

Perspectives of PLWHIV on the Need for the Integration of Reproductive Health Services with HIV Services

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Abstract: ***Introduction:** PLWHIV have unique sexual and reproductive health needs. As the primary focus of HIV programmes has shifted from information and education on the prevention of HIV infection to the provision of treatment for AIDS, there is increased need for a functioning health system that can deliver both HIV and sexual and reproductive health services. **Methods:** Mixed methods of quantitative and qualitative data collection, using a pretested, interviewer-administered questionnaire as well as focus group discussions were carried out in 2 hospitals. Data was processed using SPSS software packages version 18; tests of significance were done at $p < 0.05$. For the qualitative data, information from FGDs was analysed using the N-Vivo8. **Findings:** For the quantitative aspect, a total of 826 respondents were interviewed; mean age (standard deviation) 29.6 (8.0) years. All the respondents 826 (100.0%) had done Voluntary Counselling and Testing. Only 265 (32.1%) respondents had received PMTCT service during a current pregnancy 119 (44.9%). For those that did not receive it 437 (77.9%) would have preferred to receive it while the issue of combining (integrating) VCT, PMTCT and FP services were strongly agreed to by 446 (54.0%). For the qualitative data two FGDs were conducted. The FGD participants were aware of the available HIV prevention services and expressed their preference for the integration of HIV services and reproductive health services. **Conclusion:** PLWHIV have expressed preference for integration of HIV and reproductive health services, therefore this should guide design of services to adequately meet their reproductive health needs.*

Keywords: Reproductive health, HIV, Sexual health, Integration

1. Background

The HIV pandemic has become an important public health problem in Nigeria. Although several preventive and control programmes are in place to reverse increasing prevalence of the disease, the efforts at attainment of desired objectives like exploration of fertility desires and reproductive health care choices among PLWHIV in our public health facilities are limited by non-availability of information which shows an inefficient health system. Adjusting Sexual and Reproductive Health services to meet the needs of People Living With HIV is a growing concern and yet very few insights into these issues where HIV is most prevalent exist. With an improvement in the universal access to HIV treatment, most countries with significant declines in HIV prevalence also have a significant change in their sexual behaviour and fertility desires of either men or women. There is therefore an urgent need for interventions to address HIV care and Sexual and Reproductive Health counselling and services that account for the diverse reproductive needs of these populations. This study aims at informing the enhancement of reproductive health service counselling and service delivery among HIV-infected women and men attending HIV care services in Enugu state through integration of their services.

2. Introduction

There is a felt need expressed by the PLWHIV to meet up with reproductive goals based on the fact that their life span has reduced and this makes issues of concern about their fertility desires paramount.¹ The significance of this is the implication of transmission of HIV to their partners and new born and they have to consider the potential risks to themselves and future children and also meet the

expectations of their families.² There is also increasing advocacy on respecting the reproductive rights of PLWHIV yet there is a slightly different pattern in the health advice given to the PLWHIV on their plans for fertility.^{3,4} The integration of HIV/AIDS prevention, care, and support activities into already established health services used by the general population like the reproductive health services can help improve their access to available reproductive health choices and family planning methods.⁵ These choices can be made if reproductive health services are provided jointly with HIV-related services. Recently and in most settings, HIV and family planning services have been offered as separate services.^{6,7}

Integration is the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.⁸ Integration also means incorporating aspects of two or more types of services as a single, coordinated and combined service. Current debates on the relationship between sexual and reproductive health and HIV now focus on advantages, disadvantages and costs of co-located services in relation to strengthening of linkages between specialized services. Health service integration aims to increase access to (and quality of) health service.⁹ It would mean having various services on offer at the same facility (or through a functional referral system) with health service providers actively encouraging the use of other services during a visit.¹⁰ Integration of services can be argued to be the most logical way to organize a health system and indeed the only way that does not compromise universal access to a broad range of services.⁸

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In the 1994 International Conference on Population and Development, participants made a commitment to increase the availability of comprehensive sexual and reproductive health (SRH) services for women, men and young people globally. On the recognition that there is no standard, universal package of SRH services, emphasis was placed on the integration of services such as family planning (FP), maternal and child health (MCH), antenatal care (ANC) and prevention and management of sexually transmitted infections (STIs) and HIV in order to provide clients with a more holistic approach to their reproductive health needs.¹¹ Integrating and expanding Reproductive Health services with HIV services provide opportunities for institutions to respond to their responsibility of supporting the PLWHIV to get the care they need and for clients to benefit from knowing their HIV status. As large-scale roll-out of HIV-related programmes begins in resource-constrained settings, some countries are considering situating HIV related services and programmes within existing reproductive health and maternal and child health services.¹² This has important implications for access to services.

Over time, systems for the delivery of HIV and sexual and reproductive health services are developed in parallel whilst influencing each other; in many cases, they are now slowly being brought together or linked.¹³ As the primary focus of HIV programmes has shifted from information and education on the prevention of HIV infection to the provision of treatment for AIDS, there is an increased need for a functioning health system that can deliver both HIV and sexual and reproductive health services. Convergence, therefore, is increasingly recognised as an imperative.

To add to the foregoing, some reasons for the integration of Reproductive Health services with HIV services are highlighted below. Firstly, PLWHIV are more vulnerable to certain sexual and reproductive health problems than people who are not infected with HIV. A good example is pre-cancerous cervical cell abnormalities, which may be more prevalent and more persistent in women with HIV.¹⁴ Secondly, PLWHIV have some unique sexual and reproductive health needs, for example, treatment and support to reduce the risk of HIV transmission to infants during childbirth and breastfeeding. Moreover, integrated health services can be cost-effective, client-oriented, equitable and locally owned. The “cost” part of cost-effectiveness is based on the idea that it is more economically efficient to share resources (especially human resources) than to have everyone facing one particular disease. The “effectiveness” is based on the idea that it is more beneficial to deal with a whole person (may include his or her family, sexual contacts etc.), rather than focusing separately on just one health problem in an individual.⁸ Furthermore, there is more chance of ensuring more equitable access across the spectrum of priority conditions than do a series of single-issue programmes.⁸ Finally, the argument of AIDS ‘exceptionalism’ and the nature of the HIV epidemic mean that it is important to regard HIV/AIDS services as a special case which needs to be well resourced, expanded quickly and “protected” from the inefficiencies of the broader health system.^{14 15}

The objective of this study therefore is to explore the perspectives of PLWHIV on the need for the integration of reproductive health services such as ANC with HIV services with the aim of providing information to support policy makers on the special reproductive needs of People Living with HIV.

3. Methodology

This was a cross sectional descriptive study and involved mixed methods of quantitative and qualitative data collection. It was carried out in the University of Nigeria Teaching Hospital and Enugu State University Teaching Hospital (ESUTH) both of which are in Enugu State, South-eastern Nigeria. The HIV services rendered in this center include Voluntary Counselling and Testing (VCT), health education, relevant investigations, antiretroviral treatment of eligible, confirmed cases of HIV, PMTCT, post exposure prophylaxis (PEP) and data collection, collation and management and transmission to all relevant agencies.

All the PLWHIV registered in the ART clinics of these facilities were studied. Inclusion criteria were male and female patients who were attending the ARV clinic; who were diagnosed of HIV and aged above 15 years and who were receiving ARV drugs. Exclusion Criteria were patients who did not give their consent and patients who were mentally retarded.

The minimum sample size for each facility to be studied was 313.788 (~314) based on a similar Nigerian study with 95% confidence level and proportion of PLWHIV who desired to have children of 71.4%.¹⁶ The estimated sample size was rounded up to 400 for each facility to permit a degree of more robust analysis. To obtain this sample size, a systematic random sampling method was used. One patient was selected as the first patient by simple random sampling among the first 5 patients who registered; from then every 5th patient was selected until the sample size of 400 was completed in each facility and also for those who met the inclusion criteria.

The study instruments included a pre-tested semi structured self and/or interviewer administered questionnaire, a pre-tested Focus Group Discussion guide for the interview (FGD) guide, and a respondents’ informed consent form. Data was collected using pre-tested interviewer-administered questionnaire with standard questionnaires that had been used in similar studies.^{17, 18} Six trained interviewers (3 in each site) who understood both languages conducted a face to face interview for data collection.

Qualitative data was obtained with the use of focus group discussions. This method of data collection was employed because issues and factors (socio-economic, cultural, demographic etc.) affecting Reproductive Health choices would be better explored by qualitative methods. This ensured that findings were valuable for the target group and would also generate questions for the questionnaires. Two FGDs were conducted in a chosen place (one for the males and one for the females) so as to enable each gender group talk openly. The discussion was facilitated by a moderator (trained sociologist) and a note taker (the researcher).

Each group consisted of 8 to 10 persons chosen from the facilities. However, these persons were not included in the questionnaire survey. The interview guide for the discussion was subjected to a two-way translation (English-Igbo-English) and each FGD lasted about 60 to 90 minutes. The same was done for the FGD for the females. Participants were selected purposively to ensure that they constitute people that can give the most desired views of the events under investigation. This interview took place in a quiet place to avoid interference of noise. The FGD respondents were communicated by phone call using the phone numbers in the folders or attendance register of these facilities. These interviews were recorded with the consent of the participants and transcribed not more than 24 hours later to avoid loss of data.

For quantitative data analysis, data was entered from the data sheets and questionnaires into the computer and processed using SPSS software packages version 18; Chi-square tests were used for tests of significance for proportions and the means for continuous variables were calculated. Tests of significance were done at p -values of 0.05.

For the qualitative data, information from the FGDs was analysed using the N-Vivo 8 software. Transcripts (in MS-word or Rich Text Format) made on the same day as the interview or shortly after were reviewed initially to identify primary themes. Parts of the transcript were cut and pasted to 'source' in the software and coded into different themes. By the principle so of grounded-theory, open-coding was then used to review the data line-by-line to isolate additional relevant themes and concepts in participants' responses as well as to use the points to create nodes which are a summary of the important things said. Idea codes such as theories related to behaviour change from the example question "Are there specific factors in the public health center that make women not to attend antenatal care in recognized health facilities?" were reviewed and the themes in the data grouped into theoretical concepts, such as 'distance to facility', 'staff attitude', 'cost of service' etc based on the data along with wider bodies of theory. The results from the nodes and the results across groups and interviews were synthesized and summarized and used to guide the achievement of the objectives by drawing conclusions from the interviews.

Ethical consideration

Ethical approval for the study was obtained from the Research and Ethics Committee of both the Universities of Nigeria Teaching Hospital Enugu and the Enugu State University Teaching hospital while permission to carry out the study was obtained from the facility heads.

4. Results

Quantitative data

A total of 826 respondents were interviewed. A total of 826 respondents were interviewed; mean age (standard deviation) 29.6 (8.0) years; 65.7% female while 57.6% were married. 55.4% of them had at least 2 living children. Please see table 1 below.

Table 2 shows that all the respondents 826 (100.0%) had done Voluntary Counselling and Testing in their last clinic session. There was also a 265 (32.1%) respondents who had received PMTCT service and 561 (67.9%) who had not. Those that received PMTCT received it during a current pregnancy 119 (44.9%), 98 (37.0%) during their last pregnancy and 48 (18.1%) received it during the last 2 pregnancies. For those of them that did not receive it 437 (77.9%) would have preferred to receive it while 124 (22.1%) would not prefer to have received it.

In the same way, family planning had been discussed with 366 (44.3%) of the respondents during a current clinic session 280 (76.6%), 3 months ago 50 (13.7%), 6 months ago 21 (5.7%) and 1 year ago 15 (4.1%). For the respondents that did not receive family planning 460 (55.7%) about 431 (93.7%) of them would prefer to receive it while 29 (6.3%) would not prefer to receive it.

The issue of combining (integrating) VCT, PMTCT and FP services were strongly agreed to by 446 (54.0%), agreed to by 202 (24.5%), strongly disagreed to by 115 (13.9%) and disagreed to by 63 (7.6%) of the respondents. Please see table 2 below:

Qualitative Data

Focus Group Discussion

Themes covered in the presentation of the findings of the study include socio-demographic characteristics of the respondents; knowledge of HIV/AIDS transmission and causes, knowledge on HIV prevention, information on HIV services, information on integration services, factors for non-attendance of PLWHIV to ANC, fertility characteristics of PLWHIV, factors associated with fertility desires of the PLWHIV and ANC service for PLWHIV. The age range for the males was 23 to 41 years while for the females was 22 to 47 years. This is seen in Table 3 and 4 below.

Knowledge of HIV/AIDS transmission and causes

For most of the participants, being knowledgeable about HIV/AIDS transmission and causes means having some information on the different routes of transmission available and what harmful practices can predispose one to contracting HIV. This can help an individual make informed choices regarding sexual behaviour and healthy practices. Responses from the IDI participants showed that most of the respondents seemed to have good knowledge of what HIV/AIDS meant and ways of preventing it. Some of the respondents could understand that HIV was a deadly disease which leads to death eventually. Most of them also know the causes and transmission of HIV. They gave a range of responses to buttress this. Responses gathered from the participants on their understanding of HIV were as follows:

"HIV means Human Immunodeficiency Virus. What I understand is that it is a virus that attacks the antibodies that guards our immune system and if not properly treated, it can lead to AIDS" -FEMALE 34 YEARS

"HIV means the infection is there but has not reached up to AIDS and it can be treated. People call it nje or obirinaajaocha" -FEMALE 55 YEARS

"Apart from sexual relationship, it can be contracted from blood transfusions and Mother to Child Transfusion, breastfeeding especially when the mother is not on ARV drugs. Another route is from unsterilized instrument." - FEMALE 34 YEARS

"It can be caused by using needles together and sex without condom" -FEMALE 55 YEARS

Knowledge on HIV prevention

Preventing HIV means knowing the different causes and thereby living a healthy lifestyle devoid of harmful practices. The responses from the participants indicated that they had fair to good knowledge on ways of preventing HIV as captured in the following quotes below:

"Being faithful to your husband and being born again"- FEMALE 22 YEARS

"The HIV spread can be prevented by the HIV patients living a positive life by avoiding anything that will transfer the virus to our partners by for instance transmitting blood to the person because their own blood is already contaminated. Another way is by attending PMTCT so that you don't transmit it to the child when pregnant" -FEMALE 34 YEARS

"By using your personal things e.g. shaving stick and by avoiding intimate relationship that involve blood" -MALE 38 YEARS

Information on HIV services

This information refers to the awareness people have on the available HIV services and when and where to acquire them. Not being aware of available HIV services or having any information on them could push patients to make wrong choices in treatment seeking. Information from the respondents on the activities at the HIV clinic as well as information on the best time for the PLWHIVs to register and receive drugs and their varied responses is illustrated below:

"Oh, when you do the test, you will know your CD4 count, if it is okay, you will not start taking the drugs but if you do the test and it is too down then you will start taking the drugs. Unless you are pregnant, you can start immediately" ---MALE 23 YEARS

"We do the check here and they will teach you about the condition"--- MALE 24 YEARS

"Delay can be dangerous so you should start coming to hospital to enroll and they will be monitoring your CD4 count to know when you should start taking the drugs." --- MALE 35 YEARS

Information on integration of services

Integration means combining services to make for easy accessibility to patients who need them. A range of services can be provided at one stop for patients. It would help ensure that these services are utilized and would also save funds for the users. The participants gave a range of information below on the services that they receive at the HIV clinic and

their preferences on whether combining or integrating these services would help improve their level of use.

"ANC place is different altogether and by the time your mates are leaving the hospital, you will now begin the journey to where you will collect your drugs. It kills time. Atimes you spend the whole day" ---FEMALE 34 YEARS

"PMTCT is here but the labs are different, it will be better if they are together" ---FEMALE 37 YEARS

"No because where we get our cards is different from where we collect our drugs and is different too far from where we conduct our tests. That is why I said no" ---FEMALE 55 YEARS

Factors for non- attendance of PLWHIV to ANC

There are different reasons why most PLWHIV who are pregnant do not attend ANC. The participants gave information on some of these factors which influence non-attendance, registration. This helped to explore the role of socio economic factors e.g. house-hold related factors, social, economic; health facility factors, health worker factors, drugs and to find out other likely reasons The responses given include the following:

"I want to add that lack of money is another problem because when a woman finds out that she is pregnant, we pay N3000 to register i.e. booking for PMTCT" ---FEMALE 34 YEARS

"It may be family decision because a patient may be too ill and will need to be carried to everywhere. The family will decide on where to take him or her"---- MALE 24 YEARS

"The stigma is too much and can make someone lose a lot even their jobs so people do not always want to disclose it" - ---MALE 35 YEARS

"The drugs are free and the nurses are trying, the only problem I notice is that people with this problem are increasing so you would have to wait for a long time before you see doctor" ---MALE 38 YEARS

ANC service for PLWHIV

Pregnant PLWHIV also need ANC service for better management of both mother and baby. This is often better if patients deliver in the same facility where they registered. Information on the available ANC services for the PLWHIV were gathered from the participants. This includes where these pregnant women go to for delivery and why they go to the preferred facility specified and how. Quotes captured include:

"It is better to go to where you did your PMTCT so that you can be helped and they will take good care of the child because they already know their condition"--FEMALE 34 YEARS

"They normally go to the hospitals where they register so that when they have the baby they will immediately give the child the drugs they normally give for 6 weeks before giving the child septrin."---FEMALE 28 YEARS

"They normally go to the hospitals where they registered first and will be going there until they deliver."----MALE 35 YEARS.

5. Discussion

The respondents had a mean age of about 29.6 years (SD +8.0) years (table 1). More than 50% of the respondents were females. Majority of these females are in their reproductive age group 25-34. This supports the findings of other studies that women of the reproductive age are increasingly affected by HIV/AIDS¹⁹It also shows the importance of the vertical route of HIV transmission from mothers to their unborn child as they will be exposed to this risk during childbirth.²⁰

All the respondents had done a Voluntary Counselling and Testing (VCT) in their last clinic session. They were all in different phases of counselling which varied from a pre-counselling to post counselling for follow up and to ensure adherence to treatment. This shows that the patients are receiving adequate counselling and are exposed to the information they require for positive living. Most of the patients did not receive PMTCT but this may be because only 44.9% of the females were pregnant at the time of the study. Interestingly majority of these female respondents indicated they would have preferred to receive it indicating a service gap.

The same trend was noted on the issue of family planning where majority of the respondents who did not receive family planning would have preferred to receive it in HIV and AIDS clinics or centres. On the issue of integrating VCT, PMTCT and FP services, more than half of the patients strongly agreed to this idea. This was similar to a facility survey study which showed that 70% of women who needed additional information on family planning preferred to receive this in HIV and AIDS clinics.²¹The finding that most respondents would prefer the Reproductive Health and HIV services combined, suggests the need for integration of Reproductive and Health services and family planning with HIV-related services. This is of importance as it would also be easy for the respondents to have access to all services. Integration of family planning and Reproductive Health services with the health care of the PLWHIV has implications for reducing new HIV infections and to expand the coverage of family planning services in underserved populations.²²Furthermore, informed choices can be made if these services are provided jointly rather than offered as separate services in most settings. Policy-makers and health care providers need to anticipate the increased fertility intentions among PLWHIV when developing specific reproductive counseling packages for their health care.

6. Conclusion

PLWHIV have expressed their preference for the integration of HIV services and reproductive health services, therefore, policy makers should take into cognisance their special needs and thus design services to adequately meet the reproductive health needs of PLWHIV.

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Table 1: Baseline Socio-Demographic Data Of Patients

Socio-demographic characteristics	N= 826, Number (%)
Age (years)	
• 15-24	245 (29.7)
• 25-34	366 (44.4)
• 35-44	181 (21.9)
• 45-54	26 (3.1)
• 55 and above	8 (1.0)
Mean (standard deviation) 29.6 (8.0)	
Sex	
• Male	283 (34.3)
• Female	543 (65.7)
Ethnicity	
• Ibo	593 (71.8)
• Hausa	134 (16.2)
• Yoruba	97 (11.7)
• Others	2 (0.2)
Religion	
• Christian	693 (83.9)
• Moslem	132 (16.0)
• Traditional	1 (0.1)
Marital status	
• Married	484 (58.6)
• Single	94 (11.4)
• Widowed	6 (0.7)
• Separated/divorced	242 (29.3)
Living with partner	
• Yes	533 (64.5)
• No	293 (35.5)
How long in years (Mean = 3.18 years, SD =4 years)	
• 1-10 years	472 (88.6)
• 11-20 years	30 (5.6)
• 21-30 years	6 (1.1)
• < 1 year	25 (4.7)
Main occupation	
• Unemployed	93 (11.3)
• Farmer	91 (11.0)
• Trader	358 (43.3)
• Civil servant	167 (20.2)
• Self-employed	39 (4.7)
• Student	77 (9.3)
• Artisan	1 (0.1)
Highest educational level	
• None	52 (6.3)
• Primary	130 (15.7)
• Secondary	441 (53.4)
• Tertiary	203 (24.6)
Have children	
• Yes	469 (56.8)
• No	357 (43.2)
No of children alive N = 469	

<ul style="list-style-type: none"> • 1 • 2 • 3 • 4 	57 (12.2) 260 (55.4) 150 (32.0) 2 (0.4)
Sex of children? <ul style="list-style-type: none"> • Male • Female • Both 	194 (41.4) 154 (32.8) 121 (25.8)
Average household monthly income N = 826 <ul style="list-style-type: none"> • < N20,000 • N20,000 to N40,000 • >N40,000 to N60,000 • >N60,000 to N80,000 • >N80,000 Mean = N20,000 to N40, 000)	383 (46.4) 179 (21.7) 128 (15.5) 105 (12.7) 31 (3.8)

Table 2: Experiences with family planning services and VCT

Variables	Number (%)
Have you done a Voluntary Counseling and Testing? <ul style="list-style-type: none"> • Yes • No 	826 (100.0) 0 (0.0)
If yes, when was the last time you discussed this? <ul style="list-style-type: none"> • This clinic session • Last clinic session 	0 (0.0) 826 (100.0)
If no, would you have preferred it to be discussed? <ul style="list-style-type: none"> • Yes • No 	0 (0.0) 0 (0.0)
Did you receive PMTCT service? (Female respondents only) N = 543 <ul style="list-style-type: none"> • Yes • No 	265 (48.8) 278 (51.2)
If yes, when was this? <ul style="list-style-type: none"> • This pregnancy • Last pregnancy • Last 2 pregnancies 	119 (44.9) 98 (37.0) 48 (18.1)
If no, would you have preferred to receive it? N = 278 <ul style="list-style-type: none"> • Yes • No 	221 (79.5) 57 (20.5)
Ever discussed family planning at the clinic? N = 826 <ul style="list-style-type: none"> • Yes • No 	366 (44.3) 460 (55.7)
If yes, when was this? N = 366 <ul style="list-style-type: none"> • This clinic session • 3 months ago • 6 months ago • 1 year ago 	280 (76.5) 50 (13.7) 21 (5.7) 15 (4.1)
If no would you have preferred to have it? N = 460 <ul style="list-style-type: none"> • Yes • No 	431 (93.7) 29 (6.3)
Better to have VCT, PMTCT and FP combined (integrated) N = 826 <ul style="list-style-type: none"> • Strongly agree • Agree • Strongly disagree • Disagree 	446 (54.0) 202 (24.5) 115 (13.9) 63 (7.6)

Table 3: Socio-Demographic Characteristics of Male FGD Respondent

IDNO	AGE	OCCUPATION	EDUCATION	RESIDENCE
FGDIDNO1M	23	Trading	Primary	Ochi Street
FGDIDNO2M	35	Teaching	Secondary	Independence Layout
FGDIDNO3M	33	Trading	Secondary	Ogui New layout
FGDIDNO4M	24	Civil servant	Secondary	Iva Valley
FGDIDNO5M	41	Business Man	Secondary	Coal Camp Enugu
FGDIDNO6M	40	Trading	Primary	Ibiam Street
FGDIDNO7M	35	Trading	Primary	Achara Layout
FGDIDNO8M	38	Trading	Primary	Abakpa Nike Road

Table 4: Socio-Demographic Characteristics Of Female FGD Respondents

IDNO	AGE	OCCUPATION	EDUCATION	RESIDENCE
FGDIDNO1F	22	Trading	Primary	Idaw River
FGDIDNO2F	34	Teaching	Secondary	Awolowo Street
FGDIDNO3F	37	Trading	Secondary	Nwosu Terrace
FGDIDNO4F	28	Civil servant	Secondary	Coal Camp
FGDIDNO5F	44	Hair dressing	Secondary	Uwani Enugu
FGDIDNO6F	47	Trading	Primary	Umunaga Street
FGDIDNO7F	31	Trading	Secondary	Maryland Layout
FGDIDNO8F	38	Trading	Secondary	Achara Layout