects especially for people living with HIV/AIDS needs to be undertaken.

6.3 Recommendations to Public Health Facilities and other Development Partners in the area of Reproductive Health Services, Specifically Contraceptives

Based on the research findings, below are some of the practical recommendations or steps that can be taken to improve the area of contraception use generally by youths and specifically by FYLWHA. These can be addressed by the government of Uganda through its relevant departments and other relevant development partners.

The research found out that there is still limited awareness on existing contraceptive alternatives and their importance. Therefore, based on this, awareness campaigns to contraceptive users need to be strengthened to facilitate the adoption of different alternatives based on an informed ground and specifically the use of condoms needs to be emphasised for enhanced safer sexual practice.

Furthermore, it was revealed that the burden of contraceptive use is largely place on women by society than on men. Therefore, publicity and advertisements of contraceptives needs to be made gender sensitive such that both men and women are targeted to avoid gender discrimination. There is need to emphasise the role of men either through increasingly advertising male centred contraceptives or indicating the supportive role that men can provide to their women.

Proper diagnosis of contraceptive users before prescription of specific contraceptives needs to be made mandatory by all contraceptive providers. The state could establish regulations on private clinics and pharmacies to ensure that they do the same given that private sector is still the major provider of contraceptives especially to FYLWHA. This will spare contraceptive users from using contraceptives that do not match with their body capability hence reducing side effects.

All public health centres could introduce something like a youth corner separate from the general dispensing hospital area where youths can get contraceptive services and other Reproductive health information. This would lead to improved access to contraceptives especially for young people given the free and friendly environment in the youth corners.

The government of Uganda through the Ministry of Health needs to further promote the right to health specifically contraception use. This can be done by allocating more resources in the family planning unit of all public health centres such that contraceptives are not out of stock for most of the time. In addition to that, more NGO operating with in the area of reproductive health could consider prioritising the effort towards promoting sustainable access towards contraceptives.

There is need to initiate private-public partnerships such that the private sector is contracted by the state to provide contraceptives to the public with increased subsidisation. This would lead to increased access of contraceptives to all and moreover at reduced cost.

Finally as Kalichman (2005) points out that behaviour change interventions for individuals still have an important place in the national HIV prevention plan, the role of social work institutions is in this case vital especially in increasing individual social functioning and to influence positive behaviour change in various forms. For example the need to adopt condom use and increased condom efficacy and issues of disclosure to loved ones.

CHAPTER SEVEN

7.1 References

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Appendices

Appendix one Consent Form

Hello, my name is **Brenda Nanyonga** and I am a student at Gothenburg University-Sweden. I am currently studying my International Master's degree in Social Work and Human Rights and one of the requirements of this course is for every student to write a Degree Report/ Thesis. I am therefore conducting my research which seeks to document the Experiences of Female Youths Living With HIV/AIDS on access and utilisation of contraceptives in Kawempe division, Kampala city-Uganda.

You have been purposively selected to participate in this study because you are relevant to the study, however your participation is highly voluntary because you have the right to decide whether to participate in this study or not to. Even after accepting to participate, you still have the right to withdraw before the interview has be concluded in case you feel like not continuing. During the interview, you have the right to decline answering any questions that you might not be comfortable answering.

You are kindly request to freely share your views and experience on the study topic because they are very important to this study. Please note that there are no wrong or right answers. Also know that the information you are going to give us will be handled with maximum confidentiality and will not be used for any other purpose except for this study. Please also be assured that your real names will not be used and therefore your views cannot be traced back to you.

Only if you agree, the interview will be recorded and that will only be for the purpose of documenting what is said during the interview and to also help the researcher be able to cross check during the analysis and presentation of findings. All the data collected will only be used in this study/ project and after finishing the project it can be destroyed.

In case you have any farther questions, you are welcome to contact me or my Supervisor using the addresses below;

Brenda Nanyonga: brendananyonga@gmail.com

Ingrid Höjer: Ingrid.hojer@socwork.gu.se

Do you have any question (s) regarding the information above?

Do you agree to participate in the study?

Yes, I agree. ☐ **No, I disagree.** ☐

Appendix two Semi-structure interview

Semi Structured Interview (for Individual Respondents)

1. Nationality (ensure respondent is Ugandan).
2. Age.
3. Marital Status.
4. Number of children if any.
5. What do you know of citizen's rights to health?
6. In your own view, how has the government of Uganda ensured that FYLWHA enjoy this right?
7. From your point of view, how do policy provisions on reproductive health care manifest into real services at lower/ community level?
8. Do you use contraceptives?
9. If yes, for how long have you been using contraceptives?
10. How do you access information on contraceptives?
11. How do you access the contraceptives you use? (Probe for sources and economic implication).
12. What motivates you to use contraceptives? (Probe for facilitating factors both individual and external).
13. What are your views on condom use?
14. Would you kindly share with me any particular experiences you have had while consuming contraceptives (probe for both positive and negative experiences)
15. What are your thoughts on other people's views on your use of contraceptives? Have you had any comments on your own use of contraceptives? (stigma)
16. (what makes you strong) What is helpful? What is not helpful? (resilience factor)
17. Do you belong to any social networks? (probe for type of network)
18. Do your networks influence your decision to use contraceptives in any way?

19. Does your family/relatives influence your decision on contraceptive use?
20. If yes, how?
21. How do other peoples' perception towards your sex as female influence your contraception use? (Probe for gender issues).
22. From your individual point of view, which are the barriers to contraception use?
23. What suggestions would you like to give regarding the improvement of contraception service delivery?
24. Do you have any question or some other comments about what we have discussed today?

Appendix three

Focus Group Discussion Guide

Introductions by all participants

Explanation of study purpose

Comprehension and signing of consent forms

Discussion

1. In your own view, how has the government of Uganda ensured that FYLWHA enjoy theirs right to health?
2. From your point of view, how do provisions on reproductive health care manifest into real services at lower/ community level.
3. How do FYLWHA access information on contraception?
4. How do FYLWHA access the contraceptives they use? (Probe for sources and economic implication).
5. What motivates FYLWHA to consume or use contraceptives? (Probe for facilitating factors both individual and external).
6. What sre the facilitating factors for your contraception use?
7. What are your views on condom use?
8. What are your thoughts on other people's views on your use of contraceptives? Have you had any comments on your own use of contraceptives? (stigma)
9. How do social networks influence FYLWHA to use contraceptives?
10. How does family/relatives influence FYLWHA to use contraceptive?
11. How do other peoples' perception towards your sex as female influence your contraception use? (Probe for gender issues).
12. Which are the barriers to contraception use by FYLWHA?
13. What suggestions would you like to give regarding the improvement of contraception service delivery?
14. Do you have any question or some other comments about what we have discussed today?
15. Conclusion remarks
16. Thank the group.
17. Close discussion.