

**MOTHERS AWARENESS AND UTILIZATION OF PMTCT SERVICES IN
MAKINDYE DIVISION WAKISO DISTRICT IN CENTRAL UGANDA
A CASE STUDY OF SABAGABO SUB COUNTY.**

COMPILED

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**A RESEARCH REPORT SUBMITTED TO COLLEGE OF HUMANITIES AND SOCIAL
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DECLARATION

I Namagara Barbra declare that this work presented in this research report is my original work and has never been submitted for any award of academic qualification in any other university or institution of higher learning for any award.

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Signature 

Date 30/7/2014

APPROVAL

This is to clarify that this proposal by Namagara Barbra entitled on Mothers awareness and utilization of PMTCT services in Makindye, Sabagabo sub county Wakiso district is a product of a study that has been undertaken under my supervision and it is now ready to be submitted to the department of public administration with my approval supervisor.

Mr. MUKUYE MARK

SIGNATURE 

DATE 30/07/2014

DEDICATION

This dissertation is dedicated to my Guardian Madam Nantege scovia, Mr. Ndikusooka Benson and Madam Prisca Tibenderana whose invaluable parental care and education formed a great foundation of this research may the almighty God continue to bless you with your good and loving hearts.

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LIST OF ACRONYMS'

MTCT	Mother to Child Transmission
PMTCT	Privation of Mother to Child Transmission of HIV/AIDS
HIV	Human Immune Virus
AIDS	Acquired Immune Defenses Syndrome
VCT	Voluntary Counseling and Testing of HIV/AIDS
MOH	Ministry of Health
DHO	District Health Officer
ART	Antiretroviral Treatment
ARVS	Antiretroviral Drugs
TASO	The Aids Support Organization
WHO	World Health Organization
NGOS	Non-Governmental Organizations
ANC	Antenatal Care
STDS	Sexually Transmitted Diseases
WDLG	Wakiso District Local Government
KIU	Kampala International University
UNAIDS	United Nations program on AIDS
GOU	Government of Uganda
UNICEF	United Nation's Children's Emergency Fund

ABSTRACT

The study was about the Mothers awareness and utilization PMTCT services in Saba Gabo Sub County, makindye division in wakiso in central Uganda.

The overall of the research objective was to assess the level of PMTCT services, to assess the causes of mother to child transmission of HIV/AIDS leading to poor performance of PMTCT services in sabagabo Sub County and the possible strategies to enhance the performance of PMTCT services as a means of preventing MTCT in sabagabo Sub County Makin dye division in wakiso district.

The findings of the study was that the response of the mothers when called for PMTCT services was negative and that increasing the salary of health workers and providing transport by the government to the health workers could improve mother's awareness. Maternal mortality among HIV-infected women was high and demands further attention as improved maternal survival is also a means to improve infant survival.

The recommendation of the study was that there is need for the government to employ more health workers so that the ratio of health workers and patients is normal. This would increase on the coverage of the patients by the health workers which apparently is not good; furthermore there is need for massive sensitization and campaigns to publicize the information regarding PMTCT services especially in rural area like in sebagabo Sub County where this study was conducted. This would increase on awareness and thus utilization of the PMTCT services.

The study concluded that most of the husband did not support offer support to their spouses when seeking PMTCT services and that poor sensitization and long distance were the major factors affecting utilization of PMTCT services, the study further concluded that most of the mothers did not access PMTCT services.

CHAPTER ONE:

1.0 Introduction

This chapter covers among others the background of the study, statement of the problem, objectives of the study, research questions, conceptual framework, and scope of the study and significance of the study.

1.1 Background of the study

The term PMTCT refers to the prevention of mother to child transmission of HIV/AIDS. MCT of HIV has created enormous social and economic problems. Besides the dominant heterosexual transmission, vertical transmission from Mother-to-child accounts for more than 90% of pediatric AIDS in children (WHO, 2007).

The uptake of the PMTCT program has been fairly good. However, if the intervention has to reach more beneficiaries, there is need to look critically at human resource capacity of the implementing sites and to address the poor enrolment ratio of HIV positive mothers especially in up country areas. (Onyango S. at el, 2002).

Globally Mother-to-child transmission (MTCT) of HIV accounts for 14% of all new HIV infections worldwide, and may occur during pregnancy, labor and delivery or breastfeeding. In the absence of prevention, rates of MTCT are estimated to be 25-35 percent. In 2007, the national HIV prevalence rate among pregnant women in Malawi was 12.6% with an estimated 89,000 HIV-infected children. Survival of these children is limited with approximately 50% dying before two years of age. [World health org report 2002]

In 2007 an estimated 420 000 children were newly infected with HIV; about 87% of those infections happened in sub-Saharan Africa, 0.001% in North America. The majority of these children become infected during pregnancy, delivery or during the breast-feeding period (mainly in areas where safe and affordable replacement feeding is not available).The developed world has been successful in reducing the rate of transmission of the HIV virus from mother to child to below 2% or even

lower. However, in developing countries transmission rates remain unacceptably high in most places (UNAID 2007) report.

The "Countdown to Zero" initiative announced by the Joint United Nations Programme on HIV/AIDS ambitiously aims to eliminate pediatric HIV infection by 2015. However, despite improved access to antiretroviral, PMTCT service utilization remains suboptimal. In 2010, only 48% of HIV-infected pregnant women received antiretroviral to reduce mother-to-child transmission, and only 28% of infants born to HIV-infected mothers had HIV testing in the first 2 months of life. As a result, the estimated mother-to-child transmission rate in 2010 was 26%, and nearly 390,000 infants were born with HIV infection a rate that falls far short of what can be achieved with available biomedical interventions.

An HIV-positive mother can pass HIV on to her baby any time during pregnancy, labor, delivery and breastfeeding, so the transmission of the virus must be blocked at each stage. Current World Health Organization guidelines recommend that HIV-positive pregnant mothers should go on a regimen of three antiretroviral drugs (ARVs) as soon as possible and stay on these drugs until their infants are born and breastfeeding has concluded. Ideally, the mothers themselves will also remain on treatment once breastfeeding has concluded, for their own health.

Mother-to-child transmission of HIV/AIDS is particularly prevalent in Africa, where the number of women infected with HIV is ten times the rate found in other regions. Studies conducted in several cities in southern Africa in 1998 indicated that up to 45% of pregnant women in these cities carry HIV [Onyong 2003].

The South African national PMTCT programme was initiated late in 2001, following a Constitutional Court ruling that ordered the Department of Health (DoH) to issue single-dose Nevirapine to HIV positive pregnant mothers. In 2008 the regimen was updated to a dual therapy protocol that saw AZT being added to the treatment regimen. Infant

feeding guidelines were also amended. This came two years after the World Health Organization (WHO) had updated its PMTCT guidelines.

In 2003, the Ministry of Health (MoH) set a target of at least 75% of women attending ANC with PMTCT services by the end of 2010. By 2007, PMTCT services were available in 64% of health facilities. In 2004, an evaluation of the PMTCT program in Thyolo district in Malawi revealed a progressive loss to follow-up of HIV-infected mothers; cumulative loss to follow-up was 55% by the 36 week antenatal visit, 68% by delivery and 81% by the 6 month post-natal visit.

In Sub-Saharan Africa, increasing number of people with access to proper health services has proved to be a significant challenge. This region has been lagging behind the rest of the world with respect to achieving the millennium development goal number six (6) on prevention and control of HIV/AIDS (WHO, 2008).

Every year in Uganda over 40,000 babies get HIV infection. The Ministry of health of Uganda started to implement a PMTCT service free of charge from January 2000, In the first 2years of intervention 45,394 women were counseled 30,423 were tested and 3,726 found HIV positive, because of these 2,123 were enrolled and started ARV and 1,747 have delivered in the program only around 40% of women — babies' pair came for follow-up at week 6, the difference between the sites performance were evident both in absolute number (graphic) and in percentage particularly sites which had some "extra human resources" were able to counsel 94% of all new ANC attendance and to provide ARV to 35% of their estimated HIV positive population. But sites without any "extra human resource" were able to counsel only 26% of all new ANC attendance and to provide ARV to only 9% of their estimated HIV positive population. High prevalence found during PMTCT Services was consistent with data coming from sentinel sites. Kampala sites had 13%, up country sites 10%. HIV positive women from rural sites were less likely to come for enrolment of 34% versus 60 % (MOH Uganda, 2003).

Finally Utilization of PMTCT service in makindye division in sabagabo sub County wakiso district is below the standards as it is the case with other rural areas. This is due to inadequate resources like; drugs, money and little numbers of staff. Due to these, pregnant mothers have resorted to TBA, s who is ever available which hinders utilization of PMTCT services in sabagabo like any other rural setting in Uganda. Most mothers find it difficult to access the health centers, meaning the little available PMTCT services even are not utilized (MOH Uganda, 2013).

Also there are other reasons hindering utilization of PMTCT services like cultural practices and the knowledge of the mothers about the services available at the health centre's. Therefore, need for proper utilization of PMTCT services is still lacking. It is against this background that a study is to be done focusing on PMTCT services delivery and find out strategies for reducing the challenges facing PMTCT services [World health org 2004]

1.2 Statement of the problem

Low utilization of PMTCT services by Mothers living with HIV /AIDS is contributing to the increasing number of children with HIV/AIDS especially in the rural poor in Uganda. These rural settlements in Uganda lack basic infrastructure like roads, health centers' and schools, so they are found out to be vulnerable to preventing the spread of HW/AIDS which in turn is passed onto the children in their early stages in life or even still in their mother's womb.

For sure, the reason for this is twofold: on a public health scale it is a question of coverage: today, the majority of women in resource-poor countries are not accessing PMTCT services, and then within PMTCT services the question of best-practice protocols and their implementation is fundamental. Both these issues become interlinked where complex protocols become a potential obstacle to large scale roll-out.

According to the report from the ministry of health wakiso district in Makindye division in 2009, the prevalence of HIV/AIDS in Makindye division was 12% compared to 6.1% of the county. This indicates that with this high prevalence and without proper strategies put on ground more and more children are likely to acquire the deadly disease thus meaning that-The number of orphans with HIV/AIDS will increase after the death of their mothers, the cost of treatment of both the mother living with HIV/AIDS and the child will be too high and a lot of productive time will be wasted while taking care of these children and their mothers in hospitals which time would be used for agriculture and other income generating activities.

More to that also, this shows that due to moral decay in Uganda these days, these youth patients may end up also transmitting this disease at early ages to other youth, thus leading to an increase in the HIV/AIDS prevalence in Makindye division and the whole country at large. The study will try to analyze the factors hindering utilization of PMTCT services in Makindye division. A case study of Sabagabo sub county.

1.3 General objective of the study

The purpose of the study was on base on investigating into the factors responsible for the low utilization of PMTCT services in Makindye division in Sabagabo Sub County in central Uganda.

1.4 Specific Objectives of the study

To assess the level of awareness of PMTCT service in sabagabo sub county Wakiso District.

To assess the causes of mother to child transmission of HIV AIDS in sabagabo sub county wakiso district.

To provide strategies that can prevent mother to child transmission of HIV AIDS in Sabagabo Sub County in wakiso district.

1.5 Research questions

What is the level of awareness of mothers about PMTCT services in Makindye division in sabagabo sub county Wakiso district?

What is the impact of transport facilities on utilization of PMTCT services in Makindye division in Wakiso district?

What is the relationship between staffing and PMTCT service utilization in sabagabo sub county Makindye division in Wakiso district?

How is the availability of drugs affecting the utilization of PMTCT services in sabagabo sub county Makindye division in wakiso district?

1.7 Scope of the study

1.7.1 Content scope

The study will be made up of mother's awareness and utilization of PMTCT service; it will also cover the level of awareness on PMTCT service utilization, the impact of transport facilities on the utilization of PMTCT, the impact of under staffing on PMTCT, and finally to find out the availability of drugs and utilization of PMTCT services to enhance the PMTCT services in Makindye division Wakiso district.

1.7.2 Geographical scope

Uganda which is, officially the Republic of Uganda, is a landlocked country in East Africa. It is bordered on the east by Kenya, on the north by South Sudan, on the west by the Democratic Republic of the Congo, on the southwest by Rwanda, and on the south by Tanzania.

Uganda is the second most populous landlocked country. The southern part of the country includes a substantial portion of Lake Victoria, shared with Kenya and Tanzania, situating the country in the African Great Lakes region. Uganda also lies within the Nile basin, and has a varied but generally equatorial climate.

The official language is English. Luganda, a central language, is widely spoken across the country, and multiple other languages are also spoken including Swahili. The current President of Uganda is Yoweri Kaguta Museveni, who came to power in a coup in 1986.

Uganda's economy generates income from annual exports that include coffee (\$466.6 million), tea (\$72.1 million), fish (\$136.2 million), and other products. The country has commenced economic reforms and growth has been robust. In 2008, Uganda recorded 7% growth despite the global downturn and regional instability. Uganda's struggle to achieve their economic status was primarily due to decades of wars and corruption resulting in the nation being considered one of the poorest countries in the world.

Finally the study will be based in sabagabo sub county Makindye Division in wakiso district which is one of the divisions that make up the city of Kampala, Uganda.

Makindye is bordered by Nsambya to the north, Kibuye to the northwest, Najjanankumbi to the west, Lubowa in Wakiso District to the south, Luwafu to the southeast and Lukuli to the east. Kansanga and Kabalagala lie to Makindye's northeast. The coordinates of Makindye are: 00 16 45N, 32 11E (Latitude: 0.2791; Longitude: 32.5862). The road distance between Makindye and the central business district of Kampala is about 7 kilometres (4.3 mi).

Makindye at its peak stands 1,230 meters (4,040 Ft.) above sea level. It affords a commanding view of the surrounding areas of the city and of neighboring parts of Wakiso District. It also affords a view of Murchison Bay, a part of Lake Victoria to the east and southeast of Makindye. The residential areas on Makindye hill are of middle class proportions. Many of the homes have adjacent plots of land which are often used to grow vegetables.

1.7.3 Time scope

The study will take a period of two month [2014 may to 2014 Aug] in obtaining data on the level of PMTCT services utilization in relation to secure child infection with HIV/AIDS particularly in sabagabo sub county Makindye division in Wakiso district.

1.8 Significance of the study

Despite the attempts made by the Government of Uganda especially through the ministry of health and Non-government organizations like PEPFA (through MJAP) and UWESO, PMTCT services are poorly utilized by this community and a big percentage of HIV/AIDS positive mother still find their way to the TBA'S.

The study is to make sure that all pregnant women have access to high quality life-saving HIV prevention and treatment services, both for themselves and their children; regardless of their wealth, status or geographical location.

The research findings will also help service providers including Governments and NGOS to expand their efforts and ensuring the delivery of PMTCT services to all women, as a way of achieving universal access to PMTCT and the elimination of MTCT in Makindye division in kamala city and if at all worldwide.

The study will also help to ensure that HIV testing of pregnant women and timely access to effective antiretroviral therapy, both for the health of HIV-infected mothers and for PMTCT, during pregnancy, delivery and breastfeeding is improved in sabagabo sub county makindye division in wakiso district.

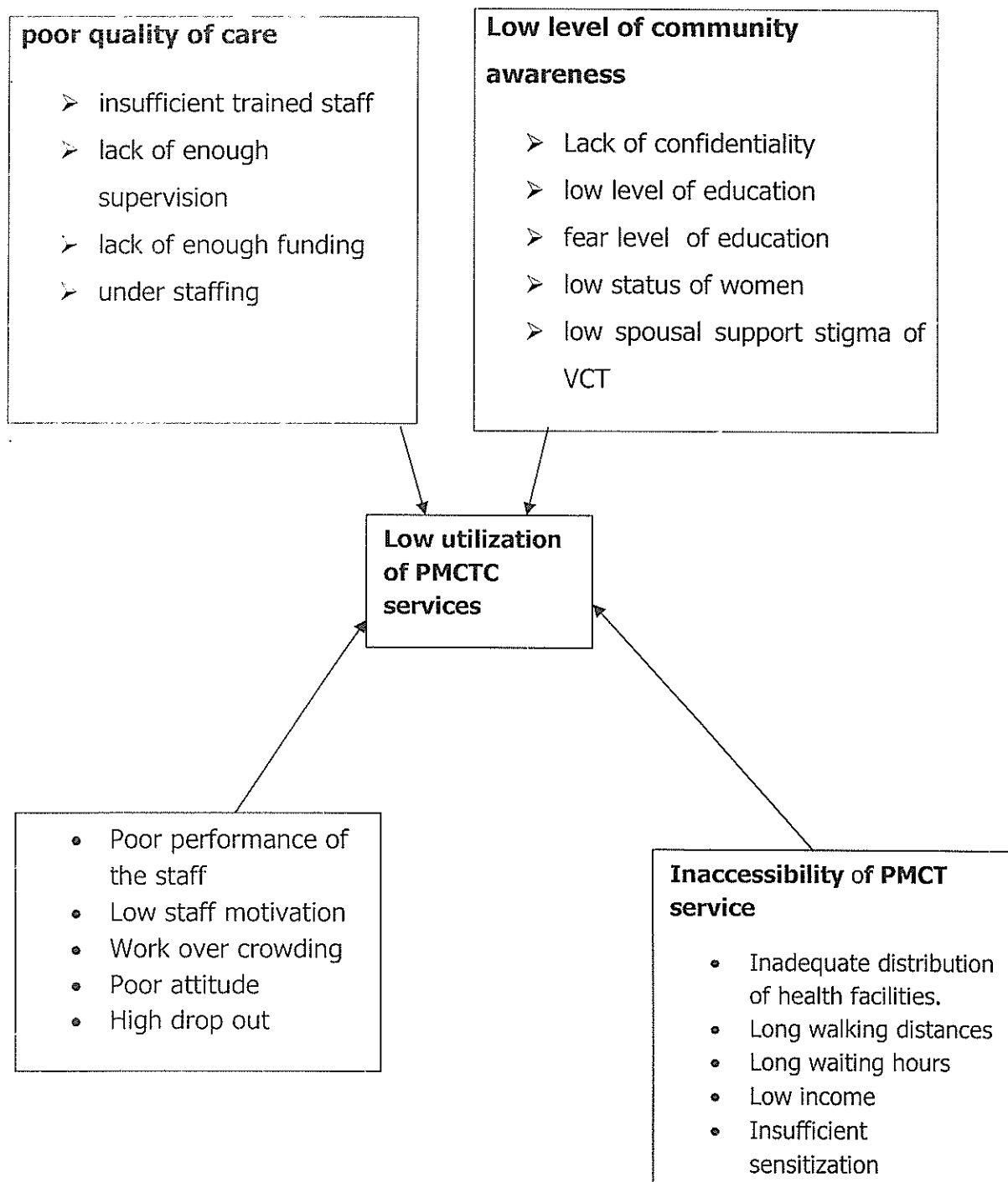
The study will also act as a driver to disseminate more information on the relevancy of PMTCT to the Community in order to facilitate utilization of the services by at least 75% of the women attending antenatal clinics in Makindye division in Kampala city.

The study could enable the researcher to gain more skills in data collection which could be used for future date for similar activities.

1.9 Conceptual framework

MOTHERS AWARENESS

UTILIZATION OF PMTCT



CHAPTER TWO:

LITERATURE REVIEW

2.0 Introduction

This chapter shows how the research problem under study fits into a body of knowledge generated over ages. It reveals investigations other researchers handled and the methodological and design issues. It also borrows literature from different authors about low utilization of PMTCT services.

According [Zombie 2012] defines Mother-to-child transmission (MTCT) is when an HIV-positive mother passes the virus to her child during pregnancy, labor, delivery or breastfeeding. Each year around 1.5 million women living with HIV become pregnant, and without antiretroviral drugs (ARVs), there is a 15 to 45 percent chance that their child will also become infected. However, among mothers that take a regimen of ARVs for the prevention of mother-to-child transmission (PMTCT), the risk of HIV transmission can be reduced to less than 5 percent.

[World health org 2013] also defines PMTCT as Preventing the transmission of HIV from a mother to her unborn child is a key intervention in curbing the spread of HIV. Nova's prevention of mother-to-child transmission (PMTCT) programme has received wide acclaim for its low transmission rates.

2.1 Level of awareness and sensitization

Knowledge is the psychological result of perception and learning and reasoning. One of the major factors for high transmission of HTV and low utilization of preventive strategies and methods is inadequate knowledge of HIV/AIDS and wrong perception. "There is nothing that will prevent me from accepting VCT if I know that I will be given drugs that will reduce the chance of infecting my child". A woman from Tanzania about PMTCT (quoted in de payola et al, 2006).

A study carried out in Uganda on 404 pregnant women who were attending Antenatal clinics, interviewed about rapid HIV test and the willingness to take an HIV test; 87% responded that they would accept an HIV test if it is offered to them. This indicates that if women have adequate information they have positive attitude towards PMTCT (Bajunirwe and Mazola, 2009).

Assessment of knowledge regarding MTCT and prevention conducted among pregnant women who were attending antenatal clinics in rural and urban Uganda shows that 80% of respondents knew that mothers with HIV could pass the virus to her child, 12% answered that she cannot pass and 8% answered they did not know (Bajunirwe et al, 2005).

Wakabi, 2004, in his report on international conference on AIDS in Thailand, he stated that from the survey carried out in Masaka district on a total of 114 mothers, 93% attended ANC during pregnancy while 61% gave birth at a health facility. During the Antenatal visit, 29% were counseled on PMTCT services, 10% took an HIV test while only 8% picked their HIV results. Those who knew that HIV can be transmitted during pregnancy were 31% as compared to 19% who knew where to get PMTCT services. So he concluded that awareness and knowledge of PMTCT services were still low in the whole district which is the case in all rural areas where Makindye division in Wakiso district is inclusive and recommended for stepping up of awareness campaigns in the whole country on PMTCT services.

Social and cultural factors such as poverty, stigmatization and low education level affect the take up of PMTCT services. Low level of education and lack of adequate information about PMTCT services for women of reproductive age contribute to low utilization of PMTCT services and non-adherence of treatment instructions. In sub Saharan African countries especially in Uganda, women are less likely to seek health care or to be cared in health care setting compared to men. Socio-economic status and low literacy are major factors influencing this outcome (Wodi, 2005).

A study done on factors influencing the utilization of preventing MTC HIV/AIDS transmission (PMTCT) services among pregnant women in south Africa reveals that from women who accepted an HIV test after counseling 96% received their HIV results and participated in necessary follow-up visits. (Pulitzer et al, 2008).

In the former days education of girl child was influenced by different factors like preference of the community for sex of the child and poverty with tradition that worsen restriction of women from financial access. These problems contribute to women not accessing the information and power imbalance both at household and community level (MOH, 2004).

Majority of the women are at home doing domestic tasks and more likely not to have access to information on preventive health care like VCT, PMTCT and ART and its location. Pregnant women may think health institutions are giving curative services only for sick people. Health providers should encourage and support the community since PMTCT service needs awareness raising and to inculcate its benefit to the community. It is preferable if supported by audio visual materials, work with community, opinion/religious leaders and if possible establishing advisory boards helps in promoting collective ownership and help to raise acceptance of PMTCT services (ICRW, 2002, UNICEF, 2003).

2.2 Transport and communication

Distance is a major obstacle to health institutions and worse when combined with scarcity of resources and infrastructure like the absence of all-weather roads, price of cost of transport and essential medication and time taken to reach health institution. These may affect the utilization of health services where PMTCT is among (Thaddeus, et al, 1994). Long distances to service limits people's access to traditional VCT systems (Joseph, KB. Matovu, et al, 2007).

Improvements of infrastructure are required to avail PMTCT services. There are evidences that feasibility of the program was possible in the poorest part of the world (UNICEF, 2003). Development of infrastructure is important and its improvement is

mandatory since it has significant benefits for improvement of other related health care areas. Mobilization of resources for prevention of mother to child transmission of HIV services helps as a changing agent for improvement of other HIV prevention programs (Scotland G.S et al, 2003).

2.3 Under utilization of staffing

In many low- and middle-income countries health systems are often poorly staffed and resourced; clinics struggle to provide existing services, let alone new ones. As a result of this limited capacity, many countries are unable to adapt their existing health systems according to World Health Organization (WHO) PMTCT guidelines, which are amended as new evidence becomes available and more cost-effective in the long-term. Therefore, many clinics are not providing HIV-infected women with the most effective drugs. One example of this is the use of single-dose nevirapine, an antiretroviral drug which, despite no longer being recommended by the WHO, in 2011 was still being used in many countries for PMTCT; including India, Egypt, Malawi, Kenya, Haiti, Uganda, China and Vietnam WHO'.

Shortages of PMTCT staff (counselors, midwives and laboratory personnel) is a big challenge facing PMTCT services as the low/little staff members who are involved in the services need motivation to deal with increased workloads but some managers think the health workers' wish for additional motivation is unreasonable (Biribonwoha et al, 2004).

In any service, human resource is the most critical one particularly in PMTCT. Trained/well skilled personnel is very important, staff shortages and motivational issues can also be very significant especially when it comes to counseling, which takes a long time to do well. In most cases PMTCT services are initiated in health institutions that are under staffed because of lack of human resource. Attrition of trained providers to private health institutions or migrate outside their country for economic and other reasons. Attrition is also caused by AIDS related death and created workload for staff

who is already de-motivated due to different reasons that include under payment and insufficient supplies. These problems can be minimized by recruiting new health workers, providing training that includes universal precautions and post exposure prophylaxis (PEP) to help prevent health workers becoming infected with HIV, frequent support and motivation to improve existing staff's efficiency, psychological and social support and ensuring resource availability (UNICEF, 2003).

In HIV/AIDS prevention activities including PMTCT services, we need to consider support staff. But what is happening in reality now is, concerning human resource for health, AIDS donors focus on training existing health workers rather than hiring or training new ones. In countries like Mozambique, Uganda and Zambia who are like most sub-Saharan African countries suffering from the unavailability and inequitable distribution of qualified health workers were observed (United Nations, 2008).

The recruitment of lay counselors who can provide good quality counseling services with training of few weeks to months is believed to decrease workloads of health professionals and it should be assisted with frequent and continuous supervision (Bassett MT, 2005).

Lack of equipment and supplies affects health facilities in most Sub-Saharan African countries. This can be not only because of limited financial resources. It is often a result of poor management and organization of available resources. "In Africa, limited human resource as well as financial resources represent major barrier to up scaling HIV related programmes are increasing and becoming available, a big and immediate challenge is human resource capacity, to deliver service and the capacity to absorb additional financial resources" (CHAGA, 2004) This makes it difficult to fulfill necessary supplies as needed.

2.4 Availability of Drugs and other essential materials

In order to implement PMTCT and other HIV/AIDS programs effectively, adequate and reliable supply management systems is necessary. Better availability of medicines and related supplies play a great role in increasing PMTCT service utilization.

Shortage of HIV test kits, preventive drugs means (NVP) and other supplies can limit the efficiency of PMTCT programs. It is therefore important to have reliable supply chains that are integrated into the systems. In general shortage of material resources, supplementary drugs, budget and inadequate funding can be considered as existing bottleneck on ensuring PMTCT services. The drugs combivir plus single dose Nevirapine were used for PMTCT in higher level facilities, while the lower level health facilities with fewer resources continued to use single dose Nevirapine only (MOH, 2009).

Continuous availability of essential material inputs especially in peripheries or rural areas has to be ensured to provide PMTCT services. It is widely believed that integration of PMTCT services into available health system ensures achievement of wide coverage through provision of the service in Antenatal clinics and delivery health units. But because of different persons including poor materials resources, many developing countries could not achieve this goal and the progress is still slow. Instead of starting new ones (PMTCT services), health institutions are struggling to maintain conventional services (UN, 2009).

Most African countries have poor supply management systems due to inadequate storage and equipment, weak inventory control and poor procurement and short shelf life of PMTCT products, which has negative effects in providing efficient services (WHO/UNICEF, 2008).

CHAPTER THREE:
RESEARCH METHODOLOGY

3.0 Introduction

This chapter basically will present the methods of data collection, the instruments upon which the study findings, conclusion and recommendations on an investigation into the factors responsible for the utilization PMTC services in Sabagabo Sub county Wakiso district in central Uganda.

3.1 Research design

The researcher used both quantitative and qualitative methods in picking of the relevant data necessary for the design. The descriptive research design was used to establish the distribution of the variables in the study population which helped the researcher in obtaining primary data. An in depth study of the existing health system will be made together with the analysis of the cultural behavior of the sample population.

3.2 Study population

The research was intended to cover a total of fifty (120) respondents. These study respondents was selected from the study area and comprised of mothers and health workers from sabagabo Sub County.

3.3 Sample size

Respondents	Number
Mothers	80
Health workers	40
Total	140

3.4 Sampling Selection

Purposive sampling procedure was used on health workers. This is because purpose sampling helped to locate respondents who had true facts relevant to the study. Stratified random sampling was used to collect data from mothers whereby they were divided into strata and a simple random sample will be got from these strata. Simple sampling was opted for because all respondents were having equal chances of being included in the sample this ensured less bias on the collected data.

3.5 Data collection tools I Methods

The researcher was able to employ the following methods to collect the data from the field;

3.5.1 Questionnaire

Questionnaires were used to collect primary data where by a set of questions was designed to collect data from respondents especially mothers selected from the study area. They were allowed to fill the questionnaires and where possible the researcher was to help in filling the questionnaires for the respondents who never received /attained formal education.

3.5.2 Interviews

In depth interviews were conducted onto health workers who are the key informants and this was to provide a lot of information which the researcher could vitally need for the study. The researcher used this tool because it enabled him to ask the respondents more questions than the use of questionnaires.

3.6 Procedure for data collection

Having obtained a letter of introduction from the department of political and administrative studies of Kampala international university, the letter was presented to the local leaders to get official permission to conduct the study in the area. The researcher approached the respondents, and explained the purpose of the study and then after the researcher started interviewing health workers while noting down the responses. After, the researcher supplied questionnaires to the mothers. The researcher

then collected the questionnaires and appreciated the respondents for their cooperation where after the process of analyzing the data to come up with conclusions and recommendations were the next step.

3.7 Data analysis

Both qualitative and quantitative data analysis was used. Qualitative data was used to analyze data in the field as it is was being collected (verbatim reporting) while quantitative data was analyzed by using computer programs like scientific package for social scientist (SPSS), Epiinfo and Microsoft excel. Also under qualitative analysis, thematic analysis was used and in quantitative data analysis, graphs, tables and pie charts were used for data analysis and presentations.

3.8 Anticipated challenges to the study

The researcher faced problem of inadequate data that was required for relevant data for the study to be productive and effective. However it was assumed that some limitations were obstacle towards reaching the intended goals. Some of these limitations included language barriers among the local people, individual differences cultural rigidities.

Some respondents approached were reluctant in giving out information about the study asking why the researcher particularly aimed at assessing the factors constraining PMTCT services and women antenatal care on HIV/AIDS.

Time planned to collect data was not enough and this delayed the researcher to write a research report in specified time. This demanded the researcher to use research assistants from the field to save time.

Lack of financial support to successfully carryout the study. The money needed for processing the work in form of typing, printing, photocopying and binding was quite a lot. This hampered the efforts in collecting data in time as it was a constraint to the

researcher. This was dealt with by use of some willing classmates and friends to freely volunteer in the exercise so as to accomplish the report in the required time.

This study was limited to the cohort of women that may be identified through health Centre registers, and therefore had at least one potential interaction with formal PMTCT services. Our exclusion criteria excluded women registered only at tertiary referral Centre's and it is possible that these women had different characteristics than our study population (e.g. urban, wealthier, high risk obstetrical problems).

Some information was not verified (e.g. infant feeding options utilized) and was basing on maternal recall only. Finally, when tracing women to their homes, interviewers were not always able to be accompanied by a HTC counselor for testing resulting in a lower proportion of women and infants tested.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter presents analyses and discusses the major findings of the study according to the study objectives stated in chapter one of this report.

4.2 Demographic data of the respondents

4.2.1 Sex composition of the respondents

The researcher tried to find out the sex composition of the respondents as shown in the Table 1 below;

Table 1:

A table showing sex composition of the respondents

Sex	Frequency	percentage
female	32	64
male	18	36
total	50	100

Source field data June, 2014

Findings as indicated in table I above indicated that most of the people who sought PMTCT services were females with 32 (64%) while the males were only 18 (36%) of the respondents that were interviewed. According to the respondents, females were many because they are the ones that bear children and at the risk of transmitting to their babies. This is why there were more females than males in the seeking PMTCT services.

4.2.2 Marital status of the respondents

It was of the researcher's interest to find out marital status of the respondents as portrayed in the following table;

Table 2 Table below shows marital status of the respondents

Status	Frequency	percentage
Single	5	10
Married	25	50
divorced	8	16
widowed	12	24
Total	50	100

Source field data, June, 2014

Study findings as indicated in table 2 above revealed that most of the respondents were married with 25 (50%) followed by those that were widowed with 12 (24%) and those that were divorced were only 8 (16%) of the respondents and lastly the single ones with 5 (10%). Since most of them were married and had chances of children bearing, they had to participate in PMTCT services to reduce the risk of passing the Virus to their babies.

4.2.3 Age distribution of the respondents

The researcher intended to find out age distribution of the respondents so as to establish the category of people who sought PMTCT services as shown in the table below;

Table 3:

A table showing age distribution of the respondents

Age group	frequency	percentage
Less than 20	5	10
20- 29	26	52
30- 39	9	18
40- 49	7	14
50- and above	4	8
Total	50	100

Source field data, June 2014

Study findings as indicated in table 3 above revealed that most of the respondents were in the age range between 20-29 with 26 (52%) followed by those in the age range of 30-39 with 9(18%) while those in the range of 40-49 came third with 7(14%). It was only 5 (10%) and 4 (8%) of the respondents who were less than 20 and 50 and above 16 respectively. This implied that the adults actively sought and accessed PMTCT services than the young and the old people as revealed by the study findings. Respondents revealed that the elderly were not involved in PMTCT services because they were not producing any more children and therefore there was no much need for accessing such services.

42.4 Level of education of the respondents

The researcher wanted to find out the level of education of the respondents as shown in the table below;

Table 4: A table showing level of education of the respondents

Level	Frequency	percentage
Zero class	14	28
Primary	16	32
Secondary	7	14
Tertiary or university	13	26
Total	50	100

Source field data, June 2014

Findings as indicated in table 4 above indicate that most of the respondents had reached primary level of education which accounts for 16 (32%) followed by those who never went to school with 14 (28%) while those of tertiary/university came third with 13 (26%) and those secondary level came last with 7 (14%). This implied that since most of the respondents were educated, the information they provided to the researcher was sufficient and reliable to accomplish the study and the margin of error was minimized due to the understanding of the elite respondents.

42.5 Religious affiliation

The researcher intended to find out the religious affiliation of the respondents and its impact on accessibility of PMTCT services as presented in the figure below;

Table 5, Table below shows religious affiliation of respondents

Religious affiliation	frequency	percentage
Protestants	26	52
Catholics	10	20
SDA	6	12
Others	8	16
Total	50	100

Source field data, June 2014

Study findings as indicated in **table 5** indicates that the protestant sought PMTCT services which accounts for 26 (52%) followed by Catholics with 10 (20%) while seventh day Adventist and others came last with 6 (12%) and 8 (16%) respectively. This implied that the church has played a big role in sensitizing its followers on the importance of seeking PMTCT services in relation to HIV/AIDS privation. This has reduced the rate of infection of the unborn or newly born children by HIV positive mothers on to their babies.

4.2.6 Occupation status of the respondents

It was also of the researcher's interest to find out about the occupation of the respondents and its role in utilization of PMTCT in Sabagabo Sub-County as shown in the table below;

Table 5: A table showing occupation of the respondents

Occupation	Frequency	Percentage
peasants	22	44
civil servants	12	24
Traders	10	10
Others	6	12
Total	50	100

Source field data, June 2014

Study findings as indicated in table 5 above indicate that most of the respondents that the researcher interviewed were peasants with 22 (44%) followed by civil servants with 12 (24%) while those of business came third with 10(20%) and others with 6(12%) of the respondents.

Since majority of the respondents were peasants, access to PMTCT services were not accessed mainly due to long distances arid limited service providers for such services at the village level. This has had an impact on PMTCT services in sabagabo Sub- County where the study was conducted. It also meant that being in a rural area, access to PMTCT was practically difficult as they must travel to health Centre IV which is located along slam road where such services are rendered.

4.3 Causes of low level of mothers awareness of PMTCT services

In the research findings, the researcher wanted to know the causes of low utilization of PMTCT in Sabagabo sub county Makindye division and this was looked into:

4.3.1 Insufficient health educators

The researcher was interested in knowing the presence of health educators in Sebagabo Sub-County as shown in the table below:

Table 6: A table showing the presence of health educators

Level of response	frequency	Percentage
YES	14	28
NO	36	72
Total	50	100

Source field data, june2014

Study findings as indicated in table 6 above indicate that there was no health educators which accounts for 36 (72%) while those who revealed that there were health educators were only 14 (28%) of the respondents. Therefore health educators were few according to the study carried out.

4.3.2 Inadequate Knowledge on PMTCT services

The researcher tried to find out knowledge of PMTCT services as presented in the table below;

Table 8: A table showing knowledge of PMTCT services

Response	frequency	percentage
YES	24	48
NO	26	52
Total	50	100

Source field data June 2014

Study findings as indicated in table 8 above revealed that most the mothers had no knowledge about PMTCT services which accounts for 26 (52%) followed by those who indicated that mothers had knowledge of PMTCT with only 24 (48%).

4.3.4 Low level of Husbands support in seeking PMTCT

The researcher ventured into knowing whether husbands provided support to their wives seeking PMTCT services as shown in the table below;

Table 9: A table showing husband's support

Response	Frequency	Percentage
YES	16	32
NO	34	68
Total	50	100

Source field data June 2014

Study findings as indicated in table 9 above indicate that most of the husbands were not supporting their spouses in seeking PMTCT services which accounts for 34 (68%) while those who indicated husbands supported their spouses were only 12 (32%) respectively. Therefore, most of the husband did not support offer support to their spouses when seeking PMTCT services according to the findings.

4.3.5 Low level of utilization of PMTCT

The researcher tried to find out the factors for low level of utilization of PMTCT services in sabagabo Sub County;

Table 10: A table showing low level of utilization of PMTCT

Factors	Frequency	Percentage
Long distances	14	28
poor sensitization	16	32
Limited health Centre's	12	24
Inadequate drugs	8	16
total	50	100

Source field data June 2014

Study findings as indicated in table 10 above that poor sensitization and distance were the major factors for low level of utilization of PMTCT services which accounts 16 (32%) and 14 (28%) respectively, followed by limited health centers with 12 (24%) while non-availability of drugs came last with 8 (16%) of the respondents. Therefore poor sensitization and distance were the major factors affecting utilization of PMTCT services as revealed by the study.

4.4 Mothers' awareness and utilization of PMTCT

4.4.1 Inaccessibility to PMTTC services

The researcher was interested in knowing mothers' accessibility in relation to PMTCT services as investigated in the table below,

Table 11: A table showing mothers accessibility to PMTCT services

Level of response	frequency	Percentage
YES	17	34
NO	23	46
Total	50	100

Source field data June 2014

Study findings as indicated in table 11 above revealed that most of the mothers did not access PMTCT services which accounts for 23 (66%) while those who indicated that mothers had accessibility to PMTCT services were only 17(34%) of the respondents that the researcher interacted with during the field study.

4.4.2 Reasons for not getting PMTCT services

The researcher tried to inquire into the reasons as to why mothers were not getting PMTCT services as shown in the table below;

Table 12; Table below showing reasons for not getting PMTCT services

Level of response	frequency	percentage
Not aware	25	50
Not willing	20	40
No transport	5	10
Total	50	100

Source field data, June 2014

Study findings as indicated in table 12 above revealed that mothers were not getting PMTCT services because they were not aware which accounts for 25 (50%) followed by those that were not willing with 20 (40%) while not having transport came last with 5(10%) of the respondents. Therefore, mothers were not getting PMTCT services because they were not aware or not willing to get services as revealed by the findings.

4.4.3 Services offered under PMTCT

The researcher tried intended to find out the services offered under PMTCT program as presented in the table below;

Table 12: A table showing services offered under PMTCT

Services	frequency	Percentage
HIV/AIDS testing and counseling	15	30
HIV prevention tips	10	20
care for babies	12	24
care of mothers	13	26
Total	50	100

Source field data June 2014

Study findings indicated in table 1 2 above revealed that the major services offered under PMTCT program were HIV/ATDS testing and counseling and self-care of mothers which accounts for 15 (30%) and 13 (26%) respectively. Care of the baby followed with 12(24) while HIV prevention came last with 1 0 (20%) of the respondents. Therefore HIV/AIDS testing and counseling and self-care of mothers were the most services offered under PMTCT services according to the study findings.

4.5 strategies of improving mothers' awareness in relation to PMTCT services

4.5.1 Measures employed by health workers to enhance mothers' awareness

The researcher wanted to find out the measures employed by health workers to enhance Mothers' awareness as shown in the table below;

Table 13: A table showing measures employed by health workers to increase mothers' awareness

measures	frequency	percentage
Friendly approach	22	44
mothers attend ANC	8	16
health workers talks with mothers	10	20
mothers seek health care	10	20
Total	50	100

Source: Field data, 2014

Study findings as indicated in table 13 above revealed that the most applicable measure employed by health workers to improve mothers awareness was having a friendly approach to mothers who seek the services which accounts for 22 (44%) followed by conducting health talks with mothers and encouraging mothers to seek health care with 10 (20%) respectively and lastly was encouraging mothers to attend antenatal (ANC) clinic with 8 (16%) of the respondents.

4.5.2 Role of local leaders in sensitizing mothers' about PMTCT

The researcher tried to examine the role of local leaders in mothers' awareness as presented in the table below:

Table 14: A table showing role of local leaders in sensitizing mothers' about PMTCT

Measures	Frequency	percentage
Community sensitization	25	50
Supervision	5	10
Mother seek PMTCT	20	40
Total	10	100

Source field data June 2014

Findings as indicated in table 14 above revealed that local leaders could help in sensitizing the community which accounts for 25 (50%) followed by encouraging mothers to seek health care with 20 (40%) while supervision came last with 5 (10%) of those that the researcher interviewed during the field study.

4.5.3 Mothers response when called to attend PMTCT services in sebagabo Sub County

The mothers' response when called for PMTCT services were as follows

Table 15: A table showing mothers response when called to attend PMTCT

services	Frequency	percentage
positive	18	36
negative	32	64
Total	50	100

Source: Field data, June 20114

Findings as indicated in table 15 above revealed that the response of the mothers when called for PMTCT services was negative which accounts for 32 (64%) while those Who said it was positive were only 18 (36%) of the respondents that the researcher interacted with during the field study. Therefore, the response of the mothers was

negative according to the majority of the respondents that the researcher interviewed which needs further help in orders mothers can be willing to adopt and practice PMTCT services in the sub county.

4.5.4 Role of government in improving PMTCT awareness

The role of government in improving mothers' awareness was as follows

Table 16: A table showing role of government in improving mother's sensitization

Services	frequency	Percentage
Increasing health workers salary	19	38
Providing transport	15	30
motivation benefits	5	10
Supervision	11	22
Total	50	100

Source: Field data, June 2014

Findings as indicated in table 16 above revealed that increasing the salary of health workers and providing transport by the government to the health workers could improve mothers awareness which accounts For I 9 (3 8%) and 15 (30%) while supervision came third with 11(22%) and lastly was providing of other fringe benefits with only 5 (10%) of the respondents.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents conclusions and recommendations based on the study objectives and the views of the respondents.

5.2 Conclusions

This study was about low prevention of mother to child transmission (PMTCT) of HIV/AIDS program efficiency and effectiveness under routine program conditions in sabagabo Sub County. PMTCT effectiveness indicated by HIV-free survival at 18-20 months was much lower under routine program conditions than results from study populations would suggest.

The study concluded that low levels of mothers awareness has been hindering utilization of PMTCT services in sebagabo sub-county and that health educators were few according to the study carried out. The study further concluded that most the mothers had no knowledge about PMTCT services.

The study also concluded that most of the husband did not support offer support to their spouses when seeking PMTCT services and that poor sensitization and long distance were the major factors affecting utilization of PMTQT services, the study further concluded that most of the mothers did not access PMTCT services.

The study further concluded that mothers were not getting PMTCT services because they were either not aware or not willing to get and that HIV/AIDS testing and counseling and self-care of mothers were the most services offered tinder PMTCT program.

The study also concluded that the most applicable measure employed by health workers to improve mother's awareness was having a friendly approach to mothers who

seek the services (PMTCT) and that local leaders could help in sensitizing the community about PMTCT services.

The further concluded that the response of the mothers when called for PMTCT services was negative and that increasing the salary of health workers and providing transport by the government to the health workers could improve mothers awareness.

Maternal mortality among HIV-infected women was high and demands further attention as improved maternal survival is also a means to improve infant survival. Improved HIV-free infant survival, and improved maternal survival, may be achieved by optimizing initiation of HAART during pregnancy and breastfeeding.

5.3 Recommendations

There is need for the government to employ more health workers so that the ratio of health workers and patients in normal. This would increase on the coverage of the patients by the health workers which apparently is not good.

There is need for government and local leaders to promote massive sensitization and campaigns in order to publicize the information regarding PMTCT services especially in rural area like in masaja village sebagabo Sub County where this study was conducted. This would increase on awareness and thus utilization of the PMTCT services.

There is need for the government particularly Ministry of Health to ensure steady supply of the required drugs for both mothers and children who seek PMTCT services at the health facility since respondents indicated that in most cases there are no drugs in health facilities. This would encourage more people to seek the services.

The government should upgrade rural murrum roads which apparently are in a poor state that affects mobility of people in rural areas in relation to accessing and utilizing PMTCT services in sebagabo Sub-County.

There is need for husbands to support their wives and children who are seeking PMTCT services since the study revealed that most of the women were not supported by their

husbands. This would reduce stigma and increase the chances of producing an HIV free babies.

Since the study was only conducted in sebgabo Sub-County, wakiso District, the researcher feels that similar studies should be conducted in other parts of the country to assess the level of utilization of PMTCT services and compare with sebgabo sub county conditions thereby looking for lasting measures to attract a massive population to utilize PMTCT services.

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APPENDICES

Appendix A: Questionnaire for mothers

Dear respondent;

I am **NAMAGARA BARBRA** a student of Kampala International University **REG NO.BPA/36170/113/DU** carrying out a study to establish the factors responsible for the low utilization of PMTCT services in sabagabo sub county makindye division central Uganda so that the recommendation for appropriate action can be made to relevant authorities and other policy makers. Please answer the following questionnaire as honestly as possible. There is no need to disclose your name and all the information given will be treated with the highest confidentiality and used only for the purpose of this study.

Thank you

Part A: Bio Data:

1. Sex

a) Male

b) Female

2. Marital status

a) Married

c) Widowed

b) Divorced/ Separated

d) Single

3. Age (years)

a) Less than 20

c) 30 -39

b) 20—29

d) 40-49

e) 50 and above

4. Level of education

a) Never been to school

b) Primary level

e) Others (specify).....

c) Secondary level

d) Tertiary / university level

5. Religion

A) Anglican /protestant

b) Roman catholic

c) SDA

d) Others (specify).....

6. Occupation

a) Peasant

b) Business person (specify).....

d) Others (specify).....

c) Civil servant

7. Does the household have in?

7.1 Electricity (YES / NO)

7.2 Radio (YES / NO)

7.3 Television (YES / NO)

8. Does any member of your household own:

9.1 Bicycle (YES/NO)

9.2 Motorcycle (YES / NO)

9.3 Car / truck (YES / NO)

Part B: Assessing the effect of transport on utilization of PMTCT services.

1. What is the possible distance to the nearest health facility?

- a) With in radius of 3km b) with in radius of 5km
c) With in radius of 10 km 10 km and above.

2. The type of road to the health facility

- a) Tarmac b) Feeder road

3. The commonest means used to the health facility.

- a) Foot b) Bicycle
c) Motorcycled) Car

4. Costs charged if a car or motorcycle is used:

- A) Charge below 2000? B) Charge above 2000?

5. How long does it take to reach the health facility?

- a) Less than 1 hour b) Between 1 -2hours
c) Between 2—4 hours d) above 4 hours

6. Does your husband give a hand during your traveling to the Health facility?

- a) Yes b No c) if no,

Why.....
.....
.....

7. What do you think the government should do to see that all pregnant women reach the health facility as quickly as possible and safely?

Part C: Assessing the level of awareness of the mothers towards PMTCT services

1 .How many times do you visit the antenatal clinic during your pregnancy?

- a) Once
- b) Two times
- c) Four times
- d) beyond four times

2. During your antenatal clinic visits, which message do the health workers normally give?.....
.....
.....

3 If PMTCT is mentioned, tell me what it means and what it involves?
.....
.....
.....

4. If PMTCT is not mentioned, have you ever had PMTCT services?
.....
.....
.....

Appendix B: Interview guide for health workers

Dear respondent;

I am **NAMAGARA BARBRA** a student of Kampala International University **REG.NO.BPA/36170/113/DU** carrying out a study to establish the factors responsible for the low utilization of PMTCT services in sabagabo sub county makindye division central Uganda so that the recommendation for appropriate action can be made to relevant authorities and other policy makers. Please answer the following questionnaire as honestly as possible. There is no need to disclose your name and all the information given will be treated with the highest confidentiality and used only for the purpose of this study.

Thank you

1. What do you think the government should do to see that all pregnant women reach the health facility as quickly as possible and safely?
2. What do you think could be the hindrance to the flow of information about services?
3. What do you think the government should do to see that all women get to know these services?
4. Are there some government interventions to enhance the performance of PMTCT in sabagabo sub county makindye division?
5. What are the responses of pregnant mothers towards the use of PMTCT services?
6. What do you think that are factors hinder the success of PMTCT in sabagabo sub county makindye division
7. What are the causes of under stuffing of health workers in sabagabo sub county makindye division?
8. How is the availability of drugs affecting the utilization of PMTCT services in sabagaba sub county makindye division?

Appendix E; expenditure used during research

A	Airtime	50,000
B	Printing and binding	50,000
C	Internet surfing	20000
D	Supervisor	40,000
E	Questioners	60,000
F	Typing	50000
	Ground total	280000