

Case Study: PMTCT Programming in Country Zed

As in many countries, Country Zed's prevention of mother-to-child transmission (PMTCT) programs continue to find it difficult to facilitate women's access to PMTCT services.¹

Overall Project Goal:

Expand access to and benefit from a full range of PMTCT interventions to:

- Reduce the number of babies born with HIV
- Improve the health of pregnant and new mothers living with HIV, as well as their babies' health
- Fight the stigma associated with HIV, and encourage and support disclosure

Project Objective:

The program has decided to pursue two strategies to increase women's willingness to test, seek results and, if positive, follow through on prophylaxis, infant feeding recommendations, and their healthcare needs. These strategies are to (1) train peer counselors to provide education and psychosocial support to HIV-positive pregnant women, as well as follow up with women after delivery; and (2) involve men in couples counseling.

Background Information:

The most recent Demographic and Health Survey reported high utilization (90%) of antenatal care by pregnant women, but only 47 percent deliver at a health facility. Most women have at least some primary schooling. Only 40 percent have access to piped water or electricity. More than half report no independent income. More than half of the women report having a partner or husband.

Country data from the WHO Multi-Country Study on Domestic Violence and the Domestic Violence Report in country Zed show the following: 41–56 percent of ever partnered women ages 15–49 had experienced physical or sexual violence from an intimate partner; 17–25 percent had experienced severe physical violence; and of these instances of severe physical violence, one-third to one-half had occurred during the past year.

In the context of pregnancy, it is becoming increasingly clear that this is a time of risk for acquiring sexually transmitted infections (STIs). Data suggest that it is not uncommon for male partners to have a sexual network with non-regular partners during the postnatal period; in addition, condom use with non-regular partners is low and with

¹ This case study is a composite of data drawn from Baek et al., 2007. *Key Findings From an Evaluation of the Mothers 2 Mothers Program in Kwazulu-Natal, South Africa*. Washington, DC: Population Council and Horizons Trust, Burke et al. n.d., *Male Participation in PMTCT Programs in Tanzania*, PPT Presentation, and additional findings from other country experiences. Thus, this case study and its data should not be taken as representative of any particular country or PMTCT intervention.

regular partner is even lower. There have been some recent poster campaigns with slogans like “test for the health of the next generation,” showing pictures of a pregnant woman holding a newborn baby. Yet, although antenatal care (ANC) use is high, a recent focus group shows that women have limited understanding of specific PMTCT interventions during pregnancy and after birth, and of their availability at the local health clinic.

When asked about their reactions to information about the importance and availability of specific medicines and recommended exclusive infant feeding practices, women expressed uncertainty about the effect of these recommendations on their pregnancy and the health of the infant. A number of women expressed feeling that women who are HIV positive should not have any more children. Regarding testing for HIV, women responded with more interest about knowing their status in the context of benefits for how to protect themselves from infection (in case the result was negative) or the possibility of seeking care in case they were already infected. It is significant that when asked about primary reasons to find out their status, their concerns about a child being infected during pregnancy constituted only 11 percent of responses.

A woman is expected to seek permission from her partner before testing. Women believe that testing without his permission will increase conflict. Men feel free to make their own decisions about whether to test or not without their partner’s permission and rarely disclose their status to their partners.

Men are reluctant to use testing sites close to their own communities for fear of lack of confidentiality. They also consider pregnancy to be too late for testing for themselves and their partners. They argue that a woman who is positive should not have any more children. If positive himself, however, he is unlikely to disclose, and will still desire more children. Men say that access to antiretrovirals (ARVs) would be a great incentive for them to agree to testing for themselves and their partners, even if the ARVs were provided only to their babies or their partners.

In the community, many people believe that if one parent is HIV+ both parents will be HIV+, and that children born will be HIV+ as well. HIV-related stigma in the community remains high—and directed at the person who first tests and discloses their status. More women than men know their HIV status, with most women tested during pregnancy. For women who reveal their HIV-status, it has not been uncommon to be abandoned and many have feared abuse by their male partners.

Both men and women in the community report that a family’s health information is supposed to be brought in to the family by the man. Women’s are not regarded as reliable sources of information. Men are also supposed to be the decision-makers in the family. Men see male community leaders and also health care providers as legitimate sources of information. Yet, men generally do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend the labor or birth of their child. Birth, delivery and care of infants are seen as exclusive purview of women, although men are increasing their involvement in sharing childrearing responsibilities as fathers with children once they become toddlers and above.

Women do discuss and health and relationship issues with other women in the community—and find other women and important source of social support, and practical information for women especially related to women’s and children’s health. However, this communication and use of information occurs separately among women, and is not directly brought in to the household.

Health care providers in the public sector have limited time to be able to provide much information and counseling to their clients. Overburdened by continued migration of health care staff as well as absences due to their own and family illnesses, midwives and nurses are stretched too thin to provide just the minimum standard of clinical care.

