ORIGINAL ARTICLE

Public Health and Preventive Medicine Archive (*PHPMA*) 2018, Volume 5, Number 1: 67-71
E-ISSN: 2503-2356

Barriers and opportunities for implementing prevention of mother to child transmission (PMTCT) in Bangli District

Ketut Espana Giri,[1*] Ni Made Sri Nopiyani,[2] Ketut Tuti Parwati Merati[3]

ABSTRACT

Background and purpose: HIV testing among pregnant women can reduce the risk of mother to child HIV transmission. The implementation of prevention of mother to child transmission (PMTCT) program in Bangli District is suboptimal. This study aims to explore challenges and opportunities for implementing PMTCT program from both user and provider perspectives.

Methods: A qualitative approach was conducted in Bangli District between April and May 2016. Data were collected using in-depth interviews with 18 informants. All informants were purposively selected and covered of 10 pregnant women, two counsellors, two laboratory analysts, two head of public health centres, one disease control officer from Bangli District Health Office and one officer from Bangli District AIDS Commission. Data were analysed using thematic method.

Results: Pregnant women chose to have ANC service at private midwife and obstetrician instead of public health centre. From health providers' perspectives barrier of PMTCT implementation included lack of health human resources and a high level of stigma and discrimination related to HIV/AIDS in the community. This study revealed that there was an opportunity for PMTCT implementation in Bangli District due to positive attitudes and supports from husband and health provider toward HIV testing. Another opportunity is to involve village health cadres and community leaders in promoting HIV testing among pregnant women.

Conclusions: Implementation of PMTCT program in health centre should include network of private practitioner and enhance village health cadres' and community leaders' participation.

Keywords: PMTCT, HIV/AIDS, health centre, barrier, opportunity, Bali

[1]Bali Province Health Office,
[2]School of Public Health Faculty of Medicine Udayana University
[3]Internal Medicine Department Faculty of Medicine Udayana University/Sanglah General Hospital Denpasar, Bali

[*]Correspondence to:
Ketut Espana Giri, Bali Province Health Office
espanagiri@ymail.com

INTRODUCTION

UNAIDS stated that HIV infects one woman every minute with more reproductive-aged women died from AIDS.[1] HIV-infected women can also transmit the virus to their children during the pregnancy (5-10%), delivery (10-20%) and lactation (5-20%).[2]

In order to prevent HIV transmission from mother to child, the Indonesian Government released the Ministry of Health Regulation No. 51/2013 on Prevention of Mother to Child Transmission (PMTCT) Guideline[3] and Instruction Letter No. GK/Menkes/001/I/2013 on the provision of PMTCT program. The strategy includes the implementation of HIV screening program in ANC services at health centres.[4]

One of the districts in Bali that have started the implementation of HIV screening in ANC services is Bangli.[5] PMTCT program has been implemented in the health centres since November 2015, however only two health centres provided the reports, which were Susut I and Tembuku II Health Centres. A total of 91 out of 155 pregnant women (58.71%) participated in PMTCT program at Susut I Health Centre, while at Tembuku II Health Centre were only 31 out of 129 pregnant women (24.03%).[6] This study aims to identify barriers and opportunities for implementing PMTCT program at the health centres.

METHODS

A qualitative approach was conducted in Bangli District between April and May 2016. Data were collected using in-depth interviews. A total of 18 informants were purposively selected, consisted of 10 pregnant women, two counsellors, two laboratory analysts, two head of health centres of Susut I and Tembuku II, one staff from district disease control program and one official staff from Bangli District AIDS Commission.

In-depth interviews were conducted to explore barriers and opportunities for implementing PMTCT program at the health centres both from user and provider perspectives. Data from interviews were analysed using thematic approach. Each interview was transcribed and coded to generate sub-themes. These themes were organised to reveal main themes both for barriers and opportunities. This study protocol has been approved by the Human Research Ethics Committee of Faculty of Medicine Udayana University/Sanglah General Hospital.

RESULTS AND DISCUSSION

Data from in-depth interviews were organized into barriers and opportunities themes. Each theme was further elaborated based on user and provider perspectives.

Barriers

From all pregnant women interviewed in this study, only one visited a health centre for the ANC, while the rest visited private midwives or obstetricians. All of them were accompanied by their husband for ANC visit and most of them said that opening hours of ANC services at the health centres overlapped with their husband working time. As a result, they visited private midwives or obstetricians because it was more convenient with their time. This can be seen in the following quote.

> *"If [we] visit a health centre, [we] must visit it in the morning, my husband also off for work in the morning… he cannot accompany me for my ANC visit then…"* (IHS_6)

Family supports, particularly from the husband, influence pregnant women decision to visit health centres for ANC service. A study conducted in 2014 found that there is a positive association between family supports and ANC service utilisation.[7]

Previous pregnancy experience also influenced pregnant women decision to utilise ANC service from health centres. For example, pregnant women will not utilize ANC service from the health centre if the baby was found with abnormal positions. For this reason, pregnant women were more inclined to visit private midwives or obstetricians. They also suggested that drugs available at the health centres were different from those provided at private midwives or obstetricians. They stated that drugs provided by health centres were not effective. These perceptions have led pregnant women to access private health services or to request a referral letter to higher healthcare facilities. This can be seen in the following quote:

> *"When [I] was sick, I went to a health centre, but it was not effective… maybe because the drugs were different… so I went there [private services], I don't mind paying… I will never get any better if I access service from a health centre…"* (IHT_4)

Perception that private midwives or obstetricians provide better medication than health centres has led pregnant women to access private services. This finding is consistent with the Health Service Use Theory[8] which stated that health seeking behaviors of people are influenced by the severity of their diseases and also by their desire for a better healthcare services.

Pregnant women who never been tested for HIV said that they have never heard about HIV testing for pregnant women. They also stated that health providers had never explained the HIV testing during pregnancy or any education program to disseminate information on HIV testing for pregnant women had never been delivered to them either, as can be seen in the following quote:

> *"I don't remember if I had received one… If it [HIV test] is compulsory I will probably do it… for me and my baby…"* (IHT_5)

Level of knowledge of pregnant women about HIV testing during pregnancy in the study areas was low. Only a few participants have heard about HIV testing during pregnancy. This finding is consistent with a study in South Africa which found that one of the major barriers for PMTCT implementation is a low level of knowledge about the program.[9]

From the provider perspective, limited human resource was found as one of the key barriers. The lack of human resource to implement PMTCT program might lead to an increasing workload. In other hand, they felt that their current workloads were already high. In addition, they also felt that the trainings for counselling and laboratory for HIV testing were inadequate. They recommended that additional staff to implement PMTCT program is essential in order to improve coverage of PMTCT, as can be seen in the following quote:

> *"Actually two counsellors are not enough…"* (KPS)

Health human resources are the most strategic input because they can optimally use other input elements including physical, financial and other human resources to pursue their objective.[10] Health providers in this study suggested that additional staff is required to implement PMTCT program. It can be explained that health providers at the health centres are already responsible with multiple tasks and programs. Several staff are responsible for PMTCT program and at least one other program on top of additional tasks outside of their primary roles. This finding is consistent with a study conducted in Bali Province in 2014 which found that in providing HIV related care, higher workload were experienced by health providers particularly medical doctor and laboratory analyst.[11] Other study in Tangerang Hospital also found that the

main contributing factor of program implementation failure was the lack of human resources or incompatible skills of the existing human resources.[12]

In addition to limited human resources, informants also stated that a high level of stigma and discrimination from the community inhibits them to provide HIV-related services. Even though level of stigma in the study areas was low to moderate, HIV-infected people were reluctant to open up their HIV status to the health providers because they were too afraid of being stigmatised and discriminated by the community. Stigma and discrimination have been strongly associated with HIV testing and treatment. Stigma may reduce people willingness to take HIV testing because of fear associated with stigma and discrimination if they were found HIV^+.[13,14]

Health providers suggested that lack of supporting facilities to implement PMTCT program at the health centres was another challenge to be addressed. These included limited of operational costs such as transportation reimbursement when they do outdoor services, limited vehicles at the health centres for outdoor activities, limited brochures and leaflets for education program, and inadequate counselling room at the health centres. While waiting for the health operational fund, health providers must cover all expenses associated to PMTCT program implementation by using their own money as well as the health centres fund to cover costs associated to fuel and administrative materials.

> *"…for transportation cost we use our own money, but for photocopying the forms we request the budget from the health centre, because we have budget for administrative materials at the health centre"* (KS)

The availability of supporting facilities and operational costs are contributing factors for optimal program performance. These should be provided to program implementer to ensure program implementation.[15,16]

Opportunities

Support from husband was identified as a key opportunity for PMTCT implementation from user perspective. Nine out of 10 pregnant women in this study said that their husband always accompanied them for ANC visit and HIV testing. All of pregnant women stated that they felt that their husband will support HIV testing to protect the mother and the baby. By taking HIV testing during pregnancy, the HIV transmission from mother to child can be prevented. Similarly, obtaining support from husband to take the test will enable pregnant women to know their HIV status earlier. This finding is consistent with a study in Central Java in 2012 which found that supports from the husband is a key factor that increases pregnant women willingness to take HIV testing.[17]

Apart from supports from the husband, pregnant women also said that they received substantial supports from the health providers from health centre. Their supports mainly manifested in providing them with information about HIV testing, suggesting them to take the test and gathering them at the auxiliary health services or community halls for the education program. In addition, health provider also phones called pregnant women to do HIV testing or their husband to obtain permission to perform HIV testing. Health providers in this study also stated that the education programs were also conducted in remote areas and district border areas.

However, three pregnant women in this study said that they never received any information related to HIV testing from health providers. A study in Semarang in 2012 also found similar finding. It revealed that a positive support from midwives improves willingness of pregnant women to take HIV testing.[17,20]

Collaboration between health providers, community member through village health cadres and community leaders improves the uptake of HIV testing among pregnant women. Village cadres and community leaders disseminated information about HIV testing during pregnancy and facilitated pregnant women gathering at the auxiliary service or community hall for HIV testing. This means that the PMTCT program mainly took place at the community hall or at the auxiliary service at village level.

> *"Supports from the community are really great, we are supporting each other… for example pregnant women class, it requires support from community leaders, head of the village… because they will organize the place not us…"* (PK_1)

Community participation is an absolute requirement for health services.[18] A study conducted in Sub-Saharan Africa in 2016 showed that there is a complex interaction between health providers, health cadres and communities. This complex interaction is the key element for trust building between community members and health providers. Limited relationship will lead to limited trust and social cohesion among health providers and communities.[19]

Informants in this study said that HIV and AIDS information system has been implemented in Bangli District. Trainings associated with this system have also been conducted in April 2016 by Bali Provincial Health Office as Bangli District just started the PMTCT program implementation in November 2015. Previously, HIV and AIDS report was only entered by the Bangli District Public Hospital, but for now onwards HIV and AIDS reports can also be entered by the health centres.

> *"…We already trained to use HIV-AIDS information systems… A staff from Bali Provincial Health Office came here to train us. We started this month to enter data via the systems from the health centre which previously can only be done via the hospital…"* (PK_1)

The introduction of electronic information system to support the work of health centres staff in managing HIV data will help them to report the data efficiently.

CONCLUSION

Barriers to implement PMTCT program from user perspective include the low utilization of ANC services at the health centres and the lack of knowledge among pregnant women related to HIV testing during pregnancy. A low utilization of ANC service from the community health centres is associated with inconvenient opening hours, and patient satisfaction of the services. From provider perspective, barriers to implement PMTCT program include lack of human resources, lack of supporting facilities, limited operational costs, and HIV-associated stigma and discrimination from the community. Several enablers for implementation of PMTCT program from user perspective include positive attitudes toward HIV testing during pregnancy from husband and ongoing supports from health providers to take HIV testing. From provider perspective, the enablers include functional collaboration between health providers, village health cadres and community leaders, positive teamwork of PMTCT team and the introduction of HIV-AIDS information systems.

ACKNOWLEDGEMENT

We would like to thank all informants who had participated in the study and stakeholders who had supported this study particularly Head of Bangli District Health Office.

REFERENCES

1. UNAIDS. The Gap Report Beginning of the End of the AIDS Epidemic; 2011.
2. WHO. Guidelines for assessing the utility of data from prevention of mother-to-child transmission (PMTCT) programmes for HIV sentinel surveilance among pregnant woman; 2013.
3. Ministry of Health of Indonesia. Pedoman Pencegahan Penularan HIV dari Ibu ke Anak [Guideline for Prevention from Mother to Child Transmission]. Jakarta: Kementerian Kesehatan RI; 2013.
4. Ministry of Health of Indonesia. Pedoman Penerapan Layanan Komprehensif HIV-IMS Berkesinambungan [Implementation Guideline of Comprehensive and Continuing HIV Care]. Jakarta: Kementerian Kesehatan RI; 2013.
5. Bali Provincial Health Office. Data Integrasi HIV Dengan Pelayanan ANC Tahun 2015 (Januari-Desember) [Data on Integration of HIV and ANC Services 2015 (January-December)]. Denpasar: Bali Provincial Health Office; 2015.
6. Bangli District Health Office. (2015). Laporan Kesehatan Ibu dan Anak [Report on Maternal and Child Health]. Bangli
7. Mardiyah YT. Faktor yang Berhubungan dengan Pemanfaatan Pelayanan Antenatal [Factors associated to utilisation of ANC services]. *e-Jurnal Pustaka Kesehatan;* 2014; 2 (1): 58-65.
8. Andersen R, Kravits J, Anderson OW (ed). Equity in Health Services, Cambridge, Mass: Ballinger Publishing Co; 1975
9. Peltzer K, et al. Barriers to Prevention of HIV transmission from mother to child (PMTCT) in a resource poor setting in the Eastern Cape, South Africa : original research article. *African Journal of Reproductive Health*; 2007: 57-66.
10. Setyawan. Manajemen Sumber Daya Manusia Strategis: Repositioning Peran, Perilaku Plus Kompetensi serta Peran SDM Strategi [Management of Strategic Human Resources: Repositioning Roles, Behaviour Plus Competency and Roles of Strategic Human Resources]. Yogyakarta: Amara Books; 2002.
11. Nopiyani NMS, Wulandari LPL, Suarjana IK. Analisis Kapasitas Sub-Sistem Sumber Daya Manusia Kesehatan untuk Implementasi Treatment as Prevention pada Pekerja Seks Perempuan di Provinsi Bali Menggunakan Workload Indicators of Staffing Need dan Studi Kualitatif [Analysis of Health Human Resource Capacity to Implement Treatment as Prevention among Sex Workers using Workload Indicators of Staffing Need and Qualitative Approach]. Denpasar: Ikatan Ahli Kesehatan Masyarakat Indonesia Cabang Bali; 2014.
12. Manggala W. Analisis Implementasi Kebijakan Jaminan Kesehatan Nasional Di Rumah Sakit Umum Kota Tanggerang Selatan [Analysis of Implementation of National Health Security Policy at Tangerang Selatan City District Hospital]. Jakarta: FKIK.UIN; 2014.
13. UNAIDS. Report on the Global Aids Epidemic. Geneve: WHO Library; 2010.
14. Jaiantilala P, et al. Acceptability, Feasibility and Challenges of Implementing an HIV Prevention Intervention for People Living with HIV/AIDS Among Healthcare Providers in Mozambique: Results of a Qualitative Study. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*; 2015: 1-9.
15. Junaidi. Implementasi Kebijakan Penanggulangan HIV-AIDS Oleh KPA di Kota Pontianak [Implementation of HIV-AIDS Control Policies in Pontianak City]. Universitas Tanjungpura Pontianak; 2013.
16. Widiyasari E. Implementasi Integrasi Program Prevention of Mother to Child HIV Transmission dengan Layanan Antenatal di Puskesmas Wilayah Kota Surabaya [Integration of PMTCT into ANC Services into Community Health Centre in Surabaya City]. Thesis. Surabaya; 2013.

17. Legiati D. Perilaku Ibu Hamil untuk Tes HIV di Kelurahan Bandarharjo dan Tanjung [HIV Testing Behaviour of Pregnant Women at Villages of Bandarhargo and Tanjung]. *Promosi Kesehatan Indonesia*; 2012: 153-164.
18. Ministry of Health of Indonesia. Perpres No. 72 Tahun 2012 tentang Sistem Kesehatan Nasional [President Regulation No. 72/2012 on National Health Systems]; 2012.
19. Meryse, et al. Optimising The Benefits of Community Health Workers' Unique Position Between Communities and The Health Sector: A Comparative Analysis of Factors Shaping Relationships in Four Countries. *Global Public Health: An International Journal for Research, Policy and Practice*; 2016.
20. Arifin. Koordinasi Pemrograman untuk Meningkatkan Kinerja Pelayanan KIA di Puskesmas [Program Coordination to Improve Performance of Maternal and Child Health Services at Community Health Centres]. Surabaya: Universitas Airlangga; 2001.

This work is licensed under a Creative Commons Attribution