

Knowledge, Attitude and Practice of General Medical Practitioners In Port Harcourt Towards The Prevention Of Mother-To-Child Transmission of HIV.

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ABSTRACT

Background: Pregnant women living with HIV infection are at risk of transmitting HIV to their babies. Most of this transmission occurs during labour and delivery and during breast feeding. About 45% of all deliveries are conducted in private clinics. This study aims to access the knowledge, attitude and practice of general medical practitioner in Port Harcourt toward the prevention of mother-to-child transmission of HIV.

Methods: A questionnaire survey was carried out on two hundred and twenty four private medical practitioners in Port Harcourt. Data management was carried out using SPSS 15 for windows® statistical software.

Results: Only 50% of respondents had read the national guideline on PMTCT while 48.2% had three or more sources of information on PMTCT. Majority of the respondents (95.5%) identified prevention of HIV in the pediatric age group as the primary aim of PMTCT. Labour was identified by 80% of respondents as the time of transmission of MTCT of HIV while 48.2% preferred a specialist unit for HIV positive pregnant women. Forty two percent would screen pregnant women without consent. About half (46.6%) do not offer antenatal or delivery services to HIV positive women. Of the doctors that offer those services 58.7% could name 2 or more drugs to prevent MTCT of HIV during pregnancy. Of the respondents, 74% would offer HIV positive women elective caesarean section. Most of the respondents (89.3%) agreed that their knowledge, attitude and practice of PMTCT was deficient and 90.1% were willing to attend an update course.

Conclusion: The Private General Practitioners were not well informed on practical aspects of prevention of MTCT of HIV/AIDS. They showed a discriminatory attitude towards HIV positive pregnant women.

Key words: Private Practitioners, HIV, PMTCT.

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INTRODUCTION

Worldwide, almost 40 million people are living with HIV, with 95% of these in the developing world¹. Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV². Eighty five percent of world's infected children are in the Sub-Saharan Africa³. AIDS causes 22.6% of mortality in all African countries, making it the leading cause of death⁴.

Pregnant women living with HIV infection have increased risk of transmitting HIV to their babies. Vertical transmission remains the main mode of acquisition of HIV infection in children with a total of 700,000 newly infected children in 2003⁵. Transmission is rare during early pregnancy and relatively frequent in late pregnancy⁶. The World Health Organization (WHO), has stated that without preventive treatment, up to 40% of children born to HIV positive women will be infected, majority through MTCT^{7,8}. It is believed that two-thirds are infected during and around the time of delivery and one-third are infected through breast-feeding. But this figure can be reduced to less than 2% through anti-retroviral prophylaxis given to the mother during pregnancy and labour and to the infant after delivery, obstetric interventions including elective caesarean section and appropriate infant feeding^{9,11}. This set of interventions is collectively known as Prevention of Mother-to-Child Transmission (MTCT) of HIV¹². In most industrialized countries where this is a standard of care, its large scale implementation has virtually eliminated new pediatric HIV infection.

Unfortunately in Sub-Saharan Africa, less than 6% of pregnant women living with HIV in 2005 were offered intervention to reduce MTCT¹³. In Nigeria, HIV positive pregnant women's access to PMTCT is limited to a few government specialist hospitals. Vertical transmission of HIV from mother to child represents an important entry point for the disease and its prevention is a major approach towards the reduction of HIV/AIDS.

Private medical practice is a template for family health care in Nigeria. A significant proportion of people in Nigeria seek medical care primarily in the "for profit" private sector where a large proportion of all deliveries are conducted. The higher level of patient privacy in private clinics as compared to public hospitals, is thus expected to encourage more HIV positive pregnant women to utilize private facilities for the anticipated confidentiality and as well as reduced stigma and discrimination.

The private general medical doctor's knowledge, attitude and practice are therefore very important towards institutionalization of PMTCT. Knowledge has been identified as a powerful tool for positive change in all aspects of human endeavor. This is also true in the fight against HIV/AIDS. The situation in the Niger Delta calls for an urgent need for scale up in the services of PMTCT as the HIV/AIDS prevalence is high in this region¹⁴.

This study therefore sets out to determine the knowledge, attitude and practice of private medical doctors to PMTCT as an important determinant to their state of readiness to

play key roles in the institutionalization of PMTCT in the country. It also tries to determine factors influencing the attitude and practice of these private doctors working in Port Harcourt.

METHODS

Private General Practitioners working in Port Harcourt metropolis constituted the study population. Two hundred and fifty private medical practitioners were randomly selected and consented to participate in the study. A questionnaire survey was then carried out. Information on their socio demographic data, knowledge, attitudes and practices concerning the transmission of mother-to-child (PMTCT) of HIV/AIDS were sought. Two hundred and twenty four completed and returned the questionnaire. This gave a response rate of 89.6%.

The questionnaire was pre-tested and validated before being administered to the participating medical practitioners. Data analysis was carried out using SPSS 15 statistical software and presented as proportions, means and standard deviations.

RESULTS

The mean age of respondents was 35.7 ± 7 years; with a range of 26-58 years. Females comprised 21%, while 79% were males. The mean number of years in practice was 8.8 years with range of 1 to 28 years. Doctors who had been in practice for 10 or more years had 3 or more sources of information on PMTCT (73.3%) compared to those with less than 10 years (43%). However they were less likely to have had formal lectures on PMTCT (46.5% against 68.9%). Only 50% of respondents had read the national guideline on PMTCT while 48.2% had three or more sources of information on PMTCT. Only 38.8% knew the magnitude of MTCT of HIV while 36.6% could name two or more risk factors for MTCT of HIV during pregnancy (figure 1). Majority of the respondents (95.5%) identified prevention of HIV in the pediatric age group as the primary aim of PMTCT. Most (80%) named labour as a time of transmission of MTCT of HIV. The majority (79.5%) knew the components of voluntary counseling and testing HIV.

Figure 2 shows the attitude of the respondents towards special units for HIV positive pregnant women. About half of them (48.2%) preferred a specialist unit for HIV positive pregnant women.

Figure 3 shows that 36.6% believe that HIV positive women should pay more to provide protective items like apron, protective goggles and boots; while 92% strongly disagree that universal basic precaution only should be adhered to when a HIV positive pregnant woman is in labour. Forty two percent strongly agreed that consent is needed before screening of pregnant women while 42% would screen pregnant women without consent. Most of the respondents (89.3%) agreed that their knowledge, attitude and practice of PMTCT was deficient and need improvement and 90.1% were willing to attend an update course.

Figure 4 shows that 46.6% of respondents refer HIV positive pregnant women, 39.3% offer antenatal and delivery services

while 8% offer antenatal services only. All referrals were to Government hospitals and the commonest reason (84.6%) for referral was to enable patients access drugs, facilities and expert care. Of the doctors that offer those services 58.7% could name 2 or more drugs to prevent MTCT of HIV during pregnancy. Of the respondents, 74% offer HIV positive pregnant women elective caesarean section. None of the doctors had received any formal training in counseling. Almost all do pre and post test counseling. Only 40% of those that manage HIV positive pregnant women could name 3 or more correct interventions they applied in labour to reduce MTCT of HIV. Most (79.5%) offered HIV positive pregnant women infant formulae as the only infant feeding option.

Figure 1:

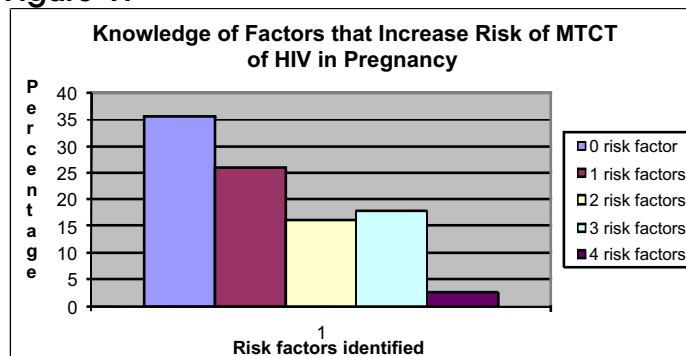


Figure 2:

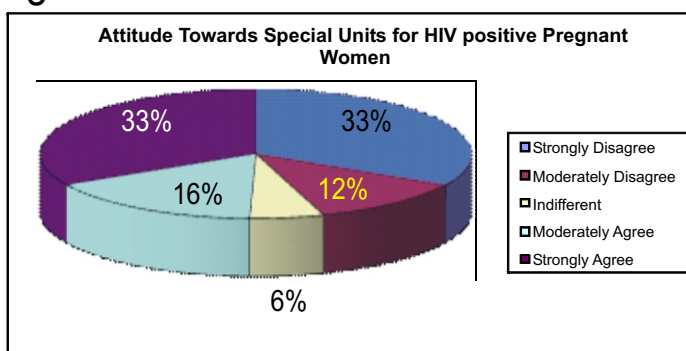


Figure 3:

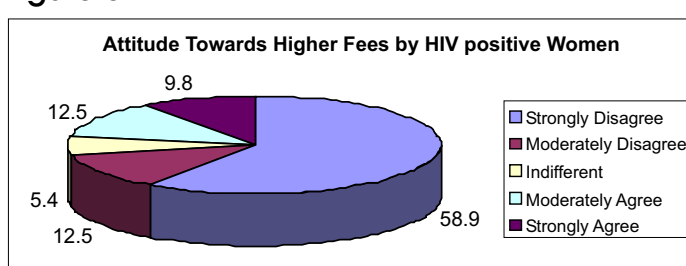
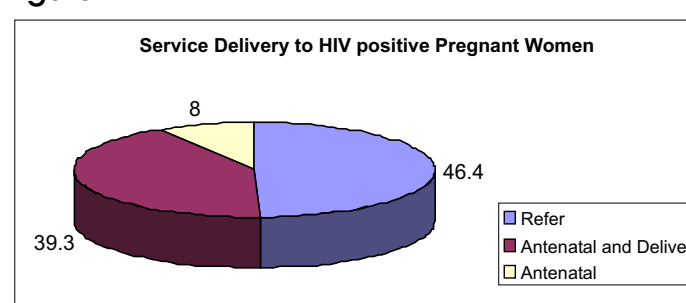


Figure 4



Majority of the doctors (78.3%) were able to name at least one drug given to the infant to PMTCT of HIV. Almost all (89.2%) continued follow-up on the mother and child pair.

DISCUSSION

The results of this study show that many of the doctors had multiple sources of information on PMTCT. The more experienced doctors had more sources of information on PMTCT than their less experienced colleagues. However they were less likely to have had formal lectures on PMTCT. The finding agrees with a similar survey by UNAIDS on nurses¹⁵. Unfortunately multiple sources of information did not translate significantly to improved knowledge as there was no correlation between the number of sources of information and their knowledge of PMTCT. This finding supported by Bennet and Weale which revealed that “awareness training programme did not make any significant difference in the knowledge and attitude between those that attended and those who did not”¹⁶. This pattern has also been seen in local studies on health care workers¹⁷.

Half of the respondents showed a discriminatory attitude towards pregnant women living with HIV/AIDS as they agreed that HIV pregnant women should have special units in order for special measures to be employed for PMTCT and one third think these women should pay more. This discriminatory attitude has been seen among health care worker in other studies¹⁸⁻²². Only 8% agreed that basic precaution against infection should only be used with HIV positive pregnant women. This exposed an important flaw in their knowledge of universal precaution against infection and implies poor compliance. The poor knowledge and compliance was also seen among health workers in Benin²⁰.

Half of the doctors felt strongly that all pregnant women should be screened for HIV/AIDS with or without their consent. This practice of screening without patients' consent was shown by Obi and Ifebunandu²³ to result in a feeling of distrust by victims. Moreover this contravenes many international charters^{24, 25} to which Nigeria is signatory on the rights of women and patients and the professional codes and conduct of physicians²⁶.

The majority of respondents refer HIV positive pregnant women out of their hospitals. The most common reason given is the need for expert care, the lack of antiretroviral drugs and facilities for management. Half of the respondents also charge more for their services to these women. This may not be unconnected to the “more profit orientation” of their practice as well as their poor knowledge and practice of universal precautions.

A small proportion of the study population (8%) offered only antenatal services and referred the women to other hospitals for delivery while 39.3% offered both antenatal care and delivery services. However only 58.7% could name two or more specific measures they employed in labour for this purpose. This shows that they are poorly informed on practical aspects of patient management, a finding noted by Ihekweazu and Starke in a study of private physicians' treatment of HIV/AIDS patients²⁷. Infant feeding options were also restrictive since many offered their patient only infant formulae feed and made no room for

situations where this was not affordable or practical.

CONCLUSION

This study demonstrates that Private General Practitioners in Port Harcourt are poorly informed on practical issues in the prevention of MTCT of HIV. They are therefore handicapped to play an effective role in this important aspect of prevention of HIV. Most of these doctors express willingness to update their knowledge and improve their knowledge and improve their attitude and practice of PMTCT. Sensitization, capacity building and appropriate clinical settings remain indispensable assets for meaningful intervention results. Organizing nationwide continuing medical education will go a long way towards preparing them to play important roles in the planned up-scaling and institutionalization of PMTCT in Nigeria. If we have to contend with the monstrous challenge of the pandemic, we must reposition our private practice and primary health care strategies.

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