Examination on the barriers to accessing prevention of mother to child transmission (PMTCT) services among expecting and lactating mothers in Uzumba Maramba Pfungwe (UMP) district

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Abstract

This study sought to find the barriers preventing pregnant and lactating mothers in accessing PMTCT services in rural Zimbabwe, Mutawatawa hospital. A total of 25 lactating and expecting mothers were conveniently approached and agreed to participate in the study. From the study it was found that all the respondents knew about PMTCT services. However, culture was cited as the major barrier in rural women accessing PMTCT services in rural areas. Other barriers noted included patriarchy, religion, distance, ill-treatment by health personnel and antenatal user fees. Society has negative attitudes towards non lactating mothers and use of formula feeding and they do not support a woman who does not breastfeed. Most of the respondents noted that there is stigma associated with formula feeding a baby. These beliefs are necessitated by long held traditional values associated with breastfeeding a child, which value breastfeeding over formula feeding. As culturally it is believed that the bond between a mother and a child is strengthened through breastfeeding. This is further worsened by some beliefs that when a child is born HIV positive it is the mother who was unfaithful. As a result most rural women end up not accessing PMTCT services because of these beliefs. As such in order to increase accessibility of PMTCT in rural areas the MOHCW should intensify their awareness campaigns to non-service users so that they can be motivated and encouraged to access PMTCT services. More so the MOHCW should partner with religious leaders and traditional leaders in disseminating information in rural areas.
<table>
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<th>Acronyms</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-Retroviral Drugs</td>
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<td>DAAC</td>
<td>District AIDS Action Coordinator</td>
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<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<td>MOHCW</td>
<td>Ministry Of Health and Child Welfare</td>
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<td>MTCT</td>
<td>Mother to Child Transmission</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>OI</td>
<td>Opportunistic Infections</td>
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<td>UMP</td>
<td>Uzumba Maramba Pfungwe</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
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<td>KAPB</td>
<td>Knowledge Attitudes Practices and Beliefs</td>
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Definition of key terms

PMTCT: are interventions carried out to reduce the risk of HIV transmission from an infected mother to a baby during pregnancy, labour, delivery and breastfeeding.

Affordability is the person’s ability to buy a service

Access: can be defined as how much a population can reach a health service.

Accessibility is the ability to reach a health service.

Utilization is making use of
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CHAPTER 1

1.1 Introduction

HIV is the leading cause of death and diseases among women of child bearing age worldwide. In sub-Saharan Africa, up to 60% of people living with HIV are women, posing serious concerns for their children’s well-being. In 2008, it was estimated that low and middle income countries, up to 1.4 million pregnant women were living with HIV. In Zimbabwe it is estimated that HIV infection causes 40% of deaths among children under 5 years of age. Also, approximately 90% of HIV infection in children less than 15 years of age is due to mother to child transmission of HIV (vertical transmission). Even though nevirapine has proved effective to PMTCT, access to the services by HIV positive pregnant and lactating mothers has shown to be a challenge.

1.2 Background

In Africa, HIV infection rates among pregnant women range from 15-40% in the countries with the highest overall HIV prevalence, with women of reproductive age comprising over 55% of HIV infected adult. Since the beginning of the HIV epidemic, over 4 million children have died of AIDS (UNAIDS, 2010). New infections continue at a rapid pace in the developing countries. Of late the primary risk of HIV infection today is perinatal (via their mothers). According to UNAIDS (2000) the HIV and AIDS pandemic is resulting in more than 600 000 infants becoming infected each year and in many countries HIV have become the major cause of infant and young child mortality. It is estimated that 3, 4 million children were living with HIV and AIDS in 2010 (WHO, UNICEF and UNAIDS (2010). Over the course of 20 years of the HIV and AIDS pandemic, however, remarkable scientific advancements have been made in overall prevention strategies that protect children, including blood screening and PMTCT of HIV.

According to Jack (2002), significant lessons have been learnt about effective methods to prevent mother to child transmission of HIV since the 1990s. These largely involve protocols that use antiretroviral medications during the perinatal period (a period around the time of birth). Such advances have resulted in the steep decline in the developing world in the number of infants infected with HIV by their mothers during pregnancy as well as during delivery. For example, studies done in South Africa, France, Tanzania and Uganda showed that the
administration of the antiretroviral drugs during pregnancy, labour and postpartum period has been associated with tremendous reduction of MTCT of HIV by up to 50 % (MoH, 2002).

It is important to note that one of the important breakthroughs in the prevention of HIV/AIDS over the past decade has been the demonstration that the use of antiretroviral drugs during pregnancy in HIV infected mothers can substantially lower the rate of mother to child transmission of HIV. In October 2000 WHO recommended that mother to child interventions based on VCT and ARV drugs be integrated into all mother to child health programmes. In August 2006 WHO updated its guidelines and recommended PMTCT programmes prioritises to HIV positive pregnant mothers in need of ART for treatment. Programmes were also encouraged to provide more efficacious ARV prophylaxis regimes were not feasible and affordable. Also the United States agency for international development (USAID) one of the major international donors in the field of HIV and AIDS prevention, also declared PMTCT as one of the corner stones of its expanded response to HIV and AIDS. The agency pledged in concert with its partners to ensure that at least 25% of HIV 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 in general including PMTCT. UNICEF is also committed to increasing the supply of test kits, training materials and anti-retroviral drugs.

Zimbabwe in its continued commitment to the fight against HIV and AIDS embraced the 1999 HIV and AIDS policy. The policy highlights prevention of mother to child transmission of HIV as one of the key strategies for fighting the HIV epidemic. Resultantly, the prevention of mother-to-child transmission (PMTCT) pilot programme was launched at four sites in 1999 and today the programme is nationwide. It aims to provide pregnant women with free VCT and give them access to antiretroviral drugs, which significantly decrease the chance of transmission occurring. The provision of drugs to prevent MTCT rose from 6.6 percent in 2005 to 46 percent in 2010.
The following diagram adopted from WHO (2007) illustrate PMTCT services related behaviour

The above diagram shows the stages undergone by a HIV positive mother who wants to prevent her child from getting infected. Resultantly, in order to prevent HIV transmission to newborns, Zimbabwe offers free PMTCT as part of antenatal care. This includes HIV counselling and testing in clinics, a single dose nevirapine for the mother during labour and for the baby at birth and counselling about breastfeeding options as illustrated in the diagram above. However, in order for women to access PMTCT services, they need to attend antenatal care. While PMTCT services are free, antenatal care is not free, posing concerns about the ability for pregnant women to afford the services.

More than a decade has gone by since PMTCT services were integrated into antenatal care in Zimbabwe. However, deaths due to HIV among children who are 5 years or younger have continued to be high which suggest that PMTCT services are being under-utilized; research has
shown that women in Zimbabwe increasingly drop out of the PMTCT programme at various stages. Therefore, the need to identify the barriers which are preventing women from accessing PMTCT is the need to carry out this research.

2.4. Potential advantages of PMTCT

Expect panel report and recommendations to the US congress and US global AIDS coordinator (2010). When comprehensively implemented, PMTCT holds the potential to:

- Substantially reduce new paediatric HIV infections, as has been accomplished in developed countries
- Dramatically improve adult, maternal, infant and child health, particularly when well integrated into maternal, new born and child health settings and in those countries where HIV contributes significantly to morbidity and mortality
- Increase awareness of infection status for women and their partners and facilitate access to comprehensive care, support and treatment services
- Identify children of HIV positive women who also need to be tested and, if necessary, access HIV care, support and treatment services
- Prevent new HIV infections in women and their male partners through prevention approaches targeted to the infection status of an individual woman and her partner.
- Prevent unintended pregnancies among HIV positive women.
- Promote appropriate reproductive health services including family planning for those HIV positive women who do not desire future pregnancies and HIV transmission prevention interventions for those who wish to become pregnant.
- Contribute to reductions in HIV related stigma and discrimination through partner, family and community education and awareness efforts.
- Help mitigate the disproportionate impact of HIV upon women and girls.
- Strengthen linkages between adult and paediatric treatment services available and PMTCT services.
- Build capacity for HIV, maternal, new born and child health and reproductive health systems through education and training of health workers, improved laboratory and data systems, infrastructural improvements of antenatal clinics and labour and delivery wards, and strengthened system for monitoring and evaluation.
2.5 Legal, human rights and policy issues

Health is one of the fundamental human rights and national governments have responsibility for the health of their people and to ensure adequate and standard health services. Basic human rights principles hold that health care must be accessible and affordable to all, irrespective of race, gender, religion, geography and income.

According to CHAG (2004) access to HIV prevention, care and support are health rights to those in need. All pregnant women have a right to these services and voluntarily. It is further noted that institutions offering VCT or PMTCT services should consult the WHO or UNAIDS guiding principles to keep the rights of clients, which all members of African states, Zimbabwe included have agreed and signed.

According to Expect panel report and recommendations to the US congress and US global AIDS coordinator (2010) to successfully reduce mother to child transmission of HIV, population level efforts to prevent HIV infection among women of childbearing age must be realised. For the individual woman, a comprehensive, coordinated continuum of services must be provided beginning with increased access to counselling, testing, and primary prevention services, as well as reproductive health choices enabling either the prevention of unintended pregnancies or appropriate planning for intended future pregnancies for women living with HIV. Resultantly WHO or UNAIDS (2007) established the following PMTCT guiding principles:

“Mandatory HIV testing is not ethical and not effective for public health. HIV testing should be voluntary

1. Pre-test information for pregnant women should include: the risk of transmitting HIV to the infant
   Measures that can be taken to reduce mother to child transmission, including antiretroviral prophylaxis and infant feeding counselling
   Benefits to infants of early diagnosis of HIV

2. Confidentiality should be protected
   Only the health care provider should have access to medical information of the client (on a need to know basis)

3. Post-test support services should be addressed
Pregnant women who received positive test results should be communicated with and an explanation of the child birth preparedness plan, use of ARV drugs for own health and to prevent MTCT, about nutrition, infant feeding options, partner and infant HIV testing, follow up and referral to appropriate health services, care and support.”

From the above one may note that all PMTCT providers should follow the above recommendations. Even though, most of sub-Saharan African countries have adopted WHO guidelines and on the process of scaling up PMTCT services. These countries utilization of ANC services is high, PMTCT service access is poor. Joint progress report of WHO/UNAIDS/UNICEF, (2008) shows that antenatal care coverage rate in South Africa and Zambia were 92% and 93% respectively but a low proportion of 64% and 65% pregnant women respectively tested for HIV, this low access to PMTCT services maybe a result of mothers having inadequate knowledge regarding the benefits of PMTCT affecting their service seeking behaviour.

1.3 Statement of the problem

PMTCT as a health intervention introduced in Zimbabwe in 1999 is facing resistance from pregnant and lactating mothers. Of all the expecting mothers in Zimbabwe as at 2009, in Buhera 2298 pregnant women have received pre-test counselling and the acceptance of HIV testing reached 93%, of all 2137 women who had an HIV test 1588(74,3%) collected their results, 437 women tested positive and only 104(24%) mother child pairs received nevirapine prophylaxis. From these statistics, it can be noted that PMTCT is facing resistance among expecting and lactating mothers and this will result in more infections. The need to assess the barrier’s which are preventing HIV positive expecting and lactating mothers to embracing PMTCT as a health intervention to prevent their babies from acquiring HIV/AIDS is the need to carry out this research.

1.4 Significance of the study

As an HIV prevention method, PMTCT need to be evaluated to inform informed decision making on modifying or stopping the programme. The results from this study will therefore help to improve PMTCT services in Uzumba Maramba Pfungwe District. The findings from this study will help the Ministry Of Health And Child Welfare to scale up for implementation
of PMTCT of HIV and AIDS as well as modelling PMTCT services in the district and other rural 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. Furthermore, this research will add into the pool of knowledge to policy makers, implementers and health planners on the possible barriers to accessing PMTCT services in rural areas.

1.5 Aim of the study

This study aim at finding the barriers which are preventing HIV positive expecting and lactating mothers from embracing PMTCT as a health intervention to prevent their babies from acquiring HIV and AIDS from them.

1.6 Objectives

- To investigate the role of knowledge about PMTCT to the utilisation of PMTCT services in UMP district.
- To investigate the role of attitudes and beliefs in the uptake of PMTCT services in UMP.
- To assess the role of service providers in ensuring high uptake of PMTCT services in UMP district.

1.9 Summary

This chapter looked at the background of the study, statement of the problem, justification and the definition of the key terms. It also explored objectives to be met by this study.
2.0 LITERATURE REVIEW

2.1 Introduction

This chapter will present the reviewed literature that has been produced globally, regionally and locally in relation to PMTCT services. This chapter will also identify gaps which this research seeks to address. This chapter will also look into theories that can explain the response of PMTCT programme; health belief model, social diffusion model and the AIDS reduction model. This chapter will be subdivided into themes namely theoretical framework, barriers to accessing PMTCT, knowledge of PMTCT services and attitudes towards PMTCT among others.

2.2 Theoretical framework

2.2.1 Social diffusion model

Social diffusion model according to Kompe, Kleinberg and Tardos (2005) is of the view that people do not exist in a vacuum, rather, they form a complex social network based on different relations and interaction. Thus, by virtue of these interactions they influence each other’s decisions in adopting an innovation. According to Rogers (1995) an individual has to adopt a new idea at a certain time in order to avoid the likely occurrence of some unwanted health event in life. Therefore, for one to embrace PMTCT it is largely a product of recommendations from social networks.

2.2.2 Health belief model

The health belief model notes that the adoption of an innovation is based on individual assessment of the risk of the condition, the seriousness of the condition and its potential consequences’, personal barriers, that is, individual assessment of the influence that facilitated or discourage adoption of the promoted behaviour and personal benefits (Catania et al., 1990). 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 the individual personal beliefs (Catania et al., 1990). It therefore can be noted that this model assets that the individual will take preventive health action when they feel susceptible to a certain condition and they feel contracting the disease has serious consequences compared to the perceived benefits accruing from the same behaviour.
2.2.3 AIDS risk reduction model

The study also used the AIDS risk reduction model, which was developed specifically for AIDS prevention. 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 and AIDS influence how women perceive AIDS. The commitment to change is shaped by perceptions of self-efficacy and social norms. In the last stage of taking action, help seeking behaviour and social factors affect the pregnant women decision making process.

2.3 Why PMTCT of HIV

2.3.1 Effects of HIV on women

HIV is becoming the leading cause of death for women in Africa. According to Kak, Chitsike, Luo and Rollins (2010) pregnant woman with HIV are at an increased risk of prenatal and postnatal complications. This is supported by 2 who noted that HIV infected women are susceptible to postpartum infections and have higher rates of postpartum complications than uninfected women, regardless of whether their babies have a vaginal or caesarean birth. In a South African study covering 50 years of maternal death it was found out that recent increases in maternal mortality are mainly due to an increase in infections associated with HIV AIDS and not pregnancy related infections, thus making HIV and AIDS the most frequent cause of maternal death(18%) in this setting. In Zambia, the maternal mortality ratio for Lusaka university teaching hospital was calculated in 1997 at 921 per 100 000 live births, a significant increase from the 160 noted in 1974 and 667 in 1989. During the same period causes of maternal death changed with a decline (94%-42%) in direct causes and an increase (6-57%) in deaths due to opportunistic infections (4). Researcher thus notes there is need for rural women to access PMTCT services.

2.3.2 Effects of HIV on new-borns

According to 5 while HIV and AIDS is not a major direct cause of neonatal death, maternal HIV status affects new-born survival by causing an increased risk of still birth and death in the neonatal period and infancy, even among those babies who do not come out HIV positive. New-borns of HIV positive women are more likely to be very low birth weight, preterm and have low Apgar scores, placing them at greater risk of death (Mahdi 2008). Also babies born to all
HIV positive mothers are susceptible to acquiring the infection, women who become infected with HIV during pregnancy or while breastfeeding have an exceptionally high risk of passing the infection to their new-born (Mahdi, 2008). This led Kak et al (2010) to note that the interaction of HIV with other infections and the indirect effects of HIV, such as poverty and maternal illness, also contribute to poor outcomes for new-borns.

2.4 Barriers to accessing PMTCT

2.4.1 Age

It is related to socio emotional development as a human being is approaching to middle age, they have more social relationships, self-reliance, settle economically and less likely to be influenced by traditional and cultural beliefs than at young ages.

Access to PMTCT services differs among ages. As women age, they are more likely to accept HIV testing. In a study carried out in Rwanda shows that acceptance of HIV testing was about 3 times higher among women 35 years or older than among younger mothers (Jamease, Pauline, Etienne, Ardent, Joseph and Hamisu 2002). One may note that in this study the age association with PMTCT services was significantly high.

In another study by Okonkwo Kimberly, Alabi, Umeike, and Nachman (2007) in Nigeria shows that pregnant women aged between 25 and 35 years were 1.9 times more likely to accept VCT than women under the age of 25. Women aged 35 years and older were 2.4 more likely than women less than 25 years of age to agree to VCT.

2.4.2 Male dominance

Many women in low income countries are socially economically depended on men or family. Without a husband known by family or community, it is culturally unacceptable for a woman to be pregnant. Unmarried pregnant women are less willing to use HIV counselling and testing and PMTCT services due to fear of reactions from their families and communities if they test HIV positive. Another reason is fear of judgemental view of health care provider towards pregnancy without a husband and positive result.

In a study conducted by Okonkwo et al (2007) on pregnant women in Nigeria shows that married women are more likely to accept HIV counselling and testing when compared to women who were single or living with their partner and not formally married. According to mahdi 2008 in a study conducted in Swaziland it was discovered that, a mother who chooses
to use PMTCT to ensure the safety and health of herself and the baby, often face the possibility of abandonment by her spouse and relatives, while the culture does not allow her to hide the condition from the family. One may note that patriarchy stands in as a barrier to many African women accessing PMTCT services. To this end one may note that unsupportive partner attitude is likely to create a barrier to women’s access to PMTCT services.

In a study conducted by nyasulu and nyasulu (2011) titled barriers to the uptake of PMTCT services in rural Blantyre and balaka districts, malawi it was discovered from focus group discussions that some women reported violence and abuse by their spouses after they had learnt of their HIV positive status. For those who joined PMTCT, four out of ten mothers reported divorce due to joining the PMTCT programme after their HIV positive status diagnosis. In the same study it was noted by the mothers that their husbands did not allow them to join PMTCT programme so that people did not look at the couple as being HIV positive. As a result, HIV positive women choose not to deliver at a health facility as a confirmation to their spouses that they had not joined the programme.

Male dominance was also echoed by males in the male focus group discussions in the nyasulu et al 2011 study. Men living with a spouce focus group discussions participants emphasised on the negative consequences a woman would end up in if they decided on their own to join PMTCT programme. Nyasulu et al 2011 noted that the male participants stated that women’s independent decision to join PMTCT was interpreted as lack of submission to their spouses which may result in abandonment and divorce. To this end one may note that because of male dominance women end up not accessing PMTCT services for fear of abandonment or divorce.

Gender inequality is one key factor for poor access to PMTCT services by pregnant and lactating women. Most women living in sub Saharan African countries have no power over their bodies and decision making powers. Additionally, norms such as encouraging men to have more sexual partners and older men to have sexual relations with younger women and inadequate knowledge about HIV and AIDS makes women more vulnerable to HIV than men. Based on WHO and UNAIDS (2008) estimates, from the global total of people living with HIV, women constitute 50% and in sub-Saharan Africa comprises 60%.

According to Perez ,Glieman, Mukotekwa, Miller , Glenshaw , Mahomva , and Dabis(2004) gender imbalances put many women in economically dependent, passive positions in the community and are unable to make independent decision without partner consent which in turn affects access to PMTCT services. According to a study by Bajunirwe and Muzoora(2005) in
Uganda among women who have access to PMTCT services indicates that 40% of them are not willing to accept HIV testing without their husbands’ consent. Another study done in Kenya, women are expected to be dependent on men and in this society it is the responsibility of men to decide every aspect of family matters (Wodi, 2005). An HIV positive, pregnant woman who has not disclosed her diagnosis to her partner, family or friends is generally less likely to accept preventive drugs and to practice unconventional methods of infant feeding, for fear of revealing that she is infected. PMTCT programmers should therefore seek to make disclosure less difficult for their clients, for example by running support groups or anti-stigma campaigns. They might also try to identify and assist those who wish to avoid or defer disclosure. Involving male partners in PMTCT programmes has been shown to improve the reach and success rate of PMTCT.

Among pregnant women who do take a test and are found to be HIV-positive, a high proportion chooses not to tell their partners. Most are afraid of violence or abandonment: in many societies it is common for men to blame their partners for being infected, even if they too have HIV (Mahdi, 2008). As many women are reliant on the support of their male partners, the risk of losing this, particularly financial, support can dissuade them from testing, or from disclosing their HIV status. In Swaziland a mother who chooses to use PMTCT to ensure the safety and health of herself and the baby, often faces the possibility of abandonment by spouse or relatives. While the culture does not allow her to hide the condition from the family (Mahdi, 2008), the study by Pathfinder in Kenya found that 43% of married women say that their husbands make decisions for them on health matters. From the above one may note that where women fear rejection and violence if they are identified as HIV infected, they will be reluctant to take advantage of the PMTCT services.

To this end the researcher concludes with Fowler, Lampe, Jamieson, Kourtis and Rogers (2007) who noted that lack of male involvement in HIV testing and women’s inability to disclose their HIV status may prevent HIV infected women from receiving appropriate antiretroviral interventions for both PMTCT and their own treatment. It is from this background that this research seeks to bridge the gap by assessing the barriers in accessing PMTCT services now that in Zimbabwe rural areas pregnant women are not allowed to register for antenatal care without their husbands.
2.4.3 Level of education and lack of adequate information about PMTCT

Women of reproductive age with low level of education and lack of adequate information about PMTCT contribute to the low access of PMTCT services and non-adherence to treatment instructions. It is a sad fact that in sub Saharan African countries women are less likely to seek health care setting compared to men. In a population based survey which was conducted in Zambia it was discovered that among the higher educated people in age group 15-29, the prevalence of HIV decreased significantly while on the other hand HIV prevalence rose or remained stable among lower educated people. In the same study mothers who had education beyond primary school were almost three times more likely to report willingness to be tested for HIV compared to those who had not finished primary school education or had not been educated at all(Knut, Musonda, Sichone, Ndlovu, Tembo And Monze 2001).

HUE policy brief (2011) in the same study noted that about 41% of women reported that health workers offered inadequate information. Inadequate information and ineffective counselling results in a gap about vertical transmission and PMTCT which could potentially lead to failure to comply with PMTCT strategies. In a South African study by Sprague et al (2011) it was found out that one of the weakest aspects of PMTCT interventions is counselling women on infant feeding. Across the facilities, many HIV positive women struggled with feeding choices, with a number practicing mixed feeding, unaware of the increased risks of transmission.

2.4.4 Stigma and discrimination

According to Karia (2008) in a study conducted in Indonesia it was found out that woman are twice as likely to experience discrimination as men. A former worker interviewed in the Eastern Cape clinic noted that the tins used for formula feeding were associated with stigma. This was confirmed by patients and health personnel interviewed. One woman noted: “I hide it [HIV positive status]; I say the baby doesn’t like breast milk to anyone who asks why I am not breastfeeding”. One health worker also noted that: “people are afraid of themselves” and “stigma prevents people from testing”. There is still a strong reluctance to access testing amongst much of the population. People living with HIV face a particularly high level of discrimination in Zimbabwe, and many people fear that if they are found to be HIV-positive they will be victimized. In places where there is little access to ARVs, some see testing as pointless, as one HIV-positive woman described to reporters in 2006: one may note that, an HIV positive pregnant woman who has not disclosed her diagnosis to her partner, family and
friends is generally less likely to accept preventive drugs and to practice unconventional methods of infant feeding, for fear of revealing that she is infected. Therefore, most women are reluctant to access PMTCT services for fear of stigma and discrimination.

In a study conducted by Nyasulu and Nyasulu (2011) titled barriers to the uptake of PMTCT services in rural Blantyre and Balaka districts, Malawi it was noted that the most commonly cited barrier by all mothers who joined PMTCT was stigma and discrimination against those who are HIV positive. It was further noted that even though the spouse is supportive, relatives can also stigmatize and discriminate an HIV positive woman.

In a study conducted by Nyasulu and Nyasulu (2011) titled barriers to the uptake of PMTCT services in rural Blantyre and Balaka districts, Malawi it was also discovered that some women fear to join PMTCT services because of fear of stigma and discrimination. In the study it was discovered that mothers felt that it was difficult to maintain privacy and confidentiality of one’s HIV status after joining PMTCT services. They said that people are bound to know that the mother is HIV positive especially when she starts following the health workers advice on stopping breastfeeding earlier than the cultural norm and when mothers are followed up by health workers or support groups members. Similarly in the same study, when mothers who declined to join PMTCT were asked for reasons why they had not joined the PMTCT programme stigma and discrimination against those who are HIV positive was the barrier most frequently mentioned. To this end one may note that fear of stigma and discrimination is a barrier hindering women from accessing PMTCT services.

2.4.5 Cost of antenatal care and delivery

According to a research conducted by HUE policy brief (2011), titled prevention of mother to child transmission (PMTCT) of HIV services; what are the barriers to accessing these services in Zimbabwe? It was discovered in an interview survey that 68% of women found the cost of antenatal care and delivery too high. It was further noted that more than 8, 5% of women spent more than 10% of their total monthly spending on antenatal care and delivery payment. This was also found to be true in a south African study conducted by Sprague, Chersich and Black(2011) titled health system weakness constrain access to PMTCT and maternal HIV series in south Africa: a qualitative enquiry, it was discovered that consultation fees charged in state public health institutions are deterring people from accessing any health services, including HIV testing and treatment, until their immune systems have become very weak. In a
study conducted in Zambia by World Bank (1997) it was discovered that maternity user fees was a major hindrance to rural women accessing PMTCT. Between 2005 and 2011 nearly a third of pregnant women in WHO south East Asia region, eastern Mediterranean region and African region did not attend any antenatal clinic (WHO, 2012). One may therefore note that this could possibly lead to impoverishment and prevent women from accessing services including PMTCT.

Cost implications of PMTCT

In a study conducted by Nyasulu and Nyasulu (2011) titled barriers to the uptake of PMTCT services in rural Blantyre and Balaka districts, Malawi it was noted by the male participants in the FGDs that financial implications the PMTCT programme has on the beneficiaries. The participants felt that the community members can afford neither replacement feeding nor exclusive breastfeeding without abrupt weaning as per health workers counselling advice. The main concern of the participants was the fact that milk was very expensive. They said they would rather spend their little resources on their essential basic needs for the household than buying infant feeds. However, they noted that if the health facilities provided infant feeds, this was not going to be a challenge.

2.4.6 Distance

The lack of transport and shortage of drugs and other resources prove a challenge for 26% of women which directly affects access to PMTCT. Pregnant women in low- and middle-income countries are often unable to easily access antenatal and PMTCT services. Besides caring for their children they are expected to work hard preparing food, fetching water or tending crops. Many live a long way from their nearest health facility and have little access to transport. According to WHO (2012) between 2005 and 2011 nearly a third of pregnant women in South-East Asia Region, Eastern Mediterranean Region and African Region, did not attend an antenatal clinic. Women that do visit an antenatal clinic often only do so once during their pregnancy. This greatly reduces the number of women that can be reached by PMTCT programmes.
2.5 Health service barriers

2.5.1 Inconvenient opening hours

Though ANC services are free and close to the people other pressing need of the family take precedent, giving the mother no opportunity to attend the clinic, a study done in India slums found out. It mentions that, the slum residents may not readily utilise health services even when provided free of charge or brought closer to their residence because of time constraints generated by pressure to raise money for bare survival (Sarin, 1997). A study, which was conducted in South Africa among ANC attendants, indicates that most of them used public transport and spent long hours to reach health facilities. 39% of the respondents spend up to 30 minutes, 26% up to one hour and 36% more than one hour to get to the clinic (Peltzer et al, 2005).

In a research conducted by Sprague, et al (2011) in South Africa it was discovered from in-depth interviews that there is considerable weakness within operational HIV service delivery. These manifested as missed opportunities for HIV testing in antenatal care due to shortages of test kits, insufficient staff assigned to HIV services, late payment of lay counsellors, with consequent absenteeism and delayed transcription of CD4 cell count results into patient files (required ART initiation). One may note that such lack of resources and staff absenteeism is an obstacle in the accessing of PPTCT by pregnant women as the delay may prolong to delivery without transcriptions of CD4 count hence failure to initiate these women before birth, thus posing the risk to the unborn child. Sprague et al (2011) further noted that they are individual factors which act as barriers to accessing PMTCT, factors like psychosocial concerns, such as fear of a positive result or a partner’s reaction and stigma. From the above it can be noted that a single system or individual delay reduced the likelihood of women accessing ART or PMTCT.

According to Sprague et al (2011) shortage of staff and supplies, delay HIV testing for pregnant women was another barrier to access of PMTCT services. Across the facilities studied, a significant proportion of the HIV positive pregnant or postnatal women interviewed failed to receive an HIV test during their first ANC visit, mainly due to shortages in staff and supplies. In both eastern and cape hospitals ,nurses provided all counselling related HIV services, with a single nurse per facility running PMTCT programme and offering all HIV counselling. As a way of coping with this workload, one nurse explained: “I provide five counselling sessions per day, and then I stop [because] I have other work to do” (eastern cape hospital, October
2008). The nurses acknowledged that there was generally no HIV testing and counselling provided for patients admitted during afternoons, weekends or on public holidays. More so, the Eastern Cape clinic, noted that shortages of HIV testing kits and stock outs of nevirapine, were reported by staff. Also system failures took the form of frequent delays in payment to lay HIV counsellors who were responsible for testing and counselling, absenteeism and low staff morale were common.

According to Karia (2008) in a study done by FIDA Kenya, it showed that health workers behaviour and attitude towards clients are key determinants to accessibility to health services. It is further noted in the study that due to negligence, and memories of mistreatment during antenatal care and delivery, mothers forego care in public health facilities which result in the majority of them seeking services from informal and unreliable sources, making over 58% of women to deliver at home

2.5.2 The low quality of services including the poor cleanliness of facilities

The low quality of services including the poor cleanliness of facilities were deterrents for service use for 34% of women, while poor provider patient interactions were deterrents for services use for 41% of women (HUE policy brief 2011). In a study conducted in South Africa by Peltzer, Skinner, Mfecane, Shisana, Nqeketo and Mosala (2005) on factors influencing access to PMTCT services shows that poor infrastructure of health facilities like cold waiting rooms and lack of waiting space have contributed to low access to PMTCT services. This means that authorities need to consider making antenatal care more acceptable for women in order for them to be able to utilise PMTCT services.

2.5.3 Other barriers

These included fear of husbands and spouse related problems, shortage of nurses in VCT resulting in long waiting time, inability to source infant foods, poverty, ensuring early HIV diagnosis.

2.6 Knowledge about PMTCT

Pregnant women readiness to access PMTCT services is determined by knowledge of the future, whether they will have a baby who is HIV positive or negative. According to UNAIDS (2010) in 2005, only 15% of HIV infected pregnant mothers received preventive drugs world over, barely making a dent in the number of infant infections. It is further noted that in 2006, the proportion was 23% and by 2009 an estimated 58% of pregnant women living with HIV in
low middle income countries received antiretroviral drugs to prevent HIV transmission to their infants. Such increase in women embracing PMTCT could be linked to how knowledgeable these women were. Therefore, one may note that pregnant women, who have adequate information on PMTCT services, assumed responsibility to use the services so that they can have the benefit of having HIV negative babies.

In a study conducted 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 (Rutemberg, 2002). From the above one may note that it is because of the little knowledge that people are often discriminated and stigmatised.

In a study carried out in USA among women of child bearing age, just over one half had correct knowledge of perinatal HIV prevention strategies. The study also noted that even among the pregnant, who should have received the knowledge through counselling, only 65% knew of the existence of PMTCT ARV prophylaxis (Anderson et al, 2004). This was also found to be true by Aurulogun (2005) in a Nigeria study which indicated that inadequate knowledge of PMTCT services was a barrier to PMTCT use.

In a study by kasinga, mogotlane and van rensburg (2008:24) it was found that low educational level between grades 6 and 8 scored lower on the knowledge of the mode of HIV transmission from mother to child in general, including through breastfeeding, when compared to those with a tertiary education. It is further noted in the same study that women with a higher educational level can understand the increased risk of HIV infection through breastfeeding better than those with lower educational grades (Kasinga et al, 2008)

Furthermore, according to KDHS (2003), knowledge and awareness of HIV and AIDS is nearly universal among adults in Kenya, except among women with low education. The Kenya demographic health survey(KDHS) and behaviour surveillance survey (2003) found that over 70% of respondents of age group 15-49 years had basic information on prevention and transmission of HIV but less than 1/3 of them had knowledge of specific action that mothers could take to prevent HIV infection. Less than 1/3 of the respondents knew about antiretroviral therapy (KDHS, 2003).
Knowledge, attitudes and practices survey which was conducted in Zimbabwe by Gliemann, Mukotekwa, Perez, Miler, Sakarovitch, Glenshaw, Engelsmann and Dabis (2006) to see the change in pregnant women access to PMTCT services before and after extensive community awareness mobilization for two years on PMTCT benefits indicates that the awareness of PMTCT among women increased. This changed PMTCT service access among and behaviour for pregnant women significantly. In another short Zimbabwean survey by Zolfo, Devaux and Tamburrini (2005) which assessed the level of HIV and AIDS knowledge amongst pregnant women and the acceptability of a PMTCT programme in rural Zimbabwe, showed that although there was a good level of HIV and AIDS knowledge among pregnant women, a demand still existed for a more comprehensive PMTCT programme. To this end one may note that knowledge about PMTCT is still poor in Zimbabwe rural areas. Hence the need of this research to investigate to see if PMTCT programmes in rural Zimbabwe have improved leading to high levels of knowledge about PMTCT in rural Zimbabwe.

In a study conducted by Kumar and St John (2003) on the knowledge, attitudes and sexual practice among the HIV infected women with repeated childbirths in Barbados revealed that a significant number of mothers did not know that they could transmit HIV to their babies and further thought that AZT given to them and their babies was to prevent HIV infection in the babies. Sandgrem et al (2007) also noted that pregnant women in Semey had a poorer knowledge than women in Hong Kong about the specifics of MTCT of HIV infection and further indicated that they reflected lack of knowledge with regard to the means of reducing MTCT of HIV infection. Abiodium et al (2007) in a study conducted in Nigeria on the awareness and knowledge about MTCT of HIV among pregnant women also revealed that low level of knowledge about MTCT is inadequate and hence there is need for adequate counselling and education about HIV and AIDS and MTCT. To this end one may note that lack of knowledge is a major barrier hindering expecting and lactating mothers from accessing PMTCT services.

In a study by Maputle and Jail (2008) at a particular hospital in polokwane South Africa high levels of knowledge were found. The study found out that women had knowledge about MTCT of HIV and AIDS infection through breastfeeding.
2.7 Attitudes towards PMTCT

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

Attitudes of discrimination and stigmatization associated with HIV in the community have a negative influence on access to PMTCT services. A study which was conducted on pregnant Nigerian women willingness to accept or reject VCT shows that 69% of the women refused VCT; the reason for their refusal is socio-cultural stigmatization (Okonkwo, 2007). Another study in Nigeria on health care providers attitude towards pre-test information and informed consent before HIV testing shows that 78% of respondents agreed there are circumstances when it is appropriate to test a patient without his or her knowledge and permission. This attitude shows neglect of the VCT guidelines and a violation of the rights of clients, which has adversely affected service utilization and access (Reis, Heisler, Amowitz, Moreland, Mafeni, Anyamele and Iacopino 2005). One may note that health care professionals, despite their ethical obligations, can have discriminatory behaviour and negative attitudes toward patients with HIV and AIDS, because of lack of resources in health facilities, inadequate knowledge about HIV and AIDS and fear of becoming contaminated hence acting as a barrier to pregnant women accessing PMTCT services.

Health care providers have fears and concerns when they are working with HIV positive clients due to the possibility of getting infected in their workplace. This can lead to health workers have discriminatory behaviour and can change their attitudes towards HIV positive clients. A study carried out in Nigeria on causes of discriminatory attitudes and practices against HIV positive women indicates that out of 1021 professionals who participated in the study 81% have fear of HIV contamination, 17% have fear of contamination from materials or instruments and 10% not having materials needed to treat them (Reis et al 2005).

In a study conducted by Sandgren et al (2007) on the attitudes of women towards PMTCT, 7% indicated that they would want to have more children, even if they were found to be HIV positive, whilst 83% were prepared not to breastfeed their babies in such a reality and were prepared to take prescribed medication. To this end one may note that these respondents articulated positive attitudes towards PMTCT. However, in a study by Kumar and St John (2003) in their study on the knowledge, attitudes and sexual practice among HIV infected
women with repeated child births in Barbados revealed that most mothers reacted negatively or were not sure whether counselling sessions would help them. Denial and high degree of fear were also reflected in the Kumar et al (2013) study which had an adverse effect on their attitudes. From this study one may note that denial and fear are some of the barriers preventing lactating and expecting mothers from accessing PMTCT services. 2.8 Enabling factors

a. Quality

In the context of PMTCT services quality includes different dimensions such as confidentiality, privacy, accessibility and convenient opening hours, waiting time, affordability, skills of counsellor and health workers, equipped delivery rooms, adequate supplies and referral linkage are considered as quality(NHAPCO,2007). If services are of such quality access to PMTCT services is likely to increase.

b. Accessibility and affordability of PMTCT services

If services are affordable in that there are close to people and the time spends is short then access to PMTCT services will increase. If PMTCT services are close to people residential services access to PMTCT services will be high.

In Kenya, the prevalence of HIV in pregnant women is estimated at 13%, while only about 10% of all pregnant women receive PMTCT services(KNHSSP 2005-2010). However, according to UNAIDS in Kenya (2006) the utilization of PMTCT service remains low with only one fourth of pregnant women accessing services. According to Chew et al (2005) study in Kenya only 8% of all infants born of HIV infected mothers received antiretroviral prophylaxis in 2005. It is further noted that the rest who did not get the prophylaxis would be considered as missed opportunities, this low percentage of infants that receives the ARV prophylaxis are put in further risk of infection as many end up being breast fed (Chewe et al, 2005)

According to Karia (2008) , through the various levels of PMTCT interventions carried out at the ANC from the time the pregnant woman makes her first visit to the time of she delivers, a lot of missed opportunities are noted that add up to reducing access to PMTCT services and effectiveness of the programme. Karia (2008) went on to note that of the pregnant women who come for first visit to the ANC in Kenya, not all are counselled; among those that are counselled, not all get tested. Those that end up being tested, not all receive their test results and for those who are found to be HIV positive, some end up not getting the mother nevirapine
prophylaxis (NVP) dose. Fewer infants than the mothers also receive the infant NVP syrup dose. To this end one may note that gaps and missed opportunities at various levels in the PMTCT service provision is another barrier to access to PMTCT services in Africa.

2.9 Summary

This chapter presented a review of the literature related to the study of the possible factors hindering accessibility of PMTCT services in rural areas.
RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the research design employed in this research paper. A precise description and explanation of the methods employed is to be done in this chapter. This involves an explanation of how the interviews and questionnaires were administered. The advantages derived from applying each and every method will also be highlighted.

3.2 Research design

The researcher adopted the survey research design. This research design was adopted because it enhanced the reliability, credibility and validity of the research. The survey enabled the researcher to use qualitative and quantitative methods to understand women’s experiences of PMTCT services, and of delays or impediments in accessing these services. The research design enabled the researcher to collect data on the level of knowledge, attitudes, religious beliefs and barriers to accessing PMTCT services.

3.3 Study population

The population comprised of 200 registered expecting and lactating mothers in UMP district (hospital official). Every pregnant or lactating mother who sought medical treatment at the OI clinic at Mutawatawa hospital during the time of the study was eligible for the study regardless of the age.

3.4 Sample and sampling techniques

a. Sample

A sample size of 25 respondents was chosen this was 12.5% of the target population, which comprised of lactating and expecting mothers. The researcher restricted the sample size to 25 respondents as this was considered to be a representative of the population of the research. Also given time and resources available to conduct the research, this sample size was considered ideal and practical. Two key informants were also sampled from a possible of six key informants.
b. Sampling method

All expecting and lactating mothers 18 years and older in Uzumba Maramba Pfungwe district who visited the opportunistic infections (OI) clinic on the day of the study were eligible to be interviewed. The researcher used convenience sampling technique to pick the sample. This was most suitable because the hospital has an OI clinic which opens every Wednesday, therefore the researcher visited the clinic on a Wednesday and used accidental or availability sampling to interview respondents. The researcher chose those respondents who were close to the end of queue waiting to see the doctor. This target population was chosen because it was accessible and they had information relevant to solving the research problem at hand.

The district medical officer and the hospital matron were the key informants. They were chosen because of the vast amount of information they possess on the subject under study.

Convenient sampling technique was chosen because it was less time consuming and cost effective thus suited well into the researcher’s needs. However, it contains an element of bias, as respondents were not selected at random.

3.5 Data collection instruments and techniques

Data was collected using semi structured questionnaires for the target population. The questionnaires were designed using dichotomous (yes/no) type of answers, multiple choice select answers and open ended questions where the respondents answered using her own wording. This type of instrument was targeted at expecting and lactating mothers who visited OI clinic during the time of the study. Since they were many, it allowed for quick collection of data and it enabled the researcher to easily analyze and present the data. It was also cheaper and easier to administer in limited time. They were anonymous allowing potentially embarrassing questions to be answered. The questionnaire allowed the researcher to guide participants along lines of thought with regards to the topic under study.

However, this technique had a number of shortfalls as the return rate could usually be low. There was no room to probe further for responses.

Semi structured interview guides were used to conduct interviews with the key informants. The researcher chose the method because it ascertains values, attitude, beliefs and experiences from key informants. It helps the interviewer to observe non-verbal behavior, thereby assessing the
respondents’ motives. The method was directed at the key informants because they are few and have more information about PMTCT and possible barriers than the general respondents. The researcher had to secure appointments with them. Placing of the appointments and securing interview dates took at least 3 days and was quite enough to make preparations. Beforehand, key informants were briefed on the issues to be discussed hence they had adequate time to prepare and gather relevant information before the interview dates.

3.6 Pretesting
The researcher pre-tested the instruments at Nhakiwa clinic in UMP district, with 3 lactating and 2 expecting mothers. Questionnaires were pretested to check the validity and reliability of the data collection instruments that were, if the instruments were measuring what they were supposed to measure. Nhakiwa clinic patients were best suited for pre-testing of the data collection instruments, since they were not going to be included in the study. This researcher took the opportunity to correct and rephrase all ambiguous and personal questions to avoid non answer error. After making necessary changes to the questionnaire, the questionnaire were sent out into the field for data collection.

3.7 Data collection procedure
Respondents were conveniently approached while they were waiting to see the nurse, the researcher approached those who were close to the end of the queue and explained to the possible respondent about the purpose of the study and how she could assist and asked if they could voluntary agree to participate. The researcher chose those who were close to the end of the queue because those at front were about to see the nurse hence had no time to be interviewed. Also the researcher could not interview respondents after they had seen the nurse because they were more interested in going home as some travel long distances, than in being interviewed.

All those who consented were interviewed individually, using the developed questionnaire. The interviews which took 15-20 minutes were conducted in Shona and English depending on the participant’s preference. To avoid participants being interviewed more than once, participants were asked if they had previously been interviewed before commencement of the interview.
Prior to data collection appointments were made with the District Medical officer and the hospital Matron to schedule for the interviews. Once this was arranged the researcher waited for the agreed time. Before the interview, the researcher once again introduced herself to the key informants and explained the purpose of the study and how they could participate. The researcher also asked for permission to record what the key informants will be saying on paper and this was granted and the researcher carried out the interview.

3.8 Data presentation and analysis

The data was presented and analysed manually using thematic content analysis approach. According to Cant-Sagaqa (2010) thematic analysis is a technique used in qualitative research and it focuses on examining themes within data, through coding of data collected to create established meaningful patterns. Data was put in the following themes knowledge, attitudes, practices and beliefs (KAPB) as well as the service provider theme. The researcher counted and reported the frequency of concepts held with data in the above mentioned categories.

This technique has the advantage that a theme captures something important about the data in relation to the research questions and represents some level of patterned response or meaning within data. Thus it was found to be the most suitable because it offered the researcher an accessible and theoretically flexible approach to analyse large data sets gathered during the research.

The transcription and verification of transcribed interviews was done by the researcher since she was the note taker during interviews with key informants. After the interview sessions, the researcher would get home, peruse the notes taken and familiarise with the data. Reading and re-reading of the transcripts was done to identify themes and develop codes.

3.9 Ethical consideration

Permission to carry the research was sought from the district medical officer and granted (see appendix 4). Respondents verbally consented to the study before agreeing to be interviewed and they were asked to put an X in the signature box as a sign for their consent (see appendix 1). The study was strictly voluntary and participants could withdraw at any time without giving reasons for their action. Respondents were informed that participation may be terminated if the participant starts to feel that the questionnaire is a direct attack to her and hence making it impossible to continue with the investigation. Respondents were also informed that their
personal responses will be treated with utmost confidentiality and their names will not be used in relation to the answers they gave.

3.10 Summary

The chapter outlined the research design and the techniques of collecting data. The researcher further went on to appraise the techniques used by highlighting their advantages and disadvantages after which the ways to minimize the techniques’ shortcomings were sited. The chapter further explored the sampling procedure.
FINDINGS

4.1 Introduction

This chapter looks at the data presentation and analysis of the research findings. The main purpose of this chapter is to review the results that were obtained from this research. Data was analysed manually and presented under the following themes knowledge, beliefs, attitudes, practices and service provider interaction.

4.2 Presentation of research findings

In this section the researcher presents the results obtained from this research.

4.2.1 Demographic information

The ages of the respondents ranged from 18 to 35 years. Majority 80% (n=20) of the respondents were married and 2(8%) were divorced, 2(8%) were widows and 1(4%) was a single mother. Almost all the respondents (23) were Christians belonging to different denominations; two did not state their religion. Most of the respondents 72% (n=18) had reached secondary level, of the 18 only 5 had seated for the ordinary level exam, 2(8%) had reached Diploma level and 20% (n=5) had reached primary level.

Majority of the respondents 23(92%) resided in rural areas only 8% (n=2) resided at the growth point. Only the two (8%) who resided at the growth point said they were employed while others were housewives. From the 20 married women 5(25%) stated that their husbands were employed, 15(75%) said their husbands were subsistent farmers. Table 1 below presents the demographic characteristics of respondents in the study.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sample(N=25)</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Table 1: Socio-demographic characteristics of study participants
<table>
<thead>
<tr>
<th>Age</th>
<th>18-20</th>
<th>21-23</th>
<th>24-26</th>
<th>27-29</th>
<th>30-32</th>
<th>33-35</th>
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<tbody>
<tr>
<td>Age</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>20</td>
<td>Single</td>
<td>1</td>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Widow</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of education</td>
<td>Primary level</td>
<td>5</td>
<td>Secondary level</td>
<td>18</td>
<td>Diploma level</td>
<td>2</td>
</tr>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>Employed</td>
<td>2</td>
<td>Housewives</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Christians</td>
<td>23</td>
<td>Non-Christians</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of origin</td>
<td>Rural</td>
<td>23</td>
<td>Growth point</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
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<td>8</td>
<td>28</td>
<td>32</td>
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<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>Expecting with no child</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<td>5</td>
<td></td>
<td></td>
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<td></td>
<td>8</td>
</tr>
</tbody>
</table>
4.2.2 Knowledge about PMTCT

All the respondents proved knowledgeable about HIV. From the 25 respondents, 13 respondents said it is sexually transmitted disease, 12 of the respondents said HIV/AIDS can be passed from an HIV positive mother to an unborn or lactating child. All respondents (25) proved knowledgeable about PMTCT as they noted that it is the prevention of mother of child transmission of HIV through use of drugs (ARVs).

Most mothers (19) said they have heard about exclusive breastfeeding as the ideal breastfeeding option for lactating mothers, while six did not answer this question. From the 15 lactating mothers 10 said they did exclusive breastfeeding for 6 months, while others did not answer the question.

Most mothers 23 said they would never formula feed their child. The major reason cited for not choosing to formula feed was fear of being stigmatised and discriminated, others cited that formula feeding is not culturally accepted in their home areas, some said it is expensive to buy and their husbands could not afford regular purchases of the milk and there is no clean water in their areas required for one to formula feed. While 2 said if their husbands permit them they would formula feed their children, since it is the husband who would buy the milk.

Most women (24) noted that PMTCT is not well advertised as many of them noted that they only came to know about it when they visited the clinic, therefore it was hard for them to get tested as they had not have discussed about it with their husbands. Others said when they were encouraged to bring their husbands for testing their husbands told them not to go again to the clinic. One was quoted as having said “murume wangu akanditi enda unoti hauna murume akafa muaccident a month ago”, go and tell them you are a widow your husband died a month ago.
Figure 1 above show some of the posters which were on the Mutawatawa hospital walls which encouraged women to seek medical assistance in time.

4.2.3 Attitudes towards PMTCT services

All the women said they should breastfeed. However, majority of the respondents (19) noted that family and relatives are more likely to reject a woman who decides not to breastfeed, 2 were of the view that family will support and 3 did not know of family responses to a women who decides not to breastfeed. All 25(100%) of the respondents said men have influence on women’s health issues. Male influence has been noted as the major reason why most women in rural areas do not access PMTCT services. One woman said a friend was told by her husband that “handitombode kunzwa nezvekuTestwa mumba muno”, I don’t want to hear about HIV testing in this house. Other reasons noted for failure by women to access PMTCT were distance, lack of knowledge, religion and cultural influence.

All the women 100 % (n=25) noted that there is stigma attached to formula feeding in Zimbabwe. Most women noted that formula feeding is attributed to HIV positive and prostitution on the part of the mother. This was also noted by the key informant who noted that
“vakadzi vemumaruva ukavaudza nezve formula feeding vanoramba, hanzi tinozosekwa nevamwe”, these rural women when you tell them to formula feed their children they do not accept it for fear of being stigmatised and discriminated.

4.2.4 Beliefs

Most women (20) said formula feeding is culturally unacceptable since culture asserts that the bond between a mother and child is created and strengthened through breastfeeding, 2 said they do not care what the culture says the bottom line is they cannot afford it and 3 did not answer this question. 21 of the respondents said their religion allows them to seek medical treatment (PMTCT), whereas 4 said their religion does not allow them to seek medical treatment. Upon asking them what they were doing at OI clinic, 3 said they cannot afford to risk their children’s health as they believed they got infected in these polygamous marriages encouraged in their church, one said she came when her husband died of what she suspected to be HIV.

4.2.5 Service provider interaction

Two of the respondents who lived within the growth point said it’s about 1km to the hospital, 20 said the nearest hospital is 10 km, and three said the nearest hospital was 15 km from their homes. Most (24) said they use foot to access the nearest health centre, one said she uses her personal car since she works in the growth point.

All the respondents said they pay $10-00 for antenatal care; however some noted that there are other fees charged during delivery. One woman noted that she had not registered with the hospital and had to deliver at the hospital; unfortunately she had to deliver through caesarean process and had to pay $100-00 for the operation and medication.

Most of the respondents (20) said they should visit the antenatal clinic once a month in the first 8 months, and in the last month towards delivery they should visit twice a month. However 15 of them said due to distance they end up visiting the clinic when they want to collect their medication after every two months or when they want to deliver, 5 said they are forced to visit the clinic when their child or they are sick.

Most of the respondents (18) said they delivered their last child within a health setting, 5 said they delivered in their homes and two were first time mothers. Of the 5 Mothers who delivered
in their homes 1 said she then went to the clinic after delivery and the other 4 said they only went to the clinic after their child fell sick.

All (25) lactating and expecting mothers said they always have regular supplies of ARVs. However, some (5) noted that the first preference is given to nurses relative and friends who in most cases do not join the queue early in the morning as most do. One woman noted that “vanambuya vane vanhu vavo vavanoziva vavanotanga kupa mapiritsi”, nurses give first preference to people they know.

From the 15 lactating mothers, 10 said their child was tested for HIV , 5 said their child was yet to be tested as the child had not yet reached 6 weeks and the 10 expecting mothers said they expect their child to be tested to see if PMTCT has really worked. From the 10 lactating mothers who had their child tested for HIV only 3 said they had received their child test results 2 said they were negative and one said they were positive and the child had been put on antiretroviral therapy (ART). The other 7 noted that they were still to receive their child’s test results. Some noted that they have been visiting the clinic for more than two weeks but still had not accessed the child’s test results and they said they are told by Sekuru and Mbuya, referring to OI nurses that the hospital is waiting for dry blood sample results from Harare (Parirenyatwa Hospital).

Most of the respondents (23) said their relationship is good while 2 said the relationship was poor. These findings conquer with Karia 2008 findings in which good relationships between health workers and clients was a key determinant to accessibility to PMTCT. Two respondents who said their relationship with the service provider was poor as the service delivery at the hospital are biased. One was quoted saying “vamwe vanambuya vanofarira vanhu vanovapa zvinhu”; some nurses favour those who give them material things.

However, the key informant noted that the hospital has a policy (Patient’s Charter) which safeguards the rights of all the patients regardless of their gender, sex and HIV status. The Hospital Matron also noted that cases of ill treatment were reported to her office, she however went on to note that some patients leave with unreported cases and never return for PMTCT services. The DAAC officer also noted that some mothers fail to access PMTCT services because they were once ill-treated by nurses and they cannot report these cases for fear of being stigmatised and labelled by other nurses. From these findings the researcher noted that ill treatment by health personnel was a barrier to rural women accessing PMTCT services.
The DAAC officer also noted that absenteeism of health workers is one factor which hinders expecting and lactating mothers from accessing PMTCT, he had this to say “we observe it—we cannot lie about it. Not respecting working hours is something we got used at this hospital (Mutawатаwa) and this has created the problem for patients. Some health personnel go for long tea break and lunch hours than expected. During lunch time, for example health workers go to other places to work in their surgeries and return late, for personal commitments.”

**Figure 2** Patients awaiting PMTCT services

Figure 2 above show some pregnant and lactating mothers who had come to receive PMTCT services at Mutawatawa hospital on the day of the study. From figure 2 above one may note that women of different age groups are accessing PMTCT services. Figure 3 show OI clinic nurses providing PMTCT services to patients at Mutawatawa hospital.

4.3 Discussion of findings

In this section, the researcher discusses the findings in the previous section. Major findings in this chapter are discussed and compared with what other investigators found out in similar studies.

4.3.1 Knowledge about PMTCT

All the respondents proved knowledgeable about HIV. From the 25 respondents, 13 respondents said it is sexually transmitted disease, 12 of the respondents said HIV/AIDS can be passed from an HIV positive mother to an unborn or lactating child. All respondents (25) proved knowledgeable about PMTCT as they noted that it is the prevention of mother of child transmission of HIV through use of drugs (ARVs). According to the AIDS risk reduction model having knowledge is the first stage which will influence accessibility of PMTCT services.
The researcher assumes that high levels of knowledge could be due to the fact that most of these mothers might have been educated about it when they visited the clinic, during pre-test or post-test counselling. As such the researcher noted that they may be a number of people who do not know about PMTCT services considering that these respondents only got to know about PMTCT when they visited the clinic. Therefore, those who deliver at home may never get to know of PMTCT services, thus inadequate knowledge was noted by this researcher as a barrier to accessing PMTCT services by women who deliver at home.

Most mothers (19) said they have heard about exclusive breastfeeding as the ideal breastfeeding option for lactating mothers, while six did not answer this question. From the 15 lactating mothers 10 said they did exclusive breastfeeding for 6 months, while others did not answer the question. An analysis by the researcher revealed that most of the women who knew more about exclusive breastfeeding were lactating mothers and those who were expecting their third child and those who did not answer were expecting first time mothers (2) and probably 4 from the apostolic sect who were expecting their second child. The researcher assumes that this is because they may not have delivered their child in a hospital setting thus did not learn about exclusive breastfeeding.

Most mothers (23) said they would never formula feed their child as it is culturally unaccepted. As such women who formula feed are often stigmatised and discriminated in social gatherings, however this is less likely to happen to their husbands. These findings are similar to a study conducted by Karia (2008) in Indonesia in which it was found that women are twice as likely to experience discrimination as men. From these findings one may note that 8% of rural women are not likely to accept formula feeding without their husbands consent. From these results the researcher noted that culture and fear of stigma and discrimination is another barrier hindering rural women from accessing PMTCT services.

Most women (24) noted that PMTCT is not well advertised as many of them noted that they only came to know about it when they visited the clinic, therefore it was hard for them to get tested as they had not have discussed about it with their husbands. Others said when they were encouraged to bring their husbands for testing their husbands told them not to go again to the clinic. One was quoted as having said “murume wangu akanditi enda unoti hauna murume akafa muaccident a month ago”, go and tell them you are a widow your husband died a month ago. From the above one may note that gender inequality is one factor preventing access of PMTCT services by expecting and lactating mothers in rural areas, when one is forced to say
she is single or widowed she is likely to give up on PMTCT. This is according to DAAC officer who said it is because of fear of judgemental view of health care providers as they are at times labelled “ndiye wekuuraya murume neAIDS uyu”, that’s the woman who killed her husband with AIDS. Thus the researcher noted that gender inequality is likely to be another reason why most women fail to access PMTCT services in rural areas, as their husbands does not support their wives in health issues.

Figure 1 above show some of the posters which were on the Mutawatawa hospital walls which encouraged women to seek medical assistance in time. However, this researcher is of the opinion that the marketing gimmicks being used to raise awareness about PMTCT in rural hospitals are a barrier to rural women accessing PMTCT services. From the picture above one may note that the poster is on its own a barrier to a lot of rural women considering that it is written in English and however some women who might only have reached primary education might not be able to read and understand the message it is trying to convey. Therefore, posters and fliers should also be written in Shona so that rural populace understand the message being portrayed.

4.3.2 Attitudes towards PMTCT

All 25(100%) of the respondents said men have influence on women’s health issues. These findings are similar to results of Sprague et al (2011) in which a former worker interviewed in the Eastern Cape South Africa noted that the tins used for formula feeding were associated with stigma. From these findings the researcher noted that fear of stigma is another barrier why rural women fail to access PMTCT services.

4.3.3 Beliefs

Most women (20) said formula feeding is culturally unacceptable since culture asserts that the bond between a mother and child is created and strengthened through breastfeeding, 2 said they do not care what the culture says the bottom line is they cannot afford it and 3 did not answer this question. 21 of the respondents said their religion allows them to seek medical treatment (PMTCT), whereas 4 said their religion does not allow them to seek medical treatment. Upon asking them what they were doing at OI clinic, 3 said they cannot afford to risk their children’s health as they believed they got infected in these polygamous marriages encouraged in their church, one said she came when her husband died of what she suspected to be HIV. The findings of 3 women who said they could not risk their child’s life is supported
by the health belief model which noted that a person must hold certain beliefs (fear of risking child’s life) to accept a health service.

4.3.4 Service provider interaction

Two of the respondents who lived within the growth point said it’s about 1km to the hospital, 20 said the nearest hospital is 10 km, and three said the nearest hospital was 15 km from their homes. Most (24) said they use foot to access the nearest health centre, one said she uses her personal car since she works in the growth point. The findings in this study are different from those found by Peltzer et al (2005) in which most of the respondents used public transport and spent up to 30 minutes, 26% up to one hour and more than one hour to get to the clinic. Peculiar in these two studies is the fact that all the respondents would spend more time to get to the hospital. In this current study one is likely to spend two hours or more to get to the hospital. As such one may note that distance is a barrier to rural women accessing PMTCT services.

All the respondents said they pay $10-00 for antenatal care; however some noted that there are other fees charged during delivery. This study is similar to the findings of World Bank (1997) which discovered that maternity user fees was a major hindrance to rural women accessing PMTCT services as some deliver at home. The researcher also noted that apart from failure to deliver within a health setting more women are dying while delivering in their homes and their cases go unreported.

Most of the respondents (20) said they should visit the antenatal clinic once a month in the first 8 months, and in the last month towards delivery they should visit twice a month. However 15 of them said due to distance they end up visiting the clinic when they want to collect their medication after every two months or when they want to deliver, 5 said they are forced to visit the clinic when their child or they are sick. These findings are somewhat similar to WHO (2012) findings in which they discovered that nearly a third of pregnant women in South East Asia region, Eastern Mediterranean region and African region did not attend an antenatal clinic, women that do visit an antenatal clinic often only do so once during their pregnancy. Thus from this study the researcher noted that distance is a barrier to rural women accessing PMTCT services.

From the 15 lactating mothers, 10 said their child was tested for HIV, 5 said their child was yet to be tested as the child had not yet reached 6 weeks and the 10 expecting mothers said they expect their child to be tested to see if PMTCT has really worked. From the 10 lactating
mothers who had their child tested for HIV only 3 said they had received their child test results 2 said they were negative and one said they were positive and the child had been put on antiretroviral therapy (ART). The other 7 noted that they were still to receive their child’s test results. These findings are similar to findings of Sprague et al (2011) in which they noted that delay HIV testing results for pregnant women and lactating mothers was a barrier to accessing PMTCT services. It is the researcher’s assumption that the period taken for results to be out may be another barrier as to why some women are not accessing PMTCT services in rural areas as they would have given up, considering the distance some of them travel. In view of the legal, human rights and policy issues surrounding PMTCT one may note that even though the government of Zimbabwe is providing adequate and standard health service they should speed up the release of test results or should establish laboratories in all rural hospitals so that PMTCT service could be effective hence accessed by all on time.

The DAAC officer also noted that absenteeism of health workers is one factor which hinders expecting and lactating mothers from accessing PMTCT, he had this to say “we observe it-we cannot lie about it. Not respecting working hours is something we got used at this hospital (Mutawatawa) and this has created the problem for patients. Some health personnel go for long tea break and lunch hours than expected. During lunch time, for example health workers go to other places to work in their surgeries and return late, for personal commitments.” These findings are similar to findings by Sprague et al (2011) in which absenteeism was found to be an obstacle in the accessing of PMTCT by pregnant women as the delay may prolong to delivery without transcriptions of CD4 count hence failure to initiate these women before birth, thus posing the risk to the unborn child. As a result of the absenteeism the researcher assumes that patients may end up visiting the clinic three times a month and not accessing PMTCT services however some will eventually give up on the PMTCT services. Thus absenteeism is a barrier to accessing PMTCT services by pregnant women and lactating mothers in rural areas.

4.3.5 Relationship between level of education and access to PMTCT services

The researcher found no association between level of education and access to PMTCT. In this current study respondents who only went for primary education as well as those who had reached Diploma level were accessing PMTCT. As such these findings are different from the findings of Knut et al (2001) in which educated people accessed PMTCT services compared to their counterparts who had not finished primary school. From these findings the researcher
noted that if PMTCT services are well advertised in these rural areas more women are likely to access PMTCT services as there is no association between level of education and access to PMTCT.

### 4.3.6 Relationship between religion, culture and access to PMTCT

The researcher found an association between religion and culture and access to PMTCT services. From this study it was noted that culture and religion stand as barriers to pregnant and lactating mothers accessing PMTCT services, as some religions and cultural views discourage their people from seeking medical treatment.

### 4.3.7 Relationship between age and access to PMTCT

The researcher also found an association between age and access to PMTCT services. It was noted by the researcher that 3 of the women who said they could not afford to risk their child’s life were above 30 years, 2 were 31 years and one was 35. A look at the ages of the respondents revealed that most women who were accessing PMTCT services were between 27 to 32 years old, whereas only 2 were from the 18 to 20 age group. These findings therefore conquer with findings of Jamease et al (2002) in which they found out that women 35 years or older were more likely to accept VCT and eventually PMTCT services. From these findings the researcher noted that age is a barrier to women accessing PMTCT services in rural areas.

### 4.3.8 Relationship between maternity fee and distance

From the above findings the researcher found an association between maternity fee and distance. If one is to pay $10 and have to walk to the hospital while pregnant the women in support with their husbands or families end up using the money to buy baby preparation instead of registering with the antenatal clinic. Resultantly they deliver at home and will not be able to access PMTCT services.

### 4.4 Summary

This chapter presented results of the research study. From the study it was noted that most pregnant and lactating mothers were knowledgeable about PMTCT services. Some of the barriers cited in this study preventing women from accessing PMTCT services were distance, culture, religion, stigma and discrimination.
Chapter 5

5.0 Summary, conclusion and recommendation’s

5.1 Introduction

This chapter gives a summary of the research findings and concludes the research also this chapter will give recommendations which are believed to help in making PMTCT accessible to rural expecting and lactating mothers.

5.2 Summary of major findings

From the study it was found that all the expecting and lactating mothers interviewed were knowledgeable about PMTCT services. From the 25 respondents 13 said HIV is a sexually transmitted disease while 12 said HIV can be passed from an HIV mother to an unborn or lactating child. All the respondents said men have influence on women’s health issues. These women also noted that there is stigma associated with formula feeding in Zimbabwe. 20 women also noted that formula feeding is culturally unacceptable; this was because of the long held cultural beliefs which believe that the bond a mother and a child is created and strengthened through breastfeeding. Majority (21) respondents said that their religion allow them to seek medical treatment, whereas 4 of the respondents said their religion does not allow them to seek medical treatment. They however said they could not afford to risk their children’s health because of what religion says hence they were accessing PMTCT services. From the study it was also discovered that culture and religion were the major barrier preventing rural women from accessing PMTCT services. Other barriers found in this study were male influence, distance, stigma and discrimination.

5.3 Conclusions

From this study one may conclude that all the respondents proved knowledgeable about HIV and PMTCT services. However the researcher is of the view that only those who visit the hospital got to be knowledgeable about PMTCT. Thus those who deliver at home never get to know of PMTCT unless they visit the hospital. From this one may conclude that home delivery is a barrier preventing pregnant and lactating mothers from accessing PMTCT services.

The researcher also concluded that society has a negative attitude towards PMTCT services as family and relatives are not likely to support HIV positive mothers as well as supporting them
in initiatives that would enhance efficiency of PMTCT services. Thus one may conclude that lack of family support is a barrier preventing expecting and lactating mothers from accessing PMTCT services in rural areas.

Cultural beliefs can be noted to be a barrier preventing rural women from accessing PMTCT services. This is because of important values put on breastfeeding which when one deviates from them will be considered a social outcast thus discriminated and stigmatised by society. Thus one may conclude that cultural beliefs results in stigma and discrimination. Therefore, fear of stigma and discrimination will result in some women not accessing PMTCT services so as to be accepted by society.

From this study the researcher found that culture and religion are the major barriers preventing lactating and expecting mothers from accessing PMTCT. This is supported by all the respondents which said that men have considerable influence in women health issues and in some cases discouraging their wives from accessing healthcare services. These barriers are worsened by distance, stigma and discrimination resultantly rural expecting and lactating mothers do not access PMTCT services in rural areas.

Relationship with service provider is an important factor in rural women accessing PMTCT services. If women are treated well by health personnel they are likely to visit the clinic often. However, when ill-treated by health workers in previous visits some women end up not visiting the hospital again. Therefore, one may conclude that bad relationships between service providers and patients can be noted as a barrier preventing women from accessing PMTCT services.

From this study one may conclude that with more awareness campaigns in rural areas, as well as partnering with religious leaders and traditional leaders in disseminating information PMTCT services will be accessed by a significant number of women.
5.4 Recommendations

From this study the researcher recommends that the following be done to make PMTCT services accessible by expecting and lactating mothers who require these services in rural areas:

- Traditional leaders should encourage their people especially expecting and lactating mothers to visit antenatal clinics.
- Traditional leaders should introduce fines for males who discourage their wives from accessing antenatal care.
- MOHCW should partner with religious leaders and traditional leaders in promoting PMTCT.
- More awareness campaigns in the language understood by all people should be enhanced and intensified in rural areas. This can be achieved through integrating health promotion into community based events like teachings at religious gatherings (*kuChina chemadzimai*) and sports occasions.
- Involve community leaders in information dissemination campaigns through educating them about PMTCT so that they have an opportunity to discuss PMTCT with their community, e.g. community meetings. This will go a long way in enhancing knowledge to women and their husbands. The community leaders should encourage them to consult healthcare practitioners if they need more clarity on the subject and to update themselves on issues relating to PMTCT.
- MOHCW should seek to correct misconceptions and myths about formula feeding as a strategy of promoting PMTCT services.
- MOHCW should conduct supervisory visits to clinics and hospitals more frequently to assess service provision, cleanliness and quality of services. The visits may be conducted by province level, district level health officers or managers.
- MOHCW should provide training courses for health workers about how to engage with patients in a more acceptable, non-discriminatory manner.

Awareness campaigns

Since awareness is key to the prevention of HIV and access to PMTCT, there is an urgent need to increase the knowledge and understanding of PMTCT, using all methods of mass media and intensive information dissemination strategies of education (for example school, church and community activities.)
Reference


Health Economics Unit (HUE), *Prevention of mother to child transmission (PMTCT) of HIV services: what are the barriers to accessing these services in Zimbabwe*, public health and family medicine at the University of Cape Town, South Africa Jack,H. (2002) *AIDS AFRICA- continental crisis*, SAfAIDS, Harare


Mahdi,M(2008), *Pregnant women still struggle to prevent HIV*. Elizabeth Glaser paediatric AIDS foundation (EGPAF) in Swaziland, July, (online) available @ [http://www.iolhivaids.co.za](http://www.iolhivaids.co.za)

Mekonnen, G.M (2009), *Factors influencing utilisation of PMTCT services in Addis Ababa-Ethiopia*, 45th international course in health development, royal tropical institute, Amsterdam


Perez,F, Glieman, J, Mukotekwa. T, Miller A, Glenshaw M, Mahomva ,A and Dabis,


PMTCT of HIV: Expect panel report and recommendations to the US congress and US global AIDS coordinator (2010)


Wodi, B (2005), Gender issues in HIV/AIDS epidemiology in Sub-Saharan Africa, available online from: [http://wagadu.org](http://wagadu.org)
Appendix 1

Main questionnaire

For lactating and expecting mothers

Interviewee consent form

My name is Eustine Rutendo Muchenje a fourth year social work student at Bindura University of Science Education. I am conducting a research on the barriers to accessing PMTCT of HIV services among expecting and lactating mothers in Uzumba Maramba Pfungwe district. The research is in partial fulfilment of an Honours Degree in Social Work. Your responses will be used for academic purposes only.

Your cooperation is therefore very much appreciated. Please note that your participation is voluntary and you are free to withdraw from the exercise whenever you feel like doing so. Information provided here will be treated with strict confidentiality.

If you agree to participate in the exercise please indicate by putting an X in the box below

Signature  ☐ Date .... /05 /2013

Ward .................................................. Village .................................................................

Section A- demographic information

1. What was your age as of your last birthday? .................................................................
2. Place of residence Rural [ ] Growth point [ ]
3. What is your religion? ....................................................................................................
4. What is your marital status? ..........................................................................................
5. How many children do you have? ..............................................................................
6. Highest level of education


7. Are you employed?  Yes [  ]  No [  ]
a. If yes what is your occupation


8. Is your husband employed?  Yes [  ]  No [  ]
a. If yes what is his occupation


9. Any other issues


Section B- Knowledge about PMTCT

1. What is your understanding of HIV/AIDS?

2. What do you understand by PMTCT?

3. Where did you get information about PMTCT?

4. What is your understanding of exclusive breastfeeding?

5. After delivery did you exclusively breastfeed your child?  Yes [  ]  No [  ]
a. If yes how long? months weeks

6. Did you receive breastfeeding advice from the clinic?

7. Would you choose to formula feed your child?  Yes [  ]  No [  ]
a. Why

8. Any other issues


Section C- Attitudes towards PMTCT

1. Should an HIV positive mother breastfeed her child
2. If an HIV positive mother decides not to breast-feed her baby, how would her family or relatives react? Will reject [ ] will support [ ] do not know [ ]

3. What do you think are the reasons why some women do not access PMTCT services?

4. Is there stigma attached to formula feeding?

5. How do you think PMTCT service can be improved in your area?

6. What does your husband think about PMTCT services? ........................................................

7. Any other issues................................................................................................................................

Section D-Beliefs

1. Where you tested as a couple? Yes [ ] No [ ]
   a. If no did you disclose your status to the husband?

2. Would you visit the hospital without the consent of your husband? [ ]

3. In your culture is formula feeding accepted?

4. Does your religion allow you to access PMTCT services? [ ] if NO why are you here.................................

5. Any other issues................................................................................................................................

Section E- Service provider’s interaction

1. How far is it to the nearest health centre?

2. What is the mode of transport you use to visit the clinic?

3. How much do you pay for antenatal care and delivery?

4. How often do you visit the antenatal clinic?

5. Where did you deliver your last child? Home [ ] Clinic [ ]
6. Was your child tested for HIV? ........if No
   why...........................................................................................................................................

   a. If yes what was the outcome of the testing of your child? Positive [ ] Negative [ ]

7. Do you always receive ARVs whenever you need them.................................................

8. What is your relationship with health service providers?
   Poor [ ] good [ ] very good [ ]

9. Any other issues....................................................................................................................

Section F- General Recommendations

What do you think should be done to promote accessibility of PMTCT in rural areas?
.....................................................................................................................................................

What are your final thoughts on PMTCT services?
.....................................................................................................................................................

Thank you for your cooperation.

Appendix 2

Interview guide for key informant (Hospital Matron)

Interviewee consent form

My name is Eustine Rutendo Muchenje a fourth year social work student at Bindura University of Science Education. I am conducting a research on the barriers to accessing PMTCT of HIV services among expecting and lactating mothers in Uzumba Maramba Pfungwe district. The research is in partial fulfilment of an Honours Degree in Social Work. Your responses will be used for academic purposes only.

Your cooperation is therefore very much appreciated. Please note that your participation is voluntary and you are free to withdraw from the exercise whenever you feel like doing so. Information provided here will be treated with strict confidentiality.

If you agree to participate in the exercise please indicate by putting an X in the box below

Signature  Date  .... /05 /2013
1. What do you think about PMTCT services in rural communities?
2. Looking on matters to do with PMTCT what do you think is hindering people from accessing these services?
3. What ways is this hospital employing to promote accessibility of PMTCT by lactating and expecting mothers?
4. In your opinion, what are the main factors influencing uptake of PMTCT services?
5. If MOHCW wanted to increase uptake of PMTCT services among rural expecting and lactating mothers, what do you think are the most important factors they should address?
6. How would you rate the turnover rate of females to PMTCT services at this hospital?
7. Do you have a policy which protects HIV positive mothers from ill-treatment from health personnel?
8. Have you ever had reports on cases of ill-treatment of HIV patients by staff members?
9. Is there stigma attached to HIV positive mother’s formula feeding their children?
10. What are your final thoughts on PMTCT services?

Thank you very much for your time and cooperation

Appendix 3

Interview guide for key informant (Hospital Matron)

Interviewee consent form

My name is EustineRutendo Muchenje a fourth year social work student at Bindura University of Science Education. I am conducting a research on the barriers to accessing PMTCT of HIV services among expecting and lactating mothers in Uzumba Maramba Pfungwe district. The research is in partial fulfilment of an Honours Degree in Social Work. Your responses will be used for academic purposes only.

Your cooperation is therefore very much appreciated. Please note that your participation is voluntary and you are free to withdraw from the exercise whenever you feel like doing so. Information provided here will be treated with strict confidentiality.

If you agree to participate in the exercise please indicate by putting an X in the box below
1) What do you think about PMTCT services in rural communities?

2) Looking on matters to do with PMTCT what do you think is hindering people from accessing these services?

3) What ways is DAAC employing to promote accessibility of PMTCT by lactating and expecting mothers?

4) In your opinion, what are the main factors influencing uptake of PMTCT services in rural areas?

5) If MOHCW wanted to increase uptake of PMTCT services among rural expecting and lactating mothers, what do you think are the most important factors they should address?

6) Have you ever had reports on cases of ill-treatment of HIV patients by hospital staff members?

7) Is there stigma attached to HIV positive mother’s formula feeding their children?

8) What are your final thoughts on PMTCT services?

Thank you very much for your time and cooperation

Appendix 3

Approval letter
The District Medical Officer  
Ministry Of Health and Child Welfare  
Mutawatawa District Hospital  
P. Bag 036  
Mutawatawa  
Zimbabwe  

24 April 2013  

Dear Ms E. Muchenje  

REF: PERMISSION TO CONDUCT RESEARCH AT MUTAWATAWA HOSPITAL.  

This letter serves to notify you that you have been granted permission to conduct an academic research on the barriers to accessing PMTCT services among expecting and lactating mothers at Mutawatawa Hospital. Please be reminded to send a copy of your final research results for our records.  

We wish you well in your studies.  

Yours sincerely  

[Signature]  

Dr Mugwagwa  

District Medical Officer