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# Perceptions About Barriers and Promoting Factors Among Service Providers and Community Members on PMTCT Services

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## 1. Introduction

Mother-to-child transmission (MTCT) of HIV is a global problem. Annually, MTCT accounts for almost two-thirds of the new infections that occur in children world-wide. Each year, at least 2 million women become infected with HIV, mainly as a result of heterosexual transmission, and approximately 750 000 children acquire HIV infection, mostly through MTCT. MTCT varies widely and is dependent on obstetric practices, mode of delivery, breastfeeding, and the mother's level of the viral load. (Moodley and Moodley 2005; UNAIDS, 2004). HIV is transmitted from mother-to-child at various stages of pregnancy including in utero, intrapartum and during breastfeeding. Untreated 20-40% of infants born to HIV infected mothers will be infected as well, whereas a combination of antiretroviral therapy during pregnancy, elective caesarean section and bottle feeding reduce the risk of vertical transmission to below 2% (Newell, 2006).

There are over 42 million people living with HIV/AIDS worldwide, 38.6 million of these are adults, 19.2 million are women and 3.2 million are children aged below 15. A total of over 3 million people have already died of HIV/AIDS related illness. More than 90% of people living with HIV are in developing countries, with sub-Saharan Africa accounting for two thirds of all the HIV-infected people in the world (AMN, 2005; UNAIDS, 2004). As the virus is predominantly transmitted through sexual contact, equal numbers of males and females are infected, mainly young people of reproductive age. Hence, there is a growing number of HIV positive children infected during pregnancy, delivery or through breast milk. The interventions have therefore, been aimed at effectively providing alternatives to breastfeeding and limiting the risk of newborn infection. Some of the interventions that limit MTCT are using caesarian section as the mode of delivery and administering antiretroviral (ARV) drugs prepartum and peripartum. However, these approaches are not always possible in developing countries and the use of ARV drugs, in particular nevirapine (NVP), zidovudine (ZDV) and zidovudine/lamivudine, have been investigated in both developing and developed countries (Giaquito et al., 2006). Although the available methods of interventions are widely used in the industrialized world, implementation seems difficult in developing countries because of political, financial, logical and societal factors. Screening of pregnant women and identification of HIV positive mothers can result in violence, rejection

and stigmatization, and has to be put in the balance of programmes aiming at reducing the number of infected children.

Malawi's HIV infection rate is estimated to be at least 14% among the adult population aged between 15 – 49 (MDHS, 2004). Over 70% of hospital beds in Malawi are occupied by people with HIV/AIDS related conditions. Survey of tuberculosis (TB) patients has revealed that over 70% are co-infected with HIV. Life expectancy which was estimated to have been over 55 years without AIDS has now come down to 42 for men and 41 for women with AIDS (UNAIDS 2006). Of the people infected with HIV virus, women and children are more infected than men. It is estimated that HIV prevalence among pregnant women may be between 19 and 30 percent (Baylor aids, 2005).

PMTCT programmes continue to be a priority as MTCT accounts for 30 percent of all new infections in Malawi and is the second major mode of transmission after unprotected sex. Every year, an estimated 30,000 babies are born HIV positive. It was for this reason that in 2001, Malawi initiated 3 PMTCT sites and in 2003, the launching was done. PMTCT programmes are being implemented by every district in Malawi and by end of 2005, PMTCT services were being implemented in 36 sites (Buhendwa, 2003). Relatively simple interventions to lower the risk of infection are available to only a small number of women and lag far behind the country's antiretroviral therapy (ART) programme, which now reaches 70,000 HIV-infected people or about 40 percent of those who need them. In 2005, 5,054 women received NVP, an ARV drug that lowers the chances of a mother infecting her baby by up to 40 percent. This was almost twice the number who received the drug in 2004 but in reality there is less total number of pregnant women in Malawi who accessed PMTCT services so far as more pregnant mothers continue to be infected (IRIN, 2007).

With the introduction of opt-out strategy in the PMTCT programme, most antenatal mothers fail to access the services as required due to problems. Women feared transportation and supplementary food costs, referral hospitals' reputation for being unfriendly and confusing and difficulties in sustaining long-term treatment would limit accessibility. Fear of stigma framed all concerns, posing challenges for contacting referrals who did not want their status disclosed (Mshana et al., 2006). The problems that limit women to access the PMTCT services can be minimized if they hold dialogue with their spouses before HIV testing. This is because as they accept HIV testing, some women decide not to inform their spouses when tested in the absence of the male spouse. Male involvement and couple counseling have been advocated as having a positive influence on the women's accessibility to the PMTCT services (Homsy et al., 2006).

A single dose of NVP given to the mother at the onset of labour and to the baby within 72 hours after delivery reduces HIV transmission rates by 38-50% and is relatively cheap and easy to administer (Avert.org. 2005; Lallemand et al., 2004; Halkin *et al.*, 2005, Scarlatti, 2004). While this is an opportunity to provide infected mothers with the ART, there is also need for mothers to know and accept their situation.

Not all antenatal mothers in the Malamulo Hospital catchment area access maternal services at the hospital. Some of them continue to access delivery services at the traditional birth attendants (TBAs) despite attending antenatal services. More emphasis is put on the women to understand their situation and access PMTCT services but PMTCT coverage continues to be low. Not much is reported about the perceptions and factors of the service providers and

communities hindering antenatal mothers from accessing PMTCT services. Therefore, the study aimed at exploring barriers and promoting factors to delivery of PMTCT services as perceived by service providers and community members. The findings would be useful in providing the basis for understanding women's situations and be able to provide them with the needed support in order to increase accessibility of PMTCT services and reduce MTCT.

## 2. Methods

### 2.1 Study design

Qualitative study using focus group discussions (FGDs), part of wider operations of HIV/AIDS prevention project around local introduction and scale up of PMTCT services for antenatal mothers.

### 2.2 Study area

Malamulo mission hospital is owned by the Seventh Day Adventist Church and is located in the southern region of Malawi, 65 km south east of Blantyre City in Thyolo District. It was established in 1902 and remains the headquarters of the Adventist Church in Malawi. The hospital has 15 mobile sites with 2 health centres and collaborates with other Non-Governmental Organizations (NGOs) including Thyolo District Hospital. The Government and NGOs deliver health care in Malawi. Among the NGOs, faith based institutions ran health facilities but are subsidized by the Government. These faith based health facilities belong to an organization called Christian Health Association of Malawi (CHAM). Malamulo hospital has a membership to this organization and the study was done within its catchment area.

Malamulo runs an Integrated HIV/AIDS Prevention Project with local and external support. At the time when this study was done, it was largely funded by USAID through an international organization called Private Partners Collaborating Together (PACT). The components were voluntary counseling and testing (VCT), management of sexually transmitted infections (STIs), home based care (HBC), youth friendly health services (YFHS), family planning (FP), prevention of mother to child transmission (PMTCT) of HIV, ART provision, nutrition, static and outreach mother and child health (MCH) services.

Thyolo is one of the districts in Malawi that receives highest rainfall annually. Tea and coffee estates surround Malamulo hospital. The hospital is one of the teaching institutions in the country for allied health workers and has 300 beds. It serves an estimated population of a little over 70,000. Communication is a problem due to poor roads and worsens during rainy season. The people's socio-economic status in this area is low. Many of them are seasonal migrant workers for the tea and coffee estates. Most people are peasant farmers who grow maize, beans, cassava and bananas mainly for home consumption. Crop harvest is usually poor since most of the people are not using modern farming methods. Malnutrition, communicable diseases such as malaria, worm infestation, TB, diarrhea diseases and STIs including HIV/AIDS are common. HIV prevalence in this population is 16% slightly higher than the national one of 14% (MDHS, 2004). Many families have experienced a loss of a member due to AIDS and the number of orphans is also high. Cultural practices such as wife inheritance among other factors are responsible for HIV proliferation.

### **2.3 Malamulo hospital PMTCT Programme**

Malamulo hospital PMTCT services began in July 2004. More antenatal care (ANC) mothers accessing services at Malamulo tested HIV positive. Malawi Government through its Health Ministry assessed the hospital and determined it legible for the ART provision in the area. Malamulo began full ART service provision in August 2004. Over 500 people have already accessed ART, 200 HIV infected antenatal mothers and 100 babies have been provided with NVP.

Malamulo PMTCT programme is a PMTCT plus because it supports the provision of specialised care to HIV-infected women namely ART, STIs, HBC, infant feeding practices and nutrition. It further adopts national and international standards according to World Health Organisation (WHO). The strategies used are primary prevention in child bearing age for both men and women, prevention of unwanted pregnancy, prevention of HIV infection from an infected mother to the child by providing NVP to them, counsel and support on safe infant feeding, care continuum for mother and baby. The working areas are antenatal, labour and delivery, postnatal and community support.

### **2.4 Sampling of informants**

The informants were purposively selected based on the theoretical assumption that there were variations and range of perceptions by community members and service providers towards the delivery of Malamulo Hospital PMTCT services. The informants were in five groups namely: 1) men, 2) women, 3) village headmen, 4) religious leaders and 5) health workers. These were community members from the 15 villages that surround the hospital and were in their child bearing ages and beyond. Their proximity to the hospital, involvement in the health services and being within 15 villages from where most service users come including antenatal mothers made them legible to participate in the study. On average, participants lived at distance ranging from 5 - 15 km away from the hospital and for logistic reasons; it was possible to reach them at such a distance.

### **2.5 Data collection**

The audio taped FGDs were conducted from October 2006 - February 2007. Appointments to get permission to conduct FGDs were made to the village headmen, heads of household and the participants before the due dates. At the time of appointments, explanations were made about who the researcher was, the fact that the study would help to get deeper understanding of their perceptions about barriers and promoting factors on the delivery of PMTCT services and possible benefits. A guide was used during the FGDs in an open conversation. It consisted of themes namely; role in pregnancy and sickness, common practices and norms related to pregnancy, home or hospital deliveries, antenatal and PMTCT services. One FGD was postponed to a later date because it was raining heavily and there was a function at the venue on that day.

Two pictures showing hospital and home deliveries were used as a starter. A total of 9 FGDs were conducted by the author with two assistants. Of these, 2 sessions were held with each of the following; women, men, village headmen, religious leaders and 1 with the health workers. To ensure privacy, all FGDs were done in a room as per participants' choice. The local school head master permitted us to use one of his school classrooms. Participants



anonymously agreed to start the discussions and end with prayers. The discussions were conducted in the afternoon to accommodate the working schedules of the participants. As no new information seemed to be emerging, and given the paucity of the participants who were willing to share openly about their perceptions towards PMTCT services, data collection was deemed complete after the ninth group. The FGDs lasted from 90 to 135 minutes. Participants were served with soft drinks before returning to their homes.

## 2.6 Data analysis

Data were analyzed qualitatively using content analysis guided by Graneheim and Lundman (2004). The process was facilitated by use of the open code soft ware developed at Umeå University, Sweden (Open Code, 2007). Texts were transcribed verbatim, open coding, categories, properties and dimensions were made (Tables 1, 2 and 3). Based on the coded data and themes were developed to explain perceptions about barriers and promoting factors among service providers and community members on the delivery of the PMTCT services.

## 2.7 Ethical consideration

Consent was obtained from Malamulo Hospital Administrative Council. Chiefs and respondents gave their oral informed consent as well. A further permission was obtained from the Health Sciences Research Council in the Ministry of Health, Malawi. All the respondents were assured that information given would be treated with strict confidentiality.

Extra marital sex	Self decided	Delivered alone	Unfaithful
Sex abstinence	Partner involvement	Disappointing	HIV testing
Pregnancy	ANC information	Women shouted	Prevention
Norms	Money given	No attention	Protective
Love	Husband prepared	Good	Infected women
Sex life	Hospital	Kind	Unprotected
Marriage	Delivery	Respect	Sickness
Stillbirth	Home	Uninterested	Condom use
Shameful	Timing	Abandon	Counseled
Adultery	Relatives involved	Patients	Cried for self
Church beliefs	Support	Problem	Health workers

Table 1. List of open codes

Beliefs	HIV testing	Place of delivery	Role in sickness and pregnancy	Suggested solutions
Couples counseled	Condom use	No medicine at home	Supportive man	Promote condom use
Couples to be faithful	Unfaithful man	Unskilled TBAs	Prayed for sickness	H/ workers as models
Sex stops before delivery	Infected couples	TBAs are attentive	Sick sent to hospital	Team work
Sex resumes after delivery	Tested HIV positive	Less expensive care	Preparations made	Older nurses to help
Herbs used in pregnancy	Wife took HIV test	Safe hospital delivery	Child care	Leadership to help
Fisi allowed if man infertile	Husband refused	Distance, sudden pains	Pregnant lady to rest	Educate communities
Baby covered with sperms	STIs are dangerous	Abandoned women	Husband to love wife	Less trainees in ward
Sex nourishes pregnancy	Protection	Women deliver alone	Church helps in kind	Behavioral change
Never eat eggs in pregnancy	ART-benefits	Decision discussed	Chiefs help the sick	Empower community
Offals uneaten in pregnancy	Babies free of HIV	Decision made alone	Patients' care	Discuss problems
Socks not used in pregnancy				

Table 2. Categories

Category	Properties	Dimensions
Discrimination	Extent	Less or more
Few months	Extent	Less or more
Behavioral change	Degree	Self or others
Disease	Degree	Self or others
Support	Origin	Felt or enacted
Responsibility	Origin	Felt or enacted
Environment	Impact	Partly or fully

Table 3. Examples of categories, properties and dimensions

### 3. Results

A total of 9 FGDs were conducted with 69 participants grouped by gender, age and occupation. At least one member from the 15 villages that surround the hospital participated in the discussions. Of the 69 participants, 47 were males and 22 were females with the mean age of 28.5 years. Fifty six were married and thirteen were singles. The participants' number of children ranged from 1 to 8 with average to low socio-economic status. The clergy represented Christians and Moslems and so were the participants. The participants' education ranged from primary school to tertiary levels and five had none.

Four themes about barriers and promoting factors on PMTCT services as perceived by service providers and community members emerged: 1) Decision: Place of delivery, 2) Perceptions concerning service providers at hospital and home deliveries, 3) Perceptions of the role of communities during pregnancy and sickness and 4) Perceptions of community interventions (Table 4). Decision: Place of delivery was referred to the decision maker and the circumstances that surrounded the place of choice for delivery. Perceptions concerning service providers at hospital and home deliveries was referred to the attitude and knowledge of the birth attendants at community and hospital levels.

Perceptions of the role of communities during pregnancy and sickness referred to the responsibilities assumed by communities at different levels in taking care of pregnant women and the sick. Perceptions of community interventions referred to suggested solutions to improve service delivery and accessibility as perceived by the participants. Involvement of care givers and their recipients is included in this theme.

#### 3.1 Decision: Place of delivery

Men decided for their pregnant wives where to deliver and to a large extent women obeyed their husbands' decisions. Some informants reported that decisions were discussed between partners, partners and family members and in certain rare situations women decided by themselves. Grandmothers, mothers and friends influenced the decisions based on their past delivery experiences. It was mentioned that previous experiences with the health facilities such as ANC information, treatment in the ANC and labour ward and family support influenced decisions about where to deliver. A female participant explained how her husband decided for her where to deliver:

*"For me it is my husband who reminds me when to begin ANC. This is because he knows my dates and is very good at encouraging me to go for hospital delivery. He also keeps money to meet delivery expenses. He buys me a piece of cloth, basin and a plastic bag among other things".*

Codes	Categories	Themes
My decision Husband's decision Discussed with partner Mother's decision Grandmother's decision Relative's decision Friends' decision Useful ANC information Given money by husband Husband-encouraging Safe hospital delivery Unsafe home delivery	Supportive husband Family support Supportive health care system Tradition	Decision: Place of delivery
Rude nurses in labour ward Delivered alone in labour ward Female nurses -disrespecting Male nurses- helpful Polite nurses in ANC Women respected in ANC Trainee nurses-less competent Trainee nurses-playful Hospital skilled personnel Home-unskilled personnel TBAs respect women TBAs' care is good	Health workers' supportive attitude Health workers' unsupportive attitude Health workers' job knowledge	Perceptions concerning service providers at hospital and home deliveries
Prepared for delivery experiences Material and moral support Couples advised on norms to follow TBAs-important for delivery Traditional healers-important for sickness Home remedy-priority before hospital Hospital treatment-encouraged Spiritual support Communities' help Patients' visited HIV/AIDS awareness Circumstances	Family care Community care Religious perspective Health personnel's views	Perceptions of the role of communities during pregnancy and sickness
Trainees supervised Health promotion Labour ward-full time nurse Leadership-important Approachable male nurses Behavioural change Promote condom use Women' early reporting Good nurses rewarded Rude nurses reprimanded Trained TBAs- important Traditional norms complied	Interventions at hospital level Interventions at community level Service recipients' role	Perceptions of community interventions

Table 4. Themes, categories and codes

Participants reported that hospital delivery was better because of safety as opposed to home delivery. Some participants felt that although home delivery was regarded as unsafe but was ideal for them because they got used to certain birth attendants and needed no preparations to access the services. It was further cited by one male participant whose wife had 8 home deliveries without complications that it was relatively cheap to have home delivery as compared with hospital delivery.



Participants stated that complications with home deliveries such as maternal and child deaths influenced women to seek hospital deliveries. Female participants with past hospital and home delivery experiences described home delivery area as unhygienic which would predispose them to infection after delivery and such situation rarely happened with hospital delivery. Participants' views on where to deliver were explained in the following way:

*"Women deliver at home because of negligence, beliefs and lack of transport. They say if grandmothers had several home deliveries without complications, why bother and have specific people to assist them during delivery. Home delivery women with difficulties seek hospital deliveries and these are good examples for women in the communities to appreciate the hospital services".*

### **3.2 Perceptions concerning service providers at hospital and home deliveries**

Female participants reported that nurses in the ANC were kind, polite and willing to help and male participants had similar impressions from their wives. Nurses in the ANC provided the women with adequate information on various health issues, treated women with respect, and motivated them to attend ANC. It was also mentioned that traditional birth attendants were equally good at treating women with care and respect and this attracted more women to them.

Participants reported that nurses in the labour ward did not respect them, were rude, and shouted at women during delivery and some of them delivered alone. This situation made women have their deliveries at the traditional birth attendants where respect and kindness were shown to them regardless of regular ANC attendance. Below is the description on how participants viewed service providers at ANC and labour ward:

*"The antenatal care clinic is fine but difficulties are found in labour ward. As nurses conduct examinations in the labour ward, the way they talk it is as if they are not willing to help. In the antenatal care, we are free to ask questions and the nurses explain and answer most of them and wherever necessary, we are referred to a doctor depending on our problems".*

Some participants expressed that male nurses were kind, respected them during delivery and were full time in labour ward monitoring the women until delivery:

*"Female nurses are rude in the labour ward. They often tell pregnant woman that her time for delivery is not yet due while it is not true. As the woman leaves the labour ward she delivers on her own. My wife told me and this happened to her. Male nurses behave well and assist women to deliver with respect, dignity and rarely women complain of them".*

All the participants stated that service providers at the hospital had knowledge, skills, medications and equipment to carry out their functions in a professional way. Therefore, they felt that hospital delivery was safe because if something went wrong during delivery, women would easily be assisted. It was mentioned that birth attendants at home had little or no education, limited knowledge, skills and lacked equipment to carry out the delivery services. Some participants stated that it was mere chance that women had successful home deliveries and recalled several incidences where women or infants died during delivery. They said that women die from preventable causes from home delivery.

### 3.3 Perceptions of the role of communities during pregnancy and sickness

All the participants stated that pregnancy needed their attention to enable women deliver successfully. Couples had sole responsibilities for the care and particularly the husband was expected to look after his pregnant wife as determined by marriage counsels. It was mentioned that during pregnancy, the couples were advised to follow the norms and make preparations for deliveries. At family level the pregnant woman was provided with basic needs such as food and was advised to start ANC on time. Participants viewed both pregnancy and sickness as events that brought all the communities together. Below is the participants' common impression on sickness:

*"I take part in pregnancy and sickness. When one of my family members gets sick, I send him to the hospital for treatment. I do the same with anyone within my village. We use a stretcher to carry the sick to the hospital. We often come together as people living in the village to help carry the sick to the hospital. We do not leave this task with the patients' families only".*

People outside the families helped pregnant women especially if their families were failing to fulfill certain obligations such as encouraging early antenatal attendance and material support. The religious leaders provided the pregnant women with moral and spiritual support and the participants encouraged utilization of health services during pregnancy and sickness. Health personnel participants stated that some young women failed to attend ANC because of laziness and obedience to their older women who usually encouraged home delivery. They further said that they were eager to see as many women in the ANC and delivery suits as possible to reduce maternal and infants mortality rates.

It was mentioned that pregnancy and sickness were associated with norms and traditional healers or birth attendants were consulted before going to the hospital. Some traditional beliefs encouraged regular intake of local herbs, home delivery and discouraged antenatal attendants to avoid getting instructions which were difficult to follow. Pregnant women were disallowed to eat offals, stand or sit at the door and husbands were not allowed to put on neck ties or socks because such things would lead to difficulties in delivery. They were further discouraged from eating eggs because this would cause chronic abdominal pains. Coincidentally, one of the HIV infected participants shared his experiences with others in stressing the importance of seeking medical treatment in sickness in the following way:

*"I got sick for a long time, eaten several herbs but did not help me until the time I went to the hospital. I tested HIV positive and I do not hide, I tell people about this. I tell them that if they fall sick, they should go to the hospital. If I did not go to the hospital, by now I should have been dead. Today I have life and leading the normal life. I am the living example and I tell people in my village to first go to the hospital. If there is no improvement after going to the hospital, then they can go to the traditional healers".*

On average, the participants abstained from sexual contact between 6-8 months before delivery and resumed it 6 months after delivery. They followed this norm to avoid traumatizing the infants, delivering deformed babies covered with sperms, malnutrition or having unwanted pregnancies. It was also reported that participants were advised to stick to each other if they were married and HIV negative (practice mutual faithfulness), use condoms if they were HIV positive or not sure of their HIV status or practice abstinence if they were not married to avoid contracting sexually transmitted infections and HIV/AIDS. Where men failed to have their wives pregnant, elders arranged that fertile men slept with

the women on mutual agreements with their husbands. The practice was called “Fisi” but was being discouraged nowadays due to HIV/AIDS.

The participants expected women to be submissive to their husbands in all matters relating to family life. Male participants suggested that before going for HIV testing, women should consult their husbands as failure to do so would cause family problems. Some participants felt that they would go for HIV testing if they thought of being HIV infected or if they got sick.

### 3.4 Perceptions of community interventions

While participants mentioned the health systems’ strengths and weaknesses, also chanted the way forward. Some participants reported that the improvements should involve all the partners who came into play. They mentioned that the health facility’s leadership should help the service providers’ attitudinal change into a more responsive and willingness to care for the recipients. The participants suggested the following; health promotion, trainee supervision, rewarding hard working nurses, disciplining the rude nurses and communicating the effected changes with the communities. All participants mentioned that the labour ward needed much attention as other hospital departments. Participants felt that it was the right time to express their problems:

*“The problem is with us because we hide. When the woman is in labour, the nurses are usually not present. The woman delivers alone and this is the report that we often get. Here we need to correct the situation. We request that nurses should be able to monitor the woman who goes into labour until delivery”.*

The ages of the trainee nurses and how they handled women in labour ward raised concerns:

*“The problem is that some of the nurses are very young, never delivered before but have to conduct deliveries. They disrespect the pregnant mothers due to lack of experience. It is important that a qualified nurse should always guide trainee nurses so that what is done should be of high quality and standard”.*

The participants requested training of the traditional birth attendants (TBAs) to assist women who may access their services due to unavoidable circumstances such as sudden labour pains. Some participants felt that empowerment of local communities would help them to be responsible for their health issues. Participants reported that individual families and the women should understand the importance of accessing health care services on time. It was mentioned that early reporting in sickness and regular ANC attendance, hospital delivery and discouraging norms that were detrimental to their health would be the way forward.

All participants were responsible for the sick in their communities and needed them to access health facility treatment on time. They further reported that they discouraged the tendency of seeking traditional remedy before the modern medical treatment. Health personnel participants felt that they needed to be role models and be able to treat their service users with respect and dignity. Below is their expression on this:

*“We need to be role models. Pregnant women should be given time to explain their side of the story and do as they wish. They should be told properly about HIV testing and allowed to decide to take the test or not. They should never be shouted at since pregnancy and delivery are stressful”.*

#### 4. Discussions

The study revealed that men largely decided for their pregnant wives where to access health care and delivery services. This is consistent with the conventional wisdom that men are dominant decision makers in matters relating to fertility (Maharaj and Cleland, 2005). This has several implications; it may be a male dominant society where men are decision makers for their families leading to women's limitations in making independent choices for their lives as is the case in other societies (Santelli et al, 2006). Further, if men were unsupportive then their wives may be negatively affected and in certain situations, family support, positive health care reputations and discussions with wives influenced decisions. Women verified their decisions with husbands, relatives or friends and were inclined to seek home delivery which showed that traditional beliefs were deep rooted in this society. This may also suggest that women in this study were less empowered to pose as powerful predictor of where they would wish to deliver.

The study showed that service providers at health facility and local levels influenced the community's acceptability and accessibility of the health services including PMTCT services. This is an important finding and it may imply that utilization of the health service is dependent on how well the recipients are treated, the trust the service users have in the service providers and the job knowledge. However, attitude and ability to treat patients with dignity and respect have a great role in influencing people's willingness to access the services (Mathole et al., 2005; Owens, 2005; Hilget and Gill, 2007). This may suggest that people seek traditional health care than modern health so long they feel welcomed and seen not as nuisance preventing others from resting. Interestingly, male nurses were more preferred than female nurses by women in the labour ward because of their dedication and respect they showed to the women in caring for them to deliver. This further implies that the long traditional culture that disregarded male nurses in delivery places is changing. Males are therefore equally accepted to conduct deliveries in labour ward as female nurses given the job knowledge and eagerness to utilize it in a dignified manner.

Pregnancy and sickness in general seemed to be community unifying events in this study. Families and communities at various levels took part in alleviating human suffering. This is congruent with what was obtained before (Mant et. al., 2005). This has several implications; families prepared for pregnant outcome and this extend to the community at large where responsible individuals were indoctrinated with traditional ideologies coupled with modern health care. Primarily, pregnant women and the sick sought remedies for their ailments from the traditional birth attendants or traditional healers and if encountered no problems, it became the habit at the expense of the modern health care. This suggests an opportunity to instill long lasting modern health care messages which are likely to be well taken up as is the case with traditional beliefs provided the messages are linked with live examples of health benefits. Communities followed traditional norms that had no health benefits and to some were detrimental to their health (Banda et al., 2007; Kamatenesi-Mugisha and Oryem-Origa, 2006). Interestingly, customs such as wife inheritance and temporal allowance of fertile men to sleep with women whose men were infertile through mutual agreement is dying away due to HIV/AIDS. This is an indication that communities understand the dangers HIV/AIDS inflicts upon them, hence take active roles in fighting against HIV/AIDS.

The study has revealed that the interventions deemed important for the acceptability, affordability and accessibility of the services by women as well as the community at large.



This concurs with what was found before that community involvement and participation are known as key elements in any given successful community projects (Loss et al., 2007; Bhuyan, 2004). This may be explained in that the communities see the project as “our project” and not “their project”. The health facility’s leadership needed to look into its staffing problems particularly in labour ward where women complained of the nurses. This implies that the hospital needs to intensify its service delivery strategies, by hiring competent and dedicated health workers or motivating the existing members of staff to do the right thing for the women and the sick at large. However, the changes made at the hospital should contain improved communication of the services provided to the community.

The community’s willingness to step up their efforts in utilizing health care services seems to be dependent on their relationship with the health service providers and the understanding health implications. This implies that there should be a trigular type of relationship involving the service providers at community and health facility levels and the communities themselves. It was evident in this study that various stakeholders experienced weaknesses in themselves and health workers in particular, pledged to be role models and would give a different face value in their health delivery involvement. This suggests that there was a reflection of what actually happens in each of the key players and there is a possibility of a change for the better.

It was further revealed that women should consult their husbands before undergoing HIV testing. This is important in that the adoption of such practice would spare women from experiencing problems within their families and has been supported by studies before (Kakimoto et al., 2007; Homby et al., 2006). This implies that women would not fear disclosing their HIV status hence not bullied or beaten up by their husbands and can pave ways for more men to access HIV testing. This may as well facilitate family unification and creation of positive living within couples’ relationships while living with HIV/AIDS.

Financial constraints, author’s hospital representation and distance to find the study participants were the study limitations. The study has the strength of exploring barriers and promoting factors to delivery of PMTCT services as perceived by service providers and community members. Further, inclusion of participants at various levels poses a fair representation of the study findings useful for service delivery improvements.

Men were decision makers in matters relating to pregnancy and where their wives should deliver, service providers’ attitude and knowledge affected health care service delivery, pregnancy and sickness were seen as unifying events by the communities. Improved communication between service providers and service users were the suggested intervention measures. Based on these findings, we recommend training of the TBAs and women’s empowerment to make independent choices in matters relating to pregnancy and child births.

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## 6. References

- Armenian Medical Network (AMN). (2005). HIV/AIDS, HIV and the Acquired Immunodeficiency Syndrome, HIV/AIDS Health Centre
- UNAIDS. (2004). Report on the global AIDS epidemic, Geneva.
- AVERT.Org, (2004). Starting Antiviral Treatment, *Averting HIV/AIDS.Org*.
- Banda Y, Chapman V, Goldenberg RL, Stringer JS, Culhane JF, Sinkala M, Vermund SH, Chi BH. (2007). Use of traditional medicine among pregnant women in Lusaka, Zambia, *Journal of Alternative and Complementary Medicine*, 13(1):123-7.
- Bhuyan KK. (2004). Health promotion through self-care and community participation: elements of a proposed programme in the developing countries, *BMC Public Health*, 4: 11.
- Baylor aids (2005). BIPAI programmes: Malawi, Facts on HIV/AIDS in Malawi, *Baylor international Pediatrics AIDS Initiative, Bayloraids.Org*.
- Buhendwa L. (2003). PMTCT services in Malawi. *Medicins Sans frontiers (MSF/B)*, Malawi.
- Giaquito C, Rampon O, De Rossi A. (2006). Antiretroviral therapy for prevention of mother-to-child transmission: focus on single-dose nevirapine. *Clinical Drug investigation*, 26(11):611-27.
- Graneheim, U.N., Lundman, B., (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness, *Nurse education today*, 24, 105 -112.
- Halkin JS *et al.*, (2005). Prevention of mother to child transmission of HIV, Progress and challenges, *Bayloraids organization, curriculum*,
- Homsy J, Kalamya JN, Obonyo J, Ojwang J, Mugumya R, Opio C, Mermin J. (2006). Routine intrapartum HIV counseling and testing for prevention of mother -to-child transmission of HIV in a rural Ugandan Hospital, *Journal of Acquired Immune Deficiency syndrome*, 42(2):149-54.
- Hilgert NI, Gil GE. (2007). Reproductive medicine in northwest Argentina: traditional and institutional systems, *Journal of Ethnobiology and Ethnomedicine*, 3(1):19.
- IRIN. (2007). Malawi: Limping PMTCT programme failing infants. UN office of the coordination of humanitarian affairs, IRIN Africa, Southern Africa, Malawi.
- Kakimoto K, Kana K, Mukoyama Y, Chheng TV, Chou TL, Sedtha C. (2007). Influence of the involvement of partners in the mother class with voluntary confidential counseling and testing acceptance for prevention of mother to child transmission of HIV programme (PMTCT programme) in Cambodia, *AIDS Care*, 19(3):381-4.
- Kamatenesi-Mugisha M, Oryem-Origa H. (2006). Medicinal plants used to induce labour during childbirth in western Uganda, *Journal of Ethnopharmacology*, 109(1):1-9.
- Loss J, Eichhorn C, Gehlert J, Donhauser J, Wise M, Nagel E. (2007). Community -based health promotion- a change for the evaluation, *Gesundheitswesen*, 69(2):77-87.
- Lallemant M *et al.*, (2004). Single dose perinatal nevirapine plus standard zidovudine to prevent mother to child transmission of HIV-1 in Thailand, *The New England Journal of Medicine*, volume 251:217-228 (3)
- Maharaj P, Cleland J. (2005). Women on top: the relative influence of wives and husbands on contraceptive use in Kwazulu-Natal, *Women Health*, 41 (2):31-41.

- Mant J, Winner S, Roche J, Wade DT. (2005). Family support for stroke: one year follow up of a randomized controlled trial, *Journal of Neurology, Neurosurgery and Psychiatry*, 76(7):1006-8.
- Mathole T, Lindmark G, Ahlberg BM. (2005). Competing knowledge claims in the provision of antenatal care: a qualitative study of traditional birth attendants in rural Zimbabwe, *Health Care for Women International*, 26 (10): 937-56.
- MDHS, (2004). Malawi Demographic and Health survey, HIV/AIDS Prevalence, National Statistics Office, *Demography and Social Statistics Division, Zomba*.
- Moodley J, Moodley D. (2005). Best practice and research, *Clinical obstetrics and gynaecology*, 19(2):169-183.
- Mshana GH, Wamoyi J, Busza J et. al. (2006). Barriers to accessing antiretroviral therapy in Kisesa, Tanzania: a qualitative study of early rural referrals to the national program. *AIDS Patient Care and STDS*, 20(9):649-57.
- Newell ML. (2006). Current issues in the transmission of mother-to-child transmission of HIV-1 infection. *Transactions of Royal Society of Tropical Medicine and Hygiene*, 100(1):1-5.
- Open Code 3.4 © 2007, UMDAC and Division of Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University, Sweden. Website: [http://www.umu.se/phmed/epidemi/forskning/open\\_code.html](http://www.umu.se/phmed/epidemi/forskning/open_code.html)
- Owens, RA. (2006). The caring behaviors of the home health nurses and influence on medication adherence, *Home Healthcare Nurse*, 24 (8):517-26.
- Santelli JS, Speizer IS, Avery A, Kendall C. (2006). An exploration of the dimensions of pregnancy intentions among women choosing to terminate pregnancy or to initiate prenatal care in New Orleans, Louisiana, *American Journal of Public Health*, 96 (11):2009-15.
- Scarlatti G. (2004). Mother -to-child of HIV-1: advances and controversies of the twentieth centuries. *AIDS review*, *AIDS review*, 6(2):67-78.
- UNAIDS. (2006). Malawi: HIV/AIDS Estimates, Uniting the world against AIDS, Geneva.

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It can be said that now is the best time for everyone infected to become aware of their own HIV status. The state of the art in HIV management progressively reveals that antiretroviral treatment can prevent transmission, as well as chronic damage in the human body, if started early. Unfortunately, antiretrovirals are not widely available in many places, especially in developing countries. In these parts of the world, diagnosis of HIV infection must be kept in the agenda as a priority, in order to understand specific details of local epidemics and as an effort to interrupt the chain of HIV transmission.

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