Title: Repeat pregnancies among women with known HIV-positive status in Chitungwiza, Zimbabwe

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Background
FP methods available at these clinics are mainly condoms, pills and injectables (Depo Provera). Clients who choose implants and sterilization as methods of contraception are referred to Chitungwiza Central Hospital or Zimbabwe National Family Planning Council or other private centres offering FP services. All FP services are not free except for condoms. Health personnel at these PMTCT sites have been formally trained in FP and some through workshops. Also, there is continuous in-service training on basic PMTCT, rapid HIV testing, infant feeding for health care workers.

Statement of the problem
Programme data from Chitungwiza clinics have shown a gradual increase in the number of women who report for antenatal care with known HIV positive status from the previous pregnancy. Of the 8844 first antenatal clinic bookings from October 2008 to September 2009, 1376 (15.6%) were HIV positive and of these HIV positive women 116 (8.4%) were booked with known HIV positive status. From October 2009 to September 2010, 5148 new bookings were recorded and of these bookings 712 (13.8%) tested HIV positive. A total of 79 (11.1%) of the HIV positive pregnant women were booked with a known HIV positive status. These mothers would have had information on PMTCT and antenatal and postnatal periods.

Specific Objectives:
To describe the: FP needs for HIV positive women participating in the PMTCT programme, health service factors that are associated with repeat pregnancies among women with known HIV status, knowledge, practices and perceptions towards FP among HIV- positive women and to determine the proportion of women that opts for permanent methods of FP and make recommendations to the Ministry of Health to develop policies and programs supporting the pregnancy intentions of HIV-positive women in Zimbabwe.

Methods: A descriptive, cross-sectional study was conducted in Chitungwiza from April-September 2011. Multi-gravida women enrolled in the PMTCT programme with known HIV-positive status (n=170) were interviewed using an interviewer-administered questionnaire and focus group discussions of 10-15 women. Quantitative data was analysed using Epi Info Version 3.3. Ethical approval for the study was given by the Medical Research Council of Zimbabwe, Ethical Review Committee of Chitungwiza Health department and Ministry of Health and Child Welfare. Informed written consent form was obtained from all respondents. No incentives were provided for the mothers to participate in the interviews.
Results
Socio-demographic characteristics

A total of 170 multigravida HIV-positive women of reproductive age were interviewed. The overall response rate was 97.7%. Ninety-seven (57.1%) of the respondents were in the 26-34 age group followed by 43 (25.3%) women of the 35-49 age group. One hundred and thirty five (79.4%) of these respondents were married, 122 (71.8%) had three to four years of secondary education followed by 26 (15.3%) who had primary education. Fifty–five (32.4%) of the respondents had two children followed by 42(27.4%) respondents who had one child and the remainder had four and above. Out of 170 respondents 61(39.5%) were employed and from those employed only 27 (15.8%) respondents were formally employed.

Family planning knowledge and use

Out of 170 respondents, 146 (85.9%) received FP information. Most of the respondents were knowledgeable on most FP methods with 166 responses for oral contraceptives followed by 159 for injectables, 132 for condoms and 119 for implants respectively. The least mentioned method was the permanent method (sterilisation and tubal ligation) with 8 responses. The commonly used FP methods before the pregnancy under review were the pill 70 (41.2%) followed by injectables 45 (26.5%), both in combination with condom use. One hundred and thirty-eight (81.2 %) respondents received family planning counselling after testing HIV positive antenatal and only 62 (36.5%) attended the sessions with their husbands or partners.

Attitudes towards family planning

Out of the 170 respondents 164 (96.4%) felt spouses should be involved in FP counselling sessions since 124 (72.9%) felt women repeatedly fall pregnant because of pressure from their husband despite known HIV status. One hundred and twenty –three (71.4%) felt repeat pregnancies were caused by inability to afford the cost of desired choice of contraception.

Practices on family planning

One hundred and thirty-eight (81.2%) out of the 170 respondents, stated that they were not always using family planning method due to prohibitive husbands/partners. Respondents who had used a condom with last sexual intercourse were 142 (83.5%). Out of the 170 respondents, 62 (36.5%) determines own method and 20 (11.7%) the method is determined by the spouse/partner. On respondents’ ability to protect themselves from unplanned pregnancies, 115 (67.6%) reported being unable to protect themselves from unwanted pregnancies and 137 (80.6) women reported having unplanned repeat pregnancies with known HIV positive status.

Health care services factors

Family planning services are offered for a fee with 97 (57.1%) always paying. The costs of family planning methods are as follows: $1.00 for two cycles of orals, $5.00 for injectables and $20.00 or more for implant. Of the 97 (57.1%) respondents who use contraceptives, 87 (89.7%) could not afford to pay for the family planning services. Key informants acknowledged the unavailability of long term methods at the clinics.
Discussion

HIV-positive women have unique fertility preferences and contraception needs that are different from HIV negative women\(^1\). Improving these women’s reproductive health issues is central to achieving the Millennium Development Goals aimed at protecting maternal health, reducing mother-to-child transmission of HIV and increasing the survival of infants born to HIV positive mothers. This requires that women have access to safe and effective methods of fertility control to avoid unwanted pregnancies.\(^2\)

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\(^1\)Williamson L M, Parkes A, Wright D, P. petticre M,Graham J. Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative. Reproductive Health Journal; 2009.6:3

\(^2\) Homsy J, Bunneli R, More D,King R et al. Reproductive intentions and outcomes Among Women on Antiretroviral Therapy in Rural Uganda: A Prospective Cohort Study. January 8 2009; 10.1371/journal.pone.0004149
The majority of the women (80.6%) had unplanned repeat pregnancies with known HIV positive status. The study findings revealed that husbands/spouses, contributed greatly to pregnancy decision-making with 44.1% of the respondents reporting that their pregnancy were due to pressure from their husbands/partners. Male involvement during FP counselling sessions after an HIV positive test was low (19.8%) in our study. Non-participation of partners in FP counselling after an HIV test makes it difficult for the women to negotiate for safer sex. Male involvement has long been accepted as key to FP acceptance and adherence since men are, indeed, still the decision makers in many of the African settings. \textsuperscript{3, 1, 4}

The respondents displayed good knowledge on the short-term methods of FP such as oral pills and injectables but not on long-acting and permanent FP methods such as implants and sterilisation probably because the nurses always put more emphasis on available methods in the clinic. The respondents had good knowledge levels on PMTCT although the knowledge did not translate into contraceptive use or prevention of unplanned pregnancies.

Economic factors play an important role in accessing FP methods, 51.2% of the 170 respondents reported not being able to afford these FP methods and 27.6% reported that contraceptives should be given for free. It costs about $20.00 - $25.00 to access long term methods and $1.00 for two packets of oral contraceptives. Also, lack of confidence among health care workers to initiate a family planning method to HIV positive women due to insufficient knowledge of possible interactions between different ARV treatment regimens and hormonal contraceptives affected FP needs and usage among women living with HIV.

**Conclusion**

Unmet needs for reproductive health remains a major issue for HIV-infected women in the Chitungwiza PMTCT program. The factors that influence repeat unplanned pregnancies among women of known HIV positive status were: inability by women to make autonomous decisions on sexual and reproductive health probably because of lack of economic independence and prevailing cultural and attitudes to women’s rights, pressure from husbands/partners for more children, non-adherence to safer sex practices, non-involvement of husbands/partners in family planning counselling after an HIV positive result.

**Recommendations**

1. Male involvement is recommended for adherence to consistent use of FP methods by women to prevent repeat pregnancies among women of known HIV positive status.

2. Community sensitisation meetings/campaigns are recommended to empower women to stand for their reproductive health rights and make autonomous decisions to prevent unplanned pregnancies.

3. Chitungwiza municipality must waive payment of contraceptives and make long term and permanent FP methods freely available for all women of child bearing age.

\textsuperscript{3} Smee N, Shetty AK, Stranix-Chibanda L. Factors associated with repeat pregnancy among women in an area of high HIV prevalence in Zimbabwe. Women’s Health Issues 2011;21(3):222-229