KNOWLEDGE AND ATTITUDE OF HIV/AIDS

A SURVEY AMONG PREGNANT WOMEN ATTENDING ANTENATAL CLINIC AT REPRODUCTIVE HEALTH CENTRE IN INDHIRA GANDHI MEMORIAL HOSPITAL

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DECLARATION

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I hereby declare that this Projects the result of my own work, except for quotations and summaries which have been duly acknowledged.

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ABSTRACT

Both qualitative and quantitative a cross- sectional study was conducted to assess the knowledge and attitude of pregnant women those who attend antenatal clinic at Indhira Gandhi Memorial Hospital on HIV/AIDS from 10th – 20th October 2013.

Data was taken from 100 pregnant women aged 18 -49 years, using a structured questionnaire translated in Dhivehi language. Descriptive statistics were done using MS Access and SPSS to describe the level of knowledge and attitude of pregnant women.

Findings of the study indicated high proportion (95.0%) of the respondents had at least some knowledge about the HIV/AIDS and levels of basic knowledge among them were high. However the knowledge on PMTCT services and HIV treatment were not adequate which had shown (84.0%) had not aware on PMTCT services and (74.0%) had not aware on HIV treatment. A large proportion (60.0%) of the respondents received HIV related information in the last 12 months and (40.0%) did not receive any information on HIV. Over half of the participants had obtained their knowledge from the health facilities while attending other services of hospital. Furthermore the 71.0% women said they had not screened during the last 12 months and 82.0% believed that they cannot refuse when doctor asks for HIV screening.

This finding highlighted that AIDS prevention programs need to improvement and they need to strengthen their BCC strategies. Also pregnant women should be given adequate information regarding PMTCT services including HIV testing and counseling. This will improve the knowledge of pregnant women on PMTCT of HIV/AIDS.

Key words: Knowledge, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), Prevention of Mother to Child Transmission (PMTCT), pregnant women.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BBS	Biological Behavioural Survey
CCHDC	Centre for Community Health and Disease Control
CHWs	Community Health Workers
DNP	Department of National Planning
FANC	Focused Antenatal Care
FHWs	Family Health Workers
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
IDU	Injecting Drug Users
IGMH	Indhira Gandhi Memorial Hospital
MDHS	Maldives Demographic Health Survey
MoH	Ministry of Health

MSM	Men Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NAP	National AIDS Program
NGOs	Non-Governmental Organizations
PMTCT	Prevention of Mother to Child Transmission
RHC	Reproductive Health Centre
RHS	Reproductive Health Survey
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
TV	Television
UNAIDS	Joint United Nations Programme on HIV/AIDS
USA	United States of America
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CHAPTER - 1INTRODUCTION

1.1 Background to the Study

1.1.1 Maldives

The Republic of the Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It consists of approximately1190 small low lying – coral islands, naturally divided into 26 atolls which of around 196 are inhabited and that stretch 820kilometers from north to south and 120 kilometers from west to east. For the administrative purpose Maldives government has divided into 20 atolls and is distributed to 6 regions. According to (DNP, 2006) the total population for the country was 298, 968 in the year 2006. In addition (CIA, 2009). The Maldives is classified as a lower middle income country. Fishing and tourism are the two main sources of national income.

1.1.2 Health Service Delivery in Maldives

Maldives' health services are organized as a five tier hierarchical structure. At the lowest level of service delivery, island level health facilities are known as Health Posts. The second level of health facilities are island Health Centres which are operational. At this level there

are at least two grades of the facilities depending upon the size of population it serves. Some of the Health Posts have a medical doctor since 2007, community health workers (CHWs) and nurses in addition to other administrative staff. The atoll level consists of around 13 hospitals in the country. At the fourth level, there are Regional Hospitals that cater to two to three atolls. There are six regional hospitals in total to provide secondary level curative care to all atolls. At the national level (fifth level), Indhira Gandhi Memorial Hospital (IGMH) in Male' serves as the tertiary care facility. The referral system works with a hierarchy ascending from family health workers (FHWs) in islands to specialists in IGMH. The establishment of public health unit within the health facility is characteristic of Maldives' strength to combine both preventive and curative services to promote preventive aspects of health. The Ministry of Health is the policy making body of the Health sector. After endorsed Public Health Act 2012; it has been renamed as Health Protection Agency (HPA) which looks after the programmatic side of the primary health care in the country. Within the HPA, the National AIDS Programme (NAP) is responsible for the planning, distribution and management of HIV/AIDS Preventive services in the country.

1.1.2 HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) was first recognized in 1981 and is caused by human immunodeficiency virus (HIV) which was isolated in USA by the end of 1983. AIDS has become a major global public health problem and its world epidemiologic pattern is still disastrous. AIDS is not only a fatal disease but also of a socioeconomic burden on both the health system and communities. Hence AIDS epidemic is the greatest challenge to human kind in the 21st century (N.Mujumali, 2011)

At the end of 2010, an estimated 34 million (31.6 –35.2 million) people were living with HIV. Globally, this translates to an increase of 17% from 2001, including 3.4 million (3 000

000–3 800 000) children less than 15 years old. This reflects continued new infections and significant scaling up of anti-retroviral therapy (ART) worldwide, which has helped in reducing AIDS-related deaths with increasing the survival of people living with HIV (WHO, 2012).

Progress report on HIV/AIDS in south - east Asia region showed that 3.5 million people living with HIV/AIDS in the region, an estimated 210 000 new HIV infections occur annually, translating into 575 people getting infected every day. HIV continues to exact its toll, with an estimated 230 000 AIDS-related deaths every year. Five high-priority countries in the Region are India, Indonesia, Myanmar, Nepal and Thailand. These account for 99% of the HIV burden in the Region.

According to the Ministry of Health (MoH) the first case of HIV in the Maldives was reported in 1991. However, the Maldives has one of the lowest estimated rates of HIV prevalence (less than 1 %) in the South and West Asia region. In addition (MOH, 2013) highlighted that as of June 2012, a total of 18 cases among Maldivians and 3014 cases among the expatriate migrant labour force have been reported (the Maldives has a mainly male expatriate migrant worker population estimated at over 70 000). From the 18 HIV-positive cases reported among Maldivians, 10 were seamen, 2were the wives of these sailors, and 2 were resort workers who traveled abroad with a foreign tourist. Other 4 included 1 MSM, 1 IDU, and 1 Drug User. Eighteen of the 3 were female.

1.2 Problem Statement

Maldives has so far experienced a low level HIV epidemic in the region. (MOH, Bilogical Behavioural Survey, 2008) has pointed out several factors that demonstrate vulnerability to an increasing epidemic: increasing drug use, increasing injecting drug use and the presence of

hidden populations of female commercial sex and men who have sex with men (MSM) in the archipelago. The population of the Maldives is young and (DNP, 2012) recorded that 49% of the Maldivian population is under the age of 25years and (MOH, Bilogical Behavioural Survey, 2008) expressed that these are most vulnerable population for drug addicts and HIV infections. The early marriage rate is increasing and youth who are sexually active in the country is increasing, serial marriage is common, condom use is limited, non-emergency blood transfusions are common and men often spend extended periods away from their home islands. Furthermore in the (MOH, Reproductive Health Survey, 2004) indicated that 14% of males and 5% of females under the age of 18 admitted to having been sexually active. Of those who were sexually active 45% never use condoms. It should be noted that the response rate for under-18 year olds was only 42%, varying from 100% in some islands to only 12% in Male.

According to (N. Mujumali, 2011) inadequate knowledge about HIV/AIDS and its prevention and a bad attitude towards HIV prevention information and services are major obstacle to success of PMTCT programme efforts. Information gathered will help to identify existing knowledge gaps that pregnant women acquire after being counseled. Moreover, the information can be disseminated through NGOs and other interested parties in provision of PMTCT services. Poor knowledge about HIV/AIDS, its transition and prevention are harmful factors which facilitate the spread of the disease in the developing countries. Nowadays, the priority of AIDS prevention is undeniable and a potential strategy in fight against HIV/AIDS should focus on raising women's awareness about HIV, its spread, treatment, promoting condoms and prevention of new infections.

The (MOH, Bilogical Behavioural Survey, 2008) has clearly shown that the risk environment of Maldives is growing rapidly and calls for close monitoring. Furthermore the

(MOH, Bilogical Behavioural Survey, 2008) highlighted that the surveillance rounds need to be implemented periodically. The national program should investigate the interplay of factors needed to halt the spread of HIV. It must learn from the experiences of other low prevalent countries, like Indonesia, where an unexpected flow of HIV among prisoners in the prison ran to a rapid rise in HIV cases. This study aimed to assess the knowledge of pregnant women about HIV/AIDS, its routes of transmission as well as prevention of mother-to-child infection while evaluating their knowledge and attitude toward voluntary counseling & testing and routing antenatal screening on HIV.

1.3 Objectives of the Study

1.3.1 General objective

The general objective of the study is to assess the knowledge and attitude of pregnant women those who are attending antenatal clinic at Indhira Gandhi Memorial Hospital (IGMH) on Prevention of Mother – to – Child Transmission (PMTCT) of HIV/AIDS from 10^{th} – 20^{th} of October 2013.

1.3.2 Specific Objectives

- To determine the level of basic knowledge about HIV/AIDS in pregnant women.
- To assess attitude towards HIV/AIDS of pregnant women on voluntary counseling and testing HIV.
- To assess pregnant women's knowledge on Mother to Child Transmission (MTCT) of HIV.
- To assess knowledge of pregnant women on PMTCT of HIV/AIDS.
- To find out the sources of information to women attending antenatal clinics on the transmission of HIV.

1.4 Research Questions and Hypothesis

1.4.1. Hypothesis

Those who attend antenatal clinic has inadequate amount of knowledge on PMTCT of HIV/AIDS.

1.4.2. Research Questions

The research questions to achieve objectives were as follows:

- How aware are women attending antenatal clinics on basic knowledge of HIV/AIDS?
- How aware are women attending antenatal clinics on PMTCT of HIV/AIDS?
- What are the sources of information to women attending antenatal clinics on HIV/AIDS?
- What are the modes of transmission of HIV/AIDS?
- What are the risk factors of HIV/AIDS?

1.5 Significance of the Study

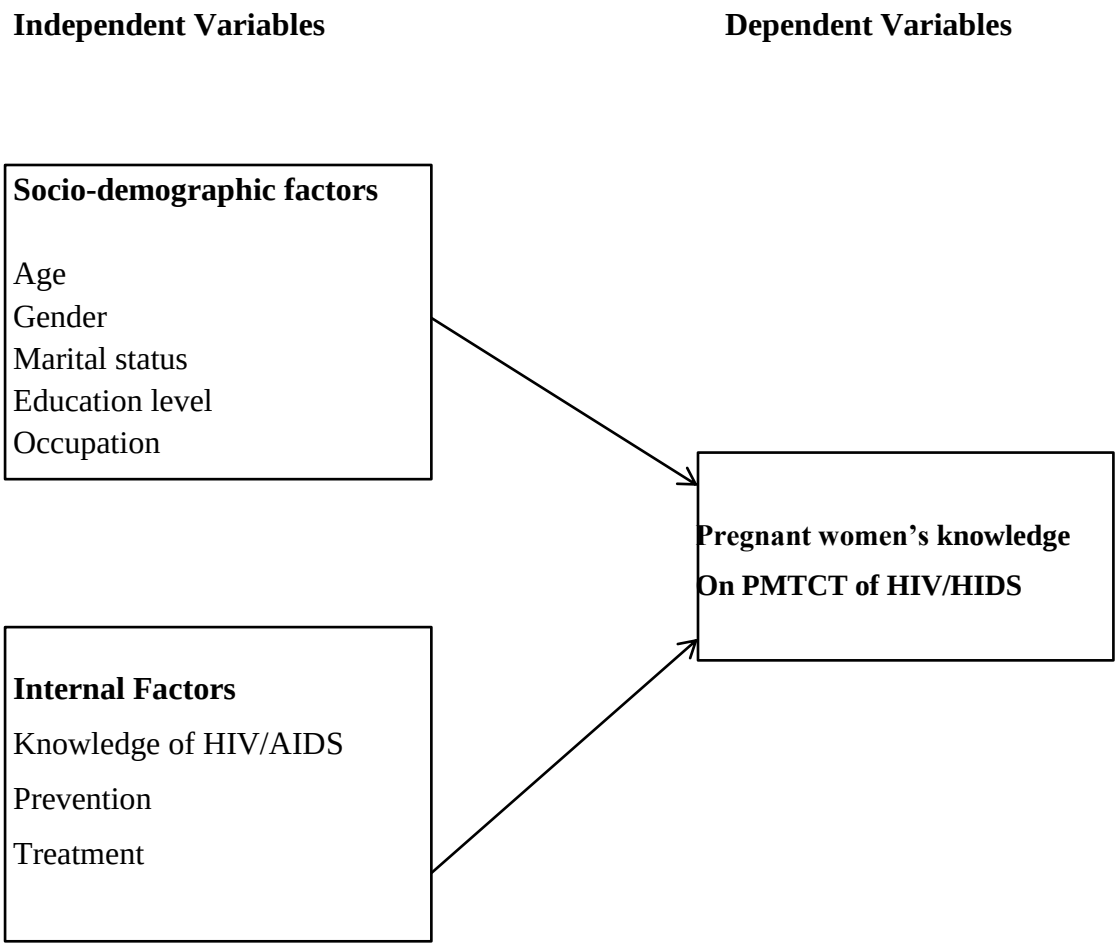
In general the study will provide general background information among pregnant mothers about HIV/AIDS and Prevention of Mother-To-Child Transmission (PMTCT) services in the IGMH. The findings from the study will help the Health Protection Agency to scale up for implementation of voluntary counseling and testing and PMTCT of HIV/AIDS at tertiary level of Maldives as well as Modeling PMTCT services in the regions and atolls and this will help to improve on the targets. In addition the findings will also provide up to date information for the academic purposes and could be used as a basis for further study in issues concerning pregnant women's knowledge on HIV/AIDS since it is a new intervention in the country.

1.6 Scope of the Study

The study is investigating the pregnant women of those who are attending antenatal clinic at IGMH have got enough knowledge on PMTCT of HIV/AIDS. The study is targeting the pregnant women who attend antenatal clinic at Indhira Gandhi Memorial Hospital from (IGMH) 10^{th} – 20^{th} October 20

1.7 The Conceptual Frame Work of Pregnant Women's knowledge and attitude about HIV/AIDS

Figure 1. The Conceptual Frame Work of Pregnant Women's knowledge and attitude about HIV/AIDS



1.7.1 Independent Variables

1.7.1.1 Socio Demographic Factors

- Age: range is 18 – 49 years. At 18 years is legally matured age in Maldives. Significantly most of the youth are getting married at the age of 18 years and above years, at these category respondents able to answer questions independently.
- Gender: refers to the characteristics of the respondents as female (pregnant women)
- Marital Status: refers to the respondent was single, divorce/separated and widowed. Marital status divided into four categories:
    - Single
    - Married
    - Divorce/Separated
    - Widowed
- Educational level: refers to educational background of the respondents. Educational level divided into four categories:
    - No education – no formal education
    - Primary school – from grade 1 to 7
    - Secondary school – from grade 8 to 10
    - Higher education – from a college or university
- Occupation: refers to the main job of respondents to earn for her living. It is divided into four categories.
    - unemployed
    - Civil Servant
    - Self –employed
    - Private Sector

1.7.1.2 Internal Factors

- Knowledge of HIV/AIDS- refers to the respondents' understanding of the basic knowledge on HIV/AIDS such as mode of transmission, Preventive measures, Risk Factors and Treatments.
- Knowledge on Prevention of HIV/AIDS- refers to the respondents understanding about how HIV spreads preventive measures to prevent spreading of HIV and preventing measure for developing AIDS disease.
- Knowledge on AIDS Treatment- this refers to respondents' knowledge about the treatment of HIV/AIDS and Prevention of Mother to Child Transmission of HIV.

1.7.2 Dependent Variables

Pregnant women's knowledge on PMTCT of HIV/AIDS is the dependent variable. It refers to the pregnant women's knowledge on PMTCT of HIV/AIDS, preventive measures which they are taking about HIV/AIDS, MTCT and infant feeding.

1.8 Definition of Terms

Knowledge: This is defined as awareness about something. In this particular study knowledge will be defined as information about HIV/AIDS or the understanding of PMTCT services.

Socio-demographic and economic characteristics: Socio- demographic and economic characteristics of a population is expressed statistically, such as age, sex, education level, income level, marital status, occupation, religion, birth rate, death rate, average size of a family, average age at marriage.

a. Age: The length of time that a person has lived.

b. Gender: The state of being male or female.

c. Education: The process of receiving or giving systematic instruction, especially at a school or university or information about or training in a particular subject. d. Occupation: Defined as the official designation of an employed or self-employed person.

Human Immunodeficiency Virus (HIV): Is a retrovirus that causes AIDS by infecting helper T cells of the immune system.

Acquired Immunodeficiency syndrome (AIDS): Is a severe immunological disorder caused by the retrovirus HIV, resulting in a defect in cell-mediated immune response that is manifested by increased susceptibility to opportunistic infections and to certain rare cancers. It is transmitted primarily by exposure to contaminated body fluids, especially blood and semen.

PMTCT are interventions carried out to reduce the risk of HIV transmission from an infected mother to her baby during pregnancy, labour, delivery and breast-feeding.

CHAPTER 2 REVIEW OF LITERATURE

2.1 THEORETICAL FRAMEWORK

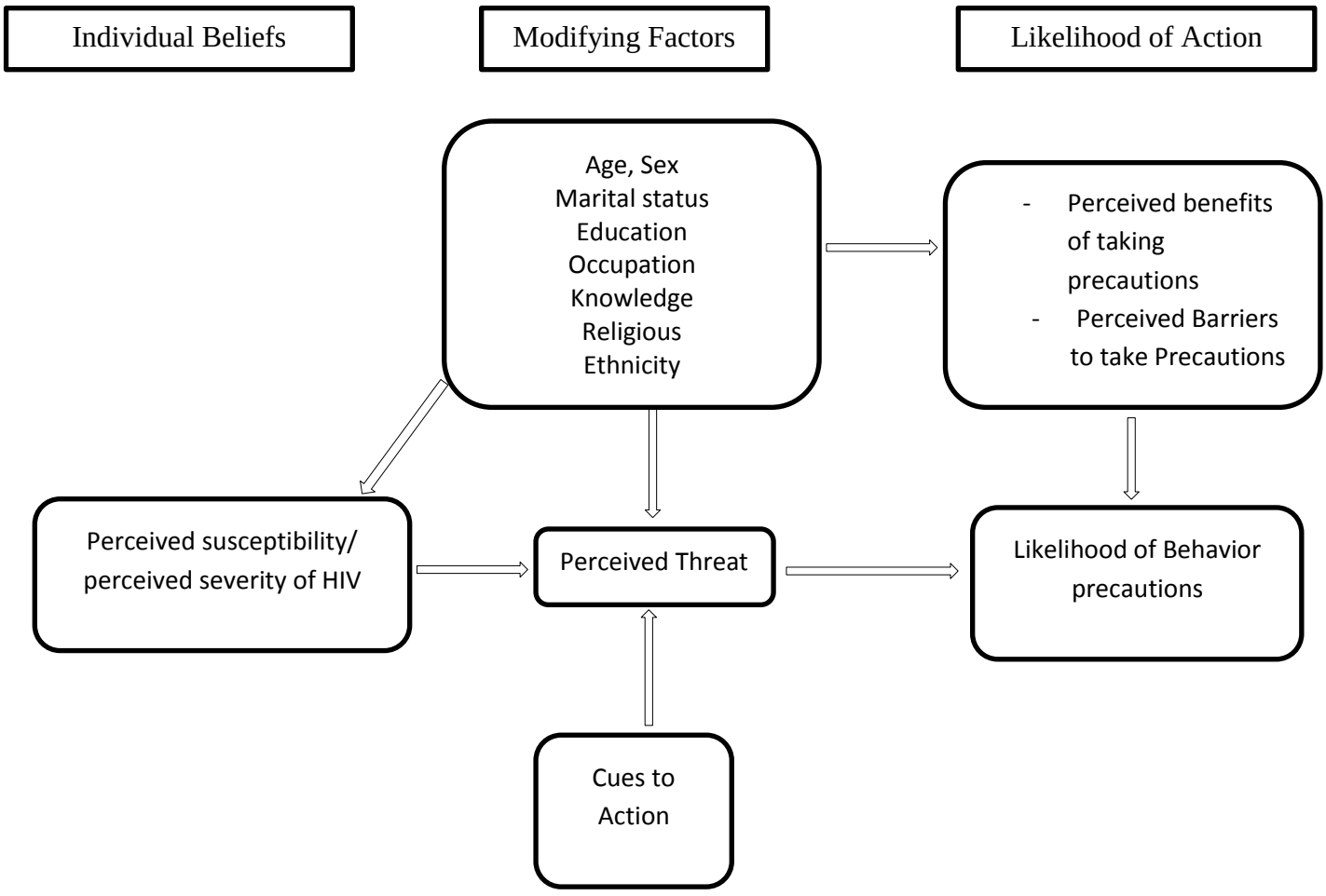
People‘s health behavior or lifestyles have been regarded as the cause of many modern diseases. Behaviour, in this perspective, is a function of the subjective value of an outcome and of the subjective probability or expectation that a particular action will achieve that outcome (Irwin, Rosenstock& Irwin, 1988). Thus, explanation of behavioural change focuses on things that go on inside people‘s heads, their knowledge, beliefs, attitudes and perceptions of others (Wasserhert, Aral & Holmes, 1999). The most widely used theories in HIV/AIDS prevention that identify determinants of behavior change include Health Belief Model, Theory of Reasoned Action and Stages of Change Theory FHI (2001, cited in. M, C. Ukeoma, 2012).However, this study will be based on Health Belief Model. According to (John, J. Cronin, 2009) this is one of the most widely used theories in social marketing, especially in health promotion.

2.1.1 Health Belief Model

The HBM is a psychological model which has been broadly applied to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. Rosenstock, Strecher and Becker (1994, cited in Margolis, 2012).The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviors and the transmission of HIV/AIDS etc. (Margolis, 2012).According to HBM a person must hold certain beliefs in order to be able to change behavior, which means that promoting action to change a particular behavior includes

changing individuals' personal beliefs. (Nyasinde Mujumali, 2010). Hence, the HBM takes an individual's past experience and characteristics into account as a pre-existing component of the model. An individual's perceptions of specific disease are founded in an individual's background and allow for assessment of issues relevant to that individual. (Lori J. Walker, 2004). Figure 2.1 provides a summary of the components of the HBM.

Figure 2. HEALTH BELIEF MODEL



Source: Jones and Bartlett Publishers 2006

2.1.2 Theoretical explanation of HIV/AIDS knowledge

According to the HBM, six main concepts influence people's decisions about whether to take action including: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Margolis, 2012).Thus today, there are many opportunities for individuals to participate in HIV preventive behaviors. However, statistics show that few individuals actually participate in HIV screening opportunities. In addition, the beliefs of the HBM theory may prove particularly well suited to the assessment of HIV preventive behavior and understanding the lack of public participation. (Lori J. Walker, 2004)

Perceived susceptibility:- refers to a person's perception of his or her risk of becoming infected with HIV. Perceived severity of the disease gauges feelings regarding the seriousness of AIDS (Lori J. Walker, 2004). Also the likelihood of seeking health interventions increases as the level of perceived susceptibility increases Rosenstock (1974 cited in Christina Leah Banda, 2013). For instance, pregnant women would be more likely to knowing HIV/AIDS information if they believe that they are susceptible of getting HIV infection during pregnancy. However (Lori J. Walker, 2004) argued that one of the study they had conducted to investigating attitudes about AIDS, homosexuality and condoms among college students, found mixed results regarding the utility of the HBM to understand AIDS related behavior. Although participants in the study reported believing AIDS to be a severe illness and that condom use cannot help prevent the spread of HIV infection, they did not perceive themselves as susceptible to AIDS nor did they feel compelled by environmental cues to change their behavior.

Perceived severity:-Perceived severity refers to the subjective evaluation of the likelihood that a problem/ illness or disability, if contracted or left untreated, will have severe consequences such as pain, death, handicap, or reduced quality of life in general, (Backer and

Maiman 1977). In the context of this study, willingness of pregnant mother to utilize FANC would depend also on personal evaluation of the seriousness of the consequences associated with pregnancy complications for example, death of the fetus. Perceived benefit indicates a person's beliefs regarding the efficacy of the self-protective behavior. Perceived barriers refer to an individual's perception of the negative aspects of the self-protective behavior. Cues to action account for internal and external events that trigger performance of the behavior, in this case obtaining an HIV-antibody test. Finally, self-efficacy refers to a person's beliefs regarding his or her ability to successfully obtain an HIV-antibody test. (Lori J. Walker, 2004)

Consequently, if perceived severity is low, then personal susceptibility would never actually be considered. However, if perceived severity of AIDS is high, then personal susceptibility is assessed and whether or not to perform self- protective behaviors (i.e., have an HIV-antibody test) is considered. Under a state of high-perceived severity, perceived susceptibility will be a stronger predictor of intent to engage in self-protective behaviors rather than a predictor of actually engaging in preventive behaviors (Rosenstock et al., 1994). This is due to the fact that other issues, addressed by other components of the HBM, such as self-efficacy, will become salient and determining whether or not the individual will follow through on the perception of threat.(Lori J. Walker, 2004)

If perceived susceptibility and perceived severity of the disease are both high, chances of engaging in self-protective behaviors are also high. However, if either perceived susceptibility or perceived severity is sufficiently low, then perceived threat is also low, as are chances of the individual engaging in the behaviors Rosenstock et al., (1994, cited in Lori J. Walker, 2004).

Perceived benefits/barriers:-Individuals choice of behavioral options depends on their perception of benefits and barriers. Therefore, a cost benefit analysis allows an individual to evaluate the outcome expectations and assess whether the expected benefit of a behavior outweigh the perceived expenditure incurred by engaging in the behavior, Rosenstock et al., (1994, cited in Lori J. Walker,2004).Compliance with recommended health seeking behavior is impeded to the extent that perceived barriers outweigh perceived benefits that would result from engaging in the health behavior Rosenstock et al., (1994, cited in Lori J. Walker, 2004). For example, inconveniences such as long waiting time at antenatal clinic, distance to the health facility would act as barriers to utilization of FANC. A pregnant woman would opt not to go to the clinic if she sees no benefit in doing so. Furthermore, health care workers negative attitude towards focused antenatal care, inadequate resources both material and human, inadequate equipment and supplies, lack of knowledge regarding benefits of FANC would also impede utilization of FANC (Simkhadaet al.2008).

Modifying factors:-These may include socio-cultural factors as well as demographic aspects such as age, parity, religion, educational status, social values, beliefs and practices of pregnant woman in relation to utilization of FANC (Chivonivoni et al. 2008).

Cues to action:- These are aspects that might lead individuals to certain behaviour. For example, information on MTCT from health professionals, radio and television may make an individual take appropriate action. Thus individuals are more likely to take appropriate action if they feel they could be affected by (susceptible to) the condition, and believe that the problem is serious enough to cause harm and that the course of action will reduce susceptibility (Chivonivoni et al. 2008).

2.2 HIV/AIDS and Route of Transmission

The causative factor of AIDS is the HIV. As the virus weakens the immune system, the body becomes susceptible to the diseases and unable to recover from other opportunistic diseases that may lead to death through secondary infection. The main mode of HIV transmission is through heterosexual contact, followed in frequency by perinatal transmission, in which the mother passes the virus to the child during pregnancy, delivery, or breastfeeding. Other modes of transmission are through infected blood and unsafe injections. (MDHS, 2009).

2.2.1Mode of transmission

HIV is transmitted through unprotected sexual intercourse (anal or vaginal), transfusion of contaminated blood, sharing of contaminated needles, and between a mother and her infant during pregnancy, childbirth and breastfeeding (WHO, 2013)

2.2.2Mother to Child Transmission (MTCT)

Mother to child transmission of HIV is the second major mode by which the virus spreads. This is a primary way of transmission of HIV to children in Uganda. It is estimated that up to 30% of the infants born of the infected mothers are likely to be infected either during pregnancy, at time of labour/ delivery or after birth through breast feeding (Makerere University, 2006). The risk of HIV transmission from mother to child is estimated at 5-10% during pregnancy; 10-20% during labor and delivery, and 10-20% in the post-partum period. In Malawi, the HIV sero-prevalence amongst pregnant women is between 16-30%. The antenatal HIV prevalence varies according to the geographical location of the clinic. Without interventions up to 30% of babies born to HIV infected mothers will acquire the virus. Thus in the absence of Prevention of Mother-to-child Transmission interventions, Malawi can expect nearly 40,000 HIV infected newborns every year. Prevention of Mother-to-child Transmission of HIV is now considered a priority if gains are to be made in reducing the high infant and child mortality rates in Malawi (Chiwa, 2011) Mother-to-Child Transmission MTCT of HIV is a major component of the AIDS epidemic, especially in Sub-Saharan Africa and the less developed countries of South and East Asia. In more developed countries,

obstetric interventions, anti-retroviral treatment and replacement feeding for the infant has resulted in significant reduction in transmission rates but this is not the case in the less developed countries. Limited accesses to the above-mentioned intervention are the main reasons for the differences in transmission rates Stringer. (2003, cited in Katushabe Juliet, 2006).

2.2.3 SITUATION OF HIV IN THE GLOBAL, REGIONAL AND COUNTRY

UNAIDS reported that after 30 years since the first HIV case was detected, the HIV epidemic still remains a serious public health concern globally with a large number of preventable new HIV infections occurring each year and millions of people dying prematurely of AIDS. Globally, 34 million people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15 – 49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions (WHO, 2012). Moreover, UNAIDS stated that new infection of HIV rates have fallen by 50% or more in 25 countries in 2012 and 13 of them in sub-Saharan Africa.

Furthermore, WHO highlighted that sub-Saharan Africa remains most severely affected, with nearly 1 in 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub – Saharan Africa than in Asia, almost 5 million people are living with HIV in South, South- East and East Asia combined. After sub – Saharan Africa, the region's most heavily affected are the Caribbean and Eastern Europe and Central Asia., where 1.0% of adults were living with HIV in 2011. (WHO, 2012)

In addition WHO estimates that the pandemic will kill an additional 3 million or more women and children worldwide. AIDS has become the leading cause of death for women aged 20 – 40 in major cities in Americas, Western Europe and sub-Saharan Africa.

2.2.4 Strategies for HIV prevention and control in Maldives

National AIDS Control Program was launched in 1987 with the aim of limiting the spread of HIV in Maldives. The President's Office formed a multi-sectorial representative body, which is called the National AIDS Council (NAC), to provide direction to National AIDS Control Program (NAP). Since then the Health Protection Agency (HPA), former CCHDC was given responsibility to implement the National Strategic Plan, under the guidance of the National HIV/AIDS Council, which consists of the stakeholders from Government, Civil Societies and Private Sector.

3. Promote safe practices and behavior among target groups

4. Decrease the prevalence of STI

2.3 Knowledge and awareness factors of HIV/AIDS

A primary and essential step towards hindering the spread of HIV to women is knowledge. The spread of the epidemic to rural areas presents a need actively to disseminate the AIDS related knowledge for health protection rather than waiting for knowledge for follow the appearance of disease in the community (Farooq, 2012).

Studies in different parts of the world discovered misconceptions and level of knowledge about the disease and its treatment. As a result (JULIET, 2006) revealed that over 90% babies were born to HIV positive women, who acquired the virus at birth or through their mother's breast milk. This is because most of them do not know their HIV status as well as PMTCT services (JULIET, 2006).

Furthermore several international studies have reported adequate level of basic knowledge, attitudes and practices about HIV/AIDS among women. Consequently one of the studies

which were conducted in Bangladesh from November 1999 – March 2000 showed awareness regarding HIV/AIDS was highest among higher educated women and lower among the illiterate women. As the educational level increased the percent of the respondents who are aware about AIDS also increased. Women with education, secondary or more belonged to high percent of awareness (Dr. Naziya Farooqui, 2012). In addition (MOH, Maldives Demographic Health Survey, 2009) showed at least 94 percent of respondents in all subgroups have heard of AIDS. Another study conducted in an urban antenatal hospital in Maharashtra in 2001 showed the 75.0% of women knew of primary transmission routes. 70.0% of them were aware of MTCT and only 8.0% knew of any methods of prevention (Dr. Naziya Farooqui, 2012).

According to (MOH, Maldives Demographic Health Survey, 2009) overall, differentials in the levels of knowledge of the various modes of prevention are not large. The largest differentials tend to be observed across educational levels. For example, 85 percent of women with more than secondary education say that the risk of HIV transmission can be reduced by using condoms and limiting sex to one partner who is not HIV positive; this compares with only 69 percent of women with no formal education. Although knowledge of HIV prevention generally increases with education, there is no clear pattern for knowledge about abstention as a method of prevention.

The (MOH, Maldives Demographic Health Survey, 2009) highlighted that the common misconceptions about HIV/AIDS are corrected. Common misconceptions about AIDS include the idea that HIV-infected people always appear ill and the belief that the virus can be transmitted through mosquito or other insect bites, by sharing food with someone who is infected, or by witchcraft or other supernatural means. Regarding the misconception 74.0% of women said that HIV cannot be transmitted by mosquito bite and 83.0% women said

sharing food with a person who has AIDS cannot be transmitted HIV. Also (MOH, Maldives Demographic Health Survey, 2009) Showed that the level of accurate knowledge about HIV transmission increases with an increase in the level of education and the wealth quintile. Another study showed that 86.8% women had heard about HIV/AIDS. A large majority of women knew that it is transmitted by close sexual relationship through infected blood, can be transmitted from mother to baby and knew that it is transmitted by reuse of infected needles while only 40.7% knew that it can be transmitted during delivery. The respondents had the knowledge that multiple sexual partners (79.4%), prostitutes and homosexual males (49.7%), during addicts (49.7%) were high risk groups. Regarding prevention of AIDS, 70.9% mentioned avoiding homosexuality, 58.7% knew the use of condoms and 74.7% women knew that screening of blood in laboratories before transfusion can prevent AIDS. (Dr. Naziya Farooqui, 2012).

Another important aspect of AIDS awareness assessed in the (MOH, Maldives Demographic Health Survey, 2009) the level of knowledge of MTCT of HIV which showed 85.0% of respondents knew the virus can be transmitted from mother to child during pregnancy, and 70.0% of the women were aware the virus can be transmitted during delivery. Women were less knowledgeable about HIV transmission by breastfeeding (64.0%). Knowledge of pregnancy, delivery, and breastfeeding as potential modes of transmission for the HIV virus is generally higher among older women than among their younger colleagues. However, the level of awareness of pregnancy as a mode of mother-to-child transmission increases with a woman's educational attainment and her wealth quintile. Knowledge of breastfeeding as a means of HIV transmission, on the other hand, decreases as the woman's education and wealth increase. Moreover there was another survey which conducted in southern rural India among women attending a rural antenatal clinic to investigate HIV related knowledge and perceived benefits and risks of HIV testing. 94.0% respondents had heard of HIV/AIDS and

60.0% of them had relatively good knowledge regarding risk factors for HIV transmission. However, 48.0% did not know that there were " means to prevent mother to child HIV transmission (Dr. Naziya Farooqui, 2012).

Poor antenatal counseling and HIV testing services are important barriers for PMTCT. This was shown in a study done in rural eastern Uganda where 10% of women who attended ANC accepted to test for HIV before being counseled. This supported the report from Mombasa, which pointed out that, the quality of antenatal HIV counseling in a routine setting was associated with increasing rates of testing for HIV and PMTCT awareness. (N. Mujumali, 2011).

The (MOH, Maldives Demographic Health Survey, 2009) indicated that most women were willing to care for a relative with AIDS at home (86.0%), buy fresh vegetables from a shopkeeper with AIDS (79.0%), allow a female teacher with AIDS to keep teaching (61.0%), or allow a male teacher with AIDS to keep teaching (59.0%). Thirty-seven percent of women express accepting attitudes on all four indicators, indicating that some degree of stigma is associated with HIV/AIDS within Maldivian society.

A study was conducted in Nigeria in 2006 to evaluate the awareness and knowledge of mother to child transmission of HIV and its prevention among pregnant women attending the antenatal clinic of a federal medical centre in Nigeria. It was found that the main sources of information included posters/billboards (37.0%), radio (36.0%), television (28.0%) and health workers (34.0%) (Dr. Naziya Farooqui, 2012). According to (Dr. Naziya Farooqui, 2012) the another survey conducted in India 2007 the main sources of knowledge for HIV/AIDS were television (63.9%), and relatives/friends (58.3%). Thirty percent of women had heard about it from their health personnel.

CHAPTER 3 METHODOLOGY

3.1 Research Design

The study was conducted as a cross-sectional descriptive study. Quantitative research processes was used to establish pregnant women's knowledge of HIV/AIDS and PMTCT, the source of information and motivational factors. On the other hand Qualitative method was used to establish the pregnant women's views and experiences regarding PMTCT and HIV screening services.

3.2 Population and Sample

The target population for the study elaborated of women who attended the antenatal care clinic for its services at IGM Hospital during the month of October. The IGM Hospital was selected to conduct this study as it conducts the majority of all antenatal care clinics in the country and it includes antenatal clients from all over the nation. In addition Voluntary Counseling and Testing (VCT) services on HIV are providing there. Using statistical software" Raosoft", the size 258 participants was calculated using total of registered clients for antenatal care during the months of September and October in IGMH of 781. A 95% confidence level, 5% margin of error, and a non-response rate of 20%. A 50% estimated population of correct knowledge will be utilized to give the most conservative sample size. However, due to the scope and time constraints only 100 was taken

Non-probability sampling, by using the convenience sampling technique, was used to select the respondents into the study. Non-probability sampling is a process of selecting respondents into the study with less chances of finding a representative sample (Lund Research Ltd, 2012).

3.2.1 Inclusion Criteria

Those pregnant women registered at the Reproductive Health Centre, aged between 18 – 49 years, and were willing to give informed consent between 1st September 2013 – 9th October 2013 are considered as sample population.

3.2.1 Exclusion Criteria

Those who refused to participate after explanation about the purpose of the study, those who were too sick to participate in the study and people who are not registered at the RHC in IGMH between 1st September 2013 – 9th October 2013.

3.3 Instrumentation

The study was conducted using interviewer administered questionnaires, by face to face interviews. A structured questionnaire was originated in English Language and it was translated in Dhivehi Language for data collection. An English translation and the Dhivehi translation of the questionnaire are attached (Appendix 1) with this document. The questionnaire was designed according to the objectives of the study. The questionnaire consisted of six sections: Section one, dealing with patient background characteristics (age, marital status, education and occupation). Section two included the basic knowledge regarding HIV/AIDS (Type of disease, transmission of disease, preventive measures and risk factors of HIV). Section three and four highlighted on the knowledge and attitude about Mother to Child Transmission on HIV/AIDS. In addition in section five and six mainly focused on the HIV screening and ways of getting information about HIV/AIDS.

Before starting the study, questionnaire was pre-tested at community with using 5 postnatal women, who are not a part of the study catchment area. The five pregnant women were chosen randomly so as to avoid bias which may arise in case same women who participated in the pretesting may have been re-sampled in the actual study. Permission was obtained from the women, to allow participating in pretesting of the study tools. Pre-testing of the data collection tools was done with the help of National AIDS Program of Maldives. Pretesting

was done one week prior to actual data collection to allow for final adjustments and modifications to the questionnaire as well as orientation. After pretesting some practically sensitive words related to HIV screening were revised to assist participating pregnant women freely express their views.

Last two days of the 1st week of October 2013, orientation on questionnaires was done by my- self and 3 research assistants who were nurses from the Reproductive Health Centre (RHC) in IGMH. The interviewing nurses have past experiences in doing these kinds of study and I interviewed them before handling them the work. Furthermore I explained them what exactly I want.

3.4 Data Collection Procedures

This study on HIV/AIDS was conducted with the help of RHC in IGMH and National HIV/AIDS Control Program of Ministry of Health, Maldives. Data collection was done by well oriented nurses, who are working at RHC in IGMH. It took almost a week for data collection. We started on 10th October 2013 to end up on 16th October 2013.

The study objective and methods were explained to the pregnant women and written consent was informed them before the data were collected. Open ended and close ended interview administered questionnaire based on the knowledge, attitude and behavior on HIV/AIDS was interviewed by nurses in IGMH. After the face to face interview they were given an information sheet which contains most basic information about HIV/AIDS.

3.5 Ethical Consideration

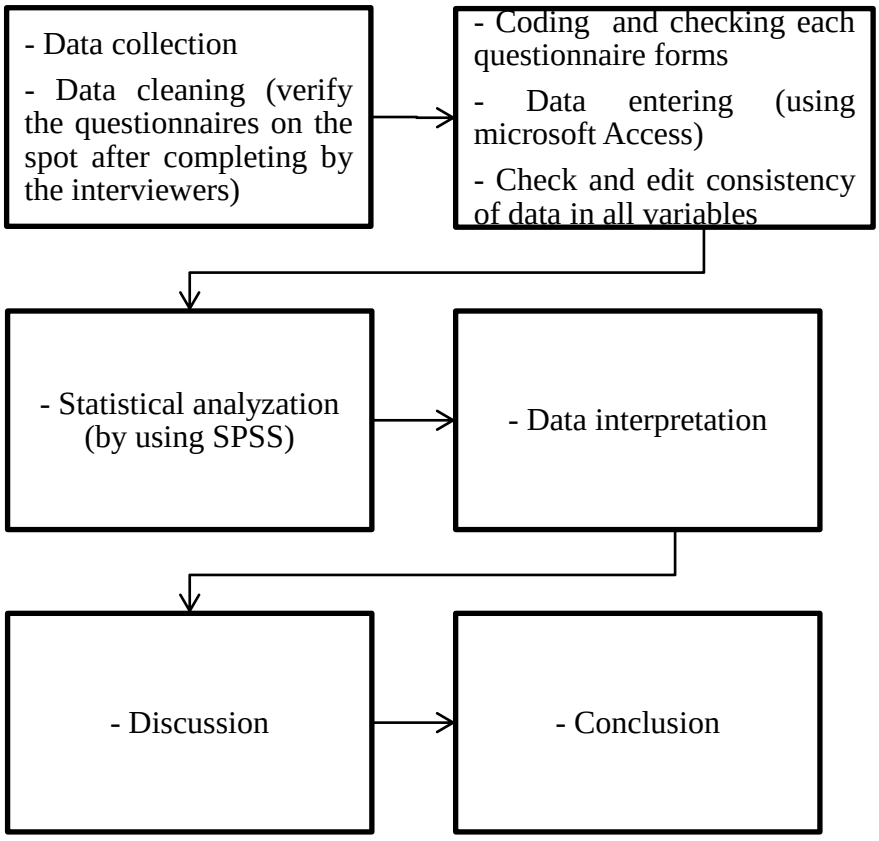
Informed written consent was taken from all the participants to the study. The consent was obtained after the aims of the study and its implications had been explained and every participant was made aware of their right to refuse and withdraw without consequence in order to prevent

negative labeling. Every participant was assured of confidentiality and privacy. Permission to carry out the study was obtained from the IGM Hospital administration. Furthermore the questionnaire was finalized with the incorporated the feedbacks of National HIV/AIDS control programme of Health Protection Agency, Ministry of Health. All transcripts were stored safely until such a time as when they can be safely destroyed to minimize the ethical issues regarding the study.

3.6 Framework for Data Analysis

Once data collection was over by using structured pre-tested questionnaires, data was entered into Microsoft Access for storage. Data was re-checked for any technical errors. Any error found was corrected. Later those data was analyzed by using SPSS version 18, the data's to produce statistics. At least 8 days were spent for Data entry and analysis.

Figure 3.6.1 Framework for data analysis



CHAPTER 4 DATA ANALYSIS AND RESULT

This cross –sectional study was conducted to determine the knowledge, attitude and practice of the pregnant women attending RHC in IGMH on HIV/AIDS. The data for the study was collected through a both qualitative and quantitative survey of 100pregnant women aged between 18 -49 years. The data was analyzed using Microsoft Access 2010and SPSS version 18.The results were presented in tables and as well as descriptive form.

Table 4.1 Socio – Demographic characteristics of the respondents

Variables	Frequency (n=100)	Percent (%)
Age		
18 – 22	3	3.0
23 – 27	28	28.0
28 - 32	34	34.0
33 – 37	25	25.0
38 - 42	8	8.0
43 – 49	2	2.0
Total	**100**	**100.0**
Marital Status		
Single	2	2.0
Married	97	97.0
Divorce	1	1.0
Widowed	0	0.0
Separated	0	0.0
Total	**100**	**100.0**
Educational Level		
Never went to school	2	2.0
Grade 1 – 7	14	14.0
Grade 8 – 12	71	71.0
Tertiary education	13	13.0
Total	**100**	**100.0**
Current Occupation		
Unemployed	73	73.0
Civil Servant	23	23.0
Self- employed	4	4.0
Total	**100**	**100.0**

Table 4.1:Socio – demographic characteristics of the respondents

4.1.1 Socio – Demographic characteristics of the respondents

The results in table 4.1 shows that majority of the participants were aged 28 – 32 years (34.0%) with a less number among 43 - 49 year old (2.0%). The other proportions of participated groups were age between 23 – 27 years (28.0%) and age between 33 – 37 years (25.0%).Overall a high number of participants in the study are seen in youth. The out of 100 pregnant women the youngest person was 18 years old and the oldest person was 49 years old.

The high percentage of participants was married (97.0%). The proportion of single and divorce (2.0%, 1.0%) were less as well as the categories of widowed and separated were not identified in the study.

The most of the respondents (71%) had secondary and higher secondary education. The second most (14%) had primary level of education. The third most (13%) had tertiary level education (University education). Very few (2%) never went to school.

Related to occupation, most of the respondents were unemployed (73%) and the second most were civil servant (23%). The other group which included in the study was self – employed and the percentage of this category is very few (4%).

Table 4.2 Basic Knowledge on HIV/AIDS among the participants of the study

Variables	Agree		Disagree		Don't know	
	N	%	N	%	N	%
5. Before this Interview, do you ever heard of information on HIV/AIDS?	95	95.0	3	3.0	2	2.0
6. Can understand someone having HIV infection by looking at that person?	5	5.0	81	81.0	14	14.0
7. Can protect from HIV/AIDS?	84	84.0	12	12.0	4	4.0

8. Is there any treatment on HIV/AIDS?	26	26.0	45	45.0	29	29.0
9. If there is treatment for HIV/AIDS, Can cure from the disease?	32	32.0	40	40.0	28	28.0
10. Can reduce the risk of HIV transmission by having sex with only one faithful, uninfected partner?	71	71.0	22	22.0	7	7.0
11. Using condom during sex, prevents HIV transmission.	74	74.0	15	15.0	11	11.0
12. Can suspect for a healthy-looking person have HIV?	52	52.0	35	35.0	13	13.0
13. Can a person get HIV from mosquito bites?	30	30.0	57	57.0	13	13.0
14. Sharing needles when injecting drugs will increase the risk of HIV infection.	92	92.0	8	8.0	00	0.0
15. One can avoid becoming infected with HIV by not having sex at all.	23	23.0	73	73.0	4	4.0
16. Can a person get HIV by sharing a meal with someone who is infected?	7	7.0	90	90.0	3	3.0
17. One can get HIV if one uses same toilet with an HIV infected person	9	9.0	86	86.0	5	5.0
18. Do you feel that you yourself are at risk for infection with HIV?	37	37.0	53	53.0	10	10.0

Table 4.2: Basic knowledge on HIV/AIDS among participants of the study

4.2.1 Basic knowledge on HIV/AIDS among participants of the study

The patients were asked about their basic knowledge on HIV/AIDS. The totals of 13 questions were asked in this section. The percentage and frequency distribution of each questions was shown in the Table 4.2

The received of information on HIV/AIDS, before this study was significantly high (95%) and not heard or not sure of heard about HIV/AIDS were less (3.0% and 2.0%). Regarding on the question can understand someone having HIV infection by looking at that person, the high percentage of people were disagree (81%) with the less percentage (5%) people were

agree and 14% of people were said that they don't know. Most of the participants were agreeing (84%) that they can protect from HIV/AIDS, 12% of participants were disagreeing and 4% said that they don't know. Regarding treatment on HIV/AIDS the high percentage of participants were disagree and don't know (45.0% and 29.0%), the only (26.0%) agree that there is treatment on HIV/AIDS. About the effectiveness of the HIV/AIDS treatment (32.0%) were agreeing that HIV treatment can cure. The high percentage of respondents disagree (40.0%) and don't know (28.0%) the HIV treatment. Most of the respondents were agreeing (71.0%) that the risk of HIV transmission can reduce by sex with only one faithful, uninfected partner, (22.0%) were disagreeing and (7.0%) were don't agreeing on this. Significantly high percentage of people agree (74.0%) using condoms during sex, can prevents HIV transmission. There were few people disagree (15.0%) and don't know (11.0%).With regarding of suspecting for a healthy looking person has HIV (52.0%) agree (35%) disagree and (13.0%) do not aware of that anyone has a chance of getting infection. Regarding the ways of HIV transmission most of participants gave the correct answers (57.0%) said HIV cannot spread through mosquito bites,(92.0%) said that sharing needles when injecting drugs increase the risk of HIV infection, (90.0%) of the participants said that a person cannot get HIV infection by sharing meal with someone who is HIV infected. Furthermore (86.0%) participants said that any one cannot get HIV by using same toilet with an HIV infected person. Hence the regarding of anybody can avoid becoming infected with HIV by not having sex at all (80.0%) participants (73.0% disagree and 4.0%) don't know) did not aware that abstinence can avoid the transmission of HIV. Regarding respondents perception of them- selves are at risk for infection with HIV (37.0%) were agree (53.0%) were disagree and (10.0%) were not aware on risk factors of HIV transmission.

Table 4.3 Knowledge about Risk Factors of HIV/AIDS

Why do you feel that you are at risk of HIV infection	Frequency(n=100)	Percent (%)
Do not believe	23	23.0
Exposed to risky behaviours	4	4.0
From Blood donors and unprotected sex	1	1.0
Not using condom	2	2.0
Not using condom and working in a risky environment	1	1.0
When using unscreened blood for blood transfusion	20	20.0
When working in health sector, there is a chance to get infection	6	6.0
While giving injection	1	1.0
While taking medical care	3	3.0
No response	39	39.0

Table 4.3.percentage of attitudes towards HIV/AIDS

4. 3.1 Knowledge about Risk Factors of HIV/AIDS

Table 4.3 show the results percentage of respondents' attitudes towards HIV/AIDS. Regarding why do they feel that they are at risk of HIV infection the most of the respondents were not response (39.0%) and (23.0%) were not believe that they are at risk for infection with HIV and (20.0%) were said that when using unscreened blood for blood transfusion can have a chance to get them HIV infection. Very few were said that when working in health sector, there is a chance to get infection (6.0%), they had exposed to risky behaviours (4.0%) and (3.0%) were said that they have a chance for HIV while working in health sector.

Table 4. 3. 2 ATTITUDES TOWARD HIV/AIDS

Why do you feel that you are not at risk for HIV infection	Frequency(n=100)	Percent (%)
Follows the Islamic rules	4	4.0
Having faithful one life partner	33	4.0
Not exposed to any risk behavior	18	18.0
Don't know	5	5.0
No response	40	40.0

Table 4.3.2 attitudes toward HIV/AIDS

4. 3. 3 ATTITUDES TOWARD HIV/AIDS

Regarding participants attitudes towards HIV/AIDS Table 4.3.2 showed that most of the participants (40.0%) were not expressed their feelings. Quiet a high proportion of the participants (33.0%) said that they were having faithful one life partner and they were not at risk for HIV infection. (18.0%) said they were not exposed to any risk behavior, very few participants said they were following according Islamic rules (4.0%) and (5.0%) were not aware on the risk behaviours of HIV/AIDS. More details are shown in the Table 4.3.2.

Table 4.4 Knowledge on HIV screening

Variables	Frequency(n=100)	Percent (%)
Did you screen for HIV during the last 12 months?		
Yes	29	29.0
No	71	71.0
Why did you screen?		
Did not screen for HIV	71	71.0
Doctors advised to do HIV screening due to pregnancy	10	10.0
Don't know	19	19.0
Do you know the reason that you did HIV screening?		
No	19	19.0
Yes	10	10.0
No response	71	71.0
Can you refuse when a doctor asks for HIV screening?		
No	82	82.0
Yes	18	18.0

Table 4.4. *knowledge on HIV screening*

4.4.1 Knowledge on HIV screening

Regarding screening on HIV Table 4.4 showed most of the participants were not screened (71.0%) on HIV during the last 12 months and only (29.0%) screened. Out of (29.0%), (10.0%) screened that doctors advised to do HIV screening due to pregnancy. Large

proportion (82.0%) of the participants said that they cannot refuse when doctor asks for HIV screening and (18.0%) participants said they can refuse when doctor asks for HIV screening.

Table 4.5 Knowledge and attitudes towards Mother to child transmission of HIV/AIDS

Question	Frequency(n=100)	Percent (%)
Can Child get HIV transmission through mother?		
Yes	84	84.0
No	16	16.0
When does child get HIV infection from mother?		
During pregnancy	74	74.0
During delivery	20	20.0
Through breastfeeding	6	6.0
Do you know the main alternatives of infant feeding when mother has HIV?		
Breastfeeding as long as the mother wishes	6	6.0
Breastfeeding for 6 months exclusively	73	73.0
Infant formula/Cow's milk	21	21.0
What is your opinion about giving Infant formula to the infants?		
Breast milk is best for the babies	2	2.0
Can give according to the doctors advise	7	7.0
Don't know	1	1.0
If mother has HIV infection than the formula is best option for the child	9	9.0
No response	3	3.0
Not a good practice	78	78.0
What is your opinion about HIV infected children living with the HIV uninfected children?		
Don't know	6	6.0
Not safe for other children	8	8.0
They can live with normal children	86	86.0

Table 4.5. *knowledge and attitudes towards Mother to child transmission of HIV/AIDS*

4.5.1 KNOWLEDGE AND ATTITUDE TOWARDS MOTHER TO CHILD TRANSMISSION OF HIV/AIDS

Table 4.5 Showed a large proportion (84.0%) of the participants believed that child can get HIV transmission through mother and (16.0%) believed that child cannot get HIV transmission through mother. Regarding the ways of mother to child transmission of HIV (74.0%) said during pregnancy, (20.0%) said during delivery and (6.0%) said through breast-feeding. Regarding the main alternatives of infant feeding when mother has HIV, (73.0%) participants said breastfeeding for 6 months exclusively and (21.0%) participants said infant formula/cow's milk and very less participants said (6.0%) breastfeeding for as long as the mother wishes. Opinion about giving infant formula to the infants 978.0%) participants said that is not a good practice, (9.0%) participants said if mother has HIV infection formula is best opinion for the child and (7.0%) participants said infant formula can give according to the doctors advise. Regarding opinion about HIV infected children living with HIV uninfected children (86.0%) participants said HIV infected children can live with normal children, (8.0%) participants said that is not safe for other children.

Table 4.6 Knowledge Regarding Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS

Question	Frequency(n=100)	Percent (%)
It's important that every pregnant woman gets tested for HIV.		
Don't know	7	7.0
No	66	66.0
Yes	27	27.0
If one is infected with HIV then she should not get pregnant again		

Don't know	10	10.0
No	11	11.0
Yes	79	97
Using protection (condoms) during pregnancy and breast-feeding reduces MTCT		
Don't know		
No	31	31.0
Yes	30	30.0
	39	39.0
Are you aware that there are services for Prevention of Mother to Child Transmission		
Don't know	0	0.0
No	85	85.0
Yes	15	15.0

Table 4.6 Knowledge on PMTCT of HIV

4. 6.1 Knowledge Regarding Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS

Table 4.6 showed the participants knowledge of prevention of mother to child transmission of HIV/AIDS. Regarding screening of pregnant women (66.0%) said that it is important that every pregnant woman gets tested for HIV and (27%) participants said that it is not important to screening pregnant women on HIV. Most (79.0%) of the participants said that if one is infected with HIV then she should not get pregnant again. (39.0%) participants said using condom during pregnancy and breastfeeding reduces MTCT on HIV. On the subject of awareness on PMTCT of HIV services, (85.0%) participants said they did not aware of PMTCT of HIV services.

Table 4. 7 Sources of Information about HIV/AIDS

Variables	**Frequency(n=100)**	**Percent (%)**
In the past 12 months, have you received information on HIV/AIDS?		

No		
Yes	60	60.0
	40	40.0
What were your sources of that information?		
Leaflets, internet and books etc		
Health Facilities	2	2.0
Internet	51	51.0
No response	7	7.0
Radio and leaflets	6	6.0
TV	1	1.0
TV and internet	8	8.0
TV and leaflets	3	3.0
TV and radio	18	18.0
TV, internet, radio and leaflets	1	1.0
	3	3.0
Would you like to receive more information on HIV/AIDS?		
Yes		
No	22	22.0
Where will you like to get the information on HIV/AIDS?	78	78.0
Don't know	45	45.0
Health care facilities	23	23.0
Health care providers	9	9.0
Internet	12	12.0
No response	11	11.0

Table 4.7.Source of information about HIV/AIDS

4. 7. 1 SOURCES OF INFORMATION ABOUT HIV/AIDS

Table 4.7 showed that in the past 12 months (60.0%) participants received information about HIV/AIDS and (40.0%) participants did not receive any information on HIV/AIDS. Regarding the source of information (51.0%) participants had received information from the health facilities. (18.0%) said they received information from leaflets (8.0% and 7.0%) of participants said they received HIV/AIDS related information from TV and leaflets. As regard of participants interests of getting HIV/AIDS related information large proportion (78.0%) participants did not have interests of getting information on HIV/AIDS and (22.0%) participants interested of getting HIV/AIDS related information. However a large number

(45.0%) of participants did not aware about the source of HIV/AIDS information. (23.0%) participants said that health facilities and (12.0%) participants said that internet as the sources of HIV/AIDS information. More detail shows on the table 4.7.

CHAPTER 5 DISCUSSION AND CONCLUSION

5.1 Summary of Main Findings

Most of the studies have explored pregnant women's knowledge, attitudes and practice toward prevention of HIV/AIDS, but I have identified only knowledge and attitudes of HIV/AIDS among the pregnant women attending antenatal clinic of IGMH. The main purpose of this study was to assess the knowledge of pregnant women attending antenatal clinic at RHC in IGMH on PMTCT of HIV/AIDS.

Collectively, findings indicated that all of the pregnant women (95.0%) in this study had at least some knowledge about the HIV/AIDS. Moreover the levels of basic knowledge among the respondents were high. However the knowledge on PMTCT services and HIV treatment were less among the respondents. (84.0%) had not aware on PMTCT services and (74.0%) had not aware on HIV treatment. Another important finding of this study is knowledge and it was one of the outcome variables in the study. A large proportion (60.0%) of the respondents received HIV related information in the last 12 months and (40.0%) did not receive any information on HIV. Over half (51.0%) of the participants claimed that they had obtained their knowledge from the health facilities while attending other services of hospital. Furthermore the 71.0% women said they had not screened during the last 12 months and 82.0% believed that they cannot refuse when doctor asks for HIV screening.

This finding highlights the importance of health facilities in any effort that tries to improve the acceptance of HIV, as well as 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 HIV/AIDS prevention program efforts. Furthermore 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. Also the respondents have not adequate knowledge regarding HIV prevention strategies as well as it had shown the gaps in the National AIDS Program and need to improve the services of ANC clinic.

5. 2 Discussion

The results of the study showed that most of the women attending antenatal clinic are age between 22 – 37 years, which consists of (87.0%) women. Furthermore the result showed (97.0%) women were married. In addition this study found that most of the participants (71.0%) had attended secondary and higher secondary. However the study showed that large proportion of the women (73.0%) was unemployed and the only (27.0%) participants were employed, which were categorized by civil servant and self-employed (23.0% and 4.0%). One of the studies conducted in Bangladesh showed awareness regarding HIV/AIDS was highest among higher educated women and lower among the illiterate women. As the educational level increased the percent of the respondents who are aware about AIDS also increased. Women with education, secondary or more belonged to high percent of awareness (Dr. Naziya Farooqui, 2012). Also this study showed the relation between the respondents' educational level and knowledge level.

Most of the respondents had heard on HIV/AIDS information, before this study (95%), had not heard and not sure of heard about HIV/AIDS were less (3.0% and 2.0%). In addition (MDHS, 2009) showed at least 94 percent of respondents in all subgroups have heard of AIDS. The result of the study showed that the misconception about HIV/AIDS had overall improvements but, in some aspects of the study it was quiet high such as (30.0%) of the respondents said that someone can get HIV from mosquito bite, (73.0%) respondents had not believed that one can avoid becoming infected with HIV by not having sex at all and (52.0%) of the participants had agreed that anyone can suspect for a healthy looking person have HIV.

However (DHS, 2009) showed that (73.0%) people had believed that AIDS cannot be transmitted by mosquito bites, (80.0%) believed that abstaining sexual intercourse reduces the HIV and (67.0%) had agreed that a healthy looking person can have HIV. These results showed that still there is an information gap within the awareness programs.

This study identified that a large proportion (92.0%) of the respondents believed that sharing needles when injecting drugs will increase the risk of HIV infection and (74.0%) believed using condom during sex prevents HIV transmission. In addition (86.0%) respondents had not believed that a person can get HIV by sharing a meal with someone who is infected and (90.0%) respondents had not believed that HIV can get if someone uses same toilet with an HIV infected person. Another study conducted in an urban antenatal hospital in India showed the 75.0% of women knew of primary transmission routes. 70.0% of them were aware of MTCT and only 8.0% knew of any methods of prevention (Dr. Naziya Farooqui, 2012). Furthermore a study conducted in Nigeria showed that among women attending ANC, all were aware of HIV/AIDS despite their level of education, 90% were aware that HIV infection could co-exist with pregnancy. About 68% were aware of MTCT but there was low knowledge of routes/modes of MTCT and more than half did not know about PMTCT (Nyasinde Mujumali, 2011). These findings highlight the overall pregnant women have adequate level of basic knowledge on HIV/AIDS.

Regarding risk factors of HIV infection most of the participants were not responded (39.0%) and (23.0%) were not believe that they are at risk for infection with HIV and (20.0%) were said that when using unscreened blood for blood transfusion can have a chance to get them HIV infection. Very few were said that when working in health sector, there is a chance to get infection (6.0%), they had exposed to risky behaviours (4.0%) and (3.0%) were said that they have a chance for HIV while working in health sector.

The result of attitudes toward HIV/AIDS showed that most of the participants (40.0%) were not responded. Quiet a high proportion of the participants (33.0%) said that they were having faithful one life partner and they were not at risk for HIV infection. (18.0%) said they were not exposed to any risk behavior. Another study conducted in same area showed that a large proportion of women knew that it is transmitted by close sexual relationship through infected blood, can be transmitted from mother to baby and knew that it is transmitted by reuse of infected needles while only 40.7% knew that it can be transmitted during delivery. The respondents had the knowledge that multiple sexual partners (79.4%), prostitutes and homosexual males (49.7%), during addicts (49.7%) were high risk groups. Regarding prevention of AIDS, 70.9% mentioned avoiding homosexuality, 58.7% knew the use of condoms and 74.7% women knew that screening of blood in laboratories before transfusion can prevent AIDS. (Dr. Naziya Farooqui, 2012).

Regarding screening on HIV Table 4.4 showed most of the participants were not screened (71.0%) on HIV during the last 12 months and only (29.0%) screened. Out of (29.0%), (10.0%) screened that doctors advised to do HIV screening due to pregnancy. Large proportion (82.0%) of the participants said that they cannot refuse when doctor asks for HIV screening and (18.0%) participants said they can refuse when doctor asks for HIV screening.

Knowledge of prevention of mother to child transmission of HIV/AIDS services, high percentage (85.0%) of participants had not aware on that services. However the all most all participants have adequate knowledge regarding screening of pregnant women (66.0%) believed that every pregnant woman should tested for HIV and (27%) participants believed that every pregnant woman should not tested on HIV. Most (79.0%) of the participants believed that if one is infected with HIV then she should not get pregnant again. (39.0%) believed that using condom during pregnancy and breastfeeding reduces MTCT on HIV.

The result had shown that (60.0%) participants received information about HIV/AIDS during the past 12 months and (40.0%) participants did not receive any information on HIV/AIDS. The most of the (51.0%) participants had received information from the health facilities. (18.0%) received information from leaflets (8.0% and 7.0%) of participants received HIV/AIDS related information from TV and leaflets. However high number of participants had no interest of getting HIV/AIDS related information (78.0%) and (22.0%) participants had interested of getting HIV/AIDS related information. Also a large number (45.0%) of participants did not aware about the source of HIV/AIDS information. (23.0%) participants said that health facilities and (12.0%) participants said that internet as the sources of HIV/AIDS information. The other two studies were conducted in Nigeria and in India were found that the main sources of information included posters/billboards (37.0%), radio (36.0%), television (28.0%) and health workers (34.0%) the another survey conducted in India 2007 the main sources of knowledge for HIV/AIDS were television (63.9%), and relatives/friends (58.3%). Thirty percent of women had heard about it from their health personnel. (Dr. Naziya Farooqui, 2012)

5.3 Implications

This study can be useful for the National AIDS Program on to strengthen and expand the PMTCT of HIV/AIDS services in the entire country. Some recommendations concerning relevant objectives of the study were suggested as follows: Most of the questionnaires regarding PMTCT of HIV/AIDS services were answered as don't know. This show high percent of patients are not aware of PMTCT of HIV/AIDS services. This could lead the whole community to have lack of knowledge regarding PMTCT of HIV/AIDS services. As a result the recommendation was that increasing public awareness of the PMTCT of HIV/AIDS services should be restrained stigma and discrimination and it would be reduced

misconceptions. The ANC clinic should increase the providing information on PMTCT services through brochures or posters, or educate the patients to be more awareness of PMTCT services using appropriate mass media.

Concerning about the patients' awareness on PMTCT services and VCT, it is recommended to integrate the VCT and PMTCT within the ANC clinic. Furthermore it was recommended to promote to take informed consent before each HIV test during pregnancy. This will increase the knowledge of patients this may lead to effective treatment. Especially if the National tuberculosis Program would like to improve the outcome of the TB treatment as well as this will help in early case detection.

5.4 Limitations of the Study

The study conducted clinic was drawn only from urban setting and selected of minimum place. Unfortunately the sample size was not big enough to make the comparisons by geographical location. As well less amount of sample were collected due to the time constrains and limited budget. To have more reliable and valid results, a larger sample is necessary. Furthermore in this study, pregnant women who were not registered in the antenatal clinic in RHC, IGMH were excluded. It was felt that at the time these pregnant women living in Male' city would not have had an opportunity to have been included in this study. Also it is likely that sample included in the study is not representative of pregnant in Male' city, as such it is a selected group (selection bias).

Several challenges were faced when collecting data. At first 3 nurses from IGMH were collected data for the first three days and later they had not given any time for this study due to their busy schedule at the hospital.

Also I had difficulty in interviewing the pregnant women; there was the limitation in communicating for data collection because of the lack of privacy at the RHC as well as the sensitivity of the topic. In addition, due to the limited time, this study is consisted only a limited knowledge and attitude components and most of the questions were close –ended.

5.5 Direction for Future Research

More research is needed to determine the Knowledge, attitude and Practice (KAP) of pregnant women on PMTCT of HIV services by using comprehensive questionnaires which need to be included the both close –ended, open –ended questionnaires and focused group discussion. Sample population should cover the all tertiary hospitals in the country, for the generalization of result for the total and sample size need to be increased to get more reliable and valid results. Also it is recommended to choose an appropriate place for patient to fill in the questionnaire for the future research for a patient's convenience. Furthermore giving more time for the study can find more in - depth understand about the situation as these are more reliable study. This will help to strengthen the PMTCT services in the country by identifying gaps and weakness in the programs.

5.6 Conclusion

Almost all of the pregnant women had adequate amount of awareness about basic knowledge of HIV/AIDS. However they had less amount of knowledge regarding PMTCT services and HIV treatment. Also a large proportion of the respondents received HIV related information from the health facilities while attending other services of hospital. A few of them got information from TV, Internet, leaflet etc. Quiet a high percentage of respondents had not aware about sources of HIV information. Furthermore a large amount of respondents had not screened during the last 12 months and 82.0% believed that they cannot refuse when doctor

asks for HIV screening. Moreover this study identified that most of the respondents corrected the most common misconception of HIV/AIDS such as, a person can get HIV by sharing a meal with someone who is infected, HIV can get if someone uses same toilet with an HIV infected person and mosquito bites can spread HIV.

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APPENDICES

1.1 Consent letter

ތާރީޚް

ނަން: ހަސަންދޮށް،

ފިލާނާގެ ދަށް

ތިބާ ހަމަވެރިވާ ކަންތައް

ވަގުތު ހޯދާ ދިރާސާ ތަކަށް.

ދިވެހިރާއްޖެ ތަކެއް ތަންދުވާ ދިރާސާ (6438، ދެމަތިވެރި ހަލާކުވާ ބަލި) ކަމަކީ ދަތުރުވާ ބަލި ކަމުގައި ދެ ދުވަހުވ ދިވެހިރާއްޖެ ކަންތައް ދިރާސާ ކުރަނީ. ދިވެހިރާއްޖެ ކަންތައް ދިރާސާ ކުރަނީ 15 -49 ހަމައަށް ވަރަށް ދަށ ދަށ ކުދިންނާ ދިރާސާ ކުރަނީ.

ދ ފިލާނާވިސް ހާދި ދިރާ ކަންތައް ދަ ދިން ތަކެއް ލިޔުމުން ދަންނަވައި ހުށަހަ. ފިލާނާގެ ތަކެއް ކަންތައް ދިރާސާ ކުރަނީ (ހަސަ، ތަކެ، ދ، ހަދާ، ހަދާ) ދިވެހިރާއްޖެ ތަކެއް ދިރާ ކަންތައް ހުށަހަ.

ވިދާ، ދ ފިލާނާގެ ދިރާ ކަންތައް ދ ހަސަ ދިރާ ކަންތައް ކަ ކަ ކަ ކަ. ދ ފިލާނާގެ ދިރާ ކަ 24 ދުވަ .

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02 ދެ 2013

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1.2 Instrument (English Questionnaire)

PART I.

Socio demographic data

1. **Age**…………

2. Marital status

a. Single ☐ b. Married ☐

c. Divorced ☐ f. Separated ☐

e. Widow ☐

3. **Level of education**

a. Never went to school ☐

b. Grade 1-7 ☐

c Grade 8 - 12. ☐

d. Tertiary Education ☐

4. **Current occupation**

a. Unemployed ☐

c. Self-employed ☐

b. Civil Servant ☐

PART II

BASIC KNOWLEDGE QUESTIONS

		Agree	**Disagree**	**Don't know**
5	Before this Interview, do you ever heard of information on HIV/AIDS?			
6	Can understand someone having HIV infection by looking at that person?			
7	Can protect from HIV/AIDS?			
8	Is there any treatment on HIV/AIDS?			
9	If there is treatment for HIV/AIDS, Can cure from the disease?			
10	Can reduce the risk of HIV transmission by having sex with only one faithful, uninfected partner?			
11	Using condom during sex, prevents HIV transmission			
12	Can suspect for a healthy-looking person have HIV?			
13	Can a person get HIV from mosquito bites?			
14	Sharing needles when injecting drugs will increase the risk of HIV infection.			
15	One can avoid becoming infected with HIV by not having sex at all.			
16	Can a person get HIV by sharing a meal with someone who is infected?			
17	One can get HIV if one uses same toilet with an HIV infected person			
18	Do you feel that you yourself are at risk for infection with HIV?			

19. If Yes to 18,
Why do you feel that you are at risk for HIV infection? (Multiple responses allowed)

……
……
……

20. If No to 18
Why do you feel that you are not at risk for HIV infection? (Multiple responses allowed)

……
……
……

PART III (Mother to child transmission)

21. Did you screen for HIV during the last 12 months?

a. Yes ☐

b. No ☐

If yes,

22. Why did you screen?

……
……
……

23. Do you know the reason that you did HIV screening?

a. Yes ☐

b. No ☐

24. Can you refuse when a doctor asks for HIV screening?

a. Yes ☐

b. No ☐

25. Can child get HIV transition through mother?

a. Yes ☐ c. Don't know ☐

b. No ☐

If yes,

26. When does child get infection from mother?

a. During pregnancy ☐ c. Through vaginal delivery ☐

b. Through breast –feeding ☐

27. Do you aware of the Prevention of Mother to Child Transmission of HIV services for PMTCT?

a. Yes ☐ c. don't know ☐

b. No ☐

28. How can mother to child transmission (MTCT) of HIV be prevented?

a. Antiretroviral therapy during pregnancy. ☐ b. Delivery by caesarean section. ☐

c. Giving antiretroviral drugs to the newborn. ☐ D. Don't know ☐

PART IV

QUESTIONS ON INFANT FEEDING

29. Do you know the main alternatives of infant feeding?

a. Breastfeeding for as long as the mother wishes ☐

b. Breastfeeding for 6months exclusively ☐

c. Infant formula /Cow's milk ☐

30. What is your opinion about giving Infant formula to the infants?

……
……
……

31. What is your opinion about HIV infected children living with the HIV uninfected children?

……
……
……

PART V

QUESTIONS ON ATTITUDE TOWARDS PMTCT

	Agree	Disagree	Don't know
It's important that every pregnant woman gets tested for HIV.			
If one is infected with HIV then she should not get pregnant again			
Using protection (condoms) during pregnancy and breastfeeding reduces MTCT			
Are you aware that there are services for Prevention of Mother to Child Transmission of HIV			

PART 6 (Questions on information sources and preference)

32) In the past 12 months, have you received information on HIV/AID? Yes ☐ No ☐

33) What were your sources of that information?

……
……
……

34) Would you like to receive more information on HIV/AIDS? Yes ☐ No ☐

If yes,

35) Where will you like to get the information on HIV/AIDS?

……
……
……