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Socio-cultural Factors Influence the Uptake of the Prevention of Mother-to-child Transmission (PMTCT) Program: A Critical Ethnographic Study

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Abstract

Addressing the socio-cultural factors is key to prevent Mother-to-Child Transmission (MTCT) of HIV. The authors explore socio-cultural factors that influence the uptake of the PMTCT program among HIV+ women in Rwanda. A qualitative critical ethnographic study was conducted among 29 HIV+ women and 26 healthcare providers, policymakers, PMTCT leaders from 2020 to 2021. Intersectionality framework guided this research. A purposeful sampling was used to select the research participants. Data were collected using observation, field-notes, individual and focus group interviews, and document review. The data analysis was performed concurrently with data collection and included reflexivity and thematic analysis. ATLAS.ti software version nine was used to facilitate analysis and organize data.

The effort to limit the number of MTCT of HIV have been global and can be attributed to rapid HIV testing during pregnancy, antiretroviral (ARV) adherence, uptake of the PMTCT program, and the counseling on infant feeding. The elements from social and cultural characteristics, including religious beliefs, interfering with the experiences, decisions, and behaviors of HIV+ women during the infant feeding choice. It is not enough to provide ARVs and counselling to HIV+ mother but beliefs, attitudes, and practices of families and community members that will interact with and negatively affect the uptake and efficacy of the PMTCT program and ARV adherence, also need to be addressed. traditional practices, religious beliefs, and infant feeding were associated with the PMTCT uptake. It is important to consider community and social factors for the accessibility and effectiveness of the PMTCT program related interventions.

Keywords: HIV, Mother-to-child transmission; prevention; socio-cultural barriers

1. Introduction

Mother-To-Child Transmission (MTCT) or vertical transmission of Human Immunodeficiency Virus (HIV) is the transmission of the HIV from infected mothers to her child during pregnancy, labor and delivery, and breastfeeding (through breastmilk) (Otieno, Karanja, &Kagira, 2017; World Health Organization [WHO], 2019. In 2021, approximately 180 000 children acquired HIV every day globally and more than 90% of this group are infected through MTCT, of which

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approximately 90% of these infections occur in sub-Saharan Africa (SSA) (United Nations Program on HIV/AIDS [UNAIDS], 2021; KFF [Henry J Kaiser Family Foundation], 2021). The risk of vertical transmission of HIV is 20 to 45% without any preventive interventions. Among that proportion, five to 10% occur during pregnancy, 10 to 20% during labor and delivery, and five to 20% through breastfeeding (WHO, 2019; Kamanzi et al., 2021). The global health plan to ward 2023 focus on ending the AIDS epidemic by 2030 (WHO, 2020). To achieve this target, prevention, treatment, and care are needed and be delivered to at least 80% of HIV + pregnant women and their children.

The implementation of the PMTCT program provides an opportunity from preventing new pediatric HIV infections and the risk can be reduced to less than 1% (WHO, 2019). Ensuring HIV+ women to have an HIV negative infant the adoption of PMTCT strategies, such as HIV testing as early as possible before or during pregnancy; prevent unwanted pregnancies; start and continue anti-retroviral therapy (ARV) and HIV counseling during pregnancy, labor, and breastfeeding, use safe childbirth practices; provide ARV prophylaxis to her infant, practice appropriate infant feeding, and accessing physical, social, and psychological support, are important (WHO, 2019).

While UNAIDS and WHO suggest that virtual elimination of MTCT of HIV is possible and it has been achieved in developed countries (UNAIDS, 2021; WHO, 2019), this goal continues to remain unattainable in low income countries with limited resources. Studies showed that HIV+ pregnant women in these countries do not access prenatal care early in pregnancy, labor or deliver untested for HIV, and most do not have access to effective ARV (Kamanzi & Richter, 2019; Nachega et al., 2012; WHO, 2019). Barriers to prevent MTCT of HIV exist at individual, family, community, health system and social levels (Kamanzi & Richter, 2019b). If MTCT of HIV is to be virtually eliminated in low income countries, a series of steps including integrating socio-cultural factors into PMTCT intervention program is essential. The question arise why should we focus on socio-cultural factors?

Socio-cultural factors play important roles in influencing health behave our and health outcomes, and utilization of health services is gained immense recognition in the literature (Otieno et al., 2017). Socio-cultural factors matter not only with shaping health decisions (weather HIV+ or negative) but also with highlighting the role played by families, community, beliefs, culture, and society in shaping those decisions (Cornelius et al., 2018; Elwell, 2016; Otieno et al., 2018). It is plausible that knowledge of socio-cultural factors may facilitate effort to understand the experiences and needs of HIV+ women when they make decision to attend the PMTCT program or not. Therefore, exploring socio-cultural factors that influence the uptake of the PMTCT program among HIV+ women will inform the development of effective interventions to promote the PMTCT program adherence.

2. Methods

A qualitative, critical ethnographic study conducted in Butare University Teaching Hospital (BUTH) in Rwanda was conducted guided by the Intersectionality framework. Purposeful

sampling was used to recruit knowledgeable participants. Inclusion criteria included a sound experience of the phenomenon of interest, willingness to communicate their experiences, and to participate in the study. A total of 55 participants were recruited of which 29 were HIV+ women using the PMTCT program and 14 HCPs working at the PMTCT program for more than six months, four PMTCT leaders, and eight policymakers. We collected the data until obtaining a rich and in-depth understanding of the phenomenon under study. We collected demographic information to better understand the background characteristics of the patients' sample. Data were collected from January 2020 to May 2021 using a semi-structured interview guide developed for this study. We employed multiple sources of data such as participant document review, observation, field notes, and individual and focus group interviews to develop an understanding of the experiences of the mother using the PMTCT program to prevent HIV transmission in Rwanda. To protect the Rwandan people, national guidelines and policies around COVID-19 prevention and response to the pandemic was implemented. The principal investigator (JK) conducted all the interviews. The principal investigator is a female, with proficiency in the national Rwandan language, share the same culture, taboos, values, misconceptions, and perceptions that shape the community where the participants live. The researcher introduced herself as an educated woman, mother, married women, nurse, who previously worked at BUTH. Each interview lasted between 45 to 60 minutes and was recorded using a digital audio recorder. Each recorded interview was assigned a unique identification number. Audio records and completed transcripts were stored on a password-protected computer. The researcher also collected field notes while conducting the interviews.

Data analysis commenced during data collection. It included reflexivity, thematic analysis, and the use of ATLAS.ti software to facilitate analysis and organization of the data. Data were collected and analyzed in Kinyarwanda. Since only one researcher understand Kinyarwanda, a subset of data was translated into English to ensure the rigor of the study. All researchers extracted codes independently for comparison. A coding framework was developed that was cross-checked and agreed upon by the other researchers. They actively participated in the process of derivation of categories, sub-categories, themes, and sub-themes. This helped to ensure that the analysis of data reflected the experiences shared by the participants and was able to answer the research questions.

We followed the framework described by Lincoln and Guba as supported by No well et al. (2017) to ensure rigor whereby trustworthiness is established through credibility, dependability, transferability, and confirmability. Credibility was achieved through prolonged engagement, persistent observation, negative case analysis, triangulation, member checking, external audits, peer review or debriefing, thick and rich descriptions, and preventing researcher bias. Transferability was achieved through a thick description. Field notes supported the contextualization of our observation and to get a better understanding of the research context. We met dependability criteria by describing the operational aspect of data generation in detail from data collection, analysis, and interpretation. Confirm ability was achieved through self-flexibility, regular interaction with research team.

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The University of Alberta Research Ethics Board approved the study (Pro00096520). Permission to access and collect data at Butare University Teaching Hospital (BUTH) was requested and received from the BUTH Ethics Committee (Ref: CHUB/DG/SA/02/0401/2020). Considering the varied literacy level, participants were given the option to give informed consent by either signature, or thumbprint, or verbally. With the permission of the study participants, their verbal approvals to participate in this study were recorded after assigning a unique identification number. All respondents were assured that the information would be treated with strict confidentiality.

3. Results

3.1. Demographic characteristics of the study population

A total of 55 participants were included in the study to exploring socio-cultural factors that influence the uptake of the PMTCT program among HIV+ women. Participants included twenty-nine participants (women) that were HIV positive, 14 HCPs, eight policymakers, and four PMTCT leaders. The mean age of the HIV+ women in the study group was 37 (range from 24-50) years. The study population was predominantly Protestants (52%), Romain Catholic (41%), and Seventh-day Adventist (7%). Most of HIV+ women were married (66%) and 69% had attained primary or secondary education with few people 31% who never attended school.
Out of 55 participants, 14 were healthcare providers (HCPs); their ages ranged from 24 to 56 years and nurses, physicians, psychologists, and social workers were interviewed. The length of their work experience of HCPs varied from 6 months to more than 15 years; 51% of them did not choose to work in the PMTCT program, and 57% did not get any training before starting their position at the PMTCT program.

3.2. Themes Emerged from the Collected Data

During field observation and interviews, participants shared cultural factors that challenge the uptake of the PMTCT program. Those included traditional practices and beliefs, religious beliefs, infant feeding, cultural ideology, and role of mother-in-law.

3.2.1. Traditional practice

Traditional practices were discussed extensively in the interviews with HIV+ mothers and HCPs. Some women did report that their children experienced traditional diseases that are not healed with modern medicine. They added that they were not feeling confident to share this with HCPs who cannot support them and do not have the same beliefs. One participant thought that her baby was exposed to HIV due to that practice and said:

My baby became positive after I brought her to traditional healer, she was tested negative in her first exam. After they removed the stuff in her mouth, they asked me to breastfeed her, and she was bleeding. And you know my breast milk has the virus. I think she got the disease at that time, yes, the HIV test of nine month she was positive.

Most of the time, the HCP team were unaware of the engagement of mothers with traditional practices. A paediatrician stated:

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Women want to pursue traditional practice with ARVs sometimes, and I am not sure that the women feel reluctant to tell me that. I do not feel like that they have to hide that; thing may adversely interact. I think we need to create an environment where they can discuss their traditional practices openly. Not their options are bad necessarily but to be realistic in how we discuss it because we do not know what they are traditionally doing. If we are aware then we can possibly advise.

Although the use of traditional medicine was not frequently reported by the women to the HCPs, some PMTCT program leaders reported clients who alternated between ARV and traditional medicine, while other clients stopped ARVs treatment entirely in favour of traditional medicine.

3.2.2. Traditional beliefs

Traditional beliefs related to conception, pregnancy and childbirth sometimes acted as barriers to accessing PMTCT services to prevent MTCT of HIV. The message shared by participants is that pregnancy and delivery are women's issues. Most women are able to bear the pain during labor, but they do not trouble their family for their pain; they keep quiet and not disturb their family until the water breaks. This exposes most HIV+ women to home delivery and the associated risk of MTCT of HIV. One client said:

I want that no one in the family should face any trouble because of meI kept quiet until the water breaks, then I tell them, this was very late by then taking me to hospital was not possible. I was assisted by a TBA and had natural delivery

Use of alternative medicines also influenced the HIV+ women to default from using the PMTCT program. Women referred to some traditional medicines, such as herbal remedies that were believed to work better. Participants shared that they could initiated and discontinued herbal medicine at any point when they choose or felt better. This was an attractive alternative treatment unlike ARVs that have to be taken daily for a lifetime. A participant stated: "Ah, I don't see any reason for taking these drugs. You know ARVs are made from herbs, so it is good for me to take herbs, any time I feel like rather than these ARVs, taking these drugs daily give me a tough time.

3.2.3. Infant feeding

HIV+ mothers have two options to feed their children: they may choose either exclusive breast feeding (EBF) or exclusive replacement feeding (ERF). However, both feeding options contain risks to child health and survival. HIV+ women tended to overestimate that breastfed babies contract HIV, and this resulted in their choosing ERF even when their financial situation was precarious. The findings showed that guiding HIV+ mother son infant feeding was the weakest aspect of the PMTCT program. HIV+ mothers struggled to make feeding choices that matched with their socio-economic contexts and that were culturally accepted. Some mothers practiced mixed feeding though this practice is not advocated by the PMTCT guideline. HIV+ mothers were frequently exposed to conflicting messages from the PMTCT program staff, family members, and traditional healers. Some HIV+ women experienced a dilemma where HCP wanted them to EBF of ERF, and the community demanded that they breastfeed longer and use

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mix feeding. This feeding dilemma exposed their infants to MTCT of HIV through breastfeeding. The majority of HIV+ mothers chose the breastfeeding option. because breastfeeding seemed to be socially constructed as being an essential feature of motherhood, replacement feeding reflected negatively on the mother's commitment to motherhood and her children. Also, HIV + mothers feared that if they chose not to breast feed that would be an indication of their HIV positive status.

The conflict between a breastfeeding culture and PMTCT guidelines was another concern raised by the participants. Various social and cultural factors about ERF influenced the experiences, attitudes, and behaviour of HIV+ women. There was pressure to breastfeed directed towards HIV+ women specifically from their in-laws, arguing that ERF in early infancy violates the rules of good motherhood. One participant stated:

The mother-in-law does not agree that I am not breastfeeding, it is against the culture. According to the culture I am supposed to breastfeed the baby up to three year or even more. You know I did not disclose my status, she does not know my disease nor why my baby is not breastfed. She said she was born before that doctor and she know much better.

Based on community infant feeding culture, prolonged breastfeeding makes infants healthier, stronger, and contribute to the healthy development. In the African community, mothers who use replacement feedings are identified as bad mothers, irresponsible, dislike their child, desire adultery, desire to kill the child, and/or desire to maintain breast beauty. Some participants expected negative reactions from their family members if they followed the PMTCT program advice. Some of these reactions were influenced by cultural and traditional values. One HIV+ mother stated: "the grand-mothers and the elders want me to follow culture and will not understand why baby is not breastfed or why baby is not given porridge or water".

Rapid weaning was recommended in the previous PMTCT guidelines, and mothers were allowed to breastfeed up to only six months. The majority of participants applied the infant feeding with rapid weaning at six months. Though an effective method in reducing the risk of MTCT of HIV, the harsh realities of rapid weaning were distressful to both mothers and their babies. One participant mentioned:

It has not been easy, it takes a lot of commitment with weaning at six months, it took a lot of courage to stop him from breastfeeding. A baby crying all night long and I have breasts filled with milk, but I cannot breastfeed. It is tormenting, it took so much strength and support from the HCPs to get through it. He was resistant to other foods.

When weaning, HIV+ mothers worried about weight gain of their babies and their financial inability to offer adequate replacement foods. Cultural preference for extended breastfeeding may eventually make rapid weaning unacceptable and inadvisable. Some HIV+ women stated that appropriate and effective counseling, education, and support from HCPs could contribute to good weaning management.

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Replacement feeding is rare in a breastfeeding culture, because many communities, particularly in Africa, believe that infants cannot survive without breast milk. The feeding method is under the surveillance of their husbands and more experienced senior women including mothers, mothers-in-law, and grandmothers. Women are expected to internalize socio-culturally prescribed practices related to pregnancy, childbirth, and child care with support from experienced senior persons. Most women have limited power in terms of making independent decisions about how to feed their infants, and their practices reflect what senior women in the family have instructed them to do. In this study, the community attached negative meanings to replacement feeding practices and labeled mothers who used replacement feeding as irresponsible.

The replacement feeding was accepted only when the mother revealed her HIV status or had a breast disease or was not allowed to breastfeed by doctors. In these cases, the community and family saw the mother as sacrificing her motherhood function for the welfare of her infant. Some HIV+ mothers tried to hide their HIV status and the weaning became more complicated when husbands were not aware of the HIV status of their wives.

3.2.4. Religious beliefs

Some HCPs reported that some HIV+ mothers had beliefs that God would cure them through their religion, and this resulted in non-adherence to their ARVs and PMTCT services. one HIV+ mother said:

I am Christian in Pentecostal church, one day my pastor told me that God healed me. I said to me that there is no need for drugs. I spent four months without drugs because I believed what my pastor told me! I went back to see my doctors with skin rash and diarrhoea. I had high viral loads. I am still having that disease.

Religion can affect health by influencing the system of meanings, and by offering feelings of strength to cope with stress and adversity of other intersecting influences. In addition, religion often defined the participants' social practices both at home and within the community. One participant stated:

I am a Christian woman, I can say that I used to pray and there is something which I cannot describe, once I pray, I feel much better. I find prayer as a way of coping with stressors and difficulties that I encountered during my sick life and everyday challenges.

3.2.5. Cultural ideology as factors that increased risk of MTCT of HIV**.**

We examined cultural ideology that put women at increased risk of MTCT of HIV. The cultural construction of women is linked with their sexuality which restricts what is permissible for them and makes it extremely difficult for women to navigate expectations and negotiate lifestyles and safe sex that will protect them from HIV. The flow of power between males and females, bounded by culturally prescribed femininities and masculinities, contributed to the MTCT of HIV. While we focus on women, HIV equally endangers men's lives through the cultural construction of manhood. Rwandan culture values sex and sexuality and tends to emphasize and

strengthen the dominance of men and boys, and subordination of women and girls. The advice from elders is that women must respect their husbands and not cause a fuss, and women's economic positions often leave women vulnerable to abuse. Cultural expectations to be good women and proper wives shape their relationships with men. The advice at puberty also emphasizes respect for elders and husbands. One mother in my study described: "Good women are those who selflessly care for their families, are quiet, do not make noise in the house, and are reasonable". Another one added: "Being a good wife means ensuring their husband's sexual fulfillment" Being a good wife and getting married do not protect Rwandan women against HIV because extramarital affairs and polygamy are common even if law does not accept it. It is culturally permissible and even expected that men will have multiple sexual partners. Findings showed that most HIV+ women experienced relationships between either one husband with multiple wives or one wife with multiples husbands. The problem with polygamy is that it exposes multiple people to STIs and HIV transmission as well as MTCT of HIV. One mother stated:

As we are talking here, he is already in bars drinking beer and having other wives. You know the men are like that, they all need partners, men cannot endure without sex, but for us we can endure and abstain.

Polygamy was believed by HCPs to negatively affect the PMTCT program adherence and expose to MTCT of HIV. HCPs said wives in polygamous households are associated with large families and some wives reported fearing disclosure of their HIV status to their husbands because they could reveal their illness to co-spouses who would then judge and blame them for bringing the disease into their families. An HCP reported that many HIV+ mothers in polygamous and large families chose not to reveal their HIV status to anyone, which in turn made it difficult for them to adhere to the PMTCT program and take their medications consistently.

3.2.6. Role of mothers-in-law in constraining the uptake of the PMTCT program.

In Rwanda like in many African countries, the mother-in-law has traditionally had an important role in matters related to reproduction and childcare. In their position as elderly women and grandmothers, they generally see themselves as being responsible for decisions concerning health issues in the family. However, some mothers stated that the mother-in-law was an influential person with great power over her daughter-in-law and this had negative influence in the PMTCT program, one stated:

She asked to do something against my will, and I have to listen to her… because she is who she is. She has a lot of control over me and my infant. It is hard to implement the PMTCT program while my status is still secret.

Another client mentioned:
Just think if this disease would have happened to me first instead of my husband, what my husband and in-laws would have thought about me? They would have thrown me out of the house; my mother-in-law would be talking about my husband's second marriage… but now things are different as my husband was the first one to get this.

4. Discussion

The effort to limit the number of MTCT of HIV have been global and can be attributed to rapid HIV testing during pregnancy, ARV adherence, uptake of the PMTCT program, and the counseling on infant feeding (Gugsa et al., 2017; Schaefer et al., 2017). The elements from social and cultural characters interfering in the experience, decision, and behavior of HIV+ women during the infant feeding choice (Sianturi et al., 2019). It is not sufficient to provide ARVs to HIV+ mothers but beliefs, attitudes, and practices of families and community members that will interactively and negatively affect the efficacy of appropriately using the PMTCT program and ARV adherence, also need to be addressed. The following discussion focuses on five sub-themes such as traditional practices, religion beliefs, infant feeding, cultural ideology, and mother-in-law and elders

4.1. Traditional practices

Traditional healing appeared as an influential community-based resource that impacted utilization of the PMTCT program. Traditional medicine had a wide reach and high acceptability compared to modern medicine (Yakob&Ncama, 2016). Some HIV+ women who claimed to have been cured of HIV after using herbal medicine and attending prayers were associated with ARV discontinuation and non-adherence. Similar findings were reported in different African countries (Yakob&Ncama, 2016). The findings of this study suggest the importance of traditional medicine to use the PMTCT program and adhere to ARVs.

4.2. Religion beliefs

Religious identity for HIV+ women cannot be separated as a private sphere of activities (Reimer-Kirkham, 2014). For the participants in this study, religion incorporated a core part of HIV+ women's lives that inform, integrate, and influence both their private and public spheres. As a complex set of social practices, religion often serves as a reference point from which they made decisions and influence the choices and actions of HIV+ women. Besides, spirituality, a less institutionalized and more individualized expression of beliefs and values, often happened concurrently with religious practices, however, both spiritual and religious practices depended on the social environment that could either enhance or hinder its practice. An intersectional analysis demonstrates how the importance of these two influences produces incomplete accounts and possible misinterpretations. Besides, HIV+ women's lived realities in terms of beliefs can bring to light how to enhance possibilities for health. Alternately, the religious identities can position HIV+ women in marginalized spaces that become pathways for health and social inequality (Reimer-Kirkham & Sharma, 2011). At the individual level, religion can change health by providing feelings of strength to cope with HIV stress, influencing the system of meanings, and providing adversity of other intersecting influences. Furthermore, as an integral aspect, religion

often defined many aspects of social practices of HIV+ women both at home and within the community.

4.3. Infant feeding

The experiences of HIV+ mothers using the PMTCT program concerning infant feeding were based on the social symbols of breastfeeding and the support of HCPS. The findings indicate that mothers consider breastfeeding an essential aspect motherhood; and if they could not breastfeed their infants it generated guilt, sadness, and insecurity. In addition, exclusive replacement feeding (ERF) is rare in a breastfeeding culture especially in many African communities where the belief exists that infants cannot survive without breast milk (Woldegiyorgis& Scherrer, 2012). The PMTCT guidelines recommend that HIV+ women EBF unless ERF meets the criteria of acceptability, feasibility, affordability, sustainability, and safety (AFASS) (Zacharius et al., 2019). However, fear of MTCT of HIV through breastfeeding has forced the HIV+ women in choosing ERF whether they meet or not AFASS criteria (Woldegiyorgis& Scherrer, 2012). Even though EBF is easier and more practical, it has a five to 15% risk of MTCT of HIV and in the context of low middle-income countries, ERF exposes infants to malnutrition risks, infections, diseases, and related deaths (Woldegiyorgis& Scherrer, 2012).

EBF contributes to stigma reduction, especially highlighting the that continued breastfeeding is a benefit of PMTCT program. HIV-related stigma tends to put breastfeeding women at risk of non-adherence to ARVs (Tenthani et al., 2023). Many participants stopped breastfeeding at six months which raised concern and suspicion among family and community members when women stopped breastfeeding earlier than the general population, where breastfeeding frequently continues through two to three years. Currently, the PMTCT guidelines recommend breastfeeding duration to be similar to the general population and infants only receive nevirapine for six weeks after birth, as the infant would be protected by maternal ARVs (World Health Organization, 2020). While HIV+ women who participated in the study appreciated the PMTCT program, it was apparent that the general knowledge and acceptance of ARVs and the PMTCT program in the community needs strengthening.

4.4. Cultural ideology and elderly power

Various social vulnerabilities arise at different stages of life through intersection with other social forces. At community level, societal and cultural norms such as patriarchy, stigma, and discrimination continue to disempower women and girls, contributing to low economic empowerment and low education (McCollum et al., 2019). In Rwanda, the link between violence and patriarchy in research reveals that men are not the only perpetrators of violence against HIV+ women. Coercive force, control and power are used by several perpetrators and instigators of violence, before and after HIV diagnosis. Some studies argue that power of elders intersects with patriarchal power in the subjugation of Rwandan women, especially women living with HIV, who are subjected to mundane and violent acts of discrimination (Jewkes, 2015). These HIV+ women frequently suffer silently and endure harmful consequence of physical injuries, psychological and emotional traumatic experiences, and economic deprivation.

4.5. Mother-in-law and elders

HIV+ women understand the hierarchical power relationship and dominance of men and elders, yet they are shrewd and adopt strategies that are less adversarial and confrontational. My findings show that cultural influence in patriarchal and elder norms is extremely entrenched in the rural and resource constrained community (Kamanzi & Richter, 2021). The results from this study illuminate the interlocking powers of both male and female elders as perpetrators and instigators of a range of abuses to HIV+ women (Risal&Gunawan, 2018). The current research is insightful in revealing that HIV+ women living in low socio-economic conditions are more vulnerable to poverty and possible exposure to oppression and gender-based violence. My research findings stated how HIV brought social disruption and changes to the family, which had previously sustained the stonework of African life (Kamanzi & Richter, 2022). These findings connect with my own work as most of the HIV+ women in the present research experienced fracturing of family and social support networks, being rejected, ostracized, divorced by partners and/or thrown out of their homes by their own mothers, sisters, or in-law family because of HIV.

Fear of being abandoned, separated, or divorced has been problematized, as basic needs such as housing and food remain a challenge for a lot of the participants. Based upon the stories, HIV+ women struggle to surmount poverty and their dehumanized life is a common concern; they are isolated and feared because of HIV. Most HIV+ women are blamed for getting HIV and some experienced divorce, abandonment, and other challenges as they are pushed to become homeless. The complex intersection of HIV illness, structural violence, and poverty is obviously visible from their accounts.

The majority of HIV+ women who use the PMTCT program live insecure lives and are poor; for those who occupy low waged jobs with lack of education experience gender inequality and are forced to depend on men and elder. This dependency exposes many HIV+ women sexual coercion and unprotected sex with the attendant risks of HIV and STDs. It is evident from the participants account that, upon being tested with HIV, majority marginalized and poor women experience divorce, abandonment, and fractured family relationships. HIV+ women experience lack of support and compassion from their partners and trusted family members, and their ostracization and isolation render them dependent on HCPs support for their ARV adherence and PMTCT care services. Most of HIV+ women tried to keep their status as secret from their husbands and families. However, women who cannot hide their HIV status risk experiencing a range of psychological, economic, sexual harassment and physical abuses due to devalued status as women living with HIV.

5. Policy Implications

The findings from this study show that the overall social, cultural, and traditional issues highlighted in this study constitute significant challenges to the uptake of the PMTCT program. Understanding how unique contextual factors limit HIV+ women's access to or utilization of the PMTCT program is critically important, if not crucial. Addressing these contextual factors necessitates engaging communities to understand the important of the PMTCT program to

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develop sustainable and innovative strategies for removing challenges that HIV+ women are facing in accessing and utilizing the PMTCT program. One specialist mentioned:

A sensitization of the community by HCPs and engaging male partners' involvement was associated with an increase in women accepting counselling, HIV testing, and ARV adherence. Furthermore, sensitization and engagement of husbands in supporting women may result in a significant increase of ARV adherence and PMTCT program uptake.

6. How Can Information from PMTCT of HIV Project Be Used?

The findings of this study can be implemented by PMTCT implementers, policy makers, researchers, and nurses working in HIV/PMTCT program to improve the services and support in moving toward quality healthcare improvement. The findings may also help to address the issue related to a high rate of MTCT of HIV in SSA/Rwanda. It will contribute to strengthen PMTCT program, build and contribute to a body of literature on the experience of mothers using PMTCT Program to prevent MTCT of HIV, and it will Improve maternal and child health.

7. Main Recommendations

Consider community and social factors for the accessibility and effectiveness of the PMTCT program related interventions. The PMTCT program will be more sustainable and effective if there is an integration of culturally appropriate interventions and carefully developed innovative health education that addresses the concerns of cultural beliefs and practices but encourage and facilitate the positive traditional values. This will help to improve attitudes, increase in knowledge, and change on negatives beliefs and behaviours that relate to better health outcomes for HIV+ women.

Promote knowledge gaps on HIV prevention are important. Strong education, counselling, and consistent message can be a useful component in increasing ARVs adherence and PMTCT program uptake. A recommendation is for interdisciplinary HCPs and all community partner's collaboration to address knowledge gaps and identify step-by-step procedures on how to address these gaps. The findings showed that most women have an HIV testing but experienced low enrollment in the PMTCT program as they keep their status hidden from their status to their families, traditional birth attendances, and communities where stigma is still pervasive. This contributes to a high number of HIV+ women not linked to PMTCT care and failure to prevent MTCT of HIV. A PMTCT leader said:

Involving all stakeholders and offering mandatory education that focusses on changing behave or and addressing attitudes can catalyze a change in how people treat and perceive the HIV+ women which can improve the PMTCT program's effectiveness.

Ensure availability of the PMTCT policies and guidelines at the PMTCT program are strong recommendation. HIV+ women using the PMTCT program receive unstandardized PMTCT techniques due to the lack of policies and guidelines.

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Beyond the blanket recommendations such as encouraging political leaders to support the PMTCT program, it must be necessary to target the areas of the PMTCT program implementation that will strengthen Rwanda efforts to improve the MTCT of HIV outcomes.

Additional, including male partners and families in the PMTCT program are recommended. It is critical to identify and build methods to enhance the positive contribution of male partners, grandmothers and in-law families as agents of positive change on overall household health. Understanding their role is a starting point to remove the cultural and social barriers that lead to negative stereotyping in Rwanda society.

The inclusion of male partners and families in the PMTCT program has the potential benefit in ARVs adherence, improve the PMTCT uptake and continuation, decrease the MTCT of HIV risk, improve maternal and child health and address the issues related to TBA, cultural norms, traditional and religious beliefs.

Enhancing the HIV+ women's accessibility of the PMTCT care is recommended. Participants recommended that the Rwandan Ministry of Health build supportive environments with all needed protocols and regulations for HIV+ women accessing PMTCT services. In this regard, participants proposed relevant and up to date information on both HIV and PMTCT of HIV should be accessible, available, and visible to women in anti-natal care clinics and health settings using local language.

It is recommended that the social and cultural aspects are considered, especially the cultural practices and beliefs as well as traditional values in African settings that are causing barriers to uptake and implement the PMTCT program. The PMTCT program will be more sustainable and effective if there is an integration of culturally appropriate interventions and carefully developed innovative health education that addresses the concerns of negative beliefs and cultural practices but encourage and facilitate the positive traditional values.

8. Conclusion

Socio-cultural factors play important roles in influencing health behaviour and health outcomes, and utilization of health services is gained massive recognition in the literature. Socio-cultural factors matter not only with shaping health decisions but also with highlighting the role played by families, community, beliefs, culture, and society in shaping those decisions. It is plausible that knowledge of socio-cultural factors may facilitate effort to understand the experiences and needs of HIV+ women when they make decision to attend the PMTCT program or not. Therefore, exploring socio-cultural factors that influence the uptake of the PMTCT program among HIV+ women will inform the development of effective interventions to promote the PMTCT program adherence.

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