Missed Opportunities for Family Planning Counselling among HIV-Positive Women Receiving HIV Care in Uganda

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Abstract

Introduction HIV-positive women who are still in the reproductive years need adequate sexual and reproductive health information to make informed reproductive health choices. However, many HIV-positive women who interface with the health system continue to miss out on this information. We sought to: a) determine the proportion of HIV-positive women enrolled in HIV care who missed family planning (FP) counselling; and b) assess if any association existed between FP counseling and current use of modern contraception to inform programming.

Methods Data were drawn from a quantitative national cross-sectional survey of 5,198 HIV-positive women receiving HIV care at 245 HIV clinics in Uganda; conducted between August and November 2016. Family planning counseling was defined as receipt of FP information by an HIV-positive woman during ANC, at the time of delivery or at the PNC visit. Analyses on receipt of FP counseling were done on 2,760 HIV-positive women aged 15-49 years who were not currently pregnant and did not intend to have children in the future. We used a modified Poisson regression model to determine the Prevalence Ratio (PR) as a measure of association between receipt of any FP counseling and current use of modern contraception, controlling for potential confounders. Analyses were performed using STATA statistical software, version 14.1.

Results Overall, 2,104 (76.2%) HIV-positive women reported that they received FP counseling at any of the three critical time-points. Of the 24% (n = 656) who did not, 37.9% missed FP counseling at ANC; 41% missed FP counseling during delivery; while 54% missed FP counseling at the post-natal care visit. HIV-positive women who received any FP counseling were significantly more likely to report current use of modern contraception than those who did not (adjusted PR [adj. PR] = 1.21; 95% Confidence Interval [CI]: 1.10, 1.33).

Conclusion Nearly one-quarter of HIV-positive women did not receive any form of FP counseling when they interfaced with the healthcare system. This presents a missed opportunity for prevention of unintended pregnancies, and suggests a need for the integration of FP counseling into HIV care at all critical time-points.

Introduction

Women of reproductive age account for about half of people living with Human Immunodeficiency Virus (HIV) globally (1). Preventing unintended pregnancies among women living with HIV is one of the four comprehensive approaches of confronting unwanted pregnancy among People Living With HIV/AIDS (PLWHA), an approach that was adopted by the World Health Organization (WHO) to promote and prevent the transmission of HIV from mothers to their babies (2). Provision of appropriate counselling and support, and contraceptives, to women living with HIV to meet their need for family planning and spacing of births is a cost-effective intervention to prevent mother-to-child transmission of HIV (3).

However, only a handful of women living with HIV have taken any credible steps to stop unplanned pregnancies.

In many African countries, many women are at risk for unintended pregnancy and HIV infection at the same time (4, 5). In a number of African countries, the rate of unintended pregnancy among women living with HIV (WLHIV) ranges from 51 to 84% (6, 7). A study conducted among WLHIV in Malawi found that only 51.2% used any form of contraception (6). Similar findings were documented in a study done in Ethiopia which found a contraceptive prevalence rate of 30.2%, suggesting a high risk of unintended pregnancy (8, 9). Indeed, a recent systematic review and meta-analysis of unintended pregnancy among WLHIV in sub-Saharan Africa found a pooled pregnancy of unintended pregnancy of 55.9% with the magnitude of unwanted pregnancy and mistimed pregnancy in six studies ranging from 14 to 59% and 9 to 47.2%, respectively (10). These studies show high rates of unwanted pregnancies for WLHIV implying that the unintended pregnancies could be substantially reduced if women used modern contraception.

Several reasons have been advanced to explain the low use of contraception among WLHIV including fears of the likely interaction between hormonal contraceptive methods and antiretroviral therapy (11), fear of side effects and the lack of social support (12). Although there is evidence that receipt of counseling can increase uptake of contraceptives (13), there are indications that many women go through the health system without receiving any form of counseling. For example, a study conducted among women attending antenatal care in Rwanda found that only 17% of pregnant women received any form of counseling on contraception (14). In a study conducted among mothers in western Uganda, it was discovered that current users of FP methods could have been higher if village health teams counselled mothers and at the same time offered alternative contraceptive methods (15). A similar study done among HIV positive women in Nigeria found that although women had knowledge of contraceptives, the percentage of women using any form of contraception was as low as 36% (16). Data from UDHS 2016 show that only 27.3% of women are using modern FP methods. It is unclear what impact if at all this would have on modern contraceptive use given that HIV infected women frequently interface with the health system and have more opportunities to receive FP counseling. This study sought to: a) determine the proportion of WLHIV who missed the opportunity to receive FP counselling, and b) assess the effect of family planning counseling on current use of modern contraceptives.

Methods

Data were drawn from a quantitative national cross-sectional survey of HIV-infected women receiving HIV care at 245 HIV clinics in Uganda. Details about the survey methodology have been published elsewhere (17). In brief, the national survey aimed to assess the unmet need for family planning and determine the uptake of other reproductive health services among WLHIV. Questions relating to family planning counselling were administered to all respondents who participated in the survey.

Study sites

Data for the primary survey were collected at 245 public and private HIV clinics across five geographical regions in Uganda (Central, Northern, Eastern, Western, and Kampala). Kampala, which is the capital city of Uganda, was considered as a separate region owing to its uniqueness. The health facilities were selected from public and private facilities across several levels of service delivery; hospitals, and the lower level health centers (HCIV, HCIII, and HCII) that had HIV care clinics and had had a minimum patient volume that was considered for their eligibility to be in the sampling frame.

Survey Measures

We obtained data on socio-demographic characteristics, disclosure of HIV status to sexual partner, relationship status, and client satisfaction with FP counselling services from all women who were not pregnant enrolled in the above-mentioned survey. Women were asked if they received any form of counseling when they interfaced with the health facility, and if they responded in the affirmative, they were asked at what point they received FP counselling, to determine if it was during ANC, immediately after delivery or during post-natal care. Women were also asked about current use of modern contraceptives; i.e. if they were currently using any of the following methods of family planning: pills, injectable, implant, intra-uterine device, female sterilization, vasectomy (by their male partners) or condom use for family planning purposes. Women were considered to have received FP counseling if, at ANC, during delivery or post-natal care, they reported that they received information about FP and/or discussed FP issues with a health provider. Women who reported that they did not receive such information or discussion on FP at any of the three visits were considered to have a missed opportunity for FP. This analysis was restricted to HIV-positive women who were not currently pregnant and who did not want to become pregnant in the future.

We used responses on household possessions to create an index representing a wealth proxy for the respondents interviewed. The list of household assets probed for included a radio, television set, bicycle, motorcycle, own/family home, cell phone, regular (land line) phone, computer, income generating business, indoor bathroom, running water either inside the house or inside the compound of your house, electricity, car, generator and solar electricity. To construct the socio-economic status (SES) index, each household item was assigned a weight ascertained through principal components analysis. Then, the scores were standardized in relation to a standard normal distribution with a mean of zero and a standard deviation of one. The scores on household possessions were then summed up and individuals were ranked and sub-divided into wealth quintiles, depending on their scores, with each quintile containing 20% of the participants. The SES index was divided into five categories, namely: Lowest, second, middle, fourth and highest wealth quintile.

Data Analysis

Analyses were done on 2,760 women to provide descriptive statistics for women's socio-demographic characteristics. The key variables of FP counselling were determined as proportions. The primary

outcome was receiving FP counselling at ANC, delivery or at post-natal care (PNC). Receipt of FP counselling was determined by women's socio-demographic characteristics. To determine the association between receipt of FP counselling and current use of modern contraception, we used prevalence ratio (PR) as the measure of association. Condom use was excluded in the final model because it tends to overestimate the modern contraception uptake and it is not reliable as a method of contraception if not used consistently and correctly.

Results

Respondents' Characteristics

Table 1 shows the socio-demographic characteristics of the 2,760 women who were included in the analysis. Nearly half (46%, $n = 1,284$) were aged 30–39 years, with the Eastern region having slightly more than half of the women (52.1%) aged 30–39 years. More than half of the respondents (58%, $n = 1,600$) were married, with the highest proportion of married HIV-positive women reported in the Eastern region (66.7%) followed by the Western region (63.1%) and Kampala region (58%) in that order. About a quarter of the women (24.3%, $n = 670$) were in a relationship but not married, with the highest proportion reported in the Central region (36.4%), Kampala region (32%) and the Northern region (27.3%) in that order. More than half of the women (57.4%, $n = 1,585$) had primary education while 24% ($n = 656$) had secondary education with the Western region (65.1%), the Central region (60.4%) and the Northern region (59%) having the highest proportion of women with primary education. It is important to note that nearly a quarter (24.6%) of women in the Northern region had no education.

About 43% ($n = 1,180$) of women were in the lowest or second lowest wealth quintile with women in the Northern region (65%), those in the Eastern region (51.4%) and those in the Western region of Uganda (46.5%) more likely to be in the lowest or second lowest wealth quintile than women in other regions. More than half of women in Kampala region (53.3%) were in the highest wealth quintile while only a small proportion of women in the other regions (5.4–16.9%) were in this category.

Forty-one per cent ($n = 1,122$) of the respondents lived within less than 4km to a health facility in all the regions with Kampala having more than half of the respondents within this distance to a health facility. Majority (97%, $n = 2,667$) of the respondents were on antiretroviral therapy (ART) with slightly more than two thirds of them (66.8%) having been on ART for more than two years. The Central region (100%), Eastern region (98.3%) and the Northern region (96.9%) recorded the highest proportion of HIV-positive women on ART. Only 15.6% ($n = 426$) of HIV-positive women reported that they disclosed their HIV sero-positive status to their sexual partners, and this trend was observed across all the other regions. Forty-three per cent ($n = 1,181$) of women had four or more (4+) biological children, with the proportion of those reporting 4+ biological children recorded in the Eastern (53.3%) and the Northern regions (52.4%) while Kampala region (27.4%) had the lowest proportion of women with 4+ biological children.

Receipt of FP counseling

Table 2 shows the percentage of women in HIV care that were not currently pregnant and who did not want to become pregnant in the future, stratified by whether or not they received any FP counselling; and if so, whether or not they received FP counseling during ANC visit, at the time of delivery or at the post-natal care (PNC) visit. Slightly more than three quarters (76%) of the women reported that they received FP counseling at any of the three points of care (ANC, delivery and PNC). Receipt of FP counselling was highest at ANC (62.1%, $n = 1,715$) but was slightly lower at the time of delivery (59%, $n = 1,629$) and at the PNC visit (46.2%, $n = 1,276$). By region, the proportion of women who received FP counseling was highest in the Western region (81.8%), the Eastern (79.4%) and the Northern region (76%) but was lowest in the Central region (72.8%) and Kampala (70.8%) (Table1). Approx. 58% of the women were found to have received FP counseling at two (24.9%) or three visits (33.1%), with wide variations across regions (Table 1).

Table 2 shows that receipt of FP counseling differed by age, region of residence, point of delivery, health facility where women were enrolled, and ART status. At least 60% of all women across all age groups received FP counselling during ANC with the highest proportion recorded among those aged 30 to 39 years. At the time of delivery, women aged 25–29 were the highest recipients of family planning at nearly 64%. Younger women below 24 years and women aged 40 or more years were the lowest recipients of FP counselling at post-natal care. The Western region had the highest proportion of women who received any form of FP counselling at 82%. Kampala and Central region had the lowest proportion of women receiving FP counselling during ANC with nearly half of women reporting that they did not receive FP counselling during contact with a point of care provider.

At the point of delivery, the Northern region and Kampala recorded at least a half of the women receiving FP counselling while the other half missed out on this service. During postnatal care, the Northern region registered the lowest proportion of women who received FP counselling at 40%. Provision of FP counseling was highest at health Centre IIs and IVs with approximately 80% of the women receiving FP counselling at these facilities. A higher proportion of married women and women educated up to secondary level received FP counselling across the three points of care than unmarried and divorced women although the point of postnatal care was the least used point for counselling. Women on ART were beneficiaries of FP counselling across the three levels of care with 62% of them obtaining counselling at ANC, 60% during delivery and 46% at postnatal care. A higher proportion of women (80% or higher) who had been on ART for two years and those with four or more biological children received FP counselling across the three points of care than their counterparts.

Association between receipt of any FP counseling and current use of modern contraception

Table 3 shows the association between receipt of any FP counselling and current use of modern contraception among women who were not pregnant and who did not want to have any other children in the future. Overall, current use of a modern contraceptive method was 21% higher among women who

received any FP counselling compared to those who didn't (adjusted [adj.] PR: 1.21; 95% confidence interval [CI]: 1.10, 1.33). Current use of modern contraception was also 28% higher among women who had attained more than the secondary level of education compared to those with primary level of education and 28% higher among those who had spent more than two years on ART. Current use of modern contraceptive use was also more than 30% higher among women who had two or more biological children than their counterparts. We found that current use of modern contraception increased with the increasing number of FP counseling visits but this analysis was restricted to the bivariate analysis due to collinearity between 'any FP counseling', the primary outcome, and 'number of FP counseling visits'.

Discussion

Our study of missed opportunities for FP counseling among HIV-positive women receiving HIV care in Uganda highlights two important findings: a) up to 24% of HIV-positive women who interfaced with the healthcare system when they were pregnant, at the time of delivery or at the post-natal care visit did not receive any form of FP counseling; and b) receipt of any FP counseling at any of the three time points is associated with current use of modern contraception. We found that receipt of FP counseling was higher during ANC (62.1%), declined at the time of delivery (59%) and was lowest at the post-natal care visit (46.2%). These findings imply that 38% of women missed FP counseling at ANC; 41% missed FP counseling at the time of delivery, while 54% missed FP counseling at the post-natal care visit. Collectively, our findings highlight a missed opportunity for FP counseling among HIV-positive women who have an unmet need for limiting childbirth and suggest a need for full-scale integration of FP counseling at all critical time-points, but most importantly at the post-natal care visit.

The fact that FP counseling was highest at ANC but lowest during post-natal services raises serious public health concerns. It shows that a significant proportion of HIV positive women who interface with the health system at the post-natal care visit are not provided with FP counselling yet they are at an increased risk for unwanted and short-interval pregnancies. Although fewer women attend post-natal care services when compared to those who attend ANC(18), possibly due to a perception of having received sufficient information about childcare and the management of post-natal complications at ANC (19, 20), this small number of women should still be targeted with adequate FP information when they come for post-natal care services. A study of post-partum contraception among 250 women in Edinburg found that nearly all women (96.7%) who attended post-natal care services did not want to have a baby in the following year but up to 35.2% of them did not know what contraception to use post-natal (21). Indeed, evidence shows that a significant proportion of women are willing to use contraception post-natal only that they lack the information needed to make informed contraceptive decisions (21, 22). Thus, the lack of FP counseling, therefore, acts as a missed opportunity to prevent unintended pregnancy and short-interval pregnancies. The low provision of FP counselling to women during delivery may not be surprising given that at that time, the woman is more concerned about safe delivery or the need to return home following a safe delivery than issues of child spacing or limiting childbirth. This observation is in

agreement with previous studies that show that contraceptive counselling during delivery may not be very effective because women are in a hurry to go home (15).

The finding that FP counseling was associated with current use of modern contraceptive methods is in agreement with previous studies in which women that received family planning messages from a health worker had a higher use of contraceptives and suggest an opportunity to reduce the unmet need for family planning services (23, 24). Studies also show that in programs that focus on HIV care and treatment, adherence counseling offers an exceptional chance to address preventive health recommendations, including family planning (24). The continued use of modern family planning methods by HIV-infected women subsequently prevents birth of HIV-positive infants and reduces cost of preventing mother-to-child transmission (PMTCT) in addition to ensuring spaced pregnancies, which results in healthier babies, despite the mother's HIV status (25).

Strengths and limitations of the study

Although we found an association between FP counselling and current use of modern contraception, we cannot infer a causal relationship between the two. To be exact, this present study cannot depict that receiving FP counselling always results in uptake of contraception. This study was cross-sectional and did not include questions on why the respondents who did not want to get pregnant were not using contraceptives so as to establish the common barriers to accessing contraceptives for women living with HIV. Nonetheless, the study addressed one of the key areas which remain salient in the effort needed to prevent mother to child transmission of HIV/AIDS. It showed that there was a missed opportunity to counsel women living with HIV on family planning which is important for program planning.

Conclusions

In conclusion, our study shows that nearly a quarter of HIV-positive women who interface with the healthcare system while pregnant, during delivery or at the post-natal care visit miss the opportunity to be counseled about contraception, which presents a missed opportunity for prevention of unwanted and untimed pregnancies among women living with HIV who may have an unmet need for limiting childbirth. This missed opportunity becomes even more prominent when we realize that women who received FP counseling at any of the three critical time-points were significantly more likely to report current use of modern contraception than women who did not. Given the increasing popularity of hormonal contraception methods, efforts should be directed at counselling women about the importance of contraception to avoid unwanted pregnancies and reduce mother-to-child transmission of HIV and there is a need to enhance FP integration into HIV care in order to increase access to contraceptives among HIV-positive women in care. We particularly recommend an improvement on provision of family planning counselling at the postnatal care visit among HIV-positive women since it improves uptake of modern contraceptives.

Declarations

Ethics approval and consent to participate

Makerere University School of Public Health Higher Degrees, Research and Ethics Committee and the Uganda National Council for Science and Technology approved this study. Permission to conduct the study was obtained from district and facility managers. Participants provided written informed consent. Sexually active adolescents (15–17 years) were enrolled and were handled as emancipated minors, with waiver of the parental or guardian consent, based on the national research guidelines. Interviews were conducted privately within or outside facility premises in seclusion to ensure confidentiality. All information provided by participants was anonymous and we ensured confidentiality of the data

Consent for publication

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Competing interests

The authors declare no competing interests

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Authors' contributions

JKBM and JNB were involved in drafting and writing this paper, JB was the statistician and responsible for the overall analysis of the data. FM and RW provided technical guidance and read through the manuscript for guidance. All authors participated in the interpretation of the data, and reviewed and approved the final version of the manuscript

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Data availability

Data for this study is available upon reasonable request from the corresponding author

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Tables

Table 1. Socio-demographic characteristics of 2,760 HIV-positive women enrolled in the main survey

Characteristic	Region					
	Total, N=2,760 (%)	Kampala, N=525 (%)	Central, N=533 (%)	Eastern, N=574 (%)	Western, N=550 (%)	Northern, N=578 (%)
Age						
15-24	240 (8.7)	71 (13.5)	45 (8.4)	32 (5.6)	43 (7.8)	49 (8.5)
25-29	420 (15.2)	105 (20)	77 (14.4)	73 (12.7)	86 (15.6)	79 (13.7)
30-39	1284 (46.5)	239 (45.5)	252 (47.3)	299 (52.1)	255 (46.4)	239 (41.3)
40-49	816 (29.6)	110 (21)	159 (29.8)	170 (29.6)	166 (30.2)	211 (36.5)
Health Facility of Enrolment						
Hospital	810 (29.4)	97 (18.5)	163 (30.8)	159 (27.7)	178 (32.5)	213 (36.9)
HC IV	850 (30.9)	47 (9.0)	140 (26.4)	234 (40.8)	213 (38.9)	216 (37.4)
HC III	838 (30.4)	228 (43.4)	195 (36.8)	137 (23.9)	139 (25.4)	139 (24.0)
HC II	200 (7.3)	139 (26.5)	1 (0.2)	37 (6.4)	18 (3.3)	5 (0.9)
Private health unit	45 (1.6)	14 (2.7)	24 (4.5)	7 (1.2)	0 (0.0)	0 (0.0)
Others	12 (0.4)	0 (0.0)	7 (1.3)	0 (0.0)	0 (0.0)	5 (0.9)
Religion						
Catholic	1159 (42.0)	178 (33.9)	233 (43.7)	171 (29.8)	230 (41.8)	347 (60.0)
Anglican / Protestant	874 (31.7)	141 (26.9)	156 (29.3)	223 (38.9)	212 (38.5)	142 (24.6)
Moslem	323 (11.7)	101 (19.2)	72 (13.5)	85 (14.8)	22 (4.0)	43 (7.4)
Pentecostal / Born Again / Evangelical	339 (12.3)	92 (17.5)	56 (10.5)	90 (15.7)	61 (11.1)	40 (6.9)
Others Religions	57 (2.3)	12 (2.3)	15 (2.8)	5 (0.9)	20 (3.6)	5 (0.9)
Marital status						
Never married	39 (1.4)	8 (1.5)	1 (0.2)	8 (1.4)	9 (1.6)	13 (2.2)
In relationship but not married	670 (24.3)	168 (32.0)	194 (36.4)	77 (13.4)	73 (13.3)	158 (27.3)
Married	1600 (58.0)	301 (57.3)	258 (48.4)	383 (66.7)	347 (63.1)	311 (53.8)
Divorced/separated	264 (9.6)	36 (6.9)	52 (9.8)	54 (9.4)	68 (12.4)	54 (9.3)
Widowed	187 (6.8)	12 (2.3)	28 (5.3)	52 (9.1)	53 (9.6)	42 (7.3)
Education¹						
No education	453 (16.4)	40 (7.6)	85 (15.9)	87 (15.2)	99 (18.0)	142 (24.6)
Primary	1585 (57.4)	241 (45.9)	322 (60.4)	323 (56.3)	358 (65.1)	341 (59)
Secondary	656	208	119	160	91 (16.5)	78 (13.5)

	(23.8)	(39.6)	(22.3)	(27.9)		
More than secondary	58 (2.1)	36 (6.9)	5 (0.9)	4 (0.7)	1 (0.2)	12 (2.1)
Missing	8 (0.3)	0 (0.0)	2 (0.4)	0 (0.0)	1 (0.2)	5 (0.9)
Wealth quintile						
Lowest	623 (22.6)	13 (2.5)	105 (19.7)	153 (26.7)	141 (25.6)	211 (36.5)
Second	557 (20.2)	23 (4.4)	112 (21.0)	142 (24.7)	115 (20.9)	165 (28.5)
Middle	537 (19.5)	38 (7.2)	107 (20.1)	147 (25.6)	129 (23.5)	116 (20.1)
Fourth	541 (19.6)	171 (32.6)	119 (22.3)	84 (14.6)	112 (20.4)	55 (9.5)
Highest	502 (18.2)	280 (53.3)	90 (16.9)	48 (8.4)	53 (9.6)	31 (5.4)
Owns a radio						
No	1035 (37.5)	191 (36.4)	157 (29.5)	227 (39.5)	203 (36.9)	257 (44.5)
Yes	1725 (62.5)	334 (63.6)	376 (70.5)	347 (60.5)	347 (63.1)	321 (55.5)
Owns a Television						
No	2092 (75.8)	182 (34.7)	404 (75.8)	501 (87.3)	477 (86.7)	528 (91.3)
Yes	668 (24.2)	343 (65.3)	129 (24.2)	73 (12.7)	73 (13.3)	50 (8.7)
Owns a Cell phone						
No	559 (20.3)	38 (7.2)	95 (17.8)	138 (24.0)	121 (22.0)	167 (28.9)
Yes	2201 (79.7)	487 (92.8)	438 (82.2)	436 (76.0)	429 (78.0)	411 (71.1)
Proximity (in Km) to health facility						
1-4	1122 (41.0)	267 (51.0)	227 (42.7)	233 (40.8)	179 (32.8)	216 (38.2)
5-9	653 (23.8)	108 (20.6)	120 (22.6)	137 (24.0)	116 (21.2)	172 (30.4)
10-15	330 (12.1)	57 (10.9)	47 (8.9)	58 (10.2)	90 (16.5)	78 (13.8)
15+	633 (23.1)	92 (17.6)	137 (25.8)	143 (25)	161 (29.5)	100 (17.7)
On antiretroviral therapy						
No	82 (3.0)	27 (5.2)	0 (0.0)	10 (1.7)	27 (4.9)	18 (3.1)
Yes	2667 (97.0)	497 (94.8)	529 (100.0)	563 (98.3)	523 (95.1)	555 (96.9)
Duration on ART (Years)						
Not on ART	251 (9.5)	83 (16.8)	57 (10.8)	39 (7)	39 (7.5)	33 (6.0)
<1 year	281 (10.6)	56 (11.3)	64 (12.1)	54 (9.7)	52 (10.0)	55 (10.1)
<2 years	345	71 (14.4)	70	59	71 (13.7)	74 (13.5)

	(13.0)		(13.3)	(10.6)		
2+ years	1767 (66.8)	284 (57.5)	336 (63.8)	405 (72.7)	357 (68.8)	385 (70.4)
Disclosed HIV status to partner						
No	2313 (84.4)	367 (70.6)	414 (78.0)	504 (88.3)	479 (87.6)	549 (96.3)
Yes	426 (15.6)	153 (29.4)	117 (22.0)	67 (11.7)	68 (12.4)	21 (3.7)
Number of biological children						
0	724 (26.2)	124 (23.6)	175 (32.8)	124 (21.6)	175 (31.8)	126 (21.8)
1	135 (4.9)	58 (11.0)	21 (3.9)	17 (3.0)	17 (3.1)	22 (3.8)
2	320 (11.6)	101 (19.2)	63 (11.8)	44 (7.7)	60 (10.9)	52 (9.0)
3	400 (14.5)	98 (18.7)	63 (11.8)	83 (14.5)	81 (14.7)	75 (13.0)
4+	1181 (42.8)	144 (27.4)	211 (39.6)	306 (53.3)	217 (39.5)	303 (52.4)
Received any FP Counselling						
No	656 (23.8)	154 (29.3)	145 (27.2)	118 (20.6)	100 (18.2)	139 (24.0)
Yes	2104 (76.2)	371 (70.7)	388 (72.8)	456 (79.4)	450 (81.8)	439 (76.0)
Number of FP Counselling Visits						
0	656 (23.8)	154 (29.3)	145 (27.2)	118 (20.6)	100 (18.2)	139 (24.0)
1	502 (18.2)	118 (22.5)	137 (25.7)	56 (9.8)	77 (14.0)	114 (19.7)
2	688 (24.9)	134 (25.5)	156 (29.3)	121 (21.1)	113 (20.5)	164 (28.4)
3	914 (33.1)	119 (22.7)	95 (17.8)	279 (48.6)	260 (47.3)	161 (27.9)

¹ Education categories refer to the highest level of education attended, whether or not that level was completed.

N=2,760

Table 2. Percentage of women in HIV care who are not currently pregnant and would not like to become pregnant that received FP counselling overall; during ANC visit, during delivery or during Post-Natal Care

Characteristic	ANC	Delivery	Post-natal Care	Any FP counseling
Total	1,715 (62.1)	1,629 (59.0)	1,276 (46.2)	2,104 (76.2)
Age-group				
15-24	138 (57.5)	134 (55.8)	106 (44.2)	172 (71.7)
25-29	259 (61.7)	267 (63.6)	206 (49.0)	328 (78.1)
30-39	822 (64.0)	779 (60.7)	623 (48.5)	1001 (78.0)
40-49	496 (60.8)	449 (55.0)	341 (41.8)	603 (73.9)
Region				
Kampala	278 (53.0)	280 (53.3)	185 (35.2)	371 (70.7)
Central	268 (50.3)	310 (58.2)	156 (29.3)	388 (72.8)
Eastern	420 (73.2)	362 (63.1)	353 (61.5)	456 (79.4)
Western	365 (66.4)	365 (66.4)	353 (64.2)	450 (81.8)
Northern	384 (66.4)	312 (54.0)	229 (39.6)	439 (76.0)
Enrolment Health Facility				
Hospital	479 (59.1)	446 (55.1)	349 (43.1)	592 (73.1)
HC IV	578 (68.0)	543 (63.9)	466 (54.8)	678 (79.8)
HC III	510 (60.9)	499 (59.5)	354 (42.2)	651 (77.7)
HC II	111 (55.5)	104 (52.0)	74 (37.0)	135 (67.5)
Private health unit	28 (62.2)	29 (64.4)	29 (64.4)	37 (82.2)
Others	6 (50.0)	5 (41.7)	2 (16.7)	7 (58.3)
Religion				
Catholic	718 (61.9)	670 (57.8)	524 (45.2)	881 (76.0)
Anglican / Protestant	545 (62.4)	528 (60.4)	434 (49.7)	676 (77.3)
Moslem	208 (64.4)	204 (63.2)	142 (44.0)	248 (76.8)
Pentecostal	208 (61.4)	196 (57.8)	156 (46.0)	256 (75.5)
Others	33 (57.9)	28 (49.1)	18 (31.6)	39 (68.4)
Marital status				
Never married	21 (53.8)	21 (53.8)	16 (41.0)	27 (69.2)
In relationship but not married	371 (55.4)	356 (53.1)	231 (34.5)	464 (69.3)
Married	1067 (66.7)	1001 (62.6)	836 (52.3)	1277 (79.8)
Divorced/separated	154 (58.3)	160 (60.6)	119 (45.1)	209 (79.2)
Widowed	102 (54.5)	91 (48.7)	74 (39.6)	127 (67.9)
Education				
No education	263 (58.1)	241 (53.2)	203 (44.8)	325 (71.7)
Primary	987 (62.3)	943 (59.5)	734 (46.3)	1219 (76.9)
Secondary	428 (65.2)	406 (61.9)	314 (47.9)	516 (78.7)
More than secondary	35 (60.3)	37 (63.8)	24 (41.4)	41 (70.7)
Missing	2 (25.0)	2 (25.0)	1 (12.5)	3 (37.5)
Wealth quintile				
Lowest	408 (65.5)	352 (56.5)	306 (49.1)	487 (78.2)
Second	379 (68.0)	324 (58.2)	270 (48.5)	427 (76.7)
Middle	316 (58.8)	332 (61.8)	265 (49.3)	410 (76.4)
Fourth	329 (60.8)	324 (59.9)	237 (43.8)	413 (76.3)
Highest	283 (56.4)	297 (59.2)	198 (39.4)	367 (73.1)
On antiretroviral therapy				
No	49 (59.8)	36 (43.9)	37 (45.1)	56 (68.3)
Yes	1661 (62.3)	1588 (59.5)	1235 (46.3)	2041 (76.5)

Duration on ART (Years)^a				
Not on ART	125 (49.8)	122 (48.6)	89 (35.5)	175 (69.7)
<1 year	154 (54.8)	144 (51.2)	116 (41.3)	201 (71.5)
<2 years	224 (64.9)	204 (59.1)	164 (47.5)	268 (77.7)
2+ years	1145 (64.8)	1106 (62.6)	857 (48.5)	1382 (78.2)
Disclosed HIV status to partner				
No	1499 (64.8)	1403 (60.7)	1130 (48.9)	1798 (77.7)
Yes	200 (46.9)	211 (49.5)	136 (31.9)	287 (67.4)
Number of biological children				
0	387 (53.5)	382 (52.8)	289 (39.9)	505 (69.8)
1	65 (48.1)	63 (46.7)	42 (31.1)	88 (65.2)
2	201 (62.8)	193 (60.3)	154 (48.1)	254 (79.4)
3	256 (64)	245 (61.3)	181 (45.3)	309 (77.3)
4+	806 (68.2)	746 (63.2)	610 (51.7)	948 (80.3)

^aExpressed out of those who reported that they were on ART

Table 3. Factors associated with receipt of any FP Counselling and current use of modern contraception (excluding condom use)

Background characteristic	Bivariate		Multivariable	
	PR (95% CI)	p-value	PR (95% CI)	p-value
Received any FP counseling				
No	Ref		Ref	
Yes	1.31 (1.19, 1.44)	<0.001	1.21 (1.10, 1.33)	<0.001*
Number of FP counseling visits				
None	Ref			
1	1.14 (1.01, 1.29)	0.04		
2	1.30 (1.62, 1.45)	<0.001		
3	1.40 (1.27, 1.55)	<0.001		
Age				
15-24	Ref		Ref	
25-29	1.08 (0.94,1.24)	0.30	1.00 (0.86,1.15)	0.97
30-39	1.11 (0.98,1.25)	0.11	0.98 (0.85,1.12)	0.73
40-49	0.74 (0.64,0.86)	0.00	0.67 (0.58,0.79)	0.00
Region				
Northern	Ref		Ref	
Kampala	1.29 (1.14,1.46)	0.00	1.29 (1.11,1.49)	0.00
Central	1.19 (1.05,1.36)	0.01	1.21 (1.06,1.37)	0.00
Eastern	1.49 (1.33,1.66)	0.00	1.41 (1.25,1.58)	0.00
Western	1.35 (1.20,1.52)	0.00	1.31 (1.16,1.48)	0.00
Level Health Facility				
Hospital	Ref		Ref	
Health Center IV	1.13 (1.04,1.24)	0.01	1.09 (0.99,1.19)	0.07*
Health Center III	1.08 (0.99,1.19)	0.09	1.05 (0.96,1.15)	0.28
Health Center II	1.16 (1.01,1.33)	0.03	1.05 (0.90,1.22)	0.53
Private Health Unit	0.94 (0.68,1.29)	0.68	0.88 (0.64,1.21)	0.44
Others	1.00 (0.57,1.77)	0.99	1.25 (0.72,2.17)	0.42
Religion				
Catholic	Ref			
Anglican / Protestant	1.09 (1.01,1.18)	0.03	1.02 (0.94,1.11)	0.59
Moslem	1.03 (0.92,1.15)	0.63	0.96 (0.85,1.08)	0.47
Protestant / Born Again	0.97 (0.86,1.09)	0.60	0.91 (0.81,1.03)	0.13
Other Religions	0.94 (0.72,1.23)	0.64	0.87 (0.66,1.14)	0.32
Marital status				
Never married	Ref		Ref	
In relationship but not married	1.77 (1.07,2.94)	0.03	1.38 (0.82,2.34)	0.23
Married	2.11 (1.28,3.49)	0.00	1.43 (0.84,2.44)	0.19
Divorced/separated	1.63 (0.97,2.73)	0.07	1.50 (0.89,2.53)	0.13
Widowed	1.23 (0.72,2.11)	0.45	1.28 (0.74,2.21)	0.38
Education				
No education	Ref		Ref	
Primary	1.09 (0.98,1.21)	0.095	1.05 (0.94,1.16)	0.39
Secondary	1.13 (1.01,1.27)	0.036	1.07 (0.95,1.20)	0.27
Above Secondary	1.22 (0.97,1.53)	0.088	1.28 (1.00,1.63)	0.05*
Wealth quintile				
Lowest	Ref		Ref	
Second	1.14 (1.02,1.27)	0.02	1.11 (0.99,1.24)	0.06
Middle	1.19 (1.07,1.33)	0.00	1.12 (1.01,1.25)	0.04*
Fourth	1.15 (1.03,1.29)	0.01	1.08 (0.96,1.21)	0.22
Highest	1.12 (1.0,1.25)	0.06	1.05 (0.92,1.19)	0.49

Duration on ART				
Not on ART	Ref			
<1 year	1.11 (0.92,1.33)	0.27	1.10 (0.92,1.32)	0.30
<2 years	1.29 (1.10,1.52)	0.00	1.28 (1.09,1.51)	0.00*
2+ years	1.23 (1.07,1.43)	0.00	1.28 (1.10,1.48)	0.00
Number of biological children				
0	Ref		Ref	
1	1.18 (0.97,1.43)	0.10	1.09 (0.86,1.37)	0.49
2	1.47 (1.29,1.66)	0.00	1.30 (1.08,1.57)	0.01*
3	1.51 (1.34,1.7)	0.00	1.37 (1.14,1.65)	0.00
		0.00		
4+	1.42 (1.28,1.57)	0.00	1.38 (1.16,1.66)	0.00