

**THE REASONS FOR LOW UTILIZATION OF LONG ACTING  
CONTRACEPTIVES AMONGST HIV POSITIVE WOMEN AT  
HARARE POST TEST SUPPORT SERVICES CLINIC, ZIMBABWE**

by

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## **Declaration**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

## **Abstract**

The study sought to answer the question, what are the reasons for low utilization of long acting contraceptives among HIV positive women attending the Harare Post-test support services clinic. The study was conducted at Harare Post-test support services clinic from September to December 2012. Data was collected using respondent administered questionnaires. A sample of 30 respondents was used for the study.

After data collection, data was grouped, analysed and presented in the form of tables, figures, charts and descriptive statistics.

The major findings from the study were that the majority of the women who attend the Harare Post-test support services clinic are within the age groups 35-49 years. Most of the women are not using and modern contraceptive method. Condoms are used by 17% of the respondents and the long acting contraceptives, Jadelle and IUCD and used by a very low number of women attending the clinic. Fear of side effects is one of the reasons why the women are not using long acting contraception. Most of the women know that the Jadelle and IUCD are long acting methods of contraception which prevents unintended pregnancy for up to five years for Jadelle and up to ten years for the IUCD. The long acting contraceptives are not available at the post test-support services clinic since the set-up of the clinic is not ideal for the provision of these services, women who need the methods are referred outside the clinic where the cost to access the services is not affordable for most of the respondents.

The conclusion drawn from the study is that women living with HIV have limited knowledge and access the long acting contraceptives at Harare Post-test support services clinic hence are not utilizing the methods.

The researcher recommends that all women attending the clinic should be educated on the benefits of using dual protection to protect against unintended pregnancy as well as HIV transmission. A proper referral system should be established so that women referred to other service providers do not pay extra fees to access family planning services at the referral centres. Any IEC material should address the myths and fears related to use of long acting contraception by HIV positive women. The young age group below 35 years should also be encouraged to access family planning services through the Post-test support services clinic.

## Opsomming

Die doel van die studie was om te bepaal wat die redes is vir die lae gebruik van langwerkende voorbehoeding onder MIV positiewe vroue wat die Harare Post-test ondersteuningsdienste kliniek besoek. Data is deur middel van vraelyste onder 30 deelnemers ingesamel.

Die resultate het getoon dat die meerderheid van vroue wat die kliniek besoek het tussen die ouderdomme van 35 en 49 was. Meeste van hulle gebruik nie moderne voorbehoeding nie, slegs 17% het aangedui dat hul kondome gebruik. Die langwerkende voorbehoeding Jadelle en IUCD word deur min die van vroue gebruik. 'n Vrees vir die nadelige uitwerking daarvan is een van die redes waarom hul nie die voorbehoeding gebruik nie. Meeste van die vroue is bewus dat Jadelle en IUCD langwerkende metodes is wat swangerskap voorkom en dat Jadelle tot 5 jaar werk en IUCD tot 10 jaar effektief kan wees. Die langwerkende metodes is egter nie by die kliniek beskikbaar nie en vroue wat die metodes verkies word na ander diensverskaffers verwys waar wat vir meeste van die vroue nie bekostigbaar is nie.

Daar kan dus van die studie afgelei word dat MIV positiewe vroue beperkte kennis en toegang rakende die langwerkende voorbehoeding het en daarom nie die metodes ten volle benut nie. Die navorser beveel aan dat alle vroue wie die kliniek besoek ingelig moet word oor die voordele van die tweeledige vorm van beskerming, nie net teen swangerskap nie maar ook teen MIV-infeksie. 'n Verwysingstelsel moet in plek gestel word sodat die vroue wat na ander diensverskaffers verwys word nie nodig het om ekstra daarvoor te betaal nie. Daar word verder ook voorgestel dat die kliniek meer inligting rakende die langwerkende voorbehoeding beskikbaar stel en ook gesinsbeplanningsdienste aanbied.

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## **Dedication**

This project is dedicated to all women living with HIV and AIDS who are having challenges in accessing knowledge and family planning options. To all HIV and AIDS organizations, governments, politicians, individuals and all decision makers in Zimbabwe and abroad who are working tirelessly to improve the lives of women, men and children living with HIV and AIDS.

**List of Abbreviations and acronyms used in the study**

AIDS: Acquired immune deficiency syndrome

ARVs: Anti-retroviral drugs

FHI: Family health international

HAART: Highly active antiretroviral therapy

HIV: Human immune deficiency virus

IUCD: Intra-uterine contraceptive device

PLHIV: People living with HIV

PMTCT: Prevention of mother to child transmission

PTSS: Post-test support services

SSR: Sub-Saharan Africa

STI: Sexually transmitted infections

NAC: National AIDS council

UNAIDS: United Nations and AIDS

UNICEF: United Nations children's emergency fund

WHO: World health organization

ZDHS: Zimbabwe demographic and health survey

ZNFPC: Zimbabwe national family planning council

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## **Chapter 1**

### **Introduction to the Study**

#### **1.1 Introduction**

Research is defined as a scientific process of enquiry. Christensen, Johnson, and Turner (2011) define science as, “the most trustworthy way of acquiring reliable and valid knowledge about the natural world”. In chapter one of the following areas will be covered, background to the study, motivation of the research project, problem statement, objectives of the study, the research methodology, limitations of the study, outline of chapters and the conclusion to the chapter.

#### **1.2. Background to the Problem**

Harare Post Test Support Services Clinic is one of the 16 post-test support clinics managed by Population Services International and provides family planning services to all men and women tested for HIV at the clinic. Besides the provision of family planning services, the clinics also provides continued psychosocial and nutrition counselling services for women living with HIV and AIDS. Other services provided at the clinic include, tuberculosis screening and group education sessions on positive living and positive prevention. The clinic also provides short acting as well as long acting contraceptives for all HIV positive women.

A total of 500 HIV positive women are provided with information on positive living and positive prevention strategies every month. These women are then offered free family planning services at the clinic. Information on family planning options is covered separately in order to encourage the HIV positive women to adopt effective family planning methods. The goal of the integration of family planning services into counselling services is to prevent unintended pregnancies among the HIV positive women. Dual protective which includes use of a reliable hormonal contraceptive method like the implant and a barrier method like using the male or female condom is encouraged to prevent further transmission of HIV.

The main long acting contraceptives available at the clinic include the injectable, Depo-Provera (medroxyprogesterone acetate), implants- two rods Jadelle and the intrauterine contraceptive devices (IUCD). Clients are referred for permanent methods like vasectomy and tubal ligation to other family planning service providers in the city. Counselling and family planning services are not charged at the Post Test Support Services Clinic but various price ranges are charged at other family planning service providers in the city. Clients pay a consultation fee of US\$6.00 at the National Family Planning service provider in the city and private doctors charge a range of US\$20, 00 to US\$40.00 for consultation. These two fees are beyond the reach of the ordinary Zimbabweans.

In order to improve the uptake of long acting contraceptives, all the five nurses at the clinic have been trained in the provision of long acting contraceptives. The implants insertion training was conducted for five days and the IUCD training was conducted for 14 days. Comprehensive family planning counselling was part of the training curriculum.

### **1.3. Motivation for Research and Problem**

All HIV positive women are offered family planning counselling and long acting as well as short acting contraceptives at the clinic. Monthly 500 new HIV positive women are provided with contraceptive methods like the pill and injectable. One nurse always remains at the site to provide contraceptives and family planning counselling and the rest of the staff conduct outreach psychosocial counselling services for HIV positive clients at the antiretroviral therapy (ART) adherence counselling clinics and the prevention of mother to child (PMTCT) clinics.

Currently the clinic is not providing long acting contraceptives since it is being assessed for its suitability to provide these additional family planning services by the health professions authority of Zimbabwe. All the equipment has been procured and the nurses have been trained.

Zimbabwe National Family Planning Council (ZNFPC) is the national training body which has been approved by the Government of Zimbabwe to train all service providers in family planning. They guide on family planning service provision for all partners. The Harare Post Test Support Services Clinic staffs were trained by ZNFPC in the provision of counselling services but still the challenge is on low utilization of long acting contraceptives by HIV positive women. The reasons for low utilization of long acting contraceptives at Harare Post Test support services clinic are not known.

### **1.4 The Problem Statement/Research Question**

Kelinger (1973:17) cited by Christensen (2011:87) define a research problem as “an interrogative sentence or statement that asks; what relation exists between two or more variables. The research question is: What are the reasons for low utilization of long acting contraceptives among people living with HIV at Harare Post-test support services clinic?

### **1.5 Significance of the Study**

The study will benefit women living with HIV, those in the reproductive age group, program planners as well as the whole country. Women living with HIV will be able to utilise long acting contraceptives when the reason for not utilizing these methods and devices are explored. The reasons for low utilization of long acting contraceptives will be explored for other women in the reproductive age group. Program planners will be able to focus their education messages on long acting contraceptives targeting HIV positive women and the barriers to use of long acting contraceptives will

be planned accordingly by program planners. The nation will also benefit as it will prevent any unwanted pregnancies among HIV positive women and hence reduce the medical costs in managing unwanted pregnancies.

### **1.6 Aim of the Study**

The aim of the study was to determine the reasons for low utilization of long acting contraceptives among HIV positive women at Harare Post Test Support Services Clinic in order to establish effective strategies which increases uptake of long acting contraceptives among HIV positive women at Harare Post-test Support Services Clinic

### **1.7 Objectives of the study**

The objectives of the study were:

- To identify the contraceptive services available for women living with HIV and AIDS at Harare Post-test support services clinic
- To identify the existing knowledge about long acting contraceptives amongst women living with HIV and AIDS
- To establish the current contraceptive practices among women living with HIV at Harare (PTSS) clinic.
- To provide recommendations to address reasons for low utilization of long acting contraceptives among HIV positive women at Harare (PTSS) clinic.

### **1.8. Research methodology**

The study was conducted amongst women living with HIV and AIDS attending the Harare post-test support services clinic. All the respondents of the study were living with HIV since the clinic only provides psychosocial support and counselling services for people living with HIV and AIDs. The sample size was 30 women living with HIV and AIDs; this was convenient for the purpose of the study. Questionnaires were used to elicit information from the respondents. Review of the available data was done to assess the availability of data on long acting contraceptives.

### **1.9 Ethical Considerations**

Ethics are norms or standards of behaviour that guide moral choices about our behaviour and our relationship with others (Cooper and Schindler, 2009). Guidance was provided by the ethical principles of autonomy, non-maleficence, beneficence and justice. Protecting the research participants

from unethical procedures, the research proposal was sent to Stellenbosch University ethical committee for analysis and approval.

Permission was sought from the institution where the research was conducted. Informed consent was sought from the research participants to contribute to the study without any coercion. The participants were informed that results would remain anonymous. In order to avoid any emotional harm, the questions were carefully worded. The researcher was honest in data analysis and interpretation. In order to gain integrity from the research participants and the institution where the research was conducted, promises were kept of sharing the research results and also the work was completed as stipulated by timelines for data collection. All records of the research were carefully maintained in a confidential place.

### **1.10 Outline of Chapters**

The study is divided into five chapters. The first chapter of the study focuses on the introduction of the research problem, the background to the problem, research questions and aim and objectives of the study. The second chapter focuses on literature review. The main authors for review used are the World Health Organisation (WHO) document on contraceptive use for women living with HIV, the Family Health International (FHI) document and the Zimbabwe national family planning guidelines. Other research studies on contraceptives for HIV positive women were reviewed as well. The third chapter focuses on the methods and procedures for data collection and analysis. The fourth chapter covered the presentation of results in the various formats of tables, pie charts and histograms. A brief summary of each table was done. The fifth chapter covered the conclusion and recommendations drawn from the study.

### **1.11 Conclusion**

This chapter covered the research problem, the objectives of the study as well as the research methodology. The following chapter will focus on detailed literature relevant to the research problem.

## Chapter 2

### Literature review

#### 2.1 Introduction

Literature review provides the background towards solving the problem established in the research. It is a process of familiarizing individuals with the information available on the topic and placing it in context of the determined objectives. Literature review might guide in designing the study so that investigators can obtain an answer to their research question and may provide information for preparing a research report (Christensen, et al (2011)). The following areas were covered under this section; an introduction to what is HIV and AIDS, the global overview and the overview of HIV and AIDs in Zimbabwe. A short introduction of the wide range of contraceptives were covered in one paragraph followed by detailed information of the main long acting contraceptives available in Zimbabwe, the implants and intra uterine contraceptive device were the long acting contraceptives covered in detail in this study.

#### 2.2. Overview of HIV Life Cycle and Progression

The human immune deficiency virus (HIV) is one of the worst epidemics to affect human kind. The first cases of HIV were discovered in the early 1980s but research has indicated that it has been around for several decades longer (Anderson, 2012). HIV enters the human body through unsafe sex, contaminated needles and blood transfusions or from mother to child (vertical or perinatal transmission). It attacks the host T-cells and hijacks the cell's machinery and reproduces itself. As the virus attacks more cells and reproduce itself, more cells are destroyed and the body is not able to fight infections leading to opportunistic infections ( the HIV Life Cycle: <http://www.thebody.com/content/art14183.html>). In order to reduce the impact of HIV on human cells antiretroviral (ARVS) drugs have been developed. ARVs do not treat HIV infection but slows the progression from HIV to AIDS by disturbing the HIV life cycle. The Stanford Dance Marathon (2012) highlighted “the introduction of ARVs as part of clinical care has made AIDS a more manageable chronic illness by helping restore patients to an economically productive and socially functional state. ARVs prolong life, making HIV and AIDS a chronic disease, not a death sentence.

Women living with HIV should use contraception with guidance from their medical practitioners since ARVs has been known to interfere with the effectiveness of hormonal contraception. A study by Jamshindi, Robinson and Burke (2012) concluded “HIV positive women should be offered a full range of hormonal contraceptive options, with conscientious counselling about possible reduced efficacy of combined oral contraceptive methods and the contraceptive implant when taken with ARVs”.



Cichoki (2009) highlights that, since 1992 scientists have estimated that about half of the people with HIV develop AIDS within 10 years after becoming infected. Further intervention strategies like early testing should be put in place in order to reverse or halt the progression from HIV to AIDS. WHO has provided guidelines on commencement of PLHIV on ARVs with a CD4 count of 350mmol/litre for developing countries in order to manage HIV before it progresses to AIDS?

### **2.3. Global Overview of HIV and AIDS**

HIV and AIDS affects populations globally and it is one of the leading causes of death amongst women of reproductive age. UNAIDS (2010) reports that globally 34, 2 million people are living with HIV and AIDS due to the prolonging effects of antiretroviral therapy. Globally it has been established that 63% of all young people living with HIV are young women. This is the age group also prone to unplanned pregnancies where effective family planning methods are not encouraged. UNAIDS (2011) reports the number of people dying from HIV related causes has reduced from 2 million in 2002 to 1.8 million in 2010, whilst the number of facilities offering ARVs have increased from 7,700 in 2007 to 22,400 in 2010.

Sub-Saharan Africa (SSA) accounts for more than 60% of all the people living with HIV and AIDS (UNAIDS 2010). Access to care treatment and support services is one of the strategic goals to reduce the number of people dying from the infection. In response to the epidemic, UNAIDS and WHO have released a five year strategy (2011-2015) aimed at building on the progress to date and establishing ambitious targets for 2015; zero new infections, zero discrimination and AIDS related death. This strategy focuses on four strategic directions optimizing HIV prevention, diagnosis, treatment and care; leveraging broader health outcomes through HIV responses, building sustainable health and community systems and reducing vulnerability and removing structural barriers to access services (UNAIDS 2011). Some of the important services for women living with HIV are family planning or reproductive health services.

### **2.4. HIV Prevalence in Zimbabwe**

Zimbabwe has been identified as one of the countries in SSA worst affected by the epidemic. The total population for Zimbabwe is estimated to be 12 million and 1.2 million people are living with HIV and of this number 620,000 women and 150,000 children are living with the infection. The first reported case of AIDS occurred in 1985 by the end of 1980s approximately 10% of the adult population were thought to be infected with HIV (HIV and AIDS in Zimbabwe, <http://www.avert.org/aids-zimbabwe.htm>). The number of people living with HIV and AIDS rose to as high as 26.7% in 1997, thereafter there was a steady decline to 14,3 % in 2010. HIV leads to premature death of parents and consequently orphans who have no one to care and guide them in life. According to the United Nation Children's emergency Fund (UNICEF) cited by UNAIDS (2009)

Zimbabwe has a high number of orphans in proportion to its population than any other country in the world. Family Health International, (2005) reports Sub-Saharan Africa women contribute 57% of people living with HIV. UNAIDS, 2009 reports the HIV epidemic is truly feminized, with women and girls comprising 56% of people living with HIV (PLHIV). Young women are three times more likely to be infected with HIV compared to their young men of the same age. Pregnant women share the burden of HIV; one in five pregnant women is infected.

In response to the HIV epidemic, Zimbabwe has established various intervention strategies to fight the epidemic. Some of the strategies include the formation of a National AIDs Coordinating (NAC) body; the coordinating body's main mandate is to coordinate all the HIV and AIDs response efforts in the country. Family planning is one of the four prongs in HIV prevention and the one direction for family planning state "prevention of unintended pregnancies in HIV infected women" (FHI, 2005).

## **2.5. Overview of Benefits of Family Planning for HIV Positive Women**

A strong national family planning program which is designed to prevent unwanted pregnancies and encourage spacing between child births is one of the most important interventions to reduce maternal and neonatal mortality and morbidity (Family planning guidelines for Zimbabwe, 2011:1). Family planning has benefits for the clients, the family and the community when they decide to use effective methods. Family Health International (FHI) (2005) confirms that family planning improves the well-being of families and communities. It also prevents unintended pregnancies thus reducing the number of infants infected and the number of future orphans. FHI goes on to emphasise that women with HIV can avoid childbearing just like women without the infection due to fear of transmitting the virus or anxiety about leaving orphans. FHI further stresses, HIV positive women can benefit from contraception since the stress related to unintended pregnancy is reduced. Mitchell & Stephens, (2004:1) argue "the issues around contraception choice for an HIV positive woman living in poverty with inadequate health care services and without access to ARV therapy will be very different from those in developed countries receiving highly active antiretroviral therapy( HAART), with wide range of contraceptive methods available". Mitchell and Stephens (2004:1), go on to expound that "HIV positive women have the same sexual desires like HIV negative women, hence the need for effective contraceptive methods to prevent unintended pregnancies".

## **2.6. Contraceptive Options for HIV Positive Women.**

Zimbabwe Demographic and Health survey (ZDHS), 2005-2006:63) revealed that the contraceptive prevalence rate among married women was 60%. The most commonly used method of contraception was the birth control pill as reflected by 43% of the survey. An evidence review conducted by National Collaborating centre for Infectious diseases (February 2010) expressed in Canada the prevalence of contraceptive use is 75%, while there is a dearth of published data specific to women

living with HIV. A 2002 Canadian study cited in the 2010 review highlighted the most frequently used methods were oral contraceptives at 32%, condoms, 21%, whilst copper bearing intrauterine devices (IUDS) had the lowest prevalence of use at 19%.

## **2.7. Choice for Contraceptive Method**

World Health organisation (2010 ) recognize that reproductive and sexual health care, including family planning services and information is recognized not only as a key intervention for improving the health of women and children but also as a human right. Family planning guidelines for Zimbabwe (2011:1) further elaborate, “the choice of a contraceptive method depends on the effectiveness of the contraceptive method in preventing unplanned pregnancy, acceptability, feasibility, sustainability and safety of the method use for a particular client profile”. FHI (2005) highlights women with HIV may consider safety and effectiveness of the method, cost and access to resupply. Mitchell and Stephens point out HIV positive women used dual methods, (condoms and oral contraceptives). Use of dual methods prevents HIV transmission as well as unintended pregnancies.

## **2.8. Medical Eligibility**

In 1999 WHO reviewed its family planning guidance and came up with the medical eligibility criterion which guides practitioners who can use contraceptive methods safely and effectively? Women living with HIV are included in the criteria and it has four categories for all contraceptives. The first criteria means there are no restrictions and the method can be used safely. The second criteria indicate the benefits outweigh the risk hence the method can be used safely. The third criteria refer to the risks of using the contraceptive outweigh the benefits hence the method should not be used unless another alternative cannot be found. The fourth criteria means the client has unacceptable health risks and method should not be used. Women living with HIV have a wide range of contraceptives to choose from, from oral contraceptive pills, injectable, implants, intrauterine devices, female and male condoms, male sterilization, lactation amenorrhoea method and fertility based awareness methods. Each contraceptive method is evaluated against the risks of the client using the WHO, medical eligibility guidelines (World Health Organisation, 2009).

## **2.9. Long Acting Contraceptives**

Contraceptive methods which act for a period of more than three months are referred to as long acting contraceptives. The long acting contraceptives to be reviewed in this study are implants and intrauterine contraceptives. Condoms will be reviewed even though they are not long acting contraceptives since women living with HIV are encouraged to use dual protection to prevent HIV infection, unintended pregnancy and sexually transmitted infections, (FHI, 2005). Dual protection is

defined as the use of a hormonal contraception like the progesterone oral contraceptive pill to prevent pregnancy and the condom to preventive HIV transmission.

### **2.9.1 Condoms**

A condom is defined by Hatcher et al (2001:11-3) as a sheath, or covering, made to fit over a man's erect penis. The Zimbabwe Family Planning guidelines (2011:82) go on further to define a condom as "a barrier method used to prevent pregnancy, STI and HIV. There are two types of condoms, the male one is made of latex and the female which are from polyurethane with two flexible rings.

The effectiveness of condoms in preventing both STI and HIV depends on the clients' ability to use condoms consistently and correctly. When used correctly every time a couple has intercourse, the male condom has a pregnancy rate as low as two percent and the female condom has five percent (FHI, 2005). FHI goes on to further highlight that condom effectiveness in reducing HIV transmission has been shown in studies on serodiscordant couples where one of the couples is positive and the other negative. Use of condoms as an HIV prevention strategy is encouraged in all related HIV prevention programs. The Zimbabwe National HIV Strategic plan (2011-2015:18) reports, "this country has so far managed to distribute the highest number of female condoms in the whole world", Wide distribution should be accompanied by intense education sessions on use of the condoms, dispelling any myths and misconceptions so that there is consistent and correct use of the condoms.

The WHO medical eligibility criteria classify the conditions of HIV infected, the presence of AIDS and use of ARV therapy as category one (1) for condom use meaning that they can be used without restrictions. Correct and consistent use of condoms in addition to an effective contraceptive method like the birth control pill, injectable, implant or IUCD is encouraged to prevent unintended pregnancies, HIV and STIs.

One of the major disadvantages of the condoms is that a woman cannot use them without the partner being aware. Health care practitioners are encouraged to counsel clients on the challenges of negotiating for condom use.

### **2.9.2 Implants**

Implants are long acting contraceptives appropriate for women of any reproductive age or parity who want long acting, highly effective reversible prevention of fertilization that does not require daily action (Blumenthal & McIntosh, (1998). The Zimbabwe Family Planning guidelines outline three types of implants, the Norplant which consist of a set of six small plastic capsules which are placed under the skin and is active for five years; contain a hormone progestin which is similar to levonogesterol. Jadelle implant contraceptive is a set of two small plastic capsules which are placed under the skin and acts for five years. This implant is available in most public health institutions and

is the preferred implant since it is easy to insert and remove. Implanon is the third type of implant which consists of one small plastic capsule and prevents pregnancy for three years.

### **2.9.3 Mode of Action of Implants.**

Implants have three main modes of action, namely thickening the cervical mucus, making it difficult for sperm to pass through; inhibit ovulation in about half of menstrual cycles; cause endometrial changes thus inhibiting implantation of the fertilized ovum and reduce sperm transportation in the upper genital tract (Zimbabwe Family Planning Guidelines, 2011).

### **2.9.4 WHO Medical Eligibility Criteria.**

According to the WHO medical eligibility criteria cited by FHI (2005), implant can be used without restriction by HIV positive women as it is in category 1, however, women taking ARVs are in category 2, as there is evidence that progestin levels are reduced by the ARV nevirapine, but these reductions are not enough to affect the use of the contraceptive. Women on implants are encouraged to use dual protection to provide additional protection from pregnancy and HIV between their partners.

### **2.9.5 Limitations of Implants**

Just like other progestin only contraceptives, implants can cause changes in menstrual bleeding, they require a trained provider to insert the device. Women have to come to the health institution for removal and they cannot stop on their own without visiting the health institution (Blumenthal and McIntosh, 1998). However, one of the distinct advantages is that implants are cost effective since the woman does not have to pay for contraceptives every month.

### **2.10 Intrauterine Contraceptive Device (IUCD)**

Intrauterine contraceptive device is a long acting reversible modern contraceptive method which prevents pregnancy for five to twelve years. IUCD is a flexible plastic which often has copper wire or sleeves and is inserted into a woman's uterus through the vagina. The most common type of IUCD is the copper T-380A. The other type the multi-load is no longer available in most countries (Hatcher, et Al 1997). The main advantage of the IUCD is that it is safe for women with challenges to hormonal contraceptives, highly effective (99.1%) and inexpensive family planning method. It is reversible and requires very little effort of the user once inserted and offers up to 12 years of protection (Biomed Central, 2012). BMC informs that IUCD's wider use would reduce the number of unintended pregnancies more than any other method; approximately 13% of all women globally use IUCD. The Kenyan demographic and health survey cited by Amua Network (2010) reports, "long term methods (LTM) in particular implants and IUCDs remain amongst the least used modern methods of

contraception used by approximately 4% of married women”. The Zimbabwe Demographic and health survey (ZDHS),2010-2011:83, indicated “use of long term family planning methods IUCD and implants decreased from 1,1% in 1988 to 0,2% in 2010-2011”, whereas a study conducted in Vietnam indicated IUCDs were used by most women (Nguyen, Park, & Ngo, 2011).

### **2.10.1 Mode of Action of IUCD**

Hatcher et al (2001:12-4) elaborated “IUCDs work chiefly by preventing sperm and egg from meeting. The family planning guidelines for Zimbabwe (2011:63) state “the IUCD inhibits fertilization, immobilises the sperms, speeds transport of the ovum through the fallopian tubes, stimulates a foreign body reaction in the endometrial making implantation less likely, thickens cervical mucus and change the endometrial lining”. Copper IUCDs are 99.1% effective in preventing pregnancy.

### **2.10.2 Side Effects of the IUCDs**

Knowledge of side effects of any contraceptive method determines the continued use of the method. Informed choice is a key component in family planning counselling. The USAID (n.d) regulatory guidelines emphasises the importance of informed choice for contraceptive use; is a measure of service provision quality. The ZDHS (2010/2011) highlighted 79% of woman were informed of side effects of implants and 76% were informed on what to do if they experienced side effects: BMC (2012) research on IUCD state IUCD have bad reputation in some countries due to adverse side effects and the advantages are often understated.

Some of the common side effects of IUCD include menstrual changes which are common in the first 3 months and are likely to lessen thereafter. Menstrual changes include longer and heavier menstrual periods, bleeding or spotting between and cramps or pain during periods. IUCDs do not protect against STIs/HIV and AIDS. Providing counselling services is important on dealing with side effects and their management (Zimbabwe FP guidelines (2011). Research on IUCDs has indicated that fear of side effects, concerns about infection and infertility and lack of technical training for providers discourages the use of IUCDs in many counties.

### **2.10.3 WHO Medical Eligibility Criteria-STI/HIV/AIDS**

IUCDs do not protect against HIV/STI and AIDS. Women with purulent cervicitis or gonorrhoea are classified in category 4 hence should not use IUCD. Women with other STIs like genital ulcers and vaginitis are in category 2; this means they can use IUCD since the benefits of using the method outweigh the risk. Women who are HIV infected are classified in category 2, this means they can use the IUCD. Women who are in the AIDS stage and are clinically well or ARVs are in category 2, IUCDs can be inserted as the benefits outweigh the risk (Family Planning guidelines 2011: 76).

#### **2.10.4 Limitations of IUCD**

The IUCDs do not protect against STI and HIV. Women that are positive should be encouraged to use a barrier method such as male or female condoms to prevent STI and HIV infection. Pelvic inflammatory disease (PID) is more likely to follow STI infection if a woman uses IUCD and PID can lead to infertility. This means IUCD users should protect themselves from STI. IUCD insertion is a medical procedure which requires pelvic examination before insertion; some women may not be comfortable with the process. Following insertion some women can experience pain and bleeding which may deter use of the contraception (Hatcher et al 2001:12-6). Despite the limitations informed consent and proper counselling is important for continuity of the IUCD.

#### **2.11. Conclusion**

Literature related to the global overview of HIV and AIDs as well as the epidemic overview in Zimbabwe has placed the subject in context. A detailed review of the long acting contraceptives with a focus on implants and intrauterine contraceptive device has provided a choice that could be feasible for a more balanced life. Information related to the condom served as guidelines as people living with the infection are encouraged to use dual protection to prevent unintended pregnancy as well as the transmission of HIV from an infected partner to an uninfected partner.

The theoretical background supporting the underlying objectives is a bridge leading towards solving the problem through presenting the transformation of data collected.

## **Chapter 3**

### **Research Methodology**

#### **3.1 Introduction**

This section explains the procedures and techniques which were employed in conducting the study. The project was carried out as a quantitative survey research in an attempt to obtain conclusive results that would be generalized to the clients attending Harare Post Test Support services clinic and to some extent to all women living with HIV and AIDS in Zimbabwe. The section will elaborate on the research design, sample, sampling frame, sample size and data collection techniques. The data collection techniques will include use of the questionnaires and a review of the existing data.

The problem statement is: What are the reasons for low utilization of long acting contraceptives among people living with HIV at Harare Post-test support services clinic? The objectives that accompany this statement provides a roadmap for the study. The objectives of the study were:

- To identify the contraceptive services available for women living with HIV and AIDS at Harare Post-test support services clinic
- To identify the existing knowledge about long acting contraceptives amongst women living with HIV and AIDS
- To establish the current contraceptive practices among women living with HIV at Harare (PTSS) clinic.
- To provide recommendations to address reasons for low utilization of long acting contraceptives among HIV positive women at Harare (PTSS) clinic.

#### **3.2 The Research Design**

Cooper & Schindler (2009) define the research design as the blue print for fulfilling objectives and answering questions. The quantitative approach was used to elicit information from patients and service providers. Wilson (2012) defines a quantitative research as “a research which is undertaken using a structured research approach with a sample of the population to produce quantifiable insights into behaviour, motivations and attitudes”. The quantitative approach involves a collection of numerical data to answer a given research question. Quantitative research allowed an understanding of the research problem in detail. It is conclusive in nature and definitive. It allows for wider statistical functions to be performed depending on what one want to establish on parameters such as the establishment of relationships amongst variables, correlations and significance testing. This means the data obtained after analysis lead to definitive conclusions that were drawn from the sample. Pertinent recommendations from the conclusions were drawn about the subject matter under investigation. The drawback encountered emanated from the nature of quantitative research as it proved to be a tedious



and very technical process. The other disadvantage of quantitative research is that a larger sample must be studied to come up with accurate results.

The qualitative attributes which involves the collection of non-numerical data was used for document review and eliciting information from service providers. This means “Qualitative research provides a holistic description of events, procedures and philosophies occurring in natural settings” (<http://www.okstate.edu/ag/agedcm4h/acdem>). The qualitative approach was also used as an initial way of understanding the subject matter which was to be investigated in order to gain an initial understanding before undertaking the study. This provided guidelines in the development of the research design and tools used including the actual commissioning of the field work.

The main advantages of qualitative research includes, “It produces more in-depth comprehensive information; the researcher gains more detailed and rich data in the form of comprehensive written description or visual evidence such as photographs and it looks at context of social meaning and how it affects individuals”( <http://www.ehow.com>).

The distinct disadvantages of the qualitative research include “the researcher will be heavily involved in the process which gives the researcher a subjective view of the study and its participants. The researcher interprets the research according to his or her own biased view, which skews the data gathered (<http://www.ehow.com>).The other disadvantage of qualitative research indicates that it is not conclusive hence data obtained cannot be used to draw conclusions or infer to the wider population.

### **3.3 Sample and Sampling Techniques**

Cooper and Schindler (2009) define a sample as “part of the target population, carefully selected to represent that population”. Christensen et al. (2011) define a sample as “a subset of the entire population”. This means the sample can be used to generalize the results to the entire population that is if it is representative of the entire population. The sample for this study was selected from all women who are HIV positive coming for services at Harare Post Test support services clinic. At least three documents of service providers were sampled as well.

The sample size is an ignored part of most studies usually because some people would just take the industry standard and few would actually calculate the sample size. However, this is a crucial component of any study. The sample size can be determined by the size of the population and the amount of money available for questionnaire design, data processing and analysis (Winston, 2012). On average 500 HIV positive testing women attend clinic services per month to gain support. The sample size can be calculated using the E-pi-info statistical software, but for convenience of this study, a sample size of 30 (6% of the expected potential interviewees) respondents, were interviewed over a period of four weekends. In order to be eligible for selection into the study the respondents were supposed to be women living with HIV.

Sampling refers to the process of drawing a sample from a population (Christensen et al, 2011:150). Wilson (2012) elaborated on sampling as “the selection of a sample of respondents that is representative of a population of interest”. In this study, the population of interest were HIV positive women. The sampling frame defined by Winston (2012) is “a list of the population of interest from which the researcher selects the individuals for inclusion in the research”. In this study the sampling frame was all women living with HIV above the age of 16years, attending the weekly clinic services were eligible for inclusion in the sample.

The non-random convenient sampling technique was used to select the research sample. Christensen, et, al. (2011:158) define the convenience sampling technique as “use of the people that are readily available or volunteer or are easily recruited for inclusion in a sample”. Winston (2012) further explains “the researcher’s convenience forms the basis for selecting the potential respondents”. In the study women living with HIV and attending the education session on Saturdays were requested to participate in the study. The specific research participants were selected on the days set aside to collect the data at the post test support services clinic. Those clients who visited the clinic on these days are the ones who were requested to participate in the study until the required sample size of 30 respondents was reached.

The main advantage of the technique employed was the ease to administer and offered no challenges to the schedule on other engagements (employment). The major challenge in the technique is a significant probability of errors in selection due to its non-random and convenient in nature. Qualification of the respondents (screening for suitability in reference to sampling frame) was eliminated, therefore allowing for the possibility of an unrepresentative sample being used.

An in-depth interview was conducted with the manager of the site on elements involving availability of relevant documents on contraceptive use at the clinic and on the particular services provided at the clinic. The manager for the post-test service clinic was asked questions related to services provided at the clinic.

### **3.4 Data Collection Techniques**

Data collection is defined as the technique for physically obtaining data to be analysed in a research study (Christensen, et, al. 2011:54). A standard fully structured respondent completed questionnaire was employed as a tool for data gathering; “Questionnaires usually form an integral part of descriptive and opinion related surveys. Questionnaires can either be in the form of self-administered ones where the respondent is asked to complete a questionnaire at their own time or structured interview, where the interviewer writes down the answers of the respondent during a telephone or face to face interview”( University of Johannesburg ,2005). Interviewee administered questionnaire was used for its two fundamental qualities;-

- ❖ Since it is structured, it is easy to analyse and easily transferable to programmes such as SPSS and MS excel.
- ❖ It allows the data collection even in the absence of the researcher which was due to other commitments (work).

The distinct advantages of the self-administered questionnaires are; since they are answered anonymously, sensitive and personal questions are much more likely to be answered truthfully; they are relatively easy to administer and analyse, most people are familiar with the concept of questionnaires and they are considered to be less intrusive than telephone or face to face interviews. One of the disadvantages of self-administered questionnaires is there may be a low response rate as people consider filling in of questionnaires as boring. In modern day living especially in the busy cities, people consider selves too busy and may tell you they do not have time to complete a long questionnaire. In order to increase on the response rate, the research questionnaires were handed out to clients who had come for the education sessions. The respondents were requested to drop the questionnaires in a marked box on leaving the clinic. In order to increase the understanding of the questions addressed and reduce the chances of data error, the questionnaire was pretested on ten clients who had the same characteristics as the research sample and any ambiguous questions were corrected. The questionnaire was simplified so that the interviewees would understand. The questionnaires were also translated into the main local languages of English and Shona. Respondents were asked the language they understood better and handed out the questionnaire with the appropriate language, (Annex (i) - English questionnaire).

The questionnaires had four main sections which sought to capture the following information in order to elicit comprehensive information on the research problem:

- Demographic information
- Practices related to long acting contraceptives
- Knowledge of the implants(Jadelle) contraceptive
- Knowledge of the intra-uterine contraceptive device.

The in-depth interview with the Site manager included a discussion on the availability of policies and guidelines on family planning as well as the services available for women living with HIV. Document review focused on the availability of procedure manuals on contraceptives for women living with HIV.

### **3.5 Data Analysis and Presentation**

Christensen (2011:374) explains “the collected data should be analysed for themes, patterns and meanings”. Once data collection was completed, the data was manually coded and entered into an

excel sheet for tabulation and statistical analysis. Data was presented in the form of frequency tables, pie charts, histograms and bar charts. Tables serve as informative supplements to the text. Only highlights of the tables were discussed. Each table has a brief title which describes the data it contains.

Qualitative data analysis from available documents was done. Document analysis of manuals and guidelines of family planning was used to verify policies and procedures available for the provision of long acting contraceptives to HIV positive women. The raw data collected from the clinic records was used to provide explanations, understanding and interpretation of the phenomena, people and situations which contribute to the low utilisation of long acting contraceptives by HIV positive women. “One of the greatest strengths for content analysis is that it provides a way of extracting information from a wealth of real world settings. The greatest limitation is that it is often very hard to review is presented in a narrative report format interpret findings” ([http://www, smartpsych.co.uk/wp-content](http://www.smartpsych.co.uk/wp-content)).

### **3.6 Summary**

The quantitative survey research was conducted to determine the reasons for low utilisation of long acting contraceptives amongst women living with HIV attending Harare post-test support services clinic from June to November 2012. The quantitative approach was used since it gave the researcher the opportunity to collect data which is conclusive and definitive in nature. Qualitative aspects were employed during the in-depth interview of the manager of the clinic to understand the policies and guidelines related to long acting contraceptive services at the clinic.

A convenience sampling technique was employed to select the respondents. The sampling frame was all women living with HIV and attending the Harare Post Test support services clinic. A total of 30 respondents were selected for the study due to limitations of time by the researcher. A standard structured questionnaire was used to collect the data. The questionnaire had four main sections which focused on demographic data, knowledge of the long acting contraceptives, knowledge of the Jadelle contraceptive implant and knowledge of the intrauterine contraceptive device. The collected data was manually analysed. Grouped and presented in the form of tables, histograms and pie charts.

## **Chapter 4**

### **Presentation of the Research Findings**

#### **4.1 Introduction**

This chapter covers the research findings from the study. The respondents were given questionnaires to respond to and submit completed documents. The respondents were assured their responses would remain anonymous and their assistance in the study would be of great benefit to the project as well as people living with HIV and AIDS. The respondents were informed they could withdraw from the study at any time if they so wishes. Those who required counselling after responding to the questionnaire were either referred to the clinic counsellors. The researcher was also available to respond to any questions the respondents had after responding to the questionnaire. The research findings are therefore presented in the form of tables, pie charts as well as descriptive statistics. The problem statement of the study was formulated as: What are the reasons for low utilization of long acting contraceptives among people living with HIV at Harare Post-test support services clinic? The research findings are presented according to the subheadings on the questionnaire focusing on the objectives of the study.

#### **4.2 Background Information**

This section focused on the biographical information covering age, marital status as well number of children of the respondents (Table 4.1).

##### **4.2.1 Gender of the Respondents**

The research focus was on women living with HIV attending the Harare Post Test support services clinic. All the respondents (100%) were HIV positive women attending the Harare Post Test Support services clinic

##### **4.2.2 Age of the Respondents**

The age of an individual determines an individual's ability to make informed decision on their choice of contraception.

**Table 4.1**

**Age of the respondents**

Age Range	Frequency	Percentage
15-24years	0	0
25-34years	6	20
35-49years	22	73
Above 50years	2	7

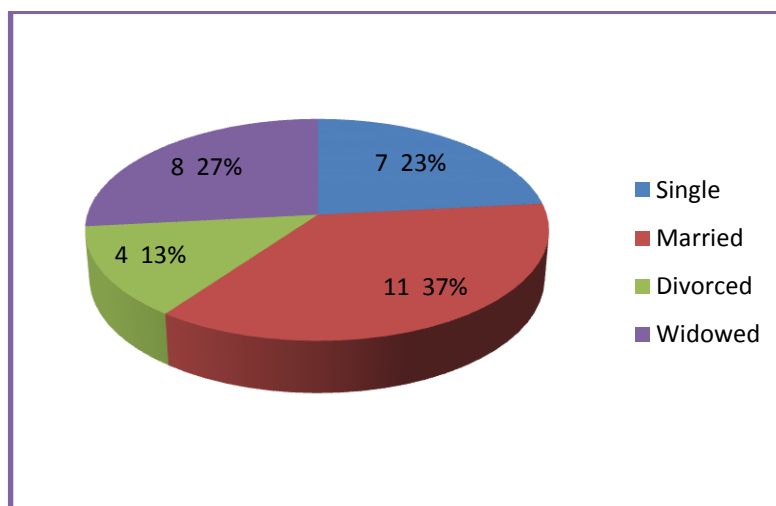
Table 4.1 illustrates that the majority (73%) of the respondents were in the age range 35-49 years followed by the age range 25-34 years (20%) whilst seven percent of the respondents were above the age of 50 years.

**4.2.3 Marital Status**

The marital status of the respondents was divided into five sections; single, married, widowed, divorced and separated (figure 4.1).

**Figure 4.1**

**Marital Status of the respondents**



The majority of the respondents, 36% were married followed by widowed 29% and single 25% then divorced 10%.

#### 4.2.4 Number of Children

The number of children ranged from no child to more than three children. Thirty nine percent of the respondents had one child followed by 36% who had two children. Two percent of the respondents had no child and eleven percent had more than three children whilst seven percent had three children.

#### 4.2.5 Age of Youngest Child

The age of the youngest child can be a guide on whether an individual would be planning to have another child or not. The age of the youngest child was divided into less than two years to above five years (table 4.2).

**Table 4.2**

**Age of youngest child**

Age range	Number	Percentage
Less than two years	1	4
2-5 years	1	4
Above 5 years	24	86
N/A	2	6

The majority of the respondents had children who were above 5 years old followed by those who did not respond to the number of children since this question was not applicable to their situation. Four percent of the respondents had children in the age range less than two years to five years.

#### 4.2.6 Intentions to have another Child.

Sixty-seven per cent of the respondents did not intend to have another child whilst 33% agreed that they intended to have another child.

**Table 4.3****Period intended to have another child**

<b>Period</b>	<b>Frequency</b>	<b>Percentage</b>
After one year	5	17
After two years	4	13
After three years	1	3
After more than four years	0	0
Do not intend to have another child	20	67

Table 4.3 illustrates, the majority of the respondents (67%) did not intend to have another child whilst 17 per cent intended to have another child after one year, 13% intended to have another child after two years and none intended to have another child after more than four years.

### **4.3 Practices Related to Long Acting Contraceptives**

This section focused on the respondents practices towards long acting contraceptives. The focus was on the type of contraception used by the respondents (Figure 4.2).

#### **4.3.1 Use of Family Planning Method.**

Sixty- eight percent of the respondents were not using any modern family planning method whilst 32% were on a family planning method.

#### **4.3.2 Method of Family Planning Being Used**

All the modern methods of family planning were highlighted and the clients had the opportunity to select the family planning method they were using. The family planning methods ranged from the pill, injectable, implant, intrauterine contraceptive device and permanent methods.



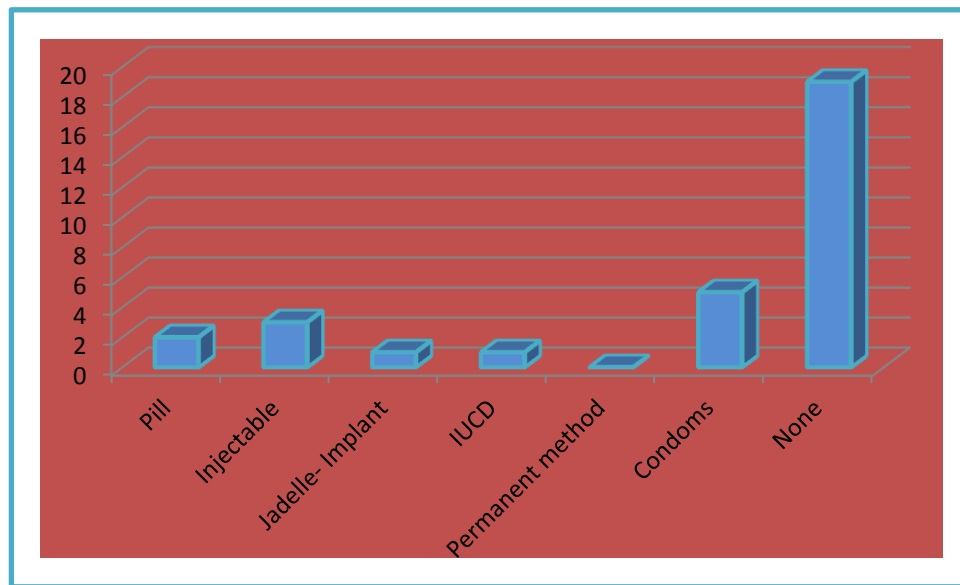
**Figure 4.2****Family Planning method being used**

Figure 4.2 shows the majority, 63% of the respondents were not on any family planning method. Earlier on 67% of the respondents did not want to have any children. None of the respondents are using permanent method of family planning whilst condoms are used by 17% of the respondents. The main long acting contraceptives, the Jadelle and intrauterine contraceptives were used by 4% of the respondents which is represented by 30.

#### 4.3.3 Reasons for not using a Long Acting Contraceptive

Reasons for not utilizing long acting contraceptives were explored and the respondents' responses ranged from planning to have children in the next three months to never use a family planning method before. Thirty percent of the respondents were not using long acting contraception because they did not have a sexual partner during the time of the study. Thirty- three per cent feared side effects whilst 10% were not sure of the side effects of long acting contraceptives hence just decided not to use them.

Ten per cent of the respondents were not sure of the mode of action of the long acting contraceptives, 6% were above 35 years old hence did not think they were supposed to use any long acting contraception whilst 3% had reached menopause and another 3 % never used contraception in their lives (Table 4.4).

#### 4.4 Knowledge Related to Implant-Jadelle

Jadelle is one of the most available long acting contraceptive implant in Zimbabwe. Jadelle is available through private and public healthcare institutions. Knowledge of the long acting contraceptives was explored starting with the pill, injectable, Jadelle, IUCD and permanent methods.

**Table 4.4**

**Knowledge of the contraceptive method which acts for more than three months**

<b>FP method</b>	<b>Number of respondents</b>	<b>Percentage</b>
<b>Pill</b>	2	7
<b>Injection( Depo Provera or Petogen)</b>	9	30
<b>Jadelle Implant</b>	6	20
<b>IUCD</b>	4	13
<b>Permanent Method</b>	4	13
<b>Don't Know</b>	5	17

##### 4.4.1 Contraceptive Method which Acts for More Than Three Months

The respondents' knowledge of the long acting contraceptives was ascertained and the responses were illustrated in table 4.4 above. There is evidence 30% of the respondents outlined the injection as a contraceptive which acts for more than three months. Twenty percent mentioned the Jadelle implant whilst 17% did not know the contraceptive method which acts for more than three months.

A further analysis of the relationship between knowledge of long acting contraception was ascertained. Thirty per cent know that Depo Provera is a long acting contraception but only 10% are using Depo Provera.

#### 4.4.2 Ever Heard of Jadelle Implant

Sixty percent of the respondents had heard about the Jadelle contraceptive method whilst 40% had not heard about this prevention method.

#### 4.4.3 Categories of Jadelle Contraceptive

The respondents' knowledge of the categories of the Jadelle implant was ascertained (figure 4.3).

**Figure 4.3**

**Categories of Jadelle Implant**

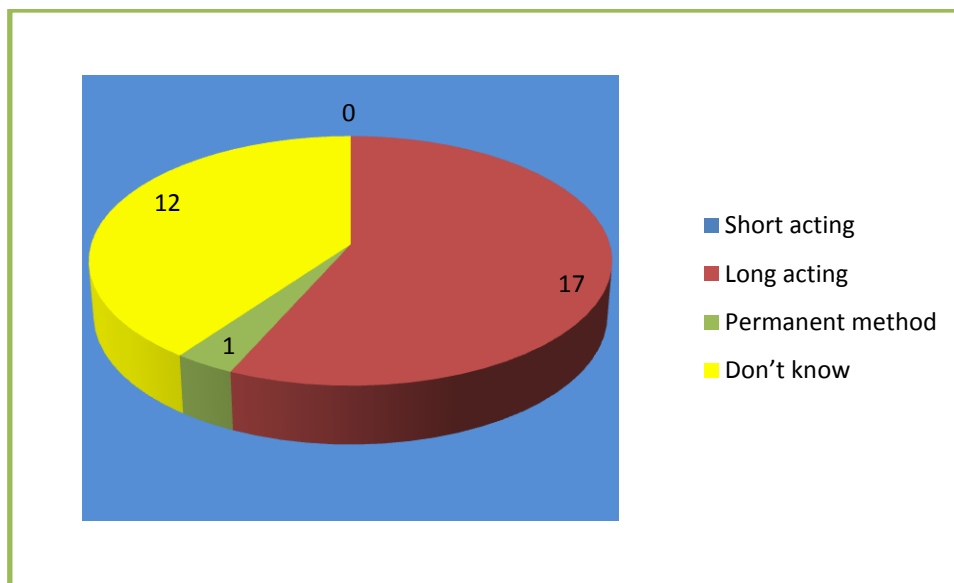


Figure 4.3 illustrates that 57% of the respondents categorised Jadelle as a long acting contraceptive whilst 40% did not know whether it was a long acting contraceptive or not whilst none categorized it as a short acting contraceptive.

#### 4.4.4 Length of Time Jadelle Protects from Unintended Pregnancy

Further questioning was aimed at ascertaining the respondents' knowledge of the length of time Jadelle prevents unintended pregnancy. Fifty-four percent of the respondents said Jadelle protects against unintended pregnancy for five years, 3% said for more than five years whilst 43% did not know the duration of protection against unintended pregnancy.

#### 4.4.5 Is Jadelle Safe for HIV Positive Women?

The knowledge of Jadelle as a safe contraception for HIV positive women was ascertained. Fifty three percent of the respondents did not know whether it was safe for HIV positive women or not, 30 % said yes it was safe for HIV positive women whilst 17% said it was not safe for HIV positive women. Further analysis was done to ascertain the relationship between knowledge of safety of a

contraceptive method and the use of the method. Four percent of the respondents were using the Jadelle as a contraceptive method whilst 33% were not using any long acting contraceptive due to fear of side effects.

#### 4.4.6. Respondents' Reasons for Jadelle as not Safe for HIV Positive Women

Further questioning ascertained why some of the respondents thought Jadelle was not a safe contraception for HIV positive women.

Fifty-seven percent of the participants responded to this question. Of these, 18 % thought the Jadelle implant is not safe for HIV positive women because it causes bleeding, another 18% said it increases the transmission of HIV to the sexual partner and another 18% said it increases HIV progression to AIDs whilst 46% did not know why it is not safe for HIV positive women.

#### 4.5 Knowledge of the Intrauterine Contraceptive Device

This section explored the knowledge of the HIV positive women to the intrauterine contraceptive device. The ZDHS 2010/2011 has indicated that utilisation of the IUCD by women of child bearing age has been less than 2% since 2005. The IUCD is a non-hormonal contraception inserted into the uterine cavity and prevents pregnancy for up to 10 years.

##### 4.5.1 Category of the IUCD

Respondents were asked their knowledge of the IUCD as long acting contraceptive and the responses are illustrated in figure 4. 4.

**Figure 4.4**

**Knowledge of IUCD as a long acting contraceptive**

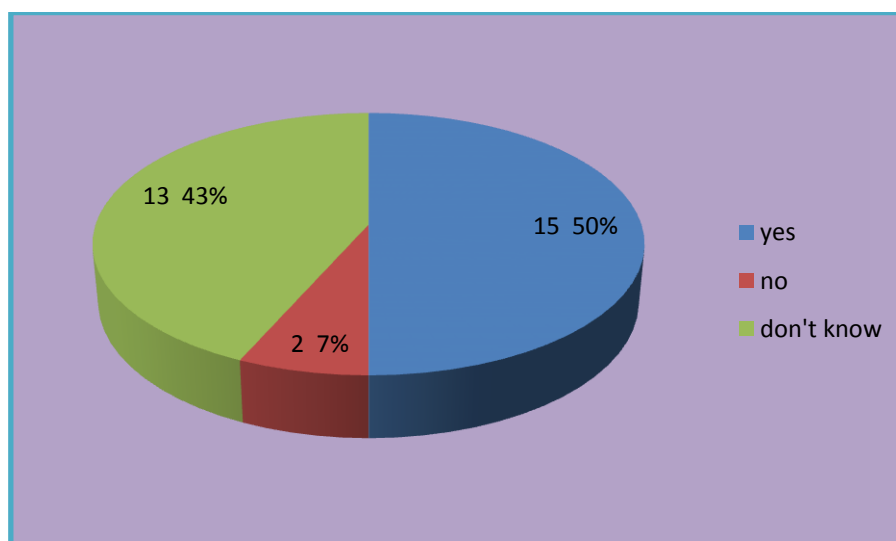


Figure 4.4 illustrated, 50% of the respondents agreed the IUCD is one of the long acting contraceptives, 7% said it is not a long acting contraceptive whilst 43% said they did not know that the IUCD is a long acting contraceptive.

#### 4.5.2 Use of IUCD by HIV Positive Women

Fifty percent of the respondents said the IUCD can be used by HIV positive women, 7% said it should not be used by HIV positive women whilst 43% said they did not know whether the IUCD should be used by HIV positive women or not.

#### 4.5.3 Why the IUCD cannot be used by HIV Positive Women

The follow on question established why the IUCD should not be used by HIV positive women. Fourteen percent of the respondents responded whilst 86% did not respond. Those responding 50 percent said it increases the transmission of HIV to the sexual partners whilst the other 50% said they did not know why it cannot be used by HIV positive women.

#### 4.5.4 Duration of Action of the IUCD

The respondents' knowledge of the duration of protection of the IUCD was ascertained and the responses were illustrated in table 4.5.

**Table 4.5**

**Duration of protection of the IUCD**

<b>Period</b>	<b>Frequency</b>	<b>Percentage</b>
Less than one year	4	13
Two to five years	3	10
More than five years	3	10
Don't know	20	67

Table 4.5 illustrates that the majority of the respondents, 67% of the respondents did not know the duration of protection of the IUCD, 10% said it protects for more than five years, another 10% said it protects for two to five years whilst 13% said it protects for less than one year.

#### **4.5.5 Availability of the IUCD at the Post Test Support Services Clinic**

Seventy percent of the respondents did not know that the IUCD was available at the post test support clinic whilst 30 % said it was available at the post test support clinic.

#### **4.5.6 Removal of the IUCD**

Sixty seven percent of the respondents said the IUCD can be removed anytime the woman plans to have a baby whilst 33% said they did not know.

Thirty percent of the respondents said they had received information on the IUCD at the post test support clinic whilst seventy percent said they had not received information at the post test support clinic.

#### **Summary**

The research findings indicated the majority of the respondents were in the age 35-49 years and the majority were married. Seventy per cent of the respondents did not intend to have another child. Sixty-eight percent of the respondents were not using any modern family planning method. The condom was used by 17% of the respondents as the only method of family planning, whilst the long acting contraceptives Jadelle and IUCD were used by 4% of the respondents.

Thirty-three percent of the respondents were not using any long acting contraceptive due to fear of side effects. The respondents' knowledge of Jadelle contraception showed that 53% of the respondents did not know whether Jadelle was safe for HIV positive women or not. Knowledge of the IUCD revealed that 50% of the respondents said that the IUCD could be used by HIV positive women whilst 43% did not know why it could be used by HIV positive women. On overall, the majority of the respondents did not know whether the long acting contraceptives were available at the post-test support clinic or not

## Chapter 5

### Summary, Conclusions and Recommendations

#### 5.1 Introduction

This chapter elaborates on the summary of the major findings of the study, a discussion focusing on each objective, recommendations and conclusions from the study findings. The study focused on the reasons for low utilization of long acting contraceptives amongst HIV positive women at Harare Post Test Support Services clinic in order to establish effective strategies which increases uptake of long acting contraceptives among these HIV positive women. The problem statement is: What are the reasons for low utilization of long acting contraceptives among people living with HIV at Harare Post-test support services clinic?

Questionnaires completed by participants were used to elicit information from the respondents. Thirty respondents were targeted and all (100%) returned the completed questionnaires. The questionnaires had four main sections which focused on the following:

- Background information
- Practices related to long acting contraceptives
- Knowledge related to the implant-Jadelle contraception
- Knowledge of the Intrauterine contraceptive device

#### **The objectives of the Study:**

- To identify the contraceptive services available for women living with HIV and AIDS at Harare Post-test support services clinic
- To identify the existing knowledge about long acting contraceptives amongst women living with HIV and AIDS
- To establish the current contraceptive practices among women living with HIV at Harare (PTSS) clinic.
- To provide recommendations to address reasons for low utilization of long acting contraceptives among HIV positive women at Harare (PTSS) clinic.

The discussion will focus on each of the objectives, major findings conclusions and the recommendations

### **5.1.1 Background of the Respondents**

All the respondents were women living with HIV and attending the Harare post-test support services clinic. The majority of the respondents were in the age group 35-49 years. Those married constituted 36% of the respondents followed by those widowed, 29%.

Thirty- nine percent of the respondents had one child followed by 30% who had two children. Sixty seven percent of the respondents did not intend to have any more children whilst 68% of the respondents were not using any form of modern contraception.

The conclusion drawn from the background information is that most women attending the Harare Post-test support services clinic are older women 35-49 years who have one or two children. They did not intend to have any more children but were not using any modern method of contraception.

### **5.1.2 Services Available for HIV Positive Women at Harare Post-test Support Services Clinic**

The availability of services increases the uptake of various contraceptives for clients. A review of the available data indicated the major family planning services available for HIV positive women were oral contraceptives and injectable. The counsellors at the clinic who are also nurses have not yet been trained on the provision of long acting contraceptives mainly the Jadelle implant and the intrauterine contraceptive device. The set-up of the clinic is not ideal for the provision of long acting contraceptives since it does not have adequate examination facilities for the clients. It is one of the requirements by the National Health professionals' regulatory body in the country to ensure adequate facilities for service provision. This means the clinic only offers short acting contraceptives to the clients and those who need long acting contraceptives are referred to the nearest clinic for accessibility of these methods. At the clinic all contraceptives are provided for free but when the clients are referred to other clinics, they have to pay for the service. The service fee ranges from United States (USD) \$10.00 to \$40.00 for the public sector clinics and up to \$70.00 for private practitioners. Medical aid is acceptable at the private practitioners but the clients are not on medical insurance due to ill health, they could not continue to be on medical aid. The conclusion drawn from this objective was that the long acting contraceptives are not available for women living with HIV at the Post Test support services clinic. However, referral is done for these services but the women cannot access them due to the high cost.

### **5.1.3 Existing Knowledge about Long Acting Contraceptives amongst HIV Positive Women at Harare Post Test Support Services Clinic**

In order to elicit the knowledge on long acting contraceptives, the practices related to long acting contraceptives was elicited followed by the knowledge of Jadelle and the intrauterine contraceptive device.



Thirty two percent of the respondents were on any modern method of contraception. Condoms which are classified as short acting methods of contraception were used by 17% of the respondents followed by the injectable which is also short acting. The long acting contraceptives which are Jadelle and the intrauterine contraceptives were used by 4% of the respondents. Some of the reasons for not using a long acting contraceptive were fear of side effects cited by 33% of the respondents and 30% of the respondents said they were not using modern contraception because they did not have a sexual partner.

Fifty seven percent of the respondents were able to cite Jadelle as a long acting contraceptive compared to thirty percent who cited the injectable (Depo-Provera as a long acting contraceptive. Sixty percent of the respondents had heard of Jadelle whilst 40% had not heard of It. Thirty percent of the respondents cited Jadelle as safe for HIV positive women whilst 53% did not know whether it is was safe for HIV positive women or not.

The conclusions from this discussion are that women living with HIV are not using the long acting contraceptive Jadelle as method of contraception. They are using mainly the condom as a form of contraception though it is encouraged that women living with HIV should use dual protection, that use of effective family planning method to prevent unintended pregnancy and condoms to prevent HIV transmission. Fear of side effects and not sure of how the contraceptive works can be a barrier to use of the contraception.

## **5.2. Knowledge of the Intrauterine Contraceptive Device**

Four percent of the respondents were using the IUCD as a method of contraception. Fifty percent of the respondents cited the IUCD as a long acting contraceptive whilst 50% agreed the IUCD is safe for HIV positive women. Seven percent of the respondents cited the IUCD cannot be used by HIV positive women due to fear of side effects. Seventy percent of the respondents did not know whether the IUCD was available at the clinic or not neither did they know that it could be removed anytime one wants to have a baby or not.

The conclusions drawn are that women living with HIV have limited knowledge on the intrauterine contraceptive device. They were not using it as a form of contraception to prevent unintended pregnancy.

## **5.3 Recommendations**

The following recommendations are made:

- All women living with HIV should be given information on family planning on the first day of their visit to the Post Test Support Services Clinic.

- The role of dual protection in prevention of unintended pregnancy as well as prevention of HIV transmission should be emphasised during the training sessions.
- The information on benefits of long acting contraceptives should include dispelling of myths and misconceptions about Jadelle and IUCD.
- A proper referral system should be put in place for those contraceptive services which the Post test support services clinic may not be providing.
- The referral system should include referral to institutions where the women will not pay any extra fee so that they will be able to take up the services.
- All age groups should be encouraged to visit the post test support services clinics so that they also benefit from the lessons learnt at the clinic.
- Information education and communication materials should focus on the benefits of using long acting contraceptives and dispel all myths associated with use of contraception by HIV positive women.

#### **5.4 Limitations of the Study**

Several challenges were encountered while conducting this research. The challenges affected mostly aspects of research scope and reach, while others had great effect on data capturing.

Time Limitations- the study was allocated a time period of three months, which was not adequate for the study. However, as much time as possible was devoted in order to complete the research in the allocated time. Data was collected during weekends when the researcher was off duty had had adequate time to visit the clinic.

Funding- the researcher funded the study wholly from personal savings. Therefore funding was a great limiting factor in terms of the scope of the study. The researcher saved personal funds in order to reduce the impact of the funding limitations.

Convenience sampling-this had risks in the form of error in selection bias. Convenience sampling was done to ensure time and monetary savings by reducing the challenges of failing to reach out to the required sample size. However, the researcher was objective in the analysis of the data.

Sample size- a small sample size of 30 respondents was convenient for the researcher since there was not adequate time and funds to use a bigger sample. The researcher was objective in data analysis. The findings may not be generalised to all people living with HIV in the country neither can it be used to generalise the findings to all women living with HIV at Harare Post-test support services clinic.

## 5.5 Conclusion

The following conclusions were therefore drawn from the study:

- There is limited knowledge on long acting contraceptives amongst women living with HIV.
  - The utilisation of long acting contraceptives, Jadelle and IUCD are reduced amongst women living with HIV at Harare Post-test Support Services Clinic.
  - Unavailability of the services for long acting contraceptives at the clinic is a barrier to utilisation of these methods.
  - High costs for services is a barrier to accessibility of long acting contraceptives
  - Fear of side effects is a barrier to acceptance and utilization of the long acting contraceptives
  - Condoms were the contraceptive methods utilized by most of the women living with HIV at the clinic.
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**Annex (i)**

**English Questionnaire**

**The Research questionnaire: For women attending the post-test support services clinic**

Stand Number 2506

Benjamin Burombo Street

Ruwa

30 May 2012

Dear Respondent

**RE: A study to determine the reasons for low utilization of long acting contraceptives amongst women attending the Harare post-test support services clinic.**

Pester Siraha; a Masters in Philosophy in HIV and AIDS management student with Stellenbosch University is conducting a research study to determine “the reasons for low utilization of long acting contraceptives amongst women attending the Harare Post-test support services clinic”.

The purpose of the study is to determine the reasons for low utilization of long acting contraceptives amongst women attending Harare Post-test support services clinic with a view to recommend effective strategies which would increase the uptake of long acting contraceptives amongst women attending Harare Post-test support services clinic.

All the information collected will be kept in a confidential manner. Only a summary of the results of the study will be shared with Stellenbosch University and Population Services International. Please do not write your name on any of the forms in order to protect your identity. You can withdraw from the study anytime you feel like doing so.

I therefore kindly request you to complete the following short questionnaire regarding your knowledge and practices on long acting contraceptives. It should take you no longer than 10 minutes. Although your response is the most important, your participation in the research is entirely voluntary.

Kindly return the completed questionnaire to the reception today before you leave the centre.

Should you have any queries or comments regarding this research, you are welcome to contact me on the following cell phone numbers: +263 772 891 849 or email, [sirahap@gmail.com](mailto:sirahap@gmail.com)

Yours sincerely

Pester Siraha

MPhil HIV and AIDS Management Student (2012)

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CROSSING(X), THE RELEVANT BLOCK BOX OR WRITING DOWN YOUR ANSWER IN THE SPACE PROVIDED.

**Example of how to complete the questionnaire?**

**Q1. What is your gender?**

Male	
Female	<b>X</b>

**Section A: Background information.**

This section refers to background or biological information. We are aware that some questions can be very sensitive. This will allow us to compare the various responses. We assure you again that your responses will remain anonymous.

**1. What is your gender?**

Male	
Female	

**Q.2.What is your age?**

15-24years	
25-34 years	
35-49years	
Above 50years	

**Q3.What is your marital status?**

Single	
Married	
Divorced	
Widowed	

**Q4. How many children do you have?**

None	
------	--

1	
2	
3	
More than 3	

**Q5. How old is your youngest child?**

Less than two years	
2-5years	
Above 5 years	
N/A	

**Q6. Do you intend to have another child? Yes/no**

Yes	
No	
N/A	

**Q7. If the answer to Q6 is yes, when do you intend to have another child?**

After one year	
After two years	
After three years	
After more than four years	

**Section B: Practices related to long acting contraceptives?**

This section explores your practices related to contraceptive use.

**Q7. Are you on any family planning method?**

Yes	
No	



**Q8. If the answer to Q7 is yes, which family planning method are you using?**

Pill	
injectable	
Jadelle	
Intrauterine contraceptive device	
Permanent method	
Other	
N/A	

**Q9. If you are not using any contraceptive method which acts for more than three months, what are the reasons for not using a long acting contraceptive?**

Planning to have a child in the next three years	
Fear of side effects	
Not sure of the mode of action of the long acting contraceptive	

Other reasons-----

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**Section C: Knowledge related to Jadelle**

This section will explore your knowledge of the long acting contraceptives and Jadelle contraceptive method.

**Q9. Which of the following contraceptive methods act for more than three months?**

Pill	
Injection( Depo Provera or Petogen	
Jadelle	
Intrauterine contraceptive device	
Permanent method	
Other	
Don't know	

**Q 12. Have you heard of a contraceptive method called Jadelle or implant?**

Yes	
No	

**Q13 .Jadelle is categorised under which of the following?**

A short acting contraceptive	
A long acting contraceptive	
A permanent method of family planning	
Don't know	

**Q14. How long does the Jadelle protect you from unintended pregnancy?**

One year	
Two years	
Five years	
More than five years	
Don't know	

**Q15. Have you received any information on the benefits of using the implants during your visit to this Post-test support centre?**

yes	
No	

**Q16. Do you think the Jadelle implant is safe for HIV positive women?**

Yes	
No	
I don't know	

**Q17. If your answer to Q16 is NO can you explain why you think it is not safe?**

It causes bleeding	
It increases the transmission of HIV to the sexual partner	
Increases HIV progression to AIDS	

Any other reason-----

**Section D: Knowledge of the intrauterine contraceptive device**

**This section will explore your knowledge of the intrauterine contraceptive device, the loop.**

**Q18. The intrauterine contraceptive device is one of the long acting contraceptives**

Yes	
No	
Don't know	

**Q19: The intrauterine contraceptive device can be used by HIV positive women?**

Yes	
No	
Don't know	

**Q20.If your answers to Q19 is No, why do you think it cannot be used by HIV positive women?**

It causes bleeding	
It increases the spread of HIV infection	
It increases the transmission of HIV to the sexual partner	

**Other reason-----**

**Q21. The intrauterine contraceptive device acts for how many years?**

Yes than one year	
Two to five years	

More than five years	
Don't know	

**Q22. The intrauterine contraceptive device (loop) is available at this post-test support clinic?**

Yes	
No	
Don't know	

**Q23. The intrauterine contraceptive device can be removed anytime you want to have another baby?**

Yes	
Know	
Don't know	

**Q24: I have received information on the intrauterine device at this clinic?**

Yes	
No	

Thank you for your time in completing this questionnaire. Kindly return the questionnaire to the reception before you leave the centre.