IMPACT OF THE FAMILY SUPPORT GROUP INITIATIVE ON THE LIVES OF HIV POSITIVE MOTHERS IN KALANGALA DISTRICT

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Dedication

I dedicate this research report to my wife Norah, my children (Josiah, Janice and Jyra), and uncle Kizza Stephen and all the well-wishers for the encouragement, guidance and moral support given to me throughout my study time.

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Abbreviations

ANC	Antenatal care
ART	Anti Retro-Viral therapy
CRS:	Catholic Relief Services
EMTCT	Elimination of Mother to Child Transmission of HIV
FSG	Family Support Group
HIV	Human Immune virus
IUD	Inter Uterine Device
M2M:	Mother to Mother
MOH	Ministry of health Uganda
PMTCT	Prevention of mother to Child transmission of HIV
PNC	Postnatal care
SASLHA,	South Africa Speech Language Associations
UAC	Uganda AIDS Commission
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
VCT	Voluntary HIV Testing

VSLA:	Village Savins and Loans Association
WLH	Women Living with HIV
YCC:	Young Child Clinic
PSS:	Peer Psychosocial Support

Abstract

Family Support Groups are meant to be a behavioral support initiative for HIV positive mothers in a way that the mothers can encourage but also be encouraged by their peers in matters of seeking health services like antenatal care, delivering at health units, adhering to treatment, giving partner support among others which practices are likely to improve and promote health outcomes of HIV positive mothers (MOH, 2011). This study assessed the impact of facility based family group initiatives on the lives of HIV positive mothers attending EMTCT programme in Kalangala district. A convergent mixed method research design using both qualitative and quantities methods was employed to answer the research questions. There were no initial estimates for FSG coverage before the study but the study reached 269 HIV positive mothers and their partners in the EMTCT program. Only 155 had ever heard of FSGs of which 99 had ever attended a session.

This study found that FSGs offer meaningful peer to peer engagement amongst HIV positive mothers which ultimately improves their antenatal care attendance. Antenatal care attendance provided an opportunity for the mother to test for HIV but being part of the FSG enhanced the mother's confidence about own status and fostered disclosure to her partner. The study also found that male partners were a strong pillar in providing support in terms of transport, food and adherence support to their HIV positive partners. Additionally, men who participated in FSGs were found to be champions and peer educators despite their busy fishing schedules. This meant that social support avenues hinged on social learning and practice can go a long way in improving not only individual but group health needs. Despite the free additional benefits FSG provide, this study found that there was generally low attendance especially for the newly identified and enrolled HIV positive pregnant mothers. This was attributed to fear of being stigmatized as an FSG group associate.

This study suggested strengthened counselling during HIV positive mother initiation into EMTCT program. It would be further valuable to integrate the recommended FSG package with other health promotion initiatives within EMTCT. This study has documented the current FSG best practices which can be adopted for continuous learning to ensure that peer avenues of information sharing are exploited for improved HIV prevention outcomes.

Operation definition

Health out comes

Health outcomes is used to refer to changes in health service utilization and improved health of people exposed to family support group programme

Self-efficacy

It is used to refer to ability of an individual to make informed health decisions on individual health and the health of those one is living with.

Coping mechanisms

These are ways through which individual move on with life to ensure that their health goals are sustained as per the slandered health package

Mentor mother

This is a mother who successfully attends FSG sessions and performs to the expected level as per the EMTCT guidelines. She is an HIV positive mother who disclosed their HIV status, attended all ANC and PNC visits, adhere to their treatment and ready to help other women of the same status to do the same.

Male champion

This a male person with an HIV positive woman, who attends FSG meetings and is ready to help other male collogues to do the same. Such a person is willing to mobilize male partners to HIV positive women to attend and provide support to them.

FSG facilitator

A health worker who is designated to technically provide support to family support group's members through organizing sessions and holding members together to achieve their health goals.

CHAPTER ONE

1.1 Introduction

Family support groups are peer led sessions with routinely organized health education sessions, often facilitated by a health worker (MOH, 2011). Under such arrangement, HIV positive mothers lead each other throughout the sessions but are overseen by a health worker. Such initiatives usually take place within a health facility or at the community level, with the aim of emphasizing dialogue between different members, and therefore share knowledge about individual experiences, concerns and ideas about how to live more positive and productive lives even when they have HIV. Family support groups are led by beneficiaries who offer services to colleagues as peer mothers. "Family support groups comprise of HIV positive. They offer peer to peer advice, share stories and strengthen one another in areas HIV prevention, treatment and general wellbeing. Peer mothers have now increasingly become useful at health facilities where they attend EMTCT programmes as they fill in the gap where clinical staff are not enough. Peer mothers are champions in supplementing health workers' outputs as they facilitate information session through sharing their own lessons and experiences influences often influence positive attitude and decisions of other HIV positive mothers

. (AVSI, 2011) Page 8.

1.1.2 Family support structure

Family support groups are defined and structured as follows:-

Ministry of health Uganda in 2011 introduced FSGs as an intervention to virtually eliminate HIV transition from mother to child and improve health among HIV positive mothers and their families. Initially, each FSG would comprise of pregnant HIV positive, and lactating women, partners, care takers to HIV positive

and friends or family members. The guidelines recommended that each FSG has a manageable number of not more than 40 members. However, now days, the benefits and popularity of FSG have attracted more people including me and those interested in learning about HIV. In cases where there are many HIV POSITIVE mothers interested in joining FSGs, ministry advised that sub groups be formed for adequate interaction during sessions. These groups should however, be as similar as possible in terms of age, sex, special needs and attendance. FSG members can be recruited from: Health facilities; ANC, labor and delivery, PNC, ART clinic, young child clinic (YCC). Such a formation is intended to build capacity of all participants to be competent on AIDS and also be able to support each other on different coping arrangements.

FSGs were designed to offer peer psychosocial Support Services, Health Education and promotion, Counseling, Clinical Care Support Services, Family/Home Based Care follow up, Linkage and referral and male behavioral change massages

Furthermore, Hong (2011) argues that Family support groups enable mothers and their partners to acquire knowledge and skills about better health practices for living with HIV and facilitates learning and awareness about positive behavior change aimed at generally improving health outcomes through making the right choices. Peer education is part of health education which is a process concerned with providing a combination of approaches to behavioral change that can assist individuals, families, and communities in making informed decisions on matters affecting restoration, achievement, and maintenance of health. Peer education through Family Support Groups is an approach which aims at providing knowledge and information and also helps individuals build the necessary skills to cope with the negative effects of HIV/AIDS taking examples from their peers. In addition, women living with HIV and their partners during sessions, sing and pray together, and share successes and joys. The Peer Mentor shares her triumphs and challenges as a Woman Living HIV and acknowledges the importance of the support group for her

and do raise awareness about necessity of positive behavior. (Rotheram-Borus et al. 2011), This is because FSGs are strong a mechanism to enhance change because they utilize peer to peer approaches which promote trust, openness and confidence among people with similar characteristics; such as these HIV positive mothers.

Although there is no clear history on when family support groups in the health sector began. Dougy (2015), suggests that family support groups date even as back as the 1970s and 1980s, in Uganda they were mainly emphasized with the elimination phase of mother to child transmission in 2012. This because the initiative is viewed as a people centered intervention by the Ministry of Health geared towards improving maternal and child health outcomes for HIV positive women, partners and their HIV exposed infants.

Elsewhere, in Africa Family Support Groups have been successful in countries like Ethiopia and South Africa where success stories have been recorded and shown effectiveness. In Ethiopia; successes were recorded in improving health outcomes for mothers and in South Africa, support groups' successes were shown in managing substance abuse (SASLHA, 2016 and ADAA, 2016). Family support groups are used not only in HIV situations but in different health conditions like Stroke, in people living with drug abuse, cancer, victims of gender based violence, in mental health, in family planning and several condition that require social support.

Therefore PLHIV form support groups to give and receive emotional, social and spiritual support. They also form support groups to develop and sustain positive strategies for living with the virus and to strengthen their knowledge about HIV and AIDS. The group is a place where PLHIV can share experiences confidentially, gain self-confidence, make friends and develop a public voice. (CRS, 2008). Therefore, Bateganya et al (2016) Family suggests support groups as an intervention to

address retention and adherence among PLHIV receiving ART according to World health Organization (WHO) guidelines.

In supporting HIV positive mothers, Family Support Groups members are meant to encourage peers to follow their treatment regimens, to give birth in a health facility to reduce the risk of transmission during delivery, teach mothers breastfeeding practices, family planning, as well as the importance of disclosure to a partner and the need to get all partners to come and test for HIV together. Through these peer-led education sessions and discussions, HIV positive mothers are expected to increase knowledge, change in attitudes and behavior, and therefore make voluntary decisions towards improving antenatal care attendance, delivery in health facilities and also on whether to encourage their male partners to get involved in maternal health as outcomes of the engagements during family support groups.(MOH,2011). However, it should be noted that, decisions on changing behavior remain voluntary and based on individual perceptions of the messages received. Discussions held during family Support Group sessions, therefore are intended to create a learning environment for health promoting behavior.

Based on the above, Kalangala district started in 2012 to implement EMTCT family support groups to reduce on HIV transmission from mother to the exposed infant and improve health outcomes of HIV positive women.

1.2 Background to the study

In the way of galvanizing efforts to tackle the HIV epidemic amongst mothers and their children, the family support group initiative is seen as one way of improving lives of HIV positive mothers through increased utilization of antenatal, delivery, postnatal care and individual health services. This was intended reduce mother to child transmission of HIV, morbidity and mortality of mothers living with HIV in the course of child bearing.

The family support group initiative for EMTCT was adopted in Uganda to emphasize meetings where a number of people including but not limited to HIV positive mothers address HIV prevention, treatment and care issues. In such settings, mothers and their partners come together to share their experiences and to offer support to one another. This is a gentle and slow process of meeting, sharing experiences, growing together and supporting each other in a simple human way (Sadie, 2010). Family support groups do this through listening, compassion, supporting and encouraging hope in times of deep distress. Family support groups place a high value on confidentiality amongst their members whereby all members promise to respect the private stories of their fellow members (Sadie, 2010).

The FSG initiative seeks to improve health service uptake, from antenatal care through to postnatal service uptake for HIV positive women. Family Support Groups are essential to achieve the United Nation and World Health Organization's virtual elimination of mother to child transmission target. The EMCT Family support groups can increase HIV-positive women's awareness of PMTCT services, and build their confidence to access PMTCT services (IAS, 2014).

In Zambia, there was a need for Family Support Groups formation so as to encourage awareness and openness about HIV to fight against discrimination, people are enlightened that HIV is not a

death sentence, so as counter the generalization that people with HIV brought it onto themselves by promiscuous behavior and above all, support groups help overcome fear of rejection by spouses, family and friends (Treatment Action Campaign, 2015).

In addition, the Elizabeth Glazer Pediatric AIDS Foundation (EGPAF, 2015) suggests that provision of community and psychosocial support provides mechanisms for women to create strong support systems that enforces health-seeking behavior and patient-driven care and consequently improve the quality of life. World Vision (2012) also agrees with EGPAF (2015); and explain that Mothers' Support Groups provide a safe space for women to discuss challenging issues such as testing, partner disclosure, breast-feeding and infant care. However, important to note is that they have sensitive, trained, facilitation and linkages to PMTCT services at facility and community level (World Vision, 2012).

In Ethiopia, the International Training & Education Center for Health (I-TECH), with support from the U.S. President's Emergency Plan for AIDS Relief, began managing support groups for HIV-positive pregnant women and mothers in three regions of Ethiopia: Axum, Gondar, and Dubti (I-TECH, 2015). This program was the first of its kind in the country, training a group of mentors offering psychosocial support to help mothers adhere to prevention of mother-to-child transmission (PMTCT) programs. As a result of the program from 2009 to 2014 were implemented, nine hundred mothers were enrolled in the mentorship program at Gondar University Hospital. Out of those 900 births, only 72 infants or 8 percent tested HIV-positive. The World Health Organization estimates that, in the absence of any intervention, transmission rates can range from 15-45 percent. In addition to urged mothers to follow treatment regimens, support groups encouraged mothers to give birth in health facilities to reduce the risk of transmission during delivery. They teach mothers breastfeeding practices, family planning, as well as the importance

of disclosure to a partner and the need to get all partners to come and test for HIV together at the health facility. Peer- led psychosocial support is critical to increasing awareness about the available choices for the HIV positive mothers and therefore increases treatment rates which as a result ensures more children are born HIV-free. (I-TECH, 2015).

In Uganda, the family support group initiative was adopted in 2011 to fuel the fight against HIV infection amongst infants of HIV positive mothers through increased and sustained capacity building through peers and health workers on a regular basis. Additionally, this frame work provides an opportunity for PLHIV to create a bond with their service providers for better health outcomes relating to maternal health through associated risk reduction. M2M (2016) shows that family support groups have worked in the provision of health education and emotional support through both one-on-one and family support group sessions. Ministry of Health further strengthened the roll out of the strategy as part of the Option B+ program, in East Central Uganda in April 2013, Mentor Mothers helped pregnant women access lifetime antiretroviral (ARV) treatment through the family support groups to contribute to the prevention of HIV transmission to he exposed infant and health outcomes of the mother. During the second quarter of 2013, the proportion of pregnant women and new mothers linked to lifelong treatment during the family support groups increased from 16% to 46% compared to the previous quarter.

1.2.2 The Family Support Group initiative

Family support is a gentle and slow process of meeting, sharing experiences, growing together and supporting each other in a simple human way. Family support groups do this through listening, compassion, supporting and encouraging hope in times of deep distress. Family support groups place high value on confidentiality amongst their members whereby all members promise to

respect the private stories of their fellow members. Confidentiality is the essence with regard to family support group meetings (Family Support Network, 2010).

The family support group guidelines provided for Facility based family support groups and community based family support groups. Health Facility based Family Support Groups are stationed at health units. Family support groups are meant to contribute the empowerment of HIV positive women to address HIV stigma and transmission. Because of gender inequality, women often are more affected and fear to disclose for fear of violence from male partners for instance, with the era of elimination of Mother to Child HIV Transmission (eMTCT) (NAFOPHANU, 2013). In FSGs, members are supposed to stay for approximately 2 years to ensure continuum of care from the facility to community. During the postnatal period, women/couples will need to get the recommended PNC/FSG care package until the babies are 18 months to enable improved health of the mother and her infant (MOH, 2011). HIV/AIDS related Stigma is associated with poor psychological and mental health outcomes (Logie and Gadalla, 2009) and affects work and family life. However within peer group settings, trained mother mentors are supposed to help their HIV-positive peers address unmet needs for understanding HIV, psychosocial support and acceptance, self-care, infant care, and over the longer term, economic needs (MSH. 2014). Therefore the package of services that family support groups are meant to provide include basic understanding of HIV prevention, psycho-social support, adherence counseling, promotion of facility delivery, encouragement of male involvement and family testing, group support, proper mother and infant feeding. However, family support groups are meant to deeply contribute to the elimination new pediatric HIV infections and improve maternal, newborn, child health and survival in the context of HIV. (Esiru, 2013). Women were further challenged by household decisions and fear of losing marital stability because of HIV programmes for example. Malaju and Alene (2013) study in

Ethiopia confirmed that Majority of the women expect termination of financial support and marriage disruption from their partners if they are found to be HIV positive. This reflects challenges involved in evaluation of complex community- focused interventions that have aims of promoting social change. (Abramisky et al, 2012). It's important to understand that the FSG groups set up and how it contributes to the health of people making them as a health promotion network in communities.

With several successes across different countries in Africa including Ethiopia and South Africa, and internationally as recommended by the World Health Organization, the Ministry of Health in Uganda adopted the use of Family Support Groups (FSG) initiative in the elimination of mother to child transmission of HIV. FSG members discuss and build peer psychosocial support to live positively and improve their health seeking behavior which leads to better access to treatment and care (MOH, 2011).

Family support groups maintain the strategic pillars of the national EMTCT program which include male participation, increased uptake of antenatal and postnatal services to foster better lives. High-quality evidence on the effect of FSGs on EMTCT programs is desired to inform whether investment to establish Mothers Support Groups/Family Support Groups throughout health facilities is justified for improved health outcomes. This is because FSG initiative is intended to provide an opportunity to people to take lead of their own affairs by creating an enabling environment for HIV positive women, male partners, family members and exposed infants to address their health needs and achieve better health.

Therefore, the study intended to evaluate the impact of Facility based family support groups' initiative in promoting health outcomes of HIV positive mothers in Kalangala district.

1.3 Problem statement

In Uganda, maternal morbidity and mortality remain high amongst HIV positive mothers largely due to inadequate antenatal care (ANC), low skilled deliveries and poor quality of other maternal health services (Ediau et al, 2013) and the maternal mortality ratio represents slow progress in improving health of mothers. (UAC, 2015) In order to address both the demand and quality of ANC, PNC and skilled deliveries, there is need for interventions focused on community and health facility linkages. In ensuring positive health outcomes amongst HIV positive mothers, family support groups were identified as a strategy to improve the performance of health programs in Uganda for HIV positive women and their HIV exposed infants (EGPAF 2015) through creating linkages with individuals and families of women living with HIV

The adoption of family support groups was intended to result into improved health seeking behaviors of HIV positive pregnant and lactating mothers and therefore result in improved health outcomes more so for the EMTCT program (Harvey, 2013). Health outcomes for FSG are basically in line with ability to overcome stigma, make informed and well oriented choices for their health as individuals and as a group and for the community they live in. However, there were no documented efforts on the impact FSGs on lives of HIV positive mothers and improving their health seeking behaviors in Kalangala districts since the programme was initiated in 2012. There is limited information in providing evidence on how the FSG approach provides the chance to women and their partners to build interpersonal relations, confidence, voluntary decision making, skills building, creating channels for action, linkages and referrals amongst the community associated to it. HIV positive women have continued to attend FSG sessions on several occasions but little is documented evidence to measure the association of health outcomes with the existence of FSG on health facilities. That is in terms of knowledge, adoption of coping mechanisms and

attraction and mobilization of male partners to support the programme. Therefore, the study aimed at providing evidence on whether family support groups have been effective in improving lives of HIV positive women in Kalangala district.

1.3 Research questions

The Research questions that guided the study include the following:

1. What is the role of the Family Support Groups' approach in empowerment of HIV positive women to access and utilize antenatal and postnatal care services?
2. How do Family Support Groups improve self-efficacy amongst HIV positive women?
3. What is the role of Family Support Groups in enhancing male involvement in antenatal and postnatal care for HIV positive women?

1.4 Objectives of the study

The general objective of the study was to evaluate the impact of family support groups' initiative in improving health lives of HIV positive mothers in Kalangala District. The study evaluated the impact of family support groups processes to health seeking behavior of HIV positive women. Such behaviors included increased access and utilization of antenatal care, postnatal care, male involvement in maternal health care, individual health improvement and adoption of health promotion behavior for HIV positive women and their families

1.4.1 Specific Objectives

1. To assess the role of the Family Support Groups in improving health seeking behavior of HIV positive mothers in seeking antenatal and postnatal care services
2. To examine the role of Family Support Groups in improving self-efficacy mechanisms amongst the HIV positive mothers
3. To assess the role of Family Support Groups in enhancing male involvement in enhancing male involvement in open and free peer to peer Antenatal, post natal and HIV education talk/programme

1.5 Significance of the study to public health and health promotion

People living with HIV are of paramount importance to public health and health promotion given their central role in the HIV/AIDS response. The study targeted FSG arrangements and initiatives that are oriented on the values of health promotion like empowerment, peer learning, behavioral change, respect, dignity and fulfillment of rights and freedoms of humans. Family Support Group initiatives were considered because of their structure and organization which is oriented on critical aspects of health promotion like empowerment of people and their involvement in modifying social determinants of health that influence lives of people living with HIV in child bearing age.

The study also specifically amplified voices and actions of women living with in a critical public health state of self-care and that of their exposed infants. The study looked at coping mechanisms, utilization of health services within the FSG package, male involvement and above all, peer learning through experience sharing and monitoring.

Related to the above, the study context has several interacting players who have contributed to the programme guided by lessons learnt from countries that succeeded in implementing the same initiatives in other communities.

Therefore, the study directly fits within the context of health promotion with its interest of enabling people to take lead their own affairs regardless of their circumstances

1.6 Scope of the study

The scope of the study was categorized into:

Content Scope

The content scope of the study was the implementation and impact of the Family Support Groups on lives of HIV positive mothers and their partners in Kalangala district.

Geographical Scope

The geographical scope of the study is Kalangala District. Located within Lake Victoria, the District is composed of 84 islands although the study area was on Buggala Island, in Bujumba HSD.

Time Scope

The time scope for the study was the period between 2012 and 2015.This period was sufficient enough to analyze the implementation of Family support groups within the EMTCT program and for focus on how changes had been achieved overtime in line with its impact on the lives of HIV positive mothers

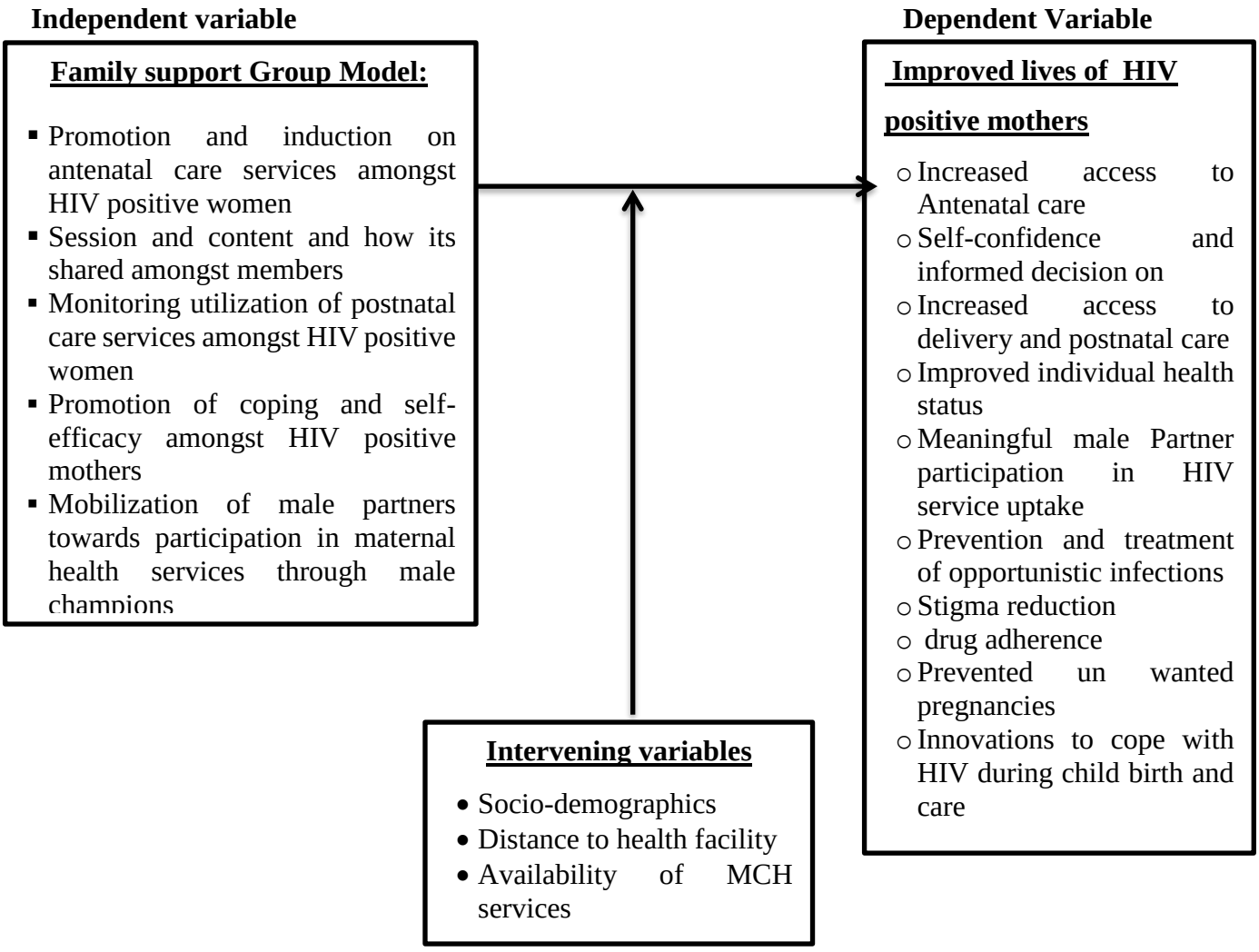
1.7 Justification of the study

Amongst the districts in Uganda, Kalangala district is one of the highly affected areas by the HIV scourge with the HIV prevalence estimated to range between 18 to 23 percent (KDLG, 2015). Due to the fact that the district is male dominated because of its social economic structure which attracts largely male population from different location in the country with a high HIV prevalence. Efforts had been made to have EMTCT implemented within all the district's health facilities as a way to curb the infection rate. In the same, Family Support Groups were introduced by the Ministry of

health to help and handle the dominant challenges of stigma, discrimination, psychosocial needs, disclosure and gender-related impediments to comprehensive HIV care. The mentioned challenges affected negatively the quality of lives of women living with HIV in child bearing age. Therefore Family Support Groups were intended to enhance and contribute improvement of maternal health outcomes.

Stigma and discrimination are regarded as strong impediments to building confidence, courage and capacity to make informed decisions on lives of HIV positive mothers yet social learning in family support groups is intended to facilitate health promotion. The Family support group initiative was deeply oriented on the belief that individuals do have a better chance of achieving their health goals when they can participate with other people who are affected by the same or similar circumstances to build inter-personal trust and trust in public institutions (Laverack, 2006). There is an obvious need to evaluate the effect of family support groups in improving maternal health outcomes, hence the need for the study.

1.8 Conceptual frame work



Source: Researcher

The figure above shows the conceptual framework of the study. It explains how the independent variables that make up the family support group initiative which include promoting the utilization of antenatal care services, postnatal care services amongst HIV positive women, and mobilization of male partners towards participation in maternal health services uptake. Decision making, which leads to improvement of in lives amongst HIV positive mothers which include; Increased timely access to Antenatal care, positive attitude towards facility based delivery with a skilled birth

attendant, utility postnatal care, and increased male involvement in EMTCT within the study. The framework also shows the variables that intervene into the relationship between the independent and dependent variables and therefore influence the significance of this relationship. These include socio-demographics, distance to health facility, availability of MCH services, knowledge about the available services, ability to make well informed decision that appropriate to culture and social set ups in communities being studied

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Chapter two explores available literature concerning the use of family support groups and how this influences maternal health especially on approaches used in improving the health of HIV positive women and their families. The family support group targets the health of HIV positive pregnant and lactating mothers and their partners. Efforts were made to provide a detailed exploration of some of the variables important in determining health of HIV positive pregnant and lactating mothers. This chapter provides evidence and descriptions from literature on how groups promote health for their members with a deeper concentration on seeking and utilization of antenatal care (ANC) and Postnatal care (PNC) services promoted by Family Support Group initiative. The effectiveness of the FSG approach in promotion of attitudinal change on norms, values and mobilisation of male partners to support the health of HIV positive women was central in this literature.

2.1.1 FSG Initiative and theoretical perspective

This study has linked Family support group initiative theoretically to social support mechanisms, social support is taken to mean a social network's provision of psychological and material resources intended to benefit an individual's ability to cope with stress (Cohen, 2004). This research is built on perspectives of social learning theory.

The Social Learning Theory asserts that people serve as initiative s of human behavior, and some people (significant others) are capable of eliciting behavioral change in certain individuals, based on the individual's value and interpretation system (Bandura, 1986). The Social learning theory developed by Albert Bandura, was constructed on the belief that behavior is learned by observation,

imitation and positive reinforcement. Role models facilitate learning, unlearning that individual's recreate behavior that they have observed directly. The theory further postulates that people learn after noticing the benefit of actions they have observed and other people perform (Jones and Bartlett2013). Social learning theory further constructs that people are driven not by inner forces, but by external factors which suggests that human functioning can be explained by a triadic interaction of behavior, personal and environmental factors. This is often known as reciprocal determinism. Environmental factors represent situational influences and environment in which behavior is preformed while personal factors include instincts, drives, traits, and other individual motivational forces (Goslin, 1969).

Family support groups for People living with HIV/AIDS are more of social learning centers where changes in the lives of people are through observed practice and self-efficacy, individuals in this setting are expected to observe and adopt positive living behavior. Members interact in a setting predetermined to influence their attitudes and actions through meetings, sessions, technical facilitation and experience sharing across all participants. Social learning theory was further be connected to Lavarack (2006) assertion that individuals do have a better chance of achieving their health goals if they can participate with other people who are affected by the same or similar circumstances to build inter-personal trust and trust in public institutions. Family support groups encourage use of participatory learning exercises in women's groups in a poor rural population. In the same argument family support groups provide a chance for people living with HIV especially pregnant and lactating women living with HIV to come together and work on issues that affect them through learning enhances decision of informed choices for better their health outcomes.

Therefore social learning theory was very important in providing linkage with the way family support group initiative health packages in addressing health needs of women living with HIV and their HIV

exposed infants. Family support group initiative reflects on different stages and processes involved in as per the MOH policy of 2011which included mobilization, antenatal visits which are supposed to be four and subsequently delivery and postnatal service uptake. Therefore, it was of value to approach the study using social learning theory in evaluating Family Support Group initiative in improving health outcomes of HIV positive women, families and their partners.

1. 2.2 Role of the Family Support Groups' approach in improving health seeking behavior of HIV positive mothers in seeking antenatal and postnatal care services

Pregnant women in general and first-time mothers in particular are provided with a vast amount of information in similar settings. Such approaches help to address MTCT among pregnant women who are known to be HIV positive and able to access the health service. Some of the pregnancies among women living with HIV are unintended (Habte and Namasasu, 2015)

Many women, especially first-time mothers, attend antenatal classes which prepare them for labour and delivery, and usually include basic baby care skills (Nut-beam, 2015). Antenatal care provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the newborn, promotion of early, exclusive breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes (Lincetto et al , 2015) . Also antenatal attendance provides an opportunity to inform or educate pregnant women about pregnancy, childbirth and care of the newborn, and therefore enable pregnant women acquire information on danger signs of pregnancy or childbirth. It was anticipated that from antenatal care, women are assisted to develop a birth plan that ensures birth preparedness and readiness in the eventuality of pregnancy or childbirth complications. In line with family support group process in line with antenatal services, women are empowered to develop a birth plan which is

expected to assist women in making choices that would contribute to good pregnancy and general maternal health outcome (Kakaire et al, 2015) during and after delivery of a child.

In addition, antenatal care use represents maternal health literacy which is very important outcome of family support group sessions and referred to by Renkert and Nut-beam (2003) as social and cognitive skills which determine the motivation and ability of women to gain access to, understand and use information to promote and maintain their health and that of their children.

Furthermore, Mojoyinola (2011) continued to present a case for better health through health literacy sessions for those who had attended regular classes of antenatal care as it could significantly improve their health seeking behavior. This provides an opportunity for women to identify and treat problems such as anemia and infection to improve their health in a timelier manner. In the same line of thought antenatal care is a very critical component for expectant mothers living with HIV. HIV positive pregnant women are required go through antenatal learning process to enable them improve confidence, decision making and get all services that promote their health and general well-being. An exploratory study done in Kabarole district by Duff et al (2010) in Uganda revealed that pregnant and postnatal women who are successful on HAART have little risk of transmitting their HIV infection to their babies, this had huge relevance for the wellbeing of the women being treated, their infants and their entire families. However, no clear details are given on how the process is structured to influence behavioral change for better health outcomes.

Though Garner eta al (2013) picked a different direction and related economic status of women to maternal health and concluded that women in low-income settings may have limited influence over their own reproductive health needs, such as the possibility to decide when and where to seek health care and its consistent with similar thoughts presented in the three maternal health delays model by

Thaddeus S, Maine D (1994) presented used by Save the Children in a report on its application during a study conducted in Malawi, Nepal, Bangladesh, and Uganda on health care-seeking practices available through baseline and end line household surveys. The initiative reflected on three delays of maternal health which included delay in recognition of danger signs and decision to seek care, delay in obtaining adequate and appropriate treatment and delay in reaching an appropriate source of care which are of health promotion significance. This application has similar intentions like those of the family support initiative used to improve the health of mothers and their infants.

Furthermore, Kalule et al (2014) added that three measures of maternal health care services were examined, namely visits to antenatal clinic, tetanus toxoid injection and place of delivery. Using binary logistic regression model, it was found that urban women are more likely than their rural counterparts to use antenatal care services, receive tetanus toxoid injection and deliver their babies in public health facilities. The same positive association was observed between a woman's educational attainment and visit to antenatal care clinic, place of delivery and tetanus toxoid injection. However, this study did not examine methods and approaches used in delivering services and how they (approaches) impact on the health of the mother especially in circumstances of HIV sero-positivity in a localized setting. Concentration is on maternal reproductive service with limited analysis of how delivery of services empowered individuals to take lead of their own affairs. Therefore it's very important to understand how specific initiatives like the Family support group initiative contributes to improving the health of HIV positive mothers through empowering them to take lead of their own lives beyond comparison of factors.

The postnatal period, defined as the time immediately after the birth of the baby and up to six weeks (42 days) after birth, is critical for the newborn and the mother. Immediately after birth, bleeding and infection pose the greatest risk to the mother's life, while preterm birth, asphyxia and severe infections

pose greatest risk to the newborn (Khanal et al. 2014). Family support group formation is intended to create an opportunity for increased utilization of postnatal services by HIV positive mothers to reduce on the likely problems that come with child birth. In the Ugandan demographic health survey of 2011 only 33% of women with live birth utilized post natal services and large percentage did not of 64% including HIV positive women. Further in a cohort study conducted by Phillips et al (2014) on a total of 358 HIV women in South Africa also revealed that the rate of disengagement appeared higher in the ANC/ ART site post-delivery and lower in the ANC ART site prior to delivery, compared to rates among women in the general ART clinic. Therefore, this demonstrates that missed visits and disengagement from care occur frequently, particularly during post-delivery among HIV-positive women initiated ART during pregnancy. On the other hand, provision and promotion of contraceptives in HIV services and as a routine part of postnatal care has shown increased uptake by HIV positive women but information about how these interventions affect unintended pregnancies or other health outcomes is lacking but information about how these interventions affect unintended pregnancies or other health outcomes not well shared across population (Kendall et al, 2014).

It is important, to evaluate and understand whether family group initiative is addressing specific needs of HIV positive women behaviorally. However, there is limited information on the use of the family group initiative as part of a postpartum retention strategy which sets in an opportunity to study where it supports retention of mothers through peer support.

2.3 Family Support Groups and improving self-efficacy strategies amongst HIV positive women

Family support groups were inspired by the development of community-based care initiatives in some settings, support groups provide an opportunity for PLHIV to share experiences and become more engaged in their health (Bateganya et al, 2015).

Family support groups enhance self-efficacy, which is used to describe an individual's confidence in successfully performing a behavior. Individuals with more self-efficacy are more likely to attempt behavioral changes since they believe that there will be success and it shapes the initiation of a behavior, amount of effort put towards that behavior, and length of time the behavior is sustained in the presence of obstacles or challenges. A strong sense of efficacy enhances human accomplishment and personal well-being in many ways. People with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. Such an efficacious outlook fosters intrinsic interest and deep engrossment in activities. They set themselves challenging goals and maintain strong commitment to their accomplishment (Bandura, 1994). The study therefore reflected on individual abilities as they got into contact with the FSG programme.

It is further argued that PLHIV find support group membership to be so rewarding that members sometimes have frequent unscheduled meetings and add other innovations to keep together (Atucungwire and Namarah, 2012). The interactions in social groups provides for opportunity to complement the health system. However, it is argued differently that there is largely untapped, potential of families and communities that must be harnessed to bring demand for quality services to scale in supportive environments. In turn, families benefit from social protection mechanisms to help them cope with the challenges of AIDS and to remain enrolled in programmes (Nigel, 2011). This evidence provides that social support mechanisms are important in promotion of health services.

Advances in the medical management of HIV disease hold the promise of extending the life expectancy of persons living with HIV disease. Enhancing quality of life and alleviating adverse psychological sequel among persons with HIV disease is of increasing importance as people learn earlier of their HIV-infected status and as improved medical treatment extends their life expectancy (Nakagwa et al, 2013). However, one of the difficulties often faced by persons with HIV involves coping with the loss of others to AIDS (Bateganya, 2015). The prevalence and adverse mental health consequences of AIDS-related bereavement have been established within communities that experience repeated losses of friends, lovers, and family members; people who are HIV positive consistently report the highest level of distress. Although people have always been confronted with loss and bereavement, loss due to AIDS carries unique ramifications that complicate adjustment and coping as there emerging demands for households. AIIDS-related bereavement among those who themselves are HIV-infected may adversely affect quality-of-life and psychological coping with their own HIV disease (Sikkema, 2016).

An assessment done in Pune India among HIV-infected individuals, focusing on coping strategies and their relationships with various domains of quality of life (QOL) found that most of the infected individuals adopted emotion-focused strategies through cognitive reframing and acceptance of their HIV status. One-third adopted problem-focused coping and sought health care, scientific information and social support. Significant associations of coping strategies were observed with marital status and work and earning domains (Rewa et al., 2014). The results of this study show that social support groups are identified as key in improving the coping strategies of people living with HIV/AIDS; this why the study focuses on evaluating whether Family support groups improve the coping mechanisms of HIV positive women to address their health needs, mainly in the islands of Kalangala.

In a similar way, Udobong (2015) investigated the relationship between family support and the coping strategies of women living with HIV/AIDS. The analyses revealed that significant relationship exists between care giving, favorable social attitude, and effective communication (exposure to information) and coping strategy of women living with HIV/AIDS. The authors recommend that the family should show itself as the most fundamental institution for the successful management of HIV/AIDS; and conclude that the family should develop favorable social attitude, provide proper and good care and sufficiently expose women living with HIV/AIDS to appropriate information to build their attitude, confidence and capacity to make decisions that promote health.

However, Kumar et al., (2015) say that a positive attitude towards the illness sets a proactive framework for the individual to cope with his or her infection; therefore, health coping mechanisms are essential to combat HIV-related stigma and discrimination. That research found that People Living with HIV use several positive strategies, classified as Clear Knowledge and Understanding of HIV, Social Support and Family Well-Being, Selective Disclosure, Employment Building Confidence, and Participation in Positive Networks. Poor understanding of HIV and fears of being labeled immoral undermined healthy coping behavior, while improved understanding, affiliation with support groups, family support, presence of children, and financial independence enhanced PLHIV confidence, such positive coping behaviors could inform culturally relevant interventions.

In conclusion, Vikas and Baral (2015) after a review that aimed at examining and analyzing the feelings, experiences and perceptions of Women living with HIV (WLHIV) and the role of support groups as a coping strategy, suggested that Support groups should be offered as a fundamental part of HIV/AIDS interventions and should be advocated as an effective and useful intervention. Further research is needed to examine the effect of support groups for women living with HIV especially

members of those settings, hence the need for evaluation of the effectiveness of family support groups with in a mixed methodological approach.

2.4 Mobilisation of male partners to support maternal health

Social support groups like family support groups are believed to increase rates of retention-in-care of HIV-positive mothers and their exposed infants, increase male participation, and improve other maternal and infant health outcomes. (Foster et al 2014). The formation of support groups specifically for men provides men with dedicated social space to negotiate, question, and re-form their concepts of masculinity. Adele (2012) presents that through these groups, men often maintain their masculine identity as the provider and protector, but they re-define the behaviors necessary to fulfill their role in promotion of the health of HIV positive women.

Male involvement in pregnancy and childbirth influences pregnancy outcomes and reduces negative maternal health behaviors, risk of preterm birth, There is epidemiological and physiological evidence that male involvement reduces maternal stress (by emotional, logistical and financial support, increases uptake of prenatal care and leads to cessation of risk behaviors such as smoking (Kaye et al, 2014).

Male involvement gives the opportunity for communication on the issue of equality between men and women. The process of empowering men, regarding reproductive health issues helps them to be more sensitive to women's needs and therefore supportive of participating in efforts of enhancing wo men's status (Dutki, 2010). Therefore in the study, the researcher intends to establish whether there is a positive association between the existence of family support groups and male involvement, so as to support or reject the strategy as one of the best interventions to improve male involvement in maternal health care.

HIV positive women desire support of their partners at every level. However involvement of males is still unrealized and dependent on a number of factors, one of which is women empowerment. Empowerment of women is argued to influence male involvement in health service uptake (Jennings et al, 2014) like women with stable income and capacity to make decision at household level. However, there limited linkage with an effective session of behavioral change and male involvement in maternal health of HIV positive mothers through an organized approach like family support group for HIV positive women of health literacy and theoretical initiative . Therefore, it is important to evaluate how effective the family support group initiative approach is in addressing health needs of HIV positive. Therefore, the element of female empowerment as a result of knowledge acquisition of knowledge through family support groups will be examined as part of the study to appreciate the contribution of the entire initiative

Mobilization of males to support maternal health is of value and important to ensure safety, men's involvement during pregnancy and childbirth plays a vital role in the safety of their female partners' pregnancy and childbirth, by ensuring access to care and provision of emotional and financial support and guaranteeing women's access to reproductive health services in general. Kaye et al (2014) Furthermore, male involvement in various health practices is recognized as an important factor and a crucial component in the optimization of Maternal and Child Health (MCH) services which improve maternal and child health outcomes (Dumbaugh et al, 2014, Ditekemena et al, 2012), and understanding the strategies that health care providers employ in order to invite or mobilize men to participate in maternal health care is very vital especially in today's dynamic cultural environment. Effective utilization of such strategies is dependent on uncovering the salient issues that facilitate male participation in maternal health care service utilization which was a major focus of this study.

A qualitative study done in Malawi by Kululanga et al (2012) highlighted several strategies used to invite men to participate in maternal health care at health facility, family and community levels which included partner notification, provider initiative, couple initiative, community mobilization and sensitization with the intention to increase pro-activeness of males in health service uptake for their partners at family level. The same strategies are usually employed during Family Support Groups. Of all the strategies, as explained by Kululanga et al (2012), the couple strategy was most appropriate although mostly used by educated and city residents with limitations of addressing all needs of individuals especially confidence building and self-belief after knowing HIV status. Additionally male peer strategy which is believed to be effective and sustainable at community level and desired in promotion of health of HIV positive mothers. Kululanga's study generalized health facility, family and community interventions without explaining the type of facility and community interventions used. This is why the current study is focused on facility based Family support groups in order to clearly evaluate how these interventions create change within HIV positive mothers especially in group settings.

An alternative study in Ethiopia revealed male participation challenges in promoting health amongst pregnant women in a cross-sectional study that was conducted by Haile and Brhan (2014) among pregnant mothers attending ANC/PMTCT found that; only Twenty percent (20%) of pregnant mothers had been accompanied by their male partner to the ANC/PMTCT service centres as couples. Another study conducted in Nepal showed that about 40% of males accompanying their partner at ANC follow up Bhatta (2013). Similarly, a study conducted in Uganda revealed that 42.7% of women attending ANC were accompanied by male partner for ANC Nantamu (2011). More surprisingly, the findings in a study conducted in Eastern Ethiopia by Fekede Asefa et al (2014) showed that 52.6% of the women were never accompanied to any of their ANC visit and only 19.7% were accompanied by their male

partners during their current visit. The reason why they were not accompanied to the visit were identified to be a pretext of being preoccupied with work, lack of knowledge that pregnancy could result in different complications, a belief that the ANC is the issue of women's only, male's feeling shame to accompany. More to that are the social constructions of masculinity in patriarchal societies with patriarchy often limit the ways in which men are "allowed" to engage in pregnancy, birth and child rearing. In many societies social space is not afforded to men who want to engage more in care taking and those who do are often stigmatized or discouraged (Nyondo et al 2014). This brings in arguments on gender norms are consistent with other studies that have been explored earlier on male involvement in other areas of maternal health.

Furthermore, Ditekemena et al (2012) concluded that factors that affect male involvement are interrelated among and within individual, community and health facility Factors, such that a successful male Involvement programme requires a multifaceted and multilevel approach that includes all the factors involved like Socio-demographic factors such as level of education, income status; health services related factors such as opening hours of services, behavior of health providers and the lack of space to accommodate male partners; and Sociologic factors such as beliefs, attitudes and communication between men and women. Indeed these thoughts are consistent with several studies on maternal health and male involvement looked at earlier and presents an opportunity and desire to understand how the family support group initiative implementers in public health facilities appreciated male involvement as a strategy to directly or indirectly improve health outcomes of HIV positive mothers.

In addition, a cross-sectional survey by Tweheyo et al (2010) used multi-stage sampling in 12 villages of Omoro county in northern Uganda to select 331 married male respondents aged 18 years or more, whose female spouses had childbirth within 24 months prior to the survey. Findings revealed that

men who were knowledgeable of ANC services, obtained health information from a health worker and whose spouses utilized skilled delivery at last pregnancy were more likely to accompany their spouses at ANC, unlike those who wanted to have more children and lived more than 5 km from the health facility. These findings suggest that empowering male partners with knowledge about ANC services may increase their ANC participation and in turn increase skilled delivery which is of value to HIV positive women and their new unborn baby. It's important to place greater emphasis on women empowerment in order to combat the spread of AIDS. (Gerritzen,2012) It is clear however, that improvement of antenatal care services by making them more male friendly, through health education campaigns to change beliefs and attitudes of men are absolutely needed through effective initiative s and methods. Is further argued by Iwelunmor et al (2014) that It is critically important to clearly develop effective family-oriented, culture-centered community-based PMTCT programs in improve the low uptake of PMTCT services Therefore, based on the above studies, it's important to study the family support group initiative specifically on its role in improving the health of mothers through peer support and empowerment to seek health services.

In conclusion, literature related to the subject in the study area was hardly available and that from other parts of the world was not specific on the impact of family support groups on lives the lives of HIV positive mothers targeted by the EMTCT programme. There was a gap in providing more evidence on how people living with HIV utilize social learning spaces to improve their health while testing associations with attendance in family groups.

CHAPTER THREE: METHODOLOGY

3.1 Introduction:

Chapter three presents the research methodology.It includes the research design, study area, study population, sample size, sampling techniques, data collection methods and how the data was managed, and later used to answer the research questions.

3.2 Research design

The study employed a case study research design. According to Zainal (2007), a case study is a study method that enables a researcher to closely examine the data within a specific context like a small geographical area or a very limited number of individuals as the subjects of study. In the same line the study was carried out in Bujumba Health Sub-district within Kalangala district.

However, conclusions from the results of the study represent the status in the whole district it was a case study. A convergent mixed methods design was used, this is the type of design in which qualitative and quantitative data is collected in parallel, analyzed separately, and then merged (Creswell, 2014). The study endeavored to understand the data at a more detailed level by the use of quantitative data and further explain the results using qualitative results. By converging quantitative and qualitative data while presenting the results, this thus enabled the researcher to develop a complete understanding of the research problem. This approach enabled the researcher to triangulate and enrich the study results with both qualitative and quantitative data. Due to the nature of the research questions, this design successfully brought out all responses on current and/or retrospective issues. The design was also cost effective in relation to time and funds spent in comprised if other designs were employed.

3.3 Study area

Bujumba Health Sub District is in Kalangala District situated in Southwestern Uganda within Lake Victoria. The study area is mainly made up of the fishing community. The fishing population has unique social characteristics as compared with the rest of the country with extra social norms and ways of living which include; high mobility, being highly male dominated, among others that expose them to a higher risk of HIV infection, lower adherence due to high mobility, and low antenatal attendance and generally poor health seeking behavior. The study was focused on how Family support groups have impacted health outcomes of HIV positive mothers in Kalangala district.

3.4 Study Population

The study population constituted HIV+ women and their partners who have ever got EMTCT services in the selected areas within Kalangala District in the period 2012-2015 which is mainly made up of the fishing community attached to Bujumba health sub district. This population has unique socio-economic characteristics as compared with the rest of the country regard as a key population as regards the national HIV/AIDS response.

3.5 Sample size inclusion criteria and Sampling techniques

3.5.1 Sample size

A semi structured questionnaire was administered 269 respondents. A sample calculated using National Statistical Service (NSS 2016), and Krejcie and Morgan 1970 . The sample size was sufficient enough to represent the study population of 900 people using the predetermined sample tables. However, proportionate samples were calculated using the sample size for each health facility as presented below.

Figure 3.5 .1 Table showing sample per population of health centre

Health centre	Population	Sample
1.Mugoye H/CIII	362	108
2. Bwendero H/CIII	288	86
3. Kalangala H/CIV	250	75
,Total	**900**	**269**

3.5.2 Inclusion criteria:

Respondents included HIV positive women and their partner who usually seek Elimination of Mother to Child HIV Transmission (EMTCT) health care services since 2012 to 2015 from health centers of Bujumba health Sub district within Kalangala district, and Key informants included; 3 FSG facilitators (health workers), 2 mentor mothers and 1 male champion and the district adherence officer

3.5.3 Sampling techniques

The simple random sampling technique was employed to select respondents from the three different FSG catchment areas (health centres) that make up the study area for quantitative data. This technique assisted the researcher to have a wider coverage of the area and also provide for a variation of views and experiences. For participants in key informant interviews and focus group discussion were purposively selected based on their role and availability in the time of the study.

3.6 Data collection methods and instruments

3.6.1 Key informant interviews

Key informant interviews were carried out using a Key Informant interview guide. As explained by Rieger (2016), the term key informant is generally associated, though not exclusively, with qualitative research in which a researcher employs interviewing of knowledgeable participants as an important part of the method of investigation. The researcher selected key stakeholders with relevant information on the area and the nature of the health seeking behaviors in the area in relation to the implementation of the family support group initiative. These included 3 FSG facilitators (health workers), 2 mentor mothers and 1 male champion and the district adherence officer

3.6.2 Individual interviews using questionnaires

Semi structured questionnaire were given to HIV positive mothers, partners to capture quantitative data on their knowledge, coping mechanisms and male involvement in maternal health of HIV positive mothers for better health outcomes contexts. All respondents in this category were found in their respective villages.

3.6.3 Focus group Discussions(FGDs)

Focus Group Discussions were conducted to capture and acquire in depth understanding of the study, further enrich and corroborate the information obtained from the other sources. Thus 2 FGDs were conducted, one for women and another for their partners.

3.6.4 Observation checklist

Observation as technique was used to confirm that health centres were conducting FSGs, with required staff, with mothers lactating, pregnant, using FSG registers and using FSG manual. This was to triangulate data collected through other methods or techniques.

3.7 Data analysis

For qualitative data, the researcher entered coded data in a computer for thematic analysis. A thematic approach was used to analyze qualitative data where themes, categories and patterns were identified.

Quantitative data analysis was done using the Statistical Package for Social Scientists (SPSS) which allowed deeper insights into the objectives of the study through developing relationships and tabulations. Analysis was based on dependent and independent variables as defined by the conceptual framework of the study.

Uni-variate data analysis included analysis of frequencies for the dependent and independent variables. This provided descriptive statistics of the variables analyzed; the variables were analyzed each at a time in order to provide a uni-variate explanation of the variables.

Bi-variate data analysis involved examining relationships through cross-tabulations between the dependent and independent variables in order to answer the research hypothesis and conclusions

were made basing on the results of the cross-tabulations using the interpretation of the Pearson correlation coefficient.

A correlation is a number between -1 and +1 that measures the degree of association between two variables (call them X and Y). A positive value for the correlation implies a positive association (large values of X tend to be associated with large values of Y and small values of X tend to be associated with small values of Y). A negative value for the correlation implies a negative or inverse association (large values of X tend to be associated with small values of Y and vice versa). This could be done manually but in general the formula is tedious therefore the computer did all this work using SPSS software.

3.8 Ethical considerations

Ethical considerations during the research included the following issues;

The researcher obtained a letter of introduction from Uganda Martyrs University and also sought permission from the administration of the Local Government, LCs and other areas where research was carried out.

All interviews were preceded by an informed consent to be provided by respondents prior to the interview. Respondents were required to provide a verbal consent before being interviewed.

Participation of respondents was entirely voluntary and the researcher allowed participants to make their own decisions on whether to participate or not. Participation in the study was basically depending on individual willingness of participants and no payments were made for the information they gave.

Information obtained during the study will be kept with at most confidentiality and used for only academic purposes. This was also assured to the respondents during data collection.

All documents reviewed and used during this study are cited correctly in the text and the references.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS OF FINDINGS

4.1 Introduction

This chapter presents results of the study, analysis and discussion in line with study goal and objectives. Results are presented in the form of tables and narratives to give a clear examination of the study concept.

4.2 Socio demographic characteristics of respondents

Using a semi-structured questionnaire, the researcher captured basic background characteristics of respondents which include; like Sub County of residence, age, sex, education level and marital status. These results are presented below.

4.2.1 Sub County of residence

Residence is critical in understanding the distribution of respondents in relation to catchment areas of sub counties and the health sub district.

Table 1: Residence and respective health centres

Sub county	**Health centre of respondents**	**Number of respondents**	**Percentage**
Bujjumba	Bwendero Health centre III	86	32.0
Kalangala T.C	Kalangala Health Centre IV	75	27.9
Mugoye	Mugoye Health Centre III	108	40.1
Total		**269**	**100.0**

Source: Field 2016

In different locations people living with HIV are attached to health centres in varying levels. Most of the respondents were attached to Mugoye health centre, followed by Bwendero Health centre and minority from Kalangala Health Centre IV

4.2.2 Sex of Respondents

Sex of respondents brought in gender picture and representation to the study. Below is the table showing respondents by sex.

Table 2: Shows a tabular presentation of the sex of respondents

Sex	**Number of respondents**	**Percentage**
Male	54	20.1
Female	215	79.9
Total	**269**	**100.0**

Source: field 2016

Majority of the respondents were female while minority male. Since the study used health centre records in generating respondent's shows that women are more involved in maternal and child health service uptake. This indicates that in uptake of sexual reproductive health services women are highly targeted due to their importance to the intervention.

4.2.3 Age of respondents

Age of individuals was considered as a critical point in influencing health care uptake. The age of respondents was captured on the questionnaire and it is presented in age groups below;

Table 3: Distribution of respondents by age groups

Age Groups	Number of respondents	Percentage
15 -19 years	13	5.0
20 - 24 years	44	17.0
25 - 29 years	81	31.3
30 - 34 years	73	28.2
35 - 39 years	29	11.2
40+ years	19	7.3
Total	**259**	**100.0**

Source: field 2016

The study revealed that few younger people are in involved in the EMTCT programmes, with a big number of youth between 20 years to 34 years.

4.2.4 Education level of respondents

Educational level attained by an individual influences knowledge and access to information about health service uptake. This factor can be used to explain variances in utilization and making informed decision on uptake of health services. Below is the tabular presentation of the highest level of education attained by respondents.

Table 4: The highest level of education attained

Highest education level attained	Number of respondents	Percentage
Primary	156	73.9
O level	46	21.8
A level	8	3.8
Tertiary	1	.5
Total	**211**	**100.0**

Source: field 2016:

Majority of the respondents who had attained education were of primary level with followed by attained O' Level with above these levels.

4.2.5 Marital status

A deliberate effort was done to analyze marital status of respondents, given its importance in the family support group initiative. Below is a figure showing a summary of the marital status of respondents.

Table 5: Showing marital status of respondents

Marital status	Number of respondents	Percentage
Single	4	1.5
Married/living together	201	74.7
Divorced/separated	54	20.1
Widowed	10	3.7
Total	**269**	**100.0**

Source: field 2016

The study revealed that majority of the respondents had sexual partners, and also with high divorce incidences

4.2.0 The role of the Family Support Groups' approach in empowering HIV positive mothers to access and utilize of antenatal and postnatal care services

The study explored ways through which FSGs empower HIV positive mothers to access and utilize antenatal and postnatal care services. The study revealed that mothers were diversely impacted on by both knowledge and skills in addressing on all health needs of living with HIV as presented below;

4.2.1 Knowledge, attendance and Benefits of FSGs

Knowledge on FSG and its components, participation in activities of FSG through attendance of learning session and related benefits were amongst the key aspects that were evaluated. The study revealed the following results below

Table 6: Respondents ever heard, attended Family Support Group and its benefits (FSG)

Response	**Ever heard of FSG**	**Attended FSG**	**FSG beneficial**
Yes	155	99	97
No	113	53	1
Total	**268**	**152**	**98**

Source: Field 2016

Majority had ever heard of FSG, though not all of them attended FSG session

Table 7: Components learnt by respondents

Components learnt	Number of respondents	Percentage
ANC	37	37.4
PNC	32	32.3
Male involvement	13	13.1
Personal health	15	15.2
Others	2	2.0
Total	**99**	**100.0**

Source: field 2016

The study further revealed that most of those who had ever attended FSG sessions responded to ANC and PNC as the components best learnt with 37.4% and 32.3%. This is further confirmed by qualitative data from key informant interviews, observation and focus group discussion.

‘‘One gets knowledge on her general health and also learns a lot in terms of after birth health needs for PLHIV’ **(14/7/2016: Adherence officer Kalangala Health centre IV)**

‘‘Mothers got to know that is possible for them to breastfeed for only 1 year. Children and mother are fed well, they are not malnourished though we are HIV positive and children are from us, you can see’’ **(FGD, 21/7/2016: Bwendero health centre III)**

‘‘FSG sessions increase AIDS knowledge competence especially on primary prevention during pregnancy and improving mother’s health. Mothers and their partners tend to overcome stigma from a self-point of view and external from

community. They are more capable of taking informed choices and influencing community actions " (**FSG facilitator, Bwendero Health centre, 24,/7/2016)**

4.2.2 Peer learning and support after sessions

Peer learning and support beyond was one component mothers revealed to be very critical in FSG. Mothers shared that sharing information doesn't stop at health centers but rather even when they go to their respective villages; they continue to provide information, support each other, remind each other on dates of the meetings, and monitor each other. This structure creates a social bond amongst members but with a bigger purpose of promoting health.

''As People living with HIV, we come together to fight the same cause, we live like a family in our village despite living with HIV and we always remind ourselves of the health tips that were provided during FSG meetings'' **(FGD, 21/7/2016 Mugoye Heath centre)**

4.2.3.1 Antennal care service utilization by FSG members

The study further evaluated how Antenatal care was promoted in FSG and its utilization. A close reflection was done during the focus group discussion and individual interviews on how ANC attendance is influenced by presence of FSG at health centers. The following are the results.

Table 8: Comparing birth at facilities and Antenatal service utilization by respondents

Response	Birth from a health facility	%age	Number of respondents attended ANC	%age	ANC visits	Number of respondents	%age
Yes	214	84.6	245	96.1	**1 to 3 visits**	34	14
No	39	15.4	10	3.9	**4 visits**	128	53
					5 or more visits	81	33
Total	**253**	**100.0**	**255**	**100.0**		243	**100**

Source: Field

In the figure above, there was close link between birth at the health centre and ANC attendance by HIV positive women. However, it's further notable that deliveries amongst HIV positive are more than required ANC visits.

During the discussions it was discovered that since FSG meetings are regular and organized on health issues at the health centres, mothers find it easy to attend and get antenatal services and most of them attend more than four times as compared to the other members on EMTCT program but Not in FSG.

> ''It helps one to know that they can give birth to children who are HIV free after following health workers guidance like fighting opportunistic infections like malaria

during pregnancy through sleeping in a treated mosquito net. **(Mentor mother Kalangala Health centre IV 16/7/2016)**

‘‘HIV positive mothers always have different thoughts on their pregnancy state hence going for ANC service uptake and further discussion’’(**FSG facilitator Mugoye III)**

Innovation need to be encouraged to sharpen uptake of antenatal services by HIV positive women to reduce transmissions amongst infants and improve health of mothers. FSG is one of the innovations that are proving to be of value. However, there is need to make it grow amongst health workers beyond a policy frame work.

4.2.3.2 Follow up of HIV pregnant women

It was further revealed that family support group members get the opportunity of creating a relationship with specific health centers beyond attendance of meetings and sessions. Health workers were referred to as being frequently contacted by instead of Traditional Birth Attendants (TBAs).

‘‘No more delivery of children by FSG mothers in traditional birth attendants’’ (**FSG member Mugoye health centre 21/8/2016)**

This means that community members appreciated the current HIV scourge and feel that scientific means are more appropriate in improving their lives.

4.2.4 Postnatal attendance and service uptake

During the study efforts were done to explore linkages and how members respond to postnatal attendances after birth of an HIV exposed infant. It was found out that mothers living with HIV both in family support group and no showed that it’s very vital for them to get after birth services

for their individual health and their children. This is possible because of the attendance of lactating HIV positive mothers with their infants in FSG session and community discussion after health centres that affect positively the entire community.

Table 9: Showing birth and visits in the PNC by respondents

Response	**Birth from a health facility**	**%age**	**Number of respondents attended PNC**	**%age**	**PNC visits**	**Number of respondents**	%age
Yes	214		182	84.3	Within one week	23	12.8
No	39		34	15.7	Within 1 month	93	51.7
					Within 2 months	35	19.4
					Within 3 months	29	16.1
Total	**253**	**100.0**	**216**	**100.0**		180	100.0

Source: field 2016

Results above represent birth at facility and postnatal utilization of services by HIV positive women. It's evident that there is a high PNC attendance though not all mothers attend. The general view is promising and was further highlighted during focus group discussions and key informants as presented below

‘‘We desire to have HIV free children and always come and attend to enable us have HIV free babies at graduation at 18months after birth. It helps the health worker to check the health of the baby and mother as recommended’’ (**FGD, 21/7/2016 Mugoye health centre III**)

“FSGs provide opportunity for routine health check-ups for the mother and the baby. The mothers have chance to constantly learn about their health and how to monitor it eg viral load and CD4 monitoring. Many people have low viral load’’ (**14/7/2016: Adherence officer Kalangala Health centre IV)**)

‘‘FSG promote seeking after birth health services in the interest of the child and the mother’s. Mothers are constantly monitored and encouraged to ensure that they adhere to postnatal visits as recommended by the Guideline which enable early infant diagnosis of HIV exposed infants. ” **(FSG facilitator Bwendero health centre 21/7/2016)**

During FSGs, mothers are educated on best feeding practices after child birth and this has contributed greatly to their wellbeing but it is important to mobilize all mothers because as per results not all respond to postnatal care. It is anticipated that all mothers with their exposed infants should be part of the PNC.

4.3.1 How Family Support Groups improve coping and self-efficacy amongst the HIV positive mothers

Coping mechanisms were examined in relation how FSG changed women living with HIV to cope with HIV. The study concentrated on understating decisions made by HIV positive mothers who attend family support groups with their partners were also making effective choices for their health. This was done through exploring how family support groups improve coping and self-efficacy amongst HIV positive women. The following are the results.

It was further revealed that Groups create identity and cohesive forces which make people believe in life, they form saving groups and other social networks to act as a response against stress. In the group people overcome stigma and believe in life ahead with their children as presented below.

Table 10: FSG respondents changed in coping with HIV

Changed their coping mechanism	**Frequency**	**Percent**	**Recommend a friend to FSG sessions**	**Frequency**	**Percent**
Yes	99	36.8	Yes	98	36.4
No	170	63.2	No	171	63.6
Total	**269**	**100.0**	**Total**	**269**	**100.0**

Source: field 2016

99 respondents who happened to have changed their coping abilities also believed that FSG are worthy recommending to a friend. This confirmed by statements from key informants as presented below.

> ‘‘Members of the groups became more frequent in seeking health services not only for their conditions but for their house hold. Adoption of livelihood innovations, several members of FSG were encouraged by their members and health workers to start saving groups at village level, to begin some businesses, have treatment supports and home visits. ’’ (**Mentor mother attached to Bwendero Health Centre III 21/7/2016)**

4.3.2 Stigma reduction, disclosure and improved physical health

The study explicitly found out that the family support group structures help to fight stigma and facilitate disclosure in the face of living with HIV. Stigma was presented that before attending family support group meetings, members had a lot fear and self-disbelief. Women living with HIV shared, that the feeling of life ending soon after being found HIV positive occupied their mind and affected their health and future life decisions. Disclosure is well revealed at the time of HIV testing where not all partners tested with their spouses as presented below.

HIV positive men and women in the two focus groups discussions that that were conducted, it was articulated further that mothers and their partners feel now comfortable to seek health services more freely.

Table 11: Tested for HIV during pregnancy and disclosure to spouses/testing with spouses

Response	**Number of respondents tested For HIV**	**Percentage**	**Number of respondents tested with spouses**	**Percentage**
Yes	199	76.5	108	46.2
No	59	22.7	126	53.8
Don't know	2	.8		
Total	**260**	**100.0**	**234**	**100.0**

This figure presents variation of high number of respondents responding positive on HIV testing during pregnancy but with a lower number first tested as spouses. Therefore at identification of HIV positive pregnant mothers there is limited disclosure and high stigma but as part of coping further results from key informants and focus group discussion revealed that mothers in FSG cope more steadily as below

''It's was very hard for us to meet like this, discuss with other people on health issues. It could not make sense at all, one could see it as a personal challenge, yet many people in society are equally facing the same problem. Mothers are now free to tell people about their HIV status. This is majorly seen between husband and wife'' **(FGD, 21/7/2016)**

4.3.2: Restoration of hope, health and having HIV free children

In the study it was discovered that Family support group members promote health beyond their own individual health. It was revealed that family support groups provide opportunity for people to live more meaningfully. Linked to that was getting information of being with an HIV free child, restores hope amongst women living with HIV and their family members.

'' Family support groups do support in drug adherence since mothers attend health centers more frequently during sessions .Because of FSG peoples' children are HIV negative most especially the second born after an HIV positive one, they always think that the magic is in health centres''. **(FGD, 21/7/2016 Mugoye Health centreeIII)**

''Family support groups help members to create a bond and a relationship with health workers to ease access to health services. Sometimes am called by women to respond to their health needs like supporting and linking them to suitable health workers to their condition'' health work **(Male champion Bwendero health Centre 21/7/201)**

4.4.1 Male Partner participation in maternal health care

Findings revealed that family support group members benefit from the importance of male participation in health services. Women living with HIV shared that FSG members are informed more specifically why male involvement is important to have their spouses (male partners) get involved in health services at any level possible. Results revealed that males are mobilized and involved in attending Family support group meeting, antennal care, postnatal care, supporting in doing house hold roles and financing health care process like nutrition, transport to health centres, and giving hope to their spouses. Women also shared that Males who are part of family support groups are used by the health works to mobilize and orient male partners to FSG mothers.

Table 12: Accompaniment during ANC

Accompanied woman during Antenatal care	**Number of respondents**	**Percentage**	**Times spouse accompanied for ANC**	**Number of respondents**	**Percentage**
Yes	109	41.6	1 - 2 times	42	40.8
No	153	58.4	3 - 6 times	61	59.2
Total	**262**	**100.0**	**Total**	**103**	**100.0**

In the figure above, majority of the respondents did not accompany their spouses during ANC

4.4.2 Mobilisation of male partners to support maternal health

The results revealed that family support groups are hubs for male mobilization to support uptake of health care. Women expressed the fact that male involvement is critical and they do all possible to mobilize their spouses to attend activities of health nature and promote health service utilization for HIV positive women as presented below.

Table 13: Respondents who encouraged males to attend ANC in comparison to HIV positive women who like to be accompanied

Encouraged spouse to accompany them for antenatal care	**Number of respondents**	**Percentage**	**Number of respondent like to be accompanied**	**Percentage**
Yes	212	81.5	255	97.3
No	48	18.5	7	2.7
Total	**260**	**100.0**	**262**	**100.0**

Source: field

A high number of respondents revealed that they tried to encourage their spouses to accompany them for health care. The analysis further revealed that majority of the respondents, desired to be accompanied by their spouse to the health centers. . The role of FSG in this regard was further articulated below.

> ‘‘FSG help men get involved in Antenatal care through accompanying their wives, men also help to remind their wives in taking ARV drugs and disclosure between partners’’’

‘‘Male partners through attending FSG and knowing what is done there, they also become patient with health workers during attendance of health centers health programmes’’

‘‘Through FSG husbands, help support women in daily chores for example through providing transport ART clinics and house hold work’’(FGD)

‘‘We as males meet during FSG; we are directly called upon to mobilize others to join FSG to consequently increase on uptake of health services. Males who have experience are usually used to disseminate HIV information more widely across different groups of people living with HIV’’ **(Male champion 21/7/2016 bwendero III)**

In conclusion, results consistent for Male involvement in pregnancy and childbirth and there is a belief that it influences pregnancy outcomes and reduces negative maternal health behaviors, risk of preterm birth, The view points and findings are consistent with Kaye et al, (2014) argument that male involvement reduces maternal stress which is emotional, logistical and financial support and increases uptake of prenatal care and leads to cessation of risk behaviors.

4.4.3 Ways through which male Partners support women living with HIV

In a focus group discussion with male partners, Participants in the FGD shared that they are encouraged to plan for health when a woman is pregnant, delivery and after delivery. They provided that this is intended to ensure that the health of a mother is well, and the family into which they live. These efforts are in doing economic activities, joining community social groups and savings with saving associations commonly known as village savings and lending

associations (VSLA) which help so much in protecting them against situations which require financial safeguards. As presented below

> ‘When my wife explained to me the need for support which was financial in nature, I decided to work hard to ensure that we have enough money to meet the daily transport needs of my wife to go to the health centre during pregnancy’ I decided to keep local poultry which give eggs every day to ensure that at home there eggs which supplements foods available as recommended by the health work **(FGD for male Partners of FSG mothers 12/8/2016 Mugoye Health centre III)**

4.4.3.1 Challenges at house hold level of participation

In the FGDs of men and women highlighted that some men just don’t want to get involved in health related matters saying that they are not available, busy looking for money yet they make decisions that affect the health of the entire household. Women expressed a concern about family planning and specifically child spacing which was the centre of most conflicts that relate to health at household level. Women report that when one produces an HIV free child, husbands start to demand for another one more quickly. Protection against un-intended pregnancies is a critical component for EMTCT

> ‘‘Some men do not support their wives during pregnancy and after birth. As result mothers want few children which is not sometimes accepted by husbands’’ (FGD Bwendero health centre 21 /7/2016)

Furthermore, males in the Focus discussion group highlighted that activities of the health centre many times do not consider fish peak sessions and low session, yet there is a social connection of health and prevailing economic activities in the fish landing sites. This results into disconnected health intervention and male participation.

‘Many times meetings are held at the health centre without our presence because we are looking for money to support our house holds especially during pregnancy and delivery, we are here because it’s an off session for fish catches.’ **(Male FGD Mugoye 12/8/2016)**

4.5 Establishing relationships between FSGs and ANC/PNC services

The study sought to assess the role of the Family Support Groups’ approach in improving HIV positive mothers through access and utilize of antenatal and postnatal care services. The results are based on outputs of the relationships represented by Pearson correlation and Chi-square coefficients.

Table 14: Establishing relationships between FSGs and ANC/PNC services

	Coefficients and Total number of respondents	**Ever attended any Family Support Groups sessions**
Attended ANC	Pearson Correlation	.044
	Sig. (2-tailed)	.601
	N	144
Number of ANC Visits	Pearson Correlation	-.170*
	Sig. (2-tailed)	.034
	N	141
Tested for HIV during pregnancy	Pearson Correlation	.135
	Sig. (2-tailed)	.102
	N	148
How long did it take you to go back to health facility	Pearson Correlation	.122
	Sig. (2-tailed)	.201
	N	112
Learnt about antenatal care	Pearson Correlation	.703**
	Sig. (2-tailed)	.000
	N	91
Learnt about postnatal care during FSG sessions	Pearson Correlation	1.000**
	Sig. (2-tailed)	.000
	N	91
Attended Postnatal care	Pearson Correlation	.163*

	Sig. (2-tailed)	.045
	N	129

*. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

Although results shown a positive relationship between FSG attendance and ANC attendance considering whether one attended ANC, there is no significant relationship with FSG attendance considering whether one has ever attended an FSG session (P-value = 0.601). Regarding the number of ANC visits, there a significant relationship (p-value = 0.034) between FSG attendance and the number of ANC visits one attended.

FSG attendance was positively related with Testing for HIV during pregnancy although there is interrelationship, it is not significant.

There was also a highly significant positive relationship between learning about antenatal care and attendance to Family support groups (correlation = 0.703, p-value = 0.000). In a similar way, a highly positive correlation is shown for learning about postnatal care.

Postnatal care attendance was also significantly related with FSG attendance with a positive correlation.

With the findings, there were significant relationships between FSG attendance and variables including; ANC visits, knowledge/learning on antenatal care, learning about postnatal care and postnatal care attendance. This implied that family support groups influenced ANC and PNC attendance within the study area hence contributing to improved health of HIV positive mothers

4.6: FSG and health outcomes

During the study respondents revealed that being part of the family support group massively contributes to coping with the disease and improved health of the individual as different FGD participants demonstrated the reduced episodes of opportunistic infections like malaria, increased CD4 count, undetectable viral load, looking healthy, being able to do their work with confidence that they are healthy and overcoming stigma related challenges. Compared with those who were eligible but did not attend family support group sessions as per the cross tabulations and correlations representing significant relationship

> ‘Some of us have high CD4 and the virus is now not even being seen during viral load examinations….. (**Women FGD Bwendero 21/7/2016)**

> Our women and us look healthy and no one can know our HIV status unless told.(M**ale FGD Mugoye)**

Therefore according to this result, FSG meetings and it’s processes built capacities of individuals to care for their lives despite being HIV positive. Skills and competences acquired are well used as presented in health seeking patterns.

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the discussion of findings, conclusions, and recommendations of the study in line with public health and health promotion. The discussion here was guided by the three specific research objectives.

5.1 Discussion of findings

The study explored ways through which FSGs enabled HIV positive mothers to access and utilize antenatal and postnatal care services and male involvement. The study revealed that mothers were diversely impacted on by both knowledge and skills in addressing on all health needs of living with HIV.

5.1.1 Social demographic characteristics

The study reflected on social demographic factors which are of value to public health in general and health promotion in particular. These considerations included location, age sex and education attainment, FSG and EMTCT being largely female focused the study captured majority of respondents were female and since the study used health centre records in generating respondents, it also shows that women are more involved in maternal and child health service uptake compared to male. This indicates that in provision of sexual reproductive health services, HIV women are highly targeted due to their importance to the EMTCT intervention. . The study revealed further that a big number of youth between 20years to 34years participated in the programme with high abilities to have children. Therefore, this implied that the motivating reason for seeking this category of health services was properly connected to individual health and child birth in the face of HIV.

However, with the majority of respondents falling within primary level education attainment category. This meant that participants were diverse and comprise of low educational attainments with limitations of appreciating current health needs of living with HIV as individuals. This requires health interventions that directly suit the this category hence confirming the need for ongoing peer support

It with majority of the respondents having sexual partners, it further amplified the importance of couples/sexual partner involvement in health service uptake in order to targeted person in in the case of a woman. Several household health decisions are made by the partner with high influence especially males who are bread winners onto which women depend in several households in most fisher communities. This is inconsistent with Katende (2014) arguments that norms of masculinity affect how members of a given household respond to health services by the status they hold like wine, children, relatives or husbands because to the EMTCT women it largely their HIV status that mattered above all things.

In short, age, sex, marital status, education and place of residence are very critical in public health and health promotion as determinants of health. These variable explain the need to always reflect on population characteristics and sharpening the intervention to the right people, knowing that the same big population will have a series of variations in age, education and sex.

5.2.1 Reported Benefits of FSGs

Women reported that access to health information greatly improved lives of those who decided to be part of FSG sessions. FSGs were articulated as being important structures that build the capacity of individuals to seek and utilize antenatal and PNC services. Despite it, being a free-programme for all HIV positive women and their partners to attend during pregnancy and after child birth, few eligible persons participated in it. This information provides a point to look at attitude change towards health service uptake since attendance was voluntary. This therefore, points to the fact that such mothers and their partners are at risk of transmitting the virus to their infant because of limited EMTCT procedural information.

This means that more efforts need to be focused on the programme to have a strong impact directly on a wider population eligible. UNICEF (2012) argued further that, since women and children access HIV services through MNCH platforms, it improves retention along the continuum of care requires not only HIV-specific interventions, but also addressing larger structural bottlenecks, including especially the weak linkages between HIV and MNCH services and systems that exist in many settings.

FSGS need to be built in addressing stronger demand-side bottlenecks, as women living with HIV are often not well informed of what services they should receive, why these services are important, or where and when they can access them. Having this information builds capacity of individuals to move towards achievement of better health outcomes connected to their situation.

In line with the above, FSG sessions are expected improve skills, knowledge and abilities to better their lives through meaningful self-management of life and utilization of health services as guided by policy. Mothers knew the importance of ANC and that of being retained at health centers after birth of their baby through learning and interpersonal empowerment processes.

This is anticipated to be an opportunity for reduction of pregnancy related complications amongst HIV pregnant women since they clearly have information and meaning of their state as HIV positives expecting to have a child.

HIV Lactating mothers got more practical information regarding their health, how they should maintain an HIV free family, accessed family planning methods and how important they are, to parents onto which children will depend. Having lactating HIV+ mother in FSG provides the opportunity for peer support and increased access of postnatal services which improve health and individual skills in handling exposed infants hence maintaining the momentum towards zero infections and zero HIV related death. It can be expanded further to Nut-beam, (2015) assertion that ‘‘many women, especially first-time mothers, attend antenatal and postnatal classes which prepare them for labour and delivery, and usually include basic baby care skills antenatal care provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the newborn, promotion of early, exclusive breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes’’ Further, (Lincetto et a al , 2015) added that attendance of such sessions provides an opportunity to inform or educate pregnant women about pregnancy, childbirth and care of the newborn and their health after child birth,

Therefore, HIV positive mothers in FSG present a great opportunity and incentive for peer to peer support and points to the desire of strengthening local well-tailored programmes that provide space for beneficiaries like women living with HIV and their partners are critical as they not only addresses their state but also enables them achieve better health during and after child birth as individuals.

FSGs are built on peer leadership, self-efficacy and leadership in aspects pertaining one's life through addressing social determinant of health. Information shared in FSG session through peer to peer and health worker involvement doesn't stop at health centers but rather even when they go to their respective villages; they continue to provide information, support each other, check on each other, remind each other on dates of the meetings, and monitor each other drug adherence and health condition. This outcome is consistent with findings by Futterman et al (2014) which concluded that Mamekhaya programme in South Africa was successful in conveying information and improving participants' emotional outlook and hopefulness. With insufficient numbers of health workers

Indeed having related results on the way mothers living with HIV acquired knowledge about HIV/AIDS through use of the peer angle on both ends was a perfect result on people participation in the health system.

It was found out that mothers living with HIV easily access after birth services for their individual health and their children which translates into improved health outcome in terms individual morbidity and future health planning. This is possible because of the routine attendance of lactating HIV positive mothers with their infants in FSG session and community discussion after health centres that affect positively the entire community.

It was revealed that Groups create identity and cohesive forces which make people believe in life and their circumstances, members respond by creating a conducive environment for them to address their social and health needs. This holds the social learning theoretical perspective where people adopt to acceptable health practices. In this regard FSG become an important social structure which inspire development of community-based care initiatives in some settings. The in circumstances where support groups provide an opportunity to PLHIV to share experiences and become more engaged in their health, hence sharpen individual roles in health care, PLHIV as individual become more confident with decisions they make on their health.

Linked to the above is, during focus group discussion it openly and uniquely emerged that members use their life stories to fight stigma. Women who entered the group early act as incentives to new entrants through telling their stories to them to build their confidence, trust and belief in proper health service uptake. Connected to the above, results are consistent with Ojikutu et al. (2016) in a study on disclosure, found out that the decision to disclose one's status was associated with perceived community-level influences as well as individual-level psychological, clinical and relationship factors. Among all women in this study, individual-level factors were deterrents to status disclosure. Therefore, deliberate efforts should be made to address disclosure from a client point of view as it affects other connected health outcomes of an individual.

These findings further revealed that the FSG process contributes to building self-esteem, self-efficacy and confidence in health service uptake like fighting against opportunistic infections and better health through viral suppression. Programmatically the initiative is in respect of human dignity and asserting control over their lives through choices and decisions made regarding better uptake of EMTCT services in prevention of HIV. In addition its argued Johnson

et al (2007) that self-efficacy depends on the aspect like higher adherence self-efficacy Inter-gration and Perseverance relate to better reported ART adherence, better psychosocial functioning, and are associated with intriguing patterns in healthcare utilization including a lower likelihood of missing scheduled appointment. In the same line programs like FSG with an interest in self-efficacy, Rodkjaer (2014) argued that to add to our understanding of a more holistic approach to patient care and might lead to an increased coping self-efficacy for patients as well as an increased involvement and responsibility for patients' own health.

The study is consistent with Rodkjaer (2014) on practices that have emanated from social learning and interactions which happen at health facilities during FSGs. However, it is for purposes of sustainability that important programmes have to be maintained with in the health Centre frame work to foster continued skilling of mothers, family members and their partners to identify and provide answers to their situation.

5.1.3 Ways through which male Partners support women living with HIV

FSG are also impact on attitudes of Male partners through respect and addressing their spacif needs Attitudes of men, are differently impacted on and this motivates their support and involvement in health care hence achieving positive health better health seeking behaviors. Male partners were found to support their female partners during the study in different ways which included transport, care during birth, birth planning, saving for childbirth and disclosure. Therefore, this upholds Dutki, (2010) view that the process of empowering and engaging men, regarding reproductive health issues helps them to be more sensitive to women's needs and therefore supportive of participating in efforts of improving women's status, regardless of their HIV status.

Therefore, there is a need for a formidable and well-structured methodology to continuously building capacities of men through peer to peer as culturally ascribed household heads. This is reflective of ability of FSG programming to impact on attitudes and appreciate the role of men in making house hold decisions. Such practices are believed to be influenced by social learning at FSG sessions while unlearning negative practices and choices.

5.1.3: FSG significance to public health and health promotion

Family support groups bring peers together to share, and learn to cope with their illness which translates into confidence and improved health behavior. HIV positive women demonstrated reduced episodes of opportunistic infections, maternal morbidity and improved health coping strategies. This means that they are more likely to overcome stigma and challenges related to being HIV positive, on treatment and attending regular peer sessions. And are in a better position to address their immediate social and personal factors which may affect their health negatively. Therefore the study is consistent with Lavarack (2006) and health promotion values of enabling people to address and appreciate their social determinants of health through community empowerment.

5.1.3 Dependency on men for provision

In all circumstances, it also emerged that in most locations in Kalangala women depend on their male partners since the fisher communities are largely male dominated. Socially and economically, men are still stronger and seen as bread winners, so women depend on them most of the times. This is because most of the activities in Kalangala favor men more than women like fishing, lumbering and water transport and trade hence making women disadvantaged. This means that women are socially affected by inequalities, and low participations in development. However, to health promotion, such gaps between men and women pose challenges to uptake of health services including those that target prevention of structured infections like HIV. Mothers with

such dependency on their male counterpart means that it is very difficult for them to make decisions on their own health given their inferior economic status at household level. Therefore, health promotion intervention in such a situation face challenges of enabling to people lead their health agenda unless when a more broad based and holistic intervention is structured to directly address economic situations of women in EMTCT and the entire community at large.

In summary, the study showed that FSG intervention had an impact on its beneficiaries in the three health centres through information dissemination and practical engagements in sessions on different health aspects, a variation in utilization of both Antenatal and postnatal services by FSG members and those who did not attend was significant, adopted several Coping mechanisms as result of interacting with others in FSG coped with HIV/AIDS. People overcome stigma, and disclosed their status, avenue for male involvement and believe in life ahead. Family support groups provided the opportunity for people to think and plan for monitoring the health of others through information of being healthy with an HIV free child which is very vital in restoration of hope amongst women living with HIV and their family members.

Self-efficacy and increased self-esteem, people living with HIV learn several things that build their confidence, capacity and attitude to make decisions that promote health at different levels. That to say at individual level, community level where they act as peer educators and disseminate HIV information as prescribed in the social learning theory. The adoption of peer learning and self-involvement practices reduces stress and build confidence amongst women living with HIV to take on life unaided.

Coping with HIV, Family support group initiative programming contributes to adoption of practices that facilitate better coping or living with HIV. Women growth in making decision

that promotes health and father understand their situation and apparent opportunities especially those connected to a better family like adherence to drug, CD4 monitoring, treatment and management of opportunistic infections. Mobilization of male partners was a critical point using innovations like notifications and male champions in elevating the health of women living with HIV and their HIV exposed infants. The study showed that family support groups are hubs for male mobilization to support uptake of health care and peer support. Furthermore, male attendance enables them appreciate the role of facilitating and supporting their partners towards having HIV free children and living healthy.

5.4 Conclusion

Family support group initiatives provide opportunity for self-realisation, self-awareness coping with HIV, enhanced male involvement and growth towards positively seeking health services for better outcomes. The methodology provides for enhanced human functioning in a regulated process as per social learning theory where those exposed to FSG practices and massages acquired capabilities and skills and adopted to better health seeking partners. Conclusively, the study found value in existence of FSGs at health centres in relation to better health outcomes for those voluntarily exposed the FSG package.

5.6 Recommendations

Following the above discussion, the following recommendations have emerged

The distrct health office should Scale up mobilization of PLHIV to participate in FSG this builds competencies on maternal health issues. This should be clearly well thought and integrated with in the health sector programmes through local government planning processes. It will provide the opportunity to HIV positive mothers improve their health competence during and before

birth which imperative in meeting both national and international goals on ending the HIV epidemic,

Male involvement needs to be strategically well planned and monitored to ensure that all possible innovations that can improve partners of male health seeking behavior are frequently adopted and integrated in the programme through recognizing their role in the social structure and the economic life of society. Their participation is very important building capacities of a health literate society since decision makers will be well integrated in health promotion practice. Normal and conventional planning has proved limited, in attracting fishermen.

This study suggested strengthened counselling during HIV positive mother initiation into EMTCT program. It would be further valuable to integrate the recommended FSG package with other health promotion initiatives within EMTCT.

This study has documented the current FSG best practices which can be adopted for continuous learning to ensure that peer avenues of information sharing are exploited for improved HIV prevention outcomes.

5.6 Suggestions for Improvement of FSG

Family Support groups were being held quarterly, which was somehow not so good for consistence and covering all topics in the Manual. The health department needs to plan and invent ways of having simple but monthly family support meetings. It is possible to connect FSG meetings with ART drug refills to ensure that mothers and their partners are met on such days.

Specific attention should be given to the needs of males to ensure their maximum participation and involvement especially their economic activities and life Male participation should be looked at in an innovative way which addresses its dynamics and way of life like considering fishing time as well in planning. This means that efforts and innovations geared towards male involvement should be reflective of their way of life in society.

It is important to build capacities of FSG facilitators to be able to meaningfully execute their function in a consistent manner to better health of mothers and that of their exposed infants through providing the very important inputs. This is singly the role of health education department in the health sector at district and national level

5. 7 Suggested Areas for Further Research

Because of different study constraints like time, use of some empowerment tools and scales and resources, the study was unable to reach details of each variable that was not in the study objectives. The researcher therefore recommends that more research may be conducted to further using different methodologies. The following areas are suggested for further research:

Explore the effect of stigma amongst people living with on health service utilization

Stigma and discrimination, is believed to both physical and psychological impacts on people living with HIV/AIDS especially negative social responses that can affect the levels of uptake of antiretroviral medication and some services for people living with HIV. This is because out of fear of stigma and discrimination, some positive people are less likely to participate in HIV services such as education programs around preventing mother-to-child transmission in pregnancy, receive treatment information, counselling or participate in other programs aimed at building better levels of social inclusion. (Wilcock and Lennon, 2009). Therefore, it's important to measure its impact on health service uptake in different forms to result in a comprehensive intervention

Effect of Partner support on facility based delivery in the context of fisher folk populations.

Despite, the known importance of partner support in health service uptake, there is continued outcry on male participation in health services. Further in-depth research is required to support generation of evidences that are particular to the fisher folk population. Seid et al (2012) confirms the importance of partner disclosure which facilitates male involvement in health service uptake.

Perceptions and attitudes on HIV test and treat programmes

There is an need to use the health belief model to examine perceptions of people living with HIV in view of HIV test and treat programme. The model is handy in analyzing perception in the interest of health promotion, results will enrich the public health fraternity with in-depth knowledge on how communities are adjusting viewpoints in line with changes in programming.

Lived experiences of children born by HIV positive parents

There is a need to document qualitative experiences of children born to HIV positive parents. Several studies have documented lived experiences of people living with HIV but there is a gap in understanding experiences of children whose parents are HIV positive. Hence ecologically not addressing house hold gaps in the HIV interventions.

Lived experiences of HIV positive women in prisons

Prisoners are serious public health importance to the country in terms of rights and freedoms. Women living with HIV in child bearing age in such contexts there is need to also have documented experiences which provide opportunity for interventional design by duty bearers.

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Appendix

Appendix 1: Questionnaire

Introduction:

I am Kizito Henry, a student of Uganda Martyrs University. As part of the requirements for the award of a Master's Degree in Public Health, I am carrying out a research titled: An evaluation of the Family Support Group initiative in improving health outcomes amongst HIV positive mothers in Kalangala District. I would like to ask a few questions about issues relating to your health that will help me come up with general findings about the research topic. Your answers will be kept confidential in coming up with the results of the study as results will only be presented in a generalized manner. You are free to answer all questions, and completing all questions will assist me come up with reliable results which might to be used by stake holders improve service provision in your area.

Section 1: Background characteristics

Residence: Where do you live?

District: _____ Sub–county: _____Parish: _____

Village: _____

No.	Questions and filters	Codes/Value (Circle code)	Skip
01	Sex	1. Male 2. Female	
02	How old were you at your last birthday?	_____ years	
03	Have you ever attended school?	1. Yes 2. No ⟶	05

No.	Questions and filters	Codes/Value (Circle code)	Skip
04	What is the highest level of school you attended: primary, '0' level, 'A' level or tertiary?	1.Primary 2.'O' Level 3.'A' Level 4.Tertiary	
05	Are you currently married/living with your spouse (Marital status)?	1. Single 2. Married/living together 3. Divorced/separated 4. Widowed	
Section 2: Knowledge and use of Family Support Groups			
05	Have you ever heard of Family Support Groups?	1. Yes 2. No	→ 10
06	Have you ever attended any Family Support Groups sessions?	1. Yes 2. No	→ 10
07	Dis you find them beneficial or helpful?	1. Yes 2. No	
08	Did your attendance in Family Support Groups change your coping mechanism (the ways in which your external and internal stress is managed, adapted or acted upon) with HIV/AIDs?	1. Yes 2. No	
09	Would you recommend a friend to Family Support Groups sessions?	1. Yes 2. No	
Section 3: Delivery, Antenatal and Postnatal care			

No.	Questions and filters	Codes/Value (Circle code)	Skip
10	Now, I would like to ask about the births/children you have had during your life. Have you ever had a child/given birth?	1. Yes 2. No	
11	How many children have you ever given birth to?	_____	
12	Was your most recent birth from a health facility?	1. Yes → 14 2. No	
13	If no, why? _____		
14	During the last pregnancy: If female: Did you attend Antenatal care If male: Did your spouse attend Antenatal care	1. Yes 2. No → 16 3. Don't know	
15	If yes, how many times?	_____ times	
16	Now, I would like to ask you about HIV Testing, I don't want to know the results: If Female: Were you tested for HIV during pregnancy If Male: Was your spouse tested for HIV during pregnancy	1. Yes → 19 2. No 3. Don't Know	
17	If no, why? _____		
18	Did you test together with your spouse	1. Yes 2. No	
19	If No, why? _____		

No.	Questions and filters	Codes/Value (Circle code)	Skip
20	After birth, did you go back to seek health care from a health provider?	1. Yes 2. No	
21	How long did it take you to go back to health facility?	1. Within one week 2. Within 1 Month 3. Within 2 months 4. Within 3 months	
21	Did you learn about antenatal care (care during pregnancy) during FSG sessions?	1. Yes 2. No	
22	Did you learn about postnatal care (care after birth) during FSG sessions?	1. Yes 2. No	
22	Did you talk about male partner support to mothers during FSG sessions?	1. Yes 2. No	
Section 4: Male Partner participation in Maternal health care			
23	During the last pregnancy: If female: Did your spouse at any time accompany you during Antenatal care If male: Did you at any time accompany your spouse for Antenatal care	1. Yes 2. No	
24	If yes, how many times (write number of times)	_____ times	Go to 26
25	If no, why? _____	1. Male partner refused	

No.	Questions and filters	Codes/Value (Circle code)	Skip
		2. Female partner refused 3. Male partner has no time 4. Other	
26	If female: Did you encourage your spouse to accompany you during Antenatal care If male: Did your spouse encourage you to accompany her during Antenatal care	1. Yes 2. No	
27	If female: Anyway, would you like it if you are accompanied by your spouse to the health facility? If male: Anyway, would you like it if you accompany your spouse to the health facility during pregnancy?	1. Yes 2. No	
28	If no, why? _____		
29	Before we end our conversation, I would like to thank you for the information you have given me. Do you have anything you would like to add on what we have talked about? _____		
30	**Thank you very much**		

Key Informant Interview Guide

Introduction:

I am Kizito Henry, a student of Uganda Martyrs University. As part of the requirements for the award of a Master's Degree in Public Health, I am carrying out a research titled: An evaluation of the Family Support Group initiative in improving health outcomes amongst HIV positive mothers in Kalangala District. You have been identified as a key informant on aspects of family support groups activities in this evaluation exercise.

I would like to ask a few questions about issues relating to FSGs that will help me come up with general findings about the research topic. Your answers will be kept confidential in coming up with the results of the study as results will only be presented in a generalized manner. You are free to answer all questions, and completing all questions will assist me come up with reliable results which might to be used by stake holders improve service provision in your area.

1. Have you ever heard of Family Support Groups? Have you ever attended any Family Support Groups sessions?

2. How do Family Support Groups benefit the members?

3. How do Family Support Groups change the coping mechanisms (the ways in which your external and internal stress is managed, adapted or acted upon) with HIV/AIDs of members?

4. How do Family Support Groups influence antenatal care (care during pregnancy) attendance amongst the HIV positive mothers?

4. How do Family Support Groups influence postnatal care (care after birth) attendance amongst the HIV positive mothers?

5. How do Family Support Groups influence male participation in maternal health services?

6. Before we end our conversation, do you have anything you would like to add on what we have talked about?

_____

Thank you very much

Appendix 3 : Focus Group Discussions

Focus Group Discussion

1. Have you ever heard of Family Support Groups? Have you ever attended any Family Support Groups sessions?

2. In what ways does Family Support Groups benefit the members?

3. In what ways does attendance of Family Support Groups change the coping mechanisms (the ways in which you're external and internal stress is managed, adapted or acted upon) with HIV/AIDs of members?

4. How do Family Support Groups influence antenatal care (care during pregnancy) attendance amongst the HIV positive mothers?

4. How do Family Support Groups influence postnatal care (care after birth) attendance amongst the HIV positive mothers?

5. How do Family Support Groups influence male participation in maternal health services?

6. Before we end our discussion, do you have anything you would like to add on what we have talked about?

Appendix 5Observation check list:

S/N	Item	Yes /NO	Comment
1	**Venues for FSG meetings**		
2	**Presence of health workers in FSGs**		
3	**Availability of FSG registers**		
4	**Presence of pregnant women**		
5	**Presence of males**		
6	**Presence of lactating mothers.**		