KNOWLEDGE AND ATTITUDE PREGNANT WOMEN HAVE ON THE USE OF PREVENTION OF MOTHER –TO- CHILD TRANSIMISION OF HIV (PMTCT) SERVICES IN MBALE REGIONAL HOSPITAL – ANTENATAL CLINIC.

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AUGUST 2006

Declaration

I, Katushabe Juliet, hereby declare that the contents of this dissertation are a result of my own findings and they have never been presented for a degree in any other university.

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Dedication

This dissertation is dedicated to my dear husband Francis Hamenya and our children; Emma, Ben and Victor, who endured it all during my absence as I endeavored to accomplish this work.

Acknowledgments

This work would not have been successfully completed without the support of many people. My special thanks go to my supervisors Dr Stella Neema. Her utmost patience in reading through my proposal, encouragement and support right from proposal development to the final report requires special mention. Sincere gratitude is also extended to my supervisor Mr. John Arube-Wani from Child Health and Development Centre for his tireless efforts in molding my proposal up to the end.

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I am greatly indebted to Francis, my husband for without him; this course would not have been completed. He provided all the support needed like financial, social, moral and psychological right from the beginning to the end.

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LIST OF ACRONYMS AND ABBREVIATIONS

ACP Aids Control Program

AIC Aids Information Center

AIDS Acquired Immune Deficiency syndrome

AMFAR	American foundation for AIDS research
ANC	Antenatal Care
ART	Antiretroviral Drugs
DC	Center for Disease Control
DDHS	District Director of Health Services
EI	Exit Interviews
FGD	Focus Group Discussion
GH	Global Health
HIV	Human Immunodeficiency Virus
IATT	United Nations Inter – Agency Task Team
IEC	Information Education and Communication
KI	Key Informant
MoH	Ministry of Health
MTCT	Mother- To- Child Transmission
PAC TG	Pediatric AIDS Clinic Trial Group Study
PMTCT	Prevention of Mother- To – Child Transmission
STDs	Sexual Transmitted Diseases
TASO	The Aids Support Organization
UNAIDS	Joint United Nations Aids Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling Testing
WHO	World Health Organization
W TAG	Women's Treatment Action Group
ZDV	Zidovudine

ABSTRACT

Mother-To-Child Transmission of HIV (MTCT) is the second major mode of HIV transmission and accounts for over 90% of HIV transmission among all the children infected with HIV in Uganda. In response to this, the government of Uganda in

collaboration with UNICEF and other partners introduced interventions countrywide to Prevent Mother to Child Transmission of HIV/AIDS (PMTCT with the goal to reduce on infant mortality and morbidity due to HIV/ and AIDS. The interventions include; HIV counseling and Testing, Antiretroviral drugs that reduce MTCT of HIV, improved care during antenatal and postnatal care, family planning and supportive/continued counseling.

Mbale Regional Referral Hospital was among the pilot hospitals identified to offer PMTCT services in 2002 to serve the Eastern region. However despite the availability of free PMTCT services, pregnant women were not using the services and yet there was a high HIV prevalence rate among women attending antenatal clinics; whereby 25% children were born HIV positive from HIV positive mothers who could have saved these children by taking up PMTCT services.

A cross-sectional design using both qualitative and quantitative approaches to data collection was carried. In all, a total of 150 pregnant women receiving antenatal care were surveyed. Also 10 key informant interviews and four focus group discussions with community members were conducted in the catchments areas of the Hospital.

A ccording to the findings, a big number (63%) of the mothers did not know about PMTCT services which were being offered in the hospital. It was noted that respondents who had little or no knowledge of the services were mostly below 20 years of age and those with low education levels. However, respondents who were aware of the PMTCT services were 25 years and above and those who had attained secondary education.

On the attitude towards PMTCT services it was found that three-quarters (76%) reported that it is good to take on PMTCT services if HIV positive and quarter (24%) of respondents reported that PMTCT services are wastage of time because AIDS has no cure. Some respondents also had a belief that there is no way an HIV positive woman can have an HIV free baby.

Utilization of PMTCT services was affected by fear to take the HIV test. Most women for example 64% did not want to take an HIV test despite indicating that they would take up PMTCT services in case found HIV positive. This was a contradictory with the attitude towards PMTCT services. Some of the reasons given for not testing were that; if one gets to know that she/he is HIV positive, one dies very quickly. Another reason was that women have to first ask for the permission from their partners to take the HIV test and in most cases do not grant it. Others felt that since AIDS has no cure it is better not to know that one has it.

Challenges that affect the PMTCT program include stigma still surrounding HIV and AIDS as a disease, which has led to a number of people not willing to know their status. This has led to low levels of utilization of the services. Also inadequate sensitization of the PMTCT services in the communities and long distances traveled by some mothers to the sites providing the services. Lack of male involvement in the program has greatly affected the utilization of PMTCT services by pregnant mothers.

The study recommends working in collaboration with all stakeholders to improve and increase on the sensitization and awareness to the communities on what PMTCT program is all about and what it entails. There is need to increase on the capacity building of the health workers in the PMTCT service provision especially in the areas of counseling and testing to avoid delays. The study also recommends the Ministry of Health to implement the PMTCT plus so that partners and other family members are catered for. Women need to be empowered in issues of socio-cultural so that they can make decisions in regards to their health and their children without causing conflicts in the family.

The study concluded that utilization of the PMTCT services were affected by the low levels of HIV testing. Also, the insufficient knowledge on PMTCT coupled with the negative attitude towards HIV testing, fear and stigma towards HIV and AIDS contributed to the low utilization of PMTCT services in Mbale Regional Hospital.

CHARPTER ONE

INTRODUCTION

1.1 Background to the study.

HIV/AIDS is a pandemic, which has affected every part of the world. It is now the number one overall cause of death in Africa, and has moved up to fourth place among all causes of death worldwide (UNAIDS 2000). With 42 million people now living with HIV/AIDS, expanding access to worldwide antiretroviral treatment for those who urgently need it is one of the most pressing challenges in international health (WHO, 2000). The HIV/AIDS epidemic is resulting in more than 600,000 infants becoming infected each year, and in many countries HIV/AIDS has become major cause of infant and young child mortality (UNAIDS 2000). It was estimated that about 2.6 million children were living with HIV/AIDS in Sub-Saharan Africa at the end of 2001. Most of these HIV infections were the result of Mother- To- Child Transmission of HIV (Advance Africa 2002). By the year 2010 it is estimated that AIDS may have increased the mortality of children under the age of 5 by more than 100% in regions most affected by the virus (MoH, 2003).

Of the forty million people living with HIV/AIDS Worldwide at the end of 2003, two and a half (2.5) million were children under 15 years of age. In the year 2002 alone 700,000 children were newly infected with HVI/AIDS virus. The most significant source of HIV infection in children and infants is transmission of HIV from mother to child during pregnancy, labour and delivery and breastfeeding (WHO, CDC, Treat 3Million by 2005)

Mother-to-Child Transmission MTCT of HIV is a major component of the AIDS epidemic, especially in Sub-Saharan Africa and the less developed countries of South and East Asia. In more developed countries, obstetric interventions, anti-retroviral treatment and replacement feeding for the infant has resulted in significant reduction in transmission rates but this is not the case in the less developed countries. Limited accesses to the above-mentioned intervention are the main reasons for the differences in transmission rates (Stringer 2003)

With the advent of major advances in antiretroviral therapy and research on HIV vaccines, Uganda has now gone full blast in the provision of free ARVs. So far about 64,000 out of 120,000 patients who need the drugs are being served. The Government was able to do this in collaboration with the UNICEF, UNAIDS, WHO and other partners to implement activities for Prevention of Mother- to- Child Transmission of HIV with the aim to reduce the high rate of HIV transmission to children. A pilot phase was done in 2000/2001 to answer questions related to the integration of the intervention within the existing health care delivery services. The sites that were selected included Nsambya hospital Mulago Hospital, Mengo hospital in Kampala District, Lacor hospital in Gulu district, Mbale hospital in Mbale district, Arua hospital in Arua district and Mbarara hospital in Mbarara hospital.

Although control measures such as IEC, management of STDs, use of barrier methods like condoms, safe blood transfusion and counselling are beginning to bear fruits in Uganda, it is apparent that MTCT and paediatrics HIV/AIDS cases will continue to

increase if no mitigating measures are taken. Studies have shown that antiretroviral therapy in pregnancy is cost effective. For example studies done in South Africa, France, Tanzania and Uganda showed that administration of the antiretroviral drugs during pregnancy, labour and postpartum period has been associated with tremendous reduction of mother-to child transmission (MTCT) of HIV by up to 50% (MoH, 2003).

There is need to identify an optimal Mother –to Child Transmission (MTCT) prevention policy in Sub-Saharan Africa now that short and affordable antiretroviral regimens are available. In this context interventions that give the best value for money are the priority (Scotland et al 2003).

Mother to child transmission of HIV is the second major mode by which the virus spreads. This is a primary way of transmission of HIV to children in Uganda. It is estimated that up to 30% of the infants born of the infected mothers are likely to be infected either during pregnancy, at time of labour/ delivery or after birth through breast feeding. (MoH, 2002)

From the findings made in Uganda and other parts of the world, it was proven that administering antiretroviral drugs to HIV positive women during pregnancy, labour and post partum period could result in reduction of mother to child transmission of the Virus by up to 50%. It was found out however that the success of the intervention is affected by factors such as breastfeeding practices and the need for its implementation with in a system with strong antenatal, intra- natal and postnatal care services.

However according to the Ministry of Health annual report (2002) the performance and uptake of PMTCT services at the individual implementing sites was outstanding while others performed poorly. Mulago hospital has the biggest number. In other wards Kampala district is performing well while other districts especially Mbale is performing very poorly. The report indicates that Mbale hospital presents an example of a site that has very low capacity to offer counselling for the mothers within the antenatal clinic setting. It is also indicated in the report that despite mothers being discouraged, mixed feeling is still being practiced by some of the HIV positive mothers and this could potentially erode success of the intervention.

The service records from Mbale Regional Referral Hospital show that from the months of January to September 2003 a total of 4,749 pregnant women attended antenatal clinic and out of these 2,965 were counselled for PMTCT of HIV. However, only 14% of the pregnant women agreed to have an HIV test after counselling and it was found out that about 14% pregnant mothers were HIV positive. The records also show that 25% children were born HIV positive from the HIV positive mothers who could have saved these children by taking up PMTCT services. It is therefore against this background that a study was carried out to investigate reasons for the low uptake of PMTCT services in Mbale.

Mbale regional hospital is located in the town centre and it gives services to the neighbouring districts of Kapchorwa, Soronko, Busia and Tororo. The hospital gives a number of health services, and PMTCT is catered under antenatal services. However the

knowledge of the pregnant districts attending mothers on PMTCT program and services, their attitude and the level utilisation of these services was a big question this study was set to find the answer.

1.2 Statement of the problem

There is high HIV prevalence rate among pregnant women in Mbale district (MoH 2002). Because of this, the Government of Uganda provided Mbale Regional Hospital with Antiretroviral drugs in prevention of mother-to-child transmission of HIV/AIDS (PMTCT) services in order to protect the unborn children from getting HIV infection from their HIV positive mothers; which is usually termed as Mother-To Child Transmission (MTCT) of HIV. Despite the availability of PMTCT services, the uptake is low (MoH, 2002). However little information is available on mother's knowledge about PMTCT and their attitude towards PMTCT services. This could be one of the reasons why the uptake is low. Therefore, the task of the study was to assess knowledge and attitude of pregnant mothers on PMTCT services as well as factors contributing to non-utilisation of PMTCT services.

1.3 Objectives of the study

1.3.1 General objective:

The overall objective of the study was to assess the knowledge and attitude of pregnant women on use of Prevention of mother-to-child transmission of HIV/AIDS (PMTCT) services in Mbale Regional Hospital.

1.3.2 Specific objectives

1. To investigate the pregnant women's knowledge of Prevention of Mother- To-Child Transmission of HIV (PMTCT) services.
2. To examine pregnant women's attitude towards antiretroviral drugs in prevention of Mother-to-Child Transmission of HIV.
3. To examine the role of the institution in the utilisation of PMTCT services.

1.4 Scope of the study

The study was investigating the knowledge people have on PMTCT and their attitude as well as utilisation of the services. The study was targeting the mothers who attend antenatal clinic and some men in the catchment's area of Mbale Regional Referral Hospital.

1.5 Significance and Justification of the study

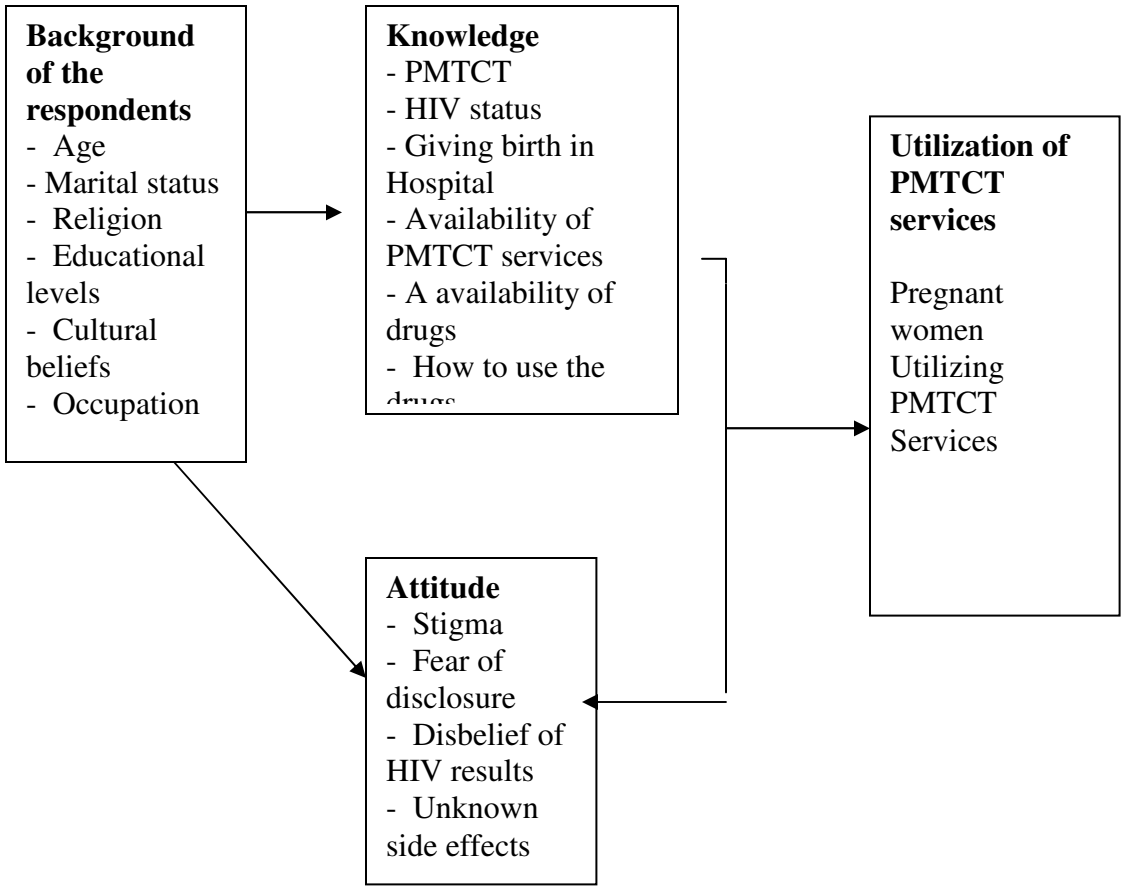
The results from the study will help to improve the Prevention of Mother-To-Child Transmission (PMTCT) services in Mbale District. The findings from the study will help the Ministry of Health to scale up for implementation of Prevention of Mother-To- Child Transmission of HIV/AIDS as well as Modelling (PMTCT) services in the district and other areas in the country and this will help to improve on the targets. The findings will also provide up-to date information for academicians and could be used as a basis for further research in issues concerning PMTCT since it is a new intervention in the country.

Paragraph 1.6

There were a number of factors that influenced knowledge and attitude of the pregnant women and this had an effect on utilisation of PMTCT services. These included socio-demographic characteristics such as age, marital status, religion, educational level and the occupation. The attitude people have towards HIV/AIDS in general and PMTCT in particular also affects utilisation of PMTCT services. However people develop the attitude about certain services after knowing what the services are. For this case the attitude towards PMTCT services was influenced by the knowledge respondents have.

Figure I

Conceptual Framework showing variables that affect the PMTCT



1.7 Definition of key concepts

Knowledge: This is defined as awareness about something. In this particular study knowledge will be defined as information about or the understanding of PMTCT services.

Attitude: According to Eagly and Chaiken (1993) attitude is tendency to evaluate a particular object with some degree of favour or disfavour. In this particular study, attitude will be defined as an evaluation of feelings based on knowledge or experience that pregnant women have about PMTCT.

Utilisation: Referred in this study, is the action of making use of the available antiretroviral drugs in prevention of mother-to-child transmission of HIV, which is usually referred to as PMTCT services.

PMTCT are interventions carried out to reduce the risk of HIV transmission from an infected mother to her baby during pregnancy, labour, delivery and breast-feeding.

1.8 Organisation of the Report

Chapter one talks about the background of the study, problem statement, objectives of the study, the scope of the stud, significance of the study, conceptual framework and the definition of the key concepts.

Chapter two presents the reviewed literature in relation to PMTCT, magnititude of HIV in young children, strategies to reduce MTCT, knowledge and attitude on PMTCT as well as utilisation of PMTCT services. The theoretical framework is also analysed in this chapter.

Chapter three presents methodology of the study which includes the study design, study area, population of the study, sampling procedures, methods of data collection, study instruments, data analysis, quality control, ethical considerations and limitations of the study.

Chapter four presents the study findings and discussions. These include; social demographic characteristics of the respondents, knowledge of respondents on PMTCT, respondents' attitudes on PMTCT, and utilisation of PMTCT services. Challenges affecting PMTCT program and accessibility of the services are also discussed in this chapter and the possible solutions.

Chapter five presents conclusions and recommendations of the study and recommendations for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section presents the literature relating to prevention of mother-to-child transmission of HIV from both International, regional and local studies. The literature is subdivided into themes namely; magnitude of HIV in young children as a result of mother-to-child transmission and the strategies that are being used to reduce MTCT. This is followed by knowledge on PMTCT; the attitude people have towards PMTCT and lastly the utilisation of PMTCT.

2.2 Magnitude of HIV/AIDS in young children.

Each year, an estimated 590,000 infants acquire human Immunodeficiency virus type 1(HIV) infection from their mothers mostly in developing countries that are unable to implement interventions now standard in the industrialised world. In resource-poor settings the HIV pandemic has eroded hard won gains in infant and child survival. The clinical trial results from international setting suggest that short course antiretroviral regimens could significantly reduce prenatal HIV transmission worldwide (Jama, 2000).

The Global Epidemiology of Paediatric HIV infection reflects the epidemiology of HIV in Women. More than 80% of the 13.8 million women living with HIV by the end of 1998 were African. Available HIV prevalence studies in pregnant women offer the most objective data for comparing epidemics in different countries and indicate the magnitude of paediatric HIV/AIDS in several urban centres in Eastern and Southern Africa; HIV

rates in pregnant women now exceed 25% (UNAIDS, 2001). Where paediatric AIDS does emerge, it will contribute to child mortality and morbidity and could undermine the impact of programs that have significantly reduced child mortality in previous decades (Connor, et al 1998).

Uganda has a high burden of HIV/AIDS with high mortality and morbidity rate. There are approximately 1,050,555 people living with HIV/AIDS in Uganda. Of these 531,909 are women who are in childbearing age. According to STD/ACP in the Ministry of Health, the HIV sero-prevalence among pregnant women in Uganda is currently 6.5%. This implies that there are about 24,843 of the babies born each year are likely to be HIV infected. About 1,274,000 females get pregnant annually and this has put them at a risk of contracting HIV and passing it on their unborn babies (HIV surveillance report 2003).

The high HIV infection rate among women of reproductive age has serious implication on the Mother to Child Transmission of HIV (MTCT). High levels of HIV prevalence among women of childbearing age in many parts of the world carry a triple tragedy (Global Health, 2003). Taking Ugandan birth rate of 52.2 per 1000 population, about 5.2% of the Ugandan population are expected to be pregnant annually. Given the 2000 Population estimates for Uganda of 21 million, a total of 1,092,000 female Ugandans are expected to be pregnant in one year. With average of HIV sero- prevalence of 6.1 % in antenatal clinics in Uganda, we expect to have about 67,000 HIV positive pregnant women each year (MoH, 2003).

2.3 Strategies in Prevention of Mother-To-Child Transmission of HIV.

Following release of results of 1998 that a short course of ZDV regimen starting from 36 weeks of pregnancy reduced the rate of transmission of HIV by 50%, (Moodley 2003), a comprehensive strategy for MTCT- prevention was developed. UNICEF has obtained considerable experience with pilot intervention projects many initiated under the umbrella of the UN Inter-Agency Task Team (IATT) on Mother –To-Child Transmission (MTCT). The entry point to the interventions is Voluntary Counselling and testing (VCT) for HIV followed by ZDV from 36 weeks and during labour to mothers who are HIV-infected, and counselling on infant feeding options.

Research conducted in USA, France and Thailand and more recently in South Africa, Tanzania and Uganda showed that administration of ARV drugs during pregnancy and labour and postpartum period can result in significant reduction of mother –to-child transmission of HIV (Petra study 2002). The success of the intervention also significantly depended upon its implementation within a context of a strong and comprehensive antenatal, labour and post natal care services (MOH-PMTCT policy2003). Planners and managers who are involved in implementation of activities for PMTCT of HIV at both the national and district levels have developed the policy document for use. It aims at streamlining and guiding the process of initiating and implementing PMTCT interventions in Uganda.

2.4 Knowledge of PMTCT services

In 1999, an estimated 570,000 children aged 14 or younger became infected with HIV. Over 90% were babies born to HIV positive women, who acquired the virus at birth or through their mother's breast milk. The vast majority of these cases occurred in Sub-Saharan Africa and other low-income countries (UNAIDS, 1999). This is because many women in low-income countries give birth at home or in the care of traditional birth attendants who do not have access to the MTCT interventions and most of them do not know their HIV status as well as PMTCT services. Dr. Chris Baryomunsi working on HIV/AIDS program under UNFPA concurs with the above where he highlighted that although PMTCT has kicked off, a lot has to be done. The majority of the mothers in Uganda do not deliver in the health facilities. Supervised delivery in this country is only about 39%. The program has failed to reach most of the women and the impact of MTCT of HIV has not been significant so far. There is need to use resources available to mobilise women to attend antenatal clinics and also deliver at health facilities (The New Vision July 1st 2003).

According to the HIV/AIDS Resource for Journalists, (2002), many South African women only learn that they are HIV- positive when they are tested during antenatal check up. Apart from implications for herself and her partner the women face the possibility of transmitting a fatal disease to her unborn baby. This places an additional burden on Women, as men are not routinely tested. Careful counselling is necessary to help and support pregnant women to explore their options in these circumstances.

The National picture remains very sobering. In a keynote address at the recent African Great lakes Conference, an access to HIV/AIDS care and support leading HIV researcher Peter Mugenyi noted that the current HIV rates is unacceptably high and appalling and would constitute a state of emergency in developing countries. One million Ugandans are infected by HIV and they have limited access to antiretroviral medicines. Mugenyi predicted, ***"The new infections will continue to spread from the huge infection reservoir, most of whom do not know their status".*** That includes a large number of women who are passing HIV on their offspring (New Vision 1st July 2003). In addition, according to AMFAR 2001, the Uganda Government has found that the rate of mother-to-child HIV transmission is 30% and out of a million live births per year100, 000 children test HIV positive.

2.5 Attitude towards PMTCT services.

According to Ojera, (MoH 2002), there are a few setbacks to the program. Being anew intervention, communities are not well sensitised and mobilised for the program; hence on the side of the clients there is stigma and discrimination. Women fear to come and test and very few disclose their HIV status to their partners.

However in Uganda the women's HIV networks are moving quickly on the front to fight mother-to-child transmission. Anew coalition called the Women's Treatment Action Group (W-TAG), led by HIV positive women, and plans to push not only for access to PMTCT but for more input into the national agenda. It was noted that there is need to fight hard for the children and the communities (PMTCT annual report 2003).

In a study done in Zambia, the findings show that there is a high level of stigma against HIV/AIDS patients. The community tends to shun persons who are known to be HIV infected or have symptoms of AIDS (UNAIDS, 2001).

In Kenya PMTCT in Nairobi and Mara Masai areas, still have little experience with ARVs, stigma and misconceptions about the drugs have emerged as important obstacles to acceptance and effective use. With limited access, PMTCT programs have made special efforts to help women adhere to the often difficult-to-follow ARV treatment regimens. Because they do not provide mothers with ongoing ARV treatment, PMTCT programs are often criticised (Rutenberg; 2002).

2.6 Utilisation of PMTCT services

The introduction of ARVs in 1996 was a turning point for hundreds of thousands of people with access to sophiscated health systems. Although they cannot cure HIV/AIDS, ARVs have dramatically reduced mortality and morbidity, prolonged lives and improve the quality of life of many people living with HIV/AIDS (Hammer et al, 2002).

The United States Agency for International Development (USAID), one of the major international donors in the field of HIV/AIDS prevention also declared PMTCT as one of the cornerstones of its expanded response to HIV/AIDS. The agency pledged in concert with its partners to ensure that at least 25% of HIV/AIDS infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants USAID, (2001). UNICEF sees AIDS not as another vertical program but as its

core business. UNICEF intends to increase the allocation of funds for HIV/AIDS in general including PMTCT. UNICEF is also committed to increasing the supply of test kits, training materials and Antiretroviral Drugs.

In Myanmar- Thailand the PMTCT pilot project started in December 2000 in two townships of Kawthaung and Tachileik and later expanded in five additional townships of Lashio, Muse, Monywa, Myitkyina and Dawe in 2001. During this time a total of 17902 new pregnant women attended antenatal care in the PMTCT townships. The number of protested counselled pregnant women in group were 12571 (70%) and 2,333 (19%) pregnant women tested for HIV and 73 were HIV positive (3%). However there is low acceptance of VCT by pregnant women according to the findings throughout the pilot sites (UNICEF 2002).

In industrialised countries such as the United States, mother-to-child transmission rates have fallen to as low as 1-2% of birth among HIV-infected mothers in recent years, due to the wide scale introduction of several interventions (Preble; 2002). The combination treatment of HIV-infected women, HIV counselling an testing, short course Zidovudine (ZDV or AZT) prophylaxis, elective caesarean delivery and the safe use of infant formula instead of breast feeding (Mclntyre, 2000). In the US between1997 and
1999 alone, perinatally acquired AIDS cases declined by 66% (CDC, 2001). So elimination of perinatally transmission of HIV is a feasible goal.

2.7 Theoretical context

The theoretical models of the study applied were the Health Belief Model (HBM) and AIDS Risk Reduction models. The health belief model, developed in 1950, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model a person must hold certain beliefs in order to be able to change behaviour. This means that promoting action to change a particular behaviour includes changing individual personal beliefs (Catania, et al., 1990).

The model is also based on the premise that the likelihood of engaging in preventive health behaviour is influenced by certain beliefs about a given condition. The model asserts that the individuals will take preventive health action when they feel susceptible to a certain condition and they feel that contracting the disease has serious consequences compared to the perceived benefits accruing from the same behaviour.

The AIDS risk reduction model which was developed in 1990 specifically for AIDS prevention, was also used for the study. The model uses constructs from health belief model to describe the process individuals go through while changing behaviour regarding HIV risk. The model identifies three stages involved in reducing risk for HIV transmission. In the first stage knowledge about HIV transmission and perceived susceptibility to HIV/AIDS influence how women perceive AIDS. The commitment to change is shaped by perceptions to self-efficacy and social norms. In the last stage of taking action, help seeking behaviour and social factors affect the pregnant women's decision-making process. Some programs that use the AIDS risk reduction model focus

on clients' risk assessment, influencing the decisions to reduce risk through self efficacy and client's support to enact the change, for example access to antiretroviral drugs and social support.

CHAPTER THREE

STUDY METHODOLOGY

3.1 Research design.

The design was cross-sectional descriptive and utilised both qualitative and quantitative methods. The qualitative method was used to establish the pregnant women's views and experiences regarding PMTCT services. The quantitative method on the other hand was used to establish pregnant women's knowledge of PMTCT, the source of information and motivational factors.

3.2 Study area

The study was conducted in Mbale District at Mbale Regional Referral hospital. Mbale hospital was chosen because among all the referral hospitals in the country that were providing PMTCT services the level of utilisation is low in Mbale referral hospital, according to Ministry of Health report (2003).

3.3 Study population

The population of the study was pregnant women who attend antenatal clinic. Also married men in the catchments area were involved in the Focus Group Discussions (FGDs) in order to get their views because men are a critical link in the HIV transmission chain, and men can support the decisions women must make related to mother-to-child transmission of HIV and prevention issues.

3.4 Sampling

Using Kish and Leslie's formula (1965), the sample size for the general population was 150 respondents, with a fixed error of 8% and a Confidence Interval at 95% and an estimation of the total attending antenatal in a month of January to September 2003 as 4749 pregnant women.

Sample size calculation

Sample size (n)=S/(1+(S/population)

S=[Z Pq] e

Where: n is the required sample size

Z is the test statistic under normal distribution

e = 0.05

Since there was no available literature on the number of women using PMTCT services, 50% was used to maximise the Sample size.

P is the proportion of the variable of interest

q = 1-P

e is the permissible error to be committed.

S/population embraces the population correction factor at 95% confidence level,

Z=1.96 from table assuring normality of the data.

$$n = \frac{1.96 \times 0.5 \times 0.5}{(0.08)} \quad 150$$

3.5.1 Qualitative data

A total of 10 key informant interviews were conducted with people who were purposively selected. These were; Two health service providers, one laboratory technician the Medical superintendent, two counsellors, one District Director of Health Services (DDHS), PMTCT coordinator, The Director AIC Mbale, and the Director TASO Mbale.

Four Focus Group Discussions (FGDs) were held; two with married men and two with women in the catchment's area of the hospital in order to explore their knowledge and attitudes on PMTCT services.

3.5.2 Quantitative data

Exit interviews:

Exit interviews were held with a sample of 150 respondents (pregnant women). Systematic random sampling was used and the clients were selected by choosing one respondent every after the second client until a sample of 150 is reached. The antenatal clinic is open every day and it is assumed that pregnant women attend antenatal every day.

3.6 Methods of data collection

Triangulation of methods was employed to provide rich information, and specific methods that were used include: key informant interview guide, questionnaire for survey respondents and focus group discussions.

3.6.1 Data collection instruments

The study used two major tools for collecting data. These are; interview guides and interview schedule. Key informant interview guide were administered to the health care service providers and helped obtain information on how PMTCT services are delivered and how sensitisation is carried out about PMTCT.

The Questionnaire helped the researcher to capture information from mothers on their knowledge and attitude towards PMTCT services.

3.7 Data analysis

Qualitative data from in-depth interviews and Focus group discussions was transcribed and analysed during and after the fieldwork. The analysis was based on themes and sub-themes of the study. Code categories were also identified and then formed the basis of conclusions about the study. Direct quotes from the respondents were also used.

Quantitative data from exit interviews was edited before leaving each respondent for uniformity and accuracy. The data was then coded and entered in the computer using the Statistical Package of Epinfo. The analysis was then made using the Statistical Package for Social Sciences (SPSS). The analysis was made basing on the following variables like age of the respondent, sex, religion, marital status, education of the respondent, access to health facility, sensitisation on PMTCT and antenatal attendance. And findings were presented and described by tables, graphs, and charts.

3.8 Quality Control

A pre-visit was done and the research instruments were pre-tested. They were then fully developed before the actual study was undertaken.

3.9 Procedures and Ethical considerations

Before embarking on the data collection process, the researcher obtained an introductory letter from Makerere University after the approval of the Proposal. This letter was then presented to the Medical superintendent Mbale Hospital, who in introduced the researcher to the relevant health workers/staff. After getting the clearance from the Hospital, the researcher obtained informed consent from the respondents and informed them about the purpose of the study. The Local council chairpersons were also contacted. With the assistance of the LCs, appointments were made with the selected people who participated in the FGDs.

3.10 Limitations of the study

The study was sensitive and some people did not want to participate in it or answer the questions asked. However to overcome this problem, the researcher had to explain fully the purpose of the study and assured the respondents confidentiality of the information given.

CHAPTER FOUR:

4.0 PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

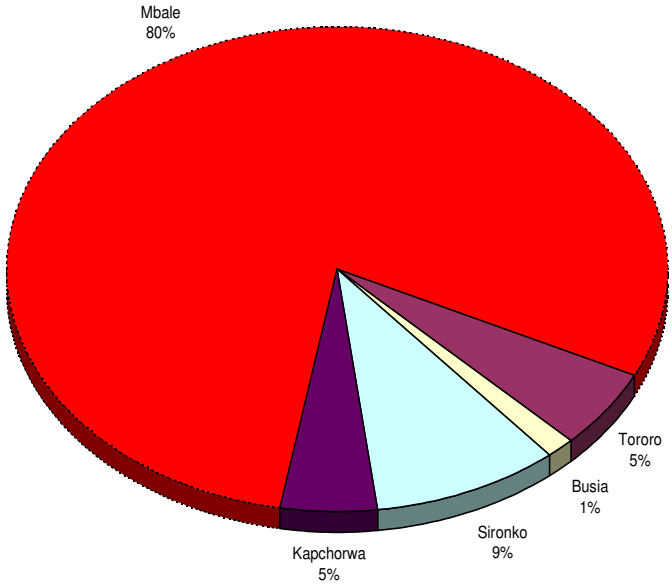
4.1 Introduction

This chapter presents the study findings and describes them in sections according to the study objectives. The first section presents the socio-demographic characteristics of the respondents, the second section represents knowledge respondents have on the use of PMTCT, and the third section presents attitude mothers have on the use of PMTCT services and lastly the challenges.

4.1.1 Social demographic characteristics of Respondents

Some of the socio-demographic characteristics of the respondents that were considered included the ethnic group, marital status, occupation, education level, religion and the age of the respondents. These variables influence the respondents' knowledge, attitude as well as utilisation of PMTCT services.

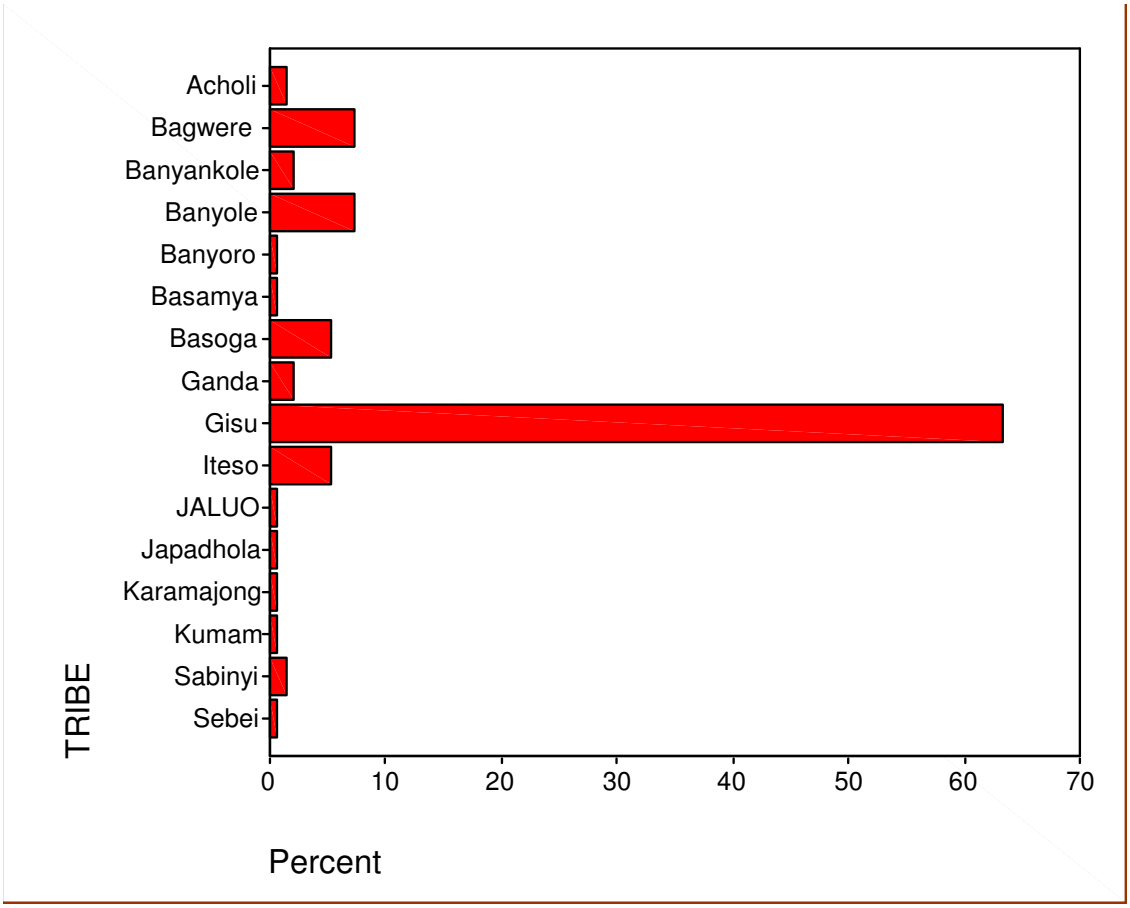
Figure II: Mothers who come for ANC services by district



It was found out that the most of the antenatal attendees at Mbale Regional Referral Hospital are from Mbale district (with 80%), followed by Sironko district (with 9%) and then Tororo and Kapchorwa districts (5% each) and lastly Busia with 1%. Few pregnant women came from Busia and Kapchorwa districts due to distance. This contradicts with the Ministry of Health plan, which assumed that pregnant mothers from the Eastern part of Uganda would get PMTCT services from Mbale Referral Hospital. This is attributed to the long distance one has to travel from districts like Kapchorwa and Busia to Mbale Hospital.

Since cultural beliefs of the respondents was one of the variables the study considered, it was important to look at the ethnic distribution of the respondents that access antenatal services in Mbale regional Hospital.

Chart I: Distribution of ethnic groups accessing Antenatal services



Though Mbale town is occupied by a number of ethnic groups, it was found that the Gisu ethnic group was dominant among the pregnant mothers that came to Mbale Regional Hospital. This is indicated in the chart I above.

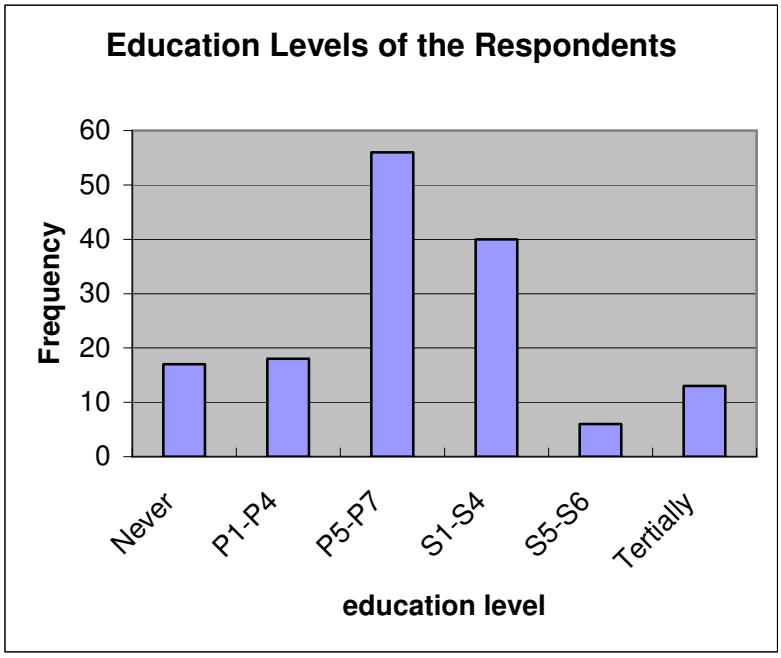
Age of the respondents was another important variable the study considered because it had an influence on the pregnant mother's knowledge on PMTCT as well as the attitude. The distribution of the age is therefore illustrated in the Figure IV below x``.

Table 1: Age of respondents

Age	Frequency	Percentage
Below 18	16	10.67
18-25	92	61.33
25-35	36	24.0
Above 35	06	4.0
Total	**150**	**100.0**

Many respondents were found to be in the age range between 18 – 25 years of age and some mothers were below eighteen years of age, while a few were above thirty-five years as illustrated in the table 1.

Chart II. Respondents level of education.



Education was one of the variables of the study that had an influence on the knowledge and attitude pregnant women had on the PMTCT. According to chart II above, many of the survey respondents were in the category of upper primary, which is P5-P7 followed by those in the ordinary level (S1-S4). Few pregnant mothers attained higher education and there was a number that never went to school at all as indicated above.

4.2 KNOWLEDGE ON PMTCT

4.2.1 Pregnant women and their knowledge on PMTCT

Knowledge of pregnant women on the prevention of mother to child transmission of HIV was assessed according to their age, marital status, education levels, religion and their occupations. Table 4.1 presents the results.

Table 4.I. Cross tabulation of Respondents age and knowledge on PMTCT

Age	Have you ever heard of PMTCT				Total	
	Yes		No			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Below 18	6	37.5	10	62.5	16	100.0
18 – 25	40	54.5	48	45.4	88	100.0
25 – 35	29	72.5	11	27.5	40	100.0
Above 35 years	4	66.6	2	33.3	6	100.0
Total	**87**	**58.0**	**63.0**	**42.0**	**150**	**100.0**

According to information in table 4.1, knowledge is positively related to age of informants. The higher the age, the more the more the knowledge. This was confirmed by the Qui-square correlations whereby the P.V was (0.02) meaning that there was a significant relationship between age and the knowledge of

PMTCT services. This was because those who are 25 years and above are more exposed to different sources of information and also have experience on antenatal issues since they always come for counselling in health centres. The other group are those who marry when they are still young and therefore do not take antenatal issues serious. One of the reasons why mothers under 18 years do not know PMTCT is that they fear to disclose the matter because some get pregnant when they are not married, and with all the fear from the parents and society who are against having children out of marriage. This is evidence that young girls are exposed to sexual activities early hence early pregnancies.

Religion as a variable was found to have relationship with the pregnant mother's knowledge of PMTCT. This is illustrated in the table 4.2.

Table 4.2 Religion by PMTCT Knowledge

Religion	Have you ever heard of PMTCT				Total	
	Yes		No			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Catholics	22	66.7	11	33.3	33	100.0
Protestants	33	64.7	18	35.3	51	100.0
Moslems	26	50	26	50	52	100.0
Others	6	42.9	8	57.1	14	100.0
Total	**87**	**58**	**63**	**42**	**150**	**100.0**

Catholics were more knowledgeable about PMTCT services. Protestants who had heard about PMTCT were close to the proportion for Catholics. Moslems were a distant third while much fewer information from other religions. It was however found that there was no significant relationship between Religion and the knowledge of the respondents.

Marital status of the respondents has got a relationship on the knowledge of PMTCT services though does not influence it much. It was found that the married/ cohabiting women are more knowledgeable of PMTCT services compared to those who are not

Though the figures represent the high number of married mothers knowing PMTCT, the number of those who do not know is still high. This is partly because the women do not have access to the information especially the electronic media like the radio (Open Gate F.M) where information on PMTCT is aired out and others cannot read; and therefore the possibility of being exposed to PMTCT and health information is minimal. This was illustrated by one of the key informants who had this to say:

> *"There are very few pregnant women who know PMTCT because most pregnant women go to the traditional birth attendants. Also the women do not have access to the information on the radio because men are the ones usually with the radio, they move with the radios morning and*

evening and worse still men do not inform their wives in case health information is aired ".

(TASO Manager)

Table 4.3: Respondents occupations and their knowledge on PMTCT

Occupation	Have you ever heard of PMTCT				Total	
	Yes		No			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Civil servants	13	100	0	0.0	13	100.0
Self employed	13	61.9	8	38.1	21	100.0
House wife	36	51.4	34	48.6	70	100.0
Others	8	44.4	10	55.6	18	100.0
Total	**87**	**58**	**63**	**42**	**150**	**100.0**

Basing on Table 4.3, all civil servants interviewed knew about PMTCT. Self employed category followed. However, only 36 (51.4%) housewives knew about PMTCT. It was found that there is an association between the respondents' occupation and the knowledge on PMTCT services. Those in formal employment (civil servants) were more knowledgeable about the services. This was based on the P.V which was (0.05). The high level of knowledge about PMTCT by civil servants is attributed to their high education levels compared to other categories. It

was also found that the same group complained about the much time they spend waiting for the antenatal services, since they always have to report back to the work places. Self-employed were the next big category who knew about PMTCT services. This group is also exposed to different media and they also interact with different levels of people when they are carrying out their activities.

The mothers' knowledge on the PMTCT services is also influenced by the mothers' education level as the table 4.4 shows relevant data.

Table 4.4: Education levels of respondents and their knowledge on PMTCT

Education levels	Have heard about PMTCT				Totals	
	Yes		No			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Never	8	47.1	9	52.9	17	100.0
P1- P5	10	55.6	8	44.4	18	100.0
P5- P7	28	50	28	50	56	100.0
S1- S4	28	70	12	30	40	100.0
S5- S6	4	66.7	2	33.3	6	100.0
Tertiary	9	69.2	4	30	13	100.0
Total	**87**	**58**	**63**	**42**	**150**	**100.0**

As can be seen from table 4.4, majority of the pregnant women interviewed attained primary education followed by the category of those who were exposed to the secondary education; and that is from senior one to senior four. However there was a significant number that attained lower primary and those who never went to school at all and a few pregnant women attained Advanced level and tertiary education as indicated in the table.

The education levels of respondents were identified as an underlining factor for knowledge on PMTCT and had very significant relationship. The P.V was (0.01) as calculated and this implies that the educated mothers are more likely to access information on PMTCT services compared to those who are less educated and those who never went to school.

People with education have got chances of being exposed to the media such as electronic and print; hence get health information than those who are not. The educated pregnant women can read, therefore any health information cannot escape their eyes. Also they can listen to most broadcast information, attend seminars, which in most cases are in English. Therefore education attained can give individuals' opportunity to participate in development issues that can further expose them and keep them informed on different issues.

The Low levels of formal education were found to be having influence on the mothers' knowledge of PMTCT. This concurs with Chris Baryomunsi where he

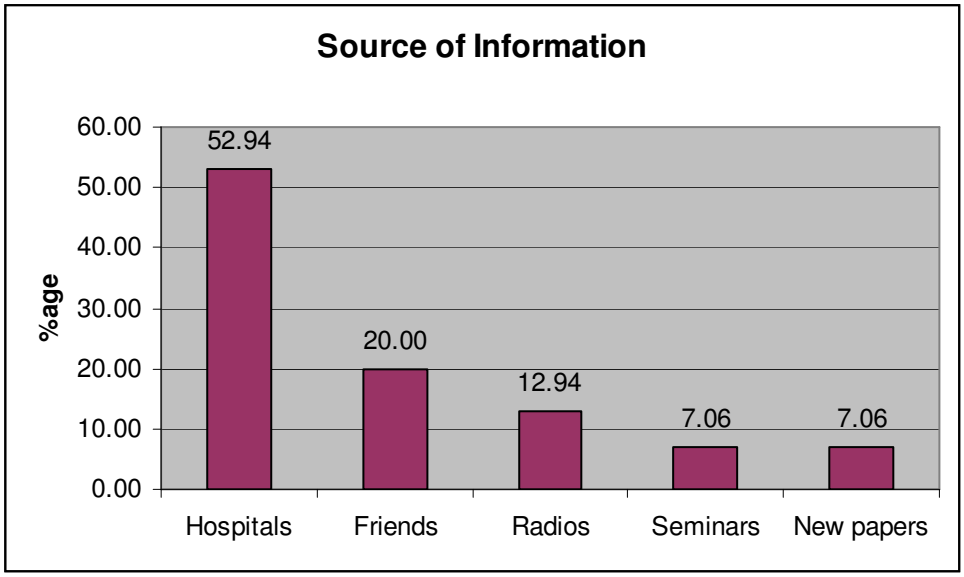
said that PMTCT has failed to reach most of the women and the impact has not been significant so far, so there is need to use resources available to mobilise women and sensitise them about PMTCT.

Table 4.5: Pregnant women's knowledge on STDs and PMTCT

Knowledge on STDs	Have you ever heard of PMTCT				Total	
	Yes		No			
	Freq	Percent	Freq	Percent	Freq	Percent
Yes	84	58.7	59	41.3	143	100.0
No	2	33.3	5	71.4	7	100.0
Total	**86**	**57.7**	**64**	**42.6**	**150**	**100.0**

As shown from Table 4.5, there is a clear relationship between knowledge of STDs and knowledge of PMTCT. People who knew about STDs had knowledge about PMTCT 84 (58%) and those with no knowledge had less knowledge on PMTCT (71.4%). It was found that other sources of information about PMTCT included; interactions with friends, during antenatal visits, radios programs and seminars. It was also clear that the most reliable source among these was sensitisation and counselling sessions at the hospital during antenatal visits and indicated in the Chart III.

Chart III: Sources of information on PMTCT



It was important to find out where the mothers access the information on PMTCT so that more efforts could be made to inform the general public and mothers in particular the benefits of PMTCT services.

However, much as some people know that there are PMTCT services, they are not convinced that the drugs can prevent the baby from getting HIV infection. Most respondents especially those in focus group discussions reported that the mother's blood is the same as that of the baby so there is no way the baby can not contract the disease. This concurs with the health belief model, which asserts that people hold certain beliefs in order to be able to change behaviour. So some people who have such beliefs as above need to be convinced more; for example that the unborn baby can be prevented from contracting HIV from the mother. More still, it was found that women know that they are at the risk of infecting their unborn babies once they are infected with HIV, and because of this some find it important to take

up PMTCT services to prevent the unborn children fro getting HIV infection. Despite the fact that a big percentage of women are aware that they can infect their unborn babies, some are not willing to have an HIV test which is the entry point of PMTCT services.

It was also important to find out from key informants what the PMTCT program in Mbale Regional hospital presently offers. This would help the researcher to understand the underlying factors behind pregnant mothers' attitudes and knowledge on PMTCT.

According to Key informants' PMTCT program involves creation of awareness and health education through out reach, counselling and testing for HIV and then giving drugs to those who are infected and encouraging them to deliver from the hospital, where they are monitored by health workers and given more information on breastfeeding options available.

To most of the key informants, PMTCT program is about saving the un born babies from being infected with HIV and reducing the transmission rate. The target group is mothers who come for antenatal at Mbale regional hospital and women of the reproductive age who can access the necessary information on the program. The hospital works in collaboration with other organisations like TASO and AIC.

Responses from Key informants also revealed that not all health workers had sufficient knowledge on PMTCT. Health workers who have knowledge are those who got orientation training on PMTCT but others have little knowledge, while others have no knowledge at all. This is illustrated in the words of one health worker.

> *"I hear about PMTCT but I don't know exactly what it includes and when it started and I do not think many mothers are aware of these services".*

If the program, which was introduced in 2002, is not well known by some health workers, then it is likely to take more time for communities to fully understand what it really entails.

Most of the study variables play a big role as far as mothers' knowledge on PMTCT is concerned. Age in particular influences the mothers' knowledge to a certain extent. For example, those between 18 and above are more exposed to most available information on health related issues and can easily determine what can influence and benefit them as far as their health is concerned un like those below 18 years, hence their less knowledge of understanding PMTCT. Religion according to the study seems to influence the knowledge, though there was no viable explanation for this. (See table II) Marital status proved not to have a big relationship with the knowledge levels of individual mothers. The married/cohabiting were the majority, and their knowledge on PMTCT was more than 50% while the percentage of respondents on other statuses was higher.

The civil servants had more knowledge on PMTCT than others. These are more exposed to information by nature of their work i.e. have access to news papers interact with people i.e. in seminars etc. also people with education background can read and write therefore their chances of coming across information on important issues in life are high.

The sources of information being almost the same for most mothers who come for antenatal, it was also found out that those who have knowledge on STDs are almost the same numbers who know about PMTCT. It was again found out that the most stakeholders involved have knowledge on PMTCT, though others are not aware, especially those who are not involved in the program. Though it was found out that sensitisation is being done up to the grassroots to increase mothers awareness on PMTCT, there is still a long way to go. Sensitisation should be done effectively not only to the mothers but also to all stakeholders i.e. fathers communities, health workers and NGO s that are involved. Health workers should all be equipped with first hand information about PMTCT so that they are always in position to council and advice people accordingly. All these done, PMTCT program will live to serve its intended purpose.

4.3 RESPONDENT'S ATTITUDE TOWARDS PMTCT SERVICES.

4.3.1 Introduction

Understanding the attitude of the pregnant mothers and the people have towards PMTCT services was one of the purpose/objectives of the study. Attitude is considered as a very important aspect among people in case there is a new program that has been implemented like PMTCT because it is not an individual issue but it affects the whole family and the community where a mother on PMTCT lives. The attitude people have towards a program may either frustrate the program or promote the program. So in this study the attitude of pregnant women towards PMTCT services was looked at and even the attitude of the few members of the community including men.

The attitudes of the respondents were examined in two ways; the attitudes of individual pregnant mothers and the community's attitudes on PMTCT program in general, and services in particular.

4.3.2 Pregnant mothers' attitudes

Table 4.6 Percentage of mothers who said it is important to have an HIV test while pregnant.

Is it important to know your HIV status?	Frequency	Percentage
Yes	115	76.7
No	35	23.3
Total	**150**	**100.0**

Most pregnant mothers felt it is important to have an HIV and know the sero status while few did not see the importance of knowing the HIV status as indicated in table 4.6.

Though the entry point of PMTCT is voluntary counselling and testing, some pregnant women still have a negative attitude towards HIV testing. The reason for this because of fear and stigma associated with HIV/ AIDS as a disease. One respondent had this to say;

> "*Why should I know I have got that 'terrible thing '. If at all Iam tested and find to be HIV positive, I can die of thoughts or I can even commit suicide so that I do not suffer like the way I see other people suffering".*

(Antenatal attendee, 17 years).

This demonstrates fear and stigma people have towards HIV and AIDS and the way People living with HIV/AIDS (PLWHA's) are stigmatised. However this is not only in Uganda but was reported in Zambia in a study on PMTCT conducted by UNAIDS in 2001 (Ref. Pg 15) whereby the findings indicated that there is a high level of stigma against HIV/AIDS patients. The community tends to shun persons who are known to be HIV infected or have symptoms of AIDS. The same study also reveals that there is limited knowledge about Mother-To-Child Transmission of HIV among the persons interviewed.

Similarly in Zimbabwe, the Joint United Nations Aids Program also conducted a study in 2001 about PMTCT and it was reported that there was low uptake of counselling for PMTCT services. However the reasons given for low uptake included stigma associated with providing the PMTCT services. There was social stigma with the service providers in the health setting and outside the clinic.

Though most pregnant women interviewed reported it was important to know the HIV status while pregnant, when probed further to know how many had the HIV test; interestingly, it was found that few of these were willing to take the HIV test after counselling. This is in line with the AIDS Risk Reduction Model which points out that Mother's commitment to change is shaped by perceptions about the PMTCT services. Some pregnant mothers were aware of benefits /advantages of PMTCT services but were not willing to test and access the services. This is further illustrated in the subsequent table 4.7.

Table 4.7: Pregnant women willing and unwilling to test for HIV after counselling

Did you take HIV test after counselling	Frequency	Percentage
Yes	55	36.7
No	95	63.3
Total	**150**	**100.0**

It is clear that a big number of the respondents were unwilling to test for HIV after counselling. The reason pregnant mothers gave for not testing for HIV was that they do not want to know because if the results are positive then it can disorganise the whole family. The other reason given was that some pregnant mothers cannot take an HIV test without the permission from the husband. All this is caused by stigma that is associated with HIV/AIDS. One pregnant woman had this to say;

> "*I do not want to know whether Iam dead or still alive besides my husband would kill me if he finds out I tested without his knowledge. And even if I asked him that we go and test, he will not allow".*

(Respondent 19 years)

In some communities, women are not involved in decision making and cannot therefore make decisions on their own, even when some decisions concern them as individuals. In serious situations like HIV testing therefore, some women are forced not to disclose their status fearing the husband's reactions. Women are therefore not only stigmatised by AIDS as a killer disease but also are scared of the husbands and communities reaction in case they are found out to be sick. Given such situations it's likely that some women may not be able to utilise PMTCT services.

This concurs with the findings from Myanmar (as indicated by UNICEF) whereby the PMTCT program had a constraint of low acceptance of VCT by pregnant women throughout all the three pilot sites. Around 72% of pregnant women

coming for antenatal services had access to VCT, however only 18% chose to take the HIV test.

4.3.3 Community attitude

The community's attitudes towards the PMTCT Program were both positive and negative. This was because people had mixed feelings about the program as some claimed they have never been sensitised about the program, while others have got scanty information on it and others no information at all.

To some Men in the community; they would encourage their wives take up PMTCT services by encouraging them to test for their HIV status, and then support them through out their pregnancy period.

> "*I have no problem with supporting my wife to take up PMTCT Services in case she is found out to be sick. I have to encourage her; after all I may be the cause of her suffering".*
>
> (Male participant in FGD).

This indicates that there are some men out there who are willing to get involved in the PMTCT program and give support to their partners if given the opportunity.

On the other hand some men that participated in the study aired their views that a woman should not take a decision to test for HIV without the partners authority or

permission to do so; because it would cause some other problems to the woman being blamed for bringing HIV/AIDS in the family as one of the male participants in the group discussion expressed;

"*If my wife goes to test without my consent, and is found to be Positive, then I know she is the one who brought the disease how can she go to test without asking me first? Am the head of the home so everything to be done by Wife should pass through me."*

(Male participant in Male FGD)

The above expression calls for PMTCT program to consider the Africa traditional cultural settings whereby men are traditionally the decision makers in home. Even if a woman sees the need for PMTCT services, her male counterpart may make it difficult for her unless the men are sensitized thoroughly on the PMTCT program as well as the benefits. Since PMTCT program enrols mothers who are HIV positive mainly, it was considered important to know the attitude people have towards an HIV positive mother having a baby in order to get a picture on how the mothers on PMTCT will or are likely to be treated in the community. The responses from the survey respondents who were mainly the antenatal attendees are indicated in the table 4.8.

Table 4.8: Responses on whether an HIV positive woman should have baby or not

Do you think an HIV+ Woman should have a baby?	Frequency	Percent
Yes	43	28.7
Don't know	17	11.3
Total	**150**	**100.0**

According to the information in the table some respondents reported that it is okay for an HIV positive woman to have a baby while the majority of the respondents reported that an HIV infected woman should not have a baby at all. The other few respondents on the other hand did not know what to say as stated in table 4.8. Those who reported that an HIV positive woman should not have a baby gave a reason that this will shorten her already 'numbered days' since she looses a lot of blood in the delivery process. The other reason was that some respondents think its obvious an HIV positive woman will infect the baby therefore are not convinced there is need for the baby. One respondent stated that;

Why should one have a double burden of having two sickly people. Who will look after this sick child In case it does not die at early age? I hear some HIV infected children are surviving up to some years and even their mothers die before them. Why should they produce when they know that there are already infected?.

(Female participant in FGD)

This indicates that there is a gap in knowledge as far as PMTCT is concerned. This knowledge gap is reflected in the previous discussions. Lack of knowledge is however not only reflected in the community members but even among the pregnant women who were interviewed at the antenatal clinic despite the efforts put in by midwives to have a big number of pregnant women test for HIV in order to reduce MTCT of HIV.

On the other hand respondents who reported that an HIV positive woman should have a baby recommended it because few of them are aware the baby can be born free of HIV because of PMTCT services if the woman attends antenatal regulary and delivers from the hospital. Surprisingly, the other respondents looked at it in the cultural perspective that; it is the tradition for every woman to produce children irrespective of the HIV status. This was emphasized in the group discussions whereby people especially men saw no problem with a woman having children while HIV positive. One of the male participants expressed it in his words that;

"As long as the woman is still in the reproductive
age group and capable to produce; it is ok for her
to have a child after all when a man imprignants
a woman he does not first ask for the HIV status.
We just have sex with a woman and sometimes
not conscious of the pregnant issues both to
our own wives and others".

(Male participant in male FGD)

This reveals that some people just produce children that are not planned for even in this era of HIV pandemic. Traditionally the African man was recognised as strong because of the number of women and children he was able to produce and a woman recognised as strong as a result of a big number of children she was capable of producing. Now that things have changed due to HIV and its associated problems still, some people have not changed the old traditions that are likely to spread the HIV infection.

Following the respondents' attitude towards a positive mother having a baby, they were asked whether an HIV positive mother should breast feed her baby. This was done in order to explore the attitude mothers had towards breastfeeding which is considered as an important cultural aspect mothers should observe. The responses are shown in the Table 4.9.

Table 4.9. Responses on whether an HIV positive woman should breastfeed

Can an HIV positive mother breastfeed*?*	Frequency	Percentage
Yes	39	26.0
No	93	62.0
Don't know	18	12.0
Total	**150**	**100.0**

Many respondents for example (62 %) were of the view that an HIV positive mother should not breastfeed the baby because the breast milk is also infected with HIV with the virus, hence the baby can be infected too. Some respondents are not convinced that a sick mother can give birth to an HIV free child. One of the male participants in the Focus Group Discussion had this to say;

> "*The HIV positive mother must not breastfeed the baby because the breast milk is already contaminated and infected with HIV virus. The mother's breast milk contains the mothers' blood so the virus will automatically infect the baby! so why give the baby a double infection?"*

The respondents who reported that the HIV positive mother can breastfeed, at least know that the baby born of an infected mother can still be safe if she is enrolled for PMTCT and also breastfeeding may not be dangerous when done exclusively. It was therefore found out during the study that it is not known by some people that an HIV positive mother if she decides to breastfeed exclusively, the baby can still be safe.

> *"HIV positive mother should breast feed her child because the baby is born sick and the mother is also sick, so there is nothing to prevent or to save."*
> (Female participant in female FGD).

It was again found that among those who reported that the baby should be breastfed thought it was every mother's obligation to breast feed her baby. Others

reported that there were mothers who can not afford to buy other types of milk so breast milk is their only option. Among these however there are those who know about exclusive breastfeeding due to counselling got when they went for PMTCT program at the antenatal clinic.

On the issue of the husbands' and community's reaction when a wife/mother does not breastfeed her child, it was found out that if the husband knows the wife is sick and was therefore advised by the health workers not to breastfeed at all if she can not do it exclusively, then he will support her, but if he does not know, then this can cause problems.

> *'If I know my wife is sick, why would I force her to breastfeed since it is risky to our child we need to understand each otherso that we do not get misunderstandings and expose ourselves to the public.*
>
> (male participant in an FGD)

The family members and community at large may not be in position to understand in case a woman is not breastfeeding her child. This may pose a number of questions, some people may think the mother wants to kill the baby and for this reason therefore she may be rejected and despised by society. It is not easy to explain to the whole community what really is stopping a woman from breastfeeding.

"*How can one go around the whole village confessing she has got AIDS and therefore cannot breastfeed her baby? It is not easy to tell people that you are HIV positive? even if they are relatives."*

(Female participant in female FGD)

The respondents' attitudes towards PMTCT services are affected by their lack of knowledge on what the package entails and the advantages of these services to the HIV infected mothers. Much as it is true some mothers are aware of detailed information on these services and others know bits of information, but a good number of these pregnant mothers need more sensitisation on this. The negative attitudes on the PMTCT services were not only with the pregnant mothers who are supposed to be the beneficiaries of these services in case they test and found to be sick, but also the communities where they come from. These communities have to be sensitised about these services if they are to support these mothers and encourage them access the services.

It is also not enough for people to know the PMTCT program and probably also get scanty information about the program when there is a lot to be known about it. It is difficult for some people to accept getting involved in something they are not convinced about.

Since it there is a small group of mothers that know very well about the PMTCT services among the many, therefore this big group of mothers who do not know cannot be left behind. They need to be sensitised, convinced so that they also can come aboard and reduce Mother-To-Child Transmission of HIV.

4.4 UTILISATION OF PMTCT SERVICES BY PREGNANT MOTHERS

4.4.1 Introduction

The study found out that there are a number of things that affect the level of utilisation of PMTCT services; these include stigma about HIV and lack of sensitisation etc.

4.4.2 PMTCT Service provision procedures and Utilisation

Most respondents reported that they could use PMTCT services in case they tested and found they were infected with HIV, but few of these are unwilling to test their blood, a step that has to be done first before these services are accessed. The reasons behind this have nothing to do with the processes one has to go through before accessing the services, which include counselling, behaviour of health workers, hospital management protocols etc.

It was found for example the time spent waiting for services at antenatal clinic etc. Which is between 1and 4 maximum does not in any way discourage mothers from coming for antenatal services.

Table 4.10 Frequencies on the respondents' comments on the time spent at antenatal

Comment on the time spent at the hospital	Frequency	Percent
Too much	93	62.0
Just right	51	34.0
Too short	4	2.7
No comment	2	1.3
Total	**150**	**100.0**

Though a big number of the respondents reported that time spent waiting for antenatal services is too much, this may not stop them from coming for the services, but however wish the time was less. One of the respondents stated that;

"Whether the time we spend waiting is much
or not, we still have to come here because we need
the services and they are free in this hospital "

(Self employed antenatal atendee)

It was found that some of those who complained of the time being too much were public servants and self employed people who come for antenatal and yet have to go to work, so would not wish to wait for long. Some of those who said the time

was much come from very far places and need to walk back. One of the respondents was quoted as follows:

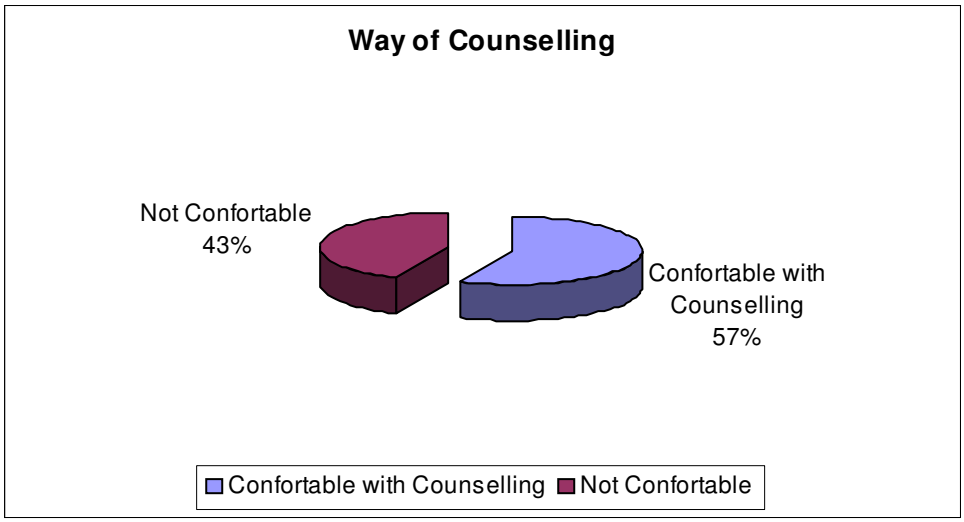
"When I know today is the day I have to go for
antenatal, I wake up early, prepare everything
because I know I have to come back home late!
if you are coming from far you take a whole day"
(Housewife antenatal attendee)

Time spent at the hospital therefore does not discourage mothers from coming to access antenatal services of which PMTCT is a package in case one is infected.

Counselling on PMTCT is done in the hospital for every pregnant mother, but this does not guarantee that all the counselled mothers go for testing. Mothers go for counselling but do not easily take the decision to test.

It was important to find out why the respondents did not want to take an HIV test after counselling because it was assumed that the problem was the form of counselling used but the findings indicate that more than half of the respondents were comfortable with the form of counselling that was being used as shown in Chart IV.

Chart IV: Percentages of mothers comfortable with the form of counselling

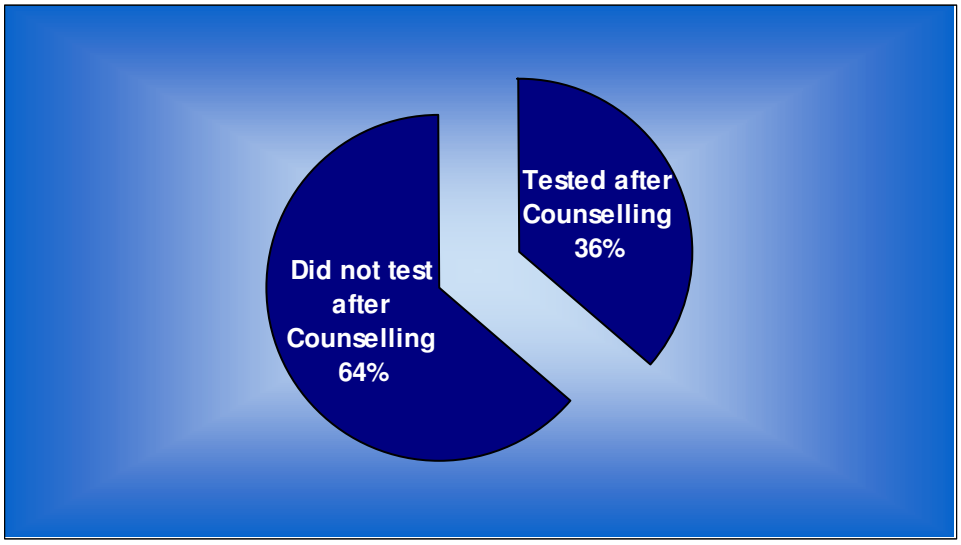


As indicated Chart IV 57% of the respondents reported that they were comfortable with the form of counselling offered, while 43% were not comfortable. Though the number of pregnant mothers who were comfortable with the form of counselling was big, this does not necessarily mean they are willing to go for HIV testing. Those who were not comfortable with counselling said so basing on the arguments that counselling was done for groups and not to individuals, this makes them uncomfortable to ask personal questions. One respondent had this to say:

> **"***We come here and the health workers give us health talk which includes PMTCT services, we watch films about HIV transmission from mother to child but iam not usually convinced to take the test because some of the films scare me and I do not have the opportunity to ask personal questions."*

(Civil servant antenatal attendee)

Chart V: Mothers who tested and those who did not test after counselling



Out of 150 respondents (36%) were willing to have their blood tested for HIV while (64%) never tested after counselling. It was found that some respondents still have stigma and fear to find out their HIV status.

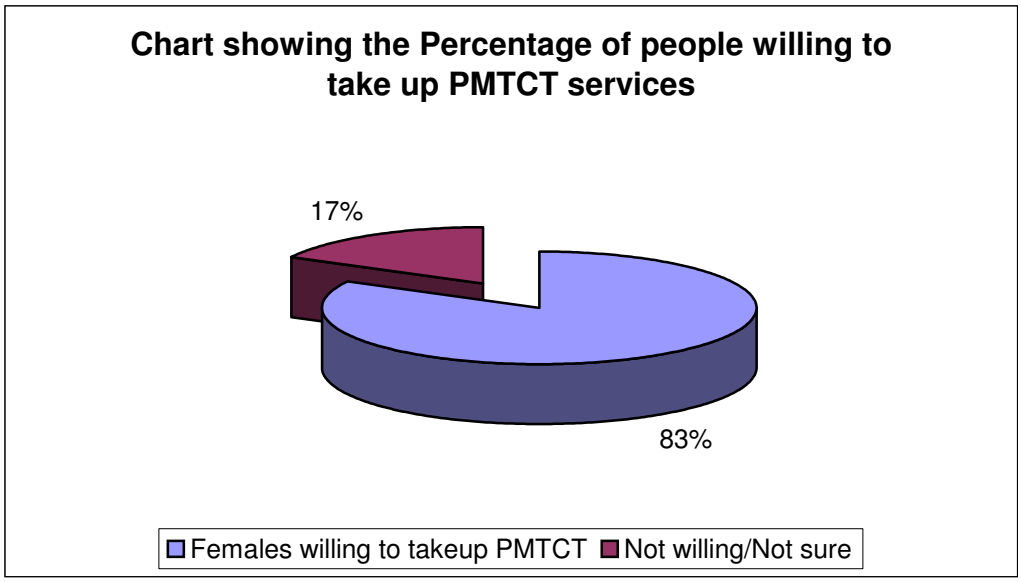
Though VCT is the entry point to PMTCT services, a big number for example 64% of the pregnant mothers were unwilling to take an HIV test despite the services being offered free of charge. This is due to the stigma still associated with HIV/AIDS. This is confirmed by the PMTCT program Officer in the Ministry of Health Dr. Jackson Ojera who noted that:

> '*while the program is set to achieve even bigger gains in reducing infant death as a result of mother-to-child transmission of HIV, there are a few setbacks to the*

program, being a new intervention, communities are not well sensitised and mobilised for the program. On the other side of the clients, there is stigma and discrimination which make women fear to come and test and very few disclose their HIV status to their partners."

This however is not only a problem in Uganda but also in the other parts of the world. According to the literature, a pilot PMTCT program in Abidjan, Ivory Coast, revealed that barriers besides fear of disclosure include difficulties with staff or clinical procedures, disbelief of HIV results and doubts about AZT efficacy. So the percentage of women in chart V that are not willing to take PMTCT services may be having some problems such as those in Abidjan. In the same way for the case of Uganda, few people know much about anti-HIV drugs, including Nevirapine. There are limited educational materials available in the local language, and illiteracy is high in rural areas as indicated in the Table 4.4 and Table 4.5. Some pregnant women worry about taking drugs that might cause problems to the foetus or the unknown side effects. When they do learn about Nevirapine, they wonder about drug resistance and efficacy because some pregnant women feel that since AIDS has no cure, the foetus can not survive the HIV infection as expressed by some respondents in the previous discussion.

Chart VI: Mothers willing to take up PMTCT services if found HIV positive



Most respondents reported that they are willing to take up PMTCT services if found HIV positive while few are unwilling to take up the services as shown in Chart VI.

It was however noted that though many respondents reported that they are willing to take up PMTCT services, some are not willing to take an HIV test and yet this is the entry point of PMTCT services. On the other hand the respondents who are not willing to take up PMTCT if found HIV positive gave a reason that it is a wastage of time since AIDS has no cure while the others were not sure that an HIV positive woman can not have an HIV /AIDS free baby. However some respondents raised a concern why PMTCT should target the children only without considering the mother. One of the respondents was quoted verbally as follows.

"My life is going, you are not helping me but you are

only concerned about my baby; who is going to look after it when I am dead?. If you could also help me and prolong my life and I look after the child for some time then it would be better."

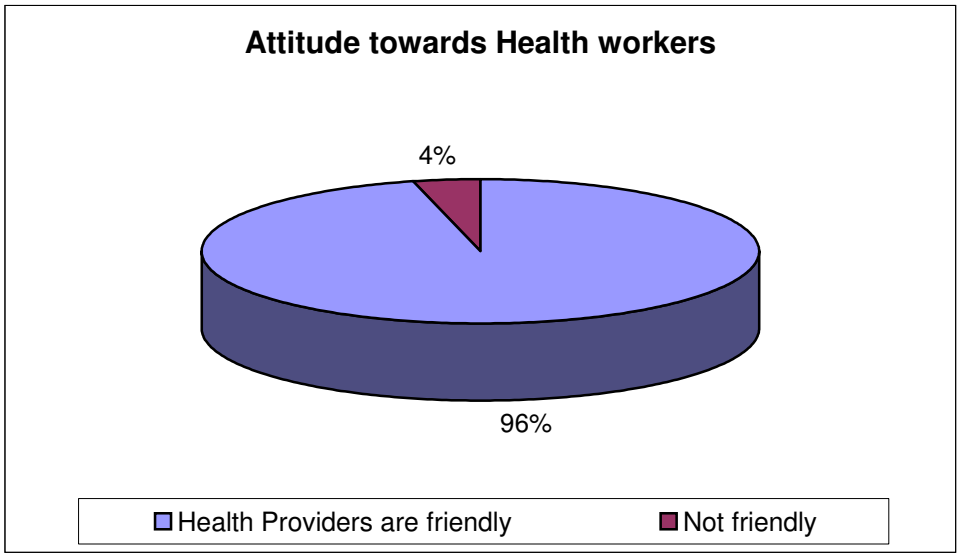
(Self employed antenatal attendee Mbale Hospital)

This experience is not only in Uganda but it is almost the same in the neighbouring country Kenya –Nairobi Masai whereby Rutenberg et,al (2001) stated that:

Although PMTCT programs still have little experience with ARVs, stigma and misconceptions about the drugs have emerged as important obstacles to acceptance and effective use. With limited access, PMTCT programs have made special efforts to help women adhere to the often difficult-to-follow ARV treatment regimens; because they do not provide mothers with ongoing on going ARV treatment, PMTCT programs are often criticised.

It was also important to find out whether the attitude pregnant mothers towards health had an effect on utilisation of PMTCT services. The results are indicated in the Chart VII

Chart VII: Respondents attitude towards health workers



Most respondents clearly justified that the health workers are friendly and that the general antenatal services were carried out well as clearly shown in the Chart VII. This however did not mean that the services were perfect it is because respondents did not know other services they were entitled to. This response was also affected by the fact that the interviews took place in the Antenatal clinic and the respondents feared ton talk anything that was negative about the health service providers.

4.5 CHALLENGES FACING PMTCT PROGRAM AND POSSIBLE SOLUTIONS.

4.5.1 Introduction

The respondents especially Key Informants advanced a number of challenges facing PMTCT program. Mothers and fathers advanced their particular problems, which they felt affect PMTCT as well as accessibility of antenatal services in general. Also the respondents both pregnant mothers and the community pointed out some problems that are likely to affect PMTCT program if not properly addressed as pointed out in the subsequent discussion.

4.5.2 Challenges affecting accessibility of PMTCT services

It was found out that people are still stigmatised about AIDS. Some pregnant mothers fear to test because they are worried of the public or community's reaction in case they are found to be HIV infected, some respondents reported that once a pregnant woman is infected with HIV, it is no longer confidential some community members will get to know about it especially after birth of the baby. This was further confirmed by one participant during FGDs in the communities who stated that:

"*Whenever I see a woman not breastfeeding,*
I suspect she is HIV positive because the health
Workers tell them not to breastfeed in case they

are infected with HIV."

(Male participant in married male FGD)

Some individual pregnant women reported that it is difficult for them to take an HIV test due to fear of their partners. These respondents would stand a risk to be d blame for having brought the disease in the family in case they tested HIV positive. One respondent had this to say;

"How can I start telling my husband that I tested and Iam HIV positive? Am sure he can tell me to leave his house even before I finish giving him the details. He would blame me for bringing a disaster in his home".

(ANC attendee, Mbale Hospital)

This was further confirmed by the responses in male focus group discussions where by the men insisted that women should always consult and seek permission from men before taking an HIV test (ref. page 39)

To some individuals therefore, testing to know ones status is regarded as disaster in case one is HIV positive. They do not see PMTCT as an opportunity for some one who is HIV positive to start benefiting from it, but rather may increase on the problems in their families. As Global Health, (2003) adds; *'not only do these*

women face a prospect of discrimination, illness and early death, but they may also pass the infection to their children or leave their children behind as orphans when they die'.

Lack of male and community involvement was also cited as a problem that can hinder pregnant mothers from accessing PMTCT services. Fathers do not take initiative to find out what takes place with in the health centres where their wives go for antenatal.

> **"***If these men were coming with their wives for antenatal once in a while, then they would be knowing something about antenatal and support their wives accordingly. But* w*ith some of these husbands their fatherly role starts and ends in bed;* a*m sorry to say this"*.
>
> (Midwife, Mbale Hospital).

The people in the communities who participated in the study had insufficient knowledge about PMTCT services and do not know how best to handle and live with the persons infected with HIV.

Mbale regional hospital is the only health facility offering PMTCT services so it is not easy to reach most districts especially on out reaches spreading the PMTCT

'gospel' given the fact that manpower is inadequate and clients are very many and always have to line up to be served.

It was also found that some cultural beliefs do pose danger and challenges to PMTCT service accessibility, some cultural issues in some areas are still attached to some health issues. For example it may not be easy for a mother not to breast feed, because of fear of what the community will think.

Lack of sufficient information by the less educated and non-educated mothers is a challenge to PMTCT program. It was found out that the educated mothers have more access to media and therefore have more knowledge on most health issues than the rest. Besides, they are so much exposed and therefore interact more with the 'outside world' than the rest. There is therefore need for local translated literature to be given out to mothers and more education programs in the local language for those who cannot read.

Another problem that affects PMTCT program was found to be lack of knowledge/ awareness about PMTCT program by the communities in general and mothers in particular. This may be the reason as to why some people have got scanty information on PMTCT.

> *"Yes, we still have along way to go as far as sensitisation and promotion of PMTCT services is concerned. It is true the services are free, and*

sensitisation is being carried out, but for sure

the program is so sophisticated that it may take

time to explain to people and they

understandit especially the community".

(*C*ouncillor Mbale Hospital.)

The ignorance about PMTCT services by the general public and specifically men and women in the reproductive age group, is setback to the progress of the program that needs to be combated by all means so that the pregnant women do not find any difficulty in making adecision to take up VCT which is the entry point to PMTCT services.

4.5.3 Possible solutions to the challenges

Respondents were asked solutions for the challenges related to PMTCT. They suggested that pregnant women need to be encouraged to come for antenatal with their partners should be involved in the PMTCT program. This can be done by developing programs, which target men right from the grass root/ communities. It was highlighted that men should be sensitised on how to encourage their wives attend for antenatal and test for HIV then support them in case they are found to be infected. It was also suggested that health workers should enforce a rule that requires every mother who attends antenatal come with a partner. This is believed to let men come face to face with reality of what women go through as far as reproduction is concerned, and can therefore support them.

It was also suggested that there is also need to train more councillors to do the counselling. When the hospital have got many trained councillors then the work load can be divided, so that some go for out reach as others remain at the hospital, and all communities can be served. This can go hand in hand with the provision of transport means as well as motivating the health workers/ councillors.

Another important suggestion was that PMTCT services be expanded to health centre IVs and centre IIIs, so that they are nearer to the people. The government should ensure that there is adequate supply of testing kits, syringes, and necessary equipments for the program.

There is need for involving other stakeholders in the community sensitisation. However these people have to be trained first. The community leaders, religious leaders, opinion leaders should all be used to create awareness to the communities.

CHARPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS.

5.1 Conclusions

The overall conclusions are based on the objectives of the study which are; Knowledge, attitude and utilisation of PMTCT services. The findings of the study indicate that some variables of the study affect the knowledge as well attitude of the pregnant mothers. These included; age, education and occupation. The older the respondents, the higher the education and the occupation the higher the knowledge of PMTCT services.

People's attitude and utilisation of PMTCT services was affected by the insufficient knowledge on what the PMTCT program entails and the benefits of the services as far as mother-to-child transmission of HIV is concerned. Other issues like lack of male participation, also affect utilisation of PMTCT services.

The results reveal that social demographic characteristics of the respondents, the knowledge and attitude towards PMTCT influenced their behaviour towards PMTCT services as the theoretical concepts explained. Indeed pregnant women felt that their unborn babies are susceptible to the HIV/AIDS infection and hence the need to protect the babies. This is in line with the Health Belief Model which asserts that people have got their own beliefs and in order for them to change behaviour and perception on certain issues, these beliefs have to be put in

consideration. For example they have to be convinced that the PMTCT services do help the pregnant mothers give birth to normal babies, and that promoting action to change a particular behaviour, includes changing individual personal beliefs. For example if the stigma associated with HIV testing is dealt with, then most people can find it easy to test and enrol for PMTCT services.

5.2 Recommendations

Much as there are those mothers and people in the community who really know about the details of PMTCT program and services, a big number still do not know the program benefits in details. Therefore, measures should be put in place to make sure the correct and detailed information reaches the community.

Husbands and the community at large should also be sensitised on how they can support pregnant women in their communities for example by encouraging them go for antenatal, advice them to deliver from the health centres and attend seminars on antenatal education. This will enable them access all the necessary information on antenatal in general and PMTCT in particular, as well as reduce stigma among these women.

There is need to increase on the human resource to handle the PMTCT program in Mbale Hospital. This can be done by training more PMTCT counsellors to handle the big number of the pregnant women who seek antenatal services.

There is need to create partnership between Ministry of Health and other NGOs so that some programs are harmonized to benefit the community and the target population**.**

The Ministry of Health should scale up PMTCT services to the Health centre IVs so that pregnant women do not have to move long distances.

The Government should implement the PMTCT Plus so that the partner and other family members can access the HIV prevention, care and support services.

5.3 Recommendations for further Research.

There is need to carry out an In-depth investigation on mothers enrolled for PMTCT program so that their experiences are documented and shared. This will help the program implementers ensure quality services without stigmatizing the clients.

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Appendices

Appendix I: Introductory letter

My name is…… a student from Makerere University doing a masters of Arts in Sociology. I am conducting a study whose objective is to generate information on the knowledge, attitude and utilization of antiretroviral drugs in prevention of Mother-to- child transmission of HIV in Mbale Hospital. All the information you provide will help the hospital and the staff to improve the services. Also the findings from this study will be used to improve the PMTCT program in the district. We will not mention your name and all the information you provide will be kept confidential. I will appreciate if you volunteer to participate in this study. Would you please avail me some time and take part in this exercise? If yes, please thank the respondent for agreeing to participate and go a head to probe the following information.

Date of interview……

Time: Start …….
End ……..

Interviewer's name……..

Appendix 1I: Structured Questionnaire for Survey Respondents

Background information of the respondent

1. Age…….. (In completed years)

2. Marital status:
    1. Married/cohabiting
    2. Never married
    3. Widowed
    4. Separated
    5. Divorced

3. Tribe……

4. District
    1. Mbale
    2. Tororo
    3. Busia
    4. Soronko
    5. Kapchorwa

Distance……..

5. Education level:
    1. Never
    2. P1-P4 (lower primary)
    3. P5-P7 (upper primary)
    4. S1-S4
    5. S5-S6
    6. Tertiary
    7. Other (specify)……..

6. Religion:
    1. Catholic
    2. Protestant
    3. Muslim
    4. Others (specify)…….

7. Occupation:
    1. Civil servant
    2. Self employed
    3. Housewife
    4. None
    5. Others (specify)…….

Knowledge

8. Do you know of any sexually transmitted diseases
   1 Yes
   2 No (skip to question 3)

9. If yes which ones do you know?
   1. Gonorrhoea
   2. Syphilis
   3. HIV/ADS
   4. Candidacies
   5. Others (specify)……..

10. In which ways can one acquire HIV/AIDS?
   1 Sexual intercourse
   2 Mother-to-child
   3 Blood transfusions
   4 Sharing body-piecing/cutting instruments
   5 Don't know
   6 Other (specify)…….

11. a. Can HIV be transmitted from a mother to a baby?
   1 Yes
   2 No (skip)
   3 Do not know
   b. If yes, how is it transmitted?

12. a. If a woman is HIV infected, is there any way to avoid HIV transmission to the baby?
   1 Yes
   2 No
   3 Do not know (skip to 14)
   b. How can it be a voided……

13. What can be done to avoid HIV transmission from mother to baby?
   1 Use of ARVs for PMTCT
   2 Not breastfeeding
   3 Caesarean section
   4 Other (specify)
   5 Do not know

14. Can an HIV positive mother do anything to reduce the risk of transmission of HIV if she decides to breastfeed her baby?
   1. Yes
   2. No (why)

3. Do not know

15. If yes, what can be done to reduce the risk of HIV transmission while breastfeeding?
1 Breastfeed only up to 6 months.
2 Early weaning with formula or diluted cow's milk
3 Take medication to treat HIV
4 Other (specify)
5 Do not know

. 16.a. Have you ever heard of PMTCT?
1. Yes
2. No (skip to qn 22)
b. If yes, what do you know about it?

17. How did you come to know? (multiple)
1. Friend/relative/peer
2. News papers (specify)
3. Radio(specify)
4. Hospital
5. Seminar/meeting

18. a. Have you ever heard of drugs that can prevent a baby from getting HIV/AIDS from the mother?
1. Yes
2. No (skip to qn 23)
b. If yes, could you be knowing some of those drugs

19. a. In your opinion, do you think it is important to know your HIV status when pregnant?
1 Yes
2 No

b.Why……..
…….
Why not……
…….

Attitudinal Questions

20. a. Do you think an HIV positive woman should have a baby?
1. Yes
2. No
b. Give reason for your answer

21. a .Should an HIV positive woman breastfeed her baby?

1. Yes
2. No (if No why)

3. Do not know

b. If yes, why

1. Obligated
3. Cannot afford formula
4. Fear of rejection
5. Others

22. If an HIV positive mother decides not to breast-feed her baby, how would her husband react?

1. Will reject
2. Will support her
3. Don't know
4. Others

23. If an HIV positive mother decides not to breastfeed her baby, how would her family/ relatives react?

1. Will reject
2. Will support her
3. Do not know

24. If an HIV positive mother decides not to breastfeed her baby, how will the community react?

1. Will reject
2. Will support her
3. Do not know

25. What are the risks involved in providing replacement feeds to a breast fed baby?

1. Child will be malnourished
2. Child will get HIV
3. Child will get more illnesses
4. Child will not grow well
5. Other (specify)
6. Do not know

Utilization of PMTCT services

26. How much time did you spend for your prenatal visit at this hospital?
    1. hours
    2. Minutes

27. Would you say that the amount of time you spent was:
    1. too much
    2. Just right
    3. Too short

28. Upon your arrival here at the Hospital, did the staff offer you PMTCT counselling?
    1. Yes
    2. No

29. If yes, how was the counselling done?
    1. One-to one
    2. Group counselling

30. a. Is there anything you did not like during the discussion about HIV/AIDS?
    1. Yes
    2. No(skip)

    b. If yes, please state what is it

……..……
……..

31. Were you comfortable with the form of counselling that was used?
    1 Yes
    2 No

32. If no, how would you like to be counselled?
……
……

33. Were you aware of the HIV counselling and testing before coming to this hospital today?
    1. Yes
    2. No

34. How did you get to know about it? (multiple)
    1. Friend/relative/peer
    1 News papers (specify)
    2 Radio(specify)
    3 Seminar/meeting
    4 Hospital
    5 Other (specify)

35. Did you take an HIV test after counselling?
1 Yes
2 No (skip)
If yes, what motivated you to take an HIV test?
……
…….

If no, why?
……

…….

36. After the test, if you were found to be HIV positive, would you accept to take up the drugs that can prevent the baby from getting HIV/AIDS?
1. Yes
2. No

If yes, why would you take up the drugs?
……
……

If no, why wouldn't you take up the drugs?
……..
……..

37. Given that HIV testing and counselling is offered at this hospital, if you have a friend or a sister who is pregnant, would you refer her to this hospital?
1. Yes
2. No

If yes, why?……..
……
Why not……

38. Would you come back to this clinic for your care?
1. Yes
2. No

If yes, why……
……

If no, why not……
……
39. Was the health service provider friendly to you?
1. Yes
2. No

40. Could you suggest some things to be improved?

1. ……
2. … ……
3. ……
4. ……
5. ……

Appendix III A: Focus group discussion guide for women

1. Have you heard about HIV/AIDS? (*Probe from where, who gets it, and how especially children and babies)*

2 Do you think an HIV positive couple should have a baby? (*Probe can HIV positive woman have a baby)*

3 Is there away this baby can be prevented from getting an HIV).

4. Are there some drugs that can prevent a child from getting an HIV. *(Probe Do all children born to HIV positive get infected with HIV/AIDS).*

5. Have you heard about PMTCT?

6. How did you come to know.*(probe the media, seminars, hospital etc)*

7. Should an HIV positive woman breast-feed her baby? (*Probe for infant feeding options or exclusive breastfeeding)*

8. If you decided to take an HIV test without consulting your husband, how would he react to you?

9. How does the community react to people who do not breast feed their babies?

Appendix III B: Focus group discussion guide for Men

1. Have you heard about HIV/AIDS? (*Probe from where, who gets it, and how especially children and babies)*

2. Do you think an HIV positive couple should have a baby? (*Probe can HIV positive woman have a baby)*
3. Is there away this baby can be prevented from getting an HIV).
4. Are there some drugs that can prevent a child from getting an HIV?
(Probe Do all children born to HIV positive get infected with HIV/AIDS).
5. Have you heard about PMTCT?
6. How did you come to know.*(probe the media, seminars, hospital etc)*
7. Should an HIV positive woman breast-feed her baby? (*Probe for infant feeding options or exclusive breastfeeding)*
8. If your wife decided to take an HIV test without consulting you, how would you react to her? *(Probe could you be willing to go for an HIV counselling with your wife if she is pregnant?)*

9. Do you encourage your wives to take an HIV test when pregnant?

10. How does the community react to people who do not breast feed their babies?

Appendix IV: Key Informant Interview guide

1. Have you heard of PMTCT? *(probe what is included, when started, availability, the target group, etc)*
2. How are people informed and who informs them?
3. Are there days you go out for PMTCT sensitization? *(probe whether there are people specifically responsible for sensitizing the public about PMTCT*)
4. Do pregnant women know about PMTCT? (Probe for response, do they utilize the services, are they informed, who informs them, are their husbands informed about PMTCT etc.)
5. How do pregnant women access the services? *(Probe: are there difficulties/problems faced by these mothers?*
6. In your opinion, what are the most pressing problems?
7. What could be the causes of these problems?
8. What are the problems hindering the program (*probe for the planned solutions to the above problems)*
9. Do the pregnant women come for VCT? *(Probe whether they accept PMTCT services and those who do not accept probe why).*
10. Suggest ways of improving PMTCT program in this area.