

# The Perceived Impact Of The PPTCT Programme On The Management Of Parent To Child HIV And AIDS Transmission: A Case Study Of Chikuku Hospital

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**ABSTRACT:** The study was carried out to investigate the perceived impact of the PPTCT programme on the management of parent-to-child HIV and AIDS transmission in Chikuku rural hospital community in Bikita district. A case study was used. A sample of ten expecting couples on Chikuku PPTCT programme and ten expecting mothers who were not on Chikuku PPTCT, but attending ANC there participated in the study. Five professional counsellors also participated. Questionnaires and the interviews were used as data collection instruments. The data collected was analysed and interpreted using descriptive statistics and narratives. Tables were used to present the data and each question was analysed. The general findings agree with the reviewed literature as reflected that awareness and knowledge of PPTCT services and knowledge of its benefits was common, but there were certain hurdles that need to be overcome in implementing and utilising them effectively. The clarion call is to review and reorganise the existing policies and current approaches in increasing PPTCT service uptake in communities similar to the study area. Recommendations were also made for programme implementers and policy makers in respect of the research findings in order to plan for the future.

**Keywords:** parent to child transmission, hiv-aids, antiretroviral therapy

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## CHAPTER ONE: THE PROBLEM AND ITS SETTING

### 1.1 Introduction

This chapter focuses on the background to the study. This gives the information on the origins of the problem under investigation, where and why the research will be carried out. This will be followed by the problem, purpose, significance, assumptions, delimitations and limitations of the study. The delimitations and limitations of the study will seal off the chapter.

### 1.2 Background to the study

HIV/AIDS emerged in the 1980s as the most terrifying epidemic of modern times. Jackson, (2002) likens it to "the black death" or "the bubonic plague" of the Middle Ages in Europe when millions died. Mainland Southern Africa is experiencing the debilitating effects of the epidemic and remains the current epicentre of its

transmission.(UNAIDS,2011).Southern Africa's HIV/AIDS prevalence rate is approximately 11% as compared to the global average of 1,1% which gives 37,8 million people .About 40% of all people living with HIV/ADS are in Southern Africa,(SAFAIDS,2011). Transmission of HIV/AIDS from an infected parent to the baby is a major cause of infection in children. Data from the Zimbabwe Ministry of Health,(2010)puts national sentinel surveillance survey of ante natal mothers as indicating that HIV seroprevalence among this group is at 30%high.This scenario causes a major threat to child survival, with an estimated 60 000children contracting HIV infection annually. Zimbabwe is committed to the fight against HIV/AIDS as indicated in the National HIV/AIDS Policy, (1999). Included in the policy document is the prevention of mother-to-child (PMTCT) as a key strategy in the fight against paediatric HIV/AIDS infection. In this study, prevention of parent-to-child transmission, (PPTCT) will draw attention to the need to protect the mothers from HIV/AIDS infection by implicating their male partners as it becomes a joint parental responsibility to protect the child. This can help in ensuring a future HIV/AIDS free generation. UNAIDS, (2011) has the following to say on the effects of the HIV/AIDS epidemic: "It can devastate whole regions, knock decades off national development, widen the gulf between rich and poor nations and push the already stigmatised groups closer to the margins of society". HIV/AIDS has had such a great negative effect health, lives and socio-economic aspects of Zimbabweans. The consequence has been widespread suffering and death among the population. Profiles from recent studies give an estimated 24% of the 15 to 19 age bracket as currently infected. NAC, (2010) states that HIV/AIDS prevalence stands at one in four adults and nine in ten deaths among Zimbabwean adults are due to the epidemic. Against this backdrop, women are said to have a higher number of people living with HIV/AIDS. The National Aids Council, (2010) also gives the general awareness of HIV/AIDS in Zimbabwe as high in some areas and low in some areas. In 2010, Masvingo province's Bikita and Zaka

districts had the highest HIV prevalence in the 15 to 44 age bracket. Consequently, there is a dire need to improve the quality and standard of life for the HIV/AIDS infected and affected by offering best practices such as HIV/AIDS awareness campaigns, voluntary counselling and testing programmes. According to The Centre for Public Health Sciences, (2012) awareness campaigns are important in the public health response to the HIV/AIDS epidemic and play a significant role in the range of services like primary prevention, treatment and psycho-social support among others. One of the goals of HIV/AIDS awareness campaigns is to facilitate the adoption of safer behaviours and hence the study aims at investigating if PMTCT, VCT and PPTCT programmes are meeting their intended goals especially in Chikuku rural community in Bikita District. The researcher noted a high incidence of children of school-going age suffering from signs and symptoms of HIV/AIDS and other opportunistic infections. The study will be narrowed to the perceptions of people on the PPTCT interventions and not those testing positive due to the inaccessibility of researching data in respect of ethical considerations. Also, due to confidentiality and privacy concerns, participants may not wish to have their status known by certain third parties who do not add value to their lives. The researcher will also highlight, where possible, the challenges facing the uptake of PPTCT services including its availability, content and quality. The values and attitudes of individuals, health professionals and community members will be incorporated as they impact on PPTCT interventions. Downing, (2009) identifies community interventions as promoting empathy, compassion and destigmatisation of individuals and PLWHAs by creating an enabling environment within which communities can support strategies at all levels. Against this background, SAFAIDS, (2011) adds that community groups can effectively assess problems, propose solutions and implement change, but they need on-going and appropriate support from health professionals and development systems. It follows, therefore, that failure to involve the community in awareness campaigns may result in unsuccessful intervention and the continued rise in HIV/AIDS sero-prevalence and high child mortality rates. Community participation also needs to be resource-intensive. This is because in resource –poor settings, including many Sub-Saharan countries with generalised epidemics, PPTCT services are becoming increasingly available. However, results conflict with regards to the potential impact of promoting reduction in risky behaviours. The quality of awareness will also be critical in this study in trying to come up with effective HIV/AIDS intervention programmes. The cost benefits of an individual knowing their status has oscillated over time and place ,depending on a multitude of factors such as stigma and discrimination, availability of social support, availability of interventions like prevention of parent-to-child transmission. Due to the above stated facts and reasons; there will be need to determine whether PPTCT services have been effective in meeting their intended goals. Since facilitative programmes like PMTCT and VCT are also currently underway at all hospitals, the researcher will carry out this research at Chikuku Rural Hospital in Bikita. The researcher will undertake a survey study among purposively selected couples in and around Chikuku rural hospital community as

participants in the study. In addition, professional counsellors, as key informants will also be interviewed.

### 1.3 Statement of the problem

How effective are the PMTCT and VCT programmes in preventing parent-to-child HIV/AIDS transmission (PPTCT)?

### 1.4 Sub-problems

- ❖ What is the level of awareness of HIV/AIDS in Chikuku community and why?
- ❖ How is the PPTCT programme being implemented?
- ❖ To what extent are PPTCT programmes meeting the objectives for which they are intended?

### 1.5 Purpose of the study

The purpose will be to determine how effective PPTCT services are in meeting their intended objectives and the needs of the clients. The study, therefore, will seek to establish the impact of HIV/AIDS awareness programmes in promoting positive attitudes and behavioural change especially in family planning. It will also seek to establish whether PMTCT and VCT programmes are being seen evidently as having an impact, or having any advantages, any positive results among the population in Chikuku rural hospital community. It would also be ascertained whether there would be an increase or decrease in the number of HIV/AIDS patients in the area under study.

### 1.6 Significance of the study

- ❖ The study will contribute immensely and positively to need to stem the HIV/AIDS scourge at all levels;
- ❖ It will provide research knowledge on the effectiveness of HIV/AIDS awareness campaigns PMTCT, VCT and PPTCT services on the infected and affected persons in the region;
- ❖ The study will also give insight into the best practices and enhance the effectiveness of HIV/AIDS interventions in our context;
- ❖ The research report will also provide the basis for further studies on HIV/AIDS counselling, VCT, PPTCT and the planning for future strategies and programmes for counselling and
- ❖ The research project will be partial fulfilment of the requirements of the award of the Bachelor of Science Honours in Counselling Degree by the Zimbabwe Open University.

### 1.7 Assumptions

- ❖ There is a growing number of HIV/AIDS infected infants in Chikuku rural community;
- ❖ PMTCT and VCT services are being implemented in Chikuku rural hospital community;
- ❖ The respondents will volunteer accurate and honest information;
- ❖ There will be minimal interview bias by the research interviewer.

### 1.8 Delimitations of the study

The study will focus on the impact of the PPTCT programme on the management of parent-to-child HIV/AIDS transmission as perceived by the Chikuku rural hospital community. This research will be centred on couples, as it will draw attention to the need to protect mothers by implicating their male partners as it becomes a joint parental responsibility to protect the child from infection.

### 1.9 Limitations of the study

The impediments of the study will arise from the constraints of time since the researcher is both a student and a classroom school teacher. Another inhibiting factor will be of inadequate financial resources in meeting data collection and research supervision during the project write-up. In spite of all these set-backs, the researcher will sample economically and carefully the respondents and intends to limit travel arrangements to weekends and school holidays.

### 1.10 Summary

The chapter presented a brief background before stating the statement of the problems, sub-problems and justification of the study. The significance and assumptions of the study were also highlighted. Delimitations and limitations of the study were also given. The study now turns to the review of related literature which marks the beginning of chapter two.

## CHAPTER TWO: REVIEW OF RELATED LITERATURE

### 2.1 Introduction

This chapter seeks to address the major issues and grapples with the conceptual framework, summarises major findings and identifies the information deficiencies to be filled by the predicted research findings. It also states the thrust of the research and the relevance of the literature to the study. In order to address some of the concerns raised in the research sub-questions, the literature will be reviewed under the following sub-topics:

- a) The prevention of mother- to-child (PMTCT) intervention
- b) The voluntary counselling and testing (VCT) intervention
- c) The parent-to-child transmission of HIV/AIDS (PPTCT) intervention
- d) The impact off couple counselling on the effectiveness of the PPTCT intervention
- e) The challenges that married women face in accessing PPTCT services
- f) The rationale for HIV/AIDS counselling in PPTCT programmes.

### 2.2 The prevention of mother-to-child (PMTCT) intervention

Dickson, Schultz and Silverman (1999) state that HIV/AIDS can be transmitted from a woman who has it to her baby before, during birth and afterwards through breast-feeding. In Sub-Saharan Africa, Zimbabwe has the highest rate of HIV/AIDS sero-prevalence with an average antenatal prevalence of 24,6% in urban areas and 28,1%in rural areas.(SAFAIDS,2011).Prevention of mother-to-child is one

of the key HIV/AIDS prevention strategies in Zimbabwe's national response to the epidemic.(NAC,2011). The Ministry of Health and Child Welfare, (2011) reports that about 30% to 35% of pregnant women are testing positive to HIV/AIDS. It follows that without any PMTCT intervention, about a third of the HIV/AIDS infected women will pass the virus their babies. It also estimated that 20% of the infected babies become infected during pregnancy, 60%during labour and another 20% after birth during breast-feeding. Most infections therefore occur during labour and delivery. The goal of PMTCT in Zimbabwe is to curb mother-to-child transmission, thereby, leading to the reduction of infant morbidity and mortality. (NAC, 2011).The four main strategies for PMTCT in Zimbabwe are:

- a) Primary prevention of HIV infection in women of child-bearing age and their partners;
- b) The prevention of HIV transmission to the infant during pregnancy and breast-feeding;
- c) The prevention of unwanted pregnancies in HIV/AIDS infected women, and
- d) The care and psycho-social support to HIV/AIDS infected women and their spouses. (NAC, 2011).

Against this background, PMTCT services were introduced at Chikuku Rural Hospital in 2001. Programme strategies included recruiting counselling staff, training health professionals, improving maternal child health (MCH) services and conducting outreach programmes on promoting HIV/AIDS awareness. The following components were implemented within MCH services: voluntary counselling and testing of HIV using rapid testing, nevirapine and support for all HIV infected mothers identified. Support included the exclusive breastfeeding of infants from 0 to 18 months. Routine monitoring data was also collected to estimate and ascertain programme uptake. Over a six year period, out of 471 pregnant women using antenatal services,298 were pre-test counselled, the acceptance of HIV testing reached 92, 9%. Of the women who decided to take an HIV test,74, 3% returned to collect results. Overall, the HIV prevalence was 20, 4%. 326 of the HIV positive pregnant women were counselled and 104 women received complete mother-to-child antiretroviral prophylaxis. PMTCT interventions provide drugs, counselling and psycho-social support to help mothers safeguard their infants against HIV infection. Ensuring that PMTCT is provided to all women that need it is a most effective way to end mother-to-child by 2015,and attain the UN's Millennium Development Goal number 6. Also ensuring that no child is born with HIV is an essential step in achieving an HIV/AIDS free generation. (SAFAIDS, 2011). Therefore, these circumstances catapulted the researcher into wanting to find more about what actually happens after people had been equipped with the vital information on paediatric HIV/AIDS prevention.

### 2.3 The voluntary counselling and testing (VCT) intervention

Boswell and Bagalley, (2002) define voluntary counselling and testing (VCT) as a term people often use to describe the process of taking an HIV test. It includes counselling before,(pre-test counselling) and after, (post-test counselling). The HIV test is voluntary, that is, it is done out of one's choice or volition. Bourke, (2009) explains that in

voluntary counselling, funds are put aside to support HIV/AIDS prevention, testing, treatment and care services. Social and legal assistance is also given to those affected by the epidemic during voluntary counselling and testing. The Centre for Public Health Sciences, (2012) also describes voluntary counselling and testing as an HIV prevention intervention normally initiated by the client and entered into by the client's free will. It goes on to explain that voluntary counselling and testing provides the opportunity for the client to confidentially explore and understand test results. From what has been said about voluntary counselling and testing, there is no doubt that it is a very good intervention strategy in as far as PMTCT and PPTCT services are concerned. The study seeks to investigate the extent to which VCT services are meeting their intended objectives in as far as PPTCT is concerned. Against this backdrop, SAFAIDS,(2010)reports that in rural Africa, almost half of the pregnant women do not have access to ANC, VCT, MCH and even safe drinking water. Rural Bikita can fall into the same pit because access to these services is still far from universal as most expecting couples still seek the services of traditional birth attendants.

#### **2.4 Parent-to-child transmission of HIV (PPTCT)**

Parent-to-child transmission of HIV/AIDS happens when the HIV virus is passed from the infected parent to the baby. SAFAIDS, (2010).The term, "parent-to-child" transmission "recognises the fact that both parents contribute to the HIV in their children". (Jackson, 2002). Other proponents of this school of thought hold that it takes both parents to produce a baby and the responsibility of giving birth to a healthy baby lies with them both. This is because the mother could have received her infection from her sexual partner although the immediate source of the child's infection during pregnancy, birth and breast-feeding is the mother. (UNICEF, 2009). Infants are in greater risk of being born HIV-positive, especially where mothers do not receive adequate PPTCT information and education. Prevention of parent-to-child transmission of HIV draws attention to the need to protect the mothers by implicating their male partners as it becomes a joint parental responsibility to protect the child. (Jackson, 2002)."Parent-to-child transmission interventional strategies" would, therefore, avoid blaming the women if the child tests positive, recognising that both parents have contributed to the child's infection. It is hoped that this joint responsibility will motivate some men to protect their wives and themselves as well. In parent-to-child transmission, babies may get infected in the mother's womb or uterus. The mother's blood and the baby's blood do not mix directly, but the barrier between them, the placenta, is quite thin. As is the case with other infections, sometimes HIV can pass across the placenta from the mother to the baby. (SAFAIDS, 2009). Also direct contact with blood and fluids during birth makes babies vulnerable to HIV infection. Babies born normally through the vagina have a lot of contact with maternal body fluids that may contain HIV. Elective caesarean section, which means having the baby by operation before the mother goes into labour, avoids much of this contact. (Ministry of Health and Child Welfare,2010). Babies may also get infected through breast-feeding. If the mother has cracked or bleeding nipples, or if she has mastitis (painful and very tender breasts), and the baby has

thrush in the mouth, the risk of transmission becomes higher. (National Aids Control Programme, 2010). Most importantly, the chances of the baby getting infected at any of these times are higher if the mother has a greater viral load. This happens when the mother gets reinfected or is beginning to get sick with AIDS or soon after infection. It is against this background that the study seeks to investigate the impact of the PPTCT programme in the presence of these problems and other intervening factors.

#### **2.5 The challenges that married women face in accessing PPTCT services.**

Married women encounter some stumbling blocks in accessing PPTCT services. These challenges are social, cultural and economic in nature. In as far as cultural problems are concerned, Bourke, (2008) explains that a woman's worth is culturally believed to rest in her ability to bear children. This, therefore, forces women to continue having children although they know that they are HIV positive. They are even afraid to disclose and discuss their HIV status or even get tested because they know that they should fulfil their duty of having children at all costs. In view of these and other challenges faced by women in PPTCT, the National Behaviour Change Strategy,(2008-2010) there is need to address issues of faithfulness, mutual family care and gender equality. The same source goes on to explain that stigma, male patriarchy which exhibits androcentric attitudes, that is ,male centred norms in marriages, abuse of power and forced sex are some of the problems that should be addressed in favour of women. SAFAIDS, (2010) adds that women have little choice over how, where and when sex takes place. Their pleasure and safety are considered less important than men's. The same source further explains that women are often economically dependent on their male partners, they lack access to adequate education and to knowledge of their rights and that they are not used to negotiating condom use. This in turn puts women at risk and when they get pregnant, the chances of infecting the unborn children are very high. Njunga and Blystad, (2010) share the same sentiments on the plight of women who they consider subservient to men and add that their limited rights are often infringed upon. This makes it difficult for most women to go for voluntary counselling and testing without the consent of their husbands. Some women (in Malawi)would go to the extent of accessing these VCT services secretly , and in the event of testing positive, they end up having problems disclosing their status as well as implementing measures to stem parent-to-child HIV/AIDS transmission. In view of this disturbing phenomenon, there would be a dire need to provide support for women who would usually face rejection or even violence in disclosing their HIV status. This is because most women would shun VCT services, opting to remain in the dark even if it means that they may infect the unborn child. Still on challenges faced by women in accessing PPTCT services, The National Aids Control Programme,(2010) adds that there is sufficient information to support limited male involvement in PPTCT. Without adequate support from male partners, efforts to curb transmission of the disease become fruitless. Another barrier is encountered in breast-feeding. UNAIDS,(2008)and WHO ,(2009) explain that if a mother chooses not to breastfeed in a culture where breastfeeding

is the norm, this may draw attention to her HIV status and invite stigma, discrimination, violence and abandonment by her family and community. In the same lines, SAFAIDS, (2010) reiterates that poverty, sexual exploitation, abuse, violence, and rejection increase women's vulnerability. To cap it all, it is usually men who engage in multiple parenting giving rise to multiple concurrent partnerships like "nyatsi", "lishembe", "second office", "small house", "mapoto" as viewed in different African settings. In the light of the foregoing, the study will seek to identify how these problems including stigma and discrimination make women vulnerable and their impact on uptake of PPTCT services.

## **2.6 The rationale for and impact of HIV/AIDS couple counselling in PPTCT programmes**

Tadesse, Muula and Misiri, (2009) emphasise that couple counselling should be the start of the programme for an effective PPTCT intervention. The same sentiments are also echoed by Jackson, (2002). Couple counselling is also favoured by researchers like Makore-Rukuni, (2004) for its benefits like giving both partners the opportunity to benefit at one time from advice on best practices and other related issues. Simply explained as "the talking cure", counselling is the medium through which people are helped to analyse whatever unfortunate situation they may be in and come up with positive decisions regarding how they should handle them. These decisions are not only for the benefit of the person seeking counselling, but also for the benefit of others around them. Thus, it contributes towards fostering responsible behaviour, in a way, leading to the reduction of the sero-prevalence. (Jonga, 2005). UNIAIDS, (2009) reports that the effects of individual counselling and disclosures of results among spouses leads to assaults, abuses and divorce because husbands often blame their wives for the infection. Therefore, the uptake of PPTCT services should involve men, fully utilising couple counselling, behaviour and normative change promotion. This type of counselling has the possibility of reducing conflicts between partners in HIV/AIDS related issues. (SAFAIDS, 2010). This most important therapeutic measure will result in effective counselling and antiretroviral therapy to protect the child. It should be noted that the problem of HIV/AIDS does not exist in isolation, but in the context of other social problems affecting individuals, couples, families and communities at large. It follows that marital conflicts, substance abuse, infidelity in or outside marriages, peer pressure and economic challenges are some of the problems that have a bearing on people's lives. These problems give rise to the feelings of denial, anger, fear, betrayal and others. This study also puts counselling on a psychological plane in the hope of dealing with these problems in positive ways that facilitate coping and general management of parent-to-child HIV transmission. The study will also seek to establish whether a couple counselling in PPTCT services perceives a family unit.

## **2.7 An attempt to fill the research gap left by previous studies**

In respect of the literature reviewed, the PPTCT service is underway in most hospitals but the extent to which it is meeting its objectives remains unknown. Although many strategies have been adopted in HIV/AIDS awareness including VCT, PMTCT and the teaching of life survival

skills, there is still a significant number of infants of school-going age suffering from the signs and symptoms of HIV/AIDS. According to researchers, the effectiveness of nevirapine in PMTCT is not 100%, hence pointing to other factors. As such, the researcher will bring to the fore, such intervening factors that may compromise PPTCT interventions. The focus and aim of this study will be on the psycho-social implications of the HIV/AIDS and examining the incorporation and effectiveness of PPTCT services within the existing ANC and MCH in resource-poor settings like Chikuku Rural Hospital community. Pertinent questions relating to the feasibility, acceptability, effects and impact of the PPTCT programme will also be addressed. In community awareness and involvement, community norms and values will be explored in examining the members' perceptions of their needs and the contextual factors that impinge on their lives as far as the PPTCT programme is concerned.

## **2.8 Summary**

The literature review section dealt with what other researchers have encountered in PPTCT interventions. This has helped in setting up avenues of what to be encountered during the research inquiry in identifying the gap to be filled. The details of those who will be selected and studied as respondents in this study will be covered in the next chapter which deals with the research methodology.

# **CHAPTER THREE: THE RESEARCH METHODOLOGY**

## **3.1 Introduction**

This chapter focuses on how the research was carried out. The chapter specifies the research design, the population under study, the sample and sampling procedure, methods of data collection, reliability and validity of instruments, ethical considerations and the way data was presented.

## **3.2 The Research Design**

The study used the case study. Simmonds, (1999) defines a case study as when the researcher intensively studies a single case or phenomenon on the assumption that it's typical of other cases. Given, (2008) explains that the case study method allows the researcher to closely examine the data within a specific context. Profiles from other studies consider a case study as a robust research method, particularly when a holistic, in-depth investigation is required. Case studies explore and investigate contemporary real life phenomena, through detailed contextual analysis of a limited number of events or conditions and their relationships. However, the case study investigator may be sloppy and allow equivocal evidence or biased views to influence the direction of findings and conclusions. (Given, 2008). Another limitation is that case studies also provide very little basis for scientific generalisation since they use a small number of subjects, some are conducted with only one subject. Then, "How can you generalise from a single case?" The design chosen assisted the researcher to apply different strategies in deriving better judgements on the perceived impact of the PPTCT programme on the management of parent-to child HIV/AIDS transmission. The data collection methods

included verbal interviews, documents, field notes and questionnaires in the case study.

### 3.3 The Study Population

Population refers to all the objects, individuals or events of interest to the researcher. Best and Kahn,(1984) identify a population as the total group of persons or subjects under investigation ,or that meet the designated set of criteria established by the study. The targeted population for this study were expecting couples who attended ANC and MCH as well as professional counsellors at Chikuku Rural Hospital.

### 3.4 The sample and sampling procedure

A subset of any population is called a sample. Borg and Gall, (1993) describe it as a small population selected for observations and analysis. Simmonds, (1999) also puts the essentials of a sample as the representativeness, adequacy and homogeneity of a population. The researcher employed the purposive sampling procedure. Given, (2008) defines purposive sampling as a non-probability sampling technique where the units under investigation are selected on the judgement of the researcher. Profiles from other studies give purposive sampling, also known as judgemental, selective or subjective sampling as focussing on the particular characteristics of a population that are of interest to the researcher and which will best facilitate in answering research questions. The types of purposive sampling include homogeneous sampling, maximum variation sampling, typical case sampling and expert sampling. However, the purposive sampling technique can be highly prone to researcher bias as it is based on the judgement of the researcher. The technique was desirable as it incorporates many types, each with different goals; hence provided the researcher with the justification to make generalisations from the sample that was being studied. The way sampling would be done had to be tied to the objectives of the research. It follows that if randomly selected, participants might not have been willing to participate in studies to do with HIV/AIDS issues as they would not wish to have their condition known to certain third parties. In the study, participants were selected on the basis of convenience, accessibility and proximity to the researcher. The researcher worked with those who were willing to participate in the study in the Chikuku Rural Hospital community. The researcher chose a sample of ten expecting couples on Chikuku PPTCT programme, ten expecting couples who were not on Chikuku PPTCT but attending ANC there and five professional counsellors.

### 3.5 Research Instruments

Simmonds, (1999) describes research instruments in the descriptive survey as taking the form of questionnaires, interview schedules, checklists, observation guides and examination records among others. In this study, the instruments included a questionnaire for expecting couples on Chikuku PPTCT, another questionnaire for expecting couples not on Chikuku PPTCT but attending ANC there and an interview schedule for professional counsellors.

#### 3.5.1 The Questionnaire

Given, (2008) defines a questionnaire as a mechanism for obtaining information and opinion which permits

respondents to consider their responses carefully without interference from the interviewer. Positing it as a document containing pertinent questions for an enquiry, Yin, (1984) adds that in a questionnaire there is anonymity and respondents are not shy to answer sensitive questions. It can be used over a large area and the respondents receive the identical set of questions. The overriding objective is to translate the researcher's information needs into a set of specific questions that respondents are willing and able to answer. However, a questionnaire is a complex instrument and an unsuitable method of evaluation where probing is required. The researcher ensured clarity and desisted from using ambiguous questions that could have had many meanings and interpretations for short, simple questions with clear instructions. The questionnaire for expecting couples on Chikuku PPTCT programme had two sections: Section (A) comprising the participants' bio-data section which had age, academic qualifications and occupational status; while Section (B) had questions soliciting for PPTCT knowledge. The questionnaire for expecting couples who were not on the Chikuku PPTCT programme had only one section which had questions based on awareness of PPTCT services. Both questionnaires had closed and open-ended questions.

#### 3.5.2 The Interview Schedule

The researcher used the structured interviews in gathering data from five professional counsellors. Simmonds, (1999) presents a structured interview as involving one person asking another person predetermined questions about a carefully selected topic. This method was selected because it enabled the researcher to examine the level of understanding a respondent has about a particular topic, usually in slightly more depth than with a postal questionnaire. It could also be used to explore how a respondent feels about a particular topic before a second method like observation. (Given, 2008). It is also a reliable source of quantitative data as all respondents are asked the same questions in the same way. However, the method could be time consuming if the sample group is too large and a substantial amount of pre planning is required. The interview schedule was prepared for professional counsellors and had questions comparing programme effectiveness against its coverage as well as some risk factors in accessing PPTCT services.

#### 3.6.1 Reliability of the instruments

Simmonds, (1999) defines reliability as the extent to which a test measures or yields the same results or score consistently. In order to determine the reliability of the instruments, the same class of respondents with the same health status in the PPTCT programme were asked the same type of questions in the questionnaire. The same class of professional counsellors were asked the same questions as well. Due to the similarity of conditions of the respondents and the research instruments to be administered on them, there was the likelihood that reliability of the research would be guaranteed.

#### 3.6.2 Validity of the research instruments

Validity is an attempt to determine whether a type of measurement actually measures what it purports to measure.(Bourg and Gall,(1993). Makore-Rukuni (2004)

also adds that validity concerns how sound the measuring instrument is. It follows that for validity to be maintained, the instruments to be used should ask questions which tackle the objectives of the research. In this study, the researcher used construct, content and face validity. Under construct validity, the instruments would measure attributes like sex and age; In content validity the researcher made sure that the study answered the sub-questions and other relevant issues under investigation; and Face validity would be achieved by ensuring that each question in the instrument was related to the topic under investigation,

### 3.6.3 Ethical Considerations

The researcher would observe some ethical considerations like confidentiality, informed consent, privacy, respect and anonymity. (Makore-Rukuni, 2004). Confidentiality involves the counsellor's obligation to keep all counselling disclosures private and secret. (Nelson-Jones, 1997). Confidentiality would have limits like when the counsellor will share client issues with other professionals in seeking clarifications of client problem. Also, when dilemma has occurred, there would be shared confidentiality. The other issue is when there would be intended harm to the client, and then confidentiality would be broken. Such issues would be explained to respondents before participating in the study. Informed consent is when parents may choose to or not to participate in a research. (Nelson-Jones, 1997). All relevant information concerning the study would be detailed to the client in respect of the pros and cons of participation; hence client would be free to decide. Usually, clients give informed consent voluntarily. Privacy and anonymity usually work together with confidentiality. The anonymity and privacy of the participants ensured that confidentiality was maintained, unless consent to release information was given. (Makore-Rukuni, 2004). Respect of client rights and dignity is another ethical consideration in conducting research that must be upheld. This in turn would incorporate privacy, confidentiality, autonomy and respecting the religion and culture of the client. (Urombo, 2002).

### 3.7 Data Analysis Plan

Data collected from all the respondents was arranged and put into different groups and distributions based on the responses obtained from the respondents. Numerical values were used to analyse, summarise and evaluate the collected data. The data was also statistically arranged in tabular form and this helped to give meaning to quantitative information gathered and helped the researcher to draw conclusions on the topic under investigation.

### 3.8 Summary.

The chapter demonstrated what the researcher did in order to collect the data. The areas covered were the research design, population under study, the sample and sampling procedure, the instruments used, reliability and validity of the instruments as well as the ethical considerations. The case study was chosen as it uses real participants and brings out data on people's experiences, feelings and emotions. The next chapter will focus on data presentation, analysis and discussion of presented data.

## CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND DISCUSSION

### 4.1 Introduction

In this chapter, the researcher is going to present, analyse and discuss the data which was collected from the questionnaire on expecting mothers and their spouses who were on Chikuku PPTCT programme; expecting couples who were not on Chikuku PPTCT programme and data from the interview schedule. The questionnaires comprised both closed and open-ended questions to give room for participants to fully express their feelings in trying to answer the research sub-questions. This information was presented in figures giving percentages of the responses. Analysis and interpretation of data followed each table.

### 4.2 Background information of the participants

#### 4.2.1 Profiles of expecting couples on Chikuku PPTCT programme

*Table 4.1 Distribution of participants by age (N=10)*

AGE IN YEARS	FREQUENCY	PERCENTAGE (%)
17-25	5	50
26-35	3	30
36-45	2	20
46-50	0	0
TOTAL	10	100

The above table shows that most of the respondents were drawn from the 17 to 26 age bracket which constituted 50% of the participants of the entire sample. This was followed by the 26 to 35 and the 36 to 45 age brackets. Such figures seem to suggest that the 17 to 25 age group is the reproductive and the most sexually active group. It might also suggest that this group had the most participants in the research study. While the 17 to 25 age group may be the most reproductive age bracket in Chikuku rural hospital community, other researchers put it at 19 to 32. UNAIDS (2009) puts 90% of women infected by the HIV/AIDS disease as falling within the 19 to 32 age group. In the same lines, Olds, Wadening and London (2009:471) posit that 5% to 10% of women of child-bearing age testing HIV-positive in East and Central Africa fall within the 19 to 32 age bracket. UNAIDS, (2010) suggests a dire need for HIV/AIDS testing among the reproductive age group as they are at an elevated risk of contracting the disease and transmitting it to others.

*Table 4.2 Distribution of expecting couples by level of education (N=10)*

CATEGORY	FREQUENCY	PERCENTAGE
Primary	4	40
Secondary	5	50
Tertiary	1	10
TOTAL	10	100

Table 4.2 shows the academic qualifications of the respondents high at 50% for those who attained secondary level. Another 40% had primary and 10% indicated that they had tertiary education. The above data suggests that most of the participants attended school and were in a

better position to read, interpret and understand the questionnaire with little or no help. The level of awareness on HIV/AIDS matters could be judged to be fairly high as they could interpret information on media such as radio, television and pamphlets from community awareness campaigns by the government, DAAC, NAC, WHO, SAFAIDS and other NGOs like Regai Dzive Shiri. According Family Health International, (2009), on knowledge, behaviour and practices-in a study carried out in Bikita and Masvingo Districts in 2009, about 90% of the population were aware of HIV/AIDS. The level of education might have an impact on the successful administration of ART, HAART and NVP in PPTCT programmes. This is because there is need to follow laid down procedures and instructions properly. Rukuni, (2002) also contends that the ability to understand and follow instructions depends on the cognitive schemas the client holds. Thus, these research findings might serve to explain cases where couples may participate in PPTCT and the results prove otherwise. It is assumed that the respondents gave fairly mature, informed and valid responses.

**Table 4.3** Distribution of expecting couples by their occupational status (N=10)

CATEGORY	FREQUENCY	PERCENTAGE
Employed	3	30
Unemployed	3	30
Self-employed	4	40
TOTAL	10	100

From the table 4.3 above, research findings show that occupational status was a bit average as it recorded 30% unemployed and 40% self-employed. Some researchers like Olds, Wadening and London, (2009) argue that the occupational status of respondents have an impact on HIV/AIDS awareness as those participants who are employed may get information from workplaces through workshops.

#### 4.4 Responses to questionnaire items

**Table 4.4.1** PPTCT knowledge by expecting couples (N=10)

CATEGORY	FREQUENCY	PERCENTAGE (%)
A lot	8	80
A little	2	20
TOTAL	10	100

Table 4.4.1 shows about 80% of the participants having received more information on PPTCT. The researcher examined the respondents' knowledge and awareness of PPTCT programmes and the availability of related services. Results show that awareness of PPTCT services at the health centre was next to universal with most of the respondents indicating that they had knowledge and know that the services were available. Downing (2009) also posits that all couples need information about the advantages of HIV/AIDS testing and PPTCT interventions in protecting their children. This would translate into couples being aware of their HIV status and seeking help in good time.

**Table 4.4.2** Couple involvement in HIV/AIDS testing (N=10)

CATEGORY	VARIABLE	FREQUENCY	PERCENTAGE
Tested	Yes	7	70
Not tested	No	3	30
TOTAL		10	100

The results from Table 4.4.2 above indicate that 70% of the participants were involved in HIV/AIDS testing as a couple, and 30% did not. Those 30% who were not tested together might suggest fear of results as the main reason behind. Studies by Kishindo, (2004); Tadesse; Muula and Misiri, (2009) show that spouses are significant stakeholders in reproductive health programmes like actively taking part in PPTCT. By leaving out spouses, some women may experience domestic violence from their husbands through lack of support, being chased out of their homes and ultimate divorce. (UNGASS.2009). In Malawi, mothers who participated in PPTCT programmes without the blessing of their husbands reported that their families were disrupted after they had disclosed their HIV status to their partners. (Njunga and Blystad, 2010). In another study, women also suffered domestic violence after consenting to an HIV test without their husbands' approval. (Banjunirwe and Mizoora, 2009).

**Table 4.4.3** Couple involvement in counselling (N=10)

CATEGORY	VARIABLE	FREQUENCY	PERCENTAGE
Counselled	Yes	10	100
Not counselled	No	0	0
TOTAL		10	100

Table 4.4.3 shows that all the participants in the study underwent couple counselling on HIV/AIDS issues and PPTCT. Provision of couple counselling in PPTCT services allows cross-pollination of information on facts, support and decision-making, while increasing knowledge and awareness of measures to control the disease. (NAC, 2010). Getting counselled together also assists in getting rid of spousal opposition, especially from husbands which leads to divorce as highlighted above. Male partners are traditionally decision-makers in most homes and women on their right do not have the power to decide to independently join PPTCT programmes. This dictates women's role to be of lower profile thereby denying them autonomy to make own decisions. (Wits Institute of Sexual and Reproductive Health, 2011).

**Table 4.4.4** Knowledge of feeding options (N=10)

VARIABLE	FREQUENCY	PERCENTAGE (%)
Yes	10	100
No	0	0
TOTAL	10	100

The Table 4.4.4 above shows that all the participants were familiar with the dietary management and food intake related problems associated with HIV/AIDS patients. It follows that replacement of infant feeding or exclusive breastfeeding with abrupt weaning at 6 months which is recommended in PPTCT may not be the cultural practice in most parts of rural Africa. If a mother is HIV- positive and joins PPTCT services, the feeding options and the general

follow-up of the mother by health workers may lead to loss of confidentiality of the mother's HIV status.(Centre for Public Health Sciences,2011). Current research worldwide suggests that there are possibilities that HIV/AIDS can be transmitted through breast milk. There is evidence to indicate that the risk of transmission through breast milk is greatest if the mother becomes infected during the breastfeeding period. Thus, to reduce the risk of HIV/AIDS in breastfed infants, it becomes essential to avoid any risk of infection during the breastfeeding period. (Ministry Of Health and Child Welfare, 2010). Nutritional care and support for PLWHAs emphasises maintaining and optimising nutritional status. (Nutritional Unit, MHCW-2005).This is because nutrient deficiencies are difficult to reverse once established.

**Table 4.4.5 Importance of couple testing (N=10)**

VARIABLE	FREQUENCY	PERCENTAGE
Yes	7	70
No	3	30
TOTAL	10	100

The results in Table 4.4.5 above show that 70% of the respondents indicated that HIV/AIDS testing was an important part of PPTCT services. The 30% who felt that it was not important might have been fearing the stigma that is associated with testing positive, making them very uncomfortable. In a study carried out in rural Blantyre, Malawi, (2011); Malawian women have shown an overwhelming fear of being associated with immoral behaviour, fear of being linked to promiscuity, infidelity and prostitution. (Nyasulu, 2011). As such, a couple on PPTCT may fear that the extended family would no longer support and care for them. There might also be fear that friends will cut ties and start gossiping about them.

#### 4.2.2 Responses to questionnaire items for expecting couples who were not on Chikuku PPTCT programme

**Table 4.4.6 PPTCT knowledge of expecting couples who were not on Chikuku PPTCT programme (N=10)**

CATEGORY	FREQUENCY	PERCENTAGE
Not aware	0	0
A little	9	90
A lot	1	10
TOTAL	10	100

Table 4.4.6 shows that 90% of the respondents had little knowledge of PPTCT services and 10% had a lot of knowledge about it. Makore-Rukuni, (2003) posits that there are some myths associated with HIV/AIDS like where some people refer to the disease as resulting from curses or witchcraft. Coupled with this view, there are also cultural factors highlighted earlier and health system factors that impede access to and utilisation of PPTCT services. Health system factors include lack of appropriate follow-up mechanisms, inaccess to ART and poorly equipped manpower. In a study to find out about the barriers to the uptake of PPTCT infected, long waiting periods at VCT centres, fear of witchcraft, the high cost of infant feeds, lack of privacy and confidentiality when people join PPTCT services featured prominently. (Nyasulu, 2011). This might

serve to explain why some people may be aware of the PPTCT services but choose not to take part. To support full utilisation of PPTCT, there is need to raise awareness, enhance provision of free infant supplementary feeds, improve services at VCT centres, improve confidentiality and giving quality couple counselling.

**Table 4.4.7 Reasons for not joining PPTCT services (N=10)**

CATEGORY	FREQUENCY	PERCENTAGE
Fear	7	70
No interest	2	20
No knowledge	1	10
TOTAL	10	100

From the Table 4.4.7 above, 70% of the participants failed to join PPTCT services out of fear, 20% did not have an interest in it, while 10% did not have knowledge about it. Fear of stigmatising attitudes, fear of being blamed, ostracised, fear of being thrown out of the home and fear of the unknown factored in. In Ethiopia, there is a wider coverage of VCT and HIV/AIDS testing but low enrolment in PPTCT services as couples try to conceal their status in societies where stigma is still pervasive. This explains why most HIV positive couples are not linked to care and failing to prevent parent-to child HIV/AIDS transmission. (The International Journal of Population Research, 2012). In a study to determine willingness to participate in PPTCT services in Kilimanjaro, Tanzania, of the 138 respondents, 103 were not willing to participate. 61, 4% have never participated. The reasons cited for poor involvement in PPTCT services were being busy (25%), cultural reasons (22%) and lack of knowledge (22%). (Tanzania Medical Students Association, 2010). Against this background, some people just do not participate in PPTCT services because they do not realise their importance due to inadequate knowledge about the programmes, while others are hindered by cultural factors in communities which pose negative perceptions towards the programmes.

**Table 4.4.8 Appropriateness of couple counselling (N=10)**

CATEGORY	FREQUENCY	PERCENTAGE
Appropriate	9	90
Inappropriate	1	10
TOTAL	10	100

From the Table 4.4.8 above, 90% of the respondents indicated that the programme is appropriate. According to the MHCW (2005), the PPTCT programme is intended to equip the parents with information on HIV/AIDS awareness and transmission during pregnancy, labour, delivery and breastfeeding, the risk factors and strategies to reduce parent-to-child HIV/AIDS transmission. It was out of this understanding that the programme gained support even from nonparticipants.

**Table 4.4.9 The effectiveness of the PPTCT programme (N=10)**

CATEGORY	VARIABLE	FREQUENCY	PERCENTAGE
Effective	Yes	8	80
Ineffective	No	2	20
TOTAL		10	100

Table 4.4.9 above shows 80% of the respondents supporting the programme for being effective. One PPTCT participant reported, "If I know my status, I will take steps to protect the unborn child." Jackson (2002) also supports couple involvement in PPTCT programme for its long term protection against HIV infection. The 20% who did not support it felt that the programme is not 100% effective, identifying some intervening factors like the timely availability of sdNVP drugs in ART during delivery.

#### 4.2.3 Responses from the interview schedule for counsellors (N=5)

The five counsellors who were interviewed in the research were trained in relevant professional counselling. This was in keeping with Petasillia (1990) who adds that personnel should be qualified and specialised in order to provide treatment programmes that are tailor-made for the clients whom they counsel and serve. On the possibility of a child acquiring HIV/AIDS from the parent in PPTCT services, all the counsellors alluded to the fact that in the absence of preventative measures, the risk of the baby acquiring infection through pregnancy, labour, delivery and breastfeeding is between 25% to 30%. This points to other findings by Olds, Wadening and London, (2009) that PPTCT services are not 100% effective. One key counsellor reported, "Many health workers do not have the necessary skill and equipment to confidentially handle the delivery of an HIV positive pregnant woman, and given the risk of accidental exposure, most nurses shy away from dealing with such cases." It follows that many health workers are not enthusiastic about handling deliveries of women who are known to be HIV positive for fear of accidental infection. This underscores the need for the need the training of health facility staff in safety precautions and procedures. The other interview questions sought to bring out the external factors that militate against the effectiveness of the PPTCT programme. The counsellors were able to identify the factors associated with the high risk of PPTCT like the long duration following the rupture of the membranes, often in the form of artificial rupture of the membranes, (ARM) and other STDs which are acute. The MHCW (2005) adds that the invasive delivery techniques that increase the baby's contact with maternal blood also militate against the success of the PPTCT programmes. One counsellor alluded to the fact that stigmatising attitudes also manifest in the hospital setting. Also mentioned were inadequate referral structures within the hospital setting. In trying to address the above highlighted external factors that affect PPTCT services, the therapists mentioned education about safe sex, early treatment of STIs, ART, HAART, safe sex during the period of high risk of transmission. Some researchers also support the administration of certain obstetrical procedures like caesarean section deliveries, but the infant may in contact with the mother's blood which may increase vulnerability. (The Centre for Public Health Sciences, 2012). On constraints encountered in the PPTCT programmes, the counsellors highlighted ethical dilemmas, citing disclosure as the main bone of contention. Where one of the partners is HIV negative, failure to inform him or her about the status would place one of partners at risk of infection. In this regard, the counsellor faces dilemma involving the ethics of confidentiality versus social responsibility. One way of resolving the dilemma would be

to counsel the client to disclose his or her HIV status to the partner, where dual disclosures to partners should be encouraged. A key constraining issue identified in the interviews is inadequate monitoring and referring within the health system. One informant said, "We don't have appropriate monitoring strategies to follow up when HIV positive women miss antenatal appointments". Another counsellor reported, "Most couples are still able to avoid PPTCT services since we have no way of tracing them so that they don't go to other facilities when the time comes for delivery. The fact that we continue to see previously undiagnosed HIV positive women during labour indicates that something is not right." All the therapists also contended that there was need for strategies to address the current lapses within the health system. Also, because of the critical shortage of skilled manpower, inadequate physical infrastructures are some of the structural inadequacies. Additionally, it is important to develop monitoring and referral structures to promote follow-up and complement the already existing PPTCT services. (UNAIDS, 2011).

#### 4.4 Discussion

The aim of the study was to establish the impact of the PPTCT programme on prevention of parent-to-child HIV/AIDS transmission in Chikuku rural hospital community. A case study was conducted among purposively sampled couples of reproductive age groups using questionnaires with both closed and open-ended questions. The respondents comprised ten couples on Chikuku PPTCT programme, ten couples who were not on Chikuku PPTCT programme and five professional counsellors. The questions addressed the level of knowledge or awareness, the implementation and effectiveness of the PPTCT programme as well as some constraints encountered in its implementation. Partners were given questionnaires to collect their data including PPTCT activity for the past 12 months as recorded in the antenatal and maternity unit registers at the hospital. Awareness of PPTCT services and knowledge of its benefits were nearly universal, although socio-economic, cultural and health system factors including stigma and the desire to prevent knowledge of sero-status impede access to and utilisation of services. Although Zimbabwe has made significant progress on HIV/AIDS awareness and PPTCT services, utilisation of PPTCT remains low. According to the literature reviewed NAC (2011) postulates that 24% of the 12 to 19 age bracket continues to be plagued by the epidemic. The literature review section also mentioned the Zimbabwean government as expanding PPTCT services in ANC sites and improving access to HIV testing within PPTCT services. (Multiple Indicator Monitoring Survey, 2010). Most respondents identified the PPTCT services to be effective. However, there are some hurdles in monitoring this effectiveness. There is need for a validated consensus model for PPTCT effectiveness monitoring. This approach will compare progress across and coordinate the global response to HIV/AIDS prevention. Free child survival becomes a standard measure that could be adopted at a population level. (Demographic Health Survey, 2009). According to the literature reviewed, multiple studies have shown that high maternal HIV plasma viral load, low CD4 lymphocyte cell count, vaginal birth and breastfeeding

are the most important risk factors. (WHO, 2010). PPTCT services should, therefore, ensure high service coverage by systematically targeting each risk factor. But, safe alternatives, even basic antenatal services especially in some rural areas, are far from universal. (NAC, 2011). Information gleaned from the questionnaires and interviews suggests that couples recognise the importance of PPTCT services and the participants have all received HIV/AIDS counselling and testing. But, it is sometimes their desperation to conceal their positive status from close family members which will compel them to stay away from the health centres they were diagnosed and give birth at traditional birth attendants' homes where sero-status is unknown. Also, as couples become concerned about the ramifications of close family members becoming cognizant of their sero-status, efforts to improve PPTCT service effectiveness should identify and involve these significant others. (Zimbabwe National AIDS Strategic Plan, 2011-2015).

#### 4.5 Summary

The chapter dealt with the presentation, analysis, interpretation and discussion of data from the two questionnaires and the interview schedule, categorising it in tables using numerical scores and percentages to summarise it. The general findings reflect that there was universal knowledge and awareness of PPTCT services in Chikuku rural hospital community, but there are certain hurdles that need to be overcome in implementing and utilising PPTCT services effectively. The next chapter will give a summary and conclusion of the entire research report with the recommendations sealing off the chapter.

## CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

### 5.1 Introduction

This chapter will summarise the research report, draw conclusions and come up with some recommendations.

### 5.2 Summary

The research was carried out to investigate the perceived impact of the PPTCT programme on the management of parent-to-child HIV/AIDS transmission in Chikuku rural community. The study was placed in some understandable context and the conceptual framework related to it was also reviewed which helped in identifying information gaps to be filled by the predicted research findings. The research was based on a case study which was intended to obtain information through questionnaires and the interview schedule with both closed and open-ended questions. These research instruments addressed the three sub-problems in trying to solicit answers for the level of awareness, the impact of the PPTCT programme and how the programme was being implemented in Chikuku rural hospital community. The respondents comprised ten couples who were on Chikuku PPTCT programme, ten other couples who were not on Chikuku PPTCT programme but attending ANC there and five professional counsellors. The researcher used the purposive sampling technique and the participants were recruited on the basis of convenience to the researcher and willingness to participate. The findings reflect that there is a fairly high awareness of

PPTCT service but low uptake of the programme. The study had a number of limitations including the purposively selected hospital based sample of HIV-positive expecting couples from Chikuku rural hospital community which might not have adequately reflected the circumstances of the same people who do not frequent ANC. In addition, the data might have been inhibited by reporting bias due to interviews being conducted within the health facility and participants fearing negative repercussions that might result from them reporting their opinions. However, the findings show that the couples recognised the importance of PPTCT services through the high awareness shown although utilisation remains low. The study also uncovered some factors involving the interplay of social, cultural and healthcare infrastructure that militate against the effective implementation of PPTCT programme.

### 5.3 Conclusions

The following conclusions were drawn from the findings: The data collected indicated a high awareness of PPTCT services and knowledge of its benefits although some economic factors and health system factors militate against its effectiveness. Coupled with this; opposition from male partners, cultural practices in breastfeeding, stigma and discrimination, shortage of skills, fear of testing positive and lack of confidentiality when people join PPTCT, factored in as some of the barriers to effective utilisation of PPTCT services. On programme implementation and its impact, the study shows a low uptake of PPTCT in the study area. The study also uncovered numerous issues that inhibit expecting sero-positive couples from taking part in PPTCT services especially in resource-constrained settings like Chikuku rural hospital community. Poor healthcare infrastructure, shortage of skilled staff, poor referral links featured as some of the impediments to the effective implementation of PPTCT in the study area.

### 5.4 Recommendations

The following recommendations are made:

- ❖ To achieve the targets in view of these findings, it would require a thorough review and reorganisation of the existing policies and current approaches to increase PPTCT service uptake especially in communities similar to the study area. Addressing these contextual problems would require engaging communities in making them understand the importance of PPTCT services, developing innovative and sustainable strategies for removing the barriers that sero-positive couples face in accessing and utilising PPTCT services.
- ❖ There should also be action to strengthen health systems in particular ANC, MCH and other services including efforts to train, motivate and retain health workers and also to improve their equipment.
- ❖ The researcher makes a clarion call for the increased access to HIV/AIDS services, counselling and testing, ART, HAART including for eligible pregnant women, with the health system playing an important role of reducing stigma and discrimination.

- ❖ At the national level, there is also need to establish effective management and coordination mechanisms.

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## APPENDICES

### QUESTIONNAIRE FOR COUPLES ON CHIKUKU PPTCT PROGRAMME

#### PREAMBLE

I am a Zimbabwe Open University student doing a BSc.Hons Counselling Degree and carrying out research on the impact of the PPTCT programme on the management of parent-to-child HIV/AIDS transmission in Chikuku rural community. Please kindly assist by providing information through completing the questionnaire. The information being requested will be confidential. No names will be required. Your participation in this exercise will be voluntary and your accepting to take part will be greatly appreciated.

#### COMPLETE THE QUESTIONNAIRE BY TICKING ON THE APPROPRIATE AND EXPLAINING WHERE REQUIRED

#### SECTION A: Demographic Data

##### 1. Age in years:

- 17-25
- 26-35
- 36-45
- 46-50

**2. Level of Education:**

- Primary
- Secondary
- Tertiary
- Other, Specify.....

**3. Occupation:**

- Employed
- Unemployed
- Self-employed

**SECTION B: PPTCT KNOWLEDGE**

**1. What do you understand by PPTCT?**

- I understand a little.
- I understand a lot.
- Other, Specify.....

**2. Were you and partner tested together?**

Yes	
No	

**3. Were you and partner counselled together?**

Yes	
No	

**4. Were you told about feeding options?**

Yes	
No	

**5. Do you think HIV testing of expecting couples is important?**

Yes	
No	

Explain your answer.....  
.....

**QUESTIONNAIRE FOR EXPECTING MOTHERS WHO ARE NOT ON CHIKUKU PPTCT PROGRAMME.**

I am a Zimbabwe Open University student pursuing a BSc Hons Counselling Degree research on the impact of the PPTCT programme on the management of parent-to-child HIV/AIDS transmission as perceived by the Chikuku community. I am asking for your views on PPTCT programmes. The information you will provide will be treated confidentially and no names will be required. Your agreeing to take part will be highly appreciated.

**TICK AND EXPLAIN WHERE APPROPRIATE.**

**1. What do you understand by PPTCT?**

- I don't understand.
- I understand a little.
- I understand a lot.
- Other, Specify.....

**2. Have you participated in PPTCT?**

Yes	
No	

**3. If you haven't joined PPTCT, what were your reasons for not doing so?**

- Fear
- Not interested
- Lack of knowledge

**4. Do you consider couples counselling appropriate?**

Yes	
No	

**5. In your opinion, is this programme effective?**

Yes	
No	

Explain your answer.....

**INTERVIEW SCHEDULE FOR COUNSELLORS**

**PREAMBLE**

I am a Zimbabwe Open University student doing a BSc Hons Counselling degree study on the impact of the PPTCT programme on the management of parent to child HIV/AIDS transmission. The information being sought is only for academic study to fulfil some of the requirements for the degree programme. No information will be published elsewhere for confidentiality to be maintained. Thank you most sincerely for agreeing to take part.

**Interview Questions**

1. Is there a possibility that after the expecting mother undergoes PPTCT, the child can still tests positive?

Explain.....  
.....

2. Are there any external factors that might affect the effectiveness of PPTCT programme?

3. What measures, if any, are available to address the external factors that might reduce the effectiveness of PPTCT?

4. How successful has been the PPTCT programme?

5. Is there any link between attending counselling and results after carrying out an HIV test on the child at 18months?

6. Are there any constrains that might affect counsellors in their proper execution of their duties in relation to the PPTCT programme?

7. Do expecting couples readily accept to join PPTCT programmes?

**CHISHONA TRANSLATION****MIBVUNZO YEMADZIMAI AKAZVITAKURA NEVARUME VAVO****NHANGANYAYA**

Ndiri mudzidzi weZimbabwe Open University ari muchidzidzo cheBScHons Counselling.Ndiri kuita tsvagurudzo maererano nemaonerwe ari kuitwa chironywa chokudzivirirwa kwekutapurwa kweutachiona hweHIV/AIDS kubva kumubereki kuenda kumwana,(PPTCT)munzvimbo yeChikuku.Ndinokumbirawo kuti mupindure mibvunzo iri muchinyorwa chino muchitaura zvamunofunga pamafambisirwe echironywa ichi.Hapana chakaipa chinaitika kwamuri kana kurasikirwa nacho uye hamumanikidzwi kubatsira mutsvagurudzo ino nemazita enyu haazonyorwi pasi.Hapanazve mumwe munhu anozoudzwa.

**CHIKAMU A:Ruzivo Pamusoro Pemunhu****1. Mune makore angave papi?**

17-25  
26-35  
36-45  
46-50

**Zvekuroorwa:**

Handisati  
Ndakarooorwa  
Ndakarambwa  
Zvimwewo,Tsanangurai.....

**3. Danho Redzidzo:**

Puraimari  
Sekondari  
Koreji  
Zvimwewo,Tsanangurai.....

**4.Zvamabasa:**

Ndinosevenza  
Handisevenzi  
Ndinokorokoza

**CHIKAMU B:Ruzivo nezvechironywa chePPTCT****1.Chii chamunoziva nezvechironywa chokutapurwa kweutachiona hwe HIV/AIDS kubva kumubereki kuenda kumwana,PPTCT?**

Hapana  
Zvishoma  
Zvakawanda  
Zvimwewo,Tsanangurai.....

**2.Ko makaongororwa ropa muri murume nomukadzi here?**

Hongu  
Kwete

**3.Makambopiwa ruzivo rwezvokugara nokurarama noutachiona uhwu nemamwe mazano here?**

Hongu  
Kwete

**4. Makadzidziswa nezvokudya kwomuचेचे kwakakodzera here?**

Hongu  
Kwete

**5.Munofunga kuti kuongororwa kwababa namai pamwepo kwakakosha here?**

Hongu  
Kwete

**MIBVUNZO YEMADZIMAI AKAZVITAKURA ANOSHANYIRA CHIPATARA CHECHIKUKU ASI ASIRI MUCHIRONGWA CHEPPTCT PACHIPATARA APA.****NHANGANYAYA**

Ndiri kuita tsvagurudzo maererano nematambirirwe ari kuitwa chironywa chokudzivirirwa kwekutapurwa kweutachiona hweHIV/AIDS kubva kumubereki kuenda kumwana,(PPTCT), munzvimbo yekwaChikuku.Ndinokumbirawo kuti mupindure mibvunzo iyi muchinyorwa chino muchitaura zvamunofunga maererano nechironywa ichi.Hapana chamunorasikirwa nacho mukubetsera mutsvagurudzo ino,uye hamumanikidzwi kuita izvi.Mazita enyu haazonyorwi pasi uye hapana mumwe munhu anozoudzwa nezvazvo.

**1. Chii chamunoziva nezvechironywa chePPTCT?**

Hapana  
Zvishoma  
Zvakawanda  
Zvimwewo,Tsanangurai.....

**2. Makambodzidziswa here nezvechironywa chePPTCT?**

Hongu  
Kwete  
Tsanangurai .....

**3. Makapinda muchironywa chePPTCT here?**

Hongu  
Kwete

**4. Kana musina kupinda muchironywa chePPTCT,zvikonzero zvipi zvakakukonesai?.**

Kutya  
Kusazvifarira  
Kushaya ruzivo

**5. Zvakakosha here kuwana ruzivo nemazano okuzvichengetedza sababa namai?**

Hongu  
Kwete

**6. Munofungei nemafambisirwe ari kuitwa chironywa chePPTCT pachipatara cheChikuku?**

Akanaka  
Handiziviwo

**7. Semaonero enyu chironywa chePPTCT chinobetsera here?**

Tsanangurai.....  
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**ABOUT THE AUTHOR**

Mashamba Tarashika is a qualified Zimbabwean teacher. His teaching stint stretches from year 2000 to date. He holds a diploma in education from the University of

Zimbabwe, a Bachelor of Science Honours in Counselling from the Zimbabwe Open University. He is currently a candidate of the Master of Social Science in Counselling Psychology degree with the Great Zimbabwe University.