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Unmet Need for Family Planning among HIV Positive Women Attending HIV Care and Treatment Services in Zewditu Memorial Hospital Addis Ababa, Ethiopia

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A Thesis submitted to the School of Graduate Studies of Addis Ababa University in partial fulfillment of the Requirements for the Degree of Masters of Public Health

February, 2014

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DECLARATION

I, the undersigned, declared that this thesis is my original work. It has not been presented for a Degree in this or any other university, and that all sources of materials used for the thesis have been fully acknowledged.

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Acknowledgment

I would like to extend my appreciation to my advisor Dr. Ayele Belachew for his invaluable guidance and support in writing this Thesis. I am grateful to the School of Public Health for providing support letter and for assigning an Advisor .

My appreciation also goes to the study participants, data collectors and supervisors for their contribution and commitment throughout the study period.

Abstract

Background: Globally there is huge increase in family planning access and use. Despite this an estimated 137 million women in the developing world, who would like to avoid childbearing, are unable to avoid it. The concept of unmet need defines the gap between women's reproductive intentions and their family planning behavior. There are few incites and substantive data available on the magnitude of unmet needs for family planning and occurrence of unintended pregnancy among HIV positive women in Ethiopia (Addis Ababa).

Objective: To assess the unmet need for family planning among HIV positive women attending HIV care and treatment services in Zewditu Memorial Hospital Addis Ababa

Methodology: Institution based cross-sectional study was conducted from March to September 2013 on 419 HIV positive women. Data was collected using structured questionnaire which was administered by counselor nurses. The data was entered in to EPIinfo and analyzed using SPSS.

Result

The study findings show that the overall prevalence of unmet need is 32.7%, comprising 21.7%of women who wanted to limit births and 11% who wanted to space births. Educational status and employment status of the women were found to be significantly associated factor with unmet need for family planning. In a multivariate analysis, HIV positive women who have unmet family planning need at $P < .019$ were having a significantly higher chance of experiencing unintended pregnancy. Family planning and condom use were most discussed with service providers during entry to ART; this was reported by 38% of the respondents.

Conclusion: Unmet family planning needs were high among HIV positive women in ART units in Addis Ababa as compared to findings of EDHS 2011. Limiters were higher than spacers. As a major indicator of these, occurrence of unintended pregnancy were higher among HIV positive women in the ART follow up units in Zewditu memorial Hospital;.

Contents

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
EDHS	Ethiopian Demographic and Health Surveys
FHI	Family Health International
FP	Family Planning
HBC	Home-Based Care
HAART	Highly Active Anti-Retroviral Therapy
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
MTCT	Mother To Child Transmission of HIV
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PLHIV	People Living With HIV
RH	Reproductive Health
TFR	Total Fertility Rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

VCT Voluntary Counseling and Testing

WHO World Health Organization

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Introduction

Background

Globally there is huge increase in family planning access and use, despite this an estimated 137 million women in the developing world who would like to avoid childbearing are unable to do so. Women who are sexually active and would prefer to avoid becoming pregnant but nevertheless are not using any method of family planning are considered to have an unmet need for family planning. The concept of unmet need refers to the gap between women's reproductive intentions and their family planning behavior, and is estimated on the basis of women's responses to survey questions about their reproductive intentions and family planning use [1,2].

In developing countries an estimated 51 million unintended pregnancies occur every year to women who are not using any family planning method. Another 25 million occur as a result of incorrect or inconsistent use of a family planning method or method failure [2].

Most women living with HIV AIDS are of child bearing age and they face difficulties concerning their childbearing and sexuality choice. Their choice can be limited by direct or indirect factor or medical factor. Unprotected vaginal intercourse is the common cause of HIV infection for women [1]. As access to ART increases, HIV can be experienced as a chronic but treatable disease. PLHIV are more likely to desire children. In developed and developing countries HIV positive women desiring child were 18% to 43% respectively[2]. Worldwide, Mother-to-child transmission is the principal way through which children become infected with HIV. Women of childbearing age account for more than half of the people living with HIV/AIDS worldwide[3].

Of the 2.5 million young children living in the world today with HIV/AIDS, about 90 percent were infected by their mothers. Most of these children live in Africa, where the vast majority of HIV-positive pregnant women also live. Prevention of mother-to-child transmission (PMTCT) is a priority on the HIV prevention agenda. In the absence of any intervention, rates of MTCT are 25 to 40 percent higher in resource-constrained countries than in the industrialized world.[3, 4]

In 2002, a World Health Organization (WHO) meeting identified prevention of unintended pregnancies to HIV-infected women as a key strategy to prevent babies from acquiring HIV from their infected mothers. Combined with other approaches, including primary prevention of HIV infection among women, and provision of care, treatment, and support for women living with HIV and their families, this could dramatically reduce MTCT [5].

The occurrence of unintended pregnancy among HIV positive women was seen to be significant in different situations. In the United States in 2005, it was found that 88% of the first pregnancies among a cohort of HIV positive women were unplanned [3].

Family planning can have a significant and cost-effective impact in HIV/AIDS prevention efforts. A number of models and USAID-funded studies indicate that family planning services in sub-Saharan Africa are preventing HIV infection in more infants than programs that promote and provide Nevirapine to HIV-positive mothers. Adding family planning services to programs for PMTCT can achieve, at less cost, the same effect as increasing antiretroviral drug coverage[6].

PLHIV have various reproductive health needs and unmet needs for family planning services have often been greatest in resource constraint countries with high HIV prevalence. These people may want to have a child, to postpone bearing a child or not have a child any more[7].

Rationale of the study

In 2009, an estimated 860,000 pregnant women were found to be living with HIV in Eastern and Southern Africa, more than in any other region of the world. The region is also home to 47 percent of the global total of children living with HIV, of which over 90 percent were infected through vertical transmission from the mother to the baby during pregnancy, delivery or breastfeeding [7]

The Ethiopia Health Sector development plan four (HSDP IV) has targeted to increase the family planning prevalence rate (CPR) from 25% to 60%. [8]

Rates of family planning use have increased recently in most developing countries, as has the desire of most married couples for smaller families. However, an estimated 17% of married women in the developing world still have an unmet need for family planning. Despite gains in access to family planning , over 120 million women still have an unmet need for family planning resulting in 80 million unintended pregnancies, some 45 million of which are terminated and 19 million under unsafe conditions [6].

Taking in to account the HIV/ AIDS burden and its consequences to the new born and also the attention that it has got both at the national and international level, it is necessary to study about un-met need for all women, unmet need for HIV positive women, s***exual*** behavior of people living with HIV/ AIDS, fertility desire of people living with HIV/AIDS, family planning practice of people living with HIV/AIDS and unmet needs of PLHIV.

There is little research and substantive data is not available on the magnitude of unmet needs for FP and related factors and among HIV positive woman in Ethiopia (Addis Ababa). Hence the present study is aimed to fill such gaps and show their magnitude and thereby uncovering intervention areas in a wide ranging vertical HIV prevention programs

3. Literature review

3.1 Sexual Behavior of people living with HIV/ AIDS

Over 69% of adults living with HIV reside in sub-Saharan Africa, where the epidemic continues to spread [9]As a result of the success of highly active antiretroviral therapy (HAART) mortality and morbidity from AIDS related disease is dramatically decreasing.

Many HIV-infected persons are now living longer and healthier lives, and are also more sexually active [10].

Despite counseling, studies in both developed countries and developing countries in the era of wide access to antiretroviral drugs indicate that many HIV positive individuals continue to exhibit high risk sexual behavior characterized by fertility intentions. A study in Kenya revealed that nearly 70% of those who had been receiving ARV for 18 to 24 months were sexually active compared with 50% of those who had been receiving ARV for less than 6 months. Similarly two studies in Uganda showed a statistically significant increase in sexual activity among ART-experienced study participants as compared with ART-naïve participants. The proportion of sexually active people was higher among ART-experienced than ART-naïve participants [11]

Similarly, a study in Brazil found that the percentage of people reporting at least one sexual encounter per months had increased from 60% initially to 78% by 24 months after starting ARV[12].

Cross-sectional study among patients on ART from an informal urban settlement in Kenya found increased rates of inconsistent condom use among women and increased rates of multiple sexual partners among married men.

A cross sectional study in Uganda Kampala showed that while 52% of the respondents were not sexually active, ARV-experienced patients were more likely to

be sexually active than ARV naïve patients, and more likely to have used a condom. Condom use at last sexual intercourse with spouse was 32% and with causal partners 100%[13].

Study done by Nicole Crepaz revealed that the likelihood of engaging in unprotected sexual behavior was higher in the group of HIV-positive who are not on HART than persons receiving HAART[14]

Ninety seven percent of patients receiving HAART were significantly more likely to report sex with a regular partner and 88 percent; ($p = .044$) and less likely to report sex with a casual partner. 40 percent of PLHA did not know their regular partner's HIV status and about 20 percent did not disclose their own status to their regular partners[11]

Research on changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda showed increases in consistent condom use from 59 to 82% with partners with negative or unknown HIV status. However, 88% of risky sexual acts at baseline and 86% at follow-up occurred within married and cohabiting couples[15].

A cross sectional study conducted in Addis Ababa (M Tamen) found that people who were sexually active at the time of study were 50.2%. 74% of these individuals used condom (79.8% used it regularly) in Addis Ababa [16].

In SNNPR, 49.1% of women who were on ART were sexually active, 42.1% abstained from sex, 5.3% had sexual practice with inconsistent condom use and 3.5% had sex with multiple sexual partners. Study done in SNNPR showed that Knowledge was high regarding the possibility of HIV transmission from mother-to-baby (71%), its prevention (81%) and about the PMTCT program(78%) [17]

3.2 Fertility desire of people living with HIV/AIDS

As ARV therapy becomes increasingly accessible, the associated improvements in health, quality of life, and survival are anticipated to influence both the biological and behavioral fertility determinants [18] .

Surveys in developed and developing countries have found that 18% to 43% of women with HIV, respectively, wanted to have children in the future. A cross-sectional study in rural Uganda showed statistically significant association between being on HAART and wanting to have more children than the other. Predictors for desiring more children were younger age, having a higher number of living children and male sex.[19]

Sexually active women and men who were sero-discordant with their parents had significantly increased odds of fertility desire. While being a widow and increased WHO stage are associated with decreased fertility desire.

A cross sectional study from South Africa indicated that 29% of HIV positive women wanted to have children in the future. Fertility desire was more common among those who had been taking ART for longer period of time [20]. The desire for children among HIV-positive women who were last tested in the past 12 months and are between age group of 15-49 was found to be 37.8%[21] Another cross sectional study from the same country found that 50% of men and 45% of women reported being open to the possibility of having a child[22].

In five public hospitals in Addis Ababa 40.2% (44.7% of the female and 35.2% of the male) respondents expressed the desire for children [16]. In SNNPR cross sectional study from five hospitals indicated desire for children among people living with HIV/AIDS was 33.9%[17].

In SNNPR and Addis Ababa proportion of study subjects who know about transmission of HIV from mother to Child were 93.4% and 90.3% respectively. In

Addis Ababa, from people who had knowledge of MTCT, 93.6% of them knew the availability of mother to child HIV transmission prevention medication which may evoke their fertility need [16, 17, 23]. Also, the use of antiretroviral drugs during pregnancy and avoidance of breastfeeding were identified as methods of reducing mother-to-child transmission of HIV by only 14% and 21% of the respondents, However, 78% did not know that an HIV positive woman who took PMTCT drugs could still deliver an HIV – infected baby [24]

3.3 Reasons for child bearing among people living with HIV/AIDS.

Since access to antiretroviral therapy has improved quality of life and survival for HIV Positive people, many will contemplate child bearing. Studies in India, and South Africa found out several triggers for the desire to have a child after HIV diagnosis. Most common reasons the study found were: wish to sustain the family genes, need to experience parenthood, social influences, PMTCT services availability, the fear of impending death of the first baby, and financial stability[25, 26].

In south Africa commonly reported reason for women and men wanting to have a child was wishing to do so while their health still permitted (21% and 39% respectively), wanting at least one child/more children (16 and 26% respectively,) marriage and replacing a child who had reportedly died of AIDS (13% and 6% respectively). The majority of women (62%) and men (65%) had discussed their fertility intentions with a main intimate partner. 24% of women and 55% of men reported being very strongly influenced in their childbearing desires by a partner's desires[22].

A study from Uganda showed four main reasons for wanting more children: "need to leave ancestry"(52%), not having any boys (14%), not having any children or all children died (12%), and not having girls (9%). Among those who

didn't want children but their partner wanted and were married or cohabiting with a partner, 24% thought that their partners wanted more children [27].

A qualitative study in Nyanza Province, Kenya revealed that the perceived detrimental effects of pregnancy and Childbirth on HIV-related poor health and immune status were frequently expressed concerns as a reason not to have or delay fertility. The majority of participants considered the risk of transmitting HIV to a child in their fertility intentions[28]

A studies from, South Africa and Malawi indicated that reasons for not wanting a child among people living with HIV/AIDS included anxiety about their own health and their child's health, fear about leaving children orphaned, not having family support, stigma by the family, low income, fear of passing on HIV infection to baby, not wanting to take risk, fear of being judge by others, risk of re-infection, having sufficient children, and being not married[20, 22, 26]

3.4. *Family planning practice of people living with HIV/AIDS*

A study demonstrated that adding family planning to PMTCT services in high-HIV prevalence countries could avert 71,000 child HIV infections compared with the 39 000 HIV-positive births averted with PMTCT[29]. Study done in Nigeria reviled that the majority (90%) of the respondents were aware that HIV can coexist with pregnancy, but only 68% were aware of any of the route of mother-to-child transmission.[24]

A prospective cohort study in Uganda found that among sexually active women 65% reported using condom at 18 months after starting ART and 63% at 2 years of follow-up. However, only 14% of women used permanent or semi-permanent family planning methods by their 2nd year on ART [30]

In India, all heterosexual women who were currently on ARVs reported consistent condom use during vaginal sex with their male regular partners [25]. In Rwanda

Fifty-four percent of HIV-positive women reported using a family planning method at the time of data collection, almost twice the proportion of HIV-negative women using a family planning method[31]. In Addis Ababa family planning use before and after HIV diagnosis was 48% and 43.3% respectively. Most commonly used family planning methods before HIV diagnosis were oral family planning pill (45.8%) and injectable (29.3%). Condom and abstinence were the most practiced methods after HIV diagnosis 65.8% and 21.1% respectively[16]. Similarly, when compared With HIV-negative women, HIV-positive respondents were significantly more likely to use a modern method of family planning, particularly more likely to use condoms.[31]

3.5 Unmet need for Family Planning among women

Unintended pregnancies often result from an unmet need for family planning. According to a study done in Togo and Nigria The unmet need for Family planning ranges from 18% in Niger to 42% in Togo, with a regional average of 19.4% [32]

Ethiopia many other African countries, has a high demand for family planning , 37% of women either wish to cease childbearing or 38 % want to wait for at least two or more years to have another child and 17% will have children in the next 2 year[33]. Current family planning prevalence rate among married women in Ethiopia is 25% (95% CI: 24.2, 26.5).

According to EDHS 2011 twenty percent of currently married women have an unmet need for family planning (16 percent for spacing and 9 percent for limiting) [33]

A study done in SNNPR, Tigray, Oromia and Amahra revealed that among currently pregnant women in Tigray 33 percent reported that their pregnancy at the time of the study was unwanted. Similarly, in Amhara region 26%; in Oromia 28%, and in SNNPR 23 percent did not want their current pregnancies.[34]

3.6 Unmet needs for Family Planning among HIV positive women

Study in Uganda reviled that pregnancies were occurring among ART users who did not want any more children (97%), among women who were not planning to have more children at the time (99%)[35]. A study done in rural Uganda reviled the un-met need for effective FP method was much greater in HIV infected individual (75%) as compared to HIV negative individual (33.8%)[36].

A study done in Addis Ababa reviled that unmet need among HIV Positive women who are on child bearing age and who are on ART were 31.1%[37]. There are very few studies done in Addis Ababa and Ethiopia in the area of unmet needs for family planning among HIV positive women. And this study is aimed to contribute to filling this information gap.

4-OBJECTIVE OF THE STUDY

General objective

- To assess the Unmet need for family planning among HIV positive women attending HIV care and treatment services in Zewditu Memorial Hospital Addis Ababa; Ethiopia**.**

Specific Objectives

- To assess the magnitude of unmet need for family planning among HIV positive women aged 15-49 years in Zewditu Memorial Hospital Addis Ababa; Ethiopia.
- To identify factors related with unmet need for family planning of HIV positive women aged 15-49 years

4. Methods

4.1. Study area and period

The study was undertaken from March 2013 to Nov 2013 in Zewditu Memorial Hospital. Zewditu Memorial Hospital is located in Addis Ababa Kirkos sub city. The hospital serves as a teaching institution for both undergraduate and postgraduate studies in medicine. The department of HIV counseling and testing and ART unit are among other departments of the hospital including follow up clinics, wards and an outpatient department. Most HIV positive people (woman and men) who visited the hospital are residents of Addis Ababa and its surroundings. There is no restriction for HIV Positive individuals to have followed up in the hospital based on socio cultural and economic reason. The hospital provides the service to HIV Positive people free of charge.

4.2. Study Design

Institutional based cross-sectional study design was implemented in Addis Ababa Zewditu memorial Hospital among women living with HIV/AIDS in Addis Ababa town.

4.3. Study Population

Currently there are 7,858 HIV Positive women who have a follow up visit in the Zewditu Memorial Hospital. All HIV positive women age 15- 49, attending ART follow up services, who come for regularly scheduled follow- up visits in Zewuditu Memorial Hospital during the data collection period and that fulfill the inclusion criteria was included in the study population.

4.4. Inclusion criteria

Female clients diagnosed with HIV and attending ART services at Zewditu Memorial Hospital and aged 15-49 years and willing to participate in the study.

4.5. Exclusion criteria

PLHIV who are feeling ill at the time of study, inability to provide informed consent and unwilling or unable to speak and hear.

4.6 Sample size and sampling strategy

Sample size determination was done according to a previous study done by Integrated Family Health Program (IFHP in Ethiopia). In the study the Total prevalence of unmet need for FP was 17 percent.[38] As the prevalence of unmet need for FP expected to be lower in HIV positive women than women in the general population because of the counseling on family planning utilization, PMTCT, condom use and others. To obtain the maximum sample size 4% margin of error with 95% confidence level of certainty was taken.

The actual sample size was calculated using a single population proportion formula of:

$$n = \frac{(z\alpha/2)^2 P(1-P)}{(d)^2} = \frac{(1.96)^2 0.17(1-0.17)}{(0.04)^2}$$

n=the required sample size

p=the proportion of unmet need

Zα\2=the critical value at 95% confidence level of certainty (1.96)

d=the margin of error between the sample and the population 4%. To compensate for non response rate due to unseen conditions 10% of the sample was added =, finally

a total sample size of **419**of woman were sampled for the study.

369x10%/90%=419

A systematic random sampling method was used to select and included the study participants in the study. The sampling interval was calculated by dividing the total number of HIV positive women who have follow up in the hospital by the sample size i.e. 7858/419= 19 but this took longer time to reach the intended subject number, to address this challenge, I took daily appointment registry list as sampling frame. Lottery method was used from the sampling frame and the first mother was selected using a simple random sampling method from the list and I took every 5 mother till I reach 419 samples.

4.*7.1. Data collection and instrument*

A structured questionnaire was developed and pre- tested in the ART treatment units with selected HIV positive women .Pre-test was done on 10 subjects in Zewuditu Memorial ART unit. The questionnaire was assessed for its clarity, length and completeness. Based on the result some skip patterns was corrected. Questions that were difficult to ask and to respond to were rephrased and the consent form was modified. The questionnaire was pretested under the supervision of the principal investigator. The questionnaire was translated and back translated from English language to Amharic. Relevant information about demographic, social and economic parameters was collected using structured questionnaire by interviewing female HIV positive clients who are attending ART clinic unit during the follow up time.

4.7.2. Data collection procedures

Informed Consent was obtained from the study participants. Socio economic and demographic characteristics and parameters were collected. Two nurses were

trained for one day as a data collector on interviewing technique, the content of the questionnaire and quality data issues. Data collectors were instructed to conduct exit interview. All HIV positive women who participated in the study were between age 15 and49 and have follow up in ART unit of the hospital. The purpose of the study was properly explained to participant before the interview. HIV positive woman who were willing to participate in the study were interview. The data collection took 3 month to meet the sample size.

4.8. Data analysis

The data was entered and cleaned using EPI Info version 7. Then it was exported to SPSS version 16 for analysis. Uni-variate, bivariate and multivariate analysis of the dates was done. Bivariate analysis was done using Chi-square or t-test as appropriate. Logistic regression was done using those variables which have statistical significance in the bivariate analysis. In the analysis, unmet need for family planning was considered as dependent variables. The independent variables were age, sex, education, occupation, religion, income, discordance status, marital status, health status and child bearing desire.

4.10. Operational definitions

Unmet need for family planning: The number of women on ART, who are currently sexually active, and are fecund, who want to use Family planning to limit or space their birth but are not using any form of family planning, and those currently pregnant women whose pregnancy is mistimed or unwanted.

Unmet need for limiting: refers to pregnant women whose pregnancy is unwanted, and fecund women who are neither pregnant nor amenorrhoeic, who are not using any method of family planning, and who want no more children.

Unmet need for spacing: includes pregnant women whose pregnancy is mistimed and fecund women who are neither pregnant nor amenorrhoeic, who are not using any method of Family planning and say they want to wait two or more years before their next birth.

Woman who are on ART follow up care: Women who have had at least one visit to the selected ART treatment unit to receive ART

Unintended pregnancy: a pregnancy that is mistimed or unwanted

Sexual desire: Refers to a wish or expressions of PLHIV drawing one sex toward another.

Fertility intentions - Wanting more children which is sub-divided into those wishing to do so immediately, within the next year, those with future intentions and those who were undecided

Family planning demand: -Is the percentage of women using family planning plus the percentage of women with unmet need for family planning.

Risky sexual behavior Is defined as inconsistent or no use of condom with partners of HIV-negative or unknown sero-status or situations such as being forced to have sex, having multiple sexual partners:

Multiple sexual partners- Having more than one partner in the preceding 12 months.

Sexually active woman: HIV positive woman who is currently married or has cohabiting or reported to have sexual partner

5.1. Variables in the study

5.1.1 1Dependent variable

- Unmet need for family planning

5.1.2. Independent variables Socio demographic characteristics (age, sex, income, marital/relationship status, improved health status, education, religion, occupation, ethnicity) Number of alive children/number of life Partner's HIV status time pregnancy/sex composition of children, partner's disclosure status, Recent family planning use, Knowledge on (MTCT, PMTCT), Partners desire for children, and Social factor (family influence and social influence)

5.1.3. Data quality management

To ensure data quality the data collectors and the supervisors were properly trained for one day. Data collection process was closely followed by Supervisors and the principal investigator. Completed questionnaires were checked daily for completeness and errors which were corrected. Pretest: research questionnaires were pretested on 10 individual from the same Institution, Translation: questionnaires were translated into Amahric and then back translated into English to check for consistency

6. Ethical approval

Ethical approval was obtained from the Research and Ethics Committee (REC) of School of Public Health Addis Ababa University. The research proposal was also submitted to Addis Ababa regional health bureau and clearance were obtained. The clearance letter were presented and briefed for the responsible authorities in the hospital and permission was obtained from them. Similar briefing was done to the health care providers who are working in the ART clinic of the hospital. During the data collection, informed consent was obtained from each respondent after explaining the objectives of the study and the rights of the respondent to participate or not in the study.

All interviews were conducted in the same place where the study participants took their treatment to keep privacy (exit interview). To maintain confidentiality no names or no codes was take. Moreover the same councilor working in the ART treatment units was used as data collector this helped in ensuring confidentiality during data collection since respondents will not be exposed to a different person. Completed questionnaires were kept in in a safe place and they were used for the purpose of the study only. Finally, dissemination of the results of the study will not be in referent with specific respondent but to the general source population.

5. RESULTS OF THE STUDY

5.1 Over view of Socio-Demographic Characteristics of the Study Population

A total of 419 clients were included in the study. There were seven clients who refused to participate in the study giving a response rate of 98.4%.

The mean age of participant was 33.7 (±5.8) years. Majority of the respondents (63.1%) were in the age range of 30-40 years of age. Two hundred fifty five (60.2%) respondents were Orthodox Christian. The majority (233 (55%)) completed above primary education. One hundred ninety nine (47%) were either married or cohabiting. Of the study participants 42.48% were private employee while 19 (1.9%) were jobless (See Table 1).

Table 1: **Socio-demographic Characteristics of HIV Positive women who have follow up services in Addis Ababa, Zewditu Memorial Hospital, Ethiopia, Nov 2013**

Age in year (n=419)	**Frequency**	**Percentage**
15-24	22	5.3
25-34	199	47.5
35-44	177	42.2
45+	21	5.0
Religion n=419		
Orthodox	242	57.8
Catholic	25	6.0
Muslim	46	11.0
Protestant	106	25.3
Ethnicity n=419		
Oromo	147	35.1
Amahara	184	43.9
Gurage	39	9.3
Tigere	44	10.5
level of Education n=419		
Illiterate	126	30
Elementary	17	6.4
Junior	96	22.9
High school	155	37

Diploma and above	15	3.6
Marital status n=419		
Married/cohabiting	288	69
Single	68	16.2
Widowed	35	8.4
Divorced	27	6.4
Occupational status =419		
Private employ	178	42.48
House wife	114	27.21
Daily laborer	60	14.32
Governmental employ	45	10.74
Jobless	8	1.91
Commercial Sex Worker	14	3.34

5.2 Sexual Behavior of **the respondents**

One hundred twenty eight (30.2%) of the study participant were having sex with sexual partner. One hundred twenty (97.8%) were having sex with one regular partners but the remaining 8 (2.2%) were having sex with more than one non regular partner(s) after they learned their HIV status. One hundred twenty eight (99%) respondents disclosed their HIV status to their sexual partners. One hundred ten (86 %) respondents' sexual partners had HIV testing but 18 (4%) did not have HIV testing. Among tested sexual partners majority 92 (84.5%) concordant HIV test results, while 18 (14.6%) had discordant results.

Table 2 Sexual Behavior of women who have follow-up services in Addis Ababa, Zewditu Memorial Hospital, Ethiopia, Nov 2013

If you are not married do you have sexual partner **n=131**	Number	Present
Yes	128	97.8
No	3	2.2
number of sexual partner (n=128)		

only one partner	120	93.7
Greater than one partner/not regular	8	6.3
did you disclose your HIV status to your partner (n=128)		
Yes	128	100
did your partner conduct HIV test n=128		
Yes	110	86%
No	18	14%
your partner HIV Test result		
Positive	92	83.6
Negative	16	14.5
Do not know	2	1.9

5.3 Fertility Desire/intention of the respondent

One hundred fifty two (36.3%) women became pregnant after they knew their HIV-status. One hundred twenty three (29.4%) reported that the child they delivered was planned. One hundred forty two 142 (33.9) respondent reported that they have an intention to have children within the coming two years.

Table 3 **Fertility Desire/intention of women attending the ARV treatment units in Addis Ababa Ethiopia**

Have you been pregnant after knowing your HIV status n=419	Frequency	Percent
Yes	152	36.3
No	256	61.1
No response	11	2.6

Was it intentional pregnancy /wanted pregnancy n =152	Frequency	Percent
Yes	123	80.9
No	29	19.1
Do you need children in the future n=419		
Yes	142	33.9
No	248	59.2
I don't know	29	6.9
when do you prefer to have children after n=142	Frequency	Percent
within a year	91	64.1
after too year	51	35.9
which sex you prefer		
Male	14	3.3
Female	76	18.1
God knows	51	12.2
Total	141	33.6

5.4 Family planning utilization

Three hundred forty five (82.5%) of the women were using at least one method of family planning before knowing their HIV status while 59 (14.1%) never used FP. Two hundred nineteen (52%) women reported that they were using family planning after starting ART. Majority 127(57.99%) of the respondents were using condom whereas 16 (7.3%) reported injectable which was the least frequently reported method. Hundred fifty (68.5 %) chose to use the specific method of family planning because of the advice they got from the health professional

Table 4: Family planning utilization of HIV positive women who have follow up services in Addis Ababa, Zewditu Memorial Hospital, Ethiopia, Nov 2013

current use of family planning n=419	Frequency	Percent
Yes	219	52.3
No	200	47.7
Type of Method used n= 419		
Condom	127	57.99
Injectable	16	7.31
OCP	18	8.22
IUD	20	9.13
Implant	19	8.68
Reason for choosing current FP method n=219		
professional advice	150	68.5
because it suite my health	163	74.4
from my friend advice/experience	13	5.9
my partner choice	1	0.5
has dual protection HIV/family planning)	30	13.7
Future family planning use n= 419		
Yes	258	61.5
No	115	27.4
Other	46	11.1
Preferred unit for taking family planning n=419		
ART Unit	142	33.4
family planning unite	216	51.6
in private clinic	59	14.1
counseling unit	2	0.4
Reason for not wanting to use family planning n=200		

want to have child	20	10
fear of reaction ART drug	97	48.5
my partner objection	2	1
Other (pregnant and in-fecund)	81	40.5

5.5 Unmet need for family planning

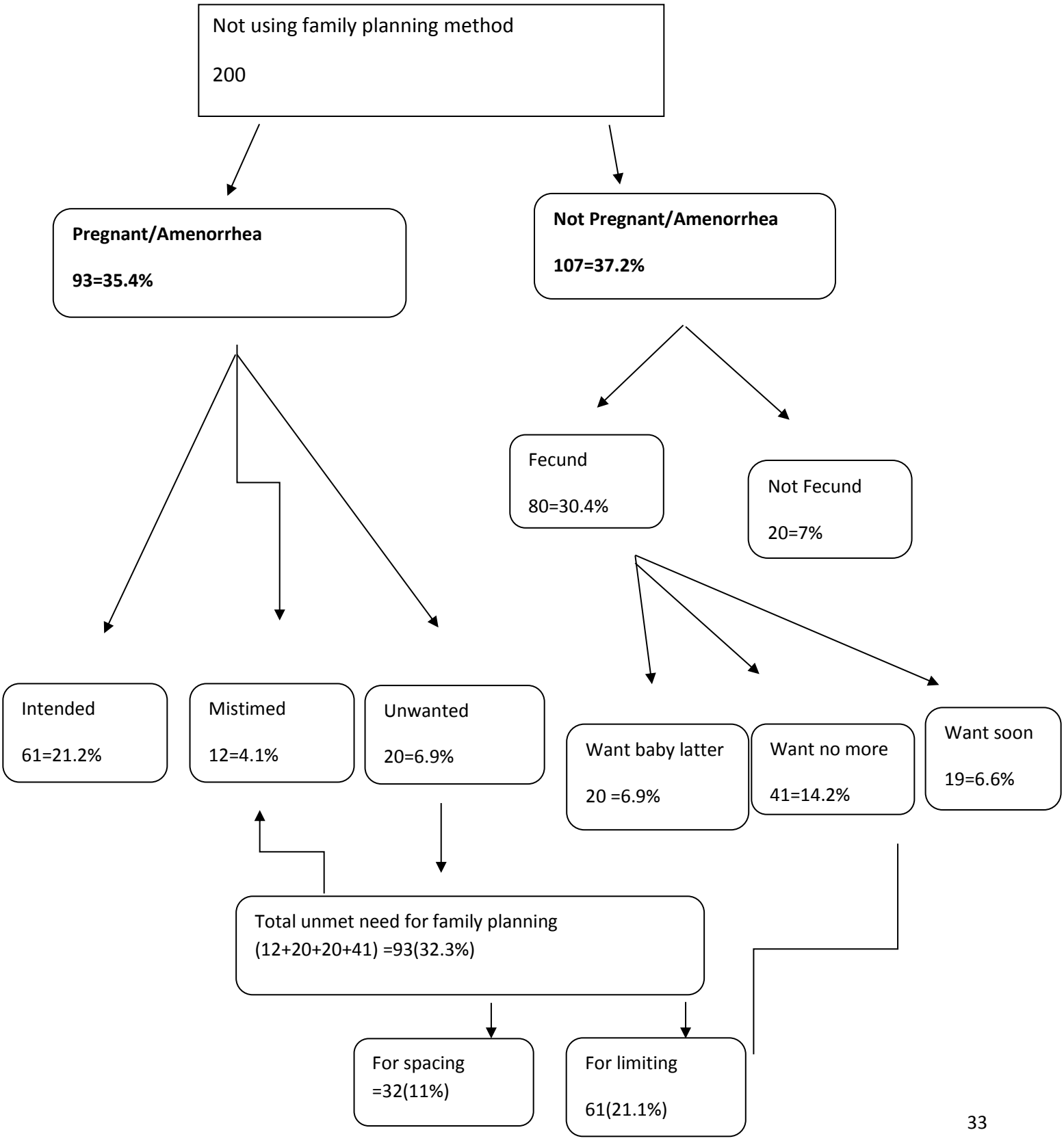
Two hundred eighty seven women (68.7%) were sexually active. Of those women who were sexually active, 52.3% of them were using one method of family planning to prevent pregnancy ,while 47.7% of them were not using any form of family planning method at the time of the data collection. Among the sexually active women and who were not using any form of family planning, 93(32%) were either pregnant or amenorrhic at the time of the data collection. Of those women who were pregnant or amenorrheic, 61(21.2%) pregnancies were intended. The rest of the pregnancies or the amenorrhea was either unwanted/unintended (6.9%) or mistimed (4.1%). One hundred seven (34.8 %) were not pregnant or amenorrhoeic and of the non-family planning users 80(27.7%) were fecund while 27 (%) were in fecund. Twenty (6.6 %) planned to have child latter, 41 (14.2%) don't want any more children while 19(6.6%) want a child soon. *Unmet need for Family planning was calculated from the* proportion of pregnant women whose pregnancy was mistimed or unwanted and the proportion of fecund none pregnant woman who were not using any form of family planning method but do not need any more children or want children after some time. Therefore, unmet need for family planning was: 4.1% 6.9%+14.8%+6.9%=**32.7%.**

Unmet need for spacing is the proportion of pregnant or aminorrheic women whose pregnancy were mistimed and proportion of non-pregnant nor aminorrheic and fecund women who did not use any form of family planning but plan to have another birth later. Thus, unmet need for spacing was: 4.1%+6.9%=**11%.**

Unmet need for limiting: refers to pregnant women whose pregnancy was unwanted, and fecund women who are neither pregnant nor amenorrhoeic, who are not using any method of contraception, and who want no more children. Thus, unmet need for limiting was: 14.8 %+6.9%=**21.7% (**Figure 2).

The Contraceptive Prevalence Rate (CPR) is the number of sexually active women using family panning method /total number of women in the study*100; 219/418*100=**52.3%.** Total demand for family planning , (CPR+ unmet need): 52.3%+32.7.1% **=85%.** Demand Satisfied, for family planning , (met need/total demand); = 52.3%/85%*100 = **61.5%.** In fecund woman, women who desired to give birth soon and pregnant women whose pregnancy were reported as intentional and woman who were pregnant while on a method were excluded in the evaluation of the unmet need.

Figure 2: Components of unmet need for family planning among sexually active women who are not using Family planning in Zewditu Memorial Hospital ART clinic: Addis Ababa, Ethiopia, Nov, 2013



5.7 Unmeet for contraceptive need and factors associated with it

As can be seen from the bivarate analysis, shown on table 7, the characteristics current pregnancy has statistically significant relation with history of pregnancy after knowing HIV status with P=.018. Significant relation was seen between method used to stop or postponed pregnancy and being student with P=.018.Wanting children later has significant association with marital status, being house wife and the number of alive children with P=0.006,P=0.002 and P=.026 respectively. Also statistical association was seen between variables of need no more children and marital status with P=.036. Whereas, age, educational status, and family planning utilization and getting counseling from the health care provider to use family planning method did not have association with mentioned indicator (p > 0.05).

Table 5 Association of current pregnancy , wanting child later and need no more children with selected variables among HIV positive women in the ART units Zewditu memorial Hospital , Addis Ababa, Ethiopia, Nov, 2013

	current pregnancy		P value
History of pregnancy after knowing HIV status	Yes	NO	
Yes	31.10%	68.90%	P=.018
No	20.70%	79.30%	
Student	Method used to stop or postponed pregnancy		
	Yes	No	
Yes	100.00%	0.00%	P=.018
No	46.80%	53.20%	
Marital status	**wanting children later**		
	yes	no	

Married	50.80%	49.20%	P= 0.006
Single	14.80%	85.20%	
Widowed	26.70%	73.30%	
Divorced	22.20%	77.80%	
being House wife			
Yes	60.70%	39.30%	
No	28.90%	71.10%	P=0.002
number of alive children			
1	48.70%	51.30%	
2	27.30%	72.70%	P=0.026
3	0.00%	100.00%	
4	0.00%	100.00%	
History of pregnancy after knowing HIV status			
Yes	52.90%	47.10%	P=0.001
No	24.00%	76.00%	
marital status	**need no more children**		
	yes	No	
Married	25.00%	75.00%	
Single	50.00%	50.00%	P=036
Widowed	58.30%	41.70%	
Divorced	40.00%	60.00%	

Table 6: Multivariate analysis of variables associated with unmet need for family planning among HIV positive ART units Zewditu memorial Hospital, Addis Ababa, Ethiopia, Nov, 2013

	Current pregnancy			
	yes	No	OR	AOR(95% CI)
student			0.874(0.096,7.913)	1.009(0.109,9.332)
yes	1(20)	4(80)		
no	91(22.2)	318(77.8)		
Being pregnant after knowing HIV status				
yes	45(29.6)	107(70.4)	1.972(1.227,3.168)	2.046(1.2269,3.297)
No	45(17.6)	211(82.4)		

Multivariate analysis for unmet need of Family planning

Those variables which showed significant statistical association in the bivariate analysis were further assessed for their statistical association with unmet need of pregnancy using multivariate analysis. Hence the statistical association that was seen between being a student and current pregnancy status was refuted in the multivariate analysis (AOR=1.009, 95% CI=0.109,9.332) while the statistical association that was seen between getting pregnant after knowing their HIV status and current pregnancy was retained in the multivariate analysis (AOR=2.046, 95% CI=1.269,3.297). Hence women who became pregnant after they knew their HIV status were two times at risk of getting current pregnancy at the time of the survey than those who didn't get pregnancy after they knew their HIV status.

6- DISCUSSIONS

This study aimed to assess the magnitude of and factors related to unmet need for family planning among HIV positive women attending HIV care and treatment services in Zewditu Memorial Hospital Addis Ababa; Ethiopia. According to the study findings unmet need for family planning was 32.3% with 11.1% of unmet need for spacing and 21.2% of unmet need for limiting. Family planning prevalence rate was 52.2% and total demand for family planning was 85.5%. Satisfied demand for family planning was 61.5%.

Ninety three percent (35.4%) of the women were pregnant at least once after they have known their HIV positive status. Among the women who had been pregnant, 20(6.9%) had unintended pregnancy while 4.1% women had mistimed pregnancy.

This study's finding of unmet need for family planning (32.2%) was comparable with another study's finding of unmet need for family planning among HIV positive women in Addis Ababa Ethiopia (31.1%)[37]. Another study which was done in Kenya showed that unmet need for family planning among HIV positive woman was 30% which is also similar to this study's finding of 32.2%[39]. This study's finding of the magnitude of unmet need for family planning was also in agreement with study done in rural Uganda which reckoned it to be 30.1%[36] .

On the contrary, the finding of this study on unmet need for family planning (32.2%) was not similar with the finding of Ethiopian Demographic and Health survey (25.3%). Total unmet family planning need in Addis Ababa was 10.6 % which shows big difference with our present study(32.3%) [33]. The difference might have resulted from the difference in study subject .This study focused on HIV positive women who might stop taking FP method due to ART whereas EDHS 2011 took general population with or without HIV condition. Study done in Jordan showed that total prevalence of unmet need to be 29.8%, limiters comprises 16.9% and spacers were 12.8% [40]. These findings of the Jordan study are in agreement with the finding of this study.

In our study unmet need for limiting (21.2%) was higher than unmet need for spacing (11.1%) unlike that of the finding in EDHS 2011. The finding of higher unmet need for

limiting than for spacing in our study implies that more mothers prefer to limit child bearing. In the EDHS 2011 report unmet need for limiting is lower(9%)than unmet need for spacing(16%). This denotes that HIV positive women's need for family planning follows different trend of family planning utilization for limiting and spacing as compared to the general population which might be a result of fertility desire of women being affected by HIV Positive status.

Fear of MTCT risk, fear of leaving orphans in case they die and the unique risk of unintended pregnancy on their health are the reason that made HIV positive women demand family planning.

This study determined that there is higher total demand (85.5%) and higher satisfied demand (61.5%) for family planning among HIV positive women than women among the general population in EDHS 2011 report where total demand was 53.9% and demand satisfied was 53.1%.

Although a study done in Addis Ababa revealed that there was association between unmet need for family planning and discordant partner[37] there was no such finding in this study.

Educational status and employment status of the women were significantly associated with unmet need of family planning. Similar finding were also reported in a study done by Hailemariam et al in SNNPR, Ethiopia and a study done in east Sudan [41, 42]. In this study, the fact that women with higher educational status and those who were employed had a better met need for family planning than their referent imply the roll of education and occupation in preventing unmet need for family planning among HIV positive women.

Another study done in Lesotho showed that unmet need for family planning was highest among poorest house hold [43]. But in this study income didn't have a statistical association with unmet need for family planning. This might be as a result of women with similar income level having follow up in the hospital where the study was conducted and the availability of free family planning method in the hospital.

7. STRENGTH AND LIMITATION OF THE STUDY

Strength

The study used quantitative method research and findings can be generalized since data were collected based on random samples of sufficient size.

This study tries to explore unmet needs for Family planning and occurrence of unintended /mistimed pregnancy under ART treatment. The study might not give full picture of the problem but it gives an insight on where to focus on meeting the unmet need for Family planning among HIV positive women.

Limitations

Sampling bias- the study did not sample all HIV positive women in different Hospital; it only includes study subjects Zewditue memorial hospital ART units. Hence, HIV positive woman in different health care system may differ from samples of women outside of the health care system. Thus, the study result may not be generalized to all HIV positive women in Addis Ababa (The study was only conducted in Zewditue memorial hospital) .

Social desirability bias- HIV counselors in Zewditue memorial hospital ARV units were trained and recruited as data collectors to ensure confidentiality of the study subjects. Counselors explained well the purpose of the study and it has no link with the services provided at the hospital, despite this, respondents may still provide responses which they consider to be desirable to counselors. Women may report a birth or current pregnancy as wanted and timely once the child is born, and this reason of a current birth or pregnancy as wanted may in fact result in an under estimate the true extent of unwanted births.

Crosectional nature of the study :it couldn't tell temporal relation between exposure and outcome The surveys might not gather all the information required to estimate infecundity. In such cases the information about women's fecundity may be based on women's own perception of their ability to get pregnant.

8 CONCLUSIONS:

The current study has revealed that unmet need for family planning services among HIV positive women were relatively high which reveals broader demand for these services and the need for new strategies to address family planning needs among HIV positive clients.

9 RECOMMENDATIONS

9.1 Government and stakeholders in the study area

Policy-makers, donors and implementers should include family planning as a core technical component of the preventing mother-to-child transmission (PMTCT) and design new strategies to strengthen the delivery of family planning services in a user friendly manner in the ART units.

9.2 Health care providers: Comprehensive, continuous and quality family planning counseling and care services should be provided for all women in the ART units despite their marital status and other condition. Pro-active family planning counseling should be provided not only at the time of screening patients for ART follow up but also, on a regular basis including after a woman enrolled in the ART units. Emergency family planning utilization in the ART units should also be advocated.

9.3 Researchers

Researchers are advised to conduct further studies on same issue outside of the health Care system and in different parts of the country to come up with more representative results.

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Annex IV

QUESTIONNAIRES

Addis Ababa University, Faculty of Medicine, school of Public Health Questionnaires for Assessing Unmet need for Family planningamong HIV positive

women who have treatment and follow up in Zewditu Memorial Hospital Addis Ababa; Ethiopia.

Information sheet

Good morning/good afternoon! My name is _____ . I am graduate student of Public Health at Addis Ababa University, faculty of Medicine, School of Public Health and we are now conducting a survey in this institution (_____ _____) to explore Unmet need for Family planningamong HIV positive women in Zewditu Memorial Hospital Addis Ababa; Ethiopia. We believe that this study will help to bring change in unmet need for Family planningamong HIV positive women.

You are selected to be one of the participants in this study and you will help us by answering the questions we ask you. We assure you that whatever answers you give us are kept strictly secret. We do not need you name and address. We also inform you that you have the full right to withdraw from study or stop the interview at any time and /or skip any questions that you don't want to answer. You may find some of the questions too personal and difficult to talk about, but your experience will be very helpful for other people. The interview takes approximately 10-15minutes.

Do you have any question to ask?

Thank you very much!
Are you willing to participate in this study?

Yes ☐ No ☐
If yes go to next page

B. Consent form

I, the undersigned have been informed that the purpose of this particular research project is to study Unmet need for Family planningamong HIV positive women.

I have been informed that that I am going to respond to this question by answering what I know concerning the issue. I have been informed that the information I give will be used only for the purpose of this study; mu identity, the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study or not to respond to questions I am not interested. Furthermore I have been informed that I can stop responding to the questions at the time in the process.

Based on the above information I agree to participate in the research voluntarily with the hope of contributing (on behalf of one) to the effort of knowing unmet need for Family planningamong HIV positive women and it's implication in the context of MTCT.

Signature:_____Date:_____

Address of investigator:Name: Dereje Ketema

Addis Ababa University MPH ; student Cell phone 0910009108

Questionnaire

Unmet need for Family planningamong HIV positive women who have follow up and treatment in Zewditu Memorial Hospital Addis Ababa.

Hello, my name is _____ I am one of the data collectors on the study with the above topic. I would like you to cooperate in answering the questions that follow. You have the right to refuse.

Name of Interviewer: _____ Date: _ _/_ _/_ _Start time: _ _/_ _ End time: _ _/_ _

Interviewer agreement

I certify that I have filled this questionnaire in accordance to the training I was given. I have checked this questionnaire and confirmed that the information in it is correct.

Signed_____ Date_____

IDENTIFICATION		
Time at the beginning of the Questionnaire Time completing the questionnaire 001. Questionnaire identification number/-/-		
Code	Questions	Categories
101	How old are you?	…. Years (age in completed years)
102	Sex	Male ……. Female…….
103	Your religion	Orthodox … 1
		Catholic ……2
		Muslim…..3
		Protestant…. 4
		Others (specify) … 89
104	What is the highest Educational level you attained	…… Grade completed
		Able to read and write 1

		unable to read and write. . . 2
		others (specify). . . . 89
105	What Ethnic groups do you belong	Oromo . . . 1
		Amhara . . . 2
		Gurage . . .3
		Others (specify) . . . 89
106	What is your current Martial /relationship status	Married.....1
		Single.....2
		Widowed.....3
		Divorced.....4
		Non married partner.....5
		Response.....6
107	if you are currently in martial/relationship, for How long you are in relationship?	. . . . . Years
108	what is your current occupation	employed worker. . . 1
		Student 3
		House wife. . . . 4
		House servant. . . . 5
		Daily laborer. . . . 6
		Merchant. . . . 7
		Commercial sex worker. . . . 8
		Government employee. . . . 9
		Private emploee. . . . 10
		Farmer. . . . 11
		Private self-employed. . . . 12

		Other (specify). . . .89
109	what is your house hold average monthly income?	. . . . Eth. Birr
		No income . . .1
		Don't know . . . 2
		No response . . .99
		Other (specify). . . .89
110	where is your current residence?	Urban . . . . Rural . . . .
111	what is the size of your family	. . . . Person
PART II INFORMATION ON SEXUAL BEHAVIOR AND CONDOM USE		
CODE	Questions	categories
201	If you are not currently married; do you have sexual partner? Or stable sexual relationship though not married	Yes…1
		No…..2
		No response….99
202	If the answer for Q201 is yes, how many sexual partners do you have?	
		only one regular partner . . . 1
		Greater than one/no regular partner . . .2
		No response . . . 99
		other (specify) . . . 89
203	Did you disclose your	Yes . . . 1

	HIV- status to your partner?	
		No . . . 2
		No response . . . 99
		other (specify) . . . 89
213	Did your partner have HIV tested	Yes . . . 1
		No . . . 2
		no partner . . . 3
		No response . . . 99
		Don't know . . . 88
		other (specify) . . . 89
214	if the answer for Q 217 is yes, what was his test result	Positive . . . 1
		Negative . . . 2
		I don't know . . . 88
		No response . . . 99
		other (specify) . . . 89

PART III - INFORMATION ON FERTILITY INTENTION		
301	How many live births have you had in your life	. . . Live births
		I did not give birth at all . . .97
		I do not have any live birth . . . 98
		No response . . . 99
		Other (specify) . . . 89
303	Have you had being pregnant after knowing your status?	yes . . . 1
		No . . . 2

304	If yes to Q 303, it is intentional/wanted pregnancy?	yes . . . 1
		No . . . 2
305	Would you like to have children in the future? (if no jump Q310)	yes . . . 1
		No . . . 2
		don't know . . . 88
		No response . . . 99
		Other (specify) . . . 89
306	When do you prefer to have a child? After..	. . . . . Months/ . . . . Years
		Undecided . . . . 1 Soon……2
		don't know . . . 88
		No response . . . 99
		Other (specify) . . . 89
307	What sex did you prefer to have ?	Male . . . 1
		Female . . . 98
		I have no choice (God Knows) . . . 4
		I did not have desired number . . .2
308	why do you want to have children	My partner desired to have children . . .1
		pressure from families . . . 2
		social / peer stigma . . . 3
		for substitution . . . 4
		for inheritance . . . 5
		my partners is in good health . . . 6
		I am on ART/hence I can have a child . . . 7

		children are an important part of marriage, either for present or future marriage . . . 8
		current child needs sibling . . .9
		original desires for childbearing unchanged by HIV . . .10
		Sex preference for children . . . 11
		Desire for HIV - negative child . . .12
		No response . . . 99
		Other (specify) . . . 89
310	(if the answer for question 305 no) why do you not want to have children in the future	Have a child already/achieved desired family size . . . 1
		fear mother to child HIV transmission risk . . . 2
		don't have adequate income to add another child . . . 3
		Health care providers advise not to have a child . . . 4
		May not be healthy in future to care of child. . . 6
		fear of orphaning / problems in caring for child . . . 7
		No response . . . 99
		Other (specify) . . . 89
PART IV- INORMATION ON FAMILY PLANNING USE & DEMAND		
401	Have you ever used family planning method before HIV diagnosis?	yes . . . 1
		No . . .2
		don't have partner . . . 3
		No response . . . 99
		Other (specify) . . . 89
402	If yes for Q401 specify the method you/your partner	Abstinence from sex . . .1

	used (more than one answer can be possible)	
		Condom. . .2
		Pill (OCP) . . . 3
		Injectable. . .4
		IUD . . . 5
		Implants . . . 6
		Tuba legation/vasectomy . . . 7
		No response . . . 99
		Other (specify) . . . 89
403	Are you using Family planning method currently (during the study period)? (if no skip to Q406)	yes . . . 1
		No . . .2
		I don't know. . . 88
		No response . . . 99
404	If yes for Q 403 specify the method you are using? (more than one answer can be possible)	Abstinence from sex. . .1
		Condom. . .2
		Pill (OCP) . . . 3
		IUD . . . 5
		Implants . . . 6
		Tuba legation/vasectomy . . . 7
		No response . . . 99
		Other (specify) . . . 89
405	Why do you choose the current family planning method?	Health professionals advise. . . 1

		Because it suites with my health . . .
		from my friends experience/advice . . . 3
		my partners choice . . . 4
		Has dual protection (HIV/conception) . . . 5
		Other (specify) . . . 89
406	Would you like to use family planning method in the future? (if no skip to Q409)	yes . . . 1
		No . . .2
		I don't know. . . 88
		No response . . . 99
		Other (specify) . . . 89
407	where do you want to get family planning service?	At ARV treatment units . . . 1
		Family planning unit . . .2
		In private clinics . . . 3
		In counseling units . . . 4
		Other (specify) . . . 89
408	if the answer for Q 406 is no what was the reason for not using family planning?	want to have child . . . 1
		Cant conceive.....2
		fear of reaction ART drugs . . . 3
		I abstained from sex . . . 4
		my partner objected . . .5
		No response . . . 99
		Other (specify) . . . 89
409	if you are using family planning methods did you disclose your sera-status	yes . . . 1

	to your family planning provider?	
		No . . .2
		No response . . . 99
		Other (specify) . . . 89
410	if the answer for Q 409 is no, why don't you disclose your sera-status to your family planning provider?	I don't trust the providers . . . 1
		I feared stigma and discrimination . . . 2
		Disclosure does not help / no use . . .3
		No response . . . 99
		Other (specify) . . . 89
	PART V Unmet need for Family Planning	
501	Are you pregnant now?	Yes……
		No……..2
		UNSURE…….3
502	If the answer is yes for question 501, did you want to get pregnant at that time?	Yes……..1
		No ……2
		No answer…..3
503	Did you want to have a baby later on or did you not want any (more) children	Yes letter …….1
		No anymore …..2
504	you did not want any (more) children	Yes I need no anymore….1

		No anymore …..2
505		WEEKS AGO 1
		MONTHS AGO 2
		YEARS AGO 3
		IN MENOPAUSE/…..4 HAS HAD HYSTERECTOMY….. 5
		BEFORE LAST BIRTH….6
		NEVER MENSTRUATED….7
506	If the answer for Q 501is yes or unsure Are you currently doing something or using any method to delay	Yes I am using ….1
		No I am not using ….2
507	What name was given to your (last) baby? RECORD NAME	
508	In what month and year was (NAME) born?	MONTH…….. YEAR……. When was his birth date …..
509	When you got pregnant with (NAME), did you want to get pregnant at that time ?	Yes ….1
		No ….2
510	Did you want to have a baby later on, or did you	I need Letter ….1

	not want any (more) children ?	
		I need no more ….2
511	Has your menstrual period returned since the birth of (NAME)?	Yes ….1
		No ….2
512	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED…1
		YES, LIVING WITH A MAN…2
		Nor married …3
513	Now I would like to ask about your (first) (husband/partner). In what month and year did you start living with him?	MONTH ….1
		I did not know the month ….2
		I did not know the year …3
514	When was the last time you had sexual intercourse?	DAYS AGO….1
		WEEKS AGO….2
		MONTHS AGO…..3
		YEARS AGO….4
515	Now I have some questions about the future. After the	I need another child …1

	child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	
		I need no more…2
		I can't get pregnant …3
		UNDECIDED/DON'T KNOW…4
516	If the answer for Q 501 is no and I am not Shure how long you are going to wait to have another kid	Month …….1
		Year……..2
		Soon ……..3
		I cant get pregnant……..4
		After I get married …..5
		Mention if any ……..6
		I did not know …..7
517	You have said that you do not want any (more) children. Can you tell me why you are not using a method to prevent pregnancy? (Register all response)	
		Not married ……1 fertility-related reasons menopausal/hysterectomy ……..2 can't get pregnant ……..3 not menstruated since last birth …….4 breastfeeding ……. 5

		god knows……6 opposition to use respondent opposed 7 husband/partner opposed . . . 8 others opposed ……. 9 religious prohibition 10 lack of knowledge knows no method … 11 knows no source …. 12 method-related reasons side effects/health concerns lack of access/too far 13 costs too much ……. 14 preferred method not available 15 no method available 16 inconvenient to use .17 interferes with body's normal processes …18 no response . . . 99 other (specify) . . . 89
518	you have said that you do not want (a/another) child soon can you tell me why you are not using a method to prevent pregnancy?	not married ……1 **Fertility-related reasons** menopausal/hysterectomy ……2 can't get pregnant ……3 not menstruated since last birth …….4 breastfeeding ……. 5 god knows……6 **opposition to use** respondent opposed 7

		husband/partner opposed . . . 8 others opposed ..... 9 religious prohibition 10 **lack of knowledge** knows no method ... 11 knows no source .... 12 **Method-related reasons side effects/health concerns** lack of access/too far 13 costs too much ..... 14 preferred method not available 15 no method available 16 inconvenient to use .17 interferes with body's normal processes ...18 no response . . . 99 other (specify) . . . 89

PART VI - Information of knowledge on MTCT and HIV Re-infection

601	Does HIV transmit from mother to child?	yes . . . 1
		No . . .2
		don't know. . . 88
		No response . . . 99
		Other (specify) . . . 89
602	If yes when does HIV transmission occur from mother to child? (multiple answers are possible)	during pregnancy . . . 1

		during labor . . . 2
		during breastfeeding . . .3
		I don't know . . . 4
		No response . . . 99
		Other (specify) . . . 89
PART VII- INFORMATION ON HIV /AIDS AND TREATMENT CONDITIONS		
701	How many years/months since HIV diagnosis?	. . . Months . . . Years
		Don't remember . . . 88
		No response . . . 99
		other (specify) . . . 89
702	When did you start receiving ARV treatment?	. . . Months . . . Years
		No response . . . 99
		other (specify) . . . 89
703	how is your overall health condition after you started Receiving ART?	Improved . . . 1
		no change . . .2
		Deteriorated . . .3
		No response . . . 99
		other (specify) . . . 89
704	Did your counselor /ART provide discuss about child bearing and family planning?	yes . . . 1
		No . . .2
		No response . . . 99
705	if yes for Q704, did your	yes . . . 1

	counselor /ART provider adequately cover issues like child bearing, and family planning	
		No . . .2
		don't know . . .3
		No response . . . 99
		other (specify) . . . 89

<u>አዲስ አበባ ዩኒቨርስቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት ቤት</u>

<u>መጠይቅ</u>

የጥናቱ ርዕስ፡- ዘውዲቱ መታሰቢያ ሆስፒታል ክትትልና ህክምና ያላቸው ልጅ በመውለድ እድሜ ክልል ወስጥ ያሉ ከ15 ዓመት እስከ 49 ዓመት የሆኑና በኤች አይ ቪ ቫይረስ የተያዙ እናቶችን የወሊድ መከላከያ ፍላጎት አለመሟላት ማጥናት ነው

አዲስ አበባ ኢትዮጵያ፤ የካቲት 2005 ዓ.ም.

ሀ-መረጃ : ጤና ይስጥልኝ፤ ስሜ ደረጀ ከተማ ይባላል። በአዲስ አበባ ዩኒቨርስቲ የህብረተሰብ ጤና አጠባበቅ ት/ቤት የሁለተኛ ዲግሪ ተማሪ ነኝ። ለሁለተኛ ዲግሪዬ ማሟያ ይሆነኝ ዘንድ በዘውዲቱ መታሰቢያ ሆስፒታል ክትትልና ህክምና ያላቸው ልጅ በመውለድ እድሜ ክልል ውስጥ ያሉ ከ15 ዓመት እስከ 49 ዓመት የሆኑና በኤች.አይ.ቪ ቫይረስ የተያዙ እናቶችን የወሊድ መከላከያ ፍላጎት አለመሟላት በሚል ርዕስ ጥናት እያካሄድኩ ነው። ይህ ጥናት እነዚህን እናቶች ወሊድ መከላከያ ፍላጎት አለመሟላትና ከእናት ወደ ልጅ ኤች.አይ.ቪ መተላለፍ ላይ ያለውን ተፅእኖ የሚያደርጉ ነገሮች ላይ መፍትሄ ለማምጣት አስተዋፅኦ ያመጣል ብዬ አምናለሁ። እርስዎ ዛሬ ለጤና ክትትል እዚህ ሆስፒታል በመምጣትዎ በዚህ ጥናት እንዲሣተፉ ከተመረጡት ውስጥ ነዎት ስለዚህ

መጠይቆቹን በመመለስ እንዲተባበሩኝ እጠይቃለሁ። የሚሠጡኝ መረጃ በሙሉ ሚስጥራዊነቱ የተጠበቀ እንደሚሆን ላረጋግጥልዎት እወዳለሁ። ለዚህ ጥናት የእርሶዎ ስም እና አድራሻ አያስፈልግም!! ምንአልባት በጥናቱ መሣተፉ ካልፈለጉ እምቢ ማለት ይችላሉ፤ ወይም በቃለ መጠይቁ መሀል ማቋረጥ ይችላሉ፤ አለበለዚያም መመለስ የማይፈልጉት ጥያቄ ካለ ይዘለለኝ ማለት ይችላሉ። አንዳንድ ጥያቄዎች ስለግል ህይወትዎ የሚመለከቱ ሊሆኑ ይችላሉ። ነገር ግን የእርሶ ልምድ ለሌሎች ትምህርት ሠጪ ስለሚሆን መልስ እንዲሠጡኝ እጠይቃለሁ። ይህ መጠይቅ ከ 10-15 ደቂቃ ያህል ሊፈጅ ይችላል።

- ሊጠይቁኝ የሚፈልጉት ነገሮች አለዎት? በጣም አመሠግናለሁ።
- በዚህ ጥናት ለመሣተፍ ፍቃደኛ ነዎት?
  አዎን ☐ አይ ☐

መልስዎ አዎን ከሆነ ወደሚቀጥለዉ ክፍል ይለፉ

ለ- የስምምነት ቅፅ

እኔ ፊርማዬ ከዚህ በታች የተመለከተዉ ግለሠብ የዚህ ጥናት አላማ እድሜያቸዉ ከ15 እስከ 49 አመት የሆኑና ከኤች.አይ.ቪ ቫይረስ ጋር የሚኖሩ እናቶችን ወሊድ መከላከያ ፍላጎት አለመሟላት ማጥናት እንደሆነ ተገልፆልኛል። ስለሁኔታው የማውቀውን መመለስ እንደሚኖርብኝ ተብራርቶልኛል። የምሠጠው መረጃ ለዚህ ጥናት አላማ ብቻ እንደሚውል ተነግሮኛል። ማንነቴና የሠጠሁት መረጃ ሚስጥራዊነት የተጠበቀ ይሆናል። በተጨማሪም በጥናቱ ያለመሣተፍ ወይም መመለስ የማልፈልገዉ ጥያቄ ካለ ማለፍ እንደምችል ተገንዝቤያለሁ።

ከላይ በተሠጠኝ መረጃ መሠረት በዚህ ጥናት ለመሣተፍ ተስማምቻለሁ

ፊርማ _____

ቀን _____

<u>የጥናት አድራጊዉ አድራሻ</u>

ስም ደረጀ ከተማ

አዲስ አበባ ዩንቨርሲቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት የሁለተኛ ዲግሪ ተማሪ

ስልክ 0910009108

መጠይቅ

ርዕስ፡- በዘውዲቱ መታሰቢያ ሆስፒታል ክትትልና ህክምና ያላቸው ልጅ በመውለድ እድሜ ክልል ውስጥ ያሉ ከ15 ዓመት እስከ 49 ዓመት የሆኑና በኤች.አይ.ቪ/ይረስ የተያዙ እናቶችን የወሊድ መከላከያ ፈላጎት አለመሟላት

አዲስ አበባ የካቲት 12 ቀን 2005 ዓ.ም.

- ጤና ይስጥልኝ ! ስሜ_____ ይባላል። ከላይ በተጠቀሰው የጥናት ላይ መረጃ ከሚሠበሰቡ ሰዎች ውስጥ እንዱ ነኝ። ቀጠሎ ባሉት ጥያቄዎች ላይ መልስ እንዲሰጡኝ በአክብሮት እጠይቅዎታለሁ፡ በመጠይቁ ያለመሣተፍ መብት አለዎት።

  የቃለ መጠይቅ አድራጊው ስም_____ ቀን_____

<u>የቃለ መጠይቅ አድራጊው ስምምነት</u>

በተሠጠኝ ስልጠና መሠረት ይህንን መጠይቅ ሞልቻለሁ። መጠይቁ በትክክል መሞላቱን አረጋግጫለሁ።

ፊርማ_____

መለያ		
ኮድ	ጥያቄ	መለያ
101	ስንት አመትዎ ነው(እድሜዎ ስንት ነው)?	…. አመት (age in completed years)
102	ፆታ	ወንድ . . . . ሴት. . . .
103	ሀይማኖት	ኦርቶዶክስ 1
		ካቶሊክ. . . . 2
		ሙስሊም. . . . 3
		ፕሮቴስታንት 4
		ሌላ ካለ ይጠቀስ. 89
104	የትምህርት ደረጃ	. . . . ክፍል ያጠናቀቀች
		ማንበብናመጻፍ የምትችል. . . . 1

		ማንበብናመጻፍ የማትችል (ያልተማረች). . . 2
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