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**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

**CONTRACEPTIVE USE AMONG WOMEN LIVING WITH HIV
ENROLLED FOR THE BIRTH COHORT STUDY**

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DECLARATION

I declare that the work contained in this dissertation is entirely a product of my own original work with the expectation of such quotations or references which have been attributed to their sources. The investigations of such work have not been presented elsewhere for any academic purpose or any purpose whatsoever.

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.....

Date/...../.....

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ABSTRACT

The study focused on contraceptive use among women living with HIV enrolled for the birth cohort study. Also core to the study was an analysis of the factors that have facilitated the use of contraception amongst women living with HIV. There is a knowledge gap and limited research and on contraception use among women living with HIV. The study was guided by a conceptual framework that shows the various factors that could predict the utilization of contraception. The research adopted a quantitative and qualitative approach and the target population for the study was 1111 women from four clinics, Rujeko, Kwadzana, Budiro, and Glenview enrolled for the study. Amongst the women 571 were positive. The research was also extended to key service provider in order to hear their views. Purposive sampling was used in order to select relevant respondents for the qualitative part of the study and thematic analysis was used to analyse the data. For the quantitative part of the study participants` data was obtained from University of Zimbabwe immunology department and it was analysed through excel and SPSS. The findings from the study demonstrated that Contraception use is generally high in Zimbabwe. Women living with HIV and women without HIV have similar patterns in contraception use and both use oral contraception pills mostly. The HIV positive women seem to be using condoms more than their counterparts. There is a knowledge gap however on hormonal contraceptive. Recommendations were made to the ministry of health to enhance family planning services so that they offer extensive education on use of various contraception. Midlands State University to take the opportunity to use the research finding of contraception use for its student family planning clinic through education, posters and online sites. Involvement of man in family planning to support women living with HIV and clear misconceptions and myths. Lastly for service provider to inform the women of the combination of using hormonal family planning when on ART.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy ARVs Antiretroviral
FP	Family Planning
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IUD	Intra Uterine Device KATH
MTCT	Mother-to-child transmission of HIV
OC	Oral Contraceptive
PMTCT	Prevention of Mother to Child Transmission
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Emergency Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Introduction

This chapter focused on the preliminary aspects of the research. It presented the research giving background of the study which gives an overview of the researchers interest in the study, the knowledge gap that the research seeks to fill, and a list of all components of the chapter, statement of the problem, purpose of the study, significance of the study, assumptions, delimitations of the study, limitations of the study, and definition of terms.

1.2 Background of the study

Sub-Saharan Africa has the highest prevalence and incidence of HIV-1 infection in the world Global Report, “UNAIDS (2010). Women of reproductive age account for 60 percent of all adult infections and 75 percent of infections among people 15–24 years old UNAIDS (2008). Sub-Saharan Africa also has high fertility rates with an estimated 14 million unintended pregnancies annually (Hubacher, Mavranezouli & McGinn, 2008).

Zimbabwe has the sixth highest HIV prevalence in sub-Saharan Africa, at 13.5% with 1.3 million people living with HIV in 2016. New infections dropped from 79,000 in 2010 to 40,000 in 2016, with behavior change communication, high treatment coverage and prevention of mother to child transmission services thought to be responsible for this decline. The Zimbabwean HIV epidemic is largely driven by unprotected heterosexual sex with an estimated 720,000 women living with HIV in Zimbabwe the country still has unmet needs for family planning (WHO, 2016).

Women with HIV infection, like other women, may wish to plan pregnancy, limit their family, or avoid pregnancy. However, there are challenges in the use of contraceptives among this group. The main problems that prevent access to and use of birth control are unavailability, poor health care services, spousal

disapproval, religious concerns, and misinformation about the effects of birth control (Dibaba, 2009).

Family Planning in which the major component is use of contraceptive methods is a key constituent of health services and it benefits the health and wellbeing of women, men, children, families, and their communities. The aim of this study is to analyse the patterns of contraceptive use and associative factors among HIV positive women.

1.3 Statement of the problem

The country's family planning program, which was integrated into the public health system in the 1980s, has expanded dramatically. Today, knowledge of contraceptives is virtually universal, and the level of use of modern methods is among the highest in sub-Saharan Africa. Still, the fertility rate in Zimbabwe remains high, and critics have charged that the family planning program is ineffective even though there has been no systematic evaluation of the program. When human reproduction is left unchecked, it results into high birth rates, bringing about large family size with the negative effects on the health of the respective mothers and children. Consequently, this has led to negative impact on the family, the community and the nation at large as a result of economic overload in covering the additional demand. Uncontrolled births can destroy a nation's development aspirations and prevent its people from enjoying an improved standard of living.

1.4 Purpose of the study

Women living with HIV continue to encounter unintended pregnancies with a concomitant risk of mother-to-child transmission of HIV infection. The study was aimed at revealing if there is a knowledge gap in contraception use among HIV positive women, as preventing unintended pregnancy among HIV-infected women is one of the strategies in the prevention of new HIV infections among children. The purpose of this analysis was also to assess contraception use

among women living with HIV and the influence of women's awareness of HIV positive status in the practice of FP. The study was also aimed at analysing prevalence and correlates of contraceptive use among HIV positive women.

1.5 Research Questions

The study was guided by the following research questions:

1. What contraceptive methods are generally utilized by women living with HIV?
2. How many women continue using the same method of contraceptive among women living with HIV?
3. What factors influence utilization of contraceptives among women living with HIV?
4. What hinders the use and services of contraceptives in the community?

1.6 Hypothesis

There is no significant differences in contraceptive use of women based on HIV status.

1.7 Significance of the study

Current policies promote integration of family planning services in HIV/AIDS prevention, care and treatment services in the hope to deliver a broader range of services to meet more needs of women living with HIV and also improve cost effectiveness in service delivery. With scale up programs of PMTCT and ART aimed at meeting the high demand of such services as a result of the HIV epidemic, timely and excellent opportunities for scale up of effective family planning programs alongside such care and treatment efforts exist.

Program managers and policy makers in the delivery of HIV/AIDS services require more information on how to bridge the gap between the increasing need

for effective contraception awareness and services and the current low utilization of the available methods of contraception. Universal access to family planning services in an integrated manner and a priority issue which is highlighted in policy documents such as Ministry of Health and Ministry of Finance Planning and Economic Development.

This study will add to existing knowledge about utilization of Contraceptives among sexually active women living with HIV at such a time when there is declining stigma of the HIV epidemic and improving quality of life due to improving HIV/AIDS care and treatment services, PMTCT and ARV therapy that in themselves influence reproductive decisions among these women. It will generate information that will help in formulation of evidence based decisions by program implementers to strengthen the uptake of contraception use.

1.8 Assumptions

The researcher assumed that all women regardless of their status could use any type or means of contraception. The researcher also assumed that the participants from all four poly clinics would answer truthfully, accurately responding to questions based on their personal experiences and that the sample would represent a population of women living with HIV and their use on contraception. The researcher has also made assumptions that all participants were willing to participate.

1.9 Delimitations

The researcher carried out this study at four poly clinics located in the high density suburbs not the whole of Harare because results would not be feasible. This research only focuses on contraceptive use among women living with HIV, however a follow-up would have been more feasible.

1.10 Limitations

The researcher used the statistical package of social sciences (SPSS) to analyse data, which involves a lot of calculations, transforming of variables, presenting information on graphs, descriptive statistics which shows the contraceptive use

of women living with HIV which may result in so many mistakes thereby producing wrong results. The issue of self-reporting while using questionnaires method limited the researcher when the participants had to be asked about their feelings and beliefs, because the results would not be valid since participants have a tendency of exaggerating their problems or reducing the frequency of the problem they may be facing on use of contraceptives. A sample of 571 women living with HIV may have been a small number to represent the whole population of women living with HIV. It was also difficult to have other important aspects of the study answered as I used secondary data to come up with the quantitative findings.

1.12 Definition of terms

Contraceptive

These are birth controls that prevent pregnancy by interfering with the normal process of ovulation, fertilization, and implantation. There are different kinds of birth control that act at different points in the process (Peacock, 2000)

1.12.1 Women

A woman is a female human being. The term woman is usually reserved for an adult, with the term girl being the usual term for a female child or adolescent. The term woman is also sometimes used to identify a female human, regardless of age, as in phrases such as "women's rights". Women with typical genetic development are usually capable of giving birth from puberty until menopause (Anne, 2000).

1.12.2 HIV

HIV stands for human immunodeficiency virus. It is the virus that can lead to acquired immunodeficiency syndrome, or AIDS, if not treated. Unlike some other viruses, the human body cannot get rid of HIV completely, even with treatment. So once you get HIV, you have it for life. HIV attacks the body's

immune system, specifically the CD4 cells (T cells), which help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body, making the person more likely to get other infections or infection-related cancers. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. These opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS, the last stage of HIV infection (Evian, Clive, 2006).

1.13 Chapter summary

This chapter has been an evaluation of contraceptive use among women living with HIV through an overview of the study, statement problem, research objectives and research questions, justification of study, delimitations and limitations of study, study assumptions and chapter summary. Therefore, the need for the present study. The next chapter review related literature.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature related to contraceptive use among women living with HIV. There is limited literature that has been published on the topic therefore there is need to fill in the knowledge gaps. According to Machi and McEvoy (2012), a literature review is a written argument that promotes thesis position by building a case from credible evidence based on previous research. The outcome of a literature review presents a logically argued case founded in a comprehensive understanding of the current state of knowledge about a topic of study. This case establishes a convincing thesis to answer the study question.

2.1 Women and HIV/AIDS

Epidemic updates by WHO (2007) on issues of HIV indicated that an estimated 33.2 million people are living with HIV/AIDS. The epidemic of HIV is mostly (67.8%) widespread in Africa and in particular Sub-Saharan Africa, it is largely heterosexual, also said to affect mostly people within the reproductive age group. Delivery of quality HIV care as well as effective services in Africa remains a challenge and therefore this region presents unusual needs for effective delivery of contraceptive services to women living with HIV (WHO, 2007). A study by Stanwood et al. (2007), in a cohort of mostly (68%) monogamous HIV-positive women in care of the United States showed that, among women who were sexually active but had not had tubal ligation, 90% were using some form of reversible contraceptive method and that women with HIV had reproductive patterns similar to those of their HIV negative counterparts. A Ugandan (Tororo) study in a cohort of HIV-positive women receiving ART over a two-year period showed that although 93 to 97% of all women reported not wanting any more children at any time, only 14% of women

used permanent or semi-permanent family planning methods and fewer than 8% used dual contraception by their second year on ART (Homsy et al., 2009).

2.2 Factors influencing utilization of contraception

Age and FP use

Rob et al. (2007), in their study on contextual influences on modern contraceptive use among women irrespective of their HIV status, in six countries in Sub-Saharan Africa that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana, showed that younger age especially age group 20-29 years was more likely to be associated with use of modern contraceptives. For example, findings in Tanzania the likelihood of contraceptive in age group 20–29 years was higher compared to age group 15–19 years [OR=1.47: 95% CI 0.85-2.55] and age group 40–49 years [OR=0.61: 95% CI 0.41-0.90]. Utomo et al. (1983), in their study on factors affecting use and non-use of contraception among women irrespective of their HIV status following analysis showed that older age was one of the four major independent factors associated with the use and non-user of contraception.

2.3 Religion

Some previous studies have sought to investigate the relationship between religious affiliations and use of contraceptives. Studies by Khan (2001) and D'Antona et al (2009) found religious opposition as reasons for contraceptive non-use and discontinuation among respondents. In Zimbabwe apostolic sectors are amongst the major religions that have affected the health seeking habits of part of the population. On the other hand, a study by Parr (2003) in his study of contraceptive use in Ghana, found no significant association between religious affiliation and contraceptive use.

2.4 Parity and contraception use

A study of demographic and socio-cultural factors influencing contraceptive use among currently married women irrespective of their HIV status in Uganda showed that higher contraceptive use was associated with a higher number of surviving children. Contraceptive use was 26.2% among women with three or more surviving children compared with 19.0% of women with no surviving children used contraceptives (Agyei and Migadde, 1995). Todd et al, (2008) in their study on factors associated with contraceptive use among hospitalized obstetric patients irrespective of their HIV status reported that contraceptive use was independently associated with having a greater number of living children. Feldman and Maposhere (2003), in their study to explore the impact of HIV/AIDS on sexual and reproductive lives of women living with HIV in Zimbabwe found that women with several children wanted to avoid further pregnancies. Another study on factors affecting use and non-use of contraception showed that the number of living children was one of the major independent factors affecting the use and non-use of contraception (Utomo et al, 1983).

2.5 HIV seropositivity, care and contraceptive use

A study to explore the impact of HIV/AIDS on sexual and reproductive lives of women living with HIV in Zimbabwe showed that contraceptive and condom use increased markedly after HIV diagnosis, especially among those attending support groups (Feldman and Maposhere, 2003). However, a study in Cameroon, postulated that fertility rates were lower in HIV-Positive women compared to their HIV-Negative counterparts. The overall fertility rate for HIV positive women was 118.7 births per 1000 woman-years compared to 171.3 births per 1000 woman for HIV negative women. The ratio of the fertility rate in HIV positive women to the fertility rate of HIV negative women was 0.69 (Eugene and Wiysonge, 2008). Gary et al. (1998), in yet another study among women with HIV-1, showed that pregnancy prevalence is greatly reduced in HIV-1-infected women, owing to lower rates of conception. The odds of pregnancy were low both in HIV-1- infected women without symptoms and in

women with symptoms of HIV-1- associated disease. The incidence rate of recognized pregnancy during the 13 prospective follow-up study was lower in HIV-1-positive than in HIV-1-negative women. Fertility rates are an indirect measure of contraceptive prevalence, the low fertility rates observed in HIV-positive women in the above two studies may be an indicator of contraceptive decisions being made or contraceptives of one form or the other being used. Homsy et al, (2009) in their prospective study of median follow up time of 2.4 years after starting ART to assess pregnancy outcomes among women on antiretroviral therapy in rural Uganda, showed that pregnancy incidence increased from 3.46 per 100 women-years in the first quarter to 9.5 per 100 women at 24 months.

2.6 Education level and family planning use

Many researchers have postulated that education level plays a vital role in health seeking behaviour. A study on fertility and FP trends among women irrespective of their HIV status in urban Karachi-Pakistan, showed a strong trend toward declining fertility and increasing utilization of contraceptives among relatively well-educated, middle-class population (Hagen et al., 1999). While another study on factors affecting use and non-use of contraception among women irrespective of their HIV status showed that current users of contraceptives were more educated or had 14 spouses who were more educated than their counterparts who were not current users. According to Rob et al. (2007) in their study on contextual influences on modern contraceptive use among women irrespective of their HIV status, in six Sub-Saharan African countries that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana showed that secondary or higher educational attainment was more likely to be associated with use of modern contraceptives in all the six countries, for example in Burkina Faso, higher educational attainment was more likely to be associated with use of modern contraceptives compared lower educational attainment.

2.7 Knowledge about contraception methods and use

Knowledge plays an important role on whether one will use or not use contraception. A study about knowledge as an important predictor of contraceptive use among young people irrespective of their HIV status showed that condom knowledge at logistic regression was associated with a 33% increased odds of ever using them among both male and female participants (Ryan et al., 2007). In another study on contraceptive use in women enrolled into preventive HIV vaccine trials reported insufficient knowledge of certain methods to be among the reasons for not using contraception and that misconceptions related to FP methods and their incorrect use might have led to inconsistent use resulting in undesired pregnancies (Kibuuka et al., 2009). Another survey conducted in 14 countries among 7000 women irrespective of their HIV status between 14-40 years showed that knowledge gap in family planning methods restricts women's contraceptive choices and hence use, and that women fail to take advantage of new contraceptive methods due to lack of knowledge and stay with the familiar options (Rossella, 2006).

2.8 Spouse and effect on contraception use

A study on correlates of consistent condom use among HIV-positive African American women living in the United States showed that women with HIV were more likely to use condoms if they had high partner communication self-efficacy and reported low partner-related barriers to condom use (Raiford et al., 2007). In another study on contextual influences on modern contraceptive use among women irrespective of their HIV status in Sub-Saharan Africa, Rob et. al. (2007) showed that partner approval was more likely to be associated with use of modern contraceptive in all the six countries that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana. For example, partner approval was 4 times more likely to be associated with modern contraceptive use in Malawi and in Kenya. Partner opposition was found to cause a statistically significant increase in unmet need accounting for as much as 20 percent of unmet need reported by women and a shift in contraceptive use favouring traditional methods over modern methods (Wolff et al., 2000).

2.9 Influence of culture on contraceptive use

Individual factors that determine a person's use of services such as FP are mediated by the characteristics of the community in which the individual lives. It is important to look beyond individual factors when examining FP use or non-use. (Tsui and Stephenson, 2002). Cultural norms and expectations are varied and include among others, fatalism attributed to HIV disease, fear of infecting the unborn child, gender roles designated by society such as the role of women in child bearing and the demand for bigger families (Srikanthan and Reid, 2008). A qualitative study to identify and describe perceptions of HIV positive Swazi women of childbearing showed that, cultural expectations override individual factors such as knowledge about one's HIV sero-positivity for example pressure from in-law's forces. HIV positive women to have children despite their status, the desire to portray "femininity" and fulfil womanhood also contribute often culture shapes perceptions of the individuals belonging to that culture on matters of fertility including contraceptive use. In a cross-sectional survey to assess use and identify condom use barriers, results showed that condoms use during the last occasional intercourse was only 36.8% of males and 47.5% of females. Failure to use condom was related to its perceived lack of efficacy and perceived quality (Sennen et al, 2005). In another study to explore religious beliefs among men and their influence their use of condoms showed that for religious reasons, most of the men avoided using condoms and were opposed to women's contraceptive use (Degni et al, 2008).

2.10 Health service delivery and contraceptive use

Health services and in particular private family planning service delivery play a big role in sexual and reproductive health behaviours, outcomes of risk perception and in this regard use of family planning by women living with HIV. In one study, results showed that the proximity of a private health facility in urban areas which likely reflects increased availability of FP methods, was positively associated with current use as was the presence of a higher number trained family planning service providers (Katende et al, 2003). In another study on contraceptive use and incidence of pregnancy in Ivory Coast among 546 HIV

positive women followed up for 2 years after delivery and given family planning counselling and free contraceptives, results showed high proportions of women using modern contraception varying from 52 to 65% and low pregnancy incidence calculated as the number of pregnancies for 100 women-years at risk of 5.70. Findings in this study indicated that counselling and regular follow-up was accompanied by a high rate of contraceptive use and a low pregnancy incidence among these women after delivery (Brou et al, 2009). In Rakai, Uganda, a community randomized trial of enhanced FP efforts in an HIV surveillance program showed a statistically significant higher use of hormonal contraceptives and lower pregnancy rates in the intervention arm as compared to the control arm. Investigators found that using trained volunteers and social marketing of contraceptives can improve contraceptive uptake among these women (Lutalo et al., 2000).

2.11 Decision making in contraceptive use

Marital status of HIV positive women has also been explored to influence their use of contraceptives. In a study carried out by the African DITRAME project, contraceptive use of HIV positive women was found to be 39% and one of the factors that were significantly related to contraceptive use was marital status. The influence of marital status on contraceptive use among HIV positive women was also reported in the study of contraceptive use and associated factors among women enrolling into HIV Care in Southwestern Uganda. This study found the odds of contraceptive use among single and previously married women remained significantly lower than that among married women Muyindike et al (2012). Marital status of HIV positive women was also reported to influence contraceptive use in the study in Uganda by Allen et al (1993). Being single was associated with more frequent use of hormonal contraceptives and most single women preferred injectable.

2.12 Clinical factors

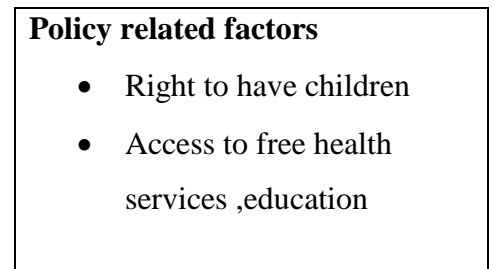
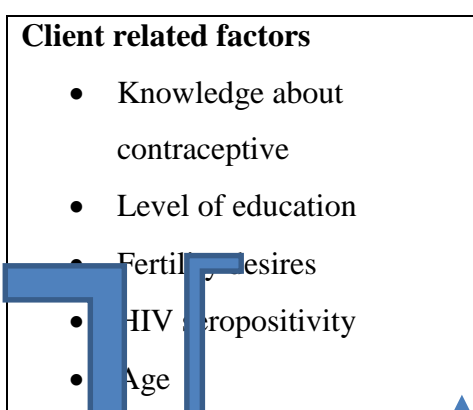
ART is associated with an increase in fertility desire, but is not associated with an increase in fertility (Maier et al, 2008). Women with HIV and on ART feel

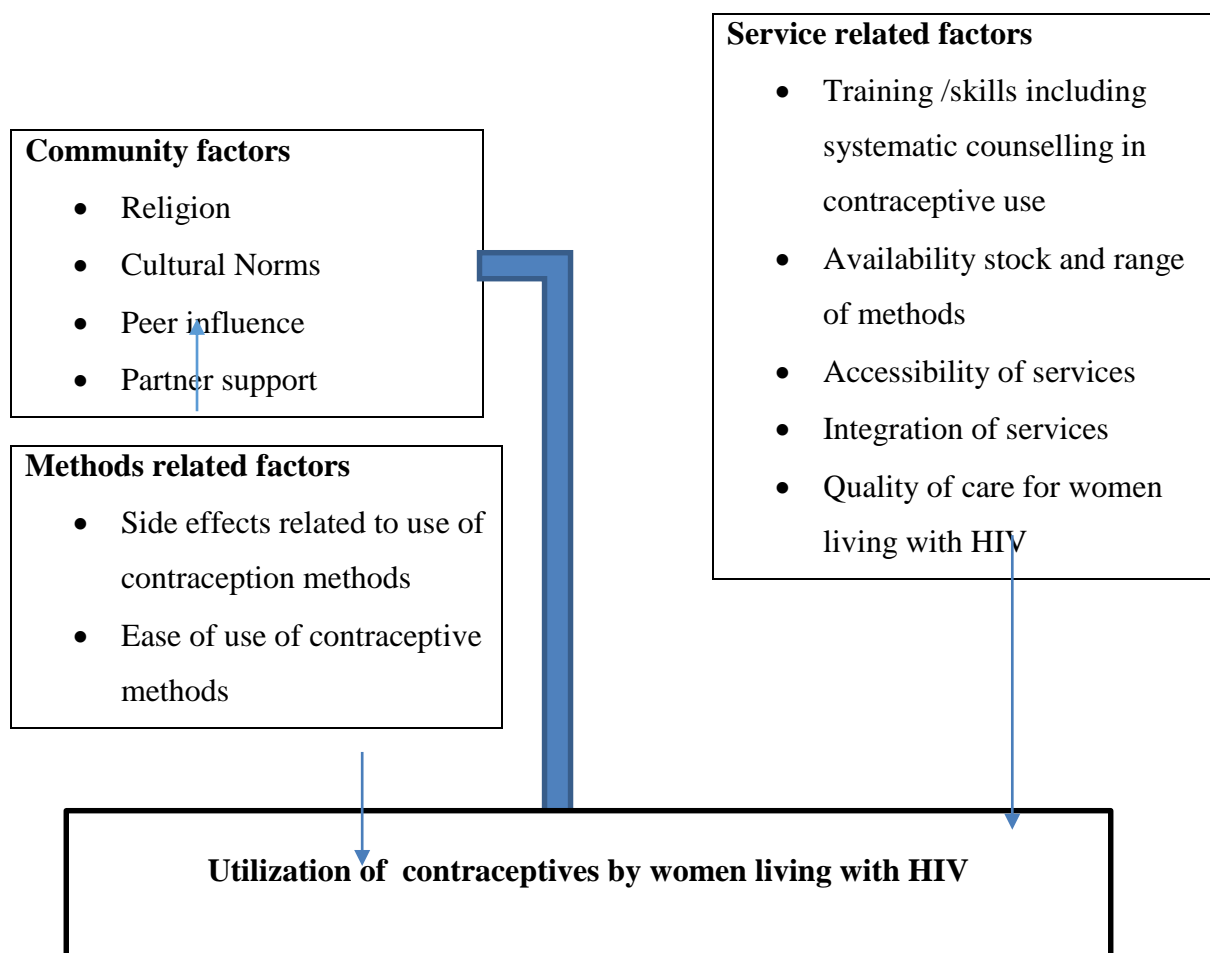
healthy and therefore feel that they can have a normal healthy life thus the increase in the fertility desire. In some centres however, this has been associated with increase in pregnancy rates especially for women who wish to have children. However, in a research that was done women also have fears of using contraceptives because of the side effects associated with the different methods. Nearly 60% of subjects discontinued the OC by 6 months. Most subjects reported no changes in headaches, weight, moodiness, and sexual satisfaction during the first 3 months of OC use. Subjects with any complaints, especially those with increased headaches or moodiness, were more likely to discontinue the OC prematurely.

Side effects are absent or mild among most OC users, but women with complaints are more likely to discontinue (Westhoff et al, 2007). However, a study carried out amongst young people in University in Uganda found that after controlling for education and ever use of contraceptives, having worries increased the likelihood of having side effects (Byamugisha, 2007). This could mean that women who are HIV positive may have more worries which probably pre disposes them to experiencing certain side effects. In the Zambian study of contraceptive use and associated factors among HIV positive women, contraceptive use was higher among healthier women with CD4+ cell counts of 250–350 cells/uL than among nulli-para and those with low CD4+ cell counts (Muyindike et al, 2012). In the study by Kaida et al (2010) however, there was no clear association between duration of HAART use and prevalence of contraceptive use.

The prevalence of contraceptive use remained steady (between 82% and 92%) for all lengths of time on HAART with the exception of women receiving HAART between one and two years, who had the lowest prevalence of contraceptive use at 67% desire. In some centres however, this has been associated with increase in pregnancy rates especially for women who wish to have children.

2.13 The Conceptual Framework





The conceptual framework above shows the various factors that could predict the utilization of contraception. These factors are socio-demographic factors, health service related factors, family factors and clinical factors. The socio-demographic factors considered in this study were age, marital status, religion, education, income and parity and these have been shown to influence the use of contraceptives among HIV positive women (Ademayi et al, 2011; Kaida et al, 2010; Muyindike et al (2012).

Utilization of Family Planning among women living with HIV is believed to be influenced by a complex interaction of many factors at individual, social and service delivery levels. Individually, parity, education, knowledge about contraception and HIV seropositivity do influence utilization of contraceptive use. Socially; cultural norms such as the fatalism attributed to HIV, designated gender roles, age of sexual onset and the demand for bigger families influence

the individual's conception choices. In addition, peer pressure; religious teachings and policy influence freedom of choice of a contraceptive method. Also, these service delivery factors such as attitudes and skills of the providers, method specific side effects, ease of use and access of the method do act directly or indirectly to influence utilization of contraception.

Family or societal factors like spouse objection, pressure to have children and disclosure are also known to predict contraceptive usage (MacPhail et al, 2007)). It is asserted that women who are able to disclose their status to their partners are more likely to use contraceptives with partners. Utilization of contraceptives is also known to be influenced by clinical factors, which included ART status, duration on ART and side effects. Women who experienced side effects might be less interested in using contraceptives (Westhoff et al, 2007). Contraceptive use is also predicted to be higher among healthier women with CD4+ cell counts of 250–350 cells/uL than among nullipara and those with low CD4+ cell counts (Muyindike et al, 2012). Factors relating to the health facility including counselling and availability of methods could predict use of contraceptives among pregnant women (Oraka et al (2010)

2.13 Chapter Summary

In conclusion contraceptive use among women living with HIV is an issue that has been of concern globally, regionally and locally. Therefore, the researcher attempts to focus on the contraceptive use of women living with HIV in Kuwadzana, Budiriro, Rujeko and Glen View, Zimbabwe as a country of low economic income state. This chapter focused on various scholarly writings and surveys done by other researchers in the field.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter identifies, explains and justifies tools used to gather data on contraceptive use among women living with HIV. The population, instruments, sampling techniques, data collection procedures and how data was analysed are described in detail. The methodology is the means by which the objectives were achieved. A qualitative design and quantitative design was used in the study.

Summary of methodologies

	Qualitative	Quantitative
Research Design	descriptive cross-sectional study	comparative descriptive survey design

Target population	HIV positive women of all age with children from 6weeks -2 years	Both HIV positive and negative women of all age with children from 6weeks -2 years
Sample and Sampling technique	purposive sampling technique	Raw secondary data was obtained
Research instrument	Questionnaires depth interview guide, focus group interview guide and key informants guide	Questionnaire
Data collection procedure	In-depth interviews and focus group discussion.	Questionnaires
	Qualitative	Quantitative
Data presentation and analysis	the thematic approach	findings are to be presented in form of tables, and bar graphs SPSS version 16 and excel were used for analysis

3.2 Research Approach

Both quantitative and qualitative research designs were used in this study. This study used a mixed methods design, which is a procedure for collecting, analysing and “mixing” both quantitative and qualitative data at some stage of the research process within a single study, to understand a research problem more completely (Creswell, 2002). The rationale for mixing is that neither quantitative nor qualitative methods are sufficient by themselves to capture the trends and details of the situation, on the issue of contraceptive use among women living with HIV. When used in combination, quantitative and qualitative

methods complement each other and allow for more complete analysis (Tashakkori & Teddlie, 1998)

A quantitative approach which according to Chiles et al (1980), is defined as a method to quantify the problem by way of generating numerical data or data that can be transformed into useable statistics. It is used to quantify attitudes, opinions, behaviours, and other defined variables and generalize results from a sample population. The researcher uses the quantitative approach because it is objective and usually free from bias. While Qualitative research is a scientific method of observation to gather non-numerical data. This type of research "refers to the meanings, concepts definitions, characteristics, metaphors, symbols, and description of things" and not to their "counts or measures. By mixing both quantitative and qualitative research and data, the researcher gains in breadth and depth of understanding and corroboration through triangulation, allowing one to identify aspects of a phenomenon more accurately by approaching it from different vantage points using different methods and techniques.

3.3 Research Design

Research design according to Creswell (2009), are plans and procedures for research that span the decision from broad assumptions to detailed methods of data collection and analysis. The researcher sought to the study, procedures of inquiry and specific methods of data collection, analysis and interpretation. A descriptive cross-sectional study was employed for qualitative techniques. A descriptive cross-sectional study is a study in which the disease or condition and potentially related factors are measured at a specific point in time for a defined population. Cross-sectional studies can be thought of as a "snapshot" of the frequency and characteristics of a condition in a population at a particular point in time which was ideal for this research (Schmidt & Kohlmann, 2008). The researcher employed the Phenomenological Approach, in a way to understand the participants 'from their own frame of reference. The researcher was able to obtain meanings attributed to the participants' experiences, through the subjective perspectives of the participants. A comparative descriptive survey design was also used for the quantitative research which was more appropriate

to the research problem. The research was using the descriptive survey method which involves the use of observations and filling in of confidential questionnaires to find in-depth information about contraceptive use among woman living with HIV, (Creswell, 2008).

3.4 Target Population

A population is defined as all members of any well-defined class of people, events or objects (Manoharan, 2010). The study was conducted in four satellite clinics, Glenview, Kuwadzana, Budiriro, and Rujeko all located in the high density suburbs of Harare. This also involved key staff who provide the services of contraception and other service providers. The study population comprised of HIV positive and negative women of all ages selected from a population of 1111 women. Therefore, the researcher did not discriminate participants based on other elements of secondary and primary diversity.

3.4.1 Inclusion criteria

- HIV positive and negative women of all ages
- HIV positive women and negative who have children between the age of 6 weeks up to 2 years

3.4.2 Exclusion criteria

- HIV positive and negative women with children above 2 years
- HIV positive and negative women who are pregnant

It was also important to get those who provide the services four key informants were interviewed from, PSI, Population services and family planning sisters in charge from all the 4 poly clinics.

3.4. Sample and Sampling technique

According to Manoharan, (2010), usually the population is too large for the researcher to survey all its members, but a small sample maybe chosen and used to represent the population. The researcher used secondary data for the 1111 women used for the quantitative research, while purposive sampling technique was used for the qualitative approach. Patton (2002) posits that purposive sampling technique is mainly used in qualitative research for the identification and selection of data -rich cases for the best use of limited resources. This requires identification and selection of individuals' who are knowledgeable about or experienced with the phenomenon in question. Hence the researcher made use of women who are living with HIV, and those negative who were willing to participate in the research.

3.5 Research Instrument

A research instrument is a tool that the researcher used to acquire and gather data and therefore, will help the researcher to find reliable data about contraceptive use among women living with HIV (Coyle, 2007). An in depth interview guide, focus group interview guide and key informants guide was developed based on the research objectives and research questions. These interview guide consisted of questions which required respondents to give detailed responses and the follow up guide questions allowed the researcher to seek clarification. Thus, the research could rephrase the questions if respondents gave short answers or did not elaborate. The guide questions sought information on contraceptive use among women living with HIV.

The questionnaire was done in either English or Shona, which necessitated translation and back translation to ensure that the meaning intended by respondents did not change as a result of the translation. The drawback was that some interviews gave unnecessary data because questions were too open, however such data was discarded during data analysis. The interviews produced

a high response rate. They facilitated the untangling of complex and sensitive issues involved in contraception use.

Data was collected through Questionnaires, in-depth interviews and focus group discussion. The researcher drafted the interview guide and questionnaires for contraceptive use among women living with HIV. The two instruments were pilot tested with those who did not participate in the actual research. This was done to familiarize with the instruments and remove unclear or ambiguous questions or phrases. The piloting of question guide questions also enabled assessment of feasibility of the research.

3.6. Data collection procedure

To collect data, the researcher collected the letter of data collection approval from the department of Psychology at school. As proof that I'm a student with Midlands State University. The research also had several meetings with the administrators of the birth cohort at the University of Zimbabwe Immunology department and received an approval letter to carry out this study. Another approval was obtained from gate keepers such as the department of Health at the city council as approval, to visit all the 4 Poly Clinics to collect data. The final letter was obtained at MRCZ, Medical Research Council Of Zimbabwe as I was working with human subjects and there for all ethical issues were followed. The data was collected over a period of 14 days with the assistance of the staff from the poly clinics. The participants were captured during the period through which they were attending the clinic together their medical services. The data collection procedure lasted for 1 hour at most per individual for in-depth interviews and focus groups. However, for the data used for quantitative findings the research received secondary raw data which was then analysed using SPSS.

3.7 Validity and reliability of methodology and instrument

Validity is defined by Creswell (2008) as the best approximation level towards the truth or falsity of a given inference, intention or conclusion. The aspect methodology assessed for included the research approach, the research design and the instrument that was used for this research. While reliability on the other hand is also defined by Creswell (2008) as the consistence of an instrument in measuring the same way each time it's used under the same condition with the same subjects. The research instruments that were used is reliable and valid especially considering that many studies have used questionnaires and results have been proved correct and with few or no mistakes at all, hence the researcher's determination to use the same methodology. However, because the research used secondary data this had been already done.

3.7.1 Trustworthiness

The researcher was largely concerned with the authenticity and acceptability of findings in the focus group and the researcher also establish that the research study's findings are credible, transferable, confirmable, and dependable. As such getting first-hand information became primary. The researcher used Triangulation and member checks by asking the same research questions to a different group of participants in order to assess which questions were relevant and also add those that had not been included.

3.8. Data presentation and analysis

3.8.1 Quantitative data

The forms were properly filled by serial number and entry was done by the principle investigator to avoid any data entry errors and inconsistent entries. The research received the secondary data which was roll and then cleaned up by the principle investigator. Data was thereafter exported to SPSS version 16 for final

editing and analysis. Also, Excel was used to complement the two statistical packages whenever necessary as some variables could not be exported to SPSS. The findings are to be presented in form of tables, and bar graphs. The analysis will include inspecting, cleaning, transforming, and modelling data. The context, sample sizes and outcomes will be tabulated in relation to the topic. Similarities and differences of the study outcomes are to be highlighted in structured tables. And homogeneous or heterogeneous results will be displayed.

3.8.2 Qualitative data

Thematic analysis was done for the qualitative data generated. The data was reviewed and coded by themes and sub-themes. The research firstly familiarised with the data transcribing the interactions and then reading and re-reading the transcripts and listening to the recordings to have a comprehensive understanding of the content of the interaction. There after the researcher identified preliminary codes, which are the features of the data that appear interesting and meaningful. Followed by the searching, reviewing of themes and defining and naming of themes.

3.9. Ethical Issues

The study was guided by the following ethical principles:

3.9.1 *Informed consent*- The researcher had her research proposal approved by the research supervisor as she was a student. Second permission was sought and granted from the Medical Research Council of Zimbabwe as the research fell under the medical field. Third permission was sought and granted from the city council of Harare to allow the research access into the clinics. Verbal and written informed consent from participants and key informants was granted after guarantying privacy and confidentiality of interview information and participant identity. Respect for participant opinions and suggestions were also

guaranteed. The participants are informed of the research intents and authorization to carry out the research. The interviews were carried out in privacy, in a free and conducive environment. Data was stored in the researcher's laptop which has a password access and not accessible to unauthorized persons

Consent guarantees that individuals are willingly participating in the study with full knowledge of related risks and benefits. A central position that the person must have all of the information that might rationally influence their willingness to partake in a way they can understand (Brent et al, 1988). The research should inform participants about: The purpose of the study, expected period and processes, participants' rights to decline in participating and to pull out from the research when it has started, and foreseeing factors that can influence their enthusiasm to participate, such as possible risks, discomfort or hostile effects.

3.9.2 Confidentiality- The researcher assured confidentiality of all the information gathered, as there were so sensitive issues that involved names. It is an explicit or implied assurance by the researcher to a participant in a research whereby the participant is confident that any information provided to the researcher will not be divulged to the people. Hence information from this study was kept confidential. Pseudo names in all case studies were used to protect the respondents' identities

3.9.3 Anonymity- of the respondents was strictly adhered to. Anonymity is protected when the subject's identity cannot be linked with personal responses Marianna (2011). The researcher observed the concept of privacy, which was maintaining a degree of secrecy of the credentials of the participants remain

unidentifiable. This was observed so as to protect and assure participants no harm since no one can actually identify who participated or not.

3.9.4 Honesty- The researcher will strive for honesty in all technical communications that is justly report data, results, methods and procedures, and publication status. It is not allowed to fabricate, falsify, or misrepresent data. It's also not accepted to deceive colleagues or the public (Fazel et al, 2008). So the researcher will make results transparent to the group while protecting individuals' personal space

3.10. Chapter Summary

This chapter outlined methods employed in carrying out the research, research design, population and sample, sample procedure, research instrument, data collection procedure, data presentation and analysis procedure.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

The chapter contains a presentation and analysis of all the data collected. Results are presented in tables and figures proceeded by narrations. The thematic approach of presentation was employed to present the findings of the interviews and focus group discussions. In this study a structured questionnaire was administered to 1111 study participants. Qualitative data was collected from 4 focus group discussions with each group consisting of 10 participants each, 12 in-depth interviews and 5 key informants to complement the quantitative data.

4.2 Characteristics of participants

A sum of 1111 women aged between 15 and 46 years with a mean age of 28 years' women were randomly selected from 4 satellite clinics in Glenview, Kuwadzana, Budiriro and Rujeko. Structured questionnaires were administered. Of the 1111 women, 572 were HIV positive giving an HIV prevalence of 51.49%. Due to inconsistencies and incompleteness of some of the data, some variables exhibited different total number of responses (n).

The general background information of the women will be summarised in table 4.1 below.

Variable		Frequency	Frequency (%)
Age (N=11111)	15 - 24 years	327	29.4
	25-34 years	575	51.8
	35-50 years	209	18.8
	Mean age (28 years)		
Marital Status (n=1109)	Single	37	3.34
	Married	844	76.10
	Married	200	18.03
	Polygamy	6	0.54
	Cohabiting	12	1.08
	Divorced	10	0.90
	Widowed		
Religion (n=1038)	Apostolic	256	24.66
	Protestant	201	19.36
	Roman	74	7.13
	Pentecostal	499	48.07
	African	4	0.39
	Traditional		
	Religion (ATR)	4	0.39
	Islam		
Education status (n=1110)	None	2	0.18
	Some primary (<grade7)	14	1.26
	Complete primary	41	3.69
	Some secondary	227	20.45
	Complete secondary	773	69.64
	Tertiary	53	4.78
Employment status (n=1106)	Unemployed	805	72.78
	Self-employed	199	17.99

	Employed	95	8.59
	Student	7	0.63
Para (n=1111)	0 children	273	24.57
Para is total	1 child	328	29.52
number of	2 children	288	25.92
children born	3 children	169	15.21
	4 children	37	3.33
	5 children	14	1.26
	6 children	1	0.09
	7 children	0	0
	8 children	1	0.09
Gravida (n=1110)	0 pregnancies	2	0.18
Gravida is the	1 pregnancy	239	21.53
total number of	2 pregnancies	301	27.11
pregnancies	3 pregnancies	282	25.41
conceived	4 pregnancies	193	17.39
	5 pregnancies	63	5.68
	6 pregnancies	24	2.16
	7 pregnancies	3	0.27
	8 pregnancies	1	0.09
	9 pregnancies	1	0.09
	10 pregnancies	1	0.09

Table 4.6: A summary of the women's background information

The average age of the women was 28.49 (SD=6.19), the median age was 28 (min=15; max=46) and the modal age was 33. Approximately half of the women (48.69%) ranged between 21 and 30 years.

Married women were the most common, over 70%. The frequent religious denomination was the Pentecostal church which was reported to be attended by more or less half of the participants. Over half of the women were fairly literate such as, they completed their secondary education. However, very few (4.78%)

proceeded to tertiary education. Majority of the participants (72.78%) reported to be unemployed.

The total monthly income was investigated. The total monthly income was inclusive of the husband’s salary, or combination of both. The average monthly income was \$261.60 (SD=\$195.97), the median monthly income being \$211.50 (min=\$0; max=\$2000) and the modal income was \$300. Figure 4.2 will show the distribution of the monthly income reported by the women.

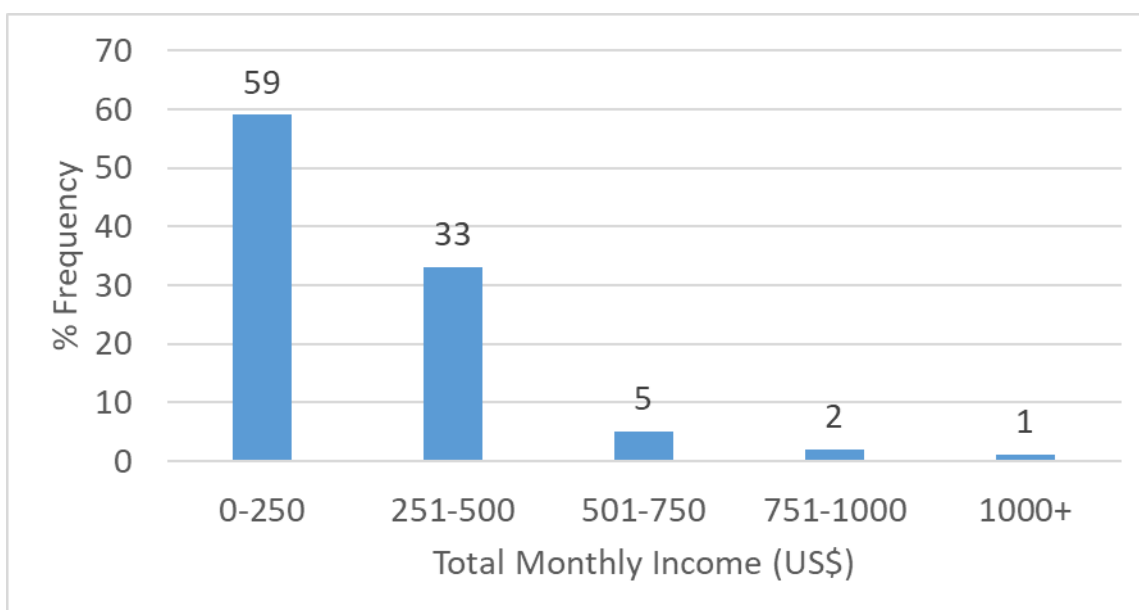


Figure 4.1: The total monthly income distribution chart

The number of women who received lower income were much more than the number of women who reported to be receiving higher income.

4.3 The demographic information for HIV positive women

The demographic information of the women who were HIV positive is shown in table 4.3

Variable	Frequency	% Frequency
Age		
15 - 24	327	29.4
25 - 34	575	51.8

35 – 50	209	18.8
Religion		
Apostolic	135	23.60
Protestant	108	18.88
Roman catholic	39	6.82
Pentecostal	249	43.53
ATR	2	0.35
Islam	4	0.70
Marital status		
Single	25	4.37
Married	401	70.10
Polygamy	126	22.03
Cohabiting	4	0.70
Divorce	11	1.92
Widowed	5	8.74
Employment status		
Unemployed	408	71.33
Self employed	112	19.58
Employed	48	8.39
Student	3	0.52
Education status		
None	0	0
Some primary	10	1.75
Complete primary	25	4.37
Some secondary	132	23.08
Complete secondary	385	67.31
Tertiary	20	3.50
Area		
Budiriro	48	8.39
Glenview	123	21.50
Kuwadzana	259	45.28

Rujeko	142	24.83
Para		
0-2 children	445	77.80
3-5 children	126	22.03
6 children and over	1	0.17
Gravida		
0-2 children	225	39.34
3-5 children	320	55.94
6 children and over	17	2.97

Table 4.7: Demographic and socioeconomic status of HIV positive women (n=572)

Over 80% percent of the HIV positive women were between the age 21 and 40 years. Most of the HIV positive women (43.5%) attended Pentecostal churches. The bulk of the HIV positive women were married (70%). Unemployment rate was high among HIV positive women, over 70%. Most of the women living with HIV however were literate with almost 70 % of them having had completed at least secondary school. The highest number of HIV positive women was from Kuwadzana. The fertility rate was quite low among the HIV positive women with over 75% of them having at most 2 children and over 90% having had carried at most 5 pregnancies.

Age by HIV Status

Age by HIV Status

Age Group (Years)	HIV Status		
	Negative	Positive	Total
15 - 24	205 (63)	122 (37)	327
25 - 34	257 (45)	318 (55)	575
35 - 50	77 (37)	132 (63)	209
Total	539 (49)	572 (51)	1111

Pearson Chi2 = 41.0683 Pr = 0.000

Table 4.8: Age by HIV status

4.4 A general background of contraception use

Eight hundred and twenty-eight (828) women of the 1111 reported to be using family planning giving a prevalence of 74.53% whilst 16.29% (181 of 1111) reported to be using contraception specifically before pregnancy. Of the 1111 women, 789 (71.01%) reported to be on contraception after pregnancy. The most common method of contraception which the women reported to be using was the oral pill. Table 4.4 will exhibit the breakdown of the various contraception methods and the percentage of women who use them.

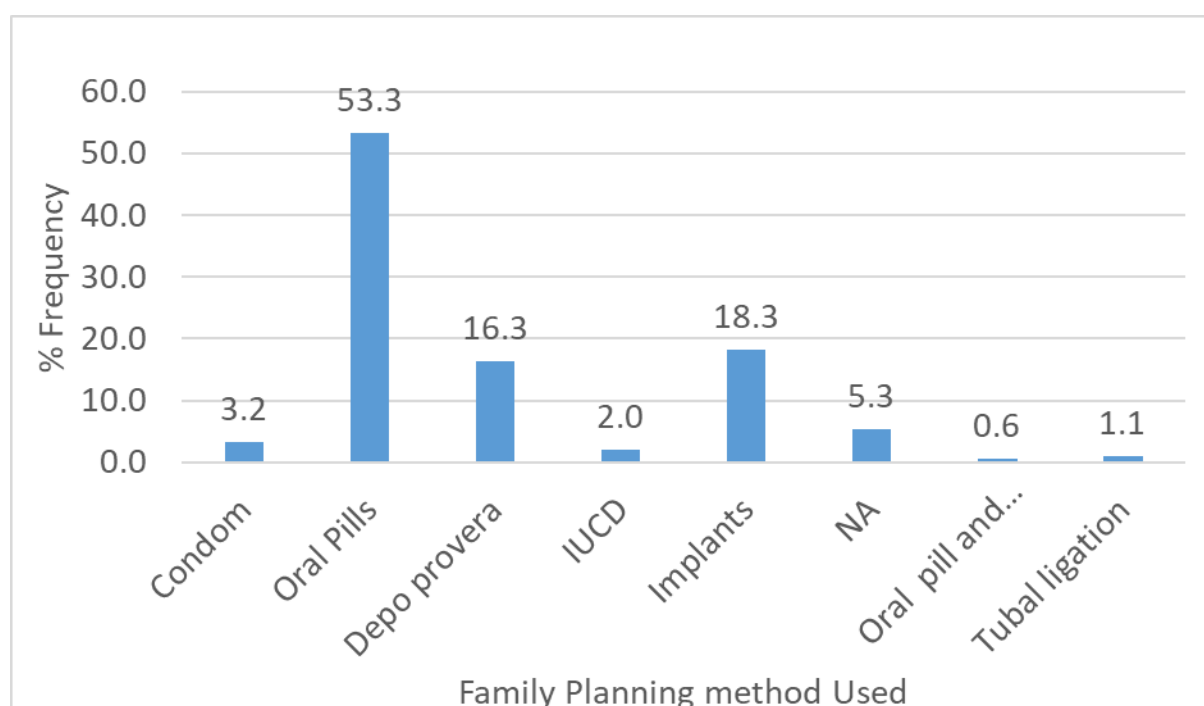


Figure 9.2: Contraception use patterns amongst the women (n=828)

Over half the women (65.34%) who reported to be using contraception confirmed to be using the oral pill as their contraceptive method whilst the rest were using other methods i.e. norplant, depo injection, jadelle, condom, loop or a combination of 2 methods.

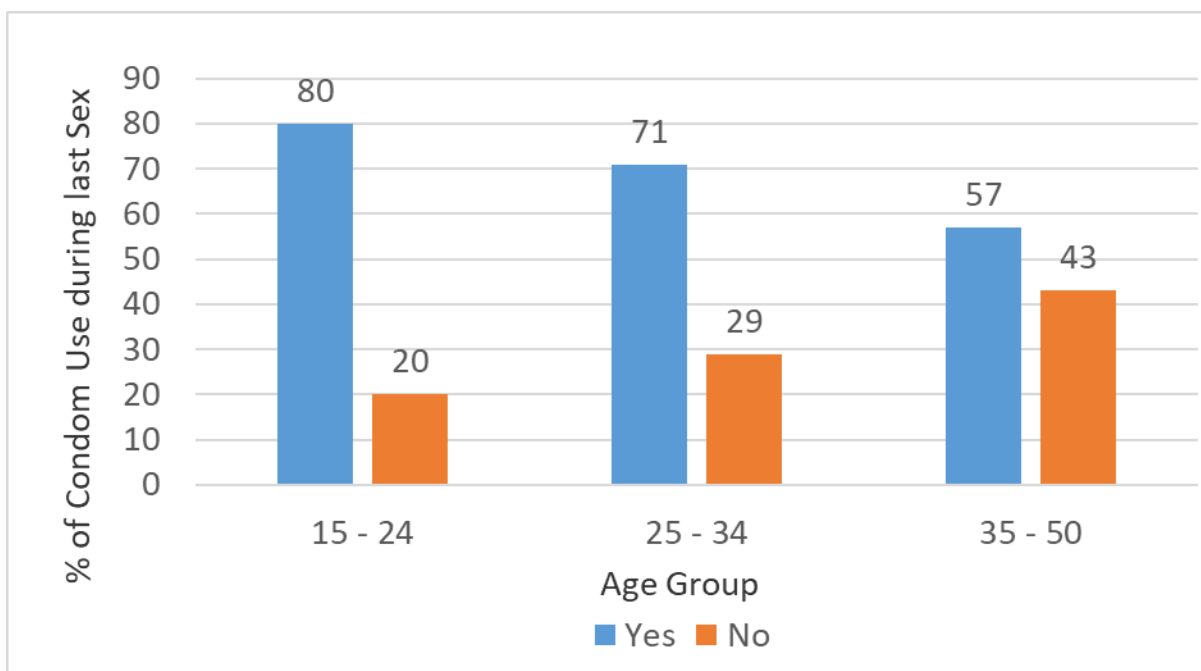


Figure 4.3: Age by % of Condom use during last Sex (n = 1077)

Regarding access to contraception, majority of the women reported to have an easy access to contraception. More information can be shown in table 4.5.

Access to Family Planning Method	Frequency	Percent
Very easy	665	60.56
Relatively easy	237	21.58
Sometimes easy	27	2.46
Very difficulty	5	0.46
Not sure	164	14.94
Total	1,098	100.00

Table 4.4: Accessibility of contraception (n=1111)

The bulk of the women (60.13%) reported to be easily accessing contraception.

4.5 Contraception use among HIV positive women (n=848)

Four hundred and fifty-three (453) of the 848 women living with HIV were reported to be on contraception. Therefore, the prevalence of contraception use among HIV positive women was 79.20%. Two hundred and seventy-seven (277) HIV positive women, 48.51% reported to have used condoms during their last sex. Table 4.6 below will summarise the pattern of contraception use among HIV positive women.

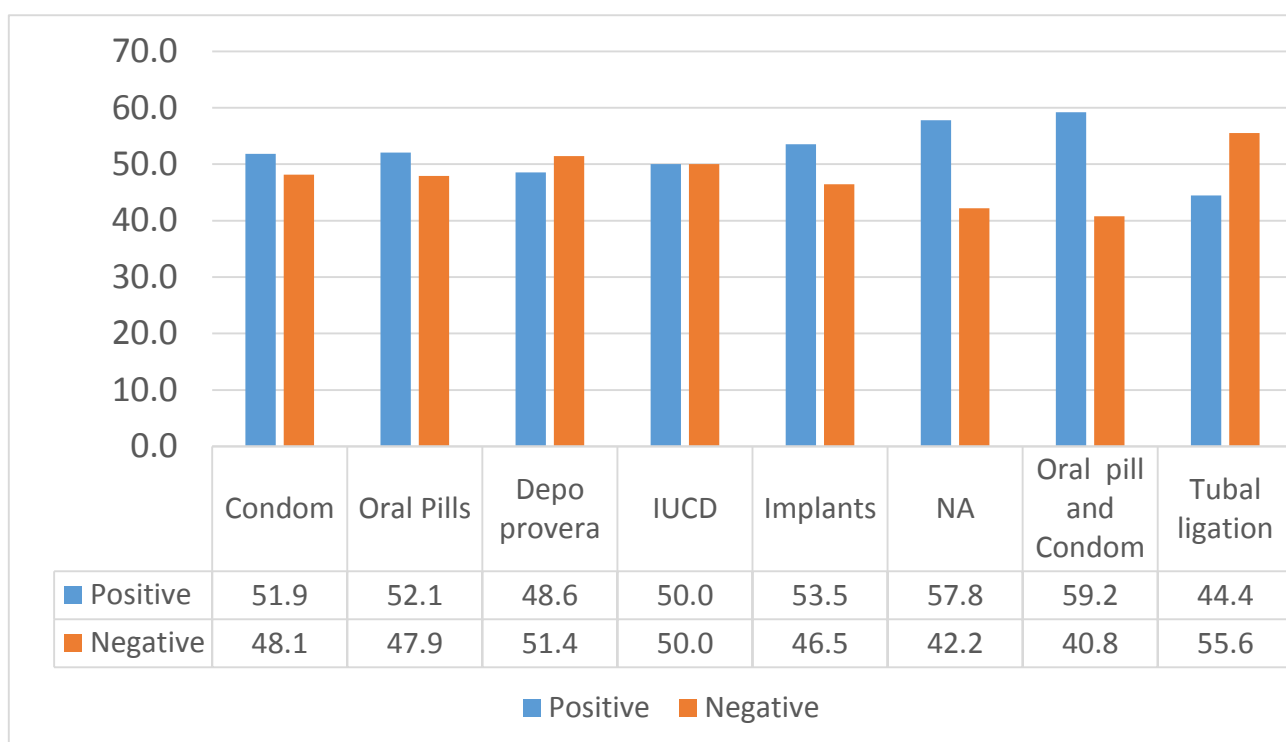


Figure 4.3: Patterns of contraception use among HIV positive women

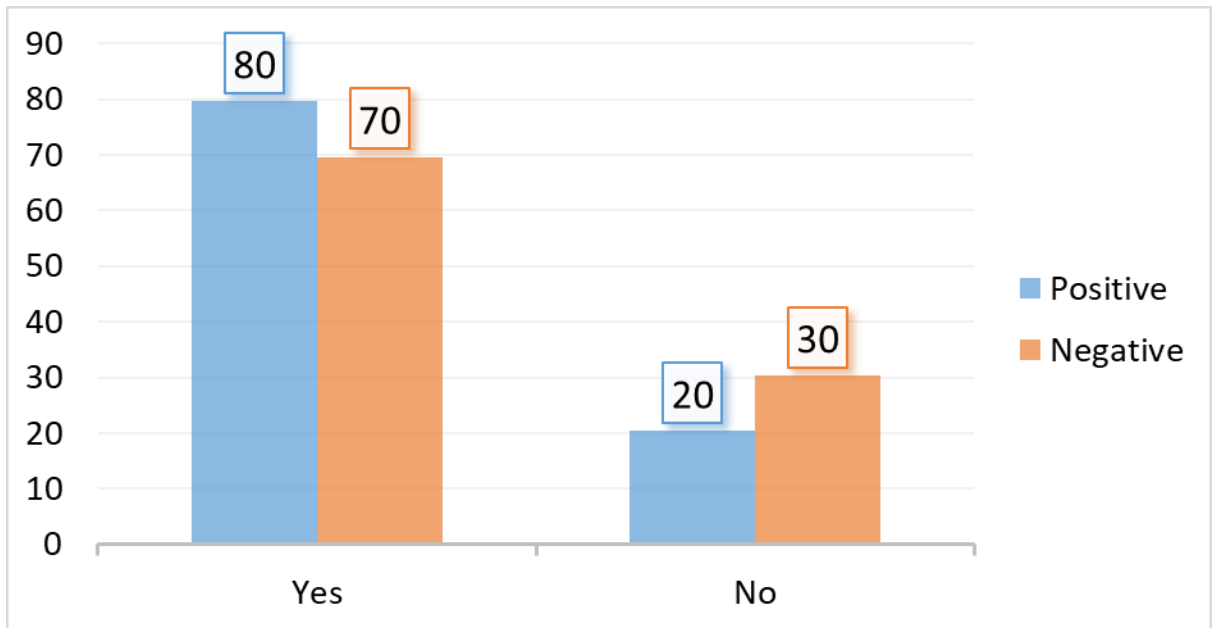


Figure 4.4: Use of Family Planning Method by HIV Status

Association of HIV Status by Demographics

		HIV Status			Pearson's chi2	P.value
Variable	Characteristic	Negative	Positive	Total		
Age Group	15 - 24	205	122	327	41.0683	0.000
		63	37	100		
	25 - 34	257	318	575		
		45	55	100		
	35 - 50	77	132	209		
	37	63	100			
Family Income	0-250	311	322	633	7.6178	0.107
		49	51	100		
	251-500	168	179	347		
		48	52	100		
	501-750	29	25	54		
		54	46	100		
	751-1000	5	13	18		
		28	72	100		
1000+	8	2	10			
	80	20	100			
	Yes	493	273	766	249.6264	0.000

Condom Use During last Sex		64	36	100		
	No	35	276	311		
		11	89	100		
Sexual Partners to date	1	408	256	664	118.6874	0.000
		62	39	101		
	2	99	186	285		
		35	65	100		
	3	19	83	102		
		19	81	100		
	4	7	21	28		
		25	75	100		
	5 - 10	6	21	27		
		22	78	100		
	11+	1	5	6		
		17	83	100		
On ART	Yes	0	45	45	0.260	0.610
		0.00	100	100		
	No	3	519	522		
		0.53	99	100		

The most common type of contraception among HIV positive women was the pill which was reported to be used by just above 50 percent of the women. Quite a lot of the women used condoms whether as the main contraception method or with some other method of contraception. Table 6 will further elaborate the patterns of contraception use from the period before the woman was pregnant.

Type of contraception before pregnancy	Type of contraception after pregnancy	Frequency	% Frequency
Pill	Pill	102	17.86
Pill	Depovera	75	13.13
Nothing	Pill	123	21.54
Pill	Condom	95	16.61
Depovera	Jadelle	77	13.49

Pill	Pill +condom	83	14.54
Pill	Loop	17	2.98

Table 4.10: Patterns of contraception use among HIV positive women before and after pregnancy (n=572)

Pill was the most common method of contraception whereby quite a number of women remained on the pill after pregnancy or changed from nothing to the pill after pregnancy. The table 7 below will show the whether the contraception was accessible or not for HIV positive women. Using Pearson’s chi2 test, at the value of 22.4555, the p. value recorded was 0.000

Association of accessibility of contraception and HIV status

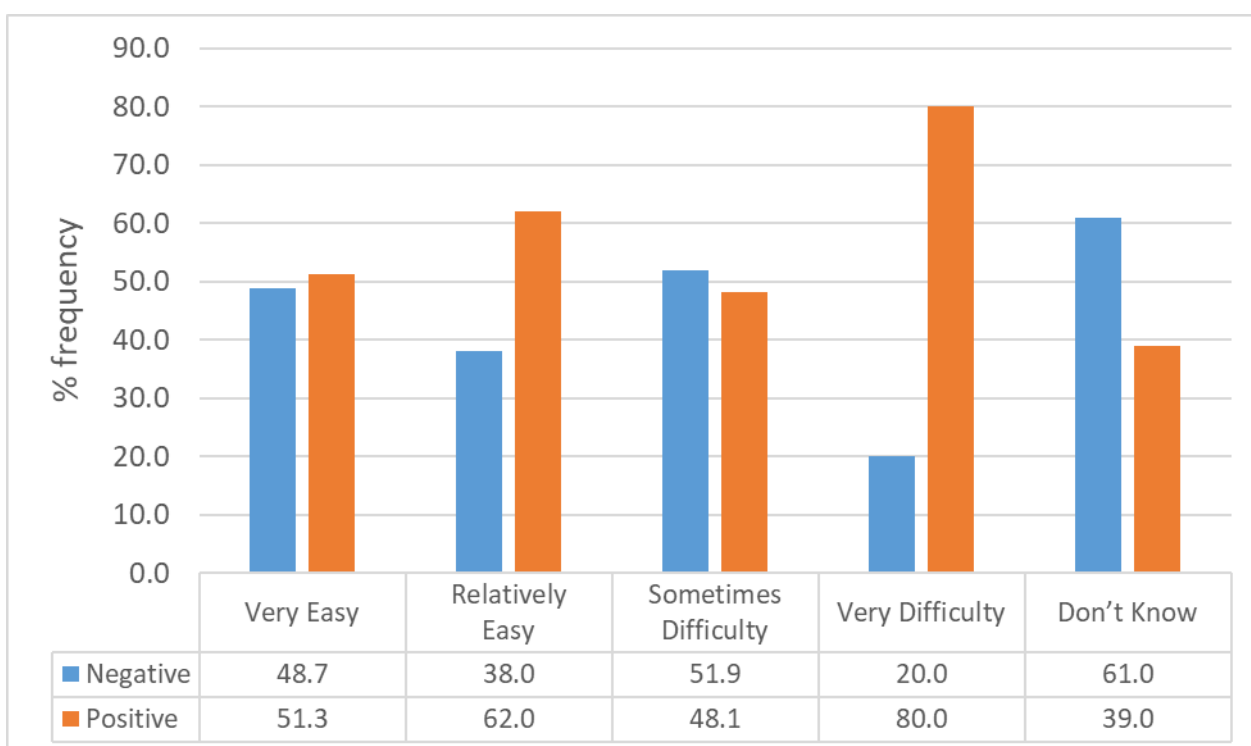


Figure 4.5: Accessibility to contraception among HIV positive women (n=1098)

The HIV positive women opting for permanent contraception

One hundred and eighty-eight HIV positive women, 32.92% reported not to want to have children again.

4.9 Disclosure of HIV status among HIV positive women

Disclosed status	Negative	Positive	Total
No	1	59	60
Yes	3	503	506

Of the 561 HIV positive women, 506 reported to have disclosed their status thereby giving a disclosure rate of 88.62%. The other 66 reported that they would disclose their statuses within a week. Table 4.9 summarises the disclosure patterns by the HIV positive women.

Person disclosed to	Frequency	% Frequency
Husband	323	63.83
Mother	82	16.21
Sister	73	14.42
Aunty	10	1.98
Brother	9	1.79
Friends	7	1.38
Boyfriend	2	0.40

Table 4.7: Disclosure patterns of HIV positive women

4.10 Cross Tabulations

A chi-square test was performed for the various variables against contraception use. The results are displayed in table 4.10 below.

Variable	Do you use any contraception?			P-value
	No (%)	Yes (%)	Total (n)	
HIV status				

Negative	30.4	69.6	537	< 0.001*
Positive	20.4	79.6	570	
Marital status				< 0.001*
Single	54.1	45.9	37	
Married	20.2	79.8	841	
Polygamy	42.2	57.8	199	
Cohabiting	0	100	6	
Divorced	16.7	83.3	12	
Widowed	20	80	10	
Religion				0.495
Apostolic	24.4	75.6	254	
Protestant	28.4	71.6	201	
Roman catholic	20.3	79.7	74	
Pentecostal	25.5	74.5	498	
ATR	0	100	3	
Islam	50	50	4	
Employment				< 0.001*
Unemployed	28.1	71.9	801	
Self employed	17.1	82.9	199	
Employed	14.7	88.3	95	
Student	57.1	42.9	7	
Education				0.341
None	0	100	2	
Some primary	7.1	92.9	14	
Completed	17.5	82.5	40	
primary	24.3	75.7	226	
Some secondary	26.5	73.5	771	
Completed	20.8	79.2	53	
secondary				
Tertiary				

Age				
Below 20	78	22	123	
21-30	28.3	71.7	540	< 0.001*
31-40	6.6	93.4	425	
Over 40	10.5	89.5	19	
Para				
2 and below	31.3	68.7	885	< 0.001*
3-5	0.9	99.1	220	
6 and above	0	100	2	
Gravida				
2 and below	47.6	52.4	538	< 0.001*
3-5	3.9	96.1	538	
6 and above	3.3	96.7	30	

*Means statistically significant

Table 4.8: Pearson chi-square test of contraception use against numerous variables

Marital status, HIV status, employment status, age, para and gravida were strongly associated with contraception use with their p-values less than 0.05. The other variables were not associated with contraception use. A binary logistic regression was further performed on the variables against contraception use. The regression model yielded a significant p-value of >0.001 on the Omnibus Test and an insignificant value of 0.297 on Hosmer and lemes how test and it had a 83.5 percent ability of predicting correctly which made it a good model. Below is the regression table in table 11 which summarizes the findings

Variable	B	SE	Wald	P-value	OR	95 %	
						Lower	Upper

HIV status	0.534	10.140	14.525	>0.001*	1.706	1.296	2.245
Marital status	-0.148	0.161	0.838	0.360	0.863	0.629	1.183
Religion	0.136	0.099	1.884	0.170	1.146	0.944	1.391
Employment	0.000	0.189	0.000	0.996	0.999	0.690	1.447
Education	0.110	0.195	0.317	0.573	1.116	0.762	1.635
Disclosure	0.473	0.368	1.649	0.199	1.605	0.780	3.304
Age	0.708	0.219	10.425	0.001*	2.030	1.321	3.121
Para	2.073	1.043	3.949	0.047*	7.951	1.029	6.150
Gravida	1.904	0.319	35.521	>0.001*	6.711	3.588	12.552

*Means statistically significant

Table 4.9: Binary logistic regression of variables against contraception use

HIV and contraception use

The odds of using contraception increases by 1.706 times when one is HIV positive and the statistic was strongly significant with a p-value of < 0.001.

Age and contraception use

The probability of contraception use increases by 2 times for every increase in age with a p-value of 0.001, hence the statistic is significant.

Gravida and para against contraception use

For every increase in gravida, there is a probability of increase in contraception by about 6.7 times and statistic was significant with a p-value of < 0.001. The probability of using contraception increases by about 7 times for every increase in para.

Marital status, religion, employment status, education status and HIV status disclosure against contraception use

The other variables' association with contraception use was not statistically significant, their p-values were greater than 0.05.

4.6 Qualitative Research Findings

4.6.1 The key characteristics of participants

Area/Clinic	Method	Number of participants	Age range	HIV status	Langagne spoken	Occupation
Budiriro	Focus group & in-depth interviews	10 FDG 6 In-depth	15-35	Positive women	shona	Majority were unemployed
kuwadzana	Focus group & in-depth interviews	10 FDG 6 in-depth	15-40	Positive women	shona	Majority were unemployed
Rujeko	Focus group & in-depth interviews	10 FDG 6 in-depth	15-35	Positive women	shona	Majority were unemployed
Glenview	Focus group & in-depth interviews	10 FDG 6 in-depth	15-35	Positive women	shona	Majority were unemployed
Budiriro	Key informant	1	40	unknown	English and shona	Sister in charge
Kuwadzana	Key informant	1	50	unknown	English	Family planning sister
Rujeko	Key informant	1	45	unknown	shona	Family planning sister

Glenview	Key informant	1	60	unknown	shona	Family planning sister
PSI Zimbabwe	Key informant	1	unknown	unknown	English	Manager
Population Services ,Belvedere	Key informant	1	35	unknown	English	Family planning provider
Mbuya nehanda hospital	Key informant	1	45	unknown	English	Matron of reproductive health

Data was further obtained from in-depth interviews, key informant interviews and focus group discussions. These were conducted to explore views from the HIV positive women on factors that facilitate or impede contraception use. Four focus group discussions were conducted in Glenview and Kuwadzana, Rujeko and Budiriro clinics. Each group had an average of 10 participants. The data was presented in the themes identified and the substantiated statements of the respondents. Data was collected in English and Shona with Shona being translated in English.

4.6.2 Family planning awareness

The aim of this analysis was to assess the practice of family planning (FP) among HIV-infected women and the influence of women's awareness of HIV positive status in the practice of FP. Participants in the FGDs expressed their knowledge and understanding of contraceptives. Some participants generally did not use hormonal methods of family planning together with condoms as they did not think this was necessary. Most women reported to be using pills whilst quite a few number use these pills together with condoms and quite a number of women use jadelle. Very few women reported to be using loop. However,

knowledge of dual protection varied. Some participants did not know about dual contraception and assumed that use of pills alone is sufficient

Some participants went on to point out that they were getting education when they visit the service providers but not told how they are used.

Yes we have heard about all the different types at the clinics, population centre in belvedrere, but the challenge is we don't know how the other methods work "tinongo nyeperana kumaraini" that is why we end up using the pill which is not complicated. (Budiriro)

A participant from kuwadzana added;

"As for me I get most information through the media. Most of the time I watch television adverts and they say something about these things" Mazuva ano Star FM inongo ita maprogramme in the morning so takuziwa (kuwadzana)

Another participant from Group 4 also indicated;

"I was informed during counselling of the importance for HIV positive women and partner to use contraceptives especially when the partner is negative"

Participant from group Budiriro said:

"I did not know that one must use more than one method at the same time"

This is evident that most of the women are well informed of the types of contraception and their availability. Mrs Pepper a service provider said:

Knowledge of contraceptives is practically universal, and the level of use of modern methods is among the highest in sub-Saharan Africa. However, the fertility rate in Zimbabwe remains high.

The research findings indicate that almost all of the participants in both groups had heard of contraceptives and were familiar with the modern methods of contraception. All the respondents had heard of condom and majority also knew of the pill, the diaphragm, foam/jelly, implant, intrauterine device and locational amenorrhea. Participants also indicated that they were receiving information of family planning from all over, clinics, hospitals, radios, newspapers, television and all kinds of media. However, some still had no understanding regardless of the awareness.

4.6.3 Factors that influence Contraceptive use

Research findings indicated that most women were using the modern contraception's. When asked why they prefer the family planning method they are using most women used pills because they thought it's easy to use. Those who do not use pills did not prefer the pill because they said it's easy to forget. Women who used condoms reported to be using condoms mainly to avoid re-infection and some to avoid spreading diseases, and most of them had no experience in using the female condom. The few women who used non-hormonal methods reported that the hormonal methods made them bleed so much. Very few of the participants from both discussions were not using contraceptives. Reasons for use of contraceptives were mostly to prevent pregnancy or spread or reinfection of HIV.

A participant disclosed;

"I came with my partner for counselling and we were told to use a contraceptive since we don't want pregnancy anymore. I have children already but wanted to add a little one, but I am afraid a new baby will get infected".

Participants who were not using contraceptives also cited non-disclosure of status and discomfort with contraceptive use as major reasons behind their non-use.

Some participants explained;

“At first we were using it but now have stopped. My husband says he doesn’t feel comfortable using it anymore and I don’t want to always force him”.

Another participant had this to say:

“I and my partner are all positive so we don’t see the need to use condom or anything. Besides I want to get pregnant. At first I was afraid but now the nurses say the baby can be protected from getting the virus”.

Some of the participants mentioned that they had an experience with torn condoms and pregnancy and therefore considered condom to be useless due to the possibility of its failure as well as the possibility of its rupture.

From the research findings this is evident that most of the participants had fear of the unknown which was also affecting them psychologically. Some women were of the believe that a women living with HIV would as give birth to a child with HIV, unacceptance to partners using condoms and lastly experiences of those who were let down by a method of family planning.

4.6.4 Status disclosure and contraceptive use

Almost all participants had disclosed their status to their partners or a family member and receiving psychological support. These women indicated to be receiving some form of support from their partners in terms of transport fares to the facilities and money for upkeep. One participant from Budiro, who had not disclosed her status, however cited fear of divorce if she disclosed her status to her husband. This was however hindering their possible use of contraceptive.

She explained;

“...Hmm, zvinonetsa kumuudza ambuya, I just can't disclose my status to him. I am waiting for him to come with me to see the nurses so they will do that and counsel us both. I fear that he will leave me, what if I'm positive and his negative and I can't tell him to use condoms too because we have never used it and it may bring suspicions”

Three participants with non-marriage sexual relationships said they were unwilling to disclose their HIV status to their sexual partners. Therefore, one of the reasons for discontinuous use of condoms in sexual relationships was the lack of awareness of sexual partners about the HIV status of their partners.

Participant E added: *“I don't think I can tell my partner I'm sick because if I do my partner will leave me. I don't even know who infected me! I ask him to use condoms because I can take contraception pills, but sometimes he doesn't like to use it and I don't insist as well because otherwise he may become suspicious and leave me.”*

Mrs Shamu a service provider felt that there was shortage of contraception counselling among women living with HIV. She went on to say most women were not informed about other contraception methods and therefore lacked adequate information on the dual use of contraception methods. Fear of side effects and a lack of adequate information were other causes of the reduction in the use of contraception methods.

The research findings indicate that contraception use of women living with HIV was easy for those who had disclosed their status to their partners or those who had received counselling as a couple. Therefore, this is evident that partner support plays a pivotal role when it comes to choosing of contraception use for these women.

4.6.5 Accessibility and information on family planning methods

Women were asked where they get their contraception. Most of the women reported to be getting them from pharmacies and some from the clinics. However, they were aware of those that are sold in the streets and the disadvantages of using them.

“Tinotenga mapills edu kuphamarcy nokuti mukadzi wekuma raini kwedu akatenga muroad three week anga atone nhumbu, plus anenge achingorowa nezuva”(a lady from where I stay bought her pills in the street and 3 weeks she was pregnant ,plus those vendors store the pills in the sun).

Mrs Peters a service provider add

Most women are now educated when it comes to where they should get their family planning methods. Today we have thousands of women visiting our facilities for procuring their family planning methods which is a safe area with proper storage to maintain their effectiveness. This we also try had to inform them. She went on to say as a non-governmental organisation they have a programme that they are running were by they go into the communities giving health talks on methods of contraception and referring them to come and get services for as little as a dollar and condoms free.

However, another responded felt the accessibility of the methods was preventing them to use the methods they desired. The respondent had this to say:

“My self I prefer depo and I have always used it, but after relocating to Harare I changed because you are expected to pay a dollar for it and I can't afford.in Mangura I used to get it for free. So now I use natural methods”.

Another participant said

“It here in town where you can get access to FP without stress in the rural areas where I come from, the clinic is far away and bus fare is expensive and for that reason we end up not using them but if they could have other station or Mbuya nyamukuta who comes every month in our areas to give us these contraceptives.”

The research findings indicate that there is great coverage in the urban areas compared to the rural areas. Also some women failure to procure FP due the minimal charge as people do not have money.

4.6.6 Side effects of hormonal contraception

Several participants had previously used hormonal contraceptive methods but suffered side effects in particular bleeding and weight gain, therefore discouraging them from using the methods again.

One of the respondent said:

“I do not use hormonal methods as when I last used them I bled for a long time. I do not want to go back to having that problem again. “

Another said:

“I used FP for 2 years and gained a lot of weight. When I removed, it I bled for so long. That is why I do not use a family planning method.”

Most respondents were of the opinion that jabelle and the injectable depo makes them bleed a lot and make them gain weight. Despite a few who were using this method in the hope of gaining weight it was the opposite for others.

Mrs Muriwo a service provider had this to say:

“Like everything that is entering the body there is need for the body to adjust therefore the reason of the bleeding however this is no reason for one to change the method as you can only experience it for the first 3 months or less”.

On the issue of gaining weight she went on to say:

Yes, hormonals make one feel hungry but it is the amount of food one takes that causes the gaining of weight. We try to inform this woman but however they always remain with the opinion that it is the family planning that makes them go big she laughed’

Research findings indicate that women were not consistent with one method of FP as a result of the perceived side effects. While for some choice of contraception method was hindered by the same perceived side effects which were regarded normal by the service provider and said not to be experienced by every woman.

4.6.7 Role of Partner in contraceptive use

Influence of partner, friends and communities played a pivotal role in contraception use. Only four of the participants, whose husbands or sexual partner were not infected with AIDS and were aware of the disease, were constantly using condoms. Many participants referred to the unwillingness of their mate or sexual partner to use condom and many of them mentioned that they could not insist on the use of condom because they could be subject to the violence practiced by their mate or sexual partner. Condoms were reported to be controversial though, some women reported their husbands not to be supporting use of condoms

One of the respondent said:

“My husband doesn’t like to use condoms. He says condom ruins the joy of sex. So I insist on it, he will start a quarrel and says ‘you are sick, what’s difference for you?’”

Another respondent said:

“murume wangu ukangotaura zvecondom unochiona hanzi urihure here,ndakukuroora kaini ,dzimwe nguwa anobva atonomira penze achitaurisa kuti vanhu wanzwe saka zve condom zvakatooma”(my husband every time you mention of a condom he says are you a prostitute ,I paid lobola for you so no condom so issues of condom are something .he even goes out and start shouting for the neighbours to here if I talk of condoms).

Research findings also indicate that besides majority of the women having a say on the type of contraception method they used, there were other influences.

One respondent had this to say:

“when we are in the neighbourhood we sit and talk of what we experience as women so if someone says something negative we learn and consider it, for example someone got pregnant on jadelle so I will not use jadelle I don't want to give birth to an infected child. Do you know that child will be called a 3310 a child that gets sick all the time and is affected easily by any disease she laughs”

Research findings indicated that majority of the women's partners regardless of their status were not for the condom and felt they had no need of using condoms with especially their wives at home who they had paid lobola for. Only those who had received some form of counselling were the ones who were religious in using the condoms.

4.6.8 Tradition verses contraception use

Most of the women did not know of any traditional contraception methods. Few women knew of few traditional methods like use of marijuana seeds. Most respondents revealed that they did not have experience of using traditional methods except of vagina tighten herbs. Except of a few.

Respondent said:

I know of using cannabis seeds (modzi), you shallow the number of seeds which is equivalent to the years do not want to have child.kana munhu achida kuita vana after 5years unoto medza modzi 5 asi ndisingaziwe kuti ko wakazoda kuita mwana before 5 year chii inozoitika.

Another participant said:

I know of tying of ropes in the waist and the number of knots is the number of years you will not have a child. My mother used it on me when I started my menstruation period and the number of notes she tried on the rope whilst it was round my waist is the number of days' I still go four my menstrual period and the number of years are children are spaced with. I don't even use contraception.

Other participants from the apostolic churches knew of a mixture of lemon milk and honey to drink as a method to use to prevent pregnancy. However, this was not scientific as to how the lemon, milk and honey mixture would work.

Participant for budiro said:

At church I have been given the mixture of lemon, milk and honey and it has worked now I have four children and I have had them when I have desired, I have also never used contraception ever in my life even going to the hospital I have never gone.

Other participant knew of the method of visiting a sagoma who would the perform ritual on ones the body. They had no better explanation for this but knew it was being used.

Research findings indicate that most of the women had no history of using traditional methods. For some who had used traditional methods before had moved on to modern methods of contraception.

4.6.9. Factors underlying contraceptive discontinuation

The study revealed that participants talked about other factors underlying contraceptive discontinuation and non-use, including, perceptions and beliefs about modern contraceptive methods. Many participants believe that contraceptive pills, injectable and the IUD are harmful, and that they cause different negative health effects on women's bodies, including, infertility, cancer and long delays in conceiving after use. Some participants went out to point and illustrate some misinformation and inaccurate beliefs about male condoms, pills, injectable and the IUD.

These were the different respondents:

"I think a condom reduces sexual feelings when having sex. I believe that man's semen should be good for female body".

I heard many times that pills were very dangerous on health. If a woman uses pills for a long time, it could cause badly to bone marrows".

My sister used oral pills and 10 years later, she got pregnant".

"Generally, pills are harmful later on. I heard from my several acquaintances that it could make women infertile".

"I heard, other contraceptive methods are same as pills. I didn't want to continue after I heard that injection might lead to infertility".

"Some people's IUD has stuck to their body and it happened to my mom. My mother has forgotten her IUD over 10 years and it disappeared in her body. Finally, she has got a surgery"

Mrs Peters a service provider had this to say:

“Women living with HIV face these unwanted pregnancies and some hormonal issues because if one is on ARV’s there is what is called drug interference, meaning the strength of the contraception or its effectiveness is reduced by the ARV’s. Therefore, these women should use non-hormonals such as loop, intrauterine device, or dual protect that is any hormonal and the condom. She added there is still a knowledge gap that needs to be filled there.

Research findings indicate that the woman generally do not use the same method, most of them had left the first method they had been using. Amongst the reasons for discontinuity side effects were the major cause, followed by other peoples shared experiences.

4.7 Chapter Summary

This chapter specifically focused on the study findings in relation to the literature review. The specific components included in this chapter study finding. The next chapter looks at the summary, discussion of findings, conclusion as well as recommendations arising from study

CHAPTER 5

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter focused on discussing the findings that came out from the research, followed by conclusions and then making recommendations. Thus the focus of the research was on contraceptive use among women living with HIV.

5.2 Background

The study was conducted on 1111 women and the prevalence of HIV was 51.4%. The prevalence found in this study is in line with other studies like UNAIDS, (2005). Most participants were young adults with the modal age being 33 hence most of these women were in their reproductive age. Women in their reproductive age are vulnerable to HIV as also reported by (WHO, 2007). In Places like Zimbabwe, married couples are not kin to use any protection during sexual intercourse such as condoms (Adetunji, 2000), which is a risk factor of catching HIV. Almost three quarters of the participants in the study were married women and consequently at risk of contracting HIV. The most common religion was Christianity and most of these Christians belonging to the Pentecostal churches followed by apostolic churches. Most apostolic churches do not allow use of any artificial contraception (Maguranyanga, 2015). This may have an effect on the contraception patterns of the women, most likely increasing their fertility rate and also encouraging the spread of the disease. Some cultures or religion have also been discovered to be affecting use of family planning (Srikanthan and Reid, 2008).

Literacy rate was high with over 70% of the women having had attended and completed at least Secondary education. Although most women were literate and quite educated, most of them did not have employment with the unemployment rates lying over 70%. Most of the participants' monthly average income at their homes was roughly 261 dollars. That amount of money is not enough to take care of basic needs. Newsday, (2018) reported cost of living to be averagely 590 dollars in Zimbabwe. There might be more challenges for an HIV positive person who needs an extra care such as drugs and quality food.

Just about 95% of the women had at most 3 children and 75% have had at most 3 pregnancies. The women's para and gravida status shows the fertility rate of the women in Zimbabwe not that high. Contrary to this study, Hubucher et al., (2008) found fertility rate to be generally high in the Sub Saharan region. The deviance could be due to various factors. Zimbabwe's current economic crisis may indirect force women to limit their number of children so that they will be able to contain the families in a resource constraint place. Literacy rate is quite high and high literacy has been shown to encourage family planning among women (Hagen et al., 1999; Rob et al., 2007).

5.3 Contraception prevalence amongst the participants

Generally, majority of the women used contraception about 75%, though few women reported to have been using contraception before they got married and many used contraception again after their pregnancies. The above results display evidence of family planning being done by the women in Zimbabwe. Among HIV positive women, contraception use was also high and a bit higher than the general population, about 80 percent. It is due to the psychological effects that they have seen their relatives and friends go through after giving birth when HIV positive. This is in support with Gary et al. (1998), in yet another study among women with HIV-1, which showed that pregnancy prevalence is greatly reduced in HIV-1-infected women, owing to lower rates of conception and related to social issues and the stigma that comes with it in the community. During the focus group discussions and the interviews, majority of the women admitted again to having been using contraception. HIV positive women were similarly found to be less fertile by Eugene and Wiysonge, (2008) in their study in Cameroon.

5.4 Contraception patterns amongst the participants

The most common method of contraception used by the women in the general population was the pill, just about 65%, the rest consisting of various hormonal

methods like depovera injection and very few of non-hormonal methods for example the loop. The most common method of contraception among HIV positive women was also the pill, about 51% and the rest consisting various hormonal methods for example jadelle. A number of HIV positive women reported to have been using condoms though, either as their only contraception method or as an addition to other methods. The reports were the same from the focus group discussions and the interviews. The results suggest a possibility of similarities in contraception use between the HIV negative women and HIV positive women. Stanwood et al., 2007 also discovered women living with HIV and those without HIV's contraception use patterns of the pill as a method of contraception to be similar.

Most women were discovered to be using contraception and the most common method being the hormonal methods of contraception. The patterns were similar whether for both HIV negative and HIV positive women. Cocohoba(2010) postulated that HIV positive women are using hormonal contraception methods were likely to face concerns of drug interaction were the ARV's reduce the strength or effectiveness of the hormonals (Cocohoba, 2010). This is in support with the research findings from the different sites that some of the women living with HIV and on antiretroviral drugs had become pregnant on hormonals. It is also believed that hormones in the hormonal contraception methods can regulate the HIV virus and promote faster viral replication (Cocohoba, 2010). The reasons for such ignorance are not clear but this could be due to lack of education since very few women only reported to be knowledgeable about the issue. The other reasons could be the issue of accessibility whereby the easily found methods are the hormonal methods.

Condom use was quite high among HIV positive women, which is a positive occurrence. The good outcome could be due to the fact that women reported to be mainly the decision makers in contraception issues. Also, majority of the

women reported to have disclosed their statuses and most of them to their husbands. Disclosing HIV status to their husbands could then make the initiation of using the condoms with their partners at ease. The good communication and supportive relationship from the women's husbands also encouraged high use of condoms in a study done by Raiferd et al., 2007. However, few women reported condoms to be an issue in their homes. They reported men to be refusing to use condoms claiming it was not proper to do so with their marital wives. Other studies like that of Sennen et al., 2005 found men to be poor condom users.

5.5 Factors impeding contraception use

There are various factors which can either improve or affect the use of contraception. Some of these factors include poor quality services in health facilities, culture, partner's consent and mis-information about use of contraception (Dibaba, 2009). In this study, contraception use was generally high even for the HIV positive women. Therefore, the possible correlates of contraception were more of encouraging women to use contraception. Few exceptions were the husbands who did not consent to methods like condoms. The other barrier mainly affecting contraception use was education that is in the case of HIV positive women and hormonal contraception use. According to Rob et al. (2007) in their study on contextual influences on modern contraceptive use among women irrespective of their HIV status, in six Sub-Saharan African countries that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana showed that secondary or higher educational attainment was more likely to be associated with use of modern contraceptives in all the six countries, for example in Burkina Faso, higher educational attainment was more likely to be associated with use of modern contraceptives compared lower educational attainment

The high uptake of contraception proves that the health facilities generally seems to be doing good in terms of social marketing of family planning services.

Most women reported to have been getting their contraception from the pharmacies and some from clinics and population services. These same places where also reported to have been educating the women on how to use different methods of contraception. The education seems not to be enough nonetheless as evidenced by the HIV positive women's lack of knowledge on hormonal contraception. There is need to provide thorough education on these contraception methods taking into consideration various factors so that women make informed decisions. Besides lack of enough information on contraception, a few disapprovals from partners, there was not much factors impeding the use of contraception. This is in support with a survey that was conducted in fourteen countries which revealed that there was lack of knowledge in family planning methods and as a result it restricts women's contraceptive choices and use, and that women fail to take advantage of new contraceptive methods due to lack of knowledge and stay with the familiar options (Rossella, 2006).

5.6 Factors influencing utilization of contraceptive use

Some participants did not know about dual contraception and assumed that use of condoms alone is sufficient. However, majority of the participants were not using family planning as they did not desire to have a child in the next 2 years. The participants generally did not use hormonal methods of family planning together with condoms as they did not think this was necessary. Some of the participants mentioned that they had an experience with torn condoms and pregnancy and therefore considered condom to be useless due to the possibility of its failure as well as the possibility of its rupture. Several participants had previously used hormonal contraceptive methods but suffered side effects in particular bleeding and weight gain, therefore discouraging them from using the methods again. This is all in accordance with Westhoff et al, (2007) whose findings were that side effects are absent or mild among most oral contraceptive users and women with complaints are more likely to discontinue. Again in a study done in Uganda women who had a lot of worries turned out to have also increased side effects with contraception methods (Byamugisha, 2007).

5.7 Conclusions

Contraception use is generally high in Zimbabwe. Women living with HIV and women without HIV have similar patterns in contraception use and both use oral contraception pills mostly. The HIV positive women seem to be using condoms more than their counterparts. There is a gap of knowledge on hormonal contraceptive methods use among HIV positive women. Outcome of this study further showed the influence of socio-demographic, socio-cultural and clinical factors on utilization of contraceptives among HIV positive women. Stigma also showed to be affecting the women psychologically as some decided even not to have children.

5.8 Recommendations

5.8.1. Midlands State University

- The school can take the opportunity to use the research finding of contraception use for its student family planning clinic. As a big institution which has a high population of women of all ages married and unmarried, and with also different HIV status, the school could equip the student with knowledge and provide psychological support for them.
- School could also use posters and an online page for students who wish to access information on the different contraceptive methods and their advantages and disadvantages.

5.8.2 .Ministry of Health and child care

- Educational interventions on contraceptive usage should be incorporated into the General healthcare and support programmes at the ART centres.
- Due to the myths and misconceptions on the issue reliability of the methods, which can lead to unmet need and contraceptive

discontinuation, is be addressed during contraceptive counselling at the facility level where it should be strengthened to prevent depression and anxiety to these women.

5.8.3 Health facility and community level

- To adequately address reproductive issues concerning women living with HIV, service providers require training and need to intensify counselling and education on contraceptive use. Focusing on appropriate contraception for the women as well as how to integrate use of ARV's and provision of contraception.
- Enhance family planning services so that they offer extensive education on use of various contraception.
- Involving men in family planning services
- More campaigns on stigma related issues when it comes to child bearing.

5.8.4 Further research

- There is need for further research to understand why HIV positive women do not use or discontinue the use of contraceptives.
- Psychological effects of giving birth when one is HIV positive.

5.9 Chapter Summary

This chapter provided a discussion of the research findings. The research findings were discussed in support with the literature review. The chapter also provided conclusions of the research and meaningful recommendations.

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APPENDIX A
INFORMED CONSENT FORM

**TOPIC: CONTRACEPTIVE USE AMONG WOMEN LIVING WITH HIV ENROLLED
FOR THE COHORT STUDY**

Principal Investigator: Youlandar Changata

Mobile number and Address: 44 leiwsam Ave

Chisipite,

Harare

Cell: 0776358679

Student: Midlands State University

Program: MSc in Community Psychology

The following information is provided to inform you about the study and your participation in it. You will be given a copy of this consent form. The purpose of this study is to analyze contraceptive use among women living with HIV cohort study. You are being asked to participate in this study which will be done in a day because you qualify and have knowledge and experience.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time. If you choose to be in the study, you will

be asked to participate in a confidentially filling, in of a questionnaire which will take not more than 20mins there after participate in a focus group discussion which will be 45mins to an hour, where women those who have come for their pre and post antenatal care can share their views.

You will be asked to answer demographic questions about yourself .You may not answer any question you do not want to answer, and you may ask to have your answers removed from the study at any time.

There is no cost to you for taking part in this study instead you will receive an amount of five us dollars for transport costs. Your name will not be recorded or any other information that might be used to identify you later, therefore no risk of a breach of confidentiality with the use of your answers to the study questions. I will try to make this experience as stress-free and comfortable as possible for you. There are no other known risks associated with this study.

For additional information about giving consent or your rights as a participant in this study, to discuss problems, concerns, and questions, or to offer input, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone 04 791792 or visit them at Corner Josiah Tongogara and Mazowe Street, Harare. Information obtained from this research will be shared with the Midlands State University.

STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY

I have read this informed consent document and the material contained in it has been explained to me verbally. All my questions have been answered, and I understand that if I refuse to take part in this study nothing will change and will receive the same services from the clinic like I have always did. I freely and voluntarily choose to Participate.

I will be participating in (tick in the box below)

FOCUS GROUP

DISCUSSION

QUESTIONNAIRE

.....

Date

.....

Signature of participant

Consent obtained by:

Date

Signature

Printed Name and Title

SHONA VERSION

Musoro weongororo: Kushandiswa kwenzira dzakasiyana siyana kudziwirira pamuwiri pakati pevakadzi vanogara neutachiwona weHIV

Principal Investigator: Youlandar Changata

Nhamba yefoni uye Address: 44 leiwsam Ave

Chisipite,

Harare

Cell: 0776358679

Mudzidzi Weku: Midlands State University

Purogiramu: MSc Community Psychology

Mashoko anotevera anopiwa kuti akuzivise pamusoro pechidzidzo uye kubatanidzwa kwako.. Chinangwa chechidzidzo ichi ndechekuongorora kushandiswa kwenzira dzakasiyana siyana dzekuronga mhuri kwemadzimai ane utachiona weHIV. Vakakumbirwa kuti uwe nechaunoita pachidzidzo ichi chichaitwa muzuwa rimwe chete nokuti une unyanzvi ne utesve nezvechidzidzo ichi.

Kutora nzvimbo kwaurikuita muchidzidzi ichi isarudzoyako.Wakasununguka kubuda muchidzidzo ichi chero nguva yaunoda .kanauka sarudza kuva muchidzidzo ichi wakatarisirwa kupindura mibvunzo pa bepa rauchapiwa zvichatora maminetsi makumi maviri mushure mazvo munozatarisirwa kuwapo panhaurirano ichaitwa kubva pamaminetsi makumi mana nemashanu kusvika

pa 1 hour.Pachange pane madzimai ane pamuviri ne wakasununguka uye wachirarama ne utachiona weHIV.

Uchakumbirwa kuti upendure mibvunzo inoenderana neupenyu wako .Wakasununguka zvekusapindura mibvunzo yauchange usingade kana kusafarira.Wakasununga zve kukumbira kubvisa mhinduro dzako muchidzidzo ichi chero nguwa ipi zvayo.

Hautarisirwa kunge uchi bhadhara kuti uwe muchidzidzo ichi asi uchange uchi tambira mari inosvika iyo madhora mashanu (\$5) yekuchandisa pakufamba.Zita rako richawadzwa pamwe nezve upenyuny u wako hapana pazvichashandiswa.Ndichaedza zvikuru kuti zvinhu zveendeke nekufamba zvakanaka pasina matambudziko.

Kana mune zvimwe zvamungadekuziwa pamusoro pekuwa muchidzidzo ichi makasununguka kubvunza ku Medical Research Council of Zimbabwe (MRCZ) on telephone 04 791792 or visit them at Corner Josiah Tongogara and Mazowe Street, Harare. Information obtained from this research will be shared with the Midlands State University.

Ndaverenga ne kuverengerwa nezvetsvagurudzo mururimi rwandinonzwisisa ndikanzwisisa zvose zvichaitwa nezvinodaiwa huye mibvunzo yangu yose ine zvekuita netsvagurudzo yapindurwa zvinogutsa.Ndazvibabta nokunzwisisa kuti kupinda mutsvagiridzo mazvokuda,hakumanikidzwe.Ndinogona kupinda kana Kuramba kupinda musvagiridzo pasina kushanduka kwemarapiwo kana mabatirwe andagara ndichiitwa pano pakiriniki

Kusaina kwangu gwaro rino kunopa mvumo vaongorori (tick in the appropriate box)

ndasarudza kupinda mutsvagiridzo.

QUESTIONNAIRE (BEPA REMIBVUNZO

YAKASIYANASIYANA)

FOCUS GROUP DISCUSSION

(NHAURIRANO)

Zita renyu----- zuva ranhasi-----

Siginecha-----

chigunwe kana asingagoni kunyora-----

Nguva_____

APPENDIX B

FOCUS GROUP DISCUSSION GUIDE

STUDY TITLE: Contraceptive use among women living with HIV enrolled for the Birth Cohort Study

Date: _____ **Time:** _____ **Venue:** _____

Number of participants: Females: _____

Name of Note-taker: _____

Start time _____ **Finish time** _____

Ice breaker: Ever since you were diagnosed with HIV what contraceptives have you been using?

1. Source of Information

- a) Please explain how women in this area find out about contraceptives?
- b) Tell me about the Family planning methods you have heard about?
- c) What have you heard about the effectiveness of the different types of contraceptive?
- d) Please explain where you buy or get your family planning method?
- e) What are some of the health care provider's advice on all contraceptives or they are specific on one?

f) Tell me about the traditional methods of family planning you know. Have you ever used any?

g) Please explain which family planning method have you used in the past 5 years or you have changed? Why do you use that contraceptive?

3. Choice of Contraceptive use

a) When it comes to making decision on contraceptives to use in your family who has the say?

b) How does your partner feel about the method of family planning you have chosen?

c) Has the disclosure of your status affected your choice of contraception? And how?

4. Fertility Intention

a) How do you feel about have children since you were diagnosed with HIV?

b) What are your experiences, with issues of contraception /contraceptive since you were diagnosed with HIV?

c) What concerns you most when it comes to issues to do with fertility with your partner?

5. Use of Services

a) In what way does the family planning services at the clinic or Health unit, meet your family planning needs. Please explain?

b) What do you think can be done to advertise and promote services of family planning to other ladies like you?

c) Who supports you the most among people around you?

FOCUS GROUP DISCUSSION GUIDE (SHONA VERSION)

STUDY TITLE: Contraceptive use among women living with HIV enrolled for the Birth Cohort Study

Zuva: _____ **Nguva:** _____ **Zvimbo:** _____

Nhamba yevatori vechikamu: Madzimai: _____

Zita remunyori: _____

Nguva yekutanga _____ **Nguva**
yekupedza _____

Ice breaker: Kubvira pamakabatwa neutachiona ndeipi dziri yekuronga mhuri yamanga muchshandisa?

1. Source of information

- a) Wakadzi wemunzimbo ino wanowanakupi nhau dzakanangana nekuronga mhuri?
- b) Ndiudzeiwo nzira dzekuronga mhuri dzemunoziva?
- c) Wakambo udzwa here mashandiro ezvenzira idzi dzekurongamhuri?
- d) Munotenga kana kupiwa kupi nzira dzekuronga mhuri dzemunoshandisa?

- e) Washandi weutano wanokupai ruziwo pamusoro penzira dzekusandisa dzese here , kana kuti wanorerekera kuimwe?
- f) Ndedzipi nzira dzechivanhu dzamunozwiwa dzekuronga mhuri.Munoshandisa dzipi?
- g) Mumakore mashanu apfura maishandisa nzira dzipi dzekuronga mhuri?

2. Sarudzo yemhando yekudzivirira pamuviri

- a) Mumba menyu ndiani anosarudza nzira yekuronga mhuri.Tsanangura?
- b) Murume wenyu anonzwa sei mairirano ne dzira yekuronga mhuri yamakasarudza?
- c) Kubva pavaka batwa neutachiona nzira yekuronga mhuri yavaishandisa ndiyo here yeuchiri kushandisa?

3. Vana waunoda kuzoita

- a) Chishuwo chako chekuzoda kuita vana ,kungadai kwakavhiringwa here nekubatwa kwako ne utachiona weHIV?
- b) Ruzivo rwako rwekuwa ne utachiona weHIV wachinja here mafungiro ako enzira dzekuronga mhuri?

4. Use of services

- a) Kwamuno enda kunotora zvekushandisa pakuronga mhuri wano kubatsirai zvinokufadzai here?
- b) Ndedzipi nzira dzingashandiswa kushambadza nzira dzekuronga mhuri kuwamwe wakadzi wakaita semi?
- c) Ndiani anokupai kurudziro pane wari pedyo nemi?

APPENDIX C

STUDY TITLE: Contraceptive use among women living with HIV enrolled for the Birth Cohort Study

IN-DEPTH INTERVIEW GUIDE

1. Ever since you were diagnosed with HIV what contraceptives have you been using? And why?
2. What are some of the health care provider's advice on all contraceptives or they are specific on one?
3. Do you face any challenges when using family planning?
4. Do you know of any traditional methods of family planning? Have you ever used traditional methods of family planning?
5. Where do you procure these methods of family planning in your area? Do you check for expiry dates?
5. Please explain which family planning method have you used in the past 5 years? Did you change from that you initially were using before?
6. When it comes to making decision on contraceptives to use in your family who has the say?
7. How does your partner feel about the method you have chosen for family planning?
8. Please explain who gives you the most support among people around you?
9. What are your experiences, with issues of contraception /contraceptive since you were diagnosed with HIV?
10. What do you think can be done to advertise and promote services of family planning to other ladies like you?
11. Do you have a history of changing a family planning method .What were the reasons?

STUDY TITLE: Contraceptive use among women living with HIV enrolled for the Birth Cohort Study

IN-DEPTH INTERVIEW GUIDE (SHONA VERSION)

1. Kubvira pamakabatwa neutachiona ndeipi dziri yekuronga mhuri yamanga muchshandisa? Tsanangura.
2. Washandi weutano wanokupai ruziwo pamusoro penzira dzekusandisa,kana kuti wanorerekera kuimwe?
3. Ndedzipi nzira dzechivanhu dzekuronga mhuri dzamunoziwa.Makambo dzishandisa here?
4. Munotengepi kana kuti munowanipi nzira dzekuronga mhuri.Munombo tarisa ma expiry data here?
5. Mumakore mashanu apfura maishandisa nzira dzipi dzekuronga mhuri?
6. Mumba menyu ndiani anosarudza nzira yekuronga mhuri.Tsanangura?
7. Murume wenyu anozvitora sei, ne nzira yamakasarudza kusandisa kuronga mhuri?
8. Ndiani anokupai kurudziro pane wari pedyo nemi?
9. Ruzivo rwako rwekuwa neutachiona weHIV wachinja here mafungiro ako enzira dzekuronga mhuri?
10. Ndedzipi nzira dzingashandiswa kushambadza nzira dzekuronga mhuri kuwamwe wakadzi wakaita semi?

11. Wakambo chinja here nzira yekuronga mhuri. Chii changa chiri chikonzero?

APPENDIX D

KEY INFORMANTS

PSI, POPULATION SERVICES, SISTER IN CHARGE AT EACH SITE

IN-DEPTH INTERVIEW GUIDE

1. Where and when do you give HIV positive mothers knowledge of the various methods of family planning?
2. What factors influence women's choice on family planning?
3. Are all the available methods of family planning recommended for these women who are also on ARV's. What are the side effects?
4. What are the specific methods that you recommend for these women?
5. In your view are there any challenges that these women living with HIV face when using the method available for family planning.
6. Based on the time you have spent giving services to HIV positive mothers are there any other methods that they use?
7. What are the common methods and why are they common?

-values were greater than 0.05

APPENDIX E

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



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Josiah Tongogara / Mazoe Street
P. O. Box CY 573
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Harare

APPROVAL

APPENDIX F



Director of Health Services

CITY OF HARARE

All correspondence to be addressed to the

DIRECTOR OF HEALTH SERVICES

DIRECTOR OF HEALTH SERVICES

Rowan Martin Building,
Civic Centre

APPENDIX G

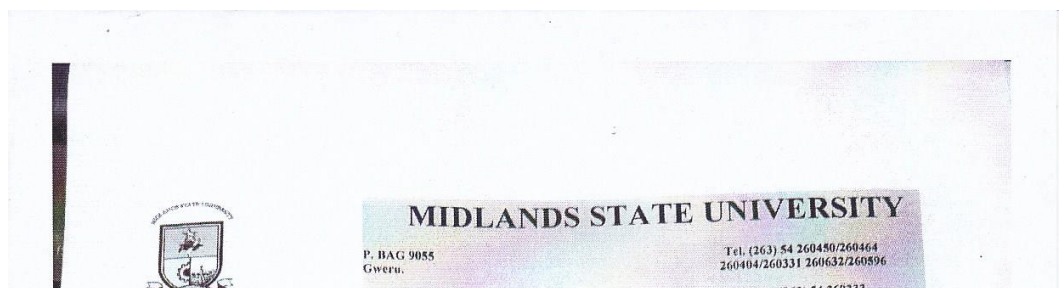
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APPENDIX H



APPENDIX I
MIDLANDS STATE UNIVERSITY

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

A GUIDE FOR WEIGHTING A DISSERTATION

NAME OF STUDENT..... REG NO.....

	ITEM	POSSIBLE SCORE	ACTUAL SCORE	COMMENTS
A	RESEARCH TOPIC AND ABSTRACT: Clear and concise	5		
B	PRELIMINARY PAGES Title page, approval form, release form, dedication, acknowledgement, appendices, table of contents	5		
C	AUDIT SHEET Clearly shown on the audit sheet	5		
D	CHAPTER 1 Background, statement of the problem, significance of the study, research questions, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Address major issues and concepts of the study. Findings from previous work, relevancy of literature to the study Identify knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of approach, design, target population, population sample, research tools, data collection procedures, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 Discussion (10) Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical implications Conclusions (5) Ability to use findings to draw conclusions Recommendations (5)	20		
I	Overall presentation of dissertation	5		
J	References	5		
	Total	100		

MARKER.....SIGNATURE.....DATE.....

MODERATOR.....SIGNATURE.....DATE.....