



Sexual Practice, Fertility Desire and Family Planning Practices of PLHIV on ART at Dilla Hospital Snnpr, Ethiopia

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ABSTRACT

Background : As life expectancy of people living with HIV/AIDS (PLHIV) is changing, the reproductive health needs of clients are constantly changing and becoming increasingly important. In particular, as PLHA realize that with treatment, HIV infection is no longer a death sentence, they endeavor to actualize their normal life obligations and prospects, which may include resumption of sexual relations and future fertility desire.

Objective : To assess sexual practice, fertility desire and family planning practices of PLHIV on ART at Dilla Hospital, SNNPR, Ethiopia.

Methods : Cross sectional study with systematic random sampling.

Conclusion : PLHIV are sexually active, continue to desire children and want to space and limit their fertility. In this study socio-demographic issues influenced sexual practices, fertility desire and demand for contraception. PLWHA could benefit from counseling in sexuality as a whole, but not just risk reduction. Safe sexual activity is an important facet of the overall quality of life of PLHIV.

KEYWORDS : sexual practice, fertility desire and family planning practice

Background

Globally, about 33.4 million people are living with HIV/AIDS and 67.1% of them are in Sub-Saharan Africa. The prevalence is high in reproductive age group with young women being most vulnerable (1).

According to the 2011 EDHS, among women age 15-49 HIV prevalence is 1.9 percent. Overall, HIV prevalence is higher for women than men in most age groups (2).

Since the development of antiretroviral therapy (ART), AIDS has substantially reduced the death rate from this disease (4).

Little is known about either the sexuality or the reproductive health and intentions of PLWHA in the context of ART in SSA settings. (5).

Family planning methods generally available globally can be used by HIV positive women (12). Most hormonal contraceptives can be used without any adverse outcomes, although WHO guidelines provide options in specific cases where drug interactions may reduce the effectiveness of certain oral contraceptives (13). Lack of access to family planning commodities, spousal opposition, side effects, health concerns over ART interactions with some hormonal family planning methods and desire of children have been cited as important factors constraining contraceptive uptake (14).

Studies on sexual and reproductive behavior of PLWHA in the region are limited (10, 17). Specifically, few attempts have been made to examine the interrelated issues of sexuality, fertility desires and contraceptive use and demand in one study. Scant consideration was given to the fact that PLWHA might be sexually active, or consider reproduction. This study will add to the emergent body of evidence on sexual and reproductive behavior of PLHIV in study setting.

METHODS

Institutional based Cross sectional study was conducted among 422 samples with systemic random sampling by using structured questionnaire. SPSS Version 17.0 software was used for data analysis. Strength of association was measured with Binary logistic regression and finally multivariate analysis was used to control possible confounders. Ethical clearance is obtained from the concerned bodies.

RESULTS

Socio-demographic characteristics

From total respondents, 215 (52.3%) were female. The age range of the study subjects were 18-64 years and majority 222(54.4%) were in the age group of 30-41.9 years. Above half 235(57.2%) of the respondents were married, followed by widowed 86(21.1%). Regarding respondents religion about

212(52%) were followers of Orthodox Christianity followed by Protestants 150(36.8%). Of all the respondents who participated in the study 74(18.1%) illiterate, 115(28.2%) had primary education, 171(41.9%) had secondary school education and 48(11.8%) were college and above. The ethnic composition of the respondents belongs to seven ethnic groups; Amhara 90(22.1%), gedeo 84(20.6%), gurage 64(15.7).

Sexual practice and desire

282 (69.1%) of respondents reported having sex in the previous 6 months. Among those about 33(11.7) had sexual intercourse with irregular/multiple sexual partners. About 29(7.1%) used condom with irregular/multiple sexual partner with variable frequency about 17(4.2%), 6(1.5%), 6(1.5%) used condom always, most of time and sometimes respectively and 4(1.%) did not use condom with irregular/multiple sexual partner. There are reductions in sexual desire following HIV infection for most 212(52%), but not all PLWHA. Although there are substantial reductions in both desires most are sexually active 89(21.9%) respondents had other STIs after HIV diagnosis and all of them had treatment.

3.3 Fertility desire

79(19.4%) respondents did not give birth at all. Majority of respondents 213(52.4) had 3 and more children. Regarding future child desire about 156(38.2%) had desire to have child in the future despite majority 109(26.7%) of them were not sure about time limit to have child in the future because of they have variable health condition. Those have 1 or more live children has less fertility desire as compared to those has no children.

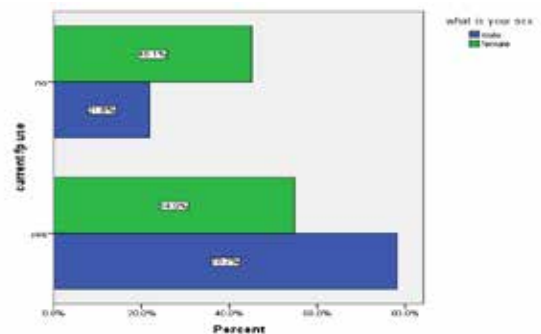


Figure 1: Distribution of current family planning methods use by sex of PLHIV on ART clinic Dilla hospital, SN-NPR, Ethiopia 2013.

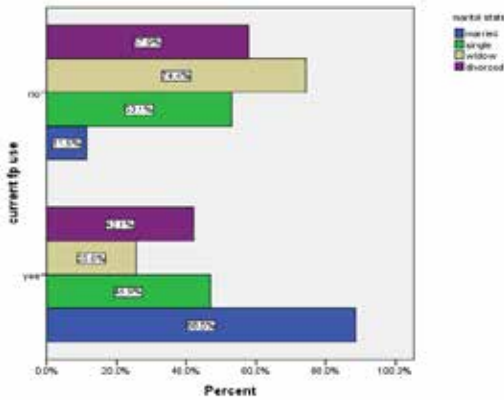


Figure 2. Distribution of current family planning methods use with marital status of PLHIV on ART at Dilla hospital, SNNPR, Ethiopia 2013.

Factors affecting sexual practice and desire

What might explain differences in sexual (in) activity in the preceding 6 months? To explore this, logistic regression was used. In binary logistic regression that respondents who reported having been sexually active in the past 6 months were more likely to be men, married, age 30-41.9, have signs and symptoms of STI after HIV infection, those disclose their HIV status to partner, have HIV tested partner, premier and above educational level and have future child desire. Marital status, age, male, have STI signs and symptoms and future child desire been significant predictors of sexual activity in multivariate analyses. Respondent's employment status and perceived self health status were not associated with a report of being sexually active in the preceding 6 months.

Table 1 Distribution of association between current family planning use and selected factors of PLHIV using ART at Dilla hospital, SNNPR, Ethiopia 2005 E.C.

Independent variables	Current family planning use		Odds ratio crud	p-value	p-value and adjusted odds ratio at 95% CI	
	Yes	No				
Age						
18-29.9	39	37	.937	.904	.019 (16.04)	(1.5, 161.57)
30-41.9	162	60	2.400	.085	.003 (15.0)	(2.57, 87.569)
42-53.9	59	34	1.542	.415	.004(16.02)	(2.397,107.10)
54-65.9	9	8				
Sex						
Male	151	42	2.955	.000 (1.9, 4.5)	.063	3.05(.941, 9.8)
Female	118	97				
Marital status						
Married	208	27	10.593	.000 (4.9, 22.6)	.001(21.1)	(3.3, 134.1)
Single	23	26	1.216	.653	.063	
Widowed	22	64	.473	.068	.163	
divorced	16	22				
Education						
Illiterate	36	38	1	0.00 (1.2, 4.23)	.203	
Premier	79	36	2.316	0.02	.137	
Secondary	119	52	2.416	(1.4,4.23)	.005	10.2(2.0,
College & >	35	13	2.842	0.09 (1.3, 6.21)	51.4)	
Religion						
Orthodox	138	74	.878	.565	.398	.496
Catholic	7	4	.824	.765	.620	2.969
Muslim	22	13	.796	.561	.014	.060
Protes-tant	102	48			.006,.568)	
Occupation						
Unem-ployed	177	101	.724	.159	.629	.703
Em-ployed	92	38				

No of current children						
0 child	38	41	2.850	0.00 (1.6, 5.06)	.000	18.0(4.2,
1-2	103	39	2.341	0.02 (1.36,4.01)	.000	76.1)
children 3 and above	128	59			.000	47.4(7.7,
					289.0)	
Future child desire						
Yes	116	40	1.876	.005 (1.21, 2.9)	.529	.60(.12, 2.8)
No	153	99				
Disclosure of HIV status to partner						
Yes	225	53	6.958	.000 (4.1 ,11.6)	.999	
No	36	59				
Partner HIV test result						
Positive	188	45	1.044	.919	.013	.144
Negative	32	8			.032	.659
Perceived self health status						
Good	185	94	1.054	.813	.873	.920(.329,
Poor	84	45			2.57)	

DISCUSSION

The response rate was 96.7 %, about 282 (69.1%) (56.3% male and 43.7% female) of respondents reported having sex in the previous 6 months. This is less than 86.7% of PLHIV were sexual active in Jimma, Ethiopia (8), Nekemet 78.4% male and 61.8% female PLHIV were sexual active (7). Also less than high income countries report more than 70% of PLWHA as sexually active (6), but higher than 45% of PLHIV were sexually active in the preceding 6 months in Mombasa, Kenya (18). Differences are possibly attributable to the study setting, socio demographic determinants and methodological difference.

33 (11.6 %) reported had sex with multiple sex partners in the last 6 months. The finding was less than similar study (14.2%) in Jimma, Ethiopia (8). The proportions of those who engaged in multiple sex among male, singles (widowed, divorced/separated and never married) with primary and secondary schooling and those do not disclose was higher than females, married and those without formal education and college and above education and disclose their status. Sexual activities with irregular sexual partner in this study are fewer than other studies.

There was reduction in sexual desire following HIV infection for most 212(52%). Although most are sexually active, many felt that sexual activity had been affected by HIV infection, with substantial reductions in sexual desire. Studies that have documented sexual experiences among PLWHA have similarly observed diminished sexual desire. Desire may reduce owing to fear and anxiety around infecting others or re-infecting themselves. Due to the possibility of HIV transmission and re-infections many PLWHA may feel that sex is mired with too much anxiety, worry, danger, and stress to still be desirable or pleasurable (18, 19). Diminished sexual urge was not universally reported by respondents in this study. About 153 (37.5%) insisted that nothing has changed for them in terms of sexual desire following their HIV diagnosis.

69.1% were sexually active, highlighting the existence of reproductive health needs, fertility desire and contraceptive needs.

156(38.2%) (44.6% male and 32.6% female) PLHIV had feature fertility desire had despite majority 109(69.7%) of them were not sure about time limit to have child in the future because of they have variable health condition. This mirrors other study (22), which has shown that infection with HIV depresses, but does not eliminate, desire for future fertility. However, these figures are higher than some studies conducted elsewhere among PLWHA with HIV/AIDS in SSA. In Nakemt, Ethiopia 41% male and 30.7 female had future fertility desire, and 23.9% fertility desire Jimma Ethiopia(9, 10), In a Ugandan study 35% of PLWHA reported that they wanted to have more children. While in Nigeria, a similar study found a relatively higher proportion (64%) of PLWHA who expressed a desire to have more children (50). Fertility

desire in this study is lower than study conducted in Addis Ababa, 40.2% (20).

Fertility desire proportion is higher in male, married followed by never married, perceived self health status good, age 30-41.9 and no or fewer number of children than desired to their contra part. This confirms to others studies finding. Study in USA among those desiring children higher proportion of men actually expects to have one or more children in the future. Generally, HIV-positive individuals who desire children are younger have fewer children and report higher ratings of their physical functioning or overall health than their counterparts who do not desire children, yet desire for future childbearing is not related to measures of HIV progression (22). This study finding also conforms to findings reported in Nigeria and South Africa (21). Higher fertility desires among married individuals can be explained by the social expectation of marriage as reported elsewhere.

Proportion of family planning methods use after diagnosis is higher than prior to diagnosis. 183(44.9%) PLHIV use any of FP methods prior to diagnosis and after diagnosis about 296(65.9%) PLHIV use any of FP methods. About 78.3% male, 118(54.9%) women of reproductive age and 208(88.5%) married couples were using any of family planning methods during study period. These figures were comparable or less than studies result conducted elsewhere. Study conducted in Jimma Ethiopia revealed that about 82.3% female use contraceptives (8) and in other study at Nakemt Ethiopia 73% of male and 60.3% female use contraceptives (7). The overall level of contraceptive use by PWH is higher than the general population. According to EDHS 2011 national survey the contraceptive prevalence rate for all Ethiopian women age 15-49 is 20 percent. The contraceptive prevalence rate is 29 percent for currently married women, and 57 percent for sexually active unmarried women. One possible reason for this high difference could be the difference in reference populations.

The common used methods prior to diagnosis were injectable 88(21.6) followed by pill 80(19.6). While the condom is by far the most popular among PWH (249(88%)) followed by injectable (113 (39.9%)) after infection. This mirrors findings of study conducted in Jimma and Nakemt Ethiopia (7, 8).

Overall unmet need was 26.5% and among married PWH 15.6% that was less than national 25% unmet need among married couples. In this study unmet was higher among single, females, illiterate or no formal schooling. This finding confirms study conducted in Nairobi Kenya. Unmet need is higher women than singles in the general population; unmet need is higher among the singles than the married among PLWHA. This might imply low demand for children among the singletons, who are mostly widows or divorcees. The level of unmet need varies by background characteristics and is higher among women compared to men. Unmet need is highest amongst the younger (18-29) and older cohorts (40 plus) of PLWHA and increases with the number of living of children. These findings highlight two related issues: high levels of unmet need for spacing among young cohorts who intend to have children in the future and high levels of unmet need for limiting among older women who have reached or exceeded their desired family size. Unmet need reduces with educational level highlighting the importance of education in empowerment in terms of knowledge and female autonomy.

CONCLUSION

69.1% PLHIV were sexual active last six month. It was positively associated with being male, young age, married, have STI after infection and future child desire.

156(38.2%) had desire to have child in the future despite majority 109(26.7%) of them were not sure about time limit to have child in the future because of they have variable health condition. Overall, the fertility desire of PLWHA is lower than the general population, not least because they are more likely to be widowed, divorced and have health and (re)infections concerns to contend with, among other reasons. Fertility desire was positively independently associated with childless or fewer number of children, young age and perceived health status as good net of other factors.

After HIV infection family planning methods use mainly condom utilization by PLHIV was increased. Family planning methods use prior to

diagnosis was 183(44.9%) it was less than current use of contraceptive 296(65.9%).

PLHIV are sexually active, continue to desire children and want to space and limit their fertility. But for a number of reasons their SRH care needs are not being met. Socio-demographic issues influenced sexual practices, fertility desire and demand for contraception. This implies that socio-cultural norms surrounding sexual behavior and fertility preferences are significant regardless of place of residence and HIV status. Parenthood is an important facet of PLWHA social status as well and childbearing is sometimes seen as a sign of health. The inherent social rewards of childbearing, in the context of poverty and limited access to social security, and its inherent risk of transmitting the virus are complex issues in reproductive decisions among PLWHA.

Sexual desire of majority of PLHIV was reduced after infection. The findings suggest that PLWHA could benefit from counseling around sexuality as a whole, not just risk reduction as is usually the case. Safe sexual activity is an important facet of the overall quality of life of PLHIV.

ART improves life expectancy, is associated with better pregnancy outcomes, reduces horizontal and vertical transmission and pregnancy and contraceptive use is not associated with disease progression. However, this information is not relayed to the clients by providers to ensure informed reproductive decision making. Therefore providers should;

RECOMMENDATIONS

- Provide comprehensive, balanced and up-to-date information on the benefits of ART, accurate reproductive health information, free of personal bias, to allow for informed choice by PLHIV in order to achieve their reproductive goals.
- Be equipped with up-to-date information on ART vis-a-vis horizontal and vertical transmission of HIV.
- Be provided with continuous training and skills on how to provide this information to their clients.
- Consider fertility desire screening as part of guidelines and counseling protocols of routine HIV/AIDS care. Meeting SRH of PLWHA means more than just counseling those who want to avoid pregnancy; a balanced counseling approach also includes supporting those who desire future childbearing.
- Educate HIV positive couples about timed unprotected sexual intercourse during ovulation only and using condoms all the other time.
- Methods of safer conception should be available. There are technologies in resource-rich settings that can ensure safer conception for PLHIV such as artificial intrauterine insemination and sperm washing.
- SRH and HIV integration is promising approach for addressing both HIV/AIDS prevention and care and reducing unintended pregnancies.

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