

**CONTRACEPTIVE USE AMONG PEOPLE LIVING WITH HIV  
AND AIDS FROM SELECTED COMMUNITIES IN SITEKI,  
SWAZILAND**

by

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## **DECLARATION**

I declare that the, Contraceptive use among People Living with HIV and AIDS from selected communities in Siteki, Swaziland, (mini-dissertation / thesis) hereby submitted to the University of Limpopo, for the degree of Master of Public Health has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

**NC Thwala Mrs.**

**March, 2011**

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This is for my mother, Julia Manana, for believing in me.

## **ABBREVIATIONS**

AIDS	Acquired immune Deficiency Syndrome
ARVs	Antiretroviral drugs
DHS	Demographic Health Survey
HAART	Highly Active Anti Retro-Viral Therapy
HIV	Human Immunodeficiency Virus
IUD	Intrauterine device
MH & SW	Ministry of Health and Social Welfare
MOH	Ministry of health
MREC	Medunsa Research and Ethics Committee
PLWHA	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
SASO	Swaziland AIDS Support Organization
SPSS	Statistical Package for the Social Sciences
STI	Sexual Transmitted infection
STIs	Sexual Transmitted Infections
UNAIDS	United Nations
UNFPA	United Nations Fund Population
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## **ABSTRACT**

**Introduction:** Swaziland is amongst the countries with the highest prevalence rates of the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS), with a reported prevalence of 26% among the sexually active adults. Improving sexual health involves strong reproductive health services including contraceptives. These and other reproductive health services remain as unmet needs in the country. The gap in service delivery applies to the population in general and people living with HIV and AIDS in particular. The discrepancy between knowledge and practice, as observed from the literature, raises questions about the type, availability and accessibility of family planning services to people living with HIV and AIDS (PLWHA) in Siteki, Swaziland.

**Aim:** The aim of the study was to investigate the use of contraceptives among PLWHA living in support groups from Siteki, Swaziland.

**Objectives:** The study objectives were to determine the socio-demographic characteristics, the preferred form of contraception, experiences on contraceptive use and the factors that influenced access to contraception for PLWHA in the selected communities

**Study methodology:** The study design for this project was a quantitative survey making use of a structured self administered questionnaire to collect data where PLWHA aged 21-49 registered in support groups with the Swaziland AIDS Support Organization (SASO) were selected. Descriptive statistics was used for data analysis.

**Results:** The results indicated that as much as people know their sero status there is still an unmet need on the use of contraception against pregnancy and infection. The findings revealed that 82.3% of the respondents living with HIV were utilizing contraceptives and among these 69% were utilizing barrier methods that could prevent both pregnancy and infection. There were 11% of the respondents who did not desire to have children but were not using contraceptives. Generally knowledge on contraception was high and all the respondents knew that they had to use condoms or dual methods to ensure safer sex and pregnancy prevention.

**Conclusions:** The findings of the study have implications for programmes to promote contraception among people living with HIV and AIDS and should assist health promoters in designing and implementing interventions that would address the barriers to contraceptive use among people living with HIV.

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# **CHAPTER ONE**

## **BACKGROUND AND LITERATURE REVIEW**

### **1.1 INTRODUCTION**

Swaziland is among the countries with the highest prevalence rates of the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS), with a reported prevalence of 26% among sexually active adults according to the Swaziland Demographic Health Survey (Swaziland, 2007), supported by the sero- sentinel surveillance data collected among pregnant women which reported a prevalence of HIV at 42% Ministry of Health and Social Welfare (MH&SW) (2008). Since the introduction of antiretroviral therapy, HIV has changed from being a fatal disease to being a chronic one (Coleman & Ball, 2007), as more people on treatment are now surviving the illness. The major mode of transmission for HIV has been attributed to hetero-sexual relationships. The Government of Swaziland declared HIV and AIDS a national disaster in 2003 and since that time, interventions have been implemented to create awareness of HIV and AIDS among the population. Improving sexual health involves strong reproductive health services including contraceptives. These and other reproductive health services remain unmet needs in the country. The gap in service delivery applies to the population in general and to people living with HIV and AIDS in particular.

### **1.2 EPIDEMIOLOGY OF HIV AND AIDS**

The global epidemic of HIV and AIDS is a well documented phenomenon. According to UNAIDS (2009) the number of people living with HIV and AIDS globally is 33.4 million and among these 31.3 million are adults.

Sub-Saharan Africa is the epicentre of the epidemic being home to about 60% of those living with HIV and AIDS worldwide (UNAIDS, 2005) which represents an estimated figure of 22.4 million people (UNAIDS, 2009). With reference to the Sub Saharan region, 59% of the HIV positive individuals are women in their reproductive years and about 75% of the global population of HIV positive women live in Sub Saharan Africa (UNAIDS, 2005).

Swaziland has one of the fastest growing HIV epidemics, with the prevalence among women increasing from 39.2% in 2006 to 42% in 2008 (MH&SW, 2008). The dramatic rise in HIV rates has resulted in the country having 190 000 (20%) of the population living with HIV and AIDS. Among these, 100 000 (53% of people living with HIV) are women and 15 000 are children (Swaziland, 2007). With high numbers of people affected, UNAIDS reports that the number of people living with HIV is increasing because of the continued acquisition of HIV infection, with 2.5 million people newly infected in 2007 worldwide (UNAIDS, 2009).

In most developing countries in general, and Swaziland in particular, the focus of health care services is on the provision of prophylaxis against infection, care for opportunistic infections and the delivery of antiretroviral treatment (Cooper *et al*, 2007). Less attention is therefore given to appropriate reproductive health services for HIV positive men and women. Health concerns that previously discouraged HIV positive people from having children are no longer an issue as more HIV positive people desire to have children (Cooper *et al*, 2007). The prevention of mother to child transmission programmes (PMTCT) have also provided HIV positive people with the option of experiencing biological parenthood. This change necessitates the need for the renewed focus on the reproductive needs of people living with HIV/AIDS (PLWHA) (Williams *et al*, 2003).

### **1.3 CONTRACEPTION**

According to UNFPA (2000), the reported prevalence of contraceptive use in the Southern African countries, South Africa, Lesotho and Botswana is 49%, 19% and 32% respectively. However, in Swaziland the contraceptive prevalence is 51% (Swaziland, 2007). *Contraception* is a term used for the prevention of pregnancy and is also commonly known as *birth control*. Several contraceptive methods are available, some created for men and others for women. Some methods such as tubal ligation and vasectomy are permanent and others such as the pill and injectables are reversible.

It is important to note that most contraceptive methods prevent pregnancy but do not prevent sexually transmitted infections (STIs) including HIV. Among the contraceptive methods, barrier methods, for instance condoms are 80 - 95% effective in preventing sexual HIV transmission when used consistently and correctly during every sexual act, however, are less effective in preventing pregnancy (Masi, 2007). In cases where male condoms are used, pregnancies occur at a rate of 15 per 100, and 21 per 100 among those using female condoms (Masi, 2007). On the other hand, hormonal contraception and sterilisation are effective in preventing pregnancy but do not prevent the heterosexual transmission of HIV. The combined use of a barrier and a hormonal contraception method therefore increases the efficacy of contraception and thus minimises the HIV transmission risk (Massad *et al*, 2007).

### **1.3.1 Hormonal contraceptives**

The WHO (2004) guidelines on contraception use for people living with HIV does not impose restrictions on the use of hormonal contraception which include pills, injectables, implants or rings.

#### ***The pill***

This is an effective contraceptive method if it is used consistently although it does not protect users from HIV infection. Medical side effects that may be experienced by users include the increased risk of breast cancer if taken by women who have not had a baby, high blood pressure, blood clots, depression, weight gain and headaches (Ijingho, 2010).

#### ***Emergency contraception***

Emergency contraception consists of pills taken immediately after unprotected sex to prevent pregnancy. This method is mostly used when there has been condom breakage or forced sex and does not protect users from HIV infection or sexually transmitted STIs. The side effects that are associated with this method include nausea, frequent urination and headaches (Ijingho, 2010).

### ***Injectables and implants***

The injection is given at intervals of four weeks, three or eight months. This method has the advantage of not being intercourse related but requires regular access to a health facility to be repeated. Implants require a trained professional to insert and last for three to five years. Their advantage is that they are long lasting and also reversible. The side effects of this method are nausea, headaches, decreased sex drive, missed periods, irregular bleeding, prolonged bleeding and heavy bleeding (Ijingho, 2010).

### ***Intrauterine device (IUD)***

The IUD prevents fertilisation and or implantation of the foetus and it is a contraceptive method created especially for women. The IUD should be used with caution by HIV positive women as it may increase the rate of menstrual bleeding and subsequently the risk of anemia (Steen & Shapiro, 2004). Concerns regarding the use of IUD by women with HIV infection are those related to contraceptive efficacy, and risk of STIS. Sexual transmission of HIV in IUD users may be increased as a result of increased volume and duration of menses and genital inflammation (Mitchell & Stephens, 2004). In addition, side effects related to the use of IUD include headache, nausea, acne, mood swings, period cramps, heavy periods and increased pelvic infection (Ijingho, 2010).

### **1.3.2 Barrier methods**

These methods include the male and female condoms, which are effective in preventing pregnancy and if used correctly and consistently are also effective in preventing sexual transmission of HIV (Delvaux & Nostlinger, 2007).

### ***Condoms***

There are both male and female condoms. Condoms are effective in protection against pregnancy and if used consistently and correctly they are also the most effective means of preventing the sexual transmission of HIV (Mitchell & Stephens, 2004). The female condom is a polyurethane sheath with two flexible rings at each end and is inserted into the vagina where it covers the introitus and the vulvar mucosa (Mitchell & Stephens, 2004).



Failure rate and accidents have been reported with condoms that have resulted in unplanned pregnancy and infection (Blackwell, 2007). This has led to the advocacy for the dual method which entails the use of another form of contraception with condom use (Mitchell & Stephens, 2004).

Limited side effects have been documented on condoms. Users may be allergic to the latex condoms, but alternative kinds of condoms can be used (Ijingho, 2010). Delvaux and Nostlinger (2007) reported that when condoms are used as a stand alone method their effectiveness can be compromised because sexually active people are often unwilling to use condoms all the time. The challenge is the promotion of condoms in stable relationships, especially among PLWHA where there is a need for long term adherence to safer sex (Cates & Steiner, 2002).

### ***Spermicides***

Spermicides refer to a barrier method that contains chemicals designed to kill sperm. They are available in jelly or foam form. Women living with HIV are not encouraged to use spermicides as they affect the vaginal lining and thus increase the risk of HIV infection (WHO, 2004). As spermicides cover the cervix and the vaginal wall their use in discordant couples is not recommended as a large area of the vagina remains exposed. The concomitant use of nonoxynol spermicides may cause epithelial disruption and increase viral transmission risk to the male partner. Spermicides provide no protection against STIs including HIV and frequent use increases the risk of HIV acquisition (Mitchell & Stephens, 2004). Spermicides have been reported to be less effective when they are used as a single method of contraception. Users may experience side effects such as burning and increased susceptibility to HIV if the spermicides are used frequently.

### **1.3.3 Permanent methods**

#### ***Female and male sterilization***

Studies have shown that the HIV positive status influences a person's fertility intentions (Cooper et al, 2007). HIV positive couples who have completed their families often opt for

sterilisation which is an irreversible, effective, permanent and cost effective form of contraception (Paiva et al, 2003). Vasectomy involves the closing of the tubes that carry sperm, while female sterilisation involves the closing of the fallopian tubes that carry the eggs from the ovaries to the uterus. Sterilisation does not reduce the HIV viral load in genital secretions nor the risk of STIs.

People who are sterilised tend to reduce the consistent use of condoms. Permanent methods are also an option for PLWHA but their use among them has not been widely documented. Sterilisation of both males and females have also been reported to have side effects which include reduced intimacy, lowered libido, ectopic pregnancies for women and the swelling of testicles for men (Cooper *et al*, 2007). Furthermore, men who have undergone vasectomy have a high risk of developing prostate cancer (Sunny, 2005).

#### ***1.3.4 Dual protection***

Protection against both unwanted pregnancy and STIs is referred to as dual protection (Delvaux & Nostlinger, 2007). Condoms are the mainstay of dual protection in combination with other methods. The use of dual methods for contraception increases protection for couples, as men are often unwilling to use condoms this 'second' method then provides protection against unwanted pregnancy. The dual protection method should be promoted especially for PLWHA who have received HIV education and who are aware of their elevated risk to STIs. The challenge is the promotion of more than one method to achieve dual protections when some people are finding it difficult to use even a single method. The use of dual method of contraception is reported to be low among PLWHA with the rates ranging between 12% - 21 % (Sama *et al* 2008; Myer *et al*, 2007).

### **1.4 KNOWLEDGE OF CONTRACEPTIVES**

A reproductive health study conducted by the WHO (2008) revealed that due to the lack knowledge on the available contraceptive methods, people are not able to make informed choices as far as contraceptives are concerned, resulting in fear to utilize them. However, general contraceptive knowledge is widespread, even among women with no education, according to

Agyei & Migadde (1995), though the service uptake still remains low. This opinion was confirmed by the demographic health survey (DHS) conducted in Swaziland in 2007 which reported that 71% of the people surveyed had knowledge of contraceptives, while only 48% were reported to be utilising them (Swaziland, 2007).

In a study conducted in America on adolescents and their knowledge and utilization of contraceptives, authors Kansen *et al*, (1992) assert that knowledge has little effect on risk reduction strategies. Results indicated that high degree of knowledge of contraception was present among the adolescents but they lacked the social skills of communication, negotiation and personal control in sexual situations. Similarly, in a study conducted in Kenya by Sama *et al* (2008) people on highly active anti-retroviral therapy (HAART) reported that knowledge of the HIV status did not act as a protective factor for reduced sexual risk behaviour. The participants in the Kenyan study continued to engage in unprotected sex and did not utilise contraceptives not even condoms despite knowledge of their HIV status. Furthermore, on the basis on the study done on sexual risk behaviour in Kigali, Rwanda, researchers Van der Straten *et al* (1998) concluded that knowledge of HIV status does not translate to the use of any form of contraception. In addition, Myer, *et al* (2007) state that the duration of anti retro viral therapy was not associated with the uptake of reproductive health services.

Myer *et al* (2007) claimed that the level of knowledge on contraception is low in Sub-Saharan Africa and that few women discuss contraception with their health care providers irrespective of the regular contact with them. Heard *et al* (2004) assert that the HIV epidemic has grown but knowledge of contraception among PLWHA is still limited.

The lack of knowledge on contraception among PLWHA has constrained the choice of contraceptives and the need to prevent pregnancy and the sexual transmission of HIV.

## **1.5 REASONS FOR NON USE OF CONTRACEPTIVES**

According to the Swaziland (2007) there are many reasons for the low utilization of contraceptives amongst people living in Swaziland.

Some of the indicated reasons for non use of contraceptives were:

### ***Socioeconomic status***

Massad *et al*, (2007) states that HIV-infected women are often poor and socially marginalised, and not in control of sexual negotiations, so they have difficulty accessing and using contraceptives, with the cost of contraceptives also a barrier (Guttmacher, 2010). This lack of decision making power on sexual relations by women, the lack of communication between partners and the fear of opposition from the husband leaves the woman with no bargaining power (Cooper *et al*, 2007) and this denies women the opportunity to object when their husbands put them at risk (UNAIDS, 2000).

In addition, being outside the structures of power and decision-making in terms of sexuality, women in general and those with HIV in particular are denied the opportunity to participate equally within the community and may be subject to punitive laws, norms and practices exercising control over their bodies and sexual relations (Maja, 2007; Aggleton, 2000). In a number of societies, women are erroneously perceived as the main transmitters of STIs, many times referred to as “women’s diseases” (Aggleton, 2000).

Consequently, women living with HIV who are pregnant or considering pregnancy they face stigma and discrimination from health care workers such as not receiving supportive care from health workers with bias and judgmental attitudes hence they are not able to freely make informed choices on contraception (Masi, 2007).

As a result of the social stigma associated with contraception especially condoms use, condoms are used on less meaningful relationships or more risky sex encounters associated with a lack of intimacy and trust (Foss *et al*, 2004).

### ***Sexual debut***

Katende *et al*, (2003) reported that few unmarried young couples use contraceptives the first time they have sexual intercourse. The use of contraception on first intercourse was associated with age, and a delay in the use of contraceptives which resulted in unintended pregnancies. Many of the unplanned pregnancies occur within a year after first intercourse as reported by Katende *et al*, (2003) where in Zimbabwe 50% of the 200 young women delivering at a Harare maternity ward, indicated that they had become pregnant after three months of becoming sexually active.

### ***Cultural values***

Culturally a women's fertility assign significant status to those who bear children to such an extent that the negative social consequences of childlessness often have the man marrying another wife, putting the first wife at a disadvantage (Doyal & Anderson, 2005). This cultural pressure on married women is an indication that the choice of having children does not necessarily lie with the female (Cooper *et al*, 2007).

### ***Social values***

While health concerns may deter HIV positive women from considering reproduction it may be counteracted by other personal emotions such as the desire to experience biological parenthood which is also influenced by social values that encourage child bearing (Katende *et al*, 2003). Social expectations regarding reproduction may deprive women of the right to make decisions about contraception as they have to submit to strong partner expectations, with women reporting that they are experiencing pressure from their partners. Social attitudes that condemn girls who plan for sex may discourage them from using contraception and thus increase their vulnerability to STIs and pregnancy (Katende *et al*, 2003).

### ***Personal reasons***

Studies conducted by Tuloro *et al* (2006), WHO (2008) and MH&SW (2002) concluded that the low utilisation of contraceptives among PLWHA is the result of the desire to have children, especially when they do not have their own. According to Masi (2007) in relationships women have little control over sexual issues including whether they will use contraception, when they

will have sex and in some circumstances, with whom they are having sex. For example, widow inheritance gives women no choice concerning sexual partner. The custom of widow inheritance refers to the taking over a widow as wife by her husband's brother or paternal cousin. The act of being taken over; the woman is denoted as passive, while the man is active (WILSA, 1998).

Some men and women disapprove of contraceptives because of the impression that the use of contraceptives promotes promiscuity. This also leads to the situation where HIV positive women are afraid of disclosing their status to their partners for fear of being rejected, this deters them from taking on protective measures, such as using condoms as they will be labeled promiscuous (Masi, 2007).

Zamberia (2009) articulates that the use of condoms depends on the male partner but according to UNFPA (2004) with the unequal power experienced within a relationship, it is difficult for women to refuse sexual relations, because of fear of violence, rejection and abandonment also the requirement by marriage to be sexually available. The result is that the female submissively accepts unsafe sex.

The number of children the individual has determines contraceptive use as children are considered as an asset socially and economically (Tuloro *et al*, 2006). As Guttmacher (2010) reported couples are not using contraception because they did not expect to have intercourse, they believe they will not fall pregnant, are experiencing lactation amenorrhea and they are having sex infrequently.

### **Knowledge and information on contraception**

Some people highlight claim that they did not know about contraception (Cates & Steiner, 2002) while others have negative attitudes about contraceptives due to misleading information about contraceptives and the "dangerous side effects" that can be experienced when using contraceptives (Katende *et al*, 2003).

Bongaarts and Bruce (1995) agree that the principal reason for the non use of contraceptives in Sub-Saharan Africa is the fear of the possible side effects of using a contraceptive, perceived to be both life threatening and not life threatening, accounts for 20% of the sexually active people in this region not using any contraceptives.

The lack of knowledge on the choice, benefits and use of a contraceptive, and limited knowledge on the side effects deters women from using contraceptives. In most cases partners perceive the side effects to be more than the benefits of using the contraceptive (Bongaarts & Bruce, 1995). Other studies that have been conducted on HIV positive people report that there is low uptake of contraceptives and that when given a choice people opt for contraceptives that only protect them from pregnancy and not disease (Joanne *et al*, 2003; Kamau *et al*, 1996). This again indicates a gap in having the correct information about contraceptive methods relevant to PLWHA as HIV positive people are supposed to have dual protection.

### **Facility based reasons**

As there are many immediate concerns of men and women living with HIV that have to be addressed by their clinicians , such as dealing with the shock of being HIV positive (Massad *et al*, 2007), many a time there is little time is left for contraceptive counseling during a consultation. Cooper *et al*, (2007) blames the counseling environment at the health care facilities, for not being conducive to open discussions on contraceptives issues, resulting in the low uptake of contraception. They further state that health care provider attitudes of being judgmental and unsympathetic toward the HIV positive patient's conditions deter people living with HIV to seek health care (Cooper *et al*, 2007).

Gaining access to contraceptives is difficult for unmarried couples as laws in some countries prohibit provision of contraceptives services and information to young and unmarried people. Even where restrictive laws are not there, there are always the members of societies disapproving of premarital sex (Katende *et al*, 2003).

Other factors that are facility based include the fear of disclosure of HIV status to someone new, as well as provider attitudes toward HIV positive clients who are sexually active (Fleischman,

(2006). The expert service provider attitude towards people with HIV, which is often overlooked, can defer people from utilising the services despite the availability of contraceptives (Galavotti & Schnell, 1994).

Fleischman (2006) conducted a study on care and support for HIV positive people, and reported that access to treatment is hindered by fragmented services. Fleischman (2006), further stated in his report that many clients often spend an entire day at the HIV/AIDS Centers leaving them with no time to access any other health services elsewhere.

### **Perceptions of PLWHA**

Rasheed *et al*, (2010) and Kamau *et al*, (1996) state that the lack of knowledge regarding: HIV and its transmission; the benefits of using a contraceptive, and not having the knowledge about the consequences of having the disease, can translate to a low perception of the severity of HIV and lack of self efficacy is hindering the uptake of contraception.

Women living with HIV are reluctant to seek family planning activities, because of fear for stigma and discrimination, yet discussing family planning options with PLWHA is an opportunity to help prevent unintended pregnancy and an entry point for enrolment to Prevention of Mother to Child Transmission programs (PMTCT) (Masi, 2007).

## **1.6 MOTIVATION FOR USE OF CONTRACEPTIVES**

As discussed in the previous paragraphs, many factors militate against the use of contraception, however, studies have also reported and revealed factors that can motivate men and women in general, as well as PLWHA to utilise contraceptives for the prevention of unintended pregnancies and STIs.

Some of the indicated reasons influencing and motivating the use of contraceptives are:



### ***Education***

Education or the lack thereof also influences the use of contraception. Educated women have greater appreciation of the economic value and health benefits of small families and are therefore more likely to protect themselves against unplanned pregnancy when compared to uneducated women (Katende *et al*, 2003).

Stephenson *et al* (2007), report that the level of education is associated with low levels of fertility and high utilisation of contraceptives, which may be influenced by autonomy in decision making which may be a result of economic development. These results were obtained from a study conducted in six African countries in East and Southern Africa which described the factors that influence contraceptive use such as employment and the number of living children.

### ***Age of contraceptive user***

Moos *et al* (2003) state that older couples use more contraception than young adults as it is socially expected for them to be engaging in sexual activity. On the other hand, the use of contraception by younger and single girls is strongly discouraged.

### ***Marital status***

Rasheed *et al* (2010) also observed that more married couples use contraception giving birth spacing; satisfaction with provider services which include confidentiality and availability of contraceptive options, and financial stability as reasons that motivate the use. The authors further articulate that unmarried women and those who are not planning to marry in the near future consider it important to avoid pregnancy and they therefore use contraceptives. The reasons motivating single women to use contraception may not be generalised as they may differ according to population and cultural backgrounds.

### ***Facility based reasons***

Access to the health facility providing contraception is also reported as a motivating factor. Access is measured by physical proximity to the health facility, the availability of contraceptive method of choice, cost, quality and skill of staff, extent of outreach to different groups, logistic

support and follow up care to the health facility providing the contraception (Katende *et al*, 2008).

### ***Perceptions of PLWHA***

Galavotti and Schnell (1994) conducted a study in which they examined the relationship between the contraceptive method of choice, perceptions of HIV and pregnancy risk. This study conducted among 3136 women reported that 58% of the participants believed that they are protected from HIV when they use a condom; while amongst those on the pill as a contraceptive method 22% indicated that they did not believe that they were at risk of contracting HIV. The authors highlighted and concluded that beliefs on the effectiveness of methods for pregnancy prevention may influence beliefs about the efficacy of the method for disease prevention (Galavotti & Schnell, 1994). The level of satisfaction with the chosen method also encourages women to use and sustain contraception (Katende *et al*, 2003).

### ***HIV status***

The substantial stigma and discriminatory views specific to reproduction associated with HIV infection impact on views towards reproduction in the context of HIV (Cooper *et al* 2007).

The HIV status of an individual modifies the reproductive desires as determined by the number of surviving children which again strongly influences the use of contraceptives (Agyei & Migadde, 1995; Cooper *et al*, 2007). It was established that couples with several children are more motivated to use contraception than childless families (Katende *et al*, 2003). In addition, the fear of partner and infant infection and of losing a child to HIV encourages the use of contraception among PLWHA (Katende *et al*, 2003).

These factors deter some individuals from having more children and hence they consistently make use of contraceptives. Some couples also use contraceptives because society disapproves of HIV and reproduction, which happens when the couple has openly declared their status (Cooper *et al*, 2007). This is because the children may be infected with the HIV virus or the parents will die and leave orphans of which society disapproves (Moos *et al*, 2003).

### ***Risk to health***

Health risks also deter some HIV positive people from the desire to have children and thus they adhere to contraceptive use (Paiva *et al*, 2002). Cooper *et al* (2007) states that HIV related concerns that include poor current state of health and fear that pregnancy could hasten the progression of HIV deter individuals from having children.

### ***Spouse support***

The husband's approval of family planning methods has also been reported as promoting contraceptive use, as indicated by a study conducted in Ethiopia among men where 88.9% were found to be in support of family planning methods (Tuloro *et al*, 2006).

## **1.7 CONTRACEPTIVES AND HIV**

As more than 80% of people living with HIV and their partners are in their reproductive age they may still have the desire to have more children even after learning about their HIV status while some may actually want to start families (Delvanx & Nostinger, 2007). Others may want to regulate their fertility and decide when to have a child. With the availability of antiretroviral treatment and an improvement in health status, there may be a renewed interest in sexual relations and the desire to have children for women and men living with HIV.

## **1.8 PROBLEM STATEMENT**

In Swaziland contraceptive counselling and HIV is guided by the reproductive health policy guidelines which promotes the Prevention of Mother to Child Transmission (PMTCT) (MH &SW, 2008). Contraceptive counselling is emphasised for all pregnant women who seek antenatal care (ANC) because 97% of all pregnant women in Swaziland seek ANC at least once during pregnancy. The reproductive policy also emphasise dual contraception as part of prevention of HIV transmission. HIV testing and contraceptive counselling and sexually transmitted infections is promoted through provision of integrated family planning and HIV services.

Sexually transmitted infections and HIV transmission amplify each other, since both sexual and reproductive ill health and HIV are rooted in the same social factors, including unequal gender relations and poverty (MH & SW, 2008). The reduction of new HIV infections and the ability to lead a healthy lifestyle depends on knowing the possible ways of preventing further infection and the acceptability of this information by the people who have to apply it.

Despite the increase in promotion of contraceptives and the availability of contraception methods, unintended pregnancies remain a global concern, accounting for 30% of all know pregnancies (Blumenthal *et al*, 2003). In the last demographic health survey done in Swaziland the percentage of contraceptive use was 51% with the resultant unwanted pregnancies, defined as a pregnancy that the female deemed undesirable out of her own free will (WHO, 2005), standing at 75% (Swaziland, 2007).

The promotion of family planning services among HIV positive people can prevent infection, STIs including HIV and pregnancy. Moreover, if a couple chooses a barrier method, contraceptive use will prevent or slow transmission of the virus from one partner to the other. Information about contraception is a major determinant of positive attitude towards family planning methods acquisition and sustained contraceptive use. Leon *et al*, (2001), state that family planning counseling implies that health workers should also assist clients in selecting an appropriate contraceptive method that best satisfies their needs and that clients leave the counseling session knowing about the side effects of the chosen method and how to use it safely and effectively. This knowledge, according to the authors Leon *et al*, (2001), is a major determinant to the continued adherence to contraceptive use by clients. The discrepancy between knowledge and practice, as observed from the literature, raises questions about the type, availability and accessibility of family planning services to people living with HIV. It is in this regard that the researcher wants to identify the factors that determine the use of contraceptives among people living with HIV and AIDS as well as determine their knowledge of available contraceptives and determinants affecting the accessibility to contraceptives in selected communities in Siteki, Swaziland.

## **1.9 RESEARCH QUESTIONS**

- What are the socio-demographic characteristics of people living with HIV from selected communities in Siteki, Swaziland that could possibly influence contraceptive use?
- Which contraceptive is commonly used by men and women from selected communities in Siteki, Swaziland who are living with HIV?
- What are the experiences of people living with HIV and AIDS regarding contraceptive use in selected communities in Siteki, Swaziland?
- What are the barriers to accessing contraception among people living with HIV from selected communities in Siteki, Swaziland?

## **1.10 AIM OF STUDY**

The aim of this study was to investigate contraceptive use among people living with HIV from selected communities in Siteki, Swaziland.

## **1.11 RESEARCH OBJECTIVES**

- To determine socio-demographic characteristics of people living with HIV in selected communities in Siteki, Swaziland in relation to contraceptive use.
- To determine which form of contraception is more favoured by people living with HIV in selected communities in Siteki, Swaziland.
- To gather factual information about the experience on contraceptives use among people living with HIV and AIDS among support groups in Siteki, Swaziland.
- To determine the factors that influence access to contraceptives services for people living with HIV and AIDS among support groups in Siteki, Swaziland.

## **CHAPTER TWO**

### **METHODOLOGY**

#### **2.1 INTRODUCTION**

This chapter describes the research methodology, including the design, setting, population and sample, data collection and analysis, measures to ensure validity and reliability and ethical considerations.

#### **2.2 STUDY DESIGN**

The study design for this project was a quantitative survey. A study design or research is a plan to approach a research question (Polit & Beck, 2004), while a survey refers to a no-experimental research whereby information is gathered from a proportion of the population to describe, explain knowledge, people's intentions, behavior, beliefs and values (Gillis & Jackson, 2002).

#### **2.3 STUDY POPULATION**

The study population is defined as the entire group that a researcher wishes to describe (Gillis & Jackson, 2001). The study population for this research comprised of adult people living with HIV and AIDS between the ages of 21-49 years who were in registered support groups and residing within Siteki communities, Swaziland.

Siteki (variant Lugongolweni) is a constituency situated in the Lubombo Region (District) of Swaziland. The constituency consist of four communities with a population of 15 519 people as recorded by the 2007 census (Swaziland, 2007). The study was carried out in two communities of the constituency, which included Mlindazwe and Langa. The total population of the study was drawn from the registered support groups in Siteki, which had 400 members (17 support groups) according to Swaziland AIDS Support Organization Register 2010 (SASO). This was the population that was feasible for the researcher to access as they had openly declared their HIV status and was registered members of support groups.

The support groups that were selected were those registered within the Siteki support communities between the ages 21-49 years who were meeting during the week of the data collection. Participation in the study was voluntary, all those who were in support groups and within the specified age range and willing to participate were enrolled into the study.

### **2.3.1 Inclusion criteria**

The eligibility criteria for participation in this study included: persons living with HIV and AIDS, registered in a support group (which means they have openly declared their HIV status) and are  $\geq 21$  years of age and older, (which means they are considered as adults and do not need consent for utilising contraceptives) who are residing in Siteki constituency in Swaziland.

### **2.3.2 Exclusion criteria**

HIV positive people not affiliated to any support group in the Siteki constituency, Swaziland and people older than 49 years of age were not included in this study. Children below the age of 21 were also excluded as they are considered to be minors and in most cases the parents do not want their children's HIV status to be known.

### **2.3.3 Study setting**

The study was conducted in designated community halls where the support group members convene weekly for their meetings.

## **2.4 STUDY SAMPLE SIZE**

A sample is a proportion of the respondents selected from the accessible population from whom information of the study is to be obtained (Fox *et al*, 2007). The sample size was calculated by using Epi-Info<sup>TM</sup> (Version 3.5.1) freely available from (<http://www.cdc.gov/epiinfo/epiinfo.htm>). A calculated total of 196 respondents (male and female) were to be enrolled in the study, based on a +/- 10% margin of error at a 95% confidence level.

A total of 230 questionnaires were distributed to people who volunteered to participate. The additional 34 questionnaires issued were to allow for a possible non-response rate and for unusable questionnaires with incomplete data.

## **2.5 DATA COLLECTION**

### **2.5.1 Data collection instrument**

In this study a structured questionnaire (Appendix A- English Version) with close ended and a few open ended questions on the knowledge and use of contraceptives was developed. The questionnaire was adapted from the general questionnaire used by the Swaziland Reproductive Health Unit (MH & SW, 2002) which focuses on collecting data on contraceptive trends and barriers regarding the use of contraceptives. Alterations were made to the questionnaire based on literature to be relevant to the target population. The researcher compiled questions and recorded possible responses as gleaned from the literature reviewed and respondents had to tick appropriate responses applicable to them and also write personal comments where applicable. The instrument was also translated to the local language, SiSwati (Appendix B) and for those participants who were not able to read and write the research assistants assisted in clarifying and helping the participants to fill the questionnaire.

### **2.5.2 Pre-test**

A pre-test of the instrument refers to a administering of the data collection instrument on a trial basis to ensure that the instrument can be clearly understood by the respondents and that it captures the required data to answer the research objectives (Polit & Beck, 2004). The researcher pre-tested the data collection tool on seven work colleagues. From the pre-test results one question was corrected and two added, the questionnaire only asked the type of contraceptive that the respondents were using assuming that all of them were sexually active at that time, so some respondents did not respond. So a question (Q16) was added asking if they have ever used contraception. The second question (Q21) was “ to list any side effects of the contraceptive being



used by the respondent if any so that they can describe their experience in using contraceptives”, and the last question (Q22) was to find out if the partner was supporting the use of contraceptive.

### **2.5.3 Pilot study**

A pilot study is a smaller version of a proposed study conducted to investigate the feasibility of the proposed study and to detect possible flaws in the data collection instrument such as inadequate time limits (Brink *et al*, 2006). A pilot study was necessary for this research because the pre-test was administered to people that could not state their HIV status so most of the questions were not applicable to them. Since the aims and objectives of this study was related to people with HIV/AIDS a pilot study was conducted on 15 people living with HIV and AIDS in a community similar to where the actual study was conducted. The pilot group was given the same questionnaire to provide their responses and the data obtained were analysed to identify any problems related to the questions asked. The pilot study was also conducted to give the researcher the experience with the subjects, familiarise herself with the settings where the questionnaires were to be administered, as well as to streamline the methodology needed to obtain the best results without any disruption of the monthly meetings of the support groups. The results of the study indicated that the target population was willing to participate in the study and had no difficulty in answering the questions. The pilot indicated that respondents could finish answering the questionnaire within an average time of twenty minutes.

### **2.5.4 Data collection for the study**

The participants were accessed through SASO who availed the scheduled dates for meetings of the support groups and who introduced the researcher to the potential participants. Once identified, the researcher explained the objectives and aims of the study to the potential participants as well as what their involvement entail, that the study was for educational purposes and information obtained was to be used to recommend strategies for addressing the issues of contraception among people living with HIV. Questionnaires were then distributed to all participants who voluntary consent to participation. The researcher supervised the proceedings and was available for consultation during filling of the questionnaires. Two assistants were also available to assist participants that were not able to read and write.

## **2.6 RELIABILITY AND VALIDITY OF INSTRUMENTS**

### **2.6.1 Reliability**

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time and if used by different researchers (Brink, 2006). The questionnaire used in this study was an adaptation from the general questionnaire used by the Swaziland Reproductive Health Unit (MH & SW, 2002) which focuses specifically on collecting data on contraceptive trends and barriers to the use of contraceptives. The instrument was also pre-tested before conducting the study.

### **2.6.2 Validity**

Validity refers to ascertaining whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied (Brink *et al*, 2006). Weiss (1995) states that during an interview the respondents may not maintain factual reality when they are pressed to provide detailed description of events and there is also the possibility that they may leave out some facts. People, when required to provide information about them they tend to present a positive picture of themselves (Brink *et al*, 2006). To counteract this anomaly in the study, the researcher created rapport with the respondents and the purpose of the study was described to them and anonymity ensured. Open and closed questions were asked and options were made available so that the respondents can be reminded of some information that s/he may have forgotten. For example, Question 17 of the questionnaire asked: “Which contraceptive are you currently using?”, and a list of contraceptives were provided and respondents only had to tick the ones that s/he knew.

### **2.6.3 Bias**

Participation bias may result from factors that affect final enrollment of the intended sample where not all eligible subjects may agree to participate.. Researcher bias was minimised through allowing participants to freely fill in the questionnaires, assisting only those with difficulty in reading and writing.

## **2.7 DATA ANALYSIS**

Brink *et al*, (2006) describes data analysis as categorizing, ordering, manipulating and summarising the data and describing them in meaningful terms. In this study data collected were entered into an Excel sheet (Microsoft Office 2007) for easy analysis and management. The data was then analysed through a statistical computer program Stata and the Statistical Package for the Social Sciences (SPSS). Descriptive statistics was used for analyses such as frequencies and linear regression. The results were then presented in frequency tables and percentages. New variables were generated and were participants were grouped in age groups and groups ranked as ranked as low, medium and high knowledge on contraceptives for better analysis and comparison of the results.

## **2.8 ETHICAL CONSIDERATIONS**

Research that involves human subjects has special concerns relating to the protection of their rights as human subjects (Brink, 2006). The researcher followed the guidelines of the Belmont report 1979, (Department of Health, Education, and Welfare, 1979). The three fundamental ethical principles being: respect for persons, beneficence and justice. The research proposal for conducting the study was submitted to the Research Ethics and Publication Committee of the School of Health Care Sciences and the MEDUNSA Campus research Ethics Committee (MREC) for approval. Upon approval (Project number MREC/H/67/2010:PG, Appendix D) at the school level the researcher further applied for permission from the Ministry of Health Science and Ethics Committee of Swaziland where approval was also given (see Appendix E and F).

### **2.8.1 Principle of respect for persons**

People were not coerced to participate in this study, all those that provided information were willing and those who withdrew or did not fill the entire questionnaire were not penalised. This was based on the principle that people had the right to decide voluntarily whether or not to participate in research without being at risk of penalty or any type of some form of prejudicial treatment by the researcher (Brink, 2006).

### **2.8.2 Principle of beneficence**

The study objectives were introduced to the potential participants and they were allowed to ask for clarifications and those who did not feel comfortable to participate were allowed to go, reassuring them that they would incur no harm (in the form of distress) that may result from their non-participation.

### **2.8.3 The principle of justice**

All participants in the support groups were eligible to participate as long as they fit the eligibility criteria. A participant's anonymity was assured by separating the identity of individuals from the information they give. No names were recorded on the questionnaires, and the questionnaires were collected and kept safe in the researcher's office. Confidentiality was also ensured through grouping of data during the analyses and presentation of results. A consent statement was written on the questionnaire stating that by answering the questionnaire the participants are consenting to participate in the study and they are willing to provide information. Separate consent forms with signatures were not provided because their identity would then have been collected about the participants who were going to impinge on their confidentiality and privacy.

## **CHAPTER THREE**

### **PRESENTATION OF RESULTS**

#### **3.1 INTRODUCTION**

This chapter presents the results of the study. The purpose of the study was to investigate the use of contraceptives among people living with HIV and AIDS in support groups from Siteki. The study attempted to determine the socio-demographic characteristics of people living with HIV in Siteki and the form of contraception they favour, their experience on contraceptive use and the factors that influenced access to contraception.

#### **3.2 DATA PRESENTATION**

The data collection instrument was a 40 item questionnaire (Appendix B). Data was collected over a period of 5 days and 196 respondents participated in the study. In the study 230 questionnaires were issued to allow for non response rate and for unusable questionnaires. Questionnaires that were incomplete and those which were filled by people outside the specified target group between the 21- 49 age bracket were discarded. The data was analysed using SPSS version 16.0 and STATA 10 computer programs and the results are presented in descriptive statistics using frequency tables and percentages.

#### **3.3 DEMOGRAPHIC CHARACTERISTICS**

##### **3.3.1 Demographic characteristics of the participants**

The first section of the questionnaire covered the demographic characteristics of the respondents, which was answering the first objective of determining the socio-demographic characteristics of people living with HIV in selected communities in Siteki, Swaziland in relation to contraceptive use. The demographic data covered the gender, age, level of education, marital status, source of income and the year HIV status was known by the respondents.

### ***Respondents age***

All respondents 100% (N=196) answered this question. The respondent's age ranged from 21 to 49 years. Of the respondents, 21.4 % (n=42) were between the age 21-25; 19.9% (n=39) were between the age range 26-30; 12.2% (n=24) were between the age 31-35; 17.9% (n=35) were between the age 36-40; 17.3% (n=34) were between the age 41-45; 11.2% (n=22) were between the age 46-49 (see table 3.1).

**TABLE 3.1 RESPONDENTS' AGE (N=196)**

<b>Age category in years</b>	<b>Frequency</b>	<b>% (n=196)</b>
21-25	42	21.4
26-30	39	19.9
31-35	24	12.2
36-40	35	17.9
41-45	34	17.3
46-49	22	11.2
<b>Total</b>	<b>196</b>	<b>100</b>

### ***Respondents' gender***

All respondents' answered this question 100% (N=196). Of the respondents, 19.4 % (n=38) were males and 80.6% (n=158) females (see table 3.2). The females outnumbered the males, which could be an indication that more HIV positive women volunteered to participate in this study or that there are more females registered in the support groups.

**TABLE 3.2 RESPONDENTS' GENDER (N=196)**

<b>Currently using contraceptives</b>		
<b>Gender</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Male</b>	38	19.4
<b>Female</b>	158	80.6
<b>Total</b>	196	100

### *Respondents' level of education*

All respondents 100% (n=196) responded to this question. Of the respondents, 9.7% (n=19) had never been to school; 33.7% (n=66) had primary education; 24% (n=47) had a secondary education; 25.5% (n=50) had a high school education; and 7.1% (n=14) had a university education (see table 3.3).

**TABLE 3.3 RESPONDENTS' LEVEL OF EDUCATION (N=196)**

Education level	Frequency	Percent
Never been to school	19	9.7
Primary	66	33.7
Secondary	47	24
High school	50	25.5
University	14	7.1
<b>Total</b>	<b>196</b>	<b>100</b>

### *Marital Status*

All respondents answered this question 100% (n=196). Of the respondents' 30.61% (n= 60) were single; 40.82% (n=80) were married; 4.6% (n=9) were separated; 9.7% (n=19) were cohabitating; and 14.3% (n=28) were widowed (see table 3.4).

**TABLE 3.4 RESPONDENTS MARITAL STATUS (N=196)**

Marital status	Frequency	Percent
Single	60	30.6
Married	80	40.8
Separated	9	4.6
Cohabitating	19	9.7
Widowed	28	14.3
<b>Total</b>	<b>196</b>	<b>100</b>

### *Source of income*

All respondents' answered this question 100% (n=196). Of the respondents 34.18% (n=67) were self employed; 8.1% (n=16) were farmers; 6.12% (n=12) were civil servants; 5.10% (n=10) were working in companies; 39.80% (n=78) were unemployed and 6.63% (n=13) were still at school (see Table 3.5).

**TABLE 3.5 RESPONDENTS SOURCE OF INCOME (N=196)**

<b>Source of Income</b>	<b>Frequency</b>	<b>Percent</b>
<b>Self employed</b>	67	34.18
<b>Farmers</b>	16	8.1
<b>Civil servants</b>	12	6.12
<b>Company worker/ labourer</b>	10	5.1
<b>Unemployed</b>	78	39.8
<b>At school</b>	13	6.63
<b>Total</b>	<b>196</b>	<b>100</b>

### *The year diagnosed as HIV positive*

All respondents answered this question 100% (n=196). Of the respondents 0.5 % (n=1) knew their HIV status in 1996; 1.5% (n=3) in 1998; 1% (n=2) in 1999; 3.1% (n=6) in 2000; 2.1% (n=4) in 2001; 2.6% (n=5) 2002; 4.6% (n=9) in 2003; 3.1% (n=6) in 2004; 9.7% (n=19) in 2005; 13.8% (n=27) in 2006; 11.7% (n=23) in 2007; 21.9% (n=43) in 2008; 16.3% (n=32) in 2009; 8.2% (n=16) in 2010.(see Table 3.6)



**TABLE 3.6: YEAR DIAGNOSED AS HIV POSITIVE**

Year diagnosed with HIV	Frequency	Percent
1996	1	0.5
1998	3	1.5
1999	2	1.0
2000	6	3.1
2001	4	2.0
2002	5	2.6
2003	9	4.6
2004	6	3.1
2005	19	9.7
2006	27	13.8
2007	23	11.7
2008	43	21.9
2009	32	16.3
2010	16	8.2
<b>Total</b>	<b>196</b>	<b>100</b>

### 3.3.2 DEMOGRAPHICS AND USE OF CONTRACEPTION

#### *Age and contraceptive use*

Among the respondents 84% (n=164) were using contraceptives among these 19.5% (n=32) were aged 21-25; 20% (n=33) were aged 26-30; 13% (n=22) were aged 31-35; 17.6% (n=29) were aged 36-40; 18.9% (n=31) were aged 41-45; and 10% (n=17) were aged 46-49 years (see table 3.7).

**TABLE 3.7 AGE OF RESPONDENTS CURRENTLY USING CONTRACEPTIVES (N=196)**

Currently using contraceptives						
	YES (N=164)		NO (N=32)			
Age category in years	Frequency	%	Frequency	%	Total (N=196)	%
21-25	32	19.5	10	31	42	21.4
26-30	33	20	6	19	39	19.9
31-35	22	13	2	6	24	12.2
36-40	29	17.6	6	19	35	17.9
41-45	31	18.9	3	9	34	17.3
46-49	17	10	5	16	22	11.2
<b>Total</b>	<b>164</b>	<b>100</b>	<b>32</b>	<b>100</b>	<b>196</b>	<b>100</b>

***Marital status and contraceptives use***

The respondents marital status was tabulated against contraceptive use, 84% (n=164) of the respondents were currently using contraceptives. Among these 26% (n=43) were single; 47.5% (n=78) were married; 5% (n=9) were separated; 10.9% (n=18) were cohabitating; and 9.7% (n=16) were widowed (see table 3.8).

The married respondents recorded a 47.5% use of contraception, among the married users 27% (n=21) used contraception for only prevention of pregnancy and not sexually transmitted infections.

**TABLE 3.8 MARITAL STATUS AND CONTRACEPTIVE USE**

Contraceptives currently being used																		
Marital Status	Pill		Inject-able		Loop		Male condom		Female condom		Tuba ligation		With-drawl		Dual Method		Total	Total Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	(%)
<b>Single</b>	5	3	10	6	0	0	13	7.8	1	0.6	0	0	0	0	14	8.4	43	26
<b>Married</b>	6	3.66	10	6.1	2	1.22	36	22	2	1.22	0	0	3	1.83	19	11.6	78	47.5
<b>Separated</b>	1	0.55	1	0.55	0	0	5	2.75	0	0	0	0	0	0	2	1.1	9	5
<b>Cohabiting</b>	1	0.61	0	0	1	0.61	8	4.9	0	0	0	0	0	0	8	4.9	18	10.9
<b>Widowed</b>	2	1.22	4	2.44	0	0	7	4.3	0	0	1	0.6	0	0	2	1.22	16	9.7
<b>Total</b>	<b>15</b>	<b>9.04</b>	<b>25</b>	<b>15.1</b>	<b>3</b>	<b>1.83</b>	<b>69</b>	<b>41.7</b>	<b>3</b>	<b>1.82</b>	<b>1</b>	<b>0.6</b>	<b>3</b>	<b>1.83</b>	<b>45</b>	<b>27.22</b>	<b>164</b>	<b>100</b>

***Level of education and use of contraceptives***

Among the 100% (n=196) respondents in the study 84% (n=164) respondents were using contraceptives. Among these 9% (n=15) had no education and using contraceptives; 37% (n=60) had primary education; 26% (n=42) had secondary education; 21% (n=35) had high school; and 7% (n=12) had university education (see table 3.9).

**TABLE 3.9 LEVEL OF EDUCATION AND USE OF CONTRACEPTIVES**

Contraceptives currently being used																		
Level of Education	Pill		Inject- Able		Loop		Male condom		Female Condom		Tuba Ligation		With- drawl		Dual Method		Total	Total
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
No education	1	0.6	3	1.8	1	0.6	6	3.6	1	0.6	0	0.6	1	0.6	2	1.2	15	9
Primary	6	3.7	12	7.4	1	0.6	30	18.6	0	0	1	0.6	1	0.6	9	5.6	60	37
Secondary	5	3.1	4	2.5	1	0.6	15	9.3	1	0.6	0	0	1	0.6	15	9.3	42	26
High school	2	1.2	6	3.6	0	0	12	7.2	1	0.6	0	0	0	0	14	8.4	35	21
University	1	0.6	0	0	0	0	6	3.6	0	0	0	0	0	0	5	3	12	7
<b>Total</b>	<b>15</b>	<b>9.2</b>	<b>25</b>	<b>15.3</b>	<b>3</b>	<b>1.8</b>	<b>69</b>	<b>42.3</b>	<b>3</b>	<b>1.8</b>	<b>1</b>	<b>1.2</b>	<b>3</b>	<b>1.8</b>	<b>45</b>	<b>27.5</b>	<b>164</b>	<b>100</b>

*Source of income and use of contraception*

The use of contraception varied depending on the source of income. A total of 33% (n=55) among the users of contraceptives were self employed. The unemployed respondents had the highest number of non-users 44% (n=14). Whilst those working in companies were all using contraceptives 6% (n=10), followed by civil servants and farmers who had 6% (n=2) non users of contraception (see table 3.10).

**TABLE 3.10 RESPONDENTS SOURCE OF INCOME AND USE OF CONTRACEPTION (N=196)**

Source of income	Currently using contraceptives			
	YES		NO	
	Frequency	%	Frequency	%
Self employed	55	33	9	28
Farmers	13	8	2	6
Civil servants	11	7	2	6
Company worker	10	6	0	0
Unemployed	67	41	14	44
At school	8	5	5	16
<b>Total</b>	<b>164</b>	<b>100</b>	<b>32</b>	<b>100</b>

### *Year HIV status was known and contraceptive use*

All respondents answered this question 100% (n=196). Among the 196 respondents 84% (N=164) of the respondents were using contraceptives, of these 9.1% (n=15) knew their HIV status between the years 1996-2000; 15% (n=24) 2001-2005; 76.2% (n=125) 2006-2010. 42.1% (n=69) across were using condoms; 27.4% (n=45) were using dual methods (condom + injection or pill) (see table 3.11). Knowing your HIV status does not compel one to use contraception.

**TABLE 3.11 YEAR HIV STATUS KNOWN AND CONTRACEPTIVE USE (N=164)**

Number of years HIV status was known	Pill		Inject-Able		Loop		Male condom		Female condom		Tuba ligation		With-drawl		Dual Method		Total	Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<b>1996-2000</b>	3	1.83	3	1.83	1	0.61	3	1.83	0	0	0	0	0	0	5	3.05	15	9.14
<b>2001-2005</b>	2	1.22	2	1.22	1	0.61	11	6.71	0	0	1	0.61	0	0	7	4.27	24	14.6
<b>2006-2010</b>	10	6.1	20	12.2	1	0.61	55	33.5	3	1.83	0	0	3	1.83	33	20.13	125	76.21
<b>Total</b>	15	9.15	25	15.2	3	1.83	69	42.0	3	1.83	1	0.61	3	1.83	45	27.45	164	100

### **3.4 CONTRACEPTIVES FAVOURED BY PEOPLE LIVING WITH HIV**

This section of the questionnaire examined the respondents' knowledge of contraceptives types and exploring the type of contraceptive that is commonly used by PLWHA, which was the second objective of this study.

#### *Knowledge about contraception*

The respondents were asked to tick from the list provided the number of contraceptives they know to determine their knowledge. To determine the degree of knowledge the responses were categorised, those that knew three contraceptives had low knowledge, four to six contraceptives was categorised as moderate knowledge and those who knew between seven to nine contraceptives were categorised as having high knowledge.

All the respondents 100% (n=196) answered this question. A total of 17.9% (n=35) of the respondents knew between 1-3 types of contraceptives; 47% (n=93) between 4-6 types of contraceptives; and 34.7% (n=68) between 7-9 types of contraceptives (see table 3.12).

**TABLE 3.12 LEVEL OF CONTRACEPTIVES KNOWLEDGE BY RESPONDENTS (N=196)**

Level of contraceptive knowledge	Frequency	Percent
Low	35	17.9
Medium	93	47.4
High	68	34.7
<b>Total</b>	<b>196</b>	<b>100</b>

**Among the users of contraceptives** 18.29% (n=30) had a low knowledge; 50.6% (n=83) had medium knowledge; 31.1% (n=51) had high knowledge (see table 3.13). Those with a low knowledge commonly used injection 33% (n=10) and condoms 37% (n=11); while 6.6% (n=2) are making use of the dual contraception method. Among those with a medium knowledge half used condoms 51% (n=42); 25% (n=21) used dual contraception. Those that had high knowledge the majority used dual contraception 43% (n=22); and 37% (n=19) used condoms (see table 3.13).

**TABLE 3.13 CONTRACEPTIVE KNOWLEDGE AND CONTRACEPTIVE USE**

Contraceptives currently being used																		
Contraceptive knowledge	Pill		Inject-Able		Loop		Male Condom		Female condom		Tuba Ligatio		With-drawl		Dual Method		Total	Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
<b>Low</b>	4	13.3	10	33.3	2	6.6	11	36.6	0	0	0	0	1	3.33	2	6.6	30	18.29
<b>Moderate</b>	5	6	12	14.4	1	1.2	40	48	2	2.4	0	0	2	2.4	21	25.3	83	50.60
<b>High</b>	6	11.7	3	5.8	0	0	18	35.2	1	1.9	1	1.9	0	0	22	43	51	31.1
<b>Total</b>	15	9.14	25	15.24	3	1.82	69	42	3	1.82	1	0.61	3	1.82	45	27.4	164	100

### *Ever used contraception*

The majority of the respondents 98.5% (193) of the respondents answered the question on whether they had ever used contraception or not, 90.3% (n=177) once used contraception, 8.2% (n=16) never used contraception and 1.5% (n=3) did not answer the question (see table, 3.14).

**TABLE 3.14 EVER USED CONTRACEPTION (N=196)**

Ever used contraceptives	Frequency	Percent
Yes	177	90.3
No	16	8.2
None response	3	1.5
<b>Total</b>	<b>196</b>	<b>100</b>

### *Contraceptives currently used by people living with HIV and AIDS*

Not all respondents answered this question as some were not using contraception during the study, those that were currently using contraceptives were 83.7% (n=164). Of the 164 respondents that were currently using contraceptives 9.1% (n=15) were on the Pill; 15.2% (n=25) Injection; 1.8% (n=3) Loop; 42.1% (n= 69) Male condom; 1.8% (n=3) Female condom; 0.6% (n=1) tubal ligation; 1.8% (n=3) Withdrawal; 27.4% (n=45) Dual (see table 3.15).

Contraceptives that had zero recordings included Spermicides and vasectomy.

**TABLE 3.15 CONTRACEPTIVES CURRENTLY USED BY RESPONDENTS (N=164)**

Contraceptives currently used by respondents'	Frequency	Percent
<b>Pill</b>	15	9.1
<b>Injectables</b>	25	15.2
<b>Loop</b>	3	1.8
<b>Male condom</b>	69	42.1
<b>Female condom</b>	3	1.8
<b>Tubal ligation</b>	1	0.6
<b>Withdrawal</b>	3	1.8
<b>Spermicides</b>	0	0
<b>Vasectomy</b>	0	0
<b>Dual</b>	45	27.4
<b>Total</b>	<b>164</b>	<b>100</b>

### 3.5 EXPERIENCES ON CONTRACEPTIVE USE AMONG PEOPLE LIVING WITH HIV AND AIDS.

This section of the questionnaire question 20-25 covered experience of the respondents on the use, support received when using contraception and side effects resulting from contraceptive use.

#### *Ease of using contraceptives*

All the respondents using contraceptives answered this question 100% (n=177). Among these 80% (n=142) said it was easy to use contraceptives while 19.7% (n=35) indicated that they are finding it difficult to use contraceptives (see table 3.16).

**Table 3.16** Ease of using contraceptives (n=177)

Ease of using contraceptives	Frequency	Percent
Easy	142	80
Difficult	35	19.7
<b>Total</b>	<b>177</b>	<b>100</b>

#### *Partner support on contraceptive use*

A total of 84% (n=164) of the respondents currently using contraceptives answered this question, among those 83% (n=136) said they were not supported by their partners while 17% (n=28) were supported by their partners (see table 3.17).

Most of those supported by partners, 45.6% (n=62) were using condoms followed by 25.7% (n=35) that were making use of the dual method. Among those not supported by partners 35.7% (n=10) were using the dual method and 35.7% (n=10) were using condoms. This state of affairs might account for inconsistency in the use of condoms because of the lack of support from the partner.

**TABLE 3.17 PARTNER SUPPORT ON CONTRACEPTIVE USE**

Contraceptives currently being used																		
Partner support	Pill		Inject-Able		Loop		Male condom		Female condom		Tubal ligation		Withdrawal		Dual Method		Total	Total Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Yes	15	11	20	14.7	3	2.2	60	44	2	1.5	1	0.73	3	2.2	35	25.7	136	83
No	5	17.8	5	10.8	0	0	9	6.6	1	3.5	0	0	0	0	10	35.7	28	17
<b>Total</b>	20	12.2	25	15.2	3	1.83	69	42.19	3	1.83	1	0.61	3	1.83	45	27.4	164	100

***Side effects on contraceptives being used***

This question was answered by 128 people out of the 164 respondents currently using contraceptives. Some of the side effects that the participants experienced with the contraceptives that they were currently using include: 13.2% (n=17) complained of headache; 10.9% (n=14) a heavy flow; 14.7% (n=19) had no periods; 1.6% (n=2) experienced period cramps; 7.8% (n=10) have gained weight; 1.6% (n=2) have lost weight; 3.1% (n=4) complained of nausea; 6.2% (n=8) had itchy private parts; 2.3% (n=3) experienced a low libido; 0.8% (n=1) experienced longer periods; 3.1% (n=4) often forgot to take the contraceptive; 1.6% (n=2) had difficulty in using the contraceptive, with the main reason given being the experience of vaginal discharge in 33.3% (n=43) of the participants (see Table 3.18).

Vaginal discharge was experienced by a majority of the respondents using contraception which is an indication of inconsistent use of condoms / protection during sexual intercourse. Among those with vaginal discharge a majority 65% (n=28) were using condoms and only; 19% (n=8) were using dual method.



**TABLE 3.18: EXPERIENCE ON CONTRACEPTION AND CONTRACEPTIVE USE**

Contraceptives used by respondents'																		
Side effects	Pill		Inject- Able		Loop		Male condom		Female condom		Tuba ligation		With- drawl		Dual Method		Total	Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Headache	0	0	5	3.9	0	0	3	2.34	0	0	0	0	0	0	8	6.24	17	13.28
Heavy period	0	0	4	3.12	1	0.78	1	0.78	1	0.78	0	0	0	0	7	5.46	14	10.93
No Period	1	0.78	9	7.02	0	0	1	0.78	0	0	1	0.78	0	0	7	5.46	19	14.84
Period cramps	0	0	0	0	1	0.78	0	0	0	0	0	0	1	0.7	0	0	2	1.56
Gained weight	0	0	4	3.12	0	0	2	1.56	0	0	0	0	0	0	4	3.12	10	7.81
Lost weight	0	0	0	0	0	0	1	0.78	0	0	0	0	0	0	1	0.78	2	1.56
Nausea	0	0	0	0	0	0	1	0.78	3	2.34	0	0	0	0	0	0	4	3.12
Itchy private Parts	2	1.56	2	1.56	0	0	0	0	1	0.78	0	0	0	0	3	2.34	8	6.25
Low libido	1	0.78	0	0	0	0	1	0.78	0	0	0	0	0	0	1	0.78	3	2.34
Long period	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0.78	1	0.78
Discharge	7	5.46	0	0	0	0	27	21.06	1	0.78	0	0	0	0	8	6.24	43	33.59
Often forget	1	0.78	0	0	0	0	2	1.56	0	0	0	0	0	0	1	0.78	4	3.12
Difficulty in Using it	1	0.78	0	0	0	0	1	0.78	0	0	0	0	0	0	0	0	2	1.56
<b>Total</b>	13	10.14	24	18.7	2	1.56	40	31.2	6	4.68	1	0.78	1	0.7	41	31.9	128	100

### 3.6 FACTORS THAT INFLUENCE ACCESS TO CONTRACEPTIVE SERVICES

This section (Q22, 26, 28-33) covers availability of health facility in the area, source of information and knowledge about contraceptives in the area.

#### *Availability of health facility in the area*

All respondents (n=196) answered this question, with 70.9% (n=139) indicated that there was a facility available in their area while 29.1% (n=57) had no facility in the area where they reside (see table 3.19).

**TABLE 3.19 AVAILABILITY OF A FACILITY PROVIDING CONTRACEPTION IN THE AREA (N=196)**

Place providing contraception in the area	Frequency	Percentage
Yes	139	70.9
No	57	29.1
<b>Total</b>	<b>196</b>	<b>100</b>

Among those who were using contraceptives 100% (n= 164), 70% (n=114) had the facility in their area; 30.5% (n=50) did not have a health facility in their area (see table 3.20).

**TABLE 3.20 AVAILABILITY OF A FACILITY IN THE AREA AND CONTRACEPTIVE USE (N=164)**

Contraceptives currently being used																		
Health Facility in area	Pill		Injectable		Loop		Male condom		Female condom		Tubal ligation		Withdrawal		Dual Method		Total	%
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Yes	13	7.93	21	12.81	3	1.83	43	26.23	3	1.83	0	0	1	0.61	30	18.3	114	69.5
No	2	1.22	4	2.44	0	0	26	15.85	0	0	1	0.61	2	1.22	15	9.15	50	30.5
<b>Total</b>	<b>15</b>	<b>9.15</b>	<b>25</b>	<b>15.25</b>	<b>3</b>	<b>1.83</b>	<b>69</b>	<b>42.08</b>	<b>3</b>	<b>1.83</b>	<b>1</b>	<b>0.61</b>	<b>3</b>	<b>1.83</b>	<b>45</b>	<b>27.45</b>	<b>164</b>	<b>100</b>

*Contraceptive information during post counseling on HIV and AIDS*

All the respondents answered this question 100% (n=196). A total of 87% (n=170) have received information on contraceptives while 13% (n=26) indicated that they did not receive any information on contraceptives during post counseling on HIV and AIDS (see table 3.21).

**TABLE 3.21 CONTRACEPTIVE INFORMATION ON POST COUNSELING FOR HIV AND AIDS (N=196)**

Information	Frequency	Percentage
Yes	170	87
No	26	13
<b>Total</b>	<b>196</b>	<b>100</b>

*Source of information on knowledge about contraceptives*

All the respondents answered this question 100% (n=196), with 6.12% (n=12) receiving their information from the television; 16.84% (n=33) from the radio; 4.59% (n=9) from the news paper; 56.63% (n=111) at the clinic; 13.27% (n=26) from friends and 2.55% (n=5) received their information from other sources (see table 3.22).

**TABLE 3.22 SOURCE OF INFORMATION ON CONTRACEPTIVES (N=196)**

Source of information	Frequency	Percent
Television	12	6.12
Radio	33	16.84
Newspaper	9	4.59
Clinic	111	56.63
Friends	26	13.27
Other	5	2.55
<b>Total</b>	<b>196</b>	<b>100</b>

*Motivation to use contraception*

All the respondents that were currently using contraceptives answered this question 100% (n=164). From the respondents 12.1% (n=20) were using contraceptives to prevent pregnancy; 27.4% (n=45) for the prevention of sexually transmitted diseases; 5.5% (n=9) for child spacing; and 55% (n=90) used contraception for the prevention of HIV (see table 3.23).

**TABLE 3.23 RESPONDENTS' MOTIVATION TO USE CONTRACEPTION (N=164)**

Motivation to use contraceptives	Frequency	Percent
To prevent pregnancy	20	12.1
To prevent STIs	45	27.4
Child spacing	9	5.5
Prevention of HIV	90	55
<b>Total</b>	<b>164</b>	<b>100</b>

***Desire to have children***

All the respondents answered this question 100% (n=196). Of the respondents 32.14% (n=63) desired to have children; while 67.86% (n=133) indicated that they do not want any children/ additional children. This was an important aspect of the study because the desire to have children or not to have them has an influence on the use or non use of contraception (see table 3.24). Literature reviewed indicated that despite their HIV status there is a desire of HIV positive people to have children (WHO, 2008; MH & SW, 2002).

**TABLE 3.24 RESPONDENTS DESIRE TO HAVE A CHILD (N=196)**

<b>Desire to have children</b>	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	63	32.14
<b>No</b>	133	67.86
<b>Total</b>	<b>196</b>	<b>100</b>

***Marital status and the desire to have children***

All respondents answered the question regarding their desire to have children 100% (n=196), among the respondents 32% (n=63) desired to have children. Among those who desired children 38 % (n=24) that were single desire to have children; 37% (n=23) were married; 3% (n=2) were separated; 17% (n=11) were cohabitating; and 5% (n=3) were widowed (see table 3.5). A majority of the respondents’ that desired to have children were married, which may be a result of the marital role of reproduction. See table 3.25.

**TABLE 3.25 MARITAL STATUS AND THE DESIRE TO HAVE CHILDREN**

<b>Desire to have children</b>						
<b>Marital status</b>	<b>Yes</b>		<b>No</b>		<b>Total</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>
<b>Single</b>	24	38	36	27	60	30.6
<b>Married</b>	23	37	57	43	80	40.8
<b>Separated</b>	2	3.2	7	5	9	4.6
<b>Cohabitating</b>	11	17.5	8	6	19	10
<b>Widowed</b>	3	4.8	25	19	28	14.3
<b>Total</b>	<b>63</b>	<b>100</b>	<b>133</b>	<b>100</b>	<b>196</b>	<b>100</b>

*Desire to have children and contraceptive use*

Among the 196 respondents 84% (n=164) were using contraceptives among these 33% (n=54) still had the desire to have children and 67% (n=110) did not desire to have children. Among those who were not using contraceptives 16% (n=32), 28% (n=9) desired children and were not using contraceptives; what is worth noting is that there were 72% (n=23) respondents with an unmet need. These are the people who are not using contraceptives and yet they do not want to have children. (See table 3.26). Literature indicates that there is an unmet need on contraceptive services as some women do not use any form of contraceptive yet they do not desire to have children.

**TABLE 3.26 DESIRE TO HAVE A CHILD AND CONTRACEPTIVE USE**

Desire to have children	Currently using contraceptives					
	YES		NO		Total	
	N	%	N	%	N	%
YES	54	33	9	28	63	32
NO	110	67	23	72	133	67.8
<b>TOTAL</b>	<b>164</b>	<b>100</b>	<b>32</b>	<b>100</b>	<b>196</b>	<b>100</b>

*Living children and the use of contraceptives*

A majority of the respondents, 78.5% (n=154) on contraceptive had previous children. Among these respondents with children 18% (n=29) had 1 child; 21.43% (n=33) had 2 children; 16.9% (n=26) had 3 children; 13% (n=20) had 4 children; 11.7% (n=11) had 5 children; 7.14% (n=11) had 6 children; 8.44% (n=13) had 7 children; 1.3 % (n=2) had 8 children and 1.3% (n=2) had 9 children. (see table 3.27) .

TABLE 3.27

## NUMBER OF LIVING CHILDREN AND CONTRACEPTIVE USE

Contraceptives currently being used																		
No of Children	Pill		Inject-Able		Loop		Male Condom		Female condom		Tubaligation		Withdrawal		Dual		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1	3	1.92	3	1.92	1	0.64	13	8.32	0	0	0	0	0	0	9	5.76	29	18.8
2	2	1.28	3	1.92	1	0.64	14	8.96	0	0	0	0	0	0	13	8.32	33	21.4
3	2	1.28	6	3.84	0	0	7	4.48	2	1.28	0	0	0	0	9	5.76	26	16.8
4	1	0.64	4	2.56	0	0	9	5.76	0	0	1	0.64	1	0.64	4	2.56	20	13
5	1	0.64	5	3.2	0	0	8	5.12	0	0	0	0	0	0	4	2.56	18	11.6
6	2	1.28	1	0.64	1	0.64	5	3.2	0	0	0	0	0	0	2	1.28	11	7.1
7	1	0.64	2	1.28	0	0	5	3.2	1	0.64	0	0	2	1.28	2	1.28	13	8.4
8	1	0.64	0	0	0	0	1	0.64	0	0	0	0	0	0	0	0	2	1.3
9	0	0	0	0	0	0	1	0.64	0	0	0	0	0	0	1	0.64	2	1.3
<b>Total</b>	<b>1</b>	<b>8.32</b>	<b>24</b>	<b>15.36</b>	<b>3</b>	<b>1.92</b>	<b>63</b>	<b>40.32</b>	<b>3</b>	<b>1.92</b>	<b>1</b>	<b>0.64</b>	<b>3</b>	<b>1.92</b>	<b>44</b>	<b>28.16</b>	<b>154</b>	<b>100</b>

*Information on contraceptives during post counseling and contraceptive use*

Among the 164 respondents using contraceptives 100%, 89% (n=146) received information regarding contraception during post counseling while 11% (n=18) did not receive information during HIV test post counseling. The majority of the respondents whether receiving information on post counseling or not, predominantly used dual contraception and condoms. Predominantly, 36.6% (n=60) of those who received counseling were using condoms and 23.8% (n=39) were using dual contraception. Among those who did not receive information on contraceptive use during post counseling 5.49% (n=9) were using condoms and 3.66% (n=6) were using dual contraception (see table 3.28).

**TABLE 3.28 RECEIVING INFORMATION ON POST COUNSELING FOR HIV AND CONTRACEPTIVE USE**

Contraceptives currently being used																		
Received Post counseling Information	Pill		Inject-able		Loop		Male Condom		Female condom		Tuba ligation		With-drawl		Dual Method		Total	Percent
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<b>Yes</b>	14	10	24	16	3	2	60	41	3	2	1	0.68	2	1.4	39	26.7	146	100
<b>No</b>	1	5.5	1	5.5	0	0	9	50	0	0	0	0	1	5.5	6	33.3	18	100
<b>Total</b>	<b>15</b>	<b>15.5</b>	<b>25</b>	<b>21.5</b>	<b>3</b>	<b>2</b>	<b>69</b>	<b>91</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0.68</b>	<b>3</b>	<b>6.9</b>	<b>45</b>	<b>60</b>	<b>164</b>	<b>100</b>

***Reasons for not using contraceptives***

Among the 196 respondents there were only 16% (n=32) who were not using any contraceptives. Reasons given for not using contraceptives included: 6.2% (n=2) had health concerns; 6.2% (n=2) had no partner support; 3.1% (n=1) found contraceptives to be expensive; 3.1% (n=1) indicated that the health facility was too far; 3.1% (n=1) wanted to have children; for 75% (n=24) the reason given was a lack of knowledge on contraceptives while 3.1% (n=1) had no steady sexual partner (see table 3.29).

**TABLE 3.29 REASONS FOR NOT USING CONTRACEPTIVES**

Reason	Frequency	Percentage
<b>Health concerns</b>	2	6.2
<b>No support from partner</b>	2	6.2
<b>Expense</b>	1	3.1
<b>Facility is far</b>	1	3.1
<b>Desire to have children</b>	1	3.1
<b>Lack of knowledge</b>	24	75
<b>No sex partner</b>	1	3.1
<b>Total</b>	<b>32</b>	<b>100</b>

### **3.7 CONCLUSION**

This chapter discussed the data analysis according to the items on the questionnaire. Reference was made to literature reviewed where applicable. The next chapter summarizes and discusses the findings.



## **CHAPTER FOUR**

### **DATA ANALYSIS & DISCUSSION**

#### **4.1 INTRODUCTION**

In this chapter results obtained are interpreted and discussed with reference to the reviewed literature. The data was analysed according to the research objectives of this study.

#### **4.2 DEMOGRAPHIC CHARACTERISTICS OF PLWHA IN SELECTED COMMUNITIES IN SITEKI SWAZILAND**

The demographic data covered the respondents' age, gender, level of education, source of income, marital status, and the year HIV status became known to the respondents. This section answers the first objective of the study, which was to determine the socio-demographic characteristics of people living with HIV and AIDS.

##### ***Respondents' age***

The age group 21- 49 was selected to address the objectives of the study because reviewed literature indicated that in general this is regarded as the sexually reproductive years (Williamson *et al*, 2009). A drop in the number of respondents was observed in the age group between 31 and 35 years (12.2%, n = 24) and an increase was evident in the age groups 36 to 40 and 41 to 45 years, with a representation of 17% of the total population for each age category respectively. These results of this study present that the highest number of HIV-infected participants were in the younger age groups, and this is in agreement with the Swaziland (2007) results that reported a high prevalence among the age groups 20 to 24 (38% positive) and 25 to 29 (49% positive) respectively. It is also worth noting that this is the age bracket with the highest population, which is important information for programme planning for reproductive interventions in Swaziland (Swaziland, 2007).

### ***Gender***

In the selected support groups of PLWHA in Siteki the female respondents outnumbered the males by 80.6% (n = 158) to 19.4% (n = 38). Although the literature report that women are more likely to be HIV positive than men with a reported prevalence of 31% amongst women and 20% amongst men aged 15-49 years (Swaziland, 2007; UNAIDS, 2010), the findings of this study could be an indication that there is a higher registration of females in the support groups for PLWHA or that females were more willing to participate when compared to males.

### ***Education level***

People who have reached the secondary level of education are expected to understand issues of contraception and should have adequate knowledge of the methods available and places to access them. The community health survey of 2002 reports that 32.4% females and 29.4% males have primary education; 58% females and 59.9% males had a secondary or higher education (MH& SW, 2002). The last population and housing census that was conducted in Swaziland in 2007 revealed that nationally 17.8% of females had secondary education while only 0.7% had tertiary education (Swaziland, 2007).

As can be seen in Table 3.3 the percentage of participants with secondary and high school education decreased with age while the proportion of those with no education 9.7% (n=19), were mainly older participants. When compared to the national results there has been an increase in secondary education attainment, whilst tertiary education remains low in this community.

It is very important that health promotion programmes on contraceptives also incorporate education strategies that will reach the illiterate population who are in need of the information.

### ***Marital status and contraceptive use***

In this Siteki study, among those using contraceptives only about half 47.5% (n=78) of the respondents that were married and a quarter of those that were single (26%) were using contraceptives. This scenario is important because although literature indicates that those who are not in steady relationships are less likely to use contraception (Fleischman, 2006) the results of the Siteki study shows that even those in a steady relationship are not using contraceptives.

### **Source of income**

According to literature, the socio-economic status of women may contribute to their inability to use contraceptives as they depend on men economically and thus fail to have control in sexual negotiations (Massad, 2007). A great proportion, 39.8% (n=78), of the respondents in this rural community were unemployed. This study showed that the unemployed population were less likely to use contraception, presenting 44% (n=14) among non users of contraception who were unemployed. Another category that had a substantial number of respondents not utilising contraceptives was those who were still at school presenting 16% (n=5). Among the working respondents' from companies and civil servants 0% and 6% respectively, were not using contraceptives. This indicates that those in employment were more likely to use contraception.

### ***Period HIV status was known***

Results of this study show that there was an increase in the number of respondents who knew their HIV status for a period of time. A total of 21.9% (n=43) had been aware of their status since 2008; the figure was 16.3% (n=32) for 2009 and decreased to 8.2% (n=16) for 2010. There were 56% (n=105) respondents who were aware of their HIV status for more than three years. The Swaziland projections report (UNAIDS, 2010) indicates that the HIV prevalence has stabilised since 2008, which may explain the drop in those knowing their status from 2009 to 2010.

The important reason for knowing your HIV status in relation to contraception is that people living with HIV have to make use of dual contraception to prevent transmission of the HIV virus to their sexual partners.

## **4.2 CHOICE OF CONTRACEPTIVE USE OF PLWHA IN SELECTED COMMUNITIES IN SITEKI, SWAZILAND**

This section answered the second objective of the study which was to determine which form of contraception was more favored by the respondents. The high utilisation of condoms and dual methods is a positive sign about the protection against re-infection and unintended pregnancies. The need for the dual method is further emphasised by MacPhail *et al*, (2007) who state that women in long term relationships appear to be limited to the use of contraceptive methods that offer protection from sexually transmitted infections and HIV and infection.

According to Swaziland (2007) condom use in Swaziland is generally low, because it is commonly used in casual sexual encounters as they are perceived to be high risk partners, but once the relationship has been formalised men would have several sexual partners and not use protection or condoms. Swaziland (2007) also reported that condom use is the lowest among married couples and long term partners with only 12% of married women using them. The consistent use of condoms with partners, irrespective of marital status, is important for PLWHA. The findings of Swaziland (2007) are not in agreement with the findings of this study as the results showed that 73% (n=57) of the current users of contraception among married couples were using either the male or female condom or dual contraception. While among those who were single 65% (n= 28) were using condoms or the dual method.

The results of the study are different because this is a population of people living with HIV, therefore cannot be comparable to the general population. In addition, the population in this study is not a typical HIV positive population as they are a population who attend support groups so they may be more motivated than the average man in the street.

#### **4.3 EXPERIENCES WITH CONTRACEPTIVE USE AMONG PLWHA IN SELECTED COMMUNITIES IN SITHEKI, SWAZILAND**

This section covers the third objective which was to gather factual information about the experience on contraceptives use among people living with HIV and AIDS among support groups in Siteki, Swaziland.

What is worth noting is that the majority of those respondents who indicated that they were using contraceptives were among the married respondents at 47.5% (n=78) while those that had never used contraceptives were mostly from the group of singles at 81% (n=13). Contraceptive use was 5% (n=9) amongst those who were separated. The results also indicate that 80.6% (n=158) of the respondents that indicated that they were using contraceptive were females and 19.4% (n=38) were males. The MH & SW (2002) study reported that 61% of women and 94% of men who participated in that study were users of contraceptives. Reasons for the difference in gender distribution between these two studies could be because the target population was one constituency (Siteki) and not the whole Kingdom of Swaziland.

Reasons given for not using a contraceptive were that they did not have sexual partners and some were not in steady relationships. A high use of contraceptives among married people was observed and motivation given for the use was for child spacing and also for prevention of HIV and STIs. Notable 27% (n=21) of the married respondents' used contraception for prevention of pregnancy (see table 3.6, 3.21). Issues observed on the data were that there was a low use of contraception among the single respondents who may not be in stable relationships and are prone to engage in casual sex which necessitates protection from sexually transmitted infections and also unintended pregnancy.

The experiences that the PLWHA in Siteki had regarding contraception use included:

### ***Contraceptive information during post counseling on HIV and AIDS***

Information on contraceptives is important especially for PLWHA because they now have to use dual methods of contraception that will include a hormonal as well as a barrier method. This change in the emphasis on a contraception method is critical for PLWHA as they now have to protect themselves against re-infection. They also need to take care not to infect their partners, and they have to prevent unplanned pregnancies which may result in babies born with HIV.

The majority, 87% (n=170) of the participants in this Siteki study indicated that they have received information on contraceptives during post counseling on HIV and AIDS while 13% (n=26) said they did not receive any information on contraceptives. This is a good indicator of the integrated services and holistic information provided during post-test counseling for HIV. According to national statistics 58% of the women who were receiving their contraceptives from public facilities were informed about the available choices including the side effects of methods before using contraceptives (Swaziland, 2007). Similarly, the majority of the respondents in this study received their contraceptives from the public facilities that gave them access to information on contraceptives.

### ***Sources of information about contraceptives***

Literature indicates that information on contraceptives is mostly received from the radio, television and friends (Ijirigho, 2010). This study revealed that most of the information the respondents had was gained from the clinic 56.63% (n=111). This is attributed to the availability of health facilities in the area and the fact that these patients were visiting the facilities in order to obtain their medication Anti-Retro Viral drugs (ARVs). The radio and friends were their second and third source of information on contraception at 16.84% (n=33) and 13.27% (n=26) respectively. This finding concurs with the Swaziland (2007) report which indicated that 69% women and men had exposure to family planning information through the radio, MH&SW (2002) reports that 70% of woman and 74% of men listen to the radio almost every day and only 33% gain information from newspapers. This provides a medium for disseminating health promotion messages on contraception.

The results of this study indicate that only a few respondents indicated that they received information from both the newspaper and television. This may indicate that health promoters do not make efficient use of all mediums or that respondents' have infrequent access. This study revealed that the widespread coverage and availability of information, and it is essential that the facts are delivered correctly, by these sources. The Swaziland (2007) reports that exposure to information varies according to the demographic characteristics, rural women are less likely to be exposed to the television and newspaper than urban women.

### ***The ease of contraceptive use***

Among the respondents currently using contraceptives 84% (n=138) said using contraceptives was easy and 16% (n=26) said it was not easy. The usability of contraception may be explained by the fact that most of the respondents received their contraceptives from local health facilities, where education was provided and choices presented to them. Difficulty in using contraceptives could result from the fact that the peers and pharmacies, who provided information, may not have explained in detail how to manage the side effects.

### ***Partner support on contraceptive use***

According to Swaziland (2007) women who believe that their husband have a positive attitude toward contraception are more likely to use it, whereas women who do not talk to their husband about contraception are less likely to use it. In addition, disapproval of the partner is a significant drawback to contraceptive use in Swaziland (Gule, 1994). The MH&SW (2002) report found that 6% of female respondents did not use contraceptives because of opposition to use from their partners. This finding was confirmed by the Swaziland (2007) which indicated that 8.3% of the population without support from their partners was using contraceptives. However, McLean (1990) asserts that even though women report that their husbands or partners are the key decision makers in family planning and family size matters when it comes to practice behaviours, women seem to take matters into their own hands. Reasons presented in the literature for the non use of contraceptives are pressure to have sex without the necessary protection, lack of communication among partners and side effects related to contraception (Raine *et al*, 2010).

The implication is that some women will adopt family planning despite the disapproval of their partner. Among the 164 respondents in the Siteki study that were using contraceptives 83% (n=136) said they were supported by their partners while 17% (n=28) were not supported by their partners which means that among these respondents there is a high self motivation to use contraception.

### ***Side effects of contraceptive use***

The side effects experienced due to the use of contraceptives are influential in the initial decision to use contraceptives, the continuation with the chosen method as well as the satisfaction with the method and contraception. Literature indicates that fear of side effects contribute to the low uptake of contraception. In a study conducted by Bailey (2008) in Ghana she highlights that side effects account for the non-use of contraception with more women increasingly citing it as a reason increasing from 18% to 26% in 1998 and 2003. Similarly, in the United state researchers state that the worry over side effects is being cited by a majority of women as a barrier to use contraception (Sable *et al*, 2000).

A number of possible side effects options like headache, heavy flow, no periods, period cramps, gained weight, lost weight, nausea, itchy private parts, low libido, longer periods, often forget it, and difficulty in using the contraceptive were listed in the questionnaire to allow respondents to tick those they were experiencing. Amongst the listed side effects the highest response indicated vaginal discharge at 33.33% (n=43), followed by no period (14.73%, n=19), headache (13.18%, n=17) and a heavy period (10.85%, n=14).

Tuloro *et al*, (2006) reported that conditions that predispose women to vaginal discharge among others are the use of oral contraception and the presence of STIs especially when using only hormonal contraception without any barrier method such as a condom. The fact that 33.33% of the participants in the Siteki study were experiencing vaginal discharge as a side effect may be attributed to the gap in utilizing the condom or dual method. The results also indicated that 27.44% (n=45) of the respondents were using dual protection and 42% (n=69) were utilising condoms that prevent them from contracting STIs. This leaves a gap of 21% of respondents currently not using a barrier method as contraception and they may be exposed to STIs.

The data presented 14.74% (n=19) of the respondents having no period as a side effect. Literature indicates that women utilising injectables do experience loss of period (Mitchell & Stephens, 2004). According to the results of this study 15.24% (n=25) of the respondents were using injectables, which makes them prone to experiencing this side effect. The third side effect that ranked high was headache as indicated by 13.18% (n=17). Reviewed literature (Steen & Shapiro, 2004) indicate that oral contraception and injectables may cause headaches and as 9.15% (n=15) of the respondents were taking the pill, their headaches could have been attributed to their choice of contraceptive.

#### **4.5 FACTORS INFLUENCING CONTRACEPTIVE USE OF PLWHA IN SELECTED COMMUNITIES IN SITEKI, SWAZILAND**

This section covers the fourth objective of this study namely to determine the factors that influence access to contraceptives use and services for people living with HIV and AIDS among support groups in Siteki, Swaziland.



Research in HIV and AIDS health care system has revealed that the unmet need for contraception among PLWHA is greater than in the general population as indicated by the greater numbers of unintended pregnancies among this specific group of people (Cohen, 2008). Similarly in Swaziland there are reported cases of unintended pregnancies among women, even those enrolled in antiretroviral therapy programmes (Swaziland, 2007).

Some of the factors that could influence to access and use of contraceptive services are:

### ***Knowledge of contraceptives***

Information about contraceptive knowledge is a major determinant of positive attitudes towards the use of contraceptives. People with adequate knowledge about the benefits of contraception are more likely to use contraception than those who have less knowledge.

In general, the knowledge of the most readily available methods was widespread among the respondents of this Siteki study. The most commonly known contraceptive was the pill, injectables and the condoms at 96%, 92% and 100% respectively. Very few people knew about vasectomy (1%) and spermicides (0.5%) as forms of contraceptive while 56% of the respondents knew about withdrawal. The knowledge of contraceptives was the highest among the younger age groups (21-30 years), with 19% (n=38) out of the 196 respondents of this study knowing all nine types of contraceptives listed in the questionnaire.

The findings of this study resemble the findings from the MH &SW (2002) report on the awareness of the different contraceptive methods which reported that 99% of respondents were aware of condoms, 95% of the pill, 95% of injectables and 40% of the loop as common forms of contraceptive available at the local clinics. What is worth noting from the results of this study is that 18% (n=35) of the respondents had low knowledge about contraceptive methods but among them only 14% (n=5) were not using contraceptives. Whereas amongst those that had high knowledge 26% (n=51) a quarter, 25% (n=17) did not use contraceptives. Those that had high degree of knowledge did not necessarily use contraception. This is in agreement with Tuloro *et al* (2006) who reported that knowledge does not translate to practice. In the study knowledge was measured by knowing the contraceptive methods, knowledge of the correct methods for prevention of pregnancy and infection. Low knowledge referred to knowledge of only three contraceptive methods and also not being able to select the correct method for prevention of STIs and pregnancy.

### ***Age***

Literature on HIV positive people indicates that age has an effect on the use of contraception, as James *et al*, (2001) reported that when people are young and not married they tend not to use contraception. These findings of James *et al* (2001) is in contradiction to the findings of this Siteki study which indicated that 40% (n=65) of those participants that were using contraceptives were found to be between the ages 21-30 years. Whilst among the older respondents between the ages of 41-49 years there was a decrease to 30% of contraceptive usage. The findings of this Siteki study are in line with the community health survey (MH&SW, 2002) which indicated a high usage of contraceptives among the age groups 20-24 and 25-29 at 51% and 54 % respectively; and a decline in use among the age groups 40-44 and 45-49 at 36% and 25.6% respectively.

### ***Education***

According to Todd et al (2010) education contributes to knowledge and appreciation of health education information which results in the use of contraception. What is glaring from the results in this Swaziland study is that as the level of education increases the respondents also had the knowledge to use the correct methods of contraception for their status, which is the condom or dual method.

When comparing the level of education with type of contraceptive use the results showed that for those who had reached primary school 65% (n=39) used either condom or dual; among those who had reached secondary school 71% (n=32) of them using contraception were using condoms or the dual method; and lastly those who had reached high school 74% (n=26) were using the correct contraceptives and among those at tertiary education almost all of them 92% (n=11) using contraceptives were using the correct form of contraceptives.

### ***Reasons for using contraceptives***

The results show that 29% (n=48) of the respondents were only using contraceptives for prevention of pregnancy and not for the prevention of infections as well. This is a significant representation of the total population covered in this study as it represents roughly a quarter of the total respondents. The populations of PLWHA together with those who are not using

contraceptive are a public health concern as they may continue to infect others and re-infect themselves. A need for integrating reproductive health services with HIV services to ensure reinforcement of information on family planning in general and contraception in particular.

### ***Marital status***

Cooper (2007) reported that the marital status contributes to the use or non use of contraception as childlessness in marriage is often forbidden by cultural customs and traditions that afford childless women a lower status than those who have children. However, on the other hand sometimes those women not in a steady relationships have more decision making power than some women in traditional marriages or steady relationships because the gender power of the male partner on contraceptive decisions (type, use or not using) (Gule, 1994; WLSA, 1998).

In the Siteki study 98% of the 48% (n=75) married respondents were using contraceptives. The Swaziland demographic health survey reported 51% of currently married women using contraceptives (Swaziland, 2007). This result is much higher than the community health survey of 2002 which reported that married women and men accounted for 48% and 60% of those using contraceptives (MH&SW, 2002).

The difference in the percentages could be as a result of the sample sizes and study populations where the demographic health survey and the community survey present a picture of the general population and this study only presents results from a population of those living with HIV.

The high figures for married couples were followed by those who were single at 26% (n=43) and those who were cohabiting representing 10.9% (n=18) with those that were separated with the lowest representation 5% (n=9) utilising contraceptives. This is in agreement with literature (Fleischman, 2006) where it was reported that those not engaging in regular sexual activity or having constant relationships tend not to utilise contraceptives.

### ***Desire to have children***

Literature indicates that people living with HIV have the same desires as other population groups and the younger they are the more they desire to have children (Cooper *et al*, 2007). According to Tuloro *et al* (2006) HIV positive people desire children because in the African culture children

are perceived as an asset. The 'desire to have children' was important in this study because it influences the use or non use of contraception as literature indicated that HIV positive people do desire to have children and this decision resulting in them not using contraceptives, is aiding to the spread of the disease (WHO, 2008; MH& SW, 2002).

About a third, 32.14% (n=63) of the Siteki respondents indicated that they desire to have additional children while 67.86% (n=133) do not want any more children. When comparing contraceptive use and the desire to have children results revealed that 28% (n=54) of the respondents were using contraceptives and desiring to have children; 5% (n=9) were not using contraceptives and desiring to have children; and 56% (n=110) were using contraceptives and did not desire to have children. This is an indication that not desiring children was a strong factor that influenced the use of contraception, although there was also 12% (n=23) who had no desire for children and did not use contraceptives.

The findings in the study also indicated that the desire to have children decreased with age as in the age group 21-25, 12% (n=23); and the age group 26-30, 10% (n=19) indicated that they want children. This is totally in agreement with Cooper *et al* (2007) who articulate that people living with HIV who are young and not married do have a desire to have children especially with the availability of ARVs and PMTCT programmes. A relationship between age and the desire to have children was observed in the study which leads to the low utilization of contraception. The low utilization of contraception due to the desire to have children was common among the younger age group as they may not be using contraception consistently because they want to have children.

In Swaziland 75% of pregnant women were reported to have unintended pregnancies (Swaziland, 2007). This is an indication of the high need of information and coverage of reproductive health services not only in this community but countrywide. It is also an opportunity for entry for PMTCT services beginning from general contraception to assistance with pregnancy and delivery of the baby.

### ***Unmet need***

Among the Siteki respondents who knew their HIV status 84% (n=164) were utilizing contraceptives, indicating a 16% (n= 32) gap in use. The results also show that as people becoming aware of their HIV status there is an increase in contraceptive use. The respondents who knew their status between the year 2006-2010, 76% (n=125) were using contraceptives, and among these 70% (n=88) were using the correct methods, condoms and dual methods. This may be an indication of the increasing availability of services and access to information as HIV and AIDS became commonly known. The findings are in line with James *et al* (2001) who state that the people who know their status are aware of their susceptibility to infection and hence use protective measures to prevent infection, and when they have received counseling and information they are able to make informed decisions and choose the correct recommended methods for contraception for HIV positive persons.

### Availability of health facility in the area

According to literature the availability and type of health facility in the area influences the uptake of contraception (Katende, 2003). If there is a fully operational facility in the area it enhances the ability to access different health services e.g. family planning, Voluntary Counselling and Testing (VCT), and information sessions on possible choices for contraception enabling clients to comfortably choose a method that best fits them. The health facility can also assist in managing the complications and side effects as they arise as opposed to getting contraceptives over the counter. In the Siteki district three health facilities were indicated to be available that could provide family planning services including contraception. Results from the Siteki survey of the geographic or physical access to a facility indicated that 70.9% (n=139) of the respondents had a facility in the area where they are staying while 29.1% (n=57) had no facility in their area. The mean distance to the closest facility was 6 kilometers while those who indicated not to have a facility in the area referred to a mean travelling distance of 15 kilometers to the nearest health facility.

This is in agreement with the Ministry of Health and Social Welfare (MH & SW, 2008) linkages report which indicated that 80% of the population in Swaziland resides within 8 kilometers of a

health care unit, and 60% of the population is able to access the health facility within an hour. The results of this study confirmed in that there was no evidence that geographic access was constraining the use of contraception.

### ***Motivation to use contraceptives***

The findings of this study revealed that a majority 55.5% (n=90) of the respondents utilized contraception for the prevention of HIV re-infection. It is also important to note that the second largest group of respondents representing 27.4% (n=45) indicated that they were using contraceptives for the prevention of STIs. These results show that 83% (n=135) of the respondents were motivated to use contraceptives for the right reasons namely to prevent re-infections and new infections to partners. This finding concurs with Cohen (2008) and Galavotti and Schnell (1994) who also found that motivation to use contraceptives among people living with HIV is to prevent infection. However, 12% of the respondents used contraceptives because they wanted to prevent getting pregnant, which concurs with the study of Mitchell and Stephens (2004) which state that people living with HIV may use contraception but not for preventing infection but to prevent pregnancy. This category of respondents who choose contraception only to prevent pregnancy raises concern as they may not fully protect themselves and may not choose the right contraception methods for their HIV status.

### ***Administrative accessibility***

Bertrand *et al.* (1995) describe administrative accessibility as “the extent to which unnecessary rules and regulations that inhibit contraceptive choice and use are eliminated”. There are actually very few rules and regulations associated with contraceptive service provision in Swaziland. The most restrictive of these rules are related to the permanent methods of contraception. This study revealed that permanent methods are not commonly utilised in the Siteki district as only one person had done tubal ligation and no participants had done vasectomy. Reasons for this low uptake could be that for married women to have a sterilisation she needs consent from her husband (MH&SW, 2008) while men can have a vasectomy done without the consent of their wives.

### ***Cost***

Economic accessibility refers to the cost of reaching the service delivery or supply points and obtaining contraceptives services and supplies by the target population (Bertrand *et al.*, 1995). The findings of this study show that cost was not a barrier to the access and use of contraceptives as contraceptives are provided free of charge by the public health facilities where the majority, 70.9% (n=116) received their contraceptives from clinics and only 29.1% (n=48) indicated that they receive their contraceptives from the private sector. These findings differ from those of the DHS (2007) whereby only 38% of contraceptive users made use public facilities. The respondents in this study did not cite cost as a factor that influences access to contraception.

### ***Concerns on side effects***

Although a significant proportion of the contraceptive users, 78% (n=128) experienced side effects, they continued utilising the contraceptives and concerns about side effects did not feature as a strong barrier to using contraceptives among the non-users. Both the MH&SW (2002) and Swaziland (2007) reported that side effects were experienced by only 8% of the population that was studied.

### ***Marital power***

The marital power over women gives men the authority on reproductive decisions leaving the women with less or no opportunity to decide on sexual and reproductive issues and their need and access to contraception (Gule, 1994). Guttmacher (2010) agrees that unmet need is highest among poor married women and lower among economically able women.

The economically deprived groups and economic dependence on a man affected women as they do not have the power to negotiate contraceptive use if they are opposed by the man. According to Fleischman (2006), married women are pressurised to have children to prove their fertility and that people who are not in stable relationship may not use contraception because of the cultural expectation to have children (Maja, 2007), which then becomes a barrier to contraception use.

### ***Number of living children***

According to literature people living with HIV who had no children or do not have the number of children they desire tend not to use contraceptives (Mitchell & Stephens, 2004). Nostlinger, (2007) also states that a majority of the PLWHA are young and they are in the reproductive age group which makes them have the desire to enjoy parenthood and thus not use contraception despite their HIV status and the possibility of an HIV positive baby. This opinion is in line with the findings of this Siteki study as 12% of the respondents were not utilising contraceptives yet they already had children. The findings suggest the need for dissemination of reproductive health services that will not only provide for family planning services but also PMTCT which will cater for the needs of PLWHA.



## **CHAPTER FIVE**

### **CONCLUSIONS AND RECOMENDATIONS**

#### **5.1 INTRODUCTION**

Chapter four discussed the results and findings of the study with reference to the literature reviewed. This chapter presents conclusions and recommendations on the basis of the results of the study, and present areas for further future research.

#### **5.2 CONCLUSIONS ON OBJECTIVE ONE**

As expected the socio demographic characteristics of people living with HIV and AIDS resemble that of a general population in Swaziland. There was a higher representation of the young population, aged 21-30 years, when compared to other age groups which is in accordance to the population in the country (Swaziland, 2007). Registered female respondents outnumbered males in the support groups for PLWHA. This is in accordance with literature which indicates that women are more likely to be HIV positive than men (Swaziland, 2007; UNAIDS, 2010)

The majority of the respondents had no tertiary education, posing a problem to education strategies. This also has an impact on source of income as unemployment remains high in this constituency with less than 20% in a professional, semi skilled or skilled job. The half of the respondents was not in a steady relationship and the other half were married.

#### **5.3 CONCLUSIONS ON OBJECTIVE TWO**

The condom was the most favoured contraception or commonly used methods. This can be attributed to that fact that men are in control of the choice of contraceptive. There is still a gap in the promotion of dual method of contraception as only a third of the respondents were using this method which is the recommended method for PLWHA.

#### **5.4 CONCLUSIONS ON OBJECTIVE THREE**

Most of the participants received information on contraception during post-test counseling for HIV at the clinic which is a good indicator of the integrated services and holistic information provided to PLWHA. Although most people received information through health facilities, peer education and the radio were also very influential in the dissemination of information on contraception.

The majority of respondents found it easy to use contraceptives. Although there was a high use of contraceptives among married couples, a third of the married couples were using contraceptives for birth spacing and not for the prevention of STIs. As partner support leads to the increase in contraceptive usage, the results showed that among the respondents in this study there was a high motivation to use contraceptives despite the lack of male involvement and support.

Most of the participants currently using contraceptives did experience side effects but still continued using contraception irrespective of the discomfort.

#### **5.5 CONCLUSIONS ON OBJECTIVE FOUR**

Although knowledge of contraceptives was widespread among PLWHA this study revealed that knowledge does not lead to practice, which challenges the approaches used by health workers in programming for contraceptive services.

Education had a positive impact in the use of contraceptives as those with higher education attainment were using contraceptives and were found to be using the correct methods for their HIV status. Cultural norms, as cited in the literature (Gule, 1994) could have had an influence on contraceptive use, especially amongst the married women where gender imbalances in marriage are making it difficult for women to negotiate safer sex through the use of contraception.

Although many of the respondents were unemployed, the socioeconomic status was not a barrier to availability of contraceptives as it was available in the Siteki communities free of charge. Women remain minors in reproductive health decisions, as indicated by the need to have the husbands' consent when seeking sterilisation. Swaziland still upholds patriarchal standards that impact on the reproductive choices of women as men have to make decision concerning their sexuality.

Public health facilities providing contraception were accessible, and the majority of the respondents in the study utilised them. It can be concluded that the availability of health facilities promotes access and understanding of the methods and their side effects which influence sustaining use.

## **5.6 SUMMARY CONCLUSION**

It can be concluded that overall a significant number of the target population in the study were using contraceptives despite the demographics indicating that the majority of the respondents were experiencing barriers like not being educated and also being unemployed. The commonly used form of contraception in this group of people was the male condom. This is also regarded as the correct method of contraception for PLWHA this choice could have been the result of the information received during post counseling for HIV and AIDS. Although the knowledge on contraception was widespread, it was not put into practice as some respondents continued to use hormonal methods of contraception that could not prevent them from contracting sexually transmitted infections.

## **5.7 LIMITATIONS OF THE STUDY**

The study was limited to support groups of people living with HIV. The data was collected from PLWHA registered in support groups, richer data might have been obtained had it been possible to include entire population of PLWHA which was not possible due to limited resources (time, money and research assistants). The people involved only included those in the reproductive age group 21-49 years. The findings of the study can thus only be generalised to PLWHA in a similar setting.

## **5.8 RECOMMENDATIONS**

The following recommendations are made on the basis of the findings of this study.

- a) The higher representation of females in the support groups requires a concerted effort in addressing gender and cultural barriers on disclosure of HIV status and registration to support groups for PLWHA.
- b) Stakeholders working on reproductive health programs should upscale education and promotion of contraception, especially for PLWHA so as to make sure there is coverage of information on the correct methods amongst this group of people, emphasizing the use of barrier methods best suited for their status.
- c) Health education and promotion on contraceptive use should not only focus on family planning, but also the prevention of unintended pregnancy and infection. Information should be made available to all persons falling in the reproductive age group specially targeting the young people so that by the time they are sexually active they are empowered with knowledge on how to protect themselves from infection and pregnancy.
- d) Ministry of Health should provide hand out posters, pamphlets and education material on contraceptive use freely to clinics for display and distribution.
- e) Literature states that there is an unmet need in the use of contraception among those people who do not desire to have children but are not using any form of contraception (Cohen, 2008) that has to be addressed.
- f) The low use of dual contraception among the single respondents is a cause for concern. The gap in those using condoms or dual methods indicates the need for greater promotion of condoms and dual method use so as to add protection against disease and pregnancy prevention especially for PLWHA.

## **5.6 FURTHER RESEARCH**

The researcher recommends further research on the following topics:

- Information needs of people living with HIV and AIDS on contraception.
- Difficulties encountered by people living with HIV and AIDS in accessing permanent methods of contraception.
- Health care worker's attitudes towards contraception for people living with HIV and AIDS.

## **5.7 FINAL CONCLUSION**

Contraception is a key strategy for the prevention of hetero sexual transmission of HIV/ AIDS and unintended pregnancies especially in countries with a high prevalence of HIV/AIDS such as Swaziland. The results of this study indicated that contraceptive use and knowledge of contraceptives were high among people living with HIV and AIDS in selected communities in Siteki, Swaziland although some gaps were identified.

As family planning and reproductive health is not only for population control but also for the improvement of health, welfare and human rights for those involved in sexual relations, interventions should make use of integrated approaches when addressing the use of contraceptives to ensure that people adopt the practice as knowledge alone does not lead to behavior change.

## REFERENCES

Aggleton, P. (2000). *HIV and AIDS related stigmatization, discrimination and denial: forms, contexts and determinants research from Uganda and India*. London: Thomas Coram Research Unit, Institute of Education.

Agyei, W. & Migadde, M. (1995). Demographic and Sociocultural factors influencing contraceptive use in Uganda. *Journal of Bio Social Science*, 27(1): 47–60.

Bailey, CE. (2008). Fear of side effects as a barrier to modern contraceptive use among Ghanaian women. EPC annual conference report. Available at: <http://epc2008.princeton.edu>. Date accessed, March 2011.

Bertrand, JT, Harde, K, Robert J, Shahidzadeh-Mahani, A & Angel, AM. (1995). Quality of care and medical barriers in family planning programmes. *International Family Planning Perspectives*, 21(2); 64–69.

Blackwell, R. (2007). *Female barrier methods*. Faculty of Family Planning and Reproductive Health Care. London.

Available at: [www.ffprhc.org.uk/admin/./euguidancefemalebarriermethods2007.pdf](http://www.ffprhc.org.uk/admin/./euguidancefemalebarriermethods2007.pdf). Date accessed January 2011.

Blumenthal, A, Voedisch, Gemzell-Danielsson, K & Marintcheva-Patrovam, M. (2003). Strategies to prevent unintended pregnancy: increasing use of long-acting reversible contraception. *Human Reproduction*, 68 (1); 189–193.

Bongaarts, J. & Bruce, J. (1995). The causes of unmet need for contraception and the social context of services. *Studies of Family Planning*, 26 (2): 57–75.

Brink, H. (2006). 2<sup>nd</sup> edition. *Fundamentals of research methodology for health care professionals*. Cape Town: Juta.

Brink, H., Van der Walt, C. & Van Rensburg, G. (2006). 2<sup>nd</sup> edition. *Fundamentals of research methodology for healthcare professionals*. Kenwyn: Juta.

Cates, W. & Steiner, M.J. (2002). Dual protection against unintended pregnancy and sexually transmitted infections: What is the best contraceptive approach? *Sexually Transmitted Diseases*, 29(3):168-174.

Cohen, S.A. (2008). Hiding in plain sight: The role of contraception in preventing HIV. *Guttmacher Policy Review*, 11(1): 1–5.

Coleman, C.L. & Ball, K. (2007). Determinants of perceived barriers to condom use among HIV- infected middle-aged and older African American men. *Advanced Nursing*, 60 (4): 368–376.

Cooper, D., Harries, J., Myer, L., Orner, P. & Bracken, H. (2007). ‘Life is still going on’: Reproductive intentions among HIV positive women and men in South Africa. *Social Science and Medicine*, 65 (10):274–283.

Delvaux, T. & Nostlinger, C. (2007). Reproductive choice for men and women living with HIV: Contraception, abortion and fertility. *Reproductive Health Matters*, 15(29): 46–66.

Department of Health, Education, and Welfare. (1979). The Belmont report: Ethical principles and guidelines for protection of human subjects of research. Washington, DC; OPRR Reports. Available at: [www.ohsr.od.nih.gov/guidelines/belmont.html](http://www.ohsr.od.nih.gov/guidelines/belmont.html), Date accessed: August 2010.

Doyal, L. & Anderson, A. (2005). ‘My fear is to fall in love again’, How HIV positive African women survive in London. *Social Science and Medicine*, 60: 1729–1738.

Epi-Info<sup>TM</sup> (Version 3.5.1). Available from (<http://www.cdc.gov/epiinfo/epiinfo.htm>), Date accessed: May 2010.

Fleischman, J. (2006). *Integrating reproductive health and HIV and AIDS programs*. Washington: Center for Strategic and International Studies. Available at: [www.csis.org/fleis/pubs/o6o712\\_hicedis.pdf](http://www.csis.org/fleis/pubs/o6o712_hicedis.pdf) Date accessed: May 2010.

Foss, AM, Watts, CH, Vickerman, P, & Heise, L. (2004). Condoms prevention of HIV. *British Medical Journal*, 329 (7459); 185–329.

Fox, N., Hunn, A., & Mathers, N. (2007). Sampling and sample size calculation. Research Designs Services for the East Midlands: Yorkshire and the Humber. Available at: [www.rds-eastmidlands.org.uk/19-sample-size-calculation.html](http://www.rds-eastmidlands.org.uk/19-sample-size-calculation.html). Date accessed: May 2010.

Galavotti, C. & Schnell, D.J. (1994). Relationship between contraceptive method, choice and belief about HIV and pregnancy prevention. *Sexually Transmitted Diseases*, 21(1): 5–7.

Gillis, A. & Jackson, W. (2002). *Research for nurses: methods and interpretation*. Philadelphia: F.A. Davis.

Gule, G. (1994). Socio-cultural constraints to family planning in Swaziland. *Canadian Studies in Population*, 21(1): 35–49.

Guttmacher Institute (2010). *Facts on the barriers to contraceptive use in the Philippines*. Center for women's health INC. Available at (<http://www.guttmacher.org/pubs/FB-contraceptives>) Date accessed: September 2010.

Heard, I., Poternd, V., Costagliola, D., Kazatchkine, M. (2004). Contraceptive use in HIV positive women. *Acquired Immune Deficiency Syndroms*, 36 (2): 714–720.

Ijirigho, MA. (2010). Use of reproductive health information on contraception among female undergraduates of University of Ibadan. Library philosophy and practice. Available at (<http://www.uidaho.edu/mbolin/>) Date accessed: September 2010.



James, L., Chen, K.A., Phillips, D.E. & Mui, C.A. (2001). Fertility desire and intentions of HIV positive men and women. *Family Planning Perspectives*, 33(1): 144–165.

Joanne, E.M., Hoffma, S., Exner, T.M., Stein, Z.A. & Atkins, K. (2003). Family planning provider's perspectives on dual protection. *Perspectives on Sexual and Reproductive Health*, 35(2):71-78.

Katende, C., Gupta, N., & Bessinger, R. (2003). Facility-level reproductive health interventions and contraceptive use in Uganda. *International Family Planning Perspectives*, 29(3):130–137.

Kamau, R.K., Karanja, J., Sekadde-Kigundu, C., Ruminjo, J.K., Nichols, D. & Liku, J. (1996). Barriers to contraceptive use in Kenya. *East Africa Medical Journal*, 73(10): 651–9.

Kansen S., Vaughan, R.D. & Walter, H.J. (1992). Self-efficacy for AIDS preventive behaviours among tenth grade students. *Health Education*, 19(2):187–202.

Leon, F.R., Monge, A., Zumaran, I. & Rous, A. (2001). Length of counselling sessions and the amount of relevant information exchange. *Inter Family Planning Perspectives*, 27(1):28-33.

MacPhail, C., Pettifor, A., Pascoe, S. & Rees, H.V. (2007). Old South African women: a nationally representative cross-sectional survey. *BMC Medicine*, 5 (31): 1186–1741.

Maja, T.M.M. (2007). Factors impacting on contraceptive practice. *Health SA Gesondheid*, 12(1): 30–38.

Masi , F. (2007). Family planning choices for women with HIV. *Population Reports*, Series L, Number 15 Issues in World Health, USAID. Available at (<http://infok4health.org/pr/115>) Date accessed: August 2010.

Massad, S.L., Evans, C., Wilson, T., Golub, E., Sanchez-Keeland, L., Minkoff, H., Weber, K. & Watts, H. (2007). Contraceptive use among U.S. women with HIV. *Journal of Women's Health*, 16(5): 657–666.

Ministry of Health and Social Welfare (MH&SW) (2002). *Swaziland community health survey report*. Mbabane: Government Printer. Available at: [www.gamelibrary.worldbank.org//Strategicinformationassessmentswaziland.pdf](http://www.gamelibrary.worldbank.org//Strategicinformationassessmentswaziland.pdf) Date accessed: May 2010.

Ministry of Health and Social Welfare (MH&SW) (2008). *Sero sentinel surveillance survey report*. Mbabane: Central Statistics Office. [www.kmsi.isn.ethz-ch/serviceengine/files/isn/full.pdf](http://www.kmsi.isn.ethz-ch/serviceengine/files/isn/full.pdf)

Mitchell, H. & Stephens, E. (2004). Contraception choices for HIV positive women. *Sexually Transmitted Infections*, 80(3): 167–173.

Moos, M.K., Barthelomew, M.E., Lohr, K.N. (2003). Counseling in the clinical setting to prevent unintended pregnancy. An evidence based research agenda. *Contraception*, 67 (2):115–132.

Myer, L., Rebe, K. & Morroni, C. (2007). Missed opportunities to address reproductive health needs among HIV infected women in antiretroviral therapy programmes. *Tropical Medicine and International Health*, 12 (12): 1484–1489.

Paiva, V., Filipe, E.V. & Santos, N. (2003). The right to love: The desire for parenthood among men living with HIV. *Reproductive Health Matters*, 11 (22): 99–100.

Polit, D.F. & Beck, C.T. (2004). 7<sup>th</sup> edition. *Nursing research: principles and methods*. Philadelphia: Lippincott, Williams and Wilkins.

Raine T.R., Gard J.C., Boyer C.B., Haider S., Brown B.A., Ramirez Hernandez, F.A., & Harper, C.C. (2010). Contraceptive decision-making in sexual relationships: young men's experiences, attitudes and values. *Culture Health and Sex*, 12 (4): 373–386.

Rasheed, K., Ismaila, A. & Tajdeen, Y. (2010). *Knowledge, risk, perception and behaviour on HIV and AIDS among students of tertiary institution in Lagos state, Nigeria*. E-leader Budapest: Department of Actual Science. Available at ([http/Budapest/papers/ojikutu.pdf+rasheed](http://Budapest/papers/ojikutu.pdf+rasheed)) Date accessed: September 2010.

Sable, MR, Libbus, MK & Chin, JE. (2000). Factors affecting contraceptive use in women seeking pregnancy test: Missouri. *Family Planning Perspectives*, 32 (3); 124-131.

Saleem, S. & Bobak, M. (2005). Women's autonomy, education and contraceptive use in Pakistan: A national study. *Reproductive Health*, 2(8): 1186-1742.

Sama, A., Luchters, S.M., Geibel, S., Kaai, S., Munyao, P., Shikely, K.S., Mandaliya, K., van Dam, J. & Temmerman, M. (2008). Sexual risk behaviour and HAART: a comparative study of HIV-infected persons on HAART and on preventive therapy in Kenya. *Population Council*, 19(2): 85–9.

SASO. (2010). Register for support groups in Siteki, Swaziland. Unpublished.

Stephenson, R., Baschueri, A., Clements, S., Hennink, M. & Madise, N. (2007). Contextual influences on modern contraceptive use in Sub-Saharan Africa. *American Journal of Public Health*, 97(7): 1233–1240.

Steen, R. & Shapiro, K. (2004). Intrauterine contraceptive devices and the risk of pelvic inflammatory disease: Standard of care in high STI prevalence settings. *Reproductive Health Matters*, 12(230): 136–43.

Sunny, L. (2005). Is it reporting bias doubled the risk of prostate cancer in vasectomised men, in Mumbai, India? *Asian Pacific Journal*, 6(3): 320-5.

Swaziland. (2007). *Demographic Health Survey report*. Mbabane: Central statistics office. Available at: [www.nercha.org.sz/publications//report/sdhsreport.pdf](http://www.nercha.org.sz/publications//report/sdhsreport.pdf) Date accessed: May 2010.

Todd, CS, Stibich, MA, Laher, R, Malta, MS, Bastos, FI, Imbiki, K, Shaffer, DN, Sinei, SK & Gray, G. (2010). Influence of culture on contraceptive utilization among HIV positive women on Brazil, Kenya and South Africa. *AIDS and behaviour*, Department of Obstetrics and Gynecology, University of Columbia.

Tuloro, T., Deressa, W., Ahmed, A., Davey, G. (2006). The role of men in contraceptive use and fertility preference in Hossana town, Southern Ethiopia. *Ethiopia Journal of Health Development*, 20(3): 152–159.

UNAIDS. (2000). HIV and AIDS–related stigmatization, discrimination and denial: forms, contexts and determinants. Research studies from Uganda and India. Geneva: UNAIDS Information Centre. Available at ([http://www.data.unaids.org/publications/irc-pub01/jc316-Uganda-India\\_enpdf](http://www.data.unaids.org/publications/irc-pub01/jc316-Uganda-India_enpdf)), date accessed: February 2010.

UNAIDS. (2005). AIDS epidemic update. Geneva: UNAIDS. Available at (<http://www.unaids.org/epiupdate2005>) date accessed: February 2010.

UNAIDS. (2009). AIDS epidemic update. Geneva: UNAIDS. Available at (<http://www.unaids.org/pub/report2009/epidemicupdate>) Date accessed: February 2010.

UNAIDS. (2010). *Swaziland HIV estimates and projections report*. Mbabane: Printpak. Available at: ([http://www.unaids.org/2010progressreport/swaziland\\_2010\\_country-progress-report\\_en.pdf](http://www.unaids.org/2010progressreport/swaziland_2010_country-progress-report_en.pdf)) Date accessed: February 2010.

UNFPA. (2000). *State of the world population*. UNFPA. Available at (<http://www.unfpa.org/swp/2000>), Date accessed: August 2010.

UNFPA. (2004). *Women and HIV/AIDS: Confronting the crisis*. Available at: [http://www.unfpa.org/hiv/women/docs/women\\_aids.pdf](http://www.unfpa.org/hiv/women/docs/women_aids.pdf)

Weiss, RS. (1995). *Learning from strangers: The art and methodology of qualitative interview studies*. New York: Simon & Schuster.

WILSA. 1998. *Beyond inequalities: women in Swaziland*. Mbabane: Southern African Research and Documentation Centre.

World Health Organization (WHO) (2004). *Medical eligibility criteria for contraceptive use*. Geneva: WHO. Available at ([http://www.who.int/publications/sexual\\_and\\_reproductive\\_health](http://www.who.int/publications/sexual_and_reproductive_health)) Date accessed: May 2010.

World Health Organization (WHO) (2008). *Repositioning family planning*. Washington: Academy for Educational Development. Available at (<http://www.ead.org/publications/loader/cfm?url>), Date accessed: September 2010.

Williams, C.D, Finnerty, J.J, Newberry, R.N, West, R.W, Thomas, T.S, Pinkerton, J.V. (2003). Reproduction in couples who are affected by human immune deficiency virus: Medical, ethical and legal consideration. *American Journal of Obstetrics and Gynecology*, 189(2):333–341.

Williamson, L.M., Parkes, A., Wight, D., & Hart, G. (2009). *Reproductive Health*, 6(3): 60–3.

Van der Straten A., King R., Grinstead O., Serufilira A. & Allen S. (1998). Couple communication, sexual coercion and HIV risk reduction in Kigali, Rwanda. *Journal of AIDS*, 9(11): 52–67.

Zamberia, A. (2009). Sexual activity and condom use among people living with HIV in Swaziland. *African Journal of AIDS Research*, 8(1): 69–81.

## APPENDICES

### *Appendix A: Questionnaire*

<b>General Instructions:</b>	
<p>1. Please attempt to answer all questions as honestly and consistently as possible. Your personal identity will not be disclosed in this study.</p> <p>2. Remember: <b>Do not</b> reveal your name on the questionnaire as this exercise is confidential, and please give one answer per question unless if multiple answers are required.</p> <p>3. Write clearly or indicate with 'X' against appropriate response as applicable.</p> <p>4. By completing this questionnaire you are consenting to participate.</p>	
<b>QUESTIONNAIRE ON THE CONTRACEPTIVE USE AMONG PEOPLE LIVING WITH HIV AND AIDS</b>	
<b>SECTION A: DEMOGRAPHIC DATA</b>	
1. Sex of respondent	Male [ ]    Female [ ]
2. How old are you, in years?	Years -----
3. What is your denomination?	Catholic [ ] Pentecostal [ ] Evangelical [ ] Zionist [ ] Methodist [ ] Anglican [ ] Muslim [ ] Shembe [ ]
4. What is your highest level of education?	Primary [ ] Secondary [ ] High School [ ] Tertiary [ ]
5. What is your marital status?	Single [ ] Married [ ] Divorced [ ] Co-habiting [ ]

	Widowed [ ] Widower [ ]
6. What is your primary occupation?	Self-employed [ ] Farmer [ ] Civil Servant [ ] Private company [ ] Other (Specify)-----
7. What is your partner's occupation?	Self-employed [ ] Farmer [ ] Civil Servant [ ] Private company [ ] Other [ ] specify-----
8. With whom do you live?	Spouse [ ]
	Alone [ ]
	Parents [ ]
	Extended family [ ]
	other specify-----
<b>Family size</b>	
9. How many of your own living children do you have?	Sons [ ]
	Daughters [ ]
10. Would you like to have another child?	Yes [ ]
	No [ ]
	Undecided [ ]
	Don't know [ ]
11. When would you like to have another child?	Year [ ]
12. In your opinion, how long should parents wait between one pregnancy and the next?	Years [ ]
13. Does your partner want to have another child?	Yes [ ]
	No [ ]
	Undecided [ ]
	Don't know [ ]
14. How long have you known about your status?	Year [ ]



<b>SECTION B: KNOWLEDGE AND UTILISATION OF CONTRACEPTIVES</b>	
15. Do you know any contraceptives?	Yes [ ] No [ ]
16. Where did you learn about contraceptives?	Television [ ] Radio [ ] Newspaper [ ] Clinic [ ] Friends [ ] Other specify -----
17. Do you think you have adequate information on contraceptives?	Yes [ ] No [ ]
18. Which contraceptives do you know?	Oral [ ] Injectables [ ] IUCD [ ] Male condom [ ] Female condom [ ] Spermicides [ ] Vasectomy [ ] Tubal ligation [ ] Other (specify) -----
19. Are you currently using any of these contraceptive methods?	Yes [ ] No [ ]
20. If not currently using contraceptives, is there one method that you have ever used? Yes [ ] No [ ]	
21. Do or did you find it easy to use that contraceptive?	Yes [ ] No [ ]
22. What motivates you to use contraception? _____ _____ _____	
23. Which contraceptive method do you like / prefer.	

24. State reasons why you prefer the particular contraceptive.	
25. If you are not using any contraceptive method, why not?	
26. Are you using more than one method?	Yes [ ] No [ ]
27. If yes, Why are you using more than one method?	
28. Why are you using contraceptives?	a) To prevent pregnancy [ ]
	b) To prevent sexually transmitted infections [ ]
	c) For child spacing [ ]
	d) To prevent re-infection [ ]
	e) For all the above [ ]
29. Do you think by using contraceptives you can protect yourself from sexually transmitted infections and HIV?	Yes [ ]
	No [ ]
30. In your opinion what is the best contraceptive method when living with HIV?	Oral [ ] Injectables [ ] Male condom [ ] Female condom [ ] Spermicides [ ] Vasectomy [ ] Tubal ligation [ ] Other -----

31. Give reasons	Easy to use [ ] Available from local facility [ ] Preferred by partner [ ] Convenient [ ] Other -----
32. What are your specific needs in contraception?	   
<b>Access and availability</b>	
33. Is there a place in your area where you can get contraceptives?	Yes [ ] No [ ]
34. State in Kilometers the nearest facility where you can get contraceptives	Km [ ]
35. During post counselling were you told something about contraceptives?	Yes [ ] No [ ]
36. If yes, how did you benefit from the counselling?	Making a choice of contraceptive [ ] Referral to a reproductive health clinic [ ] Other specify -----
37. Have you been to a clinic to consult about contraceptive services?	Yes [ ] No [ ]
38. State what you liked about the services you received.	Receptive staff [ ] They give counselling [ ] There is a wide choice of contraceptives [ ] Other Specify -----
39. Was there anything you disliked about the clinic?	Yes [ ] No [ ]
40. Explain what you disliked about the family planning services provided.	Contraceptives methods too expensive [ ] Wait too long [ ]

	Staff unknowledgeable [ ]
	Male staff [ ]
	Desired contraceptive method unavailable [ ]
	Other specify : _____ _____ _____

*Appendix B Questionnaire (local language – Siswati)*

**Imiyalo ngekuphendvula loluphenyo:**

- 1. Phendvula yonkhe imibuto ngekwetsembeka.**
- 2. Libito lakho alidzingeke. Ngako ungalifaki.**
- 3. Bhala kubonakale nobe ufake luphawu lokuvuma “✓” eceleni kwemphephendvulo.**
- 4. Ngekuphendvula lemibuzo kusho kutsi uyavuma kubambisana natsi kuloluphenyo.**

**Sigaba sekucala: Demographic data**

1. Bulili

Ngimdvuna	
Ngimsikati	

2. Mingakhi iminyaka yakho.

Unmyaka wakho	
------------------	--

3. Ukhonta kuyiphi inkonzo.

Likhatholika	
Pentekosti	
Evangelical	
EZion	
Emadloti	
Eweseli	
Anglican	
Muslim	
Shembe	
Bofakazi bajehova	
Lenye yisho	

4. Libanga lofike kulo lemfundvo

Angifundzanga	
Primary	
Secondary	
High School	
Ekolishi	

5. Sewenzile nobe sewumutsetse yini umfati.

Angikashadi	
Ngishadile	
Sehlukene	
Siyahlalisana	
Ngingumfelakati	

6. Uhlala nabani

Ngihlala nedvodza/mfati wami	
Ngihlala nalengitsandzana naye	
Ngihlala ngedvwa	
Ngihlala nebatali bami /nebakitsi	
Ngihlala nebatfwana bami	
Nakungulokunye chaza	

7. Utiphilisa ngani

Ngiyatatisebenta	
Ngingumlimi	
Ngisebenta kahulumende	
Ngisebenta enkaneni	
Ngisafundza	
Angisebenti	

Nakungulokunye kuchaza.-----

8. Lowakakho nangabe ukhona utiphilisa ngani

Uyatatisebenta	
Ungumlimi	
Usebenta kahulumende	
Usebenta enkaneni	
Uyafundza	
Akasebenti	

Nakungulokunye kuchaza.-----

---

9. Bangaki bantfwabakho labaphilako.

Bafana	
Emantfomatana	

10. Uyafisa yini kuba nalomunye umntfwana.

Yebo	
Cha	

11. Ngekucabanga kwakho, sikhatsi lesingakanani lekufanele batali basihlale bangakamelamisi umntfwana?

Iminyaka	
----------	--

12. Ingabe wakakho usafuna yini kubanemntfwana.

Yebo	
Cha	

13. Sewunesikhatsi lesingakanani wati simo sakho. Shano umnyaka lowahlola ngawo.

Uminyaka	
----------	--

**Sigaba sesibili: Lwati ngetindlela tekuhlela umndeni.**

14. Ingabe tikhona tindlela tekuhlela umndeni lotatiko.

Yebo	
Cha	

15. Ngutiphi tindlela tekuhlela umndeni lotatiko, khetsa leto lotatiko.

Emaphilisi	
Umjovo	
Iloop	
I condom yabesilisa	
I condom yabomake	
Kugcobisa umutsi lobulala sidvodza	
Kuphakula lomdvuna	
Kuvala intalo kubomake	
Kucencuka	

Nakungulokunye, kusho. -----

---

16. Kuletindlela tekuhlela letibaliwe ngabe ikhona lokewahlela ngayo.

Yebo	
Cha	

17. Nguyiphi indlela lohlela ngayo nyalo, khetsa tonkhe lotisebentisakonyalo nangabe tingetulu kwayinye.

Emaphilisi	
Umjovo	
Iloop	
I condom yabesilisa	
I condom yabomake	
Kugcobisa umutsi lobulala sidvodza	
Kuphakula lomdvuna	
Kuvala intalo kubomake	
Kucencuka	
Nakunalenye yisho	



18. Tingakhi tindlela lotisebentisako tekuhlela.

Yinye	
Timbili	

19. Nangabe tindlela lotisebentisako timbili, chaza kutsi usebentise lani timbili, khetsa konkhe lokukwenta usebentise timbili tindlela.

Kuvikela kukhulelwa	
Kuvikela tifo tase cansini kanye ne HIV	
Kungisita kutsi ngelamise kahle	

Nakunalesinye sizatfu chaza-----

---

20. Kusebentisa lendlela lohlela ngayo ukukhandza kunjani.

Kulula	
Kulukhuni	

21. Ingabe lendlela lohlela ngayo ikuphetse njani (khetsa konkhe lokuke kwenteka kuwe).

Ngiphatfwa yinhloko	
Ngopha kakhulu	
Angisayi esikhatsini	
Kubanebuhlungu nangisesikhatsini	
Ngiyakhuluphala emtimbeni	
Ngiyehla emtimbeni	
Kungibangela ngifune kuhlanta	

Buntfu bami buyaluma	
Kungenta ngingakhanuki kulala	
Sengiya esikhatsini sikhatsi lesidze	
Kukhona lokuphuma ngembali	
Iyakhohlwakala	
Kulukhuni kuyisebentisa	

22. Ingabe lotsandzana naye uyakusekele yini ekusebentiseni lendlela lohlela ngayo.

Yebo	
Cha	

23. Nangabe kute indlela lohlela ngayo umndeni wentiwa yini/ wayekele lani nangabe wakewahlela.

24.

Letindlela tekuhlela tiyagulisana	
Lengitsandzana naye akafuni ngihlele	
Tindlela tekuhlela tidulile	
Kukhashane emfolamphilo	
Angisafuni kubanebatfwana	
Ngitelwati ngetindlelal tekuhlela	

Nangabe kukhona lokunye lokwenta ungahleli kusho. -----

25. Lwati ngendlela lohlela ngayo walutsatsaphi.

Emsakatweni wetitfombe	
Emsakatweni	
Ephephandzabeni	
Emtfolamphilo	

Kubangani	
Nakungulenywe indzawo yisho	

26. Ngukuphi lawungatsandza kutfolo khona lwati ngetindlela tekuhlela.

Emsakatweni wetitfombe	
Emsakatweni	
Ephephandzabeni	
Emtfolamphilo	
Kubangani	
Nakungulenywe indzawo yisho	

**Sigaba sesitsatfu: Kusetjentiswa kwetindlela tekuhlela umndeni.**

27. Yini lokwenta ukhutsale ngekuhlela umndeni, khetsa tizatfu tonkhe letinkwenta ukhutsale.

Kuvikela kukhulelwa	
Kuvikela tifo tase cansini kanye ne HIV	
Kungisita kutsi ngelamise kahle	

Nakunalo kunye kusho -----

---

28. Yini lokwenta usebentise lendlela loyisebentisako yekuhlela umndeni, khetsa konkhe lokwenta usebentise lendlela yekuhlela loyisebentisako.

Kuvikela kukhulelwa	
Kuvikela tifo tasecasini	
Kwelamisa kahle bantfwana	
Uvikela kutfolo ligciwane le HIV	

Nangabe kunalo kunye chaza. -----

29. Ngekubuka kwakho nguyiphi indlela lekahle yekuhlela umndeni nawuphila neligciwane le HIV.

Emaphilisi	
Umjovo	
Iloop	
I condom yabesilisa/ yabomake	
Kugcobisa umutsi lobulala sidvodza	
Kuphakula lomdvuna	
Kuvala intalo kubomake	
Kucencuka	
Nakungulokunye, kusho	

30. Lendlela loyikhetsile ngetulu isita ngani nawuphila neligciwane le HIV, khetsa konkhe lesita ngako lendlela loyincoma kubantfu labaphila neligciwane le HIV.

Ivikela kukhulelwa	
Ivikela tifo tasecasini	
Yente welamisa kahle bantfwana	
Ivikela kutfolakala kwelindlela tekuhlela umndeni	

**Sigaba sesine: kutfolakala kwelindlela tekuhlela umndeni**

31. Kukhona yini endzaweni yakini lapho lutfolakala khona lusito ngetekuhlela umndeni.

Yebo	
Cha	

32. Libanga lelinganani ngemakhilometre kuya lapho utfola khona lusito ngetekuhlela.

Libanga ngema kilometre	
-------------------------	--

33. Nasebakutjelile simo sakho nge HIV, ngabe bakuchazela yini ngetindlela tekuhlela umndeni.

Yebo	
Cha	

34. Nangabe bakweluleka ngetindlela tekuhlela, kwakusita ngani loko, khetsa tonkhe tindlela lowasitakala ngato.

Ngekukhetsa indlela lengilungelako yekuhlela	
Banginika lwati ngetindlela tekuhlela	
Bangengcisela emtfolamphilo wetekuhlela	

Nakunalokunye lowasitakala ngako chaza. -----

---

35. Ngabe uke waya emtfolamphilo mayelana netekuhlela umndeni.

Yebo	
Cha	

36. Wabatjela ngesimo sakho emtfolamphilo.

Yebo	
Cha	

37. Yini lowakutsandza ngelusito lwasemtfolamphilo

Banakekeli bengemukela	
Ngatfola kwelulekwa kabanti ngetindlela tekuhlela	
Ngakhandza tindlela letinyenti tekuhlela	

Nakunalokunye lokwakujabulisa kusho. -----

---

38. Yini longakutsadzanga ngelusito lwasemtfolamphilo.

Tindlela tekuhlela tidulile	
-----------------------------	--

Ngema sikhatsi lesidze ngingakatfoli lusito	
Banakekeli bakhombisa kubabete lwati	
Indlela yekuhlela lengiyincomako angiyikhandzanga	

Nakunalo kunye longakutsanzdanga chaza. -----

39. Nguyiphi indlela yekuhlela lebayincoma banakekeli kuwe.

Emaphilisi	
Umjovo	
Iloop	
I condom yabesilisa	
I condom yabomake	
Kugcobisa umutsi lobulala sidvodza	
Kuphakula lomdvuna	
Kuvala intalo kubomake	
Kucencuka	
Nakungulokunye, kusho	

40. Shano tizatfu letabekwa ngumnakakeli ngebuncono balendlela layincomako.

Ivikela kukhulelwa kanye netifo tasecansini	
Ivikela tifo tasecasini	
Yente welamisa kahle bantfwana	
Ivikela kutfolo ligciwane le HIV	

41. Beka umbono ngekutsi ungatsandza kusitakala kanjani mayelana netindzaba tekuhlela umndeni.

Kutfolo lusito ngekuhlela lapho ngitfolo khona emaphilisi	
Kutfolo lusito ngekuhlela lapho kuhlolwa khona simo sengati.	
Kutfolo lwati ngekuhlela nobe ngite ngakuphi kugula emtfolamphilo.	

Ngabe kukhona lomunye umbono chaza. -----

*Appendix C – Information letter for participants*

**LWATI NGALOLUCWANINGO**

Ligama lami ngingu Ncamsile Tfwala. Ngingumufunzi eNyuvesi yase Limpompo lese Medunsa. Ngifundzela i Masters kutempilo. Njengencye yetifundvo tami ngenta lucwaningo ngekusetentjiswa kwetindlela tehlela umndeni kubantfu labaphila neligciwane le HIV ne AIDS emimangweni lekhetsiwe le phanse Nkhundla yase Siteki.

Umgomo walelicwaningo kwati kabanti ngekusetjentiswa kwetindlela tekuhlela umndeni kubantfu labaphila neligciwane leHIV ne AIDS endzaweni yase Siteki eSwatini. Kwenta loku lolucwaningo lutobuka nati tinhlangotsi letilandzelako:

- Kutfolo emaciniso ngelwati nekusetjentiswa kwaletindlela tekuhlela umndeni kubantfu labaphila naleligciwane leHIV ne AIDS labasetinhlanganweni letise Siteki.
- Kutfolo lwati ngekutsi bayakhona kufinyelela ekutfoleni letindlela tekuhlela umndeni bantfu labaphila neHIV ne AIDS emimangweni yaseSiteki.
- Kutfolo tizatfu tekusetjentiswa nekungasentjentiswa kwetindlela tekuhlela umndeni kubantfu labaphila neligciwane leHIV ne AIDS emimangweni yaseSiteki.

Lolucwaningo lubhekiswe kubantfu labasemkhatsini weminyaka lelingemashumi lamabili nakunye kuya kulabaneminyaka lengemashumi lamane nemfica (21–49 years) labasetinhlanganweni lelisekela labantfu labaphila neligciwane leHIV ne AIDS emimangweni yaseSiteki. Lalabangenele lolucwaningo batowutfolakala ngaletinhlangano tebantfu labaphila naleligciwane leHIV ne AIDS letigcina luhla lwabo luphindze lusebentisane naletinhlangano.

kutfolo lo lwati kutawu setjentiswa imibuto umuntfu latayiphendvula, lengelilwimi leSiswati. Ngiyacela ke Maswati kutsi nilungenele lelicwaningo, futsi nginetsimbise kutsi konkhe lokutawutfolakala kutawugcinwa kuyimfihlo. kungenela lolucwaningo kutabakutinikela kwakho awukaphoceleleki futsi timphendvulo takho ngeke tatie ngulomunye umuntfu, kwakho nje kutsi uphendvule lemibuto ngeliciniso nangekwetsembeka.

Ncamsile Tfwala.

Contact: [00268]76026686

[00268]4041134/72

*Appendix D MREC approval certificate*

UNIVERSITY OF LIMPOPO  
Medunsa Campus



**MEDUNSA RESEARCH & ETHICS COMMITTEE**

**CLEARANCE CERTIFICATE**

P.O. Medunsa  
Medunsa  
049  
SOUTH AFRICA

MEETING: 04/2010

PROJECT NUMBER: MREC/187/2010: PG

TEL: 011 491 4000  
FAC. 011 - 491 0115

**PROJECT:**


**Title:** Contraceptive use among people living with HIV/AIDS: A case study of selected communities in eThekweni, Swaziland

**Researcher:** M E N Twala  
**Supervisor:** M o L Fernandes  
**Department:** Public Health  
**School:** Health Care Sciences  
**Degree:** MPH

**DECISION OF THE COMMITTEE:**

MREC approved the project

**DATE:** 05 May 2010

  
PROF N EBRAHIM  
DEPUTY CHAIRPERSON MREC

<b>Note:</b>	
i)	Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
ii)	The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.



*Appendix E Request for permission Ministry of Health Science and ethics committee.*

University of Limpopo (Medunsa Campus)  
National School of Public Health  
Pretoria

The Science and Ethics Committee  
Ministry of Health and Social Welfare  
Private bag  
Mbabane  
Swaziland

Dear Sir/Madam

**RE: Contraceptive use among people living with HIV and AIDS: A case study of selected communities in Siteki, Swaziland.**

I am presently involved in a research project entitled “Contraceptive use among people living with HIV and AIDS: A case study of support groups in selected communities in Siteki, Swaziland” as a prerequisite for my masters degree in Public Health. The study is done under the supervision and guidance of my supervisor from the Department of Public Health at the University of Limpopo, Medunsa Campus.

**The objectives of the study are:**

- To gather factual information about the experience on contraceptives use among people living with HIV and AIDS among support groups in Siteki, Swaziland.
- To determine socio-demographic characteristics of people living with HIV in relation to contraceptive use.
- To determine the access to contraceptives services for people living with HIV and AIDS among support groups in Siteki, Swaziland.
- To determine which form of contraception is more favoured by people living with HIV.

- To identify possible reasons for contraceptive use and non-use among people living with HIV and AIDS among support groups in Siteki, Swaziland.

The voluntary respondents will be drawn from support groups of people living with HIV and AIDS. Their names will not appear in any of the documents and confidentiality will be maintained. Your approval of this research will be appreciated.

Yours sincerely

Ncamsile Thwala

Contact: (00268) 76026686 (M)

(00268) 4041134/72

[ncamsile\\_thwala@embanet.com](mailto:ncamsile_thwala@embanet.com)

## Appendix F – Permission letter from Ministry of Health

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)



MINISTRY OF HEALTH  
P. O. BOX 5  
MBABANE  
SWAZILAND

### THE KINGDOM OF SWAZILAND

**FROM:** The Chairman  
Scientific and Ethics Committee  
Ministry of Health & Social Welfare  
P. O. Box 5  
Mbabane

**TO:** Ncamsile Thwala  
University of Limpopo  
P.O Box

**DATE:** 12<sup>th</sup> August, 2010

**REF:** MH/599B

**RE: CONTRACEPTIVE USE AMONG PEOPLE LIVING WITH HIV AND AIDS: CASE STUDY OF SELECTED COMMUNITIES IN SITEKI**

The Scientific and Ethics committee has reviewed the protocol on the above mentioned study.

In view of the fact that there are no ethical issues, you are therefore granted authority to conduct the above mentioned study.

You are kindly requested to adhere to the processes and the selected communities as outlined in the protocol and if there are any changes, you are advised to notify the chairman of the committee before you effect any changes.

The committee is looking forward to the findings of the study to inform decision making in this area.

Yours Sincerely,

A handwritten signature in black ink, appearing to be 'S. V. Magagula', written over a horizontal line.

**DR. S. V. MAGAGULA**  
**DEPUTY DIRECTOR OF HEALTH SERVICES**  
**(THE CHAIRMAN)**



