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RESOURCE CHALLENGES EXPERIENCED BY HIV-POSITIVE WOMEN ON THE PREVENTION OF MOTHER TO CHILD TRANSMISSION PROGRAMME AT A HOSPITAL IN BULAWAYO, ZIMBABWE

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ABSTRACT

The aim of the study was to gain an understanding of the lived experiences of HIV-positive women who utilised the prevention of mother-to-child transmission (PMTCT) services at a central hospital in Zimbabwe. The PMTCT programme plays an integral role in the management of HIV transmission. The effective implementation of the PMTCT programme cannot be overemphasised. This study utilised a qualitative, descriptive, phenomenological research design. Data was gathered using in-depth individual interviews that were audio recorded. Fifteen HIV-positive PMTCT clients participated in the study. Data was analysed using interpretive phenomenological analysis. The results showed that the clients attending the PMTCT programme experienced several challenges as they

utilised the services, emanating from material, financial and human resource-related challenges. The implication for effective implementation of the PMTCT programme is that there should be adequate resource provision.

Keywords: effective utilisation, lived experiences, healthcare system, HIV positive, PMTCT, PMTCT clients

INTRODUCTION AND BACKGROUND INFORMATION

The human immunodeficiency virus (HIV) is still of global concern. According to UNAIDS (2015a:1), it is estimated that 36.9 million people were living with the virus at the end of 2014 globally. The same report indicates that the prevalence of HIV is highest in the eastern and southern region as compared with western and central Africa. The situation is worse in sub-Saharan Africa where UNAIDS (2015a:1) indicated that, in 2014, there were 25.8 million people living with HIV and AIDS. Of these, 1.4 million were new HIV infections, with women accounting for more than half the number of people living with HIV and AIDS. The Southern African Development Community (SADC) report (SADC, 2011:1) indicates that SADC was at the epicentre of the global epidemic, with member states having adult HIV prevalence of at least 10%. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2015a:1), HIV prevalence in Zimbabwe is 15%, slightly lower than that of Swaziland (25.9%), Botswana (21.9%) and South Africa (19.1%). However, from a global perspective this is still high. According to the Zimbabwe National Statistics Agency (2012:220), the epidemic is a highly feminised phenomenon with a prevalence rate of 18% for women aged 15 to 49 years compared with 12% among men in the same cohort.

The prevention of mother-to-child transmission (PMTCT) is regarded as one of the most important activities contributing to the achievement of Sustainable Development Goals. The programme has the potential to substantially reduce mother-to-child transmission of HIV (Marino, 2015:1). In Europe the mother-to-child HIV transmission varies between 0.8% to 1.2%, while in the United States of America (USA) it is less than 2% (UNAIDS, 2012:1).

The PMTCT programme was piloted in most sub-Saharan countries in 1999. It showed a major breakthrough in the reduction of mother-to-child HIV prevention (Zimbabwe Ministry of Health and Child Welfare, 2011:10). In South Africa, mother to child HIV transmission was reduced to 2.7% in 2011 from 3.5% (UNAIDS 2012). However, in Zimbabwe the mother-to-child transmission stands at 7% (Zimbabwe Ministry of Health and Child Welfare, 2013a:2). According to Hampanda (2013:1), a PMTCT study found that 50% of HIV-positive pregnant women were not accessing the PMTCT programme. The same author stated that PMTCT clients were not adhering to the requisite strategies for the reduction/prevention of child vertical transmission of HIV – having a negative impact on the attainment of Millennium Development

Goals by 2015 by sub-Saharan Africa. Related to this, Hardon, Vernooij, Bongololo-Mbera, Cherutich, Desclaux and Kyaddondo (2012:1) state that this underutilisation of PMTCT services in African countries implies that HIV-positive women remain at high risk of transmitting the HIV to their infants. Lucas (2012:1) further mentions that paediatric HIV contributes significantly to infant and child mortalities in sub-Saharan Africa. Muchedzi, Chandisarewa, Keatinge, Chibanda, Woelk, Mbizvo and Shetty's (2010:1) study found that about 22% of HIV-positive pregnant women reported a delay of more than three months after being referred to access PMTCT programme despite the proximity of their homes to the health care facilities. The failure to utilise PMTCT services was mostly associated with stigma at a PMTCT setting, which resulted in non-adherence to treatment and not attending PMTCT services (Tshadinyana 2011:1).

In Zimbabwe the mother-to-child transmission of HIV is 7% (Zimbabwe Ministry of Health and Child Welfare, 2013:2). The same report indicates that mother-to-child transmission is responsible for more than 90% of infections in children, with two-thirds occurring during pregnancy or delivery (Ministry of Health and Child Welfare, 2013:29). To ensure proper and effective implementation of the PMTCT programme, Zimbabwe adopted a four-pronged approach that focuses on: primary prevention of HIV among women of reproductive age; prevention of unintended pregnancy among HIV-infected women; prevention of mother-to-child transmission of HIV and the provision of care and support for HIV-infected pregnant women, their children and their families (Zimbabwe Ministry of Health and Child Welfare, 2011:10). The country also opted for life-long antiretroviral therapy (ART) for all HIV-positive pregnant and lactating mothers for their own health and prevention of mother-to-child transmission of HIV (Zimbabwe Ministry of Health and Child Welfare, 2013:38).

PROBLEM STATEMENT

Despite the implementation of the PMTCT programme for the past 15 years, the paediatric ART coverage has remained as low as 40% compared with 85%, the universal access target (SADC, 2013:15). In an assessment carried out in Zimbabwe by the United Nations Children's Emergency Fund and the World Health Organization, the coverage of paediatric ART at the study setting was estimated to be less than 50% (UNICEF & WHO, 2012:9). In addition, the median age at the first polymerase chain reaction (PCR) at the study site was estimated to be 13 weeks, (UNICEF & WHO, 2012:10). The recommended period for the initial PCR testing is six weeks (Zimbabwe Ministry of Health and Child Welfare, 2014:6). Also of concern is the fact that in 2012, of the children born to infected mothers, 18% were HIV infected (SADC, 2013:15). Statistics still show a high mortality rate among children below the age of five (Zimbabwe National Statistics Agency, 2012; Ministry of Health and

Child Welfare, 2013b). As the success of the PMTCT programme is linked to the utilisation of PMTCT services by women living with HIV/AIDS, the researchers wondered what the PMTCT clients went through when utilising PMTCT services.

RESEARCH QUESTION

What are the lived experiences of HIV-positive women who utilised the PMTCT services at a central hospital in Bulawayo?

PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the lived experiences of women who utilised the PMTCT services at a central hospital in Bulawayo.

DEFINITION OF KEY CONCEPTS

Effective utilisation: Effective refers to producing results that are wanted or intended (*Oxford advanced learner's dictionary*, 2010:469). Utilisation means used for practical purposes (*Oxford advanced learner's dictionary*, 2010:1646). In the context of this study, effective utilisation will be used to refer to how the PMTCT services were used to achieve the intended outcomes of the programme.

Lived experiences: According to Witty (2008:116), an experience refers to the knowledge gained through observation or practice. It may refer to an incident that actively involved the person (individually or in a group context) at emotional, physical or social levels. In this study, experience refers to feelings, perceptions and observations encountered by HIV-positive women as they journeyed through the continuum of care until the baby was two years old. These were taken as the lived experiences of study participants, where lived refers to what they went through or encountered.

Healthcare system: a framework of health service delivery that includes components such as the nature of health services, characteristics of the health workforce, service-related equipment, supplies and financial resources (WHO, 2012:104).

HIV positive: a person is HIV positive when antibodies against HIV have been detected on a blood test or saliva test (UNAIDS, 2015b:12). In this study it refers to women living with HIV and meeting the inclusive criteria.

PMTCT clients: PMTCT clients referred to HIV-positive women, aged between 18 and 49 years, and who had attended antenatal care, delivered a live baby, received postnatal care and follow-up care of the baby until the age of two years at the study setting (Zimbabwe Ministry of Health and Child Welfare, 2011:6).

RESEARCH DESIGN AND METHODS

A phenomenological qualitative descriptive design was used. It helped to explore and describe the experiences of HIV-positive women as they utilised PMTCT services.

Contextual details

The study setting was a central hospital, which is also a referral centre offering specialist services to the Bulawayo Metropolitan, Matabeleland South, Matabeleland North, Midlands and Masvingo provinces. Bulawayo has an HIV-prevalence rate of 19%, while the other provinces adjacent to it, Matabeleland South and North, have a prevalence rate of 18% and 21%, respectively (Zimbabwe National Statistics Agency, 2012:220). About six hundred women attend the antenatal clinic at the study setting on a monthly basis (National AIDS Council, 2013).

Population and sample

The study population was of HIV-positive women in the PMTCT programme at the study site. Sampling was done through purposive, non-probability sampling procedures. The judgement for selecting the sample was based the following criteria:

- Being a woman living with HIV.
- Aged from 18 to 49 years.
- Booked and received antenatal care at the study setting.
- Having utilised PMTCT programme at the study setting for a minimum of four months during the antenatal period, six weeks post-delivery and a maximum of two years for paediatric follow-up care.
- Delivered a live baby at the study setting.
- Attended post-delivery services of follow-up baby care at the setting to the time their babies were two years old.

The sample consisted of 15 participants. The study participants were accessed during their antenatal or post-natal period and or when bringing their babies for follow-up care. The sample size was determined by data saturation.

Data gathering procedures

Data was collected from January 2014 to June 2014. Unstructured, in-depth, open-ended, face-to-face interviews were conducted by the researchers. One of the consultation rooms in the selected hospital was used for data gathering to ensure privacy and confidentiality. To ensure authenticity, the interviews were audio recorded and later transcribed to ensure validity and a clear audit trail. Apart from

the central research question, probing questions such as ‘what did you do then? How did you feel?’ were also asked in order to elaborate on or clarify statements. Field notes were also kept. These recorded issues of methodology and non-verbal cues helped to enhance rigour. Examples of methodological issues were those to do with the authors’ beliefs, biases and presuppositions (Giorgi 2011:195). A reflexive diary to awaken the researchers’ preconception was kept to ensure that all questions in subsequent interviews were open ended. The duration of each interview was about 30 to 45 minutes. A pilot study with three clients on PMTCT was conducted in one of the central hospitals that was not part of the study. The process enabled the researchers to rephrase the question in Ndebele/Shona and enabled the researchers to find a way to explore or ask probing questions.

Measures to ensure trustworthiness

Measures were taken to ensure trustworthiness and rigour (Polit & Beck, 2012:723–725). Credibility was ensured through prolonged engagement, data triangulation, flexibility, peer evaluation and use of a co-coder. A reflective diary was kept to ensure neutrality and objectivity. The diary enabled the researchers to be introspective and bracket out their biases. Records were kept conscientiously and locked in a cupboard, thus ensuring that an audit trail was left to be followed by any researcher. Peer debriefing was carried out as part of the evaluation and inconsistencies noted were addressed. The researchers ensured dependability by coding and recoding many times and comparing the themes and categories with a co-coder. Verbatim extracts from the interviews were used to enhance authenticity.

Ethical measures

Ethical clearance was granted by UNISA (Ethics Clearance Number HSHDC/205/2013) and by the Ministry of Health and Child Welfare. Participants gave written voluntary consent to take part in the study. Anonymity and confidentiality were observed as the names of either the participants or institution were never used. Only the researchers reviewed and transcribed the data.

Data analysis

Data from the interviews was transcribed verbatim and transcripts analysed following the steps outlined by Langdrige (2007:13). The data, from the tape-recorded interviews, was transcribed verbatim into text as Microsoft Word documents. The data complemented by field notes kept by the researchers was then analysed using interpretive phenomenological analysis (IPA). The following steps as outlined by Langdrige (2007:13) were followed:

1. Reading and re-reading the transcript
2. Note making and developing emergent themes
3. Clustering the emergent themes
4. Crafting a master table of themes composed of superordinate themes, subthemes and extracts from the interviews
5. Examining and comparing the similarities between the master tables of the themes
6. Compiling a single master list composed of a superordinate theme, themes and sub-themes.

RESULTS

Biographic information

The sample consisted of 15 participants aged between 18 and 49 years. All were married except one 24 year old who was single and another one who was widowed. The majority (13) had secondary education and two had only reached grade seven. All participants were unemployed. All of them had tested HIV positive at the institution of study, received antenatal care and delivered at this same hospital. At the time of the interview, the majority (11) of the women attended the clinic for the six weeks postnatal follow-up visit. The remainder (4) had come for paediatric follow-up care.

Resource-related challenges

A superordinate theme, containing three themes and several sub-themes emerged from data analysis as resource-related challenges experienced by HIV-positive women who utilised the PMTCT programme at one of the central hospitals in Bulawayo, Zimbabwe. Table 1 shows the summary of the results.

Table 1: Summary of superordinate-theme, themes and sub-themes.

Superordinate themes	Themes	Sub-themes
Resources for provision of PMTCT services	Cost-related challenges	<i>Payment of services which are supposed to be free</i>
		<i>Unaffordability of health care services</i>
		<i>Items for use in theatre</i>
		<i>Inconsistency regarding payment</i>
	Human resources related challenges	<i>Shortage of staff</i>

Theme 1: Cost related challenges

This sub-theme gives a reflection of clients' experiences as related to *payment for services* and inconsistencies regarding payments.

Payment of services which are supposed to be free

The government of Zimbabwe has a fee exemption policy for maternity services at all levels of care (Zimbabwe Ministry of Health and Child Welfare 2013: Circular number 1/53/30, in paragraph 1). Though it is documented that maternity services are free of charge, on the ground clients are sometimes requested to pay for services contrary to the provisions of the circular. A respondent was denied the opportunity to book for antenatal care in one of the Central Hospitals in Zimbabwe, because she did not have booking fees.

I know that maternity service is free of charge. I have even read the policy, which stipulated all the free services which included maternity and immunisation for children. I was surprised when I arrived at the hospital that I was supposed to pay \$50 for booking in order to be assisted. I was told that I cannot be treated if I don't have money (E5).

Not only was the fee exemption policy not observed, but also the charges themselves were exorbitant particularly given the fact that all participants were unemployed, forcing many to borrow as the following excerpts show:

When I came to this hospital, I had been referred from the clinic for raised blood pressure and I had been told that I needed to deliver at a central hospital. On arrival, I was told by the clerk at the reception desk that I needed to have a booking fee of \$50 for me to be attended to, which I did not have, I had to go back home without being attended to. As I am not working \$50 is too much for me. I was only able to get \$50.00 after two weeks, came back and I was booked. So if I had failed to get money, I would have ended up being dead at home (F6).

My blood pressure went up and I was requested to have an ultrasound scan done but I was told that it could not be done if I did not have money to pay for it. I had a challenge of raising the money and I ended up borrowing money from a neighbour because the nurses were saying they could not clearly detect the heart beat for my baby (E5).

As if the unaffordability of the services was not enough of a barrier, all the five participants who delivered through a caesarean section also found that there was a shortage of materials for use in the operating theatre. This meant that the clients had to find a way of providing these by subsidising the hospital as the following extracts reflect:

When it was my week to go for a Caesarean section, the doctor wrote a list of items that were required in my maternity book [she opened the book with the following items listed: surgical gloves, catheter, and urine bag] (F6).

I cannot fully remember, but what I remember is that I bought six drips, a tube for urine, needles, injections and something to put on the head – the total bill for these items was \$80. My husband was saying that he does not have that money as it was half of his salary and he still had to buy the items for the unborn child and also feed the rest of the family. And I had to borrow money from my cousin because without that material, I don't know what would have happened to me and my baby (G7).

When I was being prepared for the operation I remember I was told that there were no intravenous fluids, injections and drugs for putting me to sleep. I overheard them phoning another hospital requesting for items for use during the operation (M12).

Inconsistency regarding payments

Besides payments for the services which are supposed to be free, participants raised the issue of lack of transparency and consistency regarding fees to be paid by clients on the PMTCT programme.

During the time I booked I was told that I was expected to pay a sum of only \$50 because there is a government subsidy. To my surprise when I was discharged, I was given an invoice for \$78-00. That made me become confused as it seems that there is no clear process with the whole issue of payment (O14).

If the health care system is viewed from a systems perspectives, then the costs directly or indirectly of accessing services will in turn impact negatively on accessing PMTCT services. This could explain perhaps why the mother-to-child transmission rate remains at 7% compared with that of 2% in South Africa, for example (UNAIDS 2012:1; Zimbabwe Ministry of Health and Child Care, 2013:2).

Theme 2: Human resources-related challenges

This theme is about human resource challenges that impacted on the experiences of PMTCT clients. This section highlights the shortage of staff and also the attitudes of health practitioners.

Shortage of staff

Participants mentioned the fact that there is limited number of staff in the hospital. The impact of staffing levels manifested themselves in delays in service provision with patients being seen after having to wait for long for the doctor, even in cases of emergencies. The study findings reflected that there were delays in service provision as experienced by PMTCT clients as they had to wait for one health personnel to first finish what they are doing before receiving the health care services. The following excerpt is a reflection of the delays that occurred in service provision.

I got to the stage where I was coming for my routine check-up on a weekly basis, my blood pressure was much raised and I was admitted at the new maternity wing. I had come to the hospital in the morning and only seen by the doctor late in the evening because they said the doctor was committed elsewhere (N13).

One of the research findings was the fact that participants expressed the view that they experienced a challenge in accessing the services of a medical practitioner for an emergency operation as follows:

On one of the days, when I had come for my weekly check-ups my blood pressure was found to be high. The nurses told me that the heart-beat of my child could not be heard clearly and therefore I needed to have an emergency operation. I was then taken to theatre but the challenge that arose was that the doctor who had to operate on me was nowhere to be found. The nurses found him after about thirty minutes (E5).

DISCUSSION

The study found that contrary to the Zimbabwe government exemption policy on maternity services, some respondents were made to pay a booking fee. These findings are congruent with findings of studies carried out elsewhere in sub-Saharan Africa (Messen, Hercot, Noirhomme, Ridde, Tibouti, Tashobya and Gilson, 2011:ii27). Besides the payment for services which are supposed to be free, participants complained about the lack of transparency and consistency with regards to fees by PMTCT clients for maternal services. The study found that the policy on exemption of user fees was inconsistently applied and there was a perception that 'charging would be locally determined'. These findings concur with the findings of a study elsewhere by McPake, Witter, Ensor, Fustukian, Newlands, Martineau and Chirwa

(2013:2) with regards to financial policies in Ghana, Nepal, Sierra Leone, Zambia and Zimbabwe.

The high cost of maternity fee can prevent individuals from accessing services on time. This can be dangerous when people have complications such as elevated blood pressure, which can be dangerous to both the pregnant mother and unborn child. A study (WHO, 2013:11) found that the health care costs are prohibitive on the utilisation of health care services. A PMTCT study in Malawi, another resource poor setting like Zimbabwe, cited financial constraints as a barrier to accessing health services in a PMTCT setting (Kasenga, 2010:4). The cost of health services can also be attributed to gross underfunding by the fiscus of the Ministry of Health contrary to the provisions of the Abuja declaration. In 2013 the fiscus allocated a figure that amounted to approximately US\$7 per capita per annum (Ministry of Health, 2014:7). The parliamentary portfolio committee on health found that while the Ministry of health had submitted a budget \$712 million, it was allocated a paltry \$337 million in 2014, a figure that declined to \$301 million in 2015 (Langa, 2015:4).

Apart from being confronted with the unaffordable costs of health services, participants found that there was a shortage of material resources for use in theatre and other relevant equipment necessary for comprehensive PMTCT care. Clients who participated in this study had complications associated with hypertension during pregnancy, and they indicated that a prescription was written for them to buy these antihypertensive drugs from a pharmacy. In addition to this, the same clients expressed the fact that they experienced financial constraints to purchasing the prescribed drugs.

Because items were not in stock, clients were asked to purchase them. For the majority of the participants, the burden proved to be too much. With regards to the shortage of material resources, it is instructive to refer to studies in Tanzania (Penfold, Shamba, Hanson, Jaribu, Manzi, Marchant, Tonner, Ramsey, Schellenberg and Schellenberg, 2013:1; Rujumba, Tumwine, Tylleskar, Neema and Heggenhougen, 2012:1). Both studies found a situation of chronic stock out of vital supplies hindering the full implementation of the PMTCT programme. Participants stated that there was a limited number of hospital staff present in delays in service provision, resulting in some clients being seen after a long wait for the doctor even in emergencies. The delays in service provision experienced by PMTCT clients at the study setting may be attributable to the high vacancy levels for doctors and nurses (Zimbabwe Ministry of Health and Child Welfare, 2014:16; DFID, 2012:22; Mantula, 2011:68). According to the World Health Organization (2010), while sub-Saharan Africa is home to 11% of the global population and 2/3 of people living with HIV/AIDS, it has only 3% of the world's health care givers (Toure, Audibert and Dabis, 2010:2).

The World Health Organization recommends 2.3 health workers per thousand population (DFID, 2012:22). Of note is the fact that the Zimbabwean health worker-patient ratio is still very low compared with that recommended by the World Health

Organization. The actual doctor density was between 0.01 and 0.02 per thousand population and the nurse density was 0.5 per thousand population.

CONCLUSION

The experience of the study participants revealed that at the study setting there were challenges emanating from material, financial and human resource-related constraints. These challenges were associated with user fees, inadequacies of medical consumables and drugs. While to a large extent healthcare providers were perceived to be receptive, warm, caring and non-discriminatory, a minority viewed them as having negative attitudes.

RECOMMENDATIONS

The authors recommend the systems approach PMTCT practice model by Moyo (2015) as it is most appropriate to the resource challenges. The model has aspects of financial resource mobilisation for an alternative health financing system. It also incorporates aspects of human resource mobilisation, in-service, mentoring as well as quality assurance activities. In addition to this, the model advocates for community mobilisation and awareness on service provision. If implemented properly the model would help alleviate the challenges cited in the study. Other recommendations include a rethinking and reorganisation of health resources and systems and a re-appraisal of the role of the nurse in the care of complex and chronic conditions such as HIV/AIDS. In addition, a quantitative research on a macro scale is called for to determine the experience of PMTCT clients on a national scale. The pre- and in-service curriculum should incorporate the discharge planning process to strengthen PMTCT programmes.

LIMITATIONS

The study was conducted in only one hospital setting and while notable patterns emerged, the explanation for the patterns may need further investigations.

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