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An Observational Study to Assess the Challenges and Gaps in PPTCT Programme in KIMS, Hubli

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Abstract

Background: Every year 8 lakh children get HIV infection from their mothers either during pregnancy, child birth or breast feeding. In the absence of any active intervention, around 56,700 infected babies will be born annually. PPTCT programme was started in India in the year 2002 with an aim to reduce the perinatal transmission of HIV. Hence, determining the challenges and gaps in PPTCT programme, will be helpful to make this programme a success.

Objectives:

Ø To assess the awareness about HIV and the PPTCT programme among the pregnant population attending ANC OPD, KIMS.

Ø To compare the awareness about PPTCT programme among HIV positive pregnant women and general population visiting ANC.

Ø To assess the challenges and gaps in the implementation of PPTCT in KIMS

Methodology: A time bound observational study was conducted for a period of six month. Separate pre-tested and semi-structured questionnaire is used to collect the information from women attending ANC OPD, HIV positive women attending ANC OPD, obstetricians and PPTCT staff, KIMS. Data was entered in MS Excel & analysed using software SPSS 20.

Results:32%of the women attending ANC OPD did not know about MTCT. Only 26.5% of the ANC women who know about MTCT were aware about PPTCT and 32% of the ANC women were not aware of both MTCT and PPTCT. 86.7% of the HIV positive pregnant women who underwent post-test counselling were aware about MTCT and only 33.3% were aware about PPTCT.

Conclusion: Illiteracy and social stigma are the two main factors that are responsible for the lack of identification of the HIV cases. The main gaps in the programme are because of lack of adequate number of counsellors and lack of follow up of the patients.

Keywords: *HIV, PPTCT, ANC, gaps*

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Introduction

According to UNAIDS/WHO data there are over 39.5 million people living with HIV/AIDS worldwide and 17.5 million are women of reproductive age (UNAIDS/WHO, 2006).[1] There are an around 2.5 million HIV-infected persons in India. Nearly 30% are women of reproductive age who are often diagnosed for

the first time during pregnancy.[2]

Around 800,000 children get infected with HIV infection from their mothers every year worldwide — either during pregnancy, childbirth, or breastfeeding. Countries have the potential to prevent a large proportion of these infections through low-cost, effective interventions.[3] Informing the population about the routes of HIV transmission from a mother to her baby and that the risk of transmission can be reduced by using antiretroviral drugs are critical in reducing transmission of the virus from mothers to their babies.[4] HIV tests as part of routine antenatal care increases the proportion of women who are tested but some women do not collect test results. Although quality of counselling is one key factor in motivating women to take the HIV test, making the test a routine part of ANC is also important to encouraging women to get tested.[3]

In the absence of an active intervention, around 56,700 infected babies will be born annually. The PPTCT programme was started in India in the year 2002, with the aim of reducing the perinatal transmission of HIV, following feasibility study in 11 major hospitals in the high prevalence states.[5]

HIV sentinel surveillance (HSS) among antenatal clinic (ANC) attendees has been used to monitor HIV trends as well as to estimate the number of people with HIV. Recently, information on HIV infection has also become available from prevention of parent-to-child transmission (PPTCT) programmes.[6]

Women change their mind after agreeing to the HIV test or may have acquiesced to the health workers recommendation to have an HIV test without being convinced of the benefits. Test results are frequently delayed and women give up waiting for them, are told to come another day, or deliver before results are ready. If they have relatively little interest in finding out their HIV status, they might not want to go to the trouble of returning to the clinic or inquiring on their next visit. Also, many women agree to the test but then want to consult with their husband before receiving the results. Some husbands may object to their wife knowing whether she is infected. And some women have economic reasons, such as lack of money for transportation to return to the clinic.[3]

This study aims to find out many of such challenges and gaps facing the PPTCT programme in KIMS, Hubli.

Objectives

1. To assess the awareness about HIV and the PPTCT programme among the pregnant population attending ANC OPD, KIMS.

2. To compare the awareness about PPTCT programme among HIV positive pregnant women and general population visiting ANC.

3. To assess the challenges and gaps in the implementation of PPTCT in KIMS.

Methodology

Type of study: observational, time bound study.

Duration of study: 6 months (January to June 2011)

Source of data:

1. Pregnant women attending ANC OPD, KIMS Hubli.

2. HIV + women registered under the PPTCT programme in KIMS.

3. ICTC staff and Obstetricians, KIMS.

Methods of collection of data:

Pre tested and semi-structured questionnaire is used to collect the information from the study group after obtaining the verbal consent regarding challenges and gaps in PPTCT programme in KIMS.

Separate questionnaires were given to 50 women attending ANC OPD, 15 HIV+ women registered attending ANC OPD, 20 obstetricians and 16 PPTCT staff, KIMS.

Inclusion criteria:

1. Pregnant women attending ANC OPD, KIMS Hubli.

2. HIV + women both antenatal and postnatal registered in ICTC, KIMS.

3. ICTC staff and Obstetricians, KIMS.

Confidentiality was maintained regarding the details of the study participants.

Data was entered in MS Excel 2013 & analysed using IBM SPSS v20.0.

Results were presented in the form of percentages and Chi-Square test was applied wherever necessary.

Results

Table 1: Table showing the effect of education status and address (rural or urban) on the knowledge about HIV transmissibility among subjects attending ANC, OPD

VARIABLE	IS HIV TRANSMITTABLE?		
EDUCATION	YES	NO	DON'T KNOW
HIGHER EDUCATION	2	0	0
SECONDARY EDUCATION	27	2	1
PRIMARY EDUCATION	10	1	3
ILLITERATE	0	1	3
ADDRESS	YES	NO	DON'T KNOW
RURAL	24	4	5
URBAN	15	0	2

The knowledge about HIV transmissibility was lower among the illiterates and the people with primary education when compared with secondary and higher education completed subjects attending ANC, OPD. The knowledge about HIV transmissibility was lower among rural subjects when compared to urban subjects attending ANC, OPD. (Table 1)

Table 2: Knowledge about mode of spread of HIV among 50 ANC women Interviewed

MODE OF SPREAD	FREQUENCY	PERCENTAGE
TOUCH	7	14
SEXUAL TRANSMISSION	33	66
SNEEZE	14	28
BLOOD TRANSFUSION	31	62
DON'T KNOW	14	28

66% of the women attending ANC OPD said sexual transmission is the mode of spread of HIV and 62 % said it can be transmitted by blood transfusion

Table 3: Table showing awareness about mother to child transmission among the women attending ANC OPD

AWARENESS ABOUT MOTHER TO CHILD TRANSMISSION	FREQUENCY	PERCENTAGE
YES	34	68
NO	4	8
DON'T KNOW	12	24
TOTAL	50	100

32%of the women attending ANC OPD did not know about mother to child transmission

Table 4: Table showing awareness about PPTCT programme among the ANC population who know about MTCT

MTCT	AWARENESS OF PPTCT		TOTAL
	YES	NO	
YES	9	25	34
NO	0	16	16
TOTAL	9	41	50

Only 26.5% of the ANC women who know about MTCT were aware about PPTCT and 32% of the ANC women were not aware of both MTCT and PPTCT

· 86.7% of the HIV positive pregnant women who underwent post-test counselling were aware about MTCT and only 33.3% were aware about PPTCT

· 66.7% of the HIV positive patients faced social stigma, 46.7% of the HIV positive patients faced family stigma.

Table 5: Percentage of beneficiaries who underwent pre-test counselling

SOURCE OF DATA	COUNSELLED	NOT COUNSELLED	PERCENTAGE COUNSELLED
2011 JAN STATISTICS BY ICTC KIMS	274	1	99.6
2011 PROJECT BY KIMS STUDENT	6	9	40

In the present study it was observed that only 40% of the patients underwent pre-test counselling; while the ICTC records placed the figure as 99.6%.

Table 6: Gaps in the PPTCT programme according to staff in PPTCT, KIMS

ISSUE	FREQUENCY
AVAILABILITY OF DRUGS	9
NUMBER OF COUNSELLORS	16
FOLLOW UP OF PATIENTS	16
UPDATING OF STAFF KNOWLEDGE	9

Almost all staff in PPTCT, KIMS thought that the main gaps in the programme are because of lack of adequate number of counsellors and lack of follow up of the patients

Discussion

According to NFHS-3 data, only 40% of currently pregnant women know that HIV/AIDS can be transmitted from a mother to her child and only 15% are aware that transmission from a mother to her baby can be reduced by taking certain drugs; whereas in our study, 68% of the pregnant women knew about mother to child transmission.[4]

In our study we found that 8.2% of women tested did not receive their results.

The major reasons can be; women change their mind after agreeing to the HIV test or may have agreed to the health workers recommendation to have an HIV test without being convinced of the benefits under pressure. Test results are frequently delayed and women give up waiting for them. Also, many women agree to the test but then want to consult with their husband before receiving the results. Some husbands may object to their wife knowing whether she is infected. And some women have economic reasons, such as lack of money for transportation to return to the clinic.

Television is by far the most common source of information on AIDS, reported by 80 percent of both women and men who have heard of AIDS. The next most frequently reported sources after television are radio (37% of women and 55% of men), friends/relatives (32 % of women and 44 percent of men), and newspapers/ magazines (27% of women and 52% of men). In our study, we found that media (TV, radio and newspaper together account for 32% followed by information through health worker.[4]

In our study we found that 89.55% of the MB pairs received NVP Prophylaxis whereas in a study conducted by Parameshwari et al. Forty seven of them (83%) received nevirapine.[7]

Sites in Burundi and Rwanda, as well as in India, Kenya, and Uganda, offer pre-test counselling as a routine component of antenatal care and thus nearly all women who come for services are counselled which is similar to our study where almost all subjects received pre-test counselling.[3]

According to the PPTCT guidelines; in a developing country like India, exclusive breast feeding needs to be followed for a period of 6 months as people cannot afford the replacement feeds. But in our study we found that only 40% of the doctors advised exclusive breast feeding, while the rest advised replacement feeds.

Conclusion

Ø Around 62% of the women attending ANC OPD were aware about the routes of transmission of HIV.

Ø 32% of the ANC women were not aware of both MTCT and PPTCT pointing towards focus on awareness regarding the disease.

Ø Majority of the HIV positive pregnant women who underwent post-test counselling were aware about MTCT and only one third were aware about PPTCT.

Ø 93% of the HIV positive women have faced some kind of stigma in their life. The main gaps in the programme are because of lack of adequate number of counsellors and lack of follow up of the patients.

Limitations:

Ø Sample size was small so the results cannot be generalized.

Ø Study duration was short (1 month)

Ø -Most of the results obtained were from HIV+ women linked to the positive networks. Thus the results cannot be generalized to the entire HIV+ population.

Recommendations:

Ø Increasing the number of counsellors in ICTC, KIMS.

Ø Introducing rapid HIV tests so that women can receive same day counselling, HIV testing, and test results.

Ø Improving the quality of HIV and infant feeding counselling and active supervision

Ø Increasing the participation and linkage of positive networks to HIV+ people and providing the positive network people with job aids, monetary benefits etc.

Ø Regular training and integration of training for all health care providers concerned with PPTCT for efficient implementation.

Ø Expanding the vision of PPTCT to encompass an active role for fathers and male partners.

Ø Health campaigns to reduce stigmas and increase the awareness about HIV.

Ø Decrease the loss to follow up in the existing PPTCT centres.

Declaration

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Conflict of Interest: None declared

Ethical Approval: Not required

Informed consent: "Informed consent was obtained from all individual participants included in the study." Confidentiality and anonymity was maintained.

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