

ORIGINAL ARTICLE

# Childbearing and Family Planning Choices of Women Living With HIV and AIDS: The Lived Experiences

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## ABSTRACT

**Objective:** The main objective of this study was to assess the reproductive choices for Women Living with HIV on ART in the urban health centres within Lusaka.

**Methods:** Nine hundred and fifty six HIV-positive women receiving care in the zoned health centres were randomly sampled and 12 health care workers who were purposefully sampled and were available in the ART setting participated in the study. A survey questionnaire, in-depth interviews and focus group discussions were the main data collection tools used. Quantitative data was analysed using SPSS while qualitative data was analysed using qualitative content analysis rooted in grounded theory (Precaution Adoption Model (PAPM)).

**Results:** The majority of the respondents in this study n = 503 (64%) felt that it was important to be safe from becoming pregnant whereas n = 429 (46%) felt that it was not. Health workers counselled the respondents on nearly all of the available contraceptive methods, with an emphasis on the oral pill, injectable hormonal drug, and on male and female condoms – with the greatest emphasis on the male condom. The reasons that women had for selecting particular family planning methods varied temporally. Some women engaged in unprotected sex because their partner was also HIV seropositive. Even in situations when an HIV-positive woman was told of her sero status and given counselling on the risks of mother-to-child-transmission (MTCT), the majority of women would still engage in unprotected sex that often led to pregnancy. Nurses preferentially discouraged the women from getting pregnant using the counselling methods

described. The rationale for the counselling methods was based on age, education, medical and gynaecological complications. In the current health care setup, it was not demonstrated that reproductive health issues of people living with HIV and AIDS could be provided within the ART clinic.

**Conclusion:** As HIV continues to spread among women of childbearing age, there is an increasing need for support programs for infected women regarding sex, safer sex, pregnancy and family planning. The healthcare challenges for this group must be addressed with a two-pronged approach- women must prioritize the risk to their health with repeated exposures to HIV and the healthcare workers must empower them to make these decisions. For this to occur, it is crucial that HIV positive women have easy access to reproductive healthcare counselling in juxtaposition to the ART Clinic. The health care workers that directly counsel these women have a pivotal role in addressing these concerns. Nursing professionals who comprise the bulk of healthcare workers providing these services can play a major role in meeting these needs.

## INTRODUCTION

This paper looks at how the threat of HIV infection affects the way people living with HIV and AIDs in Zambia think about family planning choices and childbearing. Conceiving children entails a risk of HIV infection, as do other encounters involving unprotected sex, but the implications may be more wide-ranging. It is argued,

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**Key Words:** Childbearing, Family Planning Choices, Women, HIV and AIDS, Lived experiences

however, that not just risk perception of dying in pregnancy or frequent sickness in pregnancy but also cost and welfare considerations mediate the way HIV influences ideas about the number of children one chooses to have<sup>1, 2, 3</sup>. At the same time, personal circumstances, gendered power relations and availability of means of protection against infection and of family planning methods can often impede family size preferences being acted upon and reproductive rights being upheld.

This paper was premised on a number of problems that are related to the reproductive health needs of Women Living With HIV and AIDS. To date, worldwide and especially in developing countries like Zambia, health services for HIV positive individuals have focused primarily on providing prophylaxis against and care for opportunistic infections and delivery of Anti Retroviral Treatment (ART) and not reproductive health. Less attention has been given to provision of appropriate reproductive health services for HIV positive women regarding childbearing and Family Planning Choices of Women Living With HIV and AIDS<sup>4</sup>. The main objective of this study was to assess the reproductive choices for Women Living with HIV on ART in the urban health centres within Lusaka.

## RESEARCH DESIGN, METHODOLOGY AND LOCATION

This study was located in Lusaka urban sites. The site has twenty three clinics across four sub districts. The study was conducted in four clinics, one only from each sub district that offers ART services and these are: Kalingalinga, Chilenje, George and Kanyama.

This study integrated the use of qualitative and quantitative data using sequential paradigm crossing. Nine hundred and thirty two Women Living With HIV and AIDS and 12 health workers agreed to participate in this study and as such constitute the study sample. Women Living With HIV and AIDS were randomly sampled using a review register as a sampling frame. Health care workers were sampled using expert sampling. Three focus group discussions were held with Women Living With HIV and AIDS who were sampled using maximum variation sampling technique to allow representation of women with varying experiences with family planning and child bearing. Twenty-four in-depth interviews were done with health workers and Women Living With HIV and AIDS separately. Eighteen of these

were with Women Living With HIV and AIDS and six were with health workers. Survey questionnaires were distributed among a sample of HIV-seropositive women only who were on ART.

## Data Analysis

Quantitative data was analyzed with SPSS version 14.0 (Statistical Package for the Social Science, Chicago, IL, USA). Descriptive analyses were performed of population characteristics using chi-square or Fisher's exact tests for categorical variables and t tests for continuous variables. Bivariate analyses of demographic and contraceptive factors looking for associations for desire for future or current childbearing or not was performed. Qualitative data was analysed using qualitative content analysis rooted in grounded theory as presented by Glaser and Straus (1967). The underlying assumption of grounded theory and content analysis is that meaning is constructed through social interaction<sup>5, 6</sup> and it is the meanings of what is done and spoken by the health workers about contraception which was analyzed. The researcher systematically compressed many textual paragraphs or words into fewer content categories based on explicit rules of coding<sup>7,8</sup>.

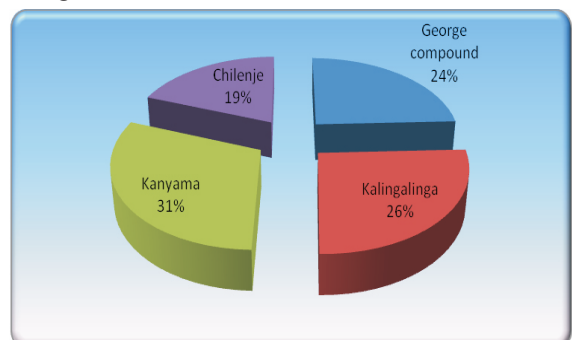
## Ethics

Ethical approval was granted by the University of Zambia biomedical Ethics committee.

## Results

Out of the 932 women living with HIV and AIDS who were enlisted in this study, 227 (24.4%) were drawn from George compound, 242 (26%) from Kalingalinga, 283 (30.4%) from Kanyama and 180 (19.3%) from Chilenje (figure 1.0).

Figure 1.0: Health Centre representation of Women Living With HIV and AIDS



A greater number (about 72%) of the participants were in the youthful risky reproductive age group 18 to 35 years. All participants were Zambians and aged 16 to 48 with a mean age  $30.1 \pm SD 6.8$  (mean + standard deviation) and the majority were teenagers  $n = 37$  (72%). A smaller proportion of the women were rather literate 362 (38.9%) (Upper secondary, college or university).

The women understudy had known their HIV status for about 60 months. The mean HIV status knowledge was  $18.1 (\pm SD 20.8; \text{mean} + \text{standard deviation})$  and the mode was just 2 months. The women had children ranging from 0 to 10. The mean child possession was  $2 (\pm SD 2)$  and the mode was 2.

A critical examination of their marital status shows that about half the number 467 (50.1%) of the women were married. Noting that all of the women were HIV positive, it was expected that if they were not married, they would in essence be engaged in other non permanent sexual relationships. This explains the numbers of women who had someone in a casual sexual relationship, in a short- and long term sexual relationships, cohabiting (living as married). There were a considerable number of women who were abstaining and living a solitary life (widowed, single and divorced) (Table 1).

**Table 1:** Type of Sexual Relationship

	n	%
I have someone in a casual sexual relationship	23	2.5
I am married	467	50.1
I am in a short-term sexual relationships	27	2.9
I am in a long-term sexual relationships	44	4.7
I am cohabiting (living as married)	67	7.2
I am now divorced and single	74	7.9
I am now widowed and single	102	10.9
I am single	128	13.7
<b>Total</b>	<b>932</b>	<b>100.0</b>

*Analysis of Perceptions of Pregnancy*

Before examining the contraception choices among these women, the researcher first wanted to establish the women's perception on pregnancy in HIV positive state. Taking not sure as the midpoint dividing the likelihood and unlikely hood of becoming pregnant, about half of the women (482 - 51.7%) in the sample did not see themselves as not very likely (107) and not likely (375) to becoming pregnant as compared to (199 - 21.4%) those who saw themselves likely (123) and very likely (76) of becoming pregnant in the next six months not withstanding their marital status (Table 2).

**Table 2:** Marital Status and Likelihood of Getting Pregnant in the Next Six Months

Marital Status	Do you see yourself having a risk of getting pregnant?					Total
	Not very likely	Not likely	Not sure	Likely	Very likely	
I have someone in a casual sexual relationship	0	11	7	3	2	23
I am married	33	163	156	71	44	467
I am in a short-term sexual relationships	5	18	3	1	0	27
I am in a long-term sexual relationships	1	24	12	5	2	44
I am cohabiting (living as married)	6	28	22	6	5	67
I am now divorced and single	13	34	9	10	8	74
I am now widowed and single	33	44	11	9	5	102
I am single	16	53	31	18	10	128
<b>Total</b>	<b>107</b>	<b>375</b>	<b>251</b>	<b>123</b>	<b>76</b>	<b>932</b>

The following research question was proposed: Is marital status associated with the likelihood of getting pregnant among HIV positive women? Using the Pearson Chi-Square test of independence with an alpha significance level of 0.05, the p value was 0.000 and we were able to reject the null hypothesis of no association. In this case we conclude that there is a relationship between marital status and likelihood of getting pregnant when HIV positive.

Age group was also profiled to see if there was any relationship with likelihood of getting pregnant if someone does not use any birth control. Taking not sure as the midpoint dividing the likelihood and unlikely hood of becoming pregnant, far less than half of the women (190 - 20.4%) in the sample saw themselves as not very likely (81) and not likely (109) to becoming pregnant as compared to (500 - 57.6%) those who saw themselves likely (197) and very likely (303) of becoming pregnant in the next six months not withstanding their age group (Table 3).

**Table 3:** Age Group and Likelihood of Getting Pregnant if Some One Does Not Use Any Birth Control

Marital Status	Do you see yourself having a risk of getting pregnant?					Total
	Not very likely	Not likely	Not sure	Likely	Very likely	
Sixteen to twenty five	6	21	56	61	85	229
Twenty six to thirty five	24	44	150	102	148	468
Thirty six to forty five	27	27	30	29	51	164
Over forty six	24	17	6	5	19	71
<b>Total</b>	<b>81</b>	<b>109</b>	<b>242</b>	<b>197</b>	<b>303</b>	<b>932</b>

When a significant test of association was performed at an alpha error rate of 0.05 to see whether age group and likelihood getting pregnant if someone does not use any birth control were independent of each other using Pearson Chi-Square test of independence, the p value was 0.000. In this case we conclude that there is a relationship between age and likelihood getting pregnant someone does not use any birth control when HIV positive.

The women were asked how they rated the importance of becoming pregnant. Less than half of the women (420 / 45.1%) in the sample rated getting pregnant as important as compared to 512 (54.9%) who rated pregnancy as not important (Table 4).

**Table 4: Level of Importance of Getting Pregnant**

Level of Importance	n	%
Extremely important	165	17.7
Important	255	27.4
Not sure	219	23.5
Not important	138	14.8
Not very important	155	16.6
Total	932	100.0

The women were asked how they rated the importance of being safe from pregnancy when they had sex with a partner (Table 5).

Majority of the respondents in this study n = 503 (54%) felt that it was important to be safe from pregnancy whereas n = 429 (46%) felt it was not, indicating a skew in the data towards pregnancy being a more important paradigm.

**Table 5: Level of Importance to Be Safe From Pregnancy When You Have Sex with A Partner**

Level of Importance	n	%
Extremely important	313	33.6
Important	190	20.4
Not sure	183	19.6
Not important	108	11.6
Not very important	138	14.8
Total	932	100.0

**Reasons Women Living with HIV and AIDS Have For Selecting Particular Family Planning Methods**

When the women were asked in the FGDs and personal interviews, the reasons they opted for a particular contraceptive method were varying from time to time. A few women among those interviewed actually engaged in unprotected sex because their partner was also HIV seropositive. Several women with HIV-seropositive partners used condoms for birth control and not for safer sex. It was evident that men seemed to be at the centre of masking decisions than the women. A few examples of the methods used and reasons for selecting them will suffice.

I use depoprovera because now it is my only means of safer sex. If I use the pill, he will see it and there will be fights in the home. So I get the injection while he is at work.

(Sexually active grand mother of three, age 44).

I just let him have his way and not wear condoms, so I wouldn't lose him (Mother of three, age 23).

He wore them as a favour to me really - to prevent pregnancy. It was entirely for me, it wasn't helping him out any . . . so it was difficult to insist (Woman, age 29).

It is very clear from the women's feelings that even if an HIV-positive woman is told of her sero status and is counselled on the risks of MTCT, they will still go on to have unprotected sex and get pregnant. In addition to contraception and risk reduction concerns, women are willing to risk vertical transmission of HIV in order to have children. In the FGDs and in-depth interviews, the data shows a strong desire for future childbearing among women who know they are HIV-positive. Below are two examples.

I just have to live with the risks of getting pregnant. I need a child. It is now safer because they give you (meaning drugs) something to protect you and the baby when you are positive...The days are gone when women used to die in pregnancy or even lose a baby.  
(Lay Counsellor, age 33).

Every one is saying it is safe to have child as long as you are taking your medication. My husband wants a baby girl. He says we could try. His mother too...what could I do any way but to get on the bandwagon...He may get a child elsewhere you know. (House manager, age 25)

**DISCUSSION**

The women had reasons for selecting particular family planning methods were varying from time to time. Several women with HIV-seropositive partners used condoms for birth control and not for safer sex. It was very clear from the women's feelings that even if an HIV-positive woman is told of her sero status and is counselled on the risks of MTCT, they will still go on to have unprotected sex and get pregnant.



An important, but not significant, decrease in the percentage of women using no method and who wanted to be pregnant (2.8%) and those who were using withdrawal method (1.2%) was noted. This finding suggests that family planning counseling had been provided and most of the women decided to avoid pregnancy. The significant decrease in the use of oral contraception in the post-knowledge phase, compared with the percentage of women using this method at the time of counseling, was similar to the decrease found in a study carried out in Rwanda<sup>9</sup> that focused on family planning intervention to reduce vertical transmission.

While in some studies knowledge following counseling on reproductive health among infected women resulted in an increase in contraceptive use, other studies found a lack of persistent use of contraception beyond one year or no significant difference compared with HIV-negative women<sup>10,11</sup>. Like this study, Silbiger<sup>12</sup> also found that women are willing to risk vertical transmission of HIV in order to have children. Now that the knowledge about the reduced risk of vertical transmission due to the administration of ARVs during pregnancy has become more widely disseminated, the desire of having a child will increase and the opposition to therapeutic abortion for pregnant HIV-infected women will decrease. It is likely that more and more HIV-infected women will plan to conceive as long as safe drugs are available that facilitate retention of pregnancy and guarantee a reduction of mother to child transmission of HIV.

An unexpected finding in our study was that few of the respondents were not using condoms to prevent pregnancy. Some authors like Galavotti<sup>13</sup> and Schnell have suggested that many HIV infected women consider methods to avoid pregnancy having similar effectiveness in the prevention of transmission. These findings confirm the need for comprehensive counseling about reproductive issues, not only at the time of HIV diagnosis but at every ART appointment.

### ***Implications for Program Managers***

The findings of the present study have significant implications for program managers in the District as well as at the health centre. Managers of family planning programs should proceed with more confidence to establish reproductive health for people living with HIV and AIDS within the ART. Retraining of health care

providers rendering care to people living with HIV and AIDs should be broad based. In addition, coordination should be established between the content of technical training courses for professional staff and lay care providers.

### ***Implications for HIV and AIDS Care***

There is need to build capacity within the counseling training for our health care providers and especially creating counseling skills that address empowering clients to solve problems that centre on negotiation.

Further research is both warranted and pertinent due to increasing numbers of women desiring to be pregnant in the face of economic adversity, the burgeoning rates of HIV and other STIs and suboptimal contraceptive methods and conflicts in condom utilization.

### ***Strengths and Limitations of This Study***

One limitation of this study is recall bias on self-reported reproductive healthcare utilization data. This may be difficult to remedy and complex because recall bias may have affected the reporting of use of method, evaluating the quality of care provided by health care workers when one is not consistently seen by the same health worker.

The study in these clinics is only generalisable to Lusaka urban. Further studies need to be conducted with similar larger cohorts of women in other districts to gain a broader perspective on current trends in contraception, safer sex, and pregnancy decision making.

In spite of these limitations, the study has strengths. This study is among the first to examine family planning use among women living with HIV and AIDS in Zambia. The study should be considered for its strength and particularly for using a rigorous study design with a very large random sample from a cross-sectional population-based study, which allows for a more generalisable inference. This study employed both quantitative and qualitative research methods that tended to support one another and explores unique features that one method could not.

### **CONCLUSION**

Women in this study have shown ambivalent positions. There are some who want to have a child and there are also others who do not want to. As for the women who

want to be pregnant, it is imperative that they receive appropriate counseling about contraception options, and it is the responsibility of health care professionals to see that these needs are met. As ART programs scale-up, they should be part of a continuum of care that includes strong family planning and other integral health services. While not all services may be integrated in all instances, looking at financial limitations, the researcher still sees a greater possibility of integrated approaches that could expand access to and coverage of family planning, STI, and HIV and AIDS services.

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