Fertility and Desire for Children Among HIV Infected Persons With Special Reference to Mumbai

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Abstract

HIV transmission is likely to increase as more infected individuals chooses to have children with their HIV-negative partners. Despite the growing importance of fertility issues for HIV-infected persons, little is known about their actual fertility desires and intentions. Paper tries to give review of studies done to examine the effect of HIV on fertility especially desire for children. An attempt has also been made to give empirical evidences of desire for children and contraceptive use among HIV-infected persons in Mumbai. It has been found that HIV affects fertility directly as well as indirectly. Almost all of the sample population wanted to have children but their HIV-status limit them from parenthood. However, a considerable percentage was intending to have at least one child in any case. Therefore, it generates the need for counseling to facilitate informed decision-making about childbearing and childrearing, and future demand for social services for children born to infected parents.

Introduction

It is now more than two decades since the first case of HIV was diagnosed. Since the onset of HIV/AIDS, all regions of the world have experienced the pandemic. According to UNAIDS/WHO, today some 37.8 million people (range: 34.6 – 42.3 million) are living with HIV, which killed 2.9 million (range: 2.6 – 3.3 million) in 2003, and an estimated 4.8 million people (range: 4.2 – 6.3 million) became newly infected with HIV in year 2003 itself. This means that HIV/AIDS has had a heavy toll of human lives and adversely affected many activities in the world. Considering regional variation, it has been found that sub-Saharan Africa remains by far the worst affected region hit by the HIV/AIDS epidemic. In the end of 2003, an estimated 25.0 million people in this region were living with HIV, which is two-third of the people living with HIV/AIDS in the world.

India has been living with the human immunodeficiency virus for about two decades. Keeping in mind the size of the country, its high population density and interstate migration, prevention of spread of HIV and also provision of health care facilities to people with HIV/AIDS are both critical and a mammoth task. The latest World Bank report says that the number of Indians with HIV infection could rise to 5.5 million by 2033 – unless urgent steps are taken (World Bank, 2004). It also stated that without a change in the treatment policy and progress in prevention, HIV/AIDS would become the single largest cause of death in the world's second most populous nation by 2033, accounting for about 17 percent of all deaths and particularly, 40 percent of

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infectious deaths. India has the largest number of people living with HIV/AIDS after the South Africa and experts fear it could soon vault to the top of the world's list.

The impact of the epidemic has included: increased morbidity rates, higher infant, childhood and adult mortality, a large number of orphans and widows, deterioration of health sector, poorer households, reduced agricultural output, disrupted business activities, adverse effects on education and fertility change. Research on impact of the epidemic on fertility has recently received some attention. HIV/AIDS has influenced fertility of individual women through proximate determinants of fertility, namely, marriage, contraception, pregnancy, abortion, breastfeeding, postpartum abstinence, pathological sterility and natural fecundity. Fertility may decline in the era of HIV/AIDS because of delayed onset of sexual relations and age at first union, reduced premarital sexual relations and remarriage and increased marital resolution.

There has been a remarkable increase in the incidence of HIV infection in women and children in the past decade. The alarming rise in the numbers of HIV infected women and children has resulted in a major public health effort directed at preventing the perinatal transmission of AIDS. As regards viral transmission to the offspring, without intervention a mother infected with HIV has a 13%-30% risk of infecting her baby. Judicious use of combination antiretroviral therapy during pregnancy and labor, delivery by caesarean section, and avoidance of breast-feeding are proved measures, which have reduced the risk of vertical transmission to less than 2%. Reproductive assistance to HIV discordant couples can make a significant impact in preventing viral transmission. However, the procedure is quite expensive which may not be availed by many of those living in developing countries.

Objective

The desire of HIV-infected persons to have children in the future has significant implications for the transmission of HIV to sexual partners and newborns. The risk of HIV transmission among individual couples is likely to increase as more infected individuals choose to have children with their HIV-negative partners. Despite the growing importance of fertility issues for HIV-infected men and women, little is known about their actual fertility desires and intentions. Therefore, the present paper tries to give extensive review of studies, which have been done to examine the effect of HIV on fertility especially desire for children. Further, an attempt has also been made to give empirical evidences of desire for children and contraceptive use among HIV infected persons in Mumbai.

Literature Review

The relationship between HIV and fertility is highly complex and are not well understood. Lower fertility among HIV positive women has been recorded in clinical settings (Allen and others, 1993; Batter and others, 1994; Ryder *et al.* 1991) and more recently in population-based studies (Carpenter and others, 1997; Sewankambo *et al.* 1994). Miscarriage, spontaneous abortion and stillbirths appear to be more common in infected women (Gray and others, 1997; Miotti *et al.* 1991; Ryder and Temmerman, 1991; Brocklehurst and Frence, 1998). The increased prevalence of amenorrhoea has also been recorded in women at the later stages of HIV infection (Widy-Wirski *et al.* 1988) and coital frequency is liable to decline. However, if many children of HIV positive women die in infancy, average periods of breastfeeding and abstinence will tend to be shorter and conception rates could increase.

A study done by Zaba and Gregson, to find out the impact of HIV on fertility in African countries, found that Fertility of HIV-positive women is lower than that of HIV-negative women, in all but the youngest age-group, and the differential increases with women's age and epidemic duration. They have also concluded that in populations that do not use contraceptives, HIV-positive women have lower fertility principally as a result of fetal losses consequent to infection with HIV and co-infection with other sexually transmitted diseases; behavioral factors tend to enhance this differential (Zaba and Gregson, 1998). A substantial reduction (29%) was observed in fertility among HIV-infected women compared with HIV-uninfected women in a study, which examines the association between HIV and fertility in Kisesa, a rural area in Tanzania. The fertility reduction was most pronounced during the terminal stages of infection, but no clear association with duration of infection was observed. Use of modern contraception was higher among HIV-infected women. However, both among contracepting and non-contracepting women, a substantial reduction in fertility was seen among HIV-infected women (Hunter, S. C. *et al.* 2003).

Biological mechanisms also influence fertility rates in HIV-positive women and men. Research has shown that women with HIV may find it more difficult to conceive than their HIV-negative counterparts. HIV infected women experience reduced pregnancy rates and higher rates of both planned abortion and miscarriage. HIV/AIDS may induce sterility, increase fetal mortality, decrease production of spermatozoa, and sometimes decrease frequency of sexual intercourse, all contributing to declining fertility. A study carried out in southwest Uganda to better understand the association between HIV disease progression and the incidence of pregnancy observed that among the women with HIV, sexual intercourse became less frequent as HIV

disease progressed. Further they found that “fertility is reduced from the earliest asymptomatic stage of HIV infection resulting from both a reduced incidence of recognized pregnancy and increased fetal loss. The greatest reduction in fertility was observed following progression to AIDS when there was a very low incidence of recognized pregnancies” (Ross, *et al.* 2004).

An earlier study of 412 HIV-positive women in Paris and southeastern France found that the incidence of pregnancy decreased by more than half, from 20.4 per 100 person-years before HIV diagnosis to 7.9 per 100 person-years after HIV diagnosis. The study also showed that the proportion of pregnancies voluntarily interrupted more than doubled from 29 percent to 63 percent after HIV diagnosis. The percentage of miscarriages and ectopic (outside the womb) pregnancies increased significantly from 8.3 percent to 25.4 percent of those conceived before and after HIV diagnosis, respectively. Also, the proportion of women who were sexually inactive rose four-fold, from 5 percent before to 20 percent after HIV diagnosis (Isabelle *et al.* 1997).

Studies suggest that HIV positive women who terminate their pregnancies are more likely to have HIV-related clinical symptoms (Pivnik *et al.* 1991; Johnstone *et al.* 1990), or to have children, or know children, who were sick or died from AIDS than women who continue their pregnancies (Kurth and Hutchison, 1990, 1991). Furthermore, Pivnik *et al.* (1991) found that the likelihood of pregnancy termination increased as time since diagnosis increased, possibly due to the greater probability of the onset of clinical symptoms. Kline *et al.* (1995) found in a study that over 60% of women with good health continued the pregnancy, compared with only 30% of women with more health problems. Further, they observed in multivariate analysis that it is the partner’s desire for children that represent the determining factor for pregnancy; the respondent’s own desire has no direct effect. Study indicate that women who are ignorant of their partner’s HIV antibody status are significantly less likely to use condoms than other women (Kline and VanLandingham, 1994), which would increase the probability of pregnancy.

Carla D'Ubaldo and colleagues of Lazzaro Spallanzani Hospital in Rome studied a cohort of 272 women from 12 Italian cities in the 1990s and found that 63 percent of the women with HIV had an intentional abortion, compared with a lower proportion (45%) of the HIV-negative women. They suggested that HIV affects the placenta by interfering with the transfer of important nutrients to the fetus, or that the virus causes abnormal development of the embryo. Other theories include a direct relationship between HIV and the fetal thymus gland, as well as an increased risk of infection due to the weakened immune system of the mother. HIV may also

directly influence the ability of HIV-positive men to produce healthy sperm. (Carla D'Ubaldo, *et al.* 1998).

A study by Panozzo *et al.* (2003) found that 45 percent of HIV- positive women and 38 percent of HIV-positive men expressed the desire for children. Another study conducted in the United States concluded that overall, 28-29 percent of HIV-infected men and women receiving medical care desire children in the future. Among those desiring children, 69 percent of women and 59 percent of men actually expect to have one or more children in the future. Further, it was observed in multivariate analyses that HIV-positive women who already had children were significantly less likely than others both to desire and to expect more births, partner's HIV status has mixed effects: Women whose partner's HIV status was known were significantly less likely to desire children but were significantly more likely to expect children in the future than are women whose partner's HIV status was unknown (James *et al,* 2001).

In societies with high HIV/AIDS rates, some couples may desire larger families to ensure survival of children, though others limit family size due to concerns about leaving orphans behind after an early death. Women in subjectively good health in particular expressed a desire to have children more often than men (Panozzo *et al.* 2003). Studies have shown that children can be considered as a source of self esteem to women with HIV infection (Andrew, Williams and Neil, 1993; Wesley *et al.* 2000) as it was found that women with children at home had significantly higher levels of self-esteem than women without children.

Safer sex is generally recommended and which usually means prevention of any kind of sexually transmitted infection as well as pregnancy. HIV-infected persons need to know that, aside from abstinence, condoms offer the best protection against STIs. Male or female condoms should be used every time intercourse occurs. This is to avoid HIV transmission to partners and to protect themselves from other STIs (Network, 2001). In a study by Panozzo *et al.* (2003), it was found that about three-fourth of the HIV-positive respondents with sero-discordant partner reported consistent use of condoms. There is concern that sexual partners of HIV-positive women using more effective contraception may not use condoms as consistently as partners of women using less effective contraception (Diaz *et al.* 1995).

Methodology

To have an idea of the association of HIV with fertility or desire for children, extensive review of the studies that are conducted allover the world, especially where the countries are most

affected by HIV, has been done. For empirical evidence of desire for children and contraceptive use, following methodology has been adopted.

Area of the study

The area of the present study is Mumbai, the capital of Maharashtra and the most populous city of India. As Mumbai is India's main economic centre, it welcomes migrant workers from all over India, especially from Uttar Pradesh and Bihar. Mumbai in Maharashtra seems to be the most vulnerable city in India from the point of view of risk behavior and susceptibility to HIV infection. The disease is not only restricted to the high-risk group but has already been spread to the general population especially among housewives. According to a survey by NACO in Mumbai, the prevalence of HIV/AIDS has crossed one percent among women attending anti-natal clinic. Taking all these issues and incidence of HIV/AIDS into consideration, Mumbai was selected to carry out the present research.

Respondents and Sample Design

Present paper utilizes data collected for the Doctoral dissertation, the title of the thesis being *"Consequences of HIV/AIDS and Coping Strategies Among HIV/AIDS Infected Persons: A Case Study of Mumbai".* Respondents in the present study were HIV/AIDS patients who were coming at the Outpatient Department of AIDS Research and Control (ARCON) Centre, which is located in the campus of Sir J.J. Hospital, Mumbai. ARCON is an organization jointly run by Government of Maharashtra and University of Texas, USA. At ARCON, patients are given treatment as well as pre-test, post-test and follow-up counseling. Considering the difficulties in drawing a probability sample of HIV infected persons in Mumbai, because of the life threatening and dreadful nature of the disease, a purposive sample has been drawn to fulfill the objectives. In the present study, all those patients who came for the follow-up counseling during the period of fieldwork were interviewed. In total, 200 HIV/AIDS patients were interviewed.

Tools and techniques of data collection

In the quantitative phase of data collection, the information from the respondents was gathered by using interview schedule. Before finalizing the interview schedule, pre testing was done at ARCON. The interview schedule contained both close ended and open-ended questions. The written consent of the respondents was taken prior to the interview considering the matter of confidentiality. In-depth interviews and case studies at the residence of some of the patients have been conducted during qualitative phase. For the purpose in view, the help from an NGO was taken, which is offering home-based care for HIV/AIDS sufferers.

Methods of data analysis

Quantitative data has been analyzed by univariate and bivariate frequency tables by using SPSS software package. A composite index has been constructed to capture the important economic dimension, which is standard of living index (SLI). Qualitative data, which was collected through in-depth interviews and case studies with the help of tape recorder, has been transcripted first. Qualitative data in verbatim are given to support some of the findings that emerged from quantitative data.

Findings and Discussion

Sample Description

The sample comprised of 65 percent males and 35 percent females. Majority of them were migrants, which was mainly because of financial reasons in case of males and marriage or family union for females. A substantial number of males migrated without family and hence increased the chances of indulgence in risky behavior. The sample population was predominantly Hindu. As far as age is concerned, majority belongs to the most productive years of life with median age of respondents as 32 years. Females were found to be younger than males. Almost all the respondents (90 percent) were literates but their education was mainly up to primary or middle school. Respondents having education more than intermediate were very few in the sample. Little more than half of the respondents (both sexes combined) were married and about one-fourth was widow or widower. Substantial proportion of respondents (18 percent) was unmarried also. The median age at marriage was found to be 20 years. Females were having median age at marriage 4.5 years less than that of the males. As far as staying pattern is concerned, it is observed that more than half of the respondents were either staying with their family, which includes spouse or children, or with their parents. It is worth mentioning here that a few of the respondents were staying alone.

As regards to occupation, about 40 percent of the males were engaged in skilled or unskilled manual work, whereas those involved in white-collar jobs were very few. Females were mostly housewives and working females were mainly engaged in unskilled manual work or as a daily wage laborer. A considerable number of males were unemployed because of their sickness and hence were dependent on others for their day-to-day needs. More than half of the respondents had their monthly income less than Rs. 3, 000/-, which varies across male and female. The standard of living index (SLI) is considered as one of the proxy variables to assess the economic condition of an individual. The index has been constructed by asking several

questions related to housing characteristics and the household possession of different assets. The details of which has been shown in the Appendix-I. It is observed that majority of the respondents fall under the category of low or medium SLI and a few respondents in the sample belong to high SLI group.

Number of Children and Desire for Children

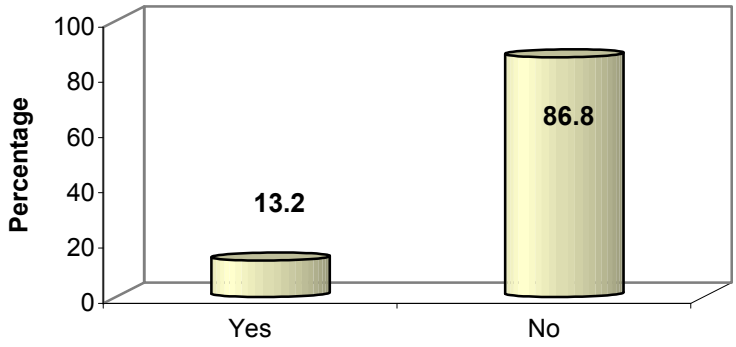
Desire for children within the context of HIV may be seen as posing threat to women, children and society. Desire for children results from inner duality: the need to love and be loved, and individuals who experience inner duality are more likely to want children (Wyatt, 1967). Pregnancy quenches the need to love and be loved, creating an incentive to have more children. For women, the desire for children is determined by social and personal expectations. Another most important demographic attribute is the availability of information on the number of living children, which has manifold implications for almost everybody especially for women. It becomes more important in case of HIV/AIDS, because in India about 85 percent of the infection occurs through sexual route of transmission. Hence, there are chances of transmitting the virus to the spouse as well as to the child through vertical transmission from mother to child. Advances in treatment, such as zidovudine and other antiretroviral drugs, have decreased transmission from infected mothers to their children to about two percent but this treatment itself cannot be afford by a larger chunk.

For further analysis, unmarried respondents have been excluded from the total sample. It was observed that around 22 percent of the respondents did not have any child and another 31 percent had only one child at the time of survey (Table 1.2). Consequently, it is very essential to give serious attention to these persons in order to prevent further transmission of the infection. When the age distribution of this group of respondents was analyzed, it was found that a majority of respondents were in ages between 20 to 35 years, which is the period of high fertility. Among those respondents who were having children, 11 percent of them had HIV positive children (Table 1.3).

At the counseling center, HIV positive persons were told about the pros and cons of conception. Hence, analysis has been done to see the timing of birth of the last child i.e. before or after the diagnosis of HIV status. It was observed that 13 percent of the respondents had their last child after diagnosis (Table 1.3). However, it is very surprising that none of those child were HIV positive, it might be possible that anti-retroviral therapy (ART) had been given to mother during

pregnancy, at the time of birth and few months after birth to prevent the transmission of virus from mother to the child.

Fig. 1: Distribution of respondents according to their desire for children



Further a question was asked to the respondents of childbearing age about their desire for children after getting infected with the virus. It was found that about 13 percent of respondents did want to have a child in spite of the regular counseling (Fig 1). Some of them expressed a desperate need to have a child especially if they had no live children. Various reasons told by them include old age security, lineage, free from the charge of being infertile, leave something of themselves behind after they died, etc. They were confident enough that they would definitely get the child in any case. Those who expressed their desire for children were mostly young (below 30 years).

Desired to have children

After my death there will be some one to take care of husband.

- Female aged 25 yrs

I want to become mother of my own child.

- Female aged 22 yrs

I am the only son in the family, there should be one to carry our family name and look for our parents after our death.

- Male aged 22 yrs

Everybody in the community called me as infertile and I want to get rid of this charge.

- Female aged 26 yrs

Remaining 87 percent of the respondents informed that they wanted to have at least one child because they felt that children gave meaning to their lives and gave them a reason to live. However, they decided not to conceive as they feared infecting their baby and were anxious about leaving either living or future children as orphans. A few were concerned about their ability to financially support their children, given their illness. This certainly affects the overall

fertility situation of the nation especially where the HIV prevalence is very high.

In the counseling sessions, HIV infected persons are advised to adopt safer sexual practices which generally means prevention from further HIV transmission and other co-infection. The best way to achieve this is the consistent use of condoms. This is worthwhile to mention here that before diagnosis of HIV, the use of condom among the respondents was almost negligible (Table 1.4). The main reasons of not using condom while doing sex with spouse were to bear child and lack of awareness about transmission. It was observed from table 1.5 that about three-fourths of the respondents were still continuing sexual relationship with their regular partner after diagnosis. However, a significant change was observed as far as use of contraception is concerned. It was found that a majority of them started using condoms regularly to avoid any kind of infection, which in turn restricts them from conception.

Not desire to have children

Since we both are having a hard time because of infection then why to invite an innocent for suffering.

- Male aged 40 yrs

I am scared that my wife and the child both will be infected.

- Male aged 38 yrs

The money for our treatment is not sufficient then who will give for the child.

- Female aged 24 yrs

Conclusions

The relationship between HIV and fertility is very complex and still it is not well understood. However, from the review of various studies it has been found that HIV affects fertility both directly as well as indirectly. Directly, HIV infection may influence women to voluntarily terminate a pregnancy out of fear of leaving an orphan or transmitting HIV to the child, it reduces the immunity for other infections and hence results in miscarriages, etc. HIV may also reduce men's fecundity and his ability to produce healthy sperms. Indirectly, women with HIV may experience infertility due to co-infection with another sexually transmitted disease. Complications of HIV, such as increased risk of cervical abnormalities, early menopause, pelvic inflammatory disease and severe wasting may also contribute to infertility in women.

Children at home contribute to an HIV-positive woman's sense of self. However, the choice to bear a child decreases with time due to increased clinical symptoms and that pregnancy was associated with multiple health problems. It was also found that women with good health were more likely to carry a pregnancy to term, than women with more health problems. Women who

already had children and whose partner's HIV status was known were less likely to desire children. The partner's desire for children may represent a more important factor in women's reproductive behaviour than the wishes and needs of women themselves. Therefore, counseling programs needs to address not only women's reproductive intensions, but those of her partner as well.

As far as desire for children is concerned, almost all of the sample population wanted to have children but their HIV status limit them from parenthood. However, a considerable percentage was intending to have at least one child in future at any cost. Therefore, the fact that many HIV-infected adults desire and expect to have children has important implications for the prevention of vertical and heterosexual transmission of HIV and the future demand for social services for children born to infected parents. For many HIV infected men and women, health care workers can play a central role in decision-making about childbearing and childrearing. In this regard, counselors' role is seen as particularly crucial. They should give advice as how to balance safer sex practices and the desire to reproduce.

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APPENDIX – I

Standard of living index

Items and Scoring pattern for construction of standard of living index

Items	Categories	Scoring
Type of house	Bungalow	4
	Flat	3
	Chawl	2
	Slum/others	0
Number of rooms	≥3	3
	2	2
	1	1
Type of toilet facility	Toilet in residence	3
	Shared toilet/public	2
	Field/bushes/others	0
Separate room for kitchen	Yes	2
	No	0
Type of fuel for cooking	Gas	3
	Kerosene	2
	Others	0
Own house	Yes	2
	No	0
Does household own	Car	4
	Telephone	3
	Washing machine	3
	Refrigerator	3
	No television	0
	Black & white television	2
	Colour television	3
	Scooter/moped/motorcycle	2
	Radio/transistor/tape	2
	Cycle	1
	Cot/table/chair	1
	Others	3
Drinking water facility	Inside home	2
	Outside home	0
Electricity	Yes	2
	No	0

The value of standard of living index for the present study ranges from 1 to 46. Further, index has been categorized into low, medium and high, on the basis of final index value, which are as follows:

Low SLI: 1 to 15

Medium SLI: 16 to 30

High SLI: 31 to 46

Table 1.1: Distribution of respondents according to various background characteristics						
Background Characteristics	Male		Female		Total	
	Percent	Number	Percent	Number	Percent	Number
Migration status by place of birth						
Migrants	66.7	86	45.1	32	59.0	118
Non-migrants	33.3	43	54.9	39	41.0	82
Came with family [a]						
Yes	27.3	18	93.5	29	48.5	47
No	72.7	48	6.5	2	51.5	50
Age group						
20-24	7.0	9	15.5	11	10.0	20
25-29	14.0	18	36.6	26	22.0	44
30-34	36.4	47	26.8	19	33.0	66
35-39	22.5	29	12.7	9	19.0	38
40 +	20.2	26	8.5	6	16.0	32
Median age (in years)	33	129	29	71	32	200
Education of respondents						
Illiterate	11.6	15	8.5	6	10.5	21
Literate or primary school	26.4	34	22.5	16	25.0	50
Middle school	24.8	32	28.2	20	26.0	52
High school certificate	14.0	18	29.6	21	19.5	39
Intermediate or diploma	14.7	19	5.6	4	11.5	23
Graduation and above	8.5	11	5.6	4	7.5	15
Occupation of respondents						
Non-working/ housewife	9.3	12	52.1	37	24.5	49
Professional/technical/managerial, etc.	4.7	6	1.4	1	3.5	7
Services	13.2	17	5.6	4	10.5	21
Small business	16.3	21	7.0	5	13.0	26
Daily wage labor/ manual worker	44.9	58	32.3	23	40.5	81
Others	11.6	15	1.4	1	8.0	16
Marital status						
Unmarried	27.1	35	1.4	1	18.0	36
Married	62.0	80	32.4	23	51.5	103
Widow	6.2	8	54.9	39	23.5	47
Remarried	0.0	0	2.8	2	1.0	2
Divorced or separated	4.7	6	8.4	6	6.0	12
Median age at marriage (in yrs)	24.0	94	18.5	70	20	164
Monthly income (in Rupees) [b]						
Up to 1500	17.1	20	67.6	23	28.5	43
1501 - 3000	36.8	43	20.6	7	33.1	50
3001 - 5000	28.2	33	8.8	3	23.8	36
More than 5000	17.9	21	2.9	1	14.6	22
Standard of living						
Low	48.1	62	42.3	30	46.0	92
Medium	41.1	53	50.7	36	44.5	89
High	10.9	14	7.0	5	9.5	19
Grand Total	64.5	129	35.5	71	100.0	200

[a] *Includes only ever-married and migrant sample*

[b] *Includes only currently working respondents*

Table 1.2: Distribution of respondents according to their number of children						
Number of children [a]	**Male**		**Female**		**Total**	
	Percent	Number	Percent	Number	Percent	Number
Childless	22.3	21	18.6	13	20.7	34
One child	29.8	28	32.9	23	31.1	51
Two children	24.5	23	27.1	19	25.6	42
Three or more children	23.4	22	21.4	15	22.5	37
Total	**100.0**	**94**	**100.0**	**70**	**100.0**	**164**

[a] *Includes only ever-married sample*

Table 1.3: Percent distribution of respondents by the number of positive children and birth status of the last child		
	Percent	**Frequency**
No. of HIV positive children		
None	89.2	116
One	10.0	13
Two	0.8	1
Last child born		
After diagnosis	13.1	17
Before diagnosis	86.9	113
Total	**100.0**	**130**

Table 1.4: Distribution of respondents by their condom use pattern with spouse before diagnosis of HIV						
Condom Use Pattern	***Male***		**Female**		**Total**	
	Percent	Number	Percent	Number	Percent	Number
Condom use						
Always	0.0	0	0.0	0	0.0	0
Rarely	5.3	5	12.9	9	8.5	14
Never	94.7	89	87.1	61	91.5	150
Total	**100.0**	**94**	**100.0**	**70**	**100.0**	**164**
Reasons for non-use of condom*						
Lack of pleasure	4.3	4	0.0	0	2.4	4
Wanted child	88.3	83	81.4	57	85.4	140
Allergy from the material	0.0	0	1.4	1	0.0	0
Lack of knowledge about condom	12.8	12	8.6	6	11.0	18
Lack of knowledge of transmission	60.6	57	51.4	36	56.7	93
Lack of availability	19.1	18	14.3	10	17.1	28
Misconceptions	2.4	3	4.6	4	4.9	8

* *Multiple responses*

Table 1.5: Distribution of respondents by their sexual behaviour and condom use with spouse after diagnosis of HIV

Sexual behavior	Male		Female		Total	
	Percent	Number	Percent	Number	Percent	Number
Continuation of sexual relation [a]						
Yes	71.3	57	88.0	22	75.2	79
No	28.7	23	12.0	3	24.8	26
Total	**100.0**	**80**	**100.0**	**25**	**100.0**	**105**
Condom use						
Always	78.9	45	90.9	20	82.3	65
Rarely	10.5	6	4.5	1	8.9	7
Never	10.5	6	4.5	1	8.9	7
Total	**100.0**	**57**	**100.0**	**22**	**100.0**	**79**

[a] *Includes currently married sample*