

Original Research Article

KNOWLEDGE AND ATTITUDE ON PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV AMONG PREGNANT WOMEN ATTENDING ANTENATAL CLINIC AT KISII LEVEL FIVE HOSPITAL IN KISII COUNTY, KENYA.

KEY WORDS

Acquired Immune Deficiency Syndrome, Prevention of Mother to Child Transmission of HIV, Mother to Child Transmission of HIV, Human Immunodeficiency Virus, Care and Treatment Clinic, Acquired Immune Deficiency Syndrome

ABSTRACT

Introduction: The acquired immune deficiency syndrome (AIDS) epidemic is the greatest challenge to human kind in the 21st century. Over 35.5 million people are infected with HIV worldwide and the majority of these infections are in the reproductive age group. There are 2.3 million children under 15 years living with HIV, and 530,000 children were newly infected with HIV during 2006, most of them through mother to child transmission of the virus. A child dies of AIDS nearly every minute of every day.

Objective: To assess knowledge and attitude on PMTCT of HIV among pregnant women attending antenatal clinic in Kisii general hospital. **Methodology:** An institution-based cross-sectional study was conducted among pregnant mothers attending antenatal care clinic at Kisii general hospital from February to April, 2014. A systematic random sampling technique was used to select the respondents. Data were collected through structured pre-tested questionnaire. The data were then summarized into SPSS version 20.0, for windows and analyzed. Chi-square was used to calculate the association between, education, Occupation and age against knowledge on PMTCT. **Findings:** The findings from the study showed that the knowledge on PMTCT was positively related to Occupation ($P = 0.05$). A big number (52%) of the mothers did not know about PMTCT services which were being offered in the hospital. The study showed that the knowledge on PMTCT was positively related to age ($P = 0.02$). It was noted that respondents who had little or no knowledge of the services were mostly below 20 years of age and those with low education levels ($P = 0.01$). On the attitude towards PMTCT services it was found that three-quarters (77%) reported that it is good to take on PMTCT services if HIV positive and quarter (23%) of respondents reported that PMTCT services are wastage of time because AIDS has no cure.

Challenges that affect the PMTCT program include stigma still surrounding HIV and AIDS as a disease, which has led to a number of people not willing to know their status. **Conclusion:** The utilization of the PMTCT services were affected by the low levels of HIV testing. The insufficient knowledge on PMTCT coupled with the negative attitude towards HIV testing, fear and stigma towards HIV and AIDS contributed to the low utilization of PMTCT services in Kisii level 5 Hospital in Kisii County.

Recommendation: The study recommends working in collaboration with all stakeholders to improve and

increase on the sensitization and awareness to the communities on what PMTCT program is all about and what it entails. There is need to increase on the capacity building of the health workers in the PMTCT service provision especially in the areas of counseling and testing to avoid delays. Women need to be empowered in issues of socio-cultural so that they can make decisions in regards to their health and their children without causing conflicts in the family.

INTRODUCTION

The Acquired Immune Deficiency Syndrome (AIDS) epidemic is the greatest challenge to human kind in the 21st century. AIDS was first recognized in 1981 and is caused by human immunodeficiency virus (HIV) which was isolated in USA by the end of 1983. There are two types, namely HIV-1 and HIV-2. HIV-1 is more common, infects people worldwide and causes AIDS. HIV-2 though less aggressive and found mainly in West Africa causes a similar illness.

In 2009, around 400,000 children below 15yrs became infected with HIV (UNAIDS, 2010), almost all of MTCT infections occurred in Sub Saharan Africa, and more than 90% are as a result of mother-to-child transmission (MTCT) during pregnancy, labour/delivery, and breastfeeding.

Transmission during pregnancy is about 5 – 10%, during labor and delivery is 10 – 20% and during breastfeeding is 10 – 15% and without interventions, there is a 20-45% chance that a baby born to an HIV-infected mother will become infected (UNAIDS, 2010).

The risk of MTCT can be reduced up to 2% if comprehensive approach of PMTCT will be put in place (De Cock KM et al 2000). These comprehensive approach include the following elements, primary prevention of HIV among women of childbearing age and their partners, prevention of unintended pregnancies among women infected with HIV, prevention of HIV transmission from mothers to their infants, provision of treatment, care and support to women infected with HIV and their partners, infants and families. In other words MTCT of HIV has a dramatic deleterious impact on child survival and therefore PMTCT is of crucial importance.

HIV/AIDS has affected every level of society in Kenya. The current estimates are that 1.8 million people are living with HIV nationally with most of them being adults in their most productive years. The National HIV prevalence rate among adults 15-49 years of age is 7%. Rates of AIDS-related morbidity and mortality are increasing steadily among adults, particularly women, as is AIDS-related mortality in children less than 5 years of age. HIV has orphaned approximately 1 million children in the country (KDHS, 2003).

There is still fear of disclosing one's HIV status (or of learning it) because of the stigma that exists for people leaving with HIV/AIDS which hinders women from seeking PMTCT services and results in poor adherence to PMTCT interventions, in particular safer infant-feeding decisions. Being open about one's HIV status is one of the most powerful ways to reduce HIV-related stigma. Disclosing one's status also has other benefits, it can encourage partners to be tested for HIV and prevent the spread of HIV by allowing those infected to openly take appropriate prevention steps. Therefore knowledge and awareness on PMTCT of HIV has an impact on the practice of HIV testing, taking medication and attitude toward PMTCT interventions among pregnant mothers.

79 PROBLEM STATEMENT

80 Despite improvements in PMTCT services over the years, MTCT of HIV infections is high especially in
81 sub-Saharan Africa. In 2009 alone around 400,000 children less than 15yrs became infected with HIV and
82 1.3 million children and adults died of AIDS (**UNAIDS, 2010**), almost all of these infections occur in sub
83 Saharan Africa, and more than 90% are as a result of mother-to-child transmission (MTCT) during
84 pregnancy, labour/delivery, and breastfeeding.

85 Studies done in Uganda and Tanzania on awareness and knowledge about HIV and PMTCT in pregnant
86 women, in southwestern Tanzania shows a low level of knowledge on MTCT during pregnancy and
87 moderate knowledge on the risk of breastfeeding and MTCT (**Gundel et al 2009**).

88 The risk of MTCT can be reduced up to 2% if comprehensive approach of PMTCT will be put in place
89 (**De Cock KM et al 2000**).Treating mothers with ARV in late pregnancy and breastfeeding period has
90 shown to result in low postnatal HIV transmission. However little information is available on pregnant
91 women's knowledge and attitude towards PMTCT intervention, and whether there are educational and
92 behavioral change impacts from antenatal HIV counseling.

93 JUSTIFICATION

94 The purpose of this study was to assess the acquisition of knowledge about HIV MTCT among pregnant
95 women who have been counseled on PMTCT and their attitude towards PMTCT interventions.
96 Knowledge of the interventions of PMTCT is important, so that pregnant women can be aware and
97 through motivation they can have a positive attitude towards PMTCT.

98 The **Broad objective** was to assess knowledge and attitude on PMTCT of HIV among pregnant women
99 attending Antenatal clinic at Kisii level 5 Hospital in Kisii County, with Specific objectives as to
100 investigate the pregnant women's knowledge of Prevention of Mother- to-Child Transmission of HIV
101 (PMTCT) services, to examine pregnant women's attitude towards antiretroviral drugs in prevention of
102 Mother-to-Child Transmission of HIV and to examine the role of the hospitals in the utilization of
103 PMTCT services.

104 LITERATURE REVIEW

105 The World Health Organization estimates that over 2.3 million children under 15 years worldwide have
106 been infected with HIV through MTCT (**Marten et al 2010**).

107 Estimates by UNAIDS/WHO 2008 shows that the percentage of women infected with HIV globally has
108 been roughly the same over the last several years. Half of the adults aged 15 years or above living with
109 HIV are women and most are in sub-Saharan Africa where the ratio between women and men is 3 to 1.
110 The concentration of HIV infected children in sub-Saharan Africa reflects the estimates that about 60% of
111 HIV infected adults are women and that women in Africa tend to have more children than elsewhere in
112 the world.

113 A study conducted in an inner-city hospital in Atlanta to determine the effectiveness of HIV counseling
114 on the acquisition and retention of HIV knowledge before counseling, after and 48hours post partum
115 showed that, HIV counseling increases short term knowledge but there is a decrease in knowledge with
116 time (**Risby J, 1995**).

117 It was also shown in Gaborone, Botswana in 2003 that 67% of pregnant women got PMTCT information
118 from clinic counselors, 74% from radio and about 69% answered correctly more than 9 out of 12 factual
119 questions about PMTCT. Almost all respondents, 94% believed that all pregnant women should be tested
120 for HIV but only 56% had been tested (**Creek T et al 2004**).

121 In Lagos, Nigeria Ekaneem studied on knowledge and acceptability of HIV voluntary counseling and
122 testing in pregnancy as a strategy for PMTCT of HIV among women attending ANC at two health
123 facilities. The study revealed that 89.9% had good knowledge of the modes of HIV transmission but
124 knowledge of specific aspects of PMTCT was poor. Forty one percent were not aware of the association
125 between breast milk and HIV transmission and awareness of ARV drugs among the study group was poor
126 (**Ekaneem EE, 2007**).

127 It was shown in rural Nigeria that among women attending ANC all were aware of HIV/AIDS despite
128 their level of education, 90% were aware that HIV infection could co-exist with pregnancy. About 68%
129 were aware of MTCT but there was low knowledge of routes/modes of MTCT and more than half did not
130 know about PMTCT (**Moses O. et al 2007**).

131 It was shown in Eastern Cape in South Africa that most pregnant women 92.4% and their husbands or
132 partners never had an HIV test, the barriers being fear of being positive, unaware of where to get tested
133 and lack of confidentiality of the test results. On the other hand factors that encouraged them to go for a
134 test were having HIV/AIDS information, wanting to know HIV status and concern for the transmission
135 from mother to the unborn child (**Peltzer K. et al 2007**)

136 Poor antenatal counseling and HIV testing services are important barriers for PMTCT. This was shown in
137 a study done in rural eastern Uganda where 10% of women who attended ANC accepted to test for HIV
138 before being counseled. This supported the report from Mombasa, which pointed out that, the quality of
139 antenatal HIV counseling in a routine setting was associated with increasing rates of testing for HIV and
140 PMTCT awareness (**Delva W. et al 2006**)

141 Evaluation of the UNICEF sponsored PMTCT pilot project done in Tanzania in 2002 to obtain local
142 experience and determine the feasibility of integrating PMTCT within ANC and MCH services showed
143 that majority of women delivering at regional and district health facilities were of unknown status.
144 Counseling rates ranged from 9-56%, high acceptance and good use of HIV rapid testing found to be
145 80%. It was also found that not all staff assigned to ANC had PMTCT training. There was lack of skills,
146 materials, job aids and scripts for HIV related counseling, infant feeding, family planning, prevention and
147 ongoing support counseling, low male involvement and community participation (**Schwarendruber A. et
148 al 2000**)

149 In another study done in Tanzania at the Kilimanjaro Christian Medical Centre (KCMC) on testing a
150 PMTCT infant feeding counseling program where mothers were given brochures to take and read at home
151 with the objective of improving PMTCT counseling and infant feeding knowledge and practices of HIV+
152 and HIV- mothers it was shown that the program increased knowledge and practices (**Leshabari S. et al,
153 2005**).

154 In Kenya PMTCT in Nairobi and Masai Mara areas, still have little experience with ARVs, stigma and
155 misconceptions about the drugs have emerged as important obstacles to acceptance and effective use.

With limited access, PMTCT programs have made special efforts to help women adhere to the often difficult-to-follow ARV treatment regimens. Because they do not provide mothers with ongoing ARV treatment, PMTCT programs are often criticised (Rutenberg; 2002).

A study conducted among the youths in Kakamega District Hospital, Nakuru Provincial General Hospital, Karatina District Hospital and Thika District Hospital in Kenya showed that study participants were less knowledgeable about specific ways to prevent MTCT and this was more likely among 15-19 year olds than 20-24 year olds. It is noteworthy that up to 41% of 15-19 year olds and 22% of 20-24 year olds did not correctly name any preventive measure. However, nearly all the survey respondents in both age groups knew that an HIV-positive mother could transmit the virus to her newborn baby (Heidi et al, 2006). Similarly in a study conducted in a rural district community and Homa-Bay District Hospital in South Western Kenya, maternal knowledge on MTCT of HIV was as low as 8.9% in the study area. (Moth et al, 2005)

Inadequate knowledge about HIV/AIDS, MTCT and its prevention and a bad attitude towards HIV prevention information and services are major setback to success of PMTCT programme efforts. Information gathered will help to identify existing knowledge gaps that pregnant women acquire after being counseled. The information can be implemented by private and public programmers towards optimizing provision of PMTCT services.

METHODOLOGY

Kisii level 5 hospital is located within Kisii town in Kisii central district which is one of the Districts in Nyanza province, and it is the headquarters of Kisii County. The study conducted from 10th March, 2014 to 28th March 2014 was of a cross sectional study which was used to establish pregnant women's knowledge on PMTCT and their attitude towards PMTCT. Sample size of 328 respondents was calculated using *Fisher et al 1998* formula. Sampling technique was Convenience sampling.

All pregnant women who attended Antenatal Clinic who have had counseling on PMTCT were included in the study while those who refused to participate after explanation about the purpose of the study were excluded.

Pre-tested structured questionnaire was prepared by reviewing previously done studies on the topic of interest. The data were collected using structured interviewer administered questionnaire prepared to address knowledge and attitude associated with PMTCT services. The questionnaires were administered to all volunteer pregnant women who fulfilled the inclusion criteria while they were attending ANC clinic at the hospital. Data was entered into and analyzed using the SPSS database program version 20. The Chi-square test was used to measure the strength of associations between variables, a p-value of = or <0.05 was considered to be statistically significant. Ethical approval and clearance was taken from Kisii level 5 Hospital administration. Information which was communicated with individual subjects was kept private and maintained confidential. Coding was used to eliminate names and other personal identification of respondents throughout the study process to ensure anonymity.

RESULTS

Social demographic characteristics of Respondents

Some of the socio-demographic characteristics of the respondents that were considered included the marital status, occupation, education level, religion and the age of the respondents.

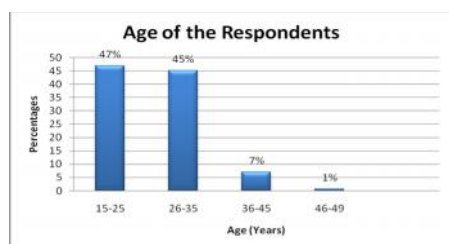


Figure 1: Age of the respondents.

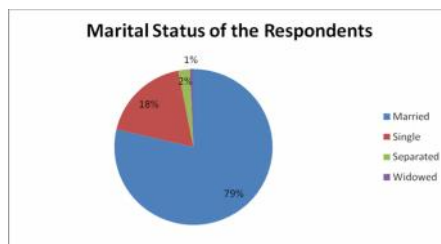


Figure 2: Marital status of the respondents

Majority of the female interviewed during the research were women aged between 15 to 35 years of age (92%), with only 1% being over 45 years of age. Most (79 %), of the women interviewed were married 18 % single, 2% separated and 1% widowed.

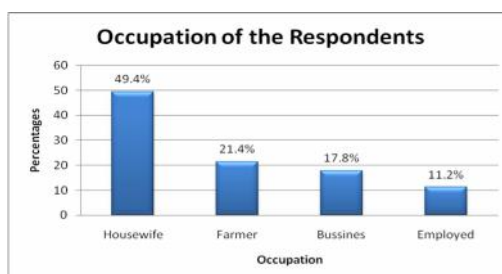
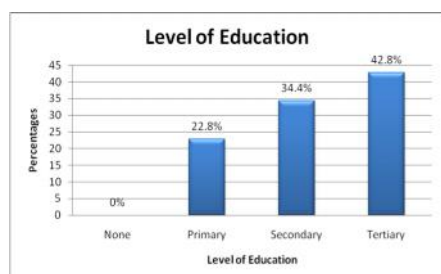


Figure 3: Level of Education of the Respondents. Figure 4: Occupation of the respondents

Most (42.8%) of the women interviewed had tertiary level of education, that is, they had either gone through or were in colleges or universities, while only 22.8% of the women had primary level of education and no respondent had no education at all. Among the women interviewed, 49.4% were housewives, 21.4% were farmers while only 11.2% were employed.

Knowledge on PMTCT

Cross tabulation of respondents' age and knowledge on PMTCT

Table 1: Association between the respondent's age and knowledge on PMTCT.

Age	Have you ever heard of PMTCT				Total	
	Yes		No			
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
15- 25	58	37.7	96	62.3	154	100.0
26- 35	81	54.7	67	45.3	148	100.0
35- 45	17	73.9	6	26.1	23	100.0
46- 49	2	66.7	1	33.3	3	100.0
Total	158	48.2	170	51.8	328	100.0

The findings from the study showed that the knowledge on PMTCT was positively related to age ($P = 0.02$) of the respondents as it is clear from the table above that the higher the age, the more the more the knowledge.

Cross tabulation of respondents' occupations and their knowledge on PMTCT

Table 2: Association between respondent's occupation and their knowledge on PMTCT

Occupation	Have you ever heard of PMTCT				Total	
	Yes		No			
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Employed	37	100.0	0	0.0	37	11.0
Business	32	55.2	26	44.8	58	18.0
House wife	63	38.9	99	61.1	162	49.0
Farmers	26	36.6	45	63.4	71	22.0
Total	158	48.2	170	51.8	328	100.0

The findings from the study showed that the knowledge on PMTCT was positively related to Occupation. ($P = 0.05$). All the employed respondents interviewed knew about PMTCT. Those in business category followed at 32 (55.2%). However, only 26 (36.6%) farmers knew about PMTCT.

Cross tabulation of education levels of respondents and their knowledge on PMTCT

Table 3: Association between respondents' level of education and knowledge on PMTCT

Education level	Have you heard of PMTCT				Totals	
	Yes		No			
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Primary	7	9.3	68	90.7	75	23.0
Secondary	25	22.1	88	77.9	113	34.0
Tertiary	126	90	14	10	140	43.0
Totals	158	48.2	170	51.8	328	100.0

The study showed that the knowledge on PMTCT was positively related to Education ($P = 0.01$). Majority (90%) of the pregnant women with tertiary education had knowledge on PMTCT followed by the category of those who were exposed to the secondary education (22.1%), however only 9.3% of those with primary education knew about PMTCT.

Source of information on PMTCT

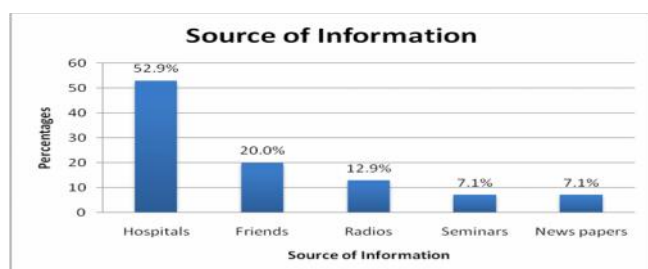


Figure 5: Source of information on PMTCT

Most (52.9%) of the women interviewed obtained the information about PMTCT from hospitals, 20% from friends and only 7.1% in the seminars or news papers.

Pregnant women's knowledge on STDs and PMTCT

Table 4: Pregnant women's knowledge on STDs and PMTCT

Knowledge on STDs	Have you ever heard of PMTCT				Totals	
	Yes		No			
	Frequency	Percentages	Frequency	Percentages	Frequency	Percentages
Yes	158	53.2	139	46.8	297	90.5
No	0	0.0	31	100.0	31	9.5
Totals	158	48.2	170	51.8	328	100.0

Respondents who knew about STDs had knowledge about PMTCT 158 (53.2%) and those with no knowledge had less knowledge on PMTCT (100%).

Attitude(s) towards PMTCT services.

Percentage of mothers who said it is important to have an HIV test while pregnant.

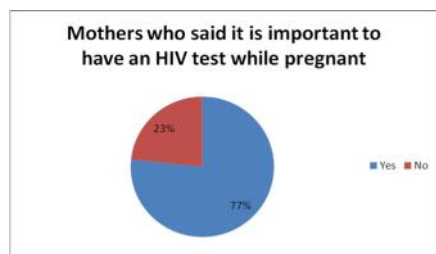


Figure 6: whether HIV positive woman should have a baby or not

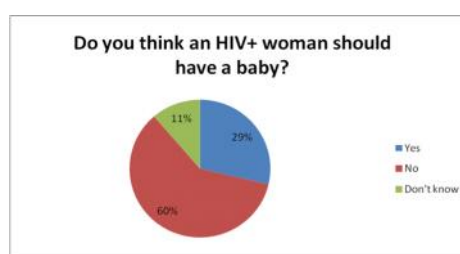


Figure 7: Percentage of mothers on important of having HIV test while pregnant.

Most 252 (77%) of the pregnant mothers felt it is important to have an HIV and know their status while 76 (23%) did not see the importance of knowing their HIV status.

Responses on whether HIV positive woman should have a baby or not

Some (29%) of the respondents reported that it was okay for an HIV positive woman to have a baby while the majority(60%) of the respondents reported that an HIV infected woman should not have a baby at all, the other few respondents on the other hand did not know what to say.

Responses on whether HIV positive woman should breastfeed her baby.

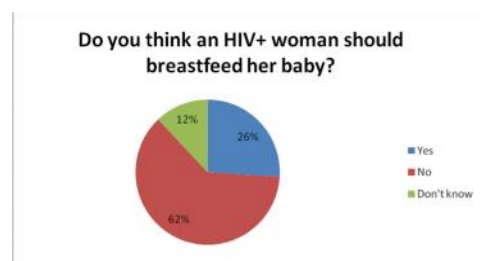


Figure 8: Responses on whether an HIV positive Woman should breastfeed her baby.

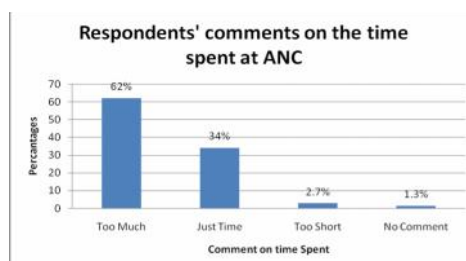


Figure 9: The respondents' comments on the time spent at the Antenatal Clinic

Many respondents (62 %) were of the view that an HIV positive mother should not breastfeed the baby.

Utilization of PMTCT services by pregnant mothers.

The respondents' comments on the time spent at the Antenatal Clinic

Most (62%) of the respondents reported to have spent too much time waiting for the services at ANC, however only 2.7% said that the time was too short.

Percentages of respondents comfortable with the form of counseling

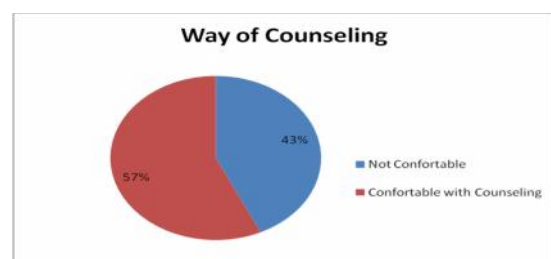


Figure 10: Percentages of respondents comfortable with the form of counseling

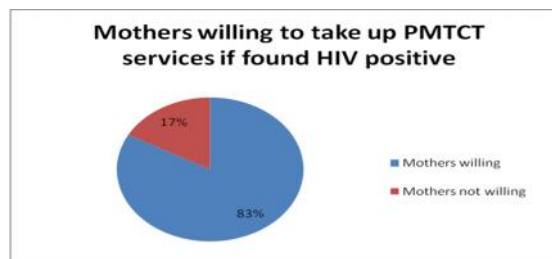


Figure 11: Mothers willing to take up PMTCT services if found HIV positive

Only 57% of the respondents reported that they were comfortable with the form of counseling offered, while 43% were not comfortable.

Mothers willing to take up PMTCT services if found HIV positive

Most respondents reported that they are willing to take up PMTCT services if found HIV positive while few are unwilling to take up the services.

DICUSSION

Knowledge on PMTCT

Kisii Level 5 hospital MCH/FP clinic serves a wide range of clients whose level of education ranges from primary to tertiary and this is because it's located in an urban area. The respondents interviewed in the study were educated from primary, secondary and tertiary, with the majority (42.8%) having tertiary level

of education, however only 158 (48.2%) of the respondents had knowledge on PMTCT. The majority of the respondents 297 (90.5%) had knowledge sexually transmitted infections (STIs), these findings concurred with previous studies done by (Ekaneem E. E. and Moses O. et al, 2007) at Lagos and rural Nigeria respectively.

The study findings also revealed that the higher the age, the more the more the knowledge. This association was confirmed by the Chi-square correlations whereby the P.V was (0.02) meaning that there was a significant relationship between age and the knowledge of PMTCT services. This was because those who are 26 years and above are more exposed to different sources of information and also have experience on antenatal issues since they always come for counseling in Health Centre. The other groups are those who marry when they are still young and therefore do not take antenatal issues serious, these findings coincided with those previously found by (Moth et al, 2005) at Kakamega, Nakuru, Karatina and Thika district Hospitals in Kenya. One of the reasons why mothers under 25 years do not known PMTCT is that they fear to disclose the matter because some get pregnant when they are not married, and with all the fear from the parents and society who are against having children out of marriage.

It was found that there was an association between the respondents' occupation and the knowledge on PMTCT services ($P = 0.05$). Those in formal employment were more knowledgeable about the services. The high level of knowledge about PMTCT by civil servants is attributed to their high education levels ($P = 0.01$) compared to other categories. It was also found that the same group complained about the much time they spend waiting for the antenatal services, since they always have to report back to the work places. Those involved in business, and other occupations were the next big category who knew about PMTCT services. This group is also exposed to different media and they also interact with different levels of people when they are carrying out their activities. All Employed interviewed knew about PMTCT. Self employed category followed. However, only 26 (36.6%) Farmers knew about PMTCT. It was found that there is an association between the respondents' occupation and the knowledge on PMTCT services. Those in formal employment were more knowledgeable about the services ($P = 0.05$).

It was found that other sources of information about PMTCT included; interactions with friends, during antenatal visits, radios programs and seminars. It was also clear that the most reliable source among these was sensitization and counseling sessions at the hospital during antenatal visits.

Most stakeholders involved have knowledge on PMTCT, though others are not aware, especially those who are not involved in the program. Though sensitization is being done up to the grassroots to increase mothers awareness on PMTCT, there is still a long way to go. Sensitization should be done effectively not only to the mothers but also to all stakeholders i.e. fathers communities, health workers and NGO s that are involved. Health workers should all be equipped with first hand information about PMTCT so that they are always in position to council and advice people accordingly. If all this is done, the PMTCT program will live to serve its intended purpose.

Attitude(s) towards PMTCT of HIV services.

Most pregnant mothers felt it is important to have an HIV and know the status while few did not see the importance of knowing the HIV status this was because, some pregnant women still have a negative attitude towards HIV testing. The reason for this being fear and stigma associated with HIV/ AIDS as a disease.

This demonstrates fear and stigma people have towards HIV and AIDS and the way People living with HIV/AIDS (PLWHA's) are stigmatized. However this is not only in Kenya but was reported in Zambia in

324 a study on PMTCT conducted by **UNAIDS in 2001** whereby the findings indicated that there is a high
325 level of stigma against HIV/AIDS patients, the community tends to shun persons who are known to be
326 HIV infected or have symptoms of AIDS.

327 Those who reported that an HIV positive woman should not have a baby gave a reason that this will
328 shorten her already 'numbered days' since she loses a lot of blood in the delivery process. The other
329 reason was that some respondents think it's obvious an HIV positive woman will infect the baby therefore
330 are not convinced there is need for the baby. This indicates that there is a gap in knowledge as far as
331 PMTCT is concerned.

332 On the other hand respondents who reported that an HIV positive woman should have a baby
333 recommended it because few of them are aware the baby can be born free of HIV because of PMTCT
334 services if the woman attends antenatal regularly and delivers from the hospital. Surprisingly, the other
335 respondents looked at it in the cultural perspective that; it is the tradition for every woman to produce
336 children irrespective of the HIV status.

337 The respondents who reported that the HIV positive mother can breastfeed, at least knew that the baby
338 born of an infected mother can still be safe if she is enrolled for PMTCT and also breastfeeding may not
339 be dangerous when done exclusively. It was therefore found out during the study that it is not known by
340 some people that an HIV positive mother if she decides to breastfeed exclusively, the baby can still be
341 safe.

342 It was again found that among those who reported that the baby should be breastfed thought it was every
343 mother's obligation to breast feed her baby. Others reported that there were mothers who cannot afford to
344 buy other types of milk so breast milk is their only option. Among these however there are those who
345 know about exclusive breastfeeding due to counseling got when they went for PMTCT program at the
346 antenatal clinic.

347 On the issue of the husbands' and community's reaction when a wife/mother does not breastfeed her
348 child, it was found out that if the husband knows the wife is sick and was therefore advised by the health
349 workers not to breastfeed at all if she cannot do it exclusively, then he will support her, but if he does not
350 know, then this can cause problems.

351 The family members and community at large may not be in position to understand in case a woman is not
352 breastfeeding her child. This may pose a number of questions, some people may think the mother wants
353 to kill the baby and for this reason therefore she may be rejected and despised by society. It is not easy to
354 explain to the whole community what really is stopping a woman from breastfeeding.

355 The respondents' attitudes towards PMTCT services are affected by their lack of knowledge on what the
356 package entails and the advantages of these services to the HIV infected mothers. Much as it is true some
357 mothers are aware of detailed information on these services and others know bits of information, but a
358 good number of these pregnant mothers need more sensitization on this. The negative attitudes on the
359 PMTCT services were not only with the pregnant mothers who are supposed to be the beneficiaries of
360 these services in case they test and found to be sick, but also the communities where they come from.
361 These communities have to be sensitized about these services if they are to support these mothers and
362 encourage them access the services.

363 It is also not enough for people to know the PMTCT program and probably also get scanty information
364 about the program when there is a lot to be known about it. It is difficult for some people to accept getting
365 involved in something they are not convinced about.

Since there is a small group of mothers that know very well about the PMTCT services among the many, therefore this big group of mothers who do not know cannot be left behind. They need to be sensitized, convinced so that they also can come aboard and reduce Mother-to-Child Transmission of HIV.

Utilization of PMTCT services by pregnant mothers

The study found out that there are a number of things that affect the level of utilization of PMTCT services; these include stigma about HIV and lack of sensitization etc. Though a big number of the respondents reported that time spent waiting for antenatal services is too much, this may not stop them from coming for the services, but however wish the time was less.

It was found that some of those who complained of the time being too much were public servants and self employed people who come for antenatal and yet have to go to work, so would not wish to wait for long. Some of those who said the time was much come from very far places and need to walk back. Those who were not comfortable with counseling said so basing on the arguments that counseling was done for groups and not to individuals, this makes them uncomfortable to ask personal questions.

It was however noted that though many respondents reported they were willing to take up PMTCT services, some were not willing to take an HIV test and yet this was the entry point of PMTCT services. On the other hand the respondents who are not willing to take up PMTCT if found HIV positive gave a reason that it was a wastage of time since AIDS has no cure while the others were not sure that an HIV positive woman cannot have an HIV /AIDS free baby. However some respondents raised a concern why PMTCT should target the children only without considering the mother.

CONCLUSIONS

The findings of the study indicate that some variables of the study that affect the knowledge as well attitude of the pregnant mothers. These included; age, education and occupation. The older the respondents, the higher the education and the occupation, the higher the knowledge of PMTCT services.

People's attitude and utilization of PMTCT services was affected by the insufficient knowledge on what the PMTCT program entails and the benefits of the services as far as mother-to-child transmission of HIV is concerned. Other issues like lack of male participation affected the utilization of PMTCT services.

The results reveal that social demographic characteristics of the respondents, the knowledge and attitude towards PMTCT influenced their behavior towards PMTCT services as the theoretical concepts explained. Indeed pregnant women felt that their unborn babies are susceptible to the HIV/AIDS infection and hence the need to protect the babies. This is in line with the Health Belief Model which asserts that people have got their own beliefs and in order for them to change behavior and perception on certain issues, these beliefs have to be put in consideration.

RECOMMENDATIONS

As much as there are mothers and people in the community who really know about the details of PMTCT program and services, a big number still do not know the program benefits in details. Therefore, measures should be put in place to make sure the correct and detailed information reaches the community.

Husbands and the community at large should also be sensitized on how they can support pregnant women in their communities by encouraging them to go for antenatal, advice them to deliver from the health

centre and attend seminars on antenatal education. This will enable them access all the necessary information on antenatal in general and PMTCT in particular, as well as reduce stigma among these women.

There is need to increase on the human resource to handle the PMTCT program in Kisii level 5 hospital. This can be done by training more PMTCT counselors to handle the big number of the pregnant women who seek antenatal services. The Government should implement the PMTCT Plus, so that the partner and other family members can access the HIV prevention, care and support services.

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