Factors Associated with Defaulting Among Women Initiated on Option B+ in Urban Clinics - 2015.

Muchenje Ester

Submitted in Partial Fulfillment of the Master of Public Health Degree
DECLARATION

I declare that this dissertation is the original work of Ester Muchenje. It has been prepared and submitted in accordance with the guidelines for Master in Public Health dissertations for the University of Zimbabwe. It has not been submitted in part or in full to any university and/ or any publication.

Name of student: _________________________________________________

Signature: _____________________________ Date: ____________________

Name of Academic Supervisor: ________________________________

Signature: ____________________________ Date: _____________________

Chairman of Community Medicine, University of Zimbabwe Medical School

Signature: __________________________________

Date: ________________
ABSTRACT

Title: Factors associated with defaulting among women initiated on Option B+ in urban clinics, 2015.

Introduction: We carried out this study to describe the demographic characteristics of the mothers on Option B+ at Budiriro, Mabvuku, Rutsanana and Kuwadzana poly-clinics. To determine the patient level factors, the service related factors, the provider-patient relationship factors, the environmental, socio-cultural factors and the drug related factors associated with defaulting among women initiated on Option B+ at the four poly-clinics, 2015.

Methods: A 1:2 unmatched case control study was conducted. A total of 195 participants were recruited, 65 cases and 130 controls. The study was carried out at four polyclinics, Rutsanana, Mabvuku, Kuwadzana and Budiriro. Simple random sampling technique was used to select study participants from the Option B+ registers. A case was an HIV positive pregnant or lactating woman registered and initiated for Option B+ at any one of the four sites from January to April 2015 but missed at least one resupply visit or medicine pick up appointment for ART. A control was an HIV positive pregnant or lactating woman registered and initiated on Option B+ at any one of the four sites from January to April 2015 and attended all resupply visits or medicine pick up appointments for ART. Data were collected using interviewer administered questionnaires, in depth interviews, focus group discussions and key informant interviews. Quantitative data were analysed using Epi info™ 7 to generate tables and graphs. Qualitative data were analysed manually using themes. The median age for cases was 27 years (Q₁ = 23.5, Q₃ = 32 years) while that of controls was 30 years (Q₁ = 26.5, Q₃ = 35.5 years).
**Results:** Non-disclosure of HIV status and having experienced stigma because of HIV status were significant patient level factors that were associated with defaulting with OR 16.6 and 14.3 respectively, (p<0.05). Running short of medication at some point and having experienced drug side effects were significant drug related factors associated with defaulting with OR 52 and 4.0 respectively, (p<0.05). Receiving inadequate information during counselling and not having attended individual counselling sessions were significant service related factors associated with defaulting with OR 9.4 and 3.7 respectively, (p<0.05).

**Conclusions:** Factors associated with defaulting among women initiated on Option B+ vary. Some of the factors have to do with the patient while some are related to the service that they receive and their relationship with the health care provider. Some are however related to the availability and the effects of the drugs themselves. We recommend providing adequate information on all the factors that might affect the women, encouraging disclosure of status so that they get support from others and strengthening of follow up mechanisms.

**Key Words:** Prevention of mother to child transmission, Option B+, defaulting, lifelong ART
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<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>COR</td>
<td>Crude Odds Ratio</td>
</tr>
<tr>
<td>eMTCT</td>
<td>Elimination of Mother to Child Transmission</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune deficiency Virus</td>
</tr>
<tr>
<td>HSO</td>
<td>Health Studies office</td>
</tr>
<tr>
<td>H/F</td>
<td>Health Facility</td>
</tr>
<tr>
<td>IDI</td>
<td>In depth interview</td>
</tr>
<tr>
<td>JREC</td>
<td>Joint Research Ethical Committee</td>
</tr>
<tr>
<td>MPH</td>
<td>Master in Public Health</td>
</tr>
<tr>
<td>MRCZ</td>
<td>Medical Research Council of Zimbabwe</td>
</tr>
<tr>
<td>OR</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PNC</td>
<td>Post natal care</td>
</tr>
<tr>
<td>ZDHS</td>
<td>Zimbabwe Demographic Health Survey</td>
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CHAPTER 1: BACKGROUND

1.1 Introduction
The Global Plan towards the Elimination of New HIV Infections among Children and Keeping their Mothers Alive by 2015 was launched in June 2011. The goal of the elimination agenda is to eliminate new paediatric HIV infections by 2015. The targets include reduction of new paediatric HIV infections by 90%; reduction of HIV related mortality in women during pregnancy, delivery and after birth by 50%. They also target reduction of mother to child transmission to below 5% at the population level\(^1\).

It is estimated that 2.3 million new HIV infections occurred globally in 2012 and of these 260,000 were children\(^2\). In Sub-Saharan Africa 230,000 children were newly infected in 2012 and 90% of these contracted HIV through mother to child transmission\(^2\). The United Nations estimates that if there are no interventions, approximately one-third of children born to HIV positive mothers will become infected at birth, during delivery and/or during breastfeeding\(^3\). Mother to child transmission can be as high as 45% where there is no intervention to prevent transmission however studies have shown that with effective prevention of mother to child transmission (PMTCT) interventions, this transmission rate can be reduced to as low as 5%\(^4\).

A mathematical model used during the Zimbabwe Demographic Health Survey (ZDHS) of 2010-11 revealed that the HIV prevalence rate among women of child bearing (15-49 years) was 18\(^%\).\(^5\). More than 12% of infants born to HIV infected mothers are infected by the virus in Zimbabwe\(^6\). The country made great strides however to reduce the risk of mother to child transmission by initiating ART to the mothers. By 2013, about 82% of pregnant women in need of ART for prevention of mother to child transmission were initiated up from 59% in 2009\(^6\). In 2011, approximately 14,000 children were newly infected with HIV and 90% of these became
infected through mother to child transmission\textsuperscript{7}. These alarming figures justify the continued efforts in the PMTCT program and towards the elimination of new paediatric HIV infections.

\textbf{1.2 Option B+ in Zimbabwe}

Option B+ (lifelong ART) is a new treatment regimen that was adopted by Zimbabwe in February 2013\textsuperscript{8}. This is whereby all pregnant and or breastfeeding women who test HIV positive are initiated on anti-retroviral therapy (ART) throughout the pregnancy and breastfeeding period and continue taking ART for the rest of their lives. Previous regimens required that the pregnant or breastfeeding woman undergo CD4 cell count and when their CD4 was found to be less than 500ml/l that is when they would be started on ART. Option B+ does not require CD4 to be done before ART initiation\textsuperscript{9}.

The mothers are seen at the antenatal clinic (ANC) when they come to book their pregnancies and it is at that first contact that they are counselled and tested for HIV. Those found to be HIV positive are initiated on ART on the same day so that there are no delays in ART initiation\textsuperscript{9}. Those who will not have been tested during ANC can still be tested in the post-natal (PNC) department and are also initiated on ART.

\textbf{1.3 Benefits of Option B+}

Option B+ helps to increase maternal life expectancy by boosting the mother’s health so that she is kept alive\textsuperscript{9}. HIV related deaths due to opportunistic infections like tuberculosis are reduced when a mother is on Option B+ and is adhering to treatment. More than 10\% of couples who reported having tested for HIV in Zimbabwe in the ZDHS 2010-11 had discordant results\textsuperscript{5}. When the mother is the one who is HIV positive and is initiated on Option B+ transmission of the virus to the negative partner is reduced\textsuperscript{9}. It also reduces the transmission of the virus from mother to
child so that we have more HIV free babies being born while we work towards the elimination of 
new paediatric HIV infections by 2015$^9$.

Aizire et al (2013) estimated that the defaulter rate among adults on ART ranges between 33% 
and 88% globally$^{10}$. In India, the defaulter rate is around 10.9% whilst in a study done in eight  
countries in Sub-Saharan Africa, Sibanda et al found it to be 49%$^{11}$. The general ART defaulter 
rate in Ghana was 27% in 2013$^{12}$ and 31% in Nigeria in 2012$^{13}$. Kureva et al did a five year  
follow up study among PMTCT mothers in Zimbabwe and found out that defaulter rate was  
7.3% after one year of ART initiation$^{14}$. From the preliminary analysis at 4 polyclinics in Harare  
city, the defaulter rate was ranging from 30% to 52% in the third quarter and fourth quarters of  
2014.

1.4 Problem Statement
An analysis of Prevention of Mother to Child Transmission (PMTCT) records at Kuwadzana, 
Mabvuku, Rutsanana and Budiriro Poly Clinics during routine site support visits showed that  
there were high defaulter rates among women initiated on Option B+ with 30% to 52% of the  
mothers only taking their first supply of medication and never coming back for resupply from  
July to December 2014. Staff members said they were aware of this problem and had tried to  
send community health volunteers to follow them up to no avail. They indicated that they were  
not aware of the reasons for their not coming for resupplies but suspected issues to do with  
acceptance. This is worrisome because defaulting Option B+ medication is associated with HIV  
disease progression, increased mother to child transmission risk and will hinder the achievement  
of the elimination of mother to child transmission goal (eMTCT)$^9$. A literature search that was  
done through identifying key terminologies and searching for the phrase “defaulting Option B+”  
showed that the factors associated with a high defaulter rate for Option B+ in Harare have not
been explored and it is against this background that we intend to explore these factors at 4 sites in Harare City (Kuwadzana, Mabvuku, Budiriro and Rutsanana Poly clinics). The four sites were chosen because they all have a high defaulter rate compared to the other clinics in the city, they are all high volume facilities in almost the same setting (high density suburbs) and they started implementing Option B+ at almost the same time (April 2014).

Table 1: Proportion of Women Who Defaulted after Initiation on Option B+ at Kuwadzana, Rutsanana, Mabvuku and Budiriro Poly Clinics – July to September 2014

<table>
<thead>
<tr>
<th>Site</th>
<th>Quarter 3 - 2014</th>
<th>Quarter 4 - 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. initiated</td>
<td>No. defaulted</td>
</tr>
<tr>
<td>Kuwadzana</td>
<td>98</td>
<td>35</td>
</tr>
<tr>
<td>Rutsanana</td>
<td>136</td>
<td>39</td>
</tr>
<tr>
<td>Mabvuku</td>
<td>72</td>
<td>24</td>
</tr>
<tr>
<td>Budiriro</td>
<td>68</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: Kuwadzana, Rutsanana, Mabvuku and Budiriro poly clinics Option B+ registers; 2014

Justification
All HIV positive pregnant mothers are offered initiated on Option B+ whereby they will be taking ART drugs daily for the period of the pregnancy, through breastfeeding and for the rest of their lives. The initiation is however not mandatory so others can opt out. They are offered testing when they come for their ANC booking and issued with results on the same day. They are also offered ART initiation on the same day to avoid any delays which may lead to HIV
transmission from the mother to the baby. The mothers are initiated on ART regardless of their health status and CD4 count status. Pre and post counselling provide the mothers with information on importance of lifeling ART, the benefits of adhering to ART, disclosure and living positively. Many mothers have been found to accept the drugs on the initiation day, but do not continue collecting them. Some do not even take them and some take for a shorter period and they stop. Defaulting Option B+ medication causes great concern because this may lead to the development of HIV associated drug resistance, morbidity and mortality. Missing any visit in pregnancy is critical because the chances of transmitting HIV to the baby are high when one is not taking medication.

This will eventually deter the attainment of the elimination goal where we are targeting to reach zero new paediatric HIV infections by 2015. The factors that are associated with defaulting Option B+ have not been explored in Harare City as shown by the literature search that was done by this researcher. We, therefore, propose to carry out a case control study at four sites in the city of Harare that will help explore these factors. Understanding these factors will provide evidence for the formulation of objective messages to encourage HIV positive mothers who are initiated on ART to remain in care. Option B+ is a new component in Zimbabwe and there is a need for evidence based arguments and information to formulate strategies that will strengthen this component. There is need to do this research because there is not much research that have been done so far in Zimbabwe on Option B+.
CHAPTER 2: LITERATURE REVIEW

A literature search is a systematic and rigorous search for published information so as to find a pool of excellent references that are relevant to the researcher’s topic. For this study, I started by identifying the key terms associated with the topic including a range of different terms. I had to consider alternative words used interchangeably to mean the same. For the word defaulting, I had to search for two more phrases that means the same as defaulting. I searched for the phrases “drop out” and “missing medicine pick up”. For the phrase Option B+, I had to search for a phrase “lifelong ART”. I also used the technique of finding phrases and searched for the phrases “defaulting Option B+” and “dropping out from lifelong ART”. Asterisks were used for the word default in order to be able to pick words like defaulter, defaulted and defaulting.

2.1 Default and adherence
Defaulting is defined as being more than one month late for the next schedule or medication pick up\(^\text{15}\). Adherence is defined as the patient’s ability to follow a treatment plan, take medications at prescribed times and frequencies\(^\text{16}\). Though adherence and defaulting may be difficult to measure separately, in this study, we focussed more on defaulting and we defined it as having skipped the next resupply date by at least one month. There is no gold standard for assessing adherence. Patients can report on their adherence themselves, which is called self-reporting, but this is not very reliable because some may not tell the truth. Pharmacy refill data or records and pill count are also used to assess adherence, though it is more reliable where there is direct observation of the patient during drug administration\(^\text{16}\).
2.2 Patient level factors

Patient level factors are amongst major contributors to the high defaulter rate in the PMTCT programme and these may include lack of support, stigma, disclosure issues, attitudes and perceptions towards the drugs, non-acceptance of status and feeling that they are still well. Women who lack support from their partners are at high risk of defaulting treatment\(^1\). Spousal support can be seen through the active involvement of the male partner in his female partners’ treatment, for example accompanying them to the clinic, providing money for transport, reminding them to take the medicine, agreeing to test for HIV themselves and also agreeing to safer sex practices. Many women find it difficult to disclose their HIV status after testing positive because they fear to be blamed or to be sacked out of the home by their male partners. In 2010, Miller et al found out that between 3.5\% and 14.6 \% of South African women reported having been violently shouted at, blamed and/or beaten up by their partners following disclosure of a positive status\(^1\). Birbeck \textit{et al} (2009), carried out a study in Zambia in 2009 and found out that limited spousal disclosure as well as limited social support networks that is from the in-laws, relatives and the community at large, affected many women and contributed to their defaulting treatment\(^1\). Besides support from partners, women also need social support that is from the family members and the community. This however is mostly hindered by the fact that most of them do not disclose their status for fear of stigma.

HIV related stigma plays a very important role in ART care and determines a patient’s ability to be retained in care. In a Malawian study done by Sellier \textit{et al} (2006)\(^1\), mothers thought that when a mother comes to book her pregnancy, she is not adequately prepared for HIV testing and more so for a positive result in one day. They also did not consider ART to be beneficial to them as mothers and felt they were not ready for ART as they were still well\(^1\). Some women have
some myths and misconceptions about HIV treatment and these can make them stop taking their
drugs. Some patients who have experienced or heard of the side effects of the ART drugs have
opted to stop medication to prevent them from occurring.

2.3 Service related factors
The largest obstacle is travelling long distances to health centers coupled with the poor road
network. Exorbitant user fees may affect clients and lead to patient defaulting where the services
are not availed free of charge. Mothers can also wait in long queues and for long periods of time
due to various reasons that include staff shortages and non-separation of ART services from
other services. This will lead to patients sometimes getting tired and going back without
collecting medication and sometimes never to come back. In some institutions, there is a lack of
counselling space because the introduction of Option B+ did not come with any additions in the
structure of the facilities and this compromises patients’ privacy and confidentiality.²⁰

Poor monitoring strategies where health facilities do not keep patient follow-up registers may
contribute to high defaulter rate. Some might not even have defaulted but poor documentation
may fail to capture their follow-up visits, especially when the patient skips her due date but came
the following day or two after, these people may not be captured and may be classified as
defaulters.²¹ Mothers do not want to be delayed at the health facility when they come for ANC
and follow up visits because they have a lot of work to do including looking after their children,
hence if they are delayed because of many reasons that may include staff shortages and high
workload, they get frustrated and may not come for the next resupply.²²
2.4 Provider patient relationship factors
A study that was done in Ivory Coast by Painter et al (2005)\textsuperscript{23} revealed that mothers feared being scolded by health care workers at the health facilities. The mothers also highlighted that the health workers sometimes did not attend to them in time prioritizing other patients when they came for follow-up visits\textsuperscript{23}. Patients sometimes do not receive an adequate number of counselling sessions due to reasons that may include space and staff shortages and this limits the rapport between the health care worker and the patients. Health care workers are so overwhelmed by work that they end up not giving each patient adequate and quality counselling time and may resort to group counselling sessions only to save on time\textsuperscript{24}. When health workers do not spend quality time with individual patients, patients lack trust in them and in the treatment. There is a lack of shared decision making between the health care worker and the patient to the extent that some drug regimens are changed without notifying or discussing with the patient\textsuperscript{24}.

2.5 Drug related factors
The PMTCT programme faces challenges that include inconsistent supply of commodities such as ART medicines and fixed dose combinations of ART medicines\textsuperscript{8}. Patients would not want to come to the health facility on the review date given by the health care worker only to be told that the drugs are not available. They will lose confidence both in the facility, the health care worker and in the treatment itself and will opt to stop the treatment. In the previous ART regimens, patients had to swallow quite a number of tablets hence the pill burden was a barrier\textsuperscript{9}. Just the thought of taking medication for life compromise retention in care, especially to those patients who are initiated on ART while they are still healthy and they do not see the need for taking medication.
2.6 Strategies to reduce defaulter rate

In Ethiopia, Ebuy et al (2014) found that women who disclosed their HIV status whether to partner or to other people adhered to ART more than those who did not disclose. The study also revealed that women who received individual counselling on medication were more likely to adhere as compared to those who did not. Simplifying the treatment regimens by reducing the number of times the mother has to switch medications is a better strategy that might help reduce defaulter rate.

Reduction of HIV related stigma and discrimination in the community through educating the community to be more accepting and supportive of HIV positive people helps in the success of HIV prevention programmes. Males need to be involved in HIV issues starting from the voluntary testing, acceptance of the results and ART initiation, as well as stigma reduction and supporting their female partners.
CHAPTER 3: STUDY OBJECTIVES

3.1 Research Question

What are the factors associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics – 2015?

3.2 Problem Analysis

The problem of defaulting among women initiated on Option B+ in Harare City will be analysed using the problem analysis diagram shown in Figure 1.
Logical Framework

Conceptual framework adopted and modified from King and Williams: 1995

Figure 1: Problem Analysis Diagram
3.3 Study Hypothesis
This study was carried out to test the following hypothesis:

3.3.1 Null Hypothesis ($H_0$)
Disclosure of HIV status is not associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics.

3.3.2 Alternative Hypothesis ($H_1$)
Disclosure of HIV status is associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics.

3.4 Study Objectives

3.4.1 Broad Objective
To establish the factors associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics – 2015.
3.4.2 Specific Objectives

1. To describe the demographic characteristics of the mothers who default Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics - 2015

2. To determine the patient level factors associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics – 2015

3. To establish the service related factors associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics - 2015

4. To determine the provider-patient relationship factors associated with defaulting among women initiated on Option B+ at four in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics - 2015

5. To determine environmental, socio-cultural factors associated with defaulting among women initiated on Option B+ in Budiriro, Mabvuku, Rutsanana and Kuwadzana Poly clinics - 2015.

CHAPTER 4: METHODS AND MATERIALS

4.1 Study Design
A 1:2 unmatched case control study was carried out.

A case was an HIV positive pregnant or lactating woman registered and initiated for Option B+ at any one of the four sites from January to April 2015 but missed at least one resupply visit or medicine pick up appointment for ART.

Defaulting is a word that was borrowed from the Tuberculosis Control Programme where one is classified as a defaulter after missing medicines for 30 days or more. In ART there is however no clear definition of a defaulter but clients are classified as having missed appointments or lost to follow up. Loss to follow up refers to a registered ART patient who fails to report to an ART clinic for three months since their last visit. Missed appointment refers to a registered ART patient who misses a scheduled appointment to an ART clinic. Our definition for defaulter in this study is similar to that given for a missed appointment. We did not want to classify our cases as lost to follow up because the period of follow up was too short (less than 6 months) and some clients could still be followed up and be re-engaged into the programme. Different authors define defaulting differently. Deribe et al (2008)\textsuperscript{28} in a study in Ethiopia defined their defaulter as someone who had missed two scheduled appointments.

A control was an HIV positive pregnant or lactating woman registered and initiated on Option B+ at any one of the four sites from January to March 2015 who attended all resupply visits or medicine pick up appointments for ART.
Defaulters were identified from the PMTCT register and their patient cards were used to verify whether they were true defaulters or they had been misclassified as defaulters yet they were not. Misclassified cases were not included in the study.

4.2 Study Setting
The study was conducted at Kuwadzana, Budiriro, Mabvuku and Rutsanana Poly clinics of Harare City. The locations of the four poly clinics are shown in Figure 2.
Figure 2: Harare City Map showing the 4 study settings in red
Source: www.mapsofworld.com
4.3 Study Population
The study population was HIV positive pregnant and lactating women who were registered in the PMTCT register as being on Option B+ at the four Poly clinics from January to March 2015. The nurses working with Option B+ mothers at the four study sites were selected using convenience sampling into the study as key informants.

4.3.1 Inclusion Criteria
All pregnant and lactating mothers who were registered for Option B+ at the Mabvuku, Rutsanana, Budiriro and Kuwadzana polyclinics from January to March 2015 who consented to participate in writing were included into the study.

4.3.2 Exclusion Criteria
All the mothers who were not registered for Option B+ from January to March 2015, and all those who refused to participate in the study were excluded.

4.4 Sampling Method
Sampling frames for both cases and controls were developed after verifying the true status of the patients using the PMTCT register and the patients’ cards. The simple random sampling technique was then used to choose respondents from the sampling frames. Nurses working with Option B+ mothers were purposively sampled.

4.4.1 Sample Size Calculation
The sample size was calculated using Epi info version 7 by considering the following assumptions; the proportion of individuals who disclosed their status among the controls is 58%;
at 95% confidence interval, 80% power and a case to control ratio of 1:2 to detect an Odds Ratio of 2.78 (Abaynew et al; 2011). A total sample size of 177 was calculated, 10% attrition rate was added to give a total of 195 study participants, 65 cases and 130 controls.

### Table 2: Number of Women Sampled into the Study by Site– Harare City, 2015

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Number of Cases</th>
<th>Number of Controls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rutsanana</td>
<td>23</td>
<td>46</td>
<td>69</td>
</tr>
<tr>
<td>Mabvuku</td>
<td>20</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Kuwadzana</td>
<td>12</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>Budiriro</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
<td><strong>130</strong></td>
<td><strong>195</strong></td>
</tr>
</tbody>
</table>

### 4.5 Study Variables

The variables that were studied are listed in Table 3.
Table 3a: List of Dependent and Independent Variables - Harare City, 2015

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Independent variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defaulting ART</td>
<td>Demographic Factors</td>
</tr>
<tr>
<td></td>
<td>Age</td>
</tr>
<tr>
<td></td>
<td>Marital status</td>
</tr>
<tr>
<td></td>
<td>Level of education</td>
</tr>
<tr>
<td></td>
<td>HIV status at booking</td>
</tr>
<tr>
<td></td>
<td>Gestational age at booking</td>
</tr>
<tr>
<td></td>
<td>Parity</td>
</tr>
<tr>
<td></td>
<td>Gravida</td>
</tr>
<tr>
<td></td>
<td>Previous death of baby due to HIV related illness</td>
</tr>
<tr>
<td></td>
<td>Previous miscarriage or stillbirth</td>
</tr>
<tr>
<td></td>
<td>Partner’s level of education</td>
</tr>
<tr>
<td></td>
<td>Employment Status</td>
</tr>
<tr>
<td></td>
<td>Religion</td>
</tr>
</tbody>
</table>
Table 3b: List of Dependent and Independent Variables - Harare City, 2015

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Independent variables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Patient Level factors</strong></td>
</tr>
<tr>
<td>Defaulting ART</td>
<td>Risk perception</td>
</tr>
<tr>
<td></td>
<td>Partner support</td>
</tr>
<tr>
<td></td>
<td>Disclosure of status</td>
</tr>
<tr>
<td></td>
<td>Experienced stigma</td>
</tr>
<tr>
<td></td>
<td><strong>Drug Related Factors</strong></td>
</tr>
<tr>
<td>Defaulting ART</td>
<td>Experienced side effects</td>
</tr>
<tr>
<td></td>
<td>Drug stock outs</td>
</tr>
<tr>
<td></td>
<td>Drug fatigue</td>
</tr>
<tr>
<td></td>
<td><strong>Service Related Factors</strong></td>
</tr>
<tr>
<td>Defaulting ART</td>
<td>User fees</td>
</tr>
<tr>
<td></td>
<td>Distance to Health facility</td>
</tr>
<tr>
<td></td>
<td>Waiting period</td>
</tr>
<tr>
<td></td>
<td>Transport availability</td>
</tr>
<tr>
<td></td>
<td><strong>Provider – Patient Relationship Factors</strong></td>
</tr>
<tr>
<td>Defaulting ART</td>
<td>Confidentiality issues</td>
</tr>
<tr>
<td></td>
<td>Poor communication</td>
</tr>
<tr>
<td></td>
<td>Distrust</td>
</tr>
</tbody>
</table>
4.6 Pre Testing Data Collection Methods and Tools
The data collection methods and tools were pretested at Edith Opperman Poly clinic in Harare City. During the pretesting, we observed that some of the factors were not coming out well due to the fact that the interviewer will be talking directly to the affected person especially for cases. We then decided to include some focus group discussions so that we could have some general discussions with a group of mothers. This would help them talk about issues that affect them, but in a general sense without personalizing them. The interviewer administered questionnaires and the in depth interview guides were acceptable and we did not change anything about them.

4.7 Data Collection
Data were collected using interviewer administered questionnaires and interview guides for key informants. A data abstraction form was also used to gather and analyze already available patient level data at the facilities in order to calculate the defaulter rate for each facility. The data collection tools were pretested at Edith Opperman Poly clinic in Harare City because it is in the same city and might have similar characteristics with the study areas. Data were collected by the researcher alone hence there was no training needed. The cases were randomly selected from the PMTCT registers and were followed up at their last known address recorded in the registers for interviewing. The controls were randomly selected from the PMTCT registers and were interviewed at the clinics as they came for resupply.

Four focus group discussions (FGDs) were held, one at each clinic. Two of the focus group discussions were held with controls and the other two were held with cases. The discussions were audio taped and then transcribed before analysing the results. We also conducted eight in
depth interviews (IDIs), two at each clinic. One in depth interview was held with a case, while
the other one was held with a control at each of the four clinics. The in depth interviews were
also audio taped to minimize writing during the interview. They were then transcribed and
analysed manually.

All the data collection tools were translated into the vernacular Shona language and data was
collected in Shona. The researcher had to back-translate the responses after the interviews.

4.8 Data Management
Data collected using the interviewer administered questionnaires were entered into Epi info
version 7. The data were checked for double entries and omissions before analysis. To keep the
data safe, we backed up on external memory devices.

4.9 Data Analysis
Epi info version 7 was used to generate means, frequencies and tables. Bivariate analysis was
done to determine the presence of statistical significant associations between explanatory
variables and the outcome variable (defaulting). Forward stepwise logistic regression models
were performed for all explanatory variables that were associated with the outcome variable in
the bivariate analysis. All variables with a p value less than or equal to 0.05 were included in the
initial logistic models. We reported the Odds Ratios and the adjusted odds Ratios at 95%
Confidence Interval.

Qualitative data were translated into English and transcribed by the researcher since the
discussions were done in the vernacular Shona language. The data were analysed using the
MAXQDA software. It was first summarized then reduced through the use of data reduction
tables. Recurring themes were then captured and reported with some direct, informative quotes
being included in the results.
4.10 Ethical Considerations
The study was approved by the Joint Research and Ethics Committee (JREC) of the University of Zimbabwe and the Medical Research Council of Zimbabwe (MRCZ). Written informed consent was sought and obtained from all study participants. A sample of the consent form used is attached.

The study participants were guaranteed confidentiality and anonymity by not asking them their names during the interviews and not including their names on any of the study materials except the consent forms. The consent forms were kept separately from the other study materials during and after the study to avoid linking them to the other study materials. Data security was guaranteed by locking up all questionnaires in lockable cupboard during and after the study. Women who indicated a need for care, for example counselling or resupply were referred to health care providers for appropriate care.

4.11: Permission
Permission to carry out the study was sought and obtained from the Health Studies Office (HSO), the Director – Harare City Health Department, the Joint Research and Ethics Committee (JREC) and the Medical Research Council of Zimbabwe (MRCZ).
CHAPTER 5: RESULTS

**Figure 3: Description of Cases and Controls – Harare City, 2015**

A total of 195 participants were enrolled into the study at a case to control ratio of 1:2 giving us 65 cases and 130 controls from 4 Health facilities. Rutsanana contributed 35% (69) of the study participants; Mabvuku contributed 31% (60) while Kuwadzana and Budiriro contributed 19% (36) and 15% (30) respectively. Half (50%) of the women were still pregnant and the other half had delivered at the time of the study.

When I calculated the sample size I factored in 10% refusal/ non-response rate. When I went for the actual data collection, I found out that the refusal and non-response rate was at 8% for the cases and 6% for the controls. These proportions include those whom I could not find at their last...
known addresses and they were no longer contactable. I however had to go back to the sampling frame and replaced them so that I could reach the calculated sample size. In both cases and controls, all the women who refused to participate (2 cases and 3 controls) were the young women in the 19 to 24 years age group. All those whom I failed to locate were not married (3 cases and 5 controls). For those who were married the contact number of the spouse helped to locate the respondents easily because they could either tell me their new residential address over the phone or we could make appointments to meet at the clinic.
Demographic characteristics of the cases and controls who participated in the study are displayed in Table 4a and 4b.

**Table 4a: Demographic Characteristics of Cases and Controls – Harare City, 2015**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n= 65 (%)</strong></td>
<td>n= 130 (%)</td>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 18 years</td>
<td>0 (0.8)</td>
<td>1 (0.8)</td>
<td>-</td>
</tr>
<tr>
<td>18 – 24 years</td>
<td>24 (36.9)</td>
<td>24 (18.5)</td>
<td>0.0048</td>
</tr>
<tr>
<td>25 – 34 years</td>
<td>29 (44.6)</td>
<td>72 (55.4)</td>
<td>0.1560</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>12 (18.5)</td>
<td>33 (25.4)</td>
<td>0.2794</td>
</tr>
<tr>
<td>44 – 49 years</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>-</td>
</tr>
<tr>
<td>Median age</td>
<td>27 years</td>
<td>30 years</td>
<td></td>
</tr>
<tr>
<td>Q₁=23.5; Q₃=32</td>
<td></td>
<td>Q₁=26.5; Q₃=35.5</td>
<td></td>
</tr>
</tbody>
</table>

**Marital status**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married (including cohabiting)</td>
<td>42 (64.6)</td>
<td>106 (81.5)</td>
<td>0.0091</td>
</tr>
<tr>
<td>Separated/ Divorced</td>
<td>18 (27.7)</td>
<td>15 (11.5)</td>
<td>0.0046</td>
</tr>
<tr>
<td>Widowed</td>
<td>5 (7.7)</td>
<td>9 (6.9)</td>
<td>0.8445</td>
</tr>
</tbody>
</table>

**Level of Education**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never been to school</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>-</td>
</tr>
<tr>
<td>Primary</td>
<td>25 (38.5)</td>
<td>43 (33.1)</td>
<td>0.4570</td>
</tr>
<tr>
<td>Secondary</td>
<td>34 (50.3)</td>
<td>80 (61.5)</td>
<td>0.2175</td>
</tr>
<tr>
<td>Tertiary</td>
<td>6 (9.2)</td>
<td>7 (5.4)</td>
<td>0.3101</td>
</tr>
<tr>
<td>Attribute</td>
<td>Cases</td>
<td></td>
<td>Controls</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>n=</td>
<td>(%)</td>
<td>n=</td>
</tr>
<tr>
<td><strong>Partner’s level of Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never been to school</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary</td>
<td>7 (16.7)</td>
<td>17 (16.0)</td>
<td>0.9254</td>
</tr>
<tr>
<td>Secondary</td>
<td>21 (50.0)</td>
<td>63 (59.4)</td>
<td>0.2963</td>
</tr>
<tr>
<td>Tertiary</td>
<td>14 (33.3)</td>
<td>26 (24.5)</td>
<td>0.2769</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formally employed</td>
<td>20 (30.8)</td>
<td>28 (21.5)</td>
<td>0.1584</td>
</tr>
<tr>
<td>Informally employed</td>
<td>3 (4.6)</td>
<td>9 (6.9)</td>
<td>0.5273</td>
</tr>
<tr>
<td>Self employed</td>
<td>8 (12.3)</td>
<td>19 (14.6)</td>
<td>0.6601</td>
</tr>
<tr>
<td>Not working</td>
<td>34 (52.3)</td>
<td>74 (56.9)</td>
<td>0.5411</td>
</tr>
<tr>
<td><strong>Partner’s Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formally employed</td>
<td>23 (54.8)</td>
<td>56 (52.8)</td>
<td>0.8318</td>
</tr>
<tr>
<td>Informally employed</td>
<td>3 (7.1)</td>
<td>18 (17.0)</td>
<td>0.1220</td>
</tr>
<tr>
<td>Self employed</td>
<td>10 (23.8)</td>
<td>26 (24.5)</td>
<td>0.9268</td>
</tr>
<tr>
<td>Not working</td>
<td>6 (14.3)</td>
<td>6 (5.7)</td>
<td>0.8308</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apostolic (allow use of H/F)</td>
<td>25 (38.5)</td>
<td>45 (34.6)</td>
<td>0.5976</td>
</tr>
<tr>
<td>Apostolic (disallow use of H/F)</td>
<td>1 (1.5)</td>
<td>20 (15.4)</td>
<td>0.0033</td>
</tr>
<tr>
<td>Non Apostolic</td>
<td>39 (60.0)</td>
<td>65 (50.0)</td>
<td>0.1870</td>
</tr>
<tr>
<td>Traditional</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Table 4c: Maternal History of the Study Participants – Harare City, 2015

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=</td>
<td>n=</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(%)</td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td><strong>Gestational age at booking</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 to 20 weeks</td>
<td>29 (44.6)</td>
<td>81 (62.3)</td>
<td>0.0188</td>
</tr>
<tr>
<td>21 to 28 weeks</td>
<td>26 (40.0)</td>
<td>36 (27.7)</td>
<td>0.2004</td>
</tr>
<tr>
<td>29 years and above</td>
<td>10 (15.4)</td>
<td>12 (9.2)</td>
<td>0.2004</td>
</tr>
<tr>
<td><strong>Gravida</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 2</td>
<td>24 (36.9)</td>
<td>33 (25.4)</td>
<td>0.9490</td>
</tr>
<tr>
<td>3 to 4</td>
<td>29 (44.6)</td>
<td>78 (60.0)</td>
<td>0.0418</td>
</tr>
<tr>
<td>Above 4</td>
<td>12 (18.5)</td>
<td>19 (14.6)</td>
<td>0.4887</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>9 (13.8)</td>
<td>12 (9.2)</td>
<td>0.3270</td>
</tr>
<tr>
<td>1 to 2</td>
<td>21 (32.3)</td>
<td>38 (29.2)</td>
<td>0.6593</td>
</tr>
<tr>
<td>2 to 3</td>
<td>30 (46.2)</td>
<td>78 (60.0)</td>
<td>0.6070</td>
</tr>
<tr>
<td>Above 3</td>
<td>5 (7.7)</td>
<td>2 (1.5)</td>
<td>0.0294</td>
</tr>
<tr>
<td><strong>Duration of treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>45 (75)</td>
<td>98 (75)</td>
<td>1.0000</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>9 (4)</td>
<td>14 (11)</td>
<td>0.5300</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>7 (11)</td>
<td>18 (14)</td>
<td>0.5446</td>
</tr>
</tbody>
</table>
Table 4d: Maternal History of the Study Participants – Harare City, 2015

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=</td>
<td>n=</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(%)</td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td>Miscarriages/ still births</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>49 (75.4)</td>
<td>111 (85.4)</td>
<td>0.0863</td>
</tr>
<tr>
<td>1</td>
<td>15 (23.1)</td>
<td>19 (14.6)</td>
<td>0.1421</td>
</tr>
<tr>
<td>More than 1</td>
<td>1 (1.5)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Death of an infant under 1 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>56 (86.2)</td>
<td>107 (82.3)</td>
<td>0.4942</td>
</tr>
<tr>
<td>1</td>
<td>9 (13.8)</td>
<td>22 (16.9)</td>
<td>0.5796</td>
</tr>
<tr>
<td>More than 1</td>
<td>0</td>
<td>1 (0.8)</td>
<td></td>
</tr>
<tr>
<td>Was ART started during this</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>45 (69)</td>
<td>74 (57)</td>
<td>0.09</td>
</tr>
<tr>
<td>No</td>
<td>17 (20)</td>
<td>56 (43)</td>
<td></td>
</tr>
<tr>
<td>Number of visits before defaulting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 2</td>
<td>32 (49)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 to 4</td>
<td>17 (26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 to 6</td>
<td>9 (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 6 visits</td>
<td>7 (11)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The median age of the cases was 27 years while that of the controls was 30 years. More than half of the cases and controls were married. The widowed constituted almost the same proportion among both cases and controls. More than 90% of the cases had gone up to primary education, and only 10% had gone past secondary education. For the controls, more than 95% had gone up to primary education while only 5% (7) had exceeded secondary education. For those who were married, the proportion of partners who had gone up to tertiary education was higher than their female partners. Out of the 42 married cases, half of the partners had gone up to secondary education. Out of the 106 married controls, more than half had gone up to secondary education while a quarter had attained tertiary education.

The proportion of study participants who were not employed was slightly above half for both cases and controls. Among those who had some source of income, formal employment was the common source of income for both cases and controls followed by self-employment. The partners were also largely in the formal employment as compared to their female counterparts. More than half of the partners were formerly employed in both cases and controls and almost a quarter were self-employed for both groups. Unemployment rate was higher in the cases’ partners as compared to the controls’ partners. Half of the controls were of the non-Apostolic sect while the remainder were of the apostolic sect. Among those of the apostolic sect, there was a significant proportion, 15% whose religion did not allow them to use the health facility among the controls. However there was only one such woman among the cases, whose religion did not allow use of the health facility.
More than 90% of the controls booked their pregnancies at between 12 weeks and 28 weeks, while less than 10% booked at above 29 weeks. Cases booked their pregnancies later with about 85% booking at between 12 and 28 weeks while 15% booked at above 29 weeks. Multi-parity was common among both groups of participants with more than half having more than two children. There were more first time mothers amongst the cases as compared to the controls. A quarter of the cases had at least a previous history of a stillbirth or a miscarriage as compared to 15% of the controls who had the same history. Previous history of the death of at least one infant below the age of one year was common in controls as compared to cases.
The study participants were described according to their age groups and the distribution is illustrated in Figure 4.

Figure 4: Age Distribution for Cases and Controls Enrolled for the Study - Harare City, 2015

The majority of the study participants were in the 25 to 34 years age group while a quarter of the study participants were in the 35 to 44 years age group. Only one of the controls was under 18 years. There were no participants in the age group 44 to 49 years in both cases and controls.
Factors associated with defaulting among the cases and the controls were analyzed and summarized in Table 5.

### Table 5a: Patient Level Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Controls</th>
<th>Odds Ratio at 95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n= (%)</td>
<td>n= (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Level Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure to partner</td>
<td>Yes</td>
<td>27 (64)</td>
<td>82 (77)</td>
<td>0.5</td>
<td>0.1036</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>15 (36)</td>
<td>24 (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure to other people</td>
<td>Yes</td>
<td>36 (55)</td>
<td>124 (95)</td>
<td>0.1</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>29 (45)</td>
<td>6 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported by partner</td>
<td>Yes</td>
<td>16 (59)</td>
<td>81 (99)</td>
<td>0.02</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>11 (41)</td>
<td>1 (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tested during this pregnancy</td>
<td>Yes</td>
<td>55 (85)</td>
<td>106 (82)</td>
<td>1.2</td>
<td>0.6000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>10 (15)</td>
<td>24 (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Started ART immediately</td>
<td>Yes</td>
<td>45 (69)</td>
<td>103 (79)</td>
<td>0.59</td>
<td>0.1200</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>20 (31)</td>
<td>27 (21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knew someone on ART</td>
<td>Yes</td>
<td>38 (58)</td>
<td>100 (77)</td>
<td>0.42</td>
<td>0.0075</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>27 (42)</td>
<td>30 (23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced stigma</td>
<td>Yes</td>
<td>12 (18)</td>
<td>2 (2)</td>
<td>14.5</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>53 (82)</td>
<td>128 (92)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5b: Patient Level Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Controls</th>
<th>Odds Ratio at 95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Started ART 1 week after testing</td>
<td>Yes</td>
<td>20 (31)</td>
<td>27 (21)</td>
<td>1.7</td>
<td>0.1200</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>45 (69)</td>
<td>103 (79)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>Yes</td>
<td>43 (65)</td>
<td>106 (82)</td>
<td>0.4</td>
<td>0.0091</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>23 (35)</td>
<td>24 (18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscarriages</td>
<td>Yes</td>
<td>16 (25)</td>
<td>19 (15)</td>
<td>1.9</td>
<td>0.0863</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>49 (75)</td>
<td>111 (85)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tested during breastfeeding</td>
<td>Yes</td>
<td>10 (15)</td>
<td>24 (18)</td>
<td>0.0</td>
<td>0.5935</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>55 (85)</td>
<td>106 (82)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disclosure of HIV status to partner or husband was higher in the controls as compared to the cases. It was found to be a protective factor with an Odds ratio of 0.5 although it was not statistically significant. Disclosure of HIV status to other people, partner included was found to be a statistically significant protective factor. Getting support from the spouse after disclosure of status was also found to be a statistically significant protective factor. Being married and knowing someone on ART before being initiated on ART were both found to be statistically significant protective factors. Those women who experienced stigma because of their HIV status were 14 times more likely to default than those who did not experience stigma and this was found to be a statistically significant risk factor.
Table 5c: Drug Related Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Control</th>
<th>Odds</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n= (%)</td>
<td>n= (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ran short of medication</td>
<td>Yes</td>
<td>27 (42)</td>
<td>7 (5)</td>
<td>12</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>38 (58)</td>
<td>123 (95)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced side effects</td>
<td>Yes</td>
<td>35 (54)</td>
<td>29 (22)</td>
<td>4</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>30 (46)</td>
<td>101 (78)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still have side effects</td>
<td>Yes</td>
<td>3 (9)</td>
<td>1 (3)</td>
<td>2.6</td>
<td>0.3993</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>32 (91)</td>
<td>28 (97)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Women who ran short of their medicine supply at some point after ART initiation were 12 times more likely to default as compared to those who never ran short of medicine supply. Those who experienced drug side effects were also 4 times more likely to default as compared to those who did not experience side effects.
Table 5d: Service Related Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Controls</th>
<th>Odds Ratio at 95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=</td>
<td>(%)</td>
<td>n=</td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td>Individual counselling</td>
<td>Yes</td>
<td>33 (51)</td>
<td>103 (79)</td>
<td>0.3</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>32 (49)</td>
<td>27 (21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ART services offered separately</td>
<td>Yes</td>
<td>43 (66)</td>
<td>119 (92)</td>
<td>0.2</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>22 (34)</td>
<td>11 (8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Receiving individual counselling (at least one session where they had a one on one discussion with the health worker) before being initiated on Option B+ was found to be a protective factor in this study. Those women who collected their medication at a health facility where Option B+ services were offered separately from other hospital services were less likely to default as compared to their counterparts who collected medication where there were no separate Option B+ services.
Table 5e: Provider-Patient Relationship Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n= (%)</td>
<td>n= (%)</td>
<td></td>
</tr>
<tr>
<td>Free to ask questions during</td>
<td>Yes</td>
<td>42 (67)</td>
<td>119 (93)</td>
<td>0.0000</td>
</tr>
<tr>
<td>counselling questions</td>
<td>No</td>
<td>21 (33)</td>
<td>9 (7)</td>
<td></td>
</tr>
<tr>
<td>Adequately information given</td>
<td>Yes</td>
<td>36 (57)</td>
<td>119 (93)</td>
<td>0.0000</td>
</tr>
<tr>
<td>during counselling</td>
<td>No</td>
<td>27 (43)</td>
<td>9 (7)</td>
<td></td>
</tr>
</tbody>
</table>

Women who felt that they received adequate information during counselling sessions were 0.1 times less likely to default (p<0.05) as compared to those who felt that they did not receive adequate counselling. Women who reported that they were free to ask questions to from the health workers during the counselling sessions were 0.2 times less likely to default (p=<0.05) as compared to those who reported that they were not free to ask questions.
Table 5f: Environmental Socio-Cultural Factors Associated with Defaulting among Women Initiated on Option B+ - Harare City, 2015

<table>
<thead>
<tr>
<th>Factor</th>
<th>Status</th>
<th>Cases</th>
<th>Controls</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apostolic sect (disallow use of H/F)</td>
<td>Yes</td>
<td>1 (1.5)</td>
<td>20 (15.4)</td>
<td>0.0033</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>64 (98.5)</td>
<td>110 (84.5)</td>
<td></td>
</tr>
<tr>
<td>Distance from H/F above 2 km</td>
<td>Yes</td>
<td>31 (48)</td>
<td>61 (47)</td>
<td>0.91</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>34 (52)</td>
<td>69 (53)</td>
<td></td>
</tr>
<tr>
<td>Primary Education</td>
<td>Yes</td>
<td>25 (38.5)</td>
<td>43 (33.1)</td>
<td>0.4570</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>40 (61.5)</td>
<td>87 (66.9)</td>
<td></td>
</tr>
<tr>
<td>Formally Employed</td>
<td>Yes</td>
<td>20 (30.8)</td>
<td>28 (21.5)</td>
<td>0.1584</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>45 (69.1)</td>
<td>102 (78.5)</td>
<td></td>
</tr>
</tbody>
</table>

Women who were of the apostolic sect that does not allow use of the health facility were less likely to default as compared to those who were of the non-apostolic and apostolic sect that allows use of the health facility. This was found to be a statistically significant protective factor with an Odds Ratio of 0.9.
Participants were asked whether they had disclosed their HIV status to other people and if so to whom they had disclosed. Table 6 and Figure 5 summarize the responses.

Table 6: Disclosure Status for Cases and Controls – Harare City, 2015

<table>
<thead>
<tr>
<th>Disclosure status</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosed to spouse</td>
<td>27</td>
<td>81</td>
</tr>
<tr>
<td>Disclosed to own relatives</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Disclosed to spouse’s relatives</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disclosed to friend(s)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Not disclosed</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>65</td>
<td>130</td>
</tr>
</tbody>
</table>
Figure 5: Disclosure Status for Cases and Controls – Harare City, 2015

Non-disclosure of HIV status was common among the cases as compared to the controls. The majority of the women who had disclosed their HIV status found it easier to disclose to their partners. Almost two thirds of the married cases reported that they had disclosed their HIV status to their partners and more than three quarters of the married controls had also disclosed to their partners. The participants also found it easier to disclose to their own relatives and lastly to friends. None of the study participants reported having disclosed their status to their partners’ relatives.
Stratified analysis of risk factors was done to control for confounders and the results are summarized in Table 7.

**Table 7: Stratified Analysis of Factors Associated with Defaulting among Women Initiated on Option B+ – Harare City 2015 (controlling for confounders)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Crude OR</th>
<th>95% CI</th>
<th>MH Adjusted OR</th>
<th>95% CI</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ran short of medication</td>
<td>12.5</td>
<td>5.0 – 30.9</td>
<td>12.3</td>
<td>5.1 – 32.6</td>
<td>No confounding</td>
</tr>
<tr>
<td>No individual counselling</td>
<td>3.7</td>
<td>1.9 – 7.0</td>
<td>3.7</td>
<td>1.9 – 7.1</td>
<td>No confounding</td>
</tr>
<tr>
<td>No partner support</td>
<td>55.7</td>
<td>6.7 – 462.2</td>
<td>52.9</td>
<td>8.2 – 220.6</td>
<td>Confounding</td>
</tr>
<tr>
<td>Experienced side effects</td>
<td>4.1</td>
<td>2.1 – 7.7</td>
<td>4.0</td>
<td>2.1 – 7.7</td>
<td>No confounding</td>
</tr>
<tr>
<td>Experienced stigma</td>
<td>14.5</td>
<td>3.1 – 67.0</td>
<td>14.3</td>
<td>3.5 – 96.9</td>
<td>No confounding</td>
</tr>
<tr>
<td>Not disclosed HIV status</td>
<td>16.6</td>
<td>6.4 – 43.2</td>
<td>16.3</td>
<td>6.5 – 46.3</td>
<td>No confounding</td>
</tr>
<tr>
<td>Inadequate information during counselling</td>
<td>9.6</td>
<td>4.1 – 22.1</td>
<td>9.4</td>
<td>4.1 – 22.8</td>
<td>No confounding</td>
</tr>
</tbody>
</table>
Stratified analysis was carried out on seven risk factors and six of them had the Stratum specific Odds Ratios that were similar to the Mantel Hansel Adjusted Odds ratio which showed that there was no confounding. Confounding was observed on one factor, no partner support which had an Unadjusted Odds Ratio of 55.7 and the Mantel Hansel Adjusted Odds Ratio was 52.9. This showed that there was some confounding.

An assessment of the independent risk factors was done and the results are summarized in Table 8.

Table 8: Independent Risk Factors Associated with Defaulting among Women Initiated on Option B+ – Harare City, 2015

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adjusted Odds Ratio</th>
<th>95% Confidence Interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ran short of medication</td>
<td>12.3</td>
<td>5.1 – 32.6</td>
<td>0.0000</td>
</tr>
<tr>
<td>Experienced stigma</td>
<td>14.3</td>
<td>3.5 – 96.9</td>
<td>0.0000</td>
</tr>
<tr>
<td>No individual counselling</td>
<td>3.7</td>
<td>1.9 – 7.1</td>
<td>0.0000</td>
</tr>
<tr>
<td>Experienced side effects</td>
<td>4.0</td>
<td>2.1 – 7.7</td>
<td>0.0000</td>
</tr>
<tr>
<td>No partner support</td>
<td>52.9</td>
<td>8.2 – 220.6</td>
<td>0.0000</td>
</tr>
<tr>
<td>Not disclosed HIV status</td>
<td>16.3</td>
<td>6.5 – 46.3</td>
<td>0.0000</td>
</tr>
<tr>
<td>Inadequate information during counselling</td>
<td>9.4</td>
<td>4.1 – 22.8</td>
<td>0.0000</td>
</tr>
</tbody>
</table>

Not having support from partner after disclosing one’s HIV status proved to be the most risk factor with an Odds ratio of 53 and this was found to be statistically significant. Those who had
not disclosed their HIV status to other people were 16 times more likely to default as compared to those who had disclosed. The risk of defaulting was higher for the women who had experienced stigma because of their HIV status and for those who had run short of medicine supply at some point. Women who reported that they had not received adequate information during counselling were 9 times more likely to default as compared to those who reported having received adequate information. The risk of defaulting was 4 times higher in women who had experienced side effects and also for women who had not received individual counselling.

Forward stepwise logistic regression was performed on the seven statistically significant risk factors from the bivariate analysis. We added one variable at a time to those that had a p value of 0.05 or less and dropped those that had a p value above 0.05.

Table 9: Risk Factors Significantly Associated with Defaulting among Women Initiated on ART in Harare City, 2015.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Crude Odds</th>
<th>95% Confidence Interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No individual counselling</td>
<td>8.9176</td>
<td>3.5 – 22.8</td>
<td>0.0000</td>
</tr>
<tr>
<td>Ran short of medication</td>
<td>9.4017</td>
<td>3.3 – 26.5</td>
<td>0.0000</td>
</tr>
<tr>
<td>Experienced side effects</td>
<td>4.1</td>
<td>1.8 – 9.3</td>
<td>0.0008</td>
</tr>
</tbody>
</table>

After performing logistic regression, three variables remained significantly associated with defaulting (no individual counselling, running short of medication and experienced stigma).
Qualitative results

Results from the eight in-depth interviews and four focus group discussions complemented the study and helped to shed more light on the findings. Thematic analysis was done to come up with a range of factors that were associated with defaulting Option B+.

Lack of Partner Support

In the focus group discussions, participants highlighted that even if they disclose their HIV status to their partners; most of the partners were not supportive and sometimes blame the women for bringing the virus. One woman in an in depth interview reported that her partner refused to have sex with her following disclosure.

“I told him about my HIV status on the day that I was tested and that was in January 2015, since then, he has refused to sleep with me saying that I will infect him yet he refused to go and get tested too. He comes home to eat and change clothes, but no longer sleep at home”. (IDI - Rutsanana)

Stigma

Most participants indicated that although stigma was no longer very common in their communities, some women still experience it within their families. Being stigmatized by family members or close friends was said to be the worst experience and strongly associated with defaulting.

For example: “My young sister has never touched my baby for three months now, yet we stay together. She even discourages our mother from touching the baby saying that she will get the virus”. (IDI - Kuwadzana)
Medicine Supply Period too Short

Participants in a focus group discussion complained that most health facilities supply medications for a period of one month. This was said to be too short, especially after delivery. They said they could not afford to come for resupply every month after giving birth.

“During ANC we can afford to come monthly as we come for our ANC visits; however, after giving birth I think they should supply us for two months. We cannot continue to come monthly after giving birth especially considering that we will be taking this medicine for life. We will get tired at some point and stop coming”. (P6 - Mabvuku).

Side-effects of ART

Drug side effects were largely discussed in focus group discussions. Most of the participants reported having experienced some side effects that include bad dreams, skin rash and feeling dizzy.

“I developed skin rash on my face and I didn’t like it. I had to stop the medication because everyone would look at me suspiciously”. (P3 – Rutsanana)

Disclosure of HIV status

Issues of disclosure raised hot discussions during the focus group discussions. Although most women reported having disclosed their status, they said it was very difficult to do so. Most of them said they only disclosed to their partners and not to anyone else for fear of being talked about. Others, however reported that they were just taking their medication without telling anyone even their partners. In in depth interviews, participants also reported having problems with disclosure.
“I cannot tell anyone about my status. I just take my medication privately because I don’t want people to talk about me”. (IDI – Budiriro)
CHAPTER 6: DISCUSSIONS

6.1 Discussion

This study was carried out to test the hypothesis that disclosure of HIV status is not associated with defaulting among women initiated on ART at the four polyclinics in Harare city. The findings of this study revealed that disclosure variable was significantly associated with the outcome variable (defaulting). Disclosing HIV status was a significant protective factor while non-disclosure was a significant risk factor for defaulting.

Patient Level Factors

Slightly above half of the women (55%) had disclosed their HIV status to other people and those who had disclosed were more likely to remain on ART. This is contrary to findings by Dankoli et al (2014)\textsuperscript{30} in Eastern Nigeria, where they found out that 98% had disclosed their HIV status. The low disclosure rate could be because women fear negative consequences that may result from disclosure especially from partners. According to Alemayehu\textsuperscript{31}, 23% of women in Northern Ethiopia reported that they had not disclosed their status to their partners for fear of separation. Women who will have disclosed are free to take their medication at the correct time without fearing that other people will see them. They are free to go to the health facility for resupply and even to ask for financial support when they need transport money to go for resupply. They are also free to share their problems, for example, if they have side effects they can share with those they have disclosed to and are likely to get advice and encouragement to continue taking medication.

Following disclosure of HIV status to partners, more than half (59%) of the partners were supportive. Contrary to our findings, Saqay et al (2006)\textsuperscript{32} in Northern Nigeria found out that
87% of partners were supportive, while 7% were quarrelsome and 1% was abusive following disclosure of status. The low proportion of partners who are supportive could be because men are not yet actively involved in PMTCT programs, though efforts are being made to encourage them to accompany their partners for ANC visits. A supportive partner will help them to accept and to quickly accept their situation. Psychological support is needed so that one does not blame themselves for getting infected and also to accept that testing positive does not mean the end of the world. Even if the other people fail to support them, support from the person whom they stay with is crucial and very encouraging and this will make them continue taking their medication.

Women who knew someone on ART before they were initiated were 0.4 times less likely to default. Similarly, in a study in rural Tanzania, Gourlay et al (2014) found out that knowing someone on ART was associated with higher odds of being in care Odds Ratio 2.1 (p=<0.05). This could be because one feels encouraged when they know that they are not alone in the battle and that they are not the first one to get into the situation. If the people that they know have succeeded on medication, this will be more encouraging. People need some role models in life and these people will be like role models in taking ART. Where the person that they have known had a successful outcome for example, giving birth to a negative baby, this will give them hope of a positive outcome too. They also may wish to share their success stories with other women in the same situation in the future and this will make them continue taking their medication as prescribed.

Having experienced stigma because of their HIV status was found to be a statistically significant risk factor in this study. Turan explained that HIV related stigma leads to a feeling of guilt, denial, secrecy, silence and development of a negative attitude which will result in defaulting treatment. When one is first told that they are HIV positive, there is self-stigma. They start to
feel and think that they are different from others. The situation becomes worse if the outside world then fulfills this feeling by showing that they are really different from the rest of the people that they used to socialize with. Every human being wants to at least belong to a group, be it a religious or social group. If then they feel isolated from their group members they may quickly lose hope of living longer and this will lead them to default treatment. They may also think that if they stop taking the medication, they might be accepted back into the society and will belong again.

**Drug Related Factors**

Running short of medication supply at some point was associated with defaulting in this study with 42% of the respondents reporting this. In a study in Nepal, 62% of respondents reported having run out of pills. This might result from the fact that if one goes for some days without medication and they still feel they are well, they may think that they might as well stop the medication for good and will still remain well. The same factors that might have led to their running short of medication for some time might also persist and these might end up resulting in their defaulting. They might have failed to get money to go for resupply and if this problem persists then they will stop taking the medication for good. They might have had problems not wanting people to know that they are on ART and if this problem is not solved, they might as well decide to stop the medication for good. In the same Nepal study, the 62% respondents reported that they defaulted because they did not want others to notice that they were on ART.

Having experienced drug side effects was 4 times more likely to lead to defaulting. In this study, 54% reported having defaulted due to side effects. These findings are consistent with findings by Wasti et al (2012) where they found out that 58% of respondents reported having stopped
medication to avoid side effects. Some side effects may make people suspect that one is on ART without them being told. Many women do not like this, for example, if they are having skin rash, especially on the face, they might not accept it. Some side effects may be so serious that the women might feel that they cannot continue having them and might as well decide to stop the medication in order to stop having the side effects.

**Service Related factors**

Women who did not attend individual counselling were 3.7 times more likely to default. In a study done in Malawi, health providers reported that patient education is a useful approach to increasing patients’ adherence. They use individual counselling sessions as a means to strengthen patients and help them remain on medication. Individual patient counselling was said to be relevant in aligning patient’s adherence behaviour with provider’s expectations. This could be because during an individual counselling session, one has a chance of talking to the health care worker on a one on one basis. They have a chance of discussing their fears; myths and misconceptions are cleared. They have a chance of asking questions where they are not clear and their questions will be adequately answered. The rapport that will have been created during the individual counselling will create a free environment that will allow the women even to ask any other questions that may arise in the course of their medication. This will encourage them to continue taking medication as they continue getting more information from the health care worker.

Having Option B+ services being offered separately, that is at the Family and Child Health department, separate from where other patients who are not on Option B+ are served from, was also a protective factor. This could be because women feel free to come to the facility as they
come for antenatal and postnatal services, they also collect their medication and no one will know that they had come for medication. Even those who do not want to be seen by other people collecting medication will be covered because they are not seen queuing at the Pharmacy with the rest of the patients. The women who have issues at home, will just leave as if they are going for routine ANC and PNC visits while they also collect their supply.

**Provider- Patient Relationship Factors**

Women who reported that they were free to ask questions during counselling sessions were less likely to default. This could be because all the fears that they had might have been cleared during their discussions with the health care worker. They might have had the chance to discuss about the drug side effects at length and how they could overcome. If then they were to experience any of the side effects they would be clear on how to manage them besides thinking of stopping the medication.

Receiving adequate information during counselling was found to be protective against defaulting. If the benefits of taking the lifelong medication have been clearly explained to the women, the chances of them stopping the medication will be very low. They will look forward to the anticipated benefits rather than concentrating on the problems that they will be facing for example side effects and stigma. They will know that they are taking the medication for their own good and need not expect to have approval of any other person who will not benefit from the medication.
Environmental, Socio-cultural Factors

Being of the apostolic sect that does not allow use of the health facility was found to be a statistically significant protective factor. This could be because once a woman from this sect decides to visit the facility; they will have made a bold decision based on their understanding of the benefits of such behaviour. This will encourage them to continue taking their medication looking forward to the anticipated benefits.

6.2 Limitations

Our study followed up patients that were registered for Option B+ from 01 January 2015 to 31 March 2015. The follow up period was up to 30 June 2015 which is less than six months.

6.3 Conclusions

We went out to test the hypothesis that disclosure of HIV status is not associated with defaulting among women initiated on Option B+ in the four polyclinics in Harare city. In view of the above findings, we concluded that disclosure variable was significantly associated with defaulting. Those who had disclosed were more likely not to default while those who had not disclosed were more likely to default.

Independent patient related factors that include not disclosing HIV status, not getting support from partner, and having experienced stigma because of one’s HIV status were found to be associated with defaulting among women initiated on Option B+ in Harare city.
Independent drug related factors that include running short of medicine supply and having experienced side effects were found to be associated with defaulting among women initiated on ART in Harare city.

Independent service related factors that include no individual counselling and Option B+ services not being offered in a room separate from where other patients who are not on Option B+ are served from were found to be associated with defaulting among women initiated on Option B+ in Harare city.

Independent provider-patient relationship factors that include receiving inadequate information and not free to ask questions during counselling questions were found to be associated with defaulting among women initiated on Option B+ in Harare city.

### 6.4 Recommendations

In view of the above findings, we recommend that during counselling sessions, disclosure issues should be thoroughly discussed, highlighting the benefits of disclosing HIV status so that the women can get support and encouragement to continue taking medication.

Male partner involvement should be strengthened so that more men can support their HIV positive partners. Encouraging male partner testing can also help, especially if the men also test HIV positive, they are more likely to be supportive than those who do not know their own HIV status.

Community education is important. The community should know that everyone is at risk of getting HIV so they should not stigmatize others. They should also know that those who already know their HIV status are better placed than those who do not know so they should also be
encouraged to get tested and to support those who already know their status. They should learn to join hands in the fight against HIV by shunning stigma.

Clients should be encouraged to adhere to their medication.

All clients should attend at least one individual counselling session where they are free to ask questions and where rapport between client and health care provider can be created. Clients may not be able to ask questions on the counselling day, but as they start taking medication questions may arise due to what they can experience. Rapport created during counselling sessions can enable them to feel free to ask questions as they develop during the course of their medication.

Side effects associated with the medication should be discussed during counselling and how the clients can overcome them. This help clients to accept them when they experience them rather than letting them discover the side effects on their own as this may lead to varied coping mechanisms that may include stopping medication.
References


http://dx.doi.org/10.1155/2014/489370 - available at

www.hindawi.com/journals/art/2014/489370/ - accessed 17/08/15
PARTICIPANT INFORMED CONSENT

PROTOCOL TITLE: Factors Associated with Defaulting among Women Initiated on Option B+ in Urban Clinics - 2015

NAME OF RESEARCHER: Ester Muchenje
PHONE: 0772 575 437

PROJECT DESCRIPTION:
You have decided to take part in the research study named above. The study will collect your information about your age, gender and income, place of residence and risk factors for defaulting among mothers initiated on Option B+ in urban clinics. This consent form gives you information about the collection, storage and future use of data collected from you. Please ask if you have any questions. You will be asked to sign or make your mark on this form to indicate whether or not you agree to participate in the study. You will be offered a copy of this form to keep and will keep the other form for at least 3 years.

YOUR RIGHTS
Before you decide whether or not to volunteer for this study, you must understand its purpose, how it may help you, the risks to you, and what is expected of you. This process is called informed consent.

PURPOSE OF RESEARCH STUDY
The study seeks to determine factors Associated with Defaulting among Women Initiated on Option B+ in Urban Clinics. The factors being looked at are divided into patient related, service related, drug related and provider-patient relationship factors. You will also be asked on your recommendations on how mothers can be retained on Option B+. 
PROCEDURES INVOLVED IN THE STUDY

Data will be collected using an interviewer administered questionnaire and checklists. The questionnaire you will respond to consists of open ended and closed ended questions.

DISCOMFORTS AND RISKS

There are ethical risks related to storing your information. It is possible that if others find out information about you in the questionnaire, it could cause you problems of stigmatization. To minimise this risk your information will be strictly put under lock and key. Information collected from you will be used only for academic purposes.

POTENTIAL BENEFITS

There are no immediate benefits to you from having your information stored. You and others could benefit in the future from research done on you.

STUDY WITHDRAWAL

You may choose not to enter the study or withdraw from the study at any time without loss of benefits entitled to you.

CONFIDENTIALITY OF RECORDS

Completed questionnaires and checklists will be kept under lock and key for at least 3 years after which they may be destroyed. To keep your information private, your name will not be written on the questionnaire.

PROBLEMS/QUESTIONS

Please ask about this research or consent now. If you have any questions in future please ask.
AUTHORIZATION

I have read this paper about the study or it was read to me. I understand the possible risks and benefits of this study. I know being in this study is voluntary. I choose to be in this study. I know I can stop to be in this study and I know I will not lose any benefits entitled to me. I will get a copy of this consent form

__________________________________________________________________________
Client Signature or Mark                                          Date
__________________________________________________________________________
Client Name (Printed)

__________________________________________________________________________
Researcher Signature                                          Date

__________________________________________________________________________
Witness Signature                                              Date
Annex 2: Participant Consent Form – Shona

GWARO REKUBVUMA KUPINDA MUTSVAKURUDZO

MUSORO WETSVAKURUDZO: Ongororo yekutsvakurudza zvinokonzera kuti vana amai vakazvitakura nevari kuyamwisa vanenge vatangwa muchirongwa chekunwa mushonga kwehupenyu hwese cheOption B+ vamire kutora mushonga muzvipatara zvemumadhorobha – 2015

MUONGORORI: Ester Muchenje

RUNHARE : 0772 575 437

TSANANGUDZO YETSVAKURUDZO

Masarudza kupinda mutsvakurudzo yataurwa nezvayo pamusoro. Tsvakurudzo ino ichaunganidza ruzivo runosanganisira zera renyu, muri munhui, zvinokubatsirai pakurarama, kwamunogara nezvingadaro zvichikonzera kuti vana amai vanenge vatangwa pamushonga kwehupenyu hwese vamire kutora mushonga muzvipatara zvemumadhorobha. Gwaro rino rekubvuma kupinda mutsvakurudzo rinokupai ruzivo maererano nemaunganidzirwo achaitwa ruzivo, kuchengetedzwa kwezvabuda mutsvakurudzo uye zvazvingazoshandiswa munguva inotevera. Muchakumbirwa kuti muise runyoro rwenyu kana tsimba remunwe wenyu pabepa rino kuratidza kubvuma kana kusabvuma kwenyu kupinda mutsvakurudzo ino. Muchapihwa rimwe remapepa aya kuti murichengeta uye rimwe racho ndicharichengeta kwemakore anosvika matatu.
KODZERO DZENYU

Musati masarudza kuti mungada here kana kwete kupinda mutsvakurudzo ino, munofanirwa kutanga manzwisisa chinangwa chetsvakurudzo, zvazvingazokubatsirai, njodzi uye zvinotarisirwa kwamuri. Uku kunonzi kupa mvumo yekupinda mutsvakurudzo.

CHINANGWA CHETSVAKURUDZO

Tsvakurudzo iri kuitwa kuongorora zvingadai zwichikonzera kuti vana amai vanenge vatangwa pamushonga kwehupenyu hwese vamire kutora mushonga muzvipatara zvemumadhorobha. Zvikonzero izvi zvichaongorora zviri muzvikamu zvinoti; zvine chekuita nemurwere, zvine chekuita nekuwana rubatsiro pachipatara, zvine chekuita nemishonga uye zvine chekuita nehukama pakati pomurwere nomurapi. Muchakumbirawo kuti mupe kurudziro dzenyu maererano nekuti zvii zvingaitwa kuti vana amai vasamira kutora mushonga.

MAITIRWO ETSVAKURUDZO

Ruzivo ruchaunganidzwa kuburikidza nehurukuro yamuchaita nemuongorori. Muchabvunzwa mibvunzo inoda mhinduro pfupi neimwewo inoda tsanangudzo dzizere.

KUSAGADZIKANA NENJODZI

ZVAMUNGAWANA

Hapana chamungagona kuwana pakupinda mutsvakurudzo ino panguva ino. Imi nevamwe madzimai akaita semi munogona kuzobatsirika munguva inotevera kuburikidza nezvinenge zvawani kubva mutsvakurudzo ino.

KUBUDA MUTSVAKURUDZO

Munogona kusarudza kusapinda mutsvakurudzo ino kana kubuda muhurukuro iri pakati asi izvi zvese hazvina zvazvingakukanganisai pazvese zvamunofanirwa kuwana.

KUCHENGETEDZEKA KWEZVINYYORWA

Zvinyorwa zvese zve hurukuro ino zvichchengetedzwa zvakakiyirwa kwemakore matatu mushure menguva iyi zvoparadzwa. Kuitira kuti zvakavanzika zvenyu zvichchengetedzeke, zita renyu harizonyorwi pamapepa atichashandisa pakuita hurukuro.

MATAMBUDZIKO/MIBVUNZO

Sunungukai kubvunza nezve tsvakurudzo ino kana nezvekupa mvumo iye zvino. Kana mazoita mibvunzo munguva inotevera makasununguka kuzobvunza.
KUPA MVUMO


Runyoro kana tsimba remunwe wearikupa mvumo

Zuva

Zita reari kupa mvumo (Printed)

Runyoro rwemuongorori

Zuva

Runyoro rweChapupu

Zuva
Annex 3: Questionnaire for Women – English

Factors Associated with Defaulting among Women Initiated on Lifelong ART (Option B+)


Questionnaire Number: [ ]  Site Number: [ ]

Section A: Demographic Information

1. How old are you? [ ]

2. What is your marital status? Married [ ] Separated/divorced [ ] Widowed [ ]

3. What is your level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

4. What is your spouse/partner’s level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

5. What is your source of income?  Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

6. What is your spouse/partner’s source of income?  Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

7. What is your religion?  Apostolic (allow use of H/F) [ ] Traditional [ ]
   Apostolic (disallow use of H/F) [ ] Non apostolic [ ]

8. How many times have you been pregnant? [ ]

9. How many children do you have? [ ]

10. How old was your latest pregnancy when you came for booking? [ ]

11. Have you had any miscarriage or still birth?  None [ ] 1 [ ] more than 1 [ ]
12. Did you have any infant who died before reaching the age of 1 year?

- None [  ]
- Once [  ]
- More than once [  ]

Section B: Patient level factors

13. When did you know your HIV status?  

14. Was it during pregnancy or during breastfeeding?  

- Yes [  ]
- No [  ]

15. How long after testing did you start ART?  

- Immediately [  ]
- One week to one month after [  ]
- More than one month later [  ]

16. (If not immediately) What were the reasons for the delay?  

____________________________________________________________________

17. How did you feel when you were first told about your HIV status?  

____________________________________________________________________

18. How did you feel when you were first told about Option B+?  

____________________________________________________________________

19. Does your partner know your HIV status?  

- Yes [  ]
- No [  ]

20. If yes, how long after testing did you tell him about your status?  

- Immediately [  ]
- One week to a month after [  ]
- More than one month after [  ]

21. What was his first response?  

____________________________________________________________________

22. Is he supportive?  

- Yes [  ]
- No [  ]

23. Please explain  

____________________________________________________________________

24. Have you disclosed your status?  

- Yes [  ]
- No [  ]

25. Who was the first person that you told about your status?  

- Partner/husband [  ]
- Own relative [  ]
- Partner’s relative [  ]
- Friend [  ]
26. **Who else did you disclose to?**
   - Partner/husband [ ]
   - Own relatives [ ]
   - Partner’s relatives [ ]
   - Friend(s) [ ]
   - Children [ ]

27. **How did they first respond?**

28. **How do they support you?**

29. **How has disclosure affected your adherence to ART?**

30. **Did you know someone who was on ART before you were initiated?**
   - Yes [ ]
   - No [ ]

31. **Have you experienced any stigma because of your HIV status?**
   - Yes [ ]
   - No [ ]

32. **If yes, please explain**

**Section C: Service related factors**

33. **How far is the health facility from your home?** [ ]

34. **How do you get to the health facility** (mode of transport)?
   - Public transport [ ]
   - Own/family vehicle [ ]
   - Walking [ ]

35. **How long do you take to reach the facility?** [ ]

36. **Do you pay for ART services at the facility?**
   - Yes [ ]
   - No [ ]

37. **If yes, how much do you pay and how often?** US$ [ ]

38. **Are the ART services separate from the other services at the facility?**
   - Yes [ ]
   - No [ ]

39. **How do you feel about the existing set up?**
   - Good [ ]
   - Acceptable [ ]
   - Bad [ ]

40. **How many counselling sessions did you attend?** [ ]

41. **Was it individual or group counselling?**
   - Individual [ ]
   - Group [ ]
   - Both [ ]

42. **(If individual) how long did you take in the individual counselling session?** [ ]

43. **Did you get the opportunity to ask questions during the session(s)?**
   - Yes [ ]
   - No [ ]
44. Were all your questions adequately answered during the counselling sessions?
   Yes [ ]    No [ ]

45. What do you think are the benefits of lifelong ART? (Tick all applicable)
   i) Prevent transmission of the virus from mother to baby [ ]
   ii) Boost mother’s health [ ]
   iii) Prevent transmission of the virus to uninfected partner [ ]

46. What are the challenges related to service delivery at the facility? (Tick all applicable)
   i) Inadequate counselling space [ ]
   ii) Inadequate staff [ ]
   iii) Staff attitudes [ ]
   iv) Lack of confidentiality [ ]
   v) Drug stock outs [ ]

47. What would you suggest/recommend towards improving service delivery?
   ________________________________________________________________
   ________________________________________________________________

Section D: Provider Patient Relationship Factors

48. How do you feel about the way health workers conduct their work at this facility?
   ________________________________________________________________

49. What did the nurses tell you about lifelong ART?
   i) That it is good for your own health [ ]
   ii) That you should take the tablets daily [ ]
iii) That it helps prevent transmission to your baby [ ]

iv) That it protects uninfected partner [ ]

50. Do you feel like you received adequate information? Yes [ ] No [ ]

51. Were you free to ask questions during drug pick up visits? Yes [ ] No [ ]

52. If yes, were all the questions answered adequately? Yes [ ] No [ ]

53. Do you feel free to ask questions even today? Yes [ ] No [ ]

54. Please explain __________________________________________________________

55. What positive experiences have you had at this facility?
________________________________________________________________________
________________________________________________________________________

56. What negative experiences have you had at the facility?
________________________________________________________________________
________________________________________________________________________

Section E: Drug Related Factors

57. How often do you collect your drug supply? Monthly [ ] After 2 months [ ]

58. How do you feel about the interval? Too long [ ] Just good [ ]

Too short [ ]

59. Have you ever run out of your drug supply? Yes [ ] No [ ]

60. If yes, what did you then do when you ran out of medication? Nothing [ ] Bought from private pharmacy [ ] Collected at other facility [ ] Borrowed from friend [ ]

61. Have you ever skipped taking your medication? Yes [ ] No [ ]

62. If yes, how often? Once [ ] Twice [ ] More than twice [ ]
63. If yes, what were the reasons for skipping medication?
________________________________________________________________________
________________________________________________________________________

64. Have you ever failed to get supply at the facility?  
   Yes [  ]  No [  ]

65. If yes, what did you then do when you failed to get supply?  
   Nothing [  ]  Bought
   from private pharmacy [  ]  Collected at other facility [  ]  Borrowed from friend [  ]

66. What were you told about the drugs in relation to side effects?
________________________________________________________________________

67. Have you experienced any side effects?  
   Yes [  ]  No [  ]

68. If yes, please explain ___________________________________________________________________

69. Do you still have them now?  
   Yes [  ]  No [  ]

70. How did you overcome them?

i)   I went to the hospital [  ]

ii)  I stopped taking medication [  ]

Thank you for participating in the interview.
Annex 4: Questionnaire for Women – Shona

Ongorororo yekutsvakurudza zvingadaro zvichikonzera kuti vana amai vakazvitakura nevari kuyamwisa vamire kunwa mushonga wekudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana muzvipatara zvemumadhorobha - 2015

Chikamu Chekutanga: Mamiriro emunhu nezvaanoita muhupenyu

1. Mune makore mangani? [  ]
2. Makaroorwa here? Ndakaroorwa [ ] Takarambana/takasiyana [ ]
   Mumwe wangu akashayika [ ]
3. Makasvika papi pazvidzidzo zvenyu? Handina kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Ndakasvika kukoreji [ ]
4. Ko mumwe wenyu akasvika papi pazvidzidzo zvake? Haana kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Akasvika kukoreji [ ]
5. Ndezvipi zvinokuwanisai mari yokurarama? Ndinoenda kubasa [ ]
   Ndinoshanda muvanhu [ ] Ndinozvishandira [ ] Handishandi [ ]
6. Ndezvipi zvinowanisa mumwe wenyu mari yekurarama? Anoenda kubasa [ ]
   Anoshanda muvanhu [ ] Anozvishandira [ ]
   Haaendi kubasa [ ]
7. Muri vechitendero chipi? Mapositori (anobvumidzwa kuenda kuchipatara [ ]
   Mapositori asingabvumidzwi kuenda kuchipatara [ ]
   Dzimwewo chechi dzisiri dzechipositori [ ]
8. Makabata pamuviri pangani muupenyu hwenyu? ______________________
9. Mune vana vangani? __________

10. Pamakuya kuzonyoresa pamuviri penyu pekupedzisira pakanga pave nemwedzi mingani? __________

11. Makambobva/ makambotadza pamuviri here kana kubereka mwana akabuda akashaika?  Handisati [ ]  Kamwe chete [ ]  Kanopfuura kamwe chete [ ]

12. Makambobereka mwana akashaika asati akwanisa gore rimwe chete here?
   Handisati [ ]  Kamwe chete [ ]  Kanopfuura kamwe chete [ ]

Chikamu Chechipiri: Zvine chekuita nemurwere

13. Makaziva rinhi pamumire maererano neHIV? ______________________

14. Makanga muine pamuviri here kana cuti muchiyamwisa? ______________________

15. Makazotanga kunwa mushonga kwaperanga nguva yakadii kubva pamakaziva pamumire?  Ipapo ipapo [ ]  Kwaperanga svondo kusvika pamwedzi umwe chete [ ]
   Kwapfuura mwedzi [ ]

16. (Kana musina kutanga ipapo ipapo) chii chakakonzera kuti munonoke kutanga kunwa mushonga?
   ____________________________________________________________

17. Makanzwa sei pamakatanga kuudzwa nezvemamiriro enyu maererano neHIV?
   ____________________________________________________________

18. Makanzwa sei pamakatanga kuudzwa nezvekunwa mushonga kwehupenyu hwese (Option B+)?
   ____________________________________________________________

19. Mumwe wenyu anoziva here mamiriro enyu?  Hongu [ ]  Kwete [ ]
20. Kana achiziva, makamuzivisa kwapera nguva yakadii kubva pamakaziva imi

mamiriro enyu? Ipopo ipapo [ ] Kwapera svondo kusvika

pamwedzi umwe chete [ ] Kwapfuura mwedzi [ ]

21. Pamakatanga kuvazivisa vakazvitambira sei? _________________________

22. Vanokukurudzirai pakunwa mushonga here? Hongu [ ] Kwete [ ]

23. Tsanangurai ________________________________

24. Makazivisa vamwe vanhu here nezvemamiriro enyu? Hongu [ ] Kwete [ ]

25. Ndimi munhu wamakatanga kuzivisa nezvemamiriro enyu? Mumwe wangu [ ]

Hama yangu [ ] Hama yeumwe wangu [ ] Shamwari yangu [ ]

26. Ndimanizve umuve wamakazozivisa? Mumwe wangu [ ] Hama yangu [ ]

Hama yeumwe wangu [ ] Shamwari yangu [ ] Mwana wangu [ ]

27. Pamakatanga kuvazivisa vakazvitambira sei? _________________________

28. Vakakukurudzirai nenzira dzipi? _________________________________

29. Kuzivisa vamwe maererano nemamiriro enyu kwakakubatsirai kana kuti

kwakakukanganisai sei pamanwiro enyu emushonga?

_______________________________________________________________________

________________________________________________________________________

30. Maiziva here mumwe akanga ari pamushonga imi musati matanga kuuunwa?

Hongu [ ] Kwete [ ]

31. Pane pamakambosangana nekusemwa kana kubatwa zvakasiyana nevamwe nekuda

kwemamiriro enyu here? Hongu [ ] Kwete [ ]

32. Kana mati hongu, tsanangurai _________________________________
Chikamu Chechitatu: Zvine chekuita nekuwana rubatsiro pachipatara

33. Chipatara chiri kure zvakadii nekwamunogara? __________________________

34. Munofamba nei kuuya kuchipatara? Kombi/ bhazi [ ] Mota
    yemhuri [ ] tinofamba netsoka [ ]

35. Munotora nguva yakareba sei kuti musvike pachipatara? __________________

36. Pachipatara apa munobhadhara here kuti muwane mushonga wenyu?
    Hongu [ ] Kwete [ ]

37. Kana mati hongu munobhadhara marii uye panguva yakadii? ______________

38. Pamunotorera mushonga wenyu pakasiyana here nepanowanikwa rumwe rubatsiro
    pachipatara? Hongu [ ] Kwete [ ]

39. Munonzwa sei nemamiriro aripo aya? Akanaka [ ] Anogamuchirika [ ]
    Akashata [ ]

40. Makapinda muzvidzidzo zvekupangwa mazano zvingani?
    __________________________

41. Maidzidziswa muri mega here kana kuti seboka? Ndega [ ] Seboka [ ]
    Zvese [ ]

42. (Kana makadzidziswa muri mega) makatora nguva yakareba zvakadii muri
    muchidzidzo chimwe chete? ________________________________

43. Makawana mukana wekubvunza mibvunzo here pamaidzidziswa?
    Hongu [ ] Kwete [ ]

44. Mibvunzo yenyu yakapindurwa zvizere here pamaidzidziswa?
    Hongu [ ] Kwete [ ]
45. Ndezvipi zvamunofunga kuti zvakanakira kunwa mushonga wekuderedza

hutachiwana muropa kwehupenyu hwese?

Kudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana [ ]
Kuchengetedzwa kwehutano hwaamai [ ]
Kudzivirira kutapurirwa kwehutachiwana kune umwe wangu kana anga asina

hutachiwana [ ]

46. Ndeapi matambudziko amunosangana nawo pakuwana rubatsiro pachipatara?

Hapana nzvimbo yakasununguka yekuitira zvidzidzo zvekupangwa mazano [ ]
Vashandi vashoma [ ] Kusasununguka kwevashandi [ ]
Vashandi havachengetedzi zvakavanziika [ ] Mishonga inomboshaiika [ ]

47. Ndezvipi zvamungakurudzira kuti kuwana rubatsiro kuve nyore?

___________________________________________________________

___________________________________________________________

Chikamu Chechina: Hukama pakati pevarapi nevarwere

48. Munoo na sei mashandiro avana mukoti pachipatara chino?

_______________________________________________________________________

49. Vana mukoti vakakuudzai chii maererano nekunwa mushonga kwehupenyu hwese?

Vakati zvakanakira hutano hwangu saamai [ ]
Vakati ndinofanirwa kunwa mushonga uyu zuva rega rega [ ]
Vakati unodzivirira kutapurirwa mwana hutachiwana [ ]
Vakati unodzivirira kutapurirwa umwe wangu hutachiwana [ ]
50. Munoona sekuti makawana ruzivo rwakakwana here pavakakudzidzisai?

Hongu [ ] Kwete [ ]

51. Makanga makasunguka here kubvunza mibvunzo pamaiuya kuzotora mushonga?

Hongu [ ] Kwete [ ]

52. Kana mati hongu, mibvunzo yenyu yese yakapindurwa zvizere here?

Hongu [ ] Kwete [ ]

53. Munonzwa makasununguka here kubvunza mibvunzo kunyange pari zvino?

Hongu [ ] Kwete [ ]

54. Tsanangurai _____________________________________________________________

55. Ndezviyi zvakanaka zvamakabatsirika pachipatara chino?

________________________________________________________________________

56. Ndezviyi zvakashata zvamakasangana nazvo pachipatara chino?

________________________________________________________________________

Chikamu Cheshanu: Kuwanikwa Kwemishonga

57. Munotora mushonga wekunwa kwenguva yakareba sei musati madzokera kunotora

umwe kuchipatara? Svondo mbiri [ ] Mwedzi wega wega [ ]

Mwedzi miviri [ ]

58. Munoiwona sei nguva iyi? Yakarebesa [ ] Yakanaka [ ] Ipfupisa [ ]

59. Makambopererwa nemushonga here? Hongu [ ] Kwete [ ]

60. Chii chamakaita pamakapererwa nemushonga? Hapana [ ]

Ndakatenga [ ] Ndakanotora kune chimwe chipatara [ ]

Ndakakumbira kushamwari [ ]

61. Makambodarikira here kunwa mushonga wenyu? Hongu [ ] Kwete [ ]
62. Kana mati hongu, kangani? Kamwe chete [ ] Kaviri [ ]

Kanopfuura kaviri [ ]

63. Kana makadarikira, chii chakakonzera kuti mudarikire kunwa mushonga?

64. Makambosvika pachipatara mukatadza kuwana mushonga here?

Hongu [ ] Kwete [ ]

65. Kana mati hongu, chii chamakaita pamakashaya mushonga? Hapana [ ]

Ndakatenga [ ] Ndakanotora kune chimwe chipatara [ ]

Ndakakumbira kushamwari [ ]

66. Ndezviyi zvamakaudzwa maererano nezvinetso/ matambudziko angawanikwa kubva mukunwa mushonga uyu (side effects)?

67. Pane zvamakambosangana nazvo here kuburikidza nekunwa mushonga uyu?

Hongu [ ] Kwete [ ]

68. Kana mati hongu, tsanangurai ________________________________

69. Muchiri kusangana nematambudziko aya here? Hongu [ ] Kwete [ ]

70. Kana mati kwete makaakunda sei matambudziko aya?

Ndakaenda kuchipatara [ ] Ndakamira kunwa mushonga [ ]

Tatenda
Factors Associated with Defaulting among Women Initiated on Option B+ in Urban Clinics - 2015

Section A: Staffing levels

1. How many nurses are in the Maternal Neonatal and Child Health (MNCH) department? [ ]
2. How many are supposed to be in the department? [ ]
3. How many of these were trained in Option B+? [ ]
4. How many of the trained are still with the department? [ ]
5. If some have left, what were the reasons for leaving the department?
   ________________________________________________________________

Section B: Infrastructure

6. Do you have separate facilities/ rooms for Option B+? Yes [ ] No [ ]
7. Do you have a separate room for counselling services? Yes [ ] No [ ]
8. How do you usually conduct counselling sessions? Group counselling [ ]
   Individual counselling [ ] Both [ ]
9. How long does a group counselling take averagely [ ]
10. How long does an individual counselling session usually take? [ ]

Section C: Medicines

11. Have you had ART medicines stock outs from January 2015 to date?
    Yes [ ] No [ ]
12. If yes, for how long? [ ]

13. Which medicines were out of stock? _____________________________

14. Have you had any ART medicines that expired on you from January 2015 to date?
   Yes [ ]       No [ ]

15. If yes, which medicines expired on you? _____________________________

16. For how long do you supply Option B+ clients?   Two weeks [ ]
     1 month [ ]         2 months [ ]

17. How do they know their next pick up date _____________________________

18. Do you give a grace period when giving the resupply date? Yes [ ]      No [ ]

19. If yes, how long is the grace period/ buffer supply? [ ]

20. When do you classify someone as having defaulted treatment ______________

Section D: Service Delivery

21. How many clients were registered for Option B+ from January to March 2015?
    __________________

22. How many of the registered actually initiated lifelong ART? [ ]

23. How many of those who initiated have since missed at least one scheduled medicine
    pick up visit? [ ]

24. How many of these are still coming for their supplies? [ ]

25. What proportion is this? [ ]

26. What is your comment about these figures?
    ____________________________________________________________________
    ____________________________________________________________________
27. On average, how long does a woman on Option B+ spend waiting for their turn to be served when they come for medicine pick up? [ ]

28. Do you have a specific day for medicine pick up? Yes [ ] No [ ]

29. If yes, averagely how many clients are expected to be served on a medicine pick up day? [ ]

30. How do you identify those who miss the scheduled pick up visit?

____________________________________________________________________

31. How do you follow up those who miss their scheduled resupply visits?

____________________________________________________________________

____________________________________________________________________

32. What do you think are the reasons why mothers initiated on Option B+ default treatment?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

33. What do you think can be done to retain mothers on lifelong treatment?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Thank you for your participation.
Annex 6: Key Informant Guide – Shona

Mibunzo vaana Mukoti

Ongorororo yekutsvakurudza zvingadaro zvichikonzera kuti vana amai vakazvitakura nevari kuyamwisa vanire kunwa mushonga wekudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana muzvipatara zvemumadhorobha - 2015

Chikamu Chekutanga: Kuwanikwa Kwevashandi

1. Pane vakoti vangani vanoshandira kuchikamu chezve vana (MNCH department)?
   [ ]

2. Kuchikamu ichi kunofanirwa kunge kuine vakoti vangani? [ ]

3. Pavakoti ava, vangani vavo vakaita zvedzidzo zvekupa vana amai vakazvitakura nevari kuyamwisa mushonga wekunderedza hutachiona muropa kwehupenyu hwese (Option B+)? [ ]

4. Pane vakadzidziswa vangani vachiri kushandira kuchikamu chezvevana? [ ]

5. (Kana pane vasisiko), ndezipi zvikonzero zvekusiya kushandira chikamu ichi?
   ________________________________________________________________

Chikamu Chechipiri: Zvivakwa

6. Mune imba/dzimba dzakazvimirira dzega here dzekupira vana amai mushonga wekunderedza hutachiwana muropa kwehupenyu hwese?  Hongu [ ]  Kwete [ ]

7. Mune imba iri yega here yakangomirira kushandiswa pakupa vana amai zvidzidzo zvekupanga mazano?  Hongu [ ]  Kwete [ ]
8. Zvidzidzo zvekupanga mazano munowanza kuzvipa nenziра ipi? Mumapoka [ ]

Mumwe mumwe [ ] Nzira dzese dziri mbiri [ ]

9. Chidzidzo chimwe chete chekupanga mazano vana amai vari seboka chinowanza kutora nguva yakadii? [ ]

10. Chidzidzo chimwe chete chekupanga mazano kumudzimai mumwe chete chinowanza kutora nguva yakadii? [ ]

Chikamu Chechitatu: Mishonga

11. Makambopererwa nemishonga inodiwa naana amai pakuderedza hutachiwana muropa kwehupenyu hwese here kubva muna Ndira wego re rino?

Hongu [ ] Kwete [ ]

12. Kana mati hongu, kwenguva yakareba zvakadii?

13. Ndeyipi mishonga yakanga yapera?

14. Pane mishonga yekuderedza hutachiona muropa yakambopfuuridza mazuva ainofanirwa kushandiswa iri pachipatara chino here? Hongu [ ] Kwete [ ]

15. Kana mati hongu, ndeipi mishonga yakapfuuridza mazuva ainofanira kushandiswa?

16. Vana amai vakazvitakura nevanoyamwisa vari pamushonga wekuderedza hutachiwana muropa kwehupenyu hwese munopa mushonga wawanomwa kwenguva yakareba zvakadii vasati vadzoka kuzotora umwe? Svondo mbiri [ ]

Mwedzi mumwe [ ] Mwedzi miviri [ ]
17. Vana amai vanoziva sei zuva ravanofanira kudzoka kuzotora umwe mushonga?

________________________________________________________________________

18. Pamunovazivisa zuva rekudzoka kumushonga munocherechedzawo chinguva chemutsa here (grace period)?   Hongu [ ] Kwete [ ]

19. Kana mati hongu, munopa chinguva chakareba sei?

________________________________________________________________________

20. Ndepapi pamunozocherechedza munhu sokuti wamira kutora mushonga?

________________________________________________________________________

________________________________________________________________________

Chikamu Chechina: Kuwana Rubatsiro

21. Madzimai mangani akanyorwa kuti apinde pamushonga wekuderedza hutachiwana muropa kwehupenyu hwese kubva muna Ndira kusvika muna Kurume gore rino? [ ]

22. Vangani vavo vakatangisa kutora mushonga uyu? [ ]

23. Pane vakatangisa kutora mushonga, vangani vavo vakambodarikira kuuya kuzotora mushonga pazuva ravaive vapihwa kana kamwe chete zvako? [ ]

24. Vangani vavo vachiri kuuya kuzotora mushonga wavo nguva dzose? [ ]

25. Chidimbu chakadii chichiri kuuya kuzotora mushonga nguva dzose kana zvichienzaniswe nemadzimai ese akatanga kutora mushonga? [ ]

26. Munoti kudii nehuwandu uhwu?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
27. Amai vanenge vauya kuzongotora mushonga wavo vanowanza kutora nguva yakadii vakamirira kuwana rubatsiro? [ ]

28. Mune zuva ramunoti vana amai ava vauye vese pamwe chete kuzotora mushonga here?  Hongu [ ]  Kwete [ ]

29. Kana mati hongu, munotarisira kuona vana amai vakawanda zvakadii pazuva ravanouya vese? [ ]

30. Munozoziva sei vana amai vanenge vasina kuuya kuzotora mushonga?

________________________________________________________________________

________________________________________________________________________

31. Munotevera sei vana amai vanenge vasina kuuya kuzotora mushonga?

________________________________________________________________________

________________________________________________________________________

32. Munofunga kuti ndezvipi zvikonzero zvinoita kuti vana amai vanenge vari pamushonga wekuderedza hutachiwana muropa kwehupenyu hwese vamire kutora mushonga?

________________________________________________________________________

________________________________________________________________________

33. Ndezvipi zvamunofunga kuti zvingabatsira kuti vana amai varambe vachitora mushonga wavo?

________________________________________________________________________

Ndatenda
Annex 7: Focus Group Discussion Guide – English

Factors Associated with Defaulting among Women Initiated on Lifelong ART (Option B+) in Urban Clinics – 2015.

Focus Group Discussion Guide for Women on Option B+.

Date of the Focus Group Discussion: ______________________

Health Facility: ______________________

Number of Participants: ______________________

Starting Time: ______________________

Section A: Patient related factors

1. Do people in this community find it easy to disclose their HIV status to their husbands/partners?

2. For those who disclose their HIV status, how long after testing do they usually disclose?

3. For those who do not disclose what do you think are the reasons for not disclosing?

4. After disclosure, do men support their partners?

5. Is it easy to disclose HIV status to other people?

6. How does disclosure affect adherence on lifelong ART?

7. What can you say about stigma issues in this community?

Section B: Service related factors

8. What can you say about the place where you collect your medication?

9. How are counselling sessions usually conducted at this clinic?
10. Do people get opportunity to ask questions and are the questions adequately answered during counselling sessions?

11. What does the community say are the benefits of lifelong ART?

12. What service related challenges are faced by people who are on lifelong ART at this clinic?

Section C: Provider – patient relationship factors

13. What do the health workers say/ teach about lifelong ART?

14. Are people free to ask questions when they come to collect their medication?

15. What positive experiences do people experience at this facility?

16. What negative experiences do people encounter at this facility?

Section D: Drug related factors

17. Does the clinic sometimes run out medicines?

18. What do people usually do when they run out of medicines?

19. Are the issues of defaulting lifelong treatment common in this community?

20. If so, what do you think are the reasons for defaulting?

21. Are there people who experience drug side effects?

22. Which are some of the common drug side effects and how do people overcome them?

End Time: ____________________

Thank you
Annex 8: Focus Group discussion Guide – Shona

Ongororo vekutsvakurudza zvingadaro zvichikonzera kuti vana amai vakazvitakura nevari kuyamwisa vamire kunwa mushonga wekudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana muzvipatara zvemumadhorobha.

Gwaro rinotungamirira pahurukuro dzemuzvikwata nemadzimai ari kutora mushonga wekuderedza hutachiwana muropa kwehupenyu hwese.

Zuva raitwa hurukuro: ______________________________________

Zita reChipatara: ____________________________

Nhamba yevanhu vapinda muhurukuru: ____________________________

Nguva dzatangiswa hurukuro: ____________________________

Chikamu Chekutanga: Zvine chekuita nemurwere

1. Vanhu vemunharaunda vanoona zviri nyore here kuzivisa varume/ shamwari dzavo dzepabonde mamiriro avo maererano neHIV?

2. Kune avo vanozivisa varume/ shamwari dzavo vanozviita kwapera nguva yakadii kubva pavanenge vaziva ivo mamiriro avo?

3. Kune vasingazivisi varume/ shamwari dzavo, chii chingadaro chichikonzera kuti vasavazivise?

4. Ko varume kana vozoziviswa vanokurudzira here vana amai pakunwa mushonga wekuderedza hutachiwana muropa kwehupenyu hwese?
5. Zviri nyore here kuzivisa vamwewo vanhu paumire maererano neHIV?

6. Kuzivisa vanwe kunobatsira kana kukanganisa sei pakunwa mushonga?

7. Ko nyaya dzekusema vanhu vari kurarama nehutachiwana hweHIV dzakamirawo sei munharaunda yamunogara?

**Chikamu Chechipiri: Zvine chekuita nekuwana rubatsiro pachipatara**

8. Munooona sei mamiriro akaita nzimbo yamunotorera mushonga?

9. Ko zvidzidzo zvekupangwa mazano zvinowanzo pihwa nenzira dzipi pachipatara chino?

10. Vanhu vanowana mukana wekubvunza mibvunzo here uye mibvunzo yavo inopindurwa zvakakwana here panguva yekupangwa mazano?

11. Ndezvipi zvinoonekwa sekuti zvakakanira kunwa mushongwa wekuderedza hutachiwana muropa kwehupenyu hwese?

12. Ndeapi matambudziko anosanganikwa nawo pakuwana rubatsiro pachipatara chino?

**Chikamu Chechitatu: Hukama pakati pevarapi nevarwere**

13. Ndezvipi zvinotaurwa/ zvonozidziswa navana mukoti maererano nekunwa mushonga wekuderedza hutachiwana muropa kwehupenyu hwese?

14. Vanhu vakasununguka here kubvunza mibvunzo pavanouya kuzotora mushonga pachipatara pano?

15. Ndezvipi zvinoonekwa sezvakanaka zvinobatsirwa vanhu nazvo pachipatara chino?

16. Ndezvipi zvinoonekwa sezvakashata zvinosanganikwa nazvo pachipatara chino?

**Chikamu Chechina: Kuwanikwa kwemishonga**

17. Ko mushonga wacho unomboshaiwanda pachipatara chino here?
18. Ndezvipi zvinowanzoitwa nevanhu kana vashaya kana kuti vapererwa nemushonga?

19. Zvekumira kunwa mushonga wekuderedza hutachiwana muropa kwehupenyu hwese zvinowanikwawo here munharaunda ino?

20. Kana zvichiwanikwa chii chingadaro chichikonzera kuti vanhu vambomira kunwa mushonga uyu?

21. Zvinetso kana matambudziko anosanganiwa náwó kuburikidza nemushonga (side effects) anombosanganikwawo náwó here munharaunda ino?

22. Ndeapi amwe ematambudziko aya uye vanhu vanoakurira sei?

Nguva yapera hurukuro: ________________

Tatenda
Factors Associated with Defaulting among Women Initiated on Lifelong ART (Option B+)

In depth interview for women who have defaulted treatment.

Section A: Demographic Information

1. How old are you? [ ]

2. What is your marital status? Married [ ] Separated/divorced [ ] Widowed [ ]

3. What is your level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

4. What is your spouse/partner’s level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

5. What is your source of income? Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

6. What is your spouse/ partner’s source of income? Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

7. What is your religion? Apostolic (allow use of H/F) [ ] Traditional [ ]
   Apostolic (disallow use of H/F) [ ] Non apostolic [ ]

8. How many times have you been pregnant? [ ]

9. How many children do you have? [ ]

10. How old was your latest pregnancy when you came for booking? [ ]
11. Have you had any miscarriage or still birth? None [ ] 1 [ ] more than 1 [ ]
12. Did you have any infant who died before reaching the age of 1 year?
   None [ ] Once [ ] More than once [ ]

Section B: Patient level factors

13. When did you know your HIV status? _________________________________
14. Was it during pregnancy or during breastfeeding? Yes [ ] No [ ]
15. How long after testing did you start ART? Immediately [ ]
   One week to one month after [ ] More than one month later [ ]
16. (If not immediately) What were the reasons for the delay? _________________________________
17. How did you feel when you were first told about your HIV status?
   ___________________________________________________________________________________
18. How did you feel when you were first told about Option B+?
   ___________________________________________________________________________________
19. Does your partner know your HIV status? Yes [ ] No [ ]
20. If yes, how long after testing did you tell him about your status? Immediately [ ]
   one week to a month after [ ] more than one month after [ ]
21. What was his first response? __________________________________________________________________________
22. Is he supportive? Yes [ ] No [ ]
23. Please explain ______________________________________________________________________________________
24. Have you disclosed your status? Yes [ ] No [ ]
25. Who was the first person that you told about your status? Partner/husband [ ]
   own relative [ ] Partner’s relative [ ] Friend [ ]
26. Who else did you disclose to? Partner/husband [ ] own relatives [ ]
   partner’s relatives [ ] friend(s) [ ] Children [ ]

27. How did they first respond? ____________________________________________

28. How do they support you? _____________________________________________

29. How has disclosure affected your adherence to ART?
   ______________________________________________________________________

30. Did you know someone who was on ART before you were initiated? Yes [ ] No [ ]

31. Have you experienced any stigma because of your HIV status? Yes [ ] No [ ]

32. If yes, please explain _________________________________________________

Section C: Service related factors

33. How far is the health facility from your home? [ ]

34. How do you get to the health facility (mode of transport)?
   Public transport [ ] own/family vehicle [ ] walking [ ]

35. How long do you take to reach the facility? [ ]

36. Do you pay for ART services at the facility? Yes [ ] No [ ]

37. If yes, how much do you pay and how often? US$ [ ]

38. Are the ART services separate from the other services at the facility? Yes [ ] No [ ]

39. How do you feel about the existing set up? Good [ ] Acceptable [ ] Bad [ ]

40. How many counselling sessions did you attend? [ ]

41. Was it individual or group counselling? Individual [ ] Group [ ] Both [ ]

42. (If individual) how long did you take in the individual counselling session? [ ]

43. Did you get the opportunity to ask questions during the session(s)? Yes [ ] No [ ]
44. Were all your questions adequately answered during the counselling sessions?
   Yes [ ]     No [ ]

45. What do you think are the benefits of lifelong ART? (Tick all applicable)
   Prevent transmission of the virus from mother to baby [ ]
   Boost mother’s health [ ]
   Prevent transmission of the virus to uninfected partner [ ]

46. What are the challenges related to service delivery at the facility? (Tick all applicable)
   Inadequate counselling space [ ]
   Inadequate staff [ ]
   Staff attitudes [ ]
   Lack of confidentiality [ ]
   Drug stock outs [ ]

47. What would you suggest/ recommend towards improving service delivery?
   __________________________________________________________
   __________________________________________________________

Section D: Provider Patient Relationship Factors

48. How do you feel about the way health workers conduct their work at this facility?
   __________________________________________________________
49. What did the nurses tell you about lifelong ART?

That it is good for your own health [ ]

That you should take the tablets daily [ ]

That it helps prevent transmission to your baby [ ]

That it protects uninfected partner [ ]

50. Do you feel like you received adequate information? Yes [ ] No [ ]

51. Were you free to ask questions during drug pick up visits? Yes [ ] No [ ]

52. If yes, were all the questions answered adequately? Yes [ ] No [ ]

53. Do you feel free to ask questions even today? Yes [ ] No [ ]

54. Please explain ____________________________________________________________

55. What positive experiences have you had at this facility?

_________________________________________________________________________

_________________________________________________________________________

56. What negative experiences have you had at the facility?

_________________________________________________________________________

_________________________________________________________________________

Section E: Drug Related Factors

57. How often do you collect your drug supply? Monthly [ ] After 2 months [ ]

58. How do you feel about the interval?

Too long [ ] Just good [ ] Too short [ ]

59. Have you ever run out of your drug supply? Yes [ ] No [ ]
60. If yes, what did you then do when you ran out of medication?  Nothing [ ]  Bought from private pharmacy [ ]  Collected at other facility [ ] Borrowed from friend [ ]

61. Have you ever skipped taking your medication?  Yes [ ]  No [ ]

62. If yes, how often?  Once [ ]  Twice [ ]  More than twice [ ]

63. If yes, what were the reasons for skipping medication?

__________________________________________________________________  ____________________________________

__________________________________________________________________  ____________________________________

64. Have you ever failed to get supply at the facility?  Yes [ ]  No [ ]

65. If yes, what did you then do when you failed to get supply?  Nothing [ ]  Bought from private pharmacy [ ]  Collected at other facility [ ] Borrowed from friend [ ]

66. What were you told about the drugs in relation to side effects?

__________________________________________________________________

__________________________________________________________________

67. Have you experienced any side effects?  Yes [ ]  No [ ]

68. If yes, please explain  ____________________________________________

69. Do you still have them now?  Yes [ ]  No [ ]

70. How did you overcome them?

I went to the hospital [ ]

I stopped taking medication [ ]

Thank you for participating in the interview.
Annex 10: In Depth Interview Guide for Cases – Shona

Ongorororo yekutsvakurudza zvingadaro zvichikonzera kuti vana amai vakazvitakura nevari kuyamwisa vampire kunwa mushonga wekudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana muzvipatara zvemumadhorobha – 2015

Gwaro rinotumgamira hurukuro dzakadzama naana amai vakamira kutora mushonga wekuderedza hutachiwana muropa kwehupenyu hwese.

Chikamu Chekutanga: Mamiriro emunhu nezvaanoita muhupenyu

1. Mune makore mangani? [ ]

2. Makarooorwa here? Ndakarooorwa [ ] Takarambana/takasiyana [ ]
   Mumwe wangu akashayika [ ]

3. Makasvika papi pazvidzidzo zvenyu? Handina kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Ndakasvika kukoreji [ ]

4. Ko mumwe wenyu akasvika papi pazvidzidzo zvake? Haana kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Akasvika kukoreji [ ]

5. Nddezvipi zvinokuwanisai mari yokurarama? Ndinoenda kubasa [ ]
   Ndinoshanda muvanhu [ ] Ndinozvishandira [ ] Handishandi [ ]

6. Nddezvipi zvinowanisa mumwe wenyu mari yekurarama? Anoenda kubasa [ ]
   Anoshanda muvanhu [ ] Anozvishandira [ ]
   Haaendi kubasa [ ]
7. **Muri vechitendero chipi?**  Mapositori (anobvumidzwa kuenda kuchipatara [ ]

Mapositori asingabvumidzwi kuenda kuchipatara [ ]

Dzimwewo chechi dzisiri dzechipositori [ ]

8. **Makabata pamuviri pangani muupenyu hwenyu?**

9. **Mune vana vangani?**

10. **Pamakauya kuzonyoresa pamuviri penyu pekupedzisira pakanga pave nemwedzi mingani?**

11. **Makambobva/ makambotadza pamuviri here kana kubereka mwana akabuda akashaika?**
    - Handisati [ ]
    - Kamwe chete [ ]
    - Kanopfuura kamwe chete [ ]

12. **Makambobereka mwana akashaika asati akwanisa gore rimwe chete here?**
    - Handisati [ ]
    - Kamwe chete [ ]
    - Kanopfuura kamwe chete [ ]

**Chikamu Chechipiri: Zvine chekuita nemurwere**

13. **Makaziva rinhi pamumire maererano neHIV?**

14. **Makanga muine pamuviri here kana kuti muchiyamwisa?**

15. **Makazotanga kunwa mushonga kwaperu nguva yakadii kubva pamakaziva pamumire?**
    - Ipapo ipapo [ ]
    - Kwaperu svondo kusvika pamwedzi umwe chete [ ]

16. **(Kana musina kutanga ipapo ipapo) chi chakakonzera kuti munonoke kutanga kunwa mushonga?**
    - ____________________________________________________________

17. **Makanzwa sei pamakatanga kuudzwa nezvemamiriro enyu maererano neHIV?**
    - ____________________________________________________________
18. Makanzwa sei pamakatanga kuudzwa nezvekunwa mushonga kwehupenyu hwese (Option B+)?

_____________________________________________________________________

19. Mumwe wenyu anoziva here mamiriro enyu?  Hongu [ ]   Kwete [ ]

20. Kana achiziva, makamuzivisa kwapera nguva yakadii cubva pamakaziva imi
   mamiriro enyu?  Ipapo ipapo [ ]   Kwapera svondo kusvika
   pamwedzi umwe chete [ ]   Kwapfuura mwedzi [ ]

21. Pamakatanga kuvaizivisa vakazvimbira sei? ________________________________

22. Vanokukurudzirai pakunwa mushonga here?  Hongu [ ]   Kwete [ ]

23. Tsanangurai ________________________________

24. Makazivisa vanwe vanhu here nezvemamiriro enyu?  Hongu [ ]   Kwete [ ]

25. Ndi an wamakatanga kuvazivisa nezvemamiriro enyu?  Mumwe wangu [ ]
   Hama yangu [ ]   Hama yeumwe wangu [ ]   Shamwari yangu [ ]

26. Ndi anizve umwe wamakazovizisa? Mumwe wangu [ ]   Hama yangu [ ]
   Hama yeumwe wangu [ ]   Shamwari yangu [ ]   Mwana wangu [ ]

27. Pamakatanga kuvaizivisa vakazvimbira sei? ________________________________

28. Vakakukurudzirai nenzira dzipi? ________________________________

29. Kuvazivisa vanwe maererano nemamiriro enyu kwakakubatsirai kana kuti
   kwakakukanganisai sei pamanwiro enyu emushonga?

_____________________________________________________________________

_____________________________________________________________________

30. Maiziva here mumwe akanga ari pamushonga imi musati matanga kuunwa?
   Hongu [ ]   Kwete [ ]
31. Pane pamakambosangana nekusemwa kana kubatwa zvakasiyana nevamwe nekuda kwemamiriro enyu here?  Hongu [ ]  Kwete [ ]

32. Kana mati hongu, tsanangurai ________________________________

Chikamu Chechitatu: Zvine chekuita nekuwana rubatsiro pachipatara

33. Chipatara chiri kure zvakadii nekwamunogara? ______________________

34. Munofamba nei kuuya kuchipatara?  Kombi/ bhazi [ ]  Mota
   yemhuri [ ]  tinofamba netsoka [ ]

35. Munotora nguva yakareba sei kuti musvike pachipatara? __________________

36. Pachipatara apa munobhadhara here kuti muwane mushonga wenyu?
   Hongu [ ]  Kwete [ ]

37. Kana mati hongu munobhadhara marii uye panguva yakadii? ________________

38. Pamunotorera mushonga wenyu pakasiyana here nepanowanikwa rumwe rubatsiro pachipatara?
   Hongu [ ]  Kwete [ ]

39. Munonzwa sei nemamiriro aripo aya?  Akanaka [ ]  Anogamuchirika [ ]
   Akashata [ ]

40. Makapinda muzvidzidzo zvekupangwa mazano zvingani?
   __________________________

41. Maidzidziswa muri mega here kana kuti seboka?  Ndega [ ]  Seboka [ ]
   Zvese [ ]

42. (Kana makadzidziswa muri mega) makatora nguva yakareba zvakadii muri muchidzidzo chimwe chete?
   ________________________________

43. Makawana mukana wekubvunza mibvunzo here pamaidzidziswa?
   Hongu [ ]  Kwete [ ]
44. Mibvunzo yenyu yakapindurwa zvizere here pamaidzidziswa?

Hongu [ ]   Kwete [ ]

45. Ndezvipi zvamunofunga kuti zvakanakira kunwa mushonga wekuderedza

hutachiwana muropa kwehupenyu hwese?

Kudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana [ ]
Kuchengetedzwa kwehutano hwaamai [ ]
Kudzivirira kutapurirwa kwehutachiwana kune umwe wangu kana anga asina

hutachiwana [ ]

46. Ndeapi matambudziko amunosangana nawo pakuwana rubatsiro pachipatara?

Hapana nzvimbo yakasununguka yekuitira zvidzidzo zvekupangwa mazano [ ]
Vashandi vashoma [ ]   Kusasununguka kwevashandi [ ]
Vashandi havachengeticzi zvakavanzika [ ]   Mishonga inomboshaikwa [ ]

47. Ndezvipi zvamungakurudzira kuti kwana rubatsiro kuve nyore?

Chikamu Chechina: Hukama pakati pevarapi nevarwere

48. Munoono sei mashandiro avana mukoti pachipatara chino?

49. Vana mukoti vakakuudzai chii maererano nekunwa mushonga kwehupenyu hwese?

Vakati zvakanakira hutano hwangu saamai [ ]
Vakati ndinofanirwa kunwa mushonga uyu zuva rega rega [ ]
Vakati unodzivirira kutapurira mwana hutachiwana [ ]
50. Munoona sekuti makawana ruzivo rwakakwana here pavakakudzidzisai?

Hongu [ ] Kwete [ ]

51. Makanga makasunguka here kubvunza mibvunzo pamaiuya kuzotora mushonga?

Hongu [ ] Kwete [ ]

52. Kana mati hongu, mibvunzo yenyu yese yakapindurwa zvizere here?

Hongu [ ] Kwete [ ]

53. Munonzwa makasununguka here kubvunza mibvunzo kunyange pari zvino?

Hongu [ ] Kwete [ ]

54. Tsanangurai ________________________________

55. Ndezvipi zvakanaka zvamakabatsirika pachipatara chino?

_____________________________________________

56. Ndezvipi zvakashata zvamakasangana nazvo pachipatara chino?

_____________________________________________

Chikamu Cheshanu: Kuwanikwa Kwemishonga

57. Munotora mushonga wekunwa kwenguva yakareba sei musati madzokera kunotora umwe kuchipatara?

Svondo mbiri [ ] Mwedzi wega wega [ ]

Mwedzi miviri [ ]

58. Munoiwona sei nguva iyi? Yakarebesa [ ] Yakanaka [ ] Ipfupisa [ ]

59. Makambopererwa nemushonga here? Hongu [ ] Kwete [ ]
60. **Chii chamakaita pamakapererwa nemushonga?**  Hapana [ ]
    Ndakatenga [ ]
    Ndakanotora kune chimwe chipatara [ ]
    Ndakakumbira kushamwari [ ]

61. **Makambodarikira here kunwa mushonga wenyu?**  Hongu [ ]  Kwete [ ]

62. **Kana mati hongu, kangani?**  Kamwe chete [ ]  Kaviri [ ]
    Kanopfuura kaviri [ ]

63. **Kana makadarikira, chii chakakonzera kuti mudarikire kunwa mushonga?**  

64. **Makambosvika pachipatara mukatadza kuwana mushonga here?**
    Hongu [ ]  Kwete [ ]

65. **Kana mati hongu, chii chamakaita pamakashaya mushonga?**  Hapana [ ]
    Ndakatenga [ ]
    Ndakanotora kune chimwe chipatara [ ]
    Ndakakumbira kushamwari [ ]

66. **Ndezvipi zvamakaudzwa maererano nezvinetso/ matambudziko angawanikwa kubva mukunwa mushonga uyu (side effects)?**  

67. **Pane zvamakambosangana nazvo here kuburikidza nekunwa mushonga uyu?**
    Hongu [ ]  Kwete [ ]

68. **Kana mati hongu, tsanangurai**  

69. **Muchiri kusangana nematambudziko aya here?**  Hongu [ ]  Kwete [ ]

70. **Kana mati kwete makaakunda sei matambudziko aya?**
    Ndakaenda kuchipatara [ ]  Ndakamira kunwa mushonga [ ]

**Tatenda**
Annex 11: In Depth Interview Guide for Controls – English

Factors Associated with Defaulting among Women Initiated on Lifelong ART (Option B+) in Urban Clinics – 2015.

In depth Interview Guide for Women Who are Still Taking their Lifelong Medicine.

Section A: Demographic Information

1. How old are you? [ ]

2. What is your marital status? Married [ ] Separated/divorced [ ] Widowed [ ]

3. What is your level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

4. What is your spouse/partner’s level of education?
   Never been to school [ ] Primary [ ] Secondary [ ] Tertiary [ ]

5. What is your source of income? Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

6. What is your spouse/partner’s source of income? Formally employed [ ]
   Informally employed [ ] Self-employed [ ] Not working [ ]

7. What is your religion? Apostolic (allow use of H/F) [ ] Traditional [ ]
   Apostolic (disallow use of H/F) [ ] Non apostolic [ ]

8. How many times have you been pregnant? [ ]

9. How many children do you have? [ ]

10. How old was your latest pregnancy when you came for booking? [ ]

11. Have you had any miscarriage or still birth? None [ ] 1 [ ] more than 1 [ ]
12. Did you have any infant who died before reaching the age of 1 year?

None [ ]  Once [ ]  More than once [ ]

Section B: Patient level factors

13. When did you know your HIV status?  ______________________________

14. Was it during pregnancy or during breastfeeding?  

Yes [ ]  No [ ]

15. How long after testing did you start ART?  

Immediately [ ]

One week to one month after [ ]  More than one month later [ ]

16. (If not immediately) What were the reasons for the delay?  ______________________________

17. How did you feel when you were first told about your HIV status?  

18. How did you feel when you were first told about Option B+?  

19. Does your partner know your HIV status?  

Yes [ ]  No [ ]

20. If yes, how long after testing did you tell him about your status?  

Immediately [ ]

One week to a month after [ ]  More than one month after [ ]

21. What was his first response?  ______________________________

22. Is he supportive?  

Yes [ ]  No [ ]

23. Please explain  ______________________________

24. Have you disclosed your status?  

Yes [ ]  No [ ]

25. Who was the first person that you told about your status?  

Partner/husband [ ]

Own relative [ ]  Partner’s relative [ ]  Friend [ ]
26. Who else did you disclose to? Partner/husband [ ] own relatives [ ]
   partner’s relatives [ ] friend(s) [ ] Children [ ]

27. How did they first respond? ____________________________________________

28. How do they support you? _____________________________________________

29. How has disclosure affected your adherence to ART?
   ____________________________________________________________________

30. Did you know someone who was on ART before you were initiated? Yes [ ] No [ ]

31. Have you experienced any stigma because of your HIV status? Yes [ ] No [ ]

32. If yes, please explain ________________________________________________

Section C: Service related factors

33. How far is the health facility from your home? [ ]

34. How do you get to the health facility (mode of transport)?
   Public transport [ ] own/family vehicle [ ] walking [ ]

35. How long do you take to reach the facility? [ ]

36. Do you pay for ART services at the facility? Yes [ ] No [ ]

37. If yes, how much do you pay and how often? US$ [ ]

38. Are the ART services separate from the other services at the facility? Yes [ ] No [ ]

39. How do you feel about the existing set up? Good [ ] Acceptable [ ] Bad [ ]

40. How many counselling sessions did you attend? [ ]

41. Was it individual or group counselling? Individual[ ] Group [ ] Both [ ]

42. (If individual) how long did you take in the individual counselling session? [ ]

43. Did you get the opportunity to ask questions during the session(s)? Yes [ ] No [ ]
44. Were all your questions adequately answered during the counselling sessions?

Yes [ ]    No [ ]

45. What do you think are the benefits of lifelong ART? (Tick all applicable)

- Prevent transmission of the virus from mother to baby [ ]
- Boost mother’s health [ ]
- Prevent transmission of the virus to uninfected partner [ ]

46. What are the challenges related to service delivery at the facility? (Tick all applicable)

- Inadequate counselling space [ ]
- Inadequate staff [ ]
- Staff attitudes [ ]
- Lack of confidentiality [ ]
- Drug stock outs [ ]

47. What would you suggest/ recommend towards improving service delivery?

____________________________________________________________________________
____________________________________________________________________________

Section D: Provider Patient Relationship Factors

48. How do you feel about the way health workers conduct their work at this facility?

____________________________________________________________________________
____________________________________________________________________________
49. What did the nurses tell you about lifelong ART?

That it is good for your own health [ ]
That you should take the tablets daily [ ]
That it helps prevent transmission to your baby [ ]
That it protects uninfected partner [ ]

50. Do you feel like you received adequate information? Yes [ ] No [ ]

51. Were you free to ask questions during drug pick up visits? Yes [ ] No [ ]

52. If yes, were all the questions answered adequately? Yes [ ] No [ ]

53. Do you feel free to ask questions even today? Yes [ ] No [ ]

54. Please explain ______________________________________________________

55. What positive experiences have you had at this facility?

____________________________________________________________________
____________________________________________________________________

56. What negative experiences have you had at the facility?

____________________________________________________________________
____________________________________________________________________

Section E: Drug Related Factors

57. How often do you collect your drug supply? Monthly [ ] After 2 months [ ]

58. How do you feel about the interval?

   Too long [ ] Just good [ ] Too short [ ]

59. Have you ever run out of your drug supply? Yes [ ] No [ ]
60. **If yes, what did you then do when you ran out of medication?**  
   Nothing [ ]  Bought from private pharmacy [ ]  Collected at other facility [ ] Borrowed from friend [ ]

61. **Have you ever failed to get supply at the facility?**  
   Yes [ ]  No [ ]

62. **If yes, what did you then do when you failed to get supply?**  
   Nothing [ ]  Bought from private pharmacy [ ]  Collected at other facility [ ] Borrowed from friend [ ]

63. **What were you told about the drugs in relation to side effects?**

   ______________________________________________________

64. **Have you experienced any side effects?**  
   Yes [ ]  No [ ]

65. **If yes, please explain**

   ______________________________________________________

66. **Do you still have them now?**  
   Yes [ ]  No [ ]

67. **How did you overcome them?**

   I went to the hospital [ ]

   They just disappeared on their own [ ]

---

Thank you for participating in the interview.
Annex 12: In Depth Interview Guide for Controls – Shona

Ongorororo yekutsvakurudza zvingadaro zvichikonzera kuti vana amai vakazvitakura nevari kuyamwisa vamire kunwa mushonga wekudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana muzvipatara zvemumadhorobha.

Gwaro rinotungamira hurukuro dzakadzama naana amai vari kutora mushonga wekuderedza hutachiwana muropa kwehupenyu hwese zvakanaka.

Chikamu Chekutanga: Mamiriro emunhu nezvaanoita muhupenyu

1. Mune makore mangani? [ ]
2. Makaroorwa here? Ndakaroorwa [ ] Takarambana/takasiyana [ ]
   Mumwe wangu akashayika [ ]
3. Makasvika papi pazvidzidzo zvenyu? Handina kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Ndakasvika kukoreji [ ]
4. Ko mumwe wenyu akasvika papi pazvidzidzo zvake? Haana kumboenda kuchikoro [ ]
   Puraimari [ ] Sekondari [ ] Akasvika kukoreji [ ]
5. Ndezvipi zvinokuwanisai mari yokurarama? Ndinoenda kubasa [ ]
   Ndinoshanda muvanhu [ ] Ndinozvishandira [ ] Handishandi [ ]
6. Ndezvipi zvinowanisa mumwe wenyu mari yekurarama? Anoenda kubasa [ ]
   Anoshanda muvanhu [ ] Anozvishandira [ ]
   Haaendi kubasa [ ]
7. **Muri vechitendero chipi?** Mapositori (anobvumidzwa kuenda kuchipatara [ ]
Mapositori asingabvumidzwi kuenda kuchipatara [ ]

Dzimwewo chechi dzisiri dzechipositori [ ]

8. **Makabata pamuviri pangani muupenyu hwenyu?** __________________

9. **Mune vana vangani?** __________

10. **Pamakauya kuzonyoressa pamuviri penyu pekupedzisira pakanga pave nemwedzi mingani?** __________

11. **Makambobva/ makambotadza pamuviri here kana kubereka mwana akabuda akashaika?** Handisati [ ] Kamwe chete [ ] Kanopfuura kamwe chete [ ]

12. **Makambobereka mwana akashaika asati akwanisa gore rimwe chete here?**

   Handisati [ ] Kamwe chete [ ] Kanopfuura kamwe chete [ ]

---

**Chikamu Chechipiri: Zvine chekuita nemurwere**

13. **Makaziva rinhi pamumire maererano neHIV?** __________________

14. **Makanga muine pamuviri here kana kuti muchiyamwisa?** __________________

15. **Makazotanga kunwa mushonga kwaperera nguva yakadii kubva pamakaziva pamumire?** Ipapo ipapo [ ] Kwaperera svondo kusvika pamwedzi umwe chete [ ]

   Kwaperera mwedzi [ ]

16. **(Kana musina kutanga ipapo ipapo) chii chakakonzera kuti munonoke kutanga kunwa mushonga?**

   ______________________________________________________________________

17. **Makanzwa sei pamakatanga kuudzwa nezvemamiriro enyu maererano neHIV?**

   ______________________________________________________________________
18. Makanzwa sei pamakatanga kuudzwa nezvekunwa mushonga kwehupenyu hwese (Option B+)?

19. Mumwe wenyu anoziva here mamiriro enyu? Hongu [ ] Kwete [ ]


21. Pamakatanga kuva zivisa vakazvitambira sei? ________________________________

22. Vanokukurudzirai pakunwa mushonga here? Hongu [ ] Kwete [ ]

23. Tsanangurai ________________________________

24. Makazivisa vamwe vanhu here nezve mamiriro enyu? Hongu [ ] Kwete [ ]

25. Ndi an imu nха wamakatanga kuzivisa nezve mamiriro enyu? Mumwe wangu [ ] Hama yangu [ ] Hama yeumwe wangu [ ] Shamwari yangu [ ]


27. Pamakatanga kuva zivisa vakazvitambira sei? ________________________________

28. Vakakukurudzirai nenzira dzipi? ________________________________

29. Kuzivisa vamwe maererano nemamiriro enyu kwakakubatsirai kana kuti kwakakukanganisai sei pamanwiro enyu emushonga?

________________________________________________________________________
________________________________________________________________________

30. Maiziva here mumwe akanga ari pamushonga imi musati matanga kuunwa?

Hongu [ ] Kwete [ ]
31. Pane pamakambosangana nekusemwa kana kubatwa zvakasiyana nevamwe nekuda
kwemamiriro enyu here?  Hongu [ ]  Kwete [ ]

32. Kana mati hongu, tsanangurai _________________________________

Chikamu Chechitatu: Zvine chekuita nekuwana rubatsiro pachipatara

33. Chipatara chiri kure nzvakadii nekwamunogara? __________________________

34. Munofamba nei kuuya kuchipatara?  Kombi/ bhazi [ ]  Mota
    yemhuri [ ]  tinofamba netsoka [ ]

35. Munotora nguva yakareba sei kuti musvike pachipatara? ___________________

36. Pachipatara apa munobhadhara here kuti muwane mushonga wenyu?
    Hongu [ ]  Kwete [ ]

37. Kana mati hongu munobhadhara marii uye panguva yakadii? ___________________

38. Pamunotorera mushonga wenyu pakasiyana here nepanowanikwa rumwe rubatsiro
    pachipatara?  Hongu [ ]  Kwete [ ]

39. Munonzwa sei nemamiriro aripo aya?  Akanaka [ ]  Anogamuchirika [ ]
    Akashata [ ]

40. Makapinda muzvidzidzo zvekupangwa mazano zvingani?
    __________________________

41. Maidzidziswa muri mega here kana kuti seboka?  Ndega [ ]  Seboka [ ]
    Zvese [ ]

42. (Kana makadzidziswa muri mega) makatora nguva yakareba zvakadii muri
    muchidzidzo chimwe chete? ______________________________________

43. Makawana mukana wekubvunza mibvunzo here pamanidzidziswa?
    Hongu [ ]  Kwete [ ]
44. Mibvunzo yenyu yakapindurwa zvizere here pamaidzidziswa?

Hongu [ ] Kwete [ ]

45. Ndezvipi zvamunofunga kuti zvakanakira kunwa mushonga wekuderedza

hutachiwana muropa kwehupenyu hwese?

Kudzivirira kutapurirwa kwehutachiwana kubva kuna amai kuenda kumwana [ ]
Kuchengedzwa kwehutano hwaamai [ ]
Kudzivirira kutapurirwa kwehutachiwana kune umwe wangu kana anga asina

hutachiwana [ ]

46. Ndeapi matambudziko amunosangana nawo pakuwana rubatsiro pachipatara?

Hapana nzvimbo yakasununguka yekuitira zvidzidzo zvekupangwa mazano [ ]
Vashandi vashoma [ ] Kusasununguka kwevashandi [ ]
Vashandi havachengetedzi zvakavanzika [ ] Mishonga inomboshaiwa [ ]

47. Ndezvipi zvamungakurudzira kuti kuwana rubatsiro kuve nyore?

________________________________________________________________________
________________________________________________________________________

Chikamu Chechina: Hukama pakati pevarapi nevarwere

48. Munoona sei mashandiro avana mukoti pachipatara chino?

________________________________________________________________________

49. Vana mukoti vakakuudzai chii maererano nekunwa mushonga kwehupenyu hwese?

Vakati zvakanakira hutano hwangu saamai [ ]
Vakati ndinofanirwa kunwa mushonga uyu zuva rega rega [ ]
Vakati unodzivirira kutapurira mwana hutachiwana [ ]
50. Munoona sekuti makawana ruzivo rwakakwana here pavakakudzidzisai?
   Hongu [ ]       Kwete [ ]

51. Makanga makasunguka here kubvunza mibvunzo pamaiuya kuzotora mushonga?
   Hongu [ ]       Kwete [ ]

52. Kana mati hongu, mibvunzo yenyu yese yakapindurwa zvizere here?
   Hongu [ ]       Kwete [ ]

53. Munonzwa makasununguka here kubvunza mibvunzo kunyange pari zvino?
   Hongu [ ]       Kwete [ ]

54. Tsanangurai ____________________________________________________________

55. Ndezviyi zvakanaka zvamakabatsirika pachipatara chino?
    ______________________________________________________________________

56. Ndezviyi zvakashata zvamakasangana nazvo pachipatara chino?
    ______________________________________________________________________

Chikamu Cheshanu: Kuwanikwa Kwemishonga

57. Munotora mushonga wekunwa kwenguva yakareba sei musati madzokera kunotora umwe kuchipatara?
   Svondo mbiri [ ]       Mwedzi wega wega [ ]
   Mwedzi miviri [ ]

58. Munoiwona sei nguva iyi?    Yakarebesa [ ]       Yakanaka [ ]       Ipfupisa [ ]

59. Makambopererwa nemushonga here?    Hongu [ ]       Kwete [ ]
60. Chii chamakaita pamakapererwa nemushonga?  Hapana [ ]
   Ndakatenga [ ]  Ndakanotora kune chimwe chipatara [ ]
   Ndakakumbira kushamwari [ ]

61. Makambosvika pachipatara mukatadza kuwana mushonga here?
   Hongu [ ]  Kwete [ ]

62. Kana mati hongu, chii chamakaita pamakashaya mushonga?  Hapana [ ]
   Ndakatenga [ ]  Ndakanotora kune chimwe chipatara [ ]
   Ndakakumbira kushamwari [ ]

63. Ndezvi pi zvamakaudzwa maererano nezvinetso/ matambudziko angawanikwa kubva mukunwa mushonga uyu (side effects)?

   ____________________________________________________________

64. Pane zvamakambosangana nazvo here kuburikidza nekunwa mushonga uyu?
   Hongu [ ]  Kwete [ ]

65. Kana mati hongu, tsanangurai __________________________________________

66. Muchiri kusangana nematambudziko aya here?  Hongu [ ]  Kwete [ ]

67. Kana mati kwete makaakunda sei matambudziko aya?
   Ndakaenda kuchipatara [ ]  Zvakazongoperawo zvega [ ]

Tatenda
29 June 2015

Ms E Muchenje
University of Zimbabwe

Dear Madam

RE: PERMISSION TO CARRY OUT A RESEARCH AT POLYCLINICS

I acknowledge receipt of your letter in connection with the above.

Permission has been granted for you to conduct carryout a research titled: "Factors Associated with Defaulting Among Women Initiated on Option B+" at Mahvuku, Budiriro, Kuwadzana and Rutsanana Polyclinics.

For further assistance please liaise with the Sisters in Charge at the respective Polyclinics.

Yours faithfully

[Signature]

DIRECTOR OF HEALTH SERVICES
IM/rm

c.c. Sister in Charge - Mahvuku Polyclinic
   Sister in Charge - Budiriro Polyclinic
   Sister in Charge - Kuwadzana Polyclinic
   Sister in Charge - Rutsanana Polyclinic
   Nursing Manager
Annex 14: Joint Research Ethics Committee Approval Letter

**APPROVAL LETTER**

Date: 20th August 2015  
JREC Ref: 176/15

Name of Researcher: Ester Muchenje  
Address: University of Zimbabwe, Department of Community Medicine.

Re: Factors Associated With Defaulting Among Women Initiated on Option B+ In Urban Clinics-2015.

Thank you for your application for ethical review of the above mentioned research to the Joint Research Ethics Committee. Please be advised that the Joint Research Ethics Committee has reviewed and approved your application to conduct the above named study. You are still required to obtain MRCZ approval and if required by the nature of your study, RCZ approval as well, before you commence the study.

- **APPROVAL NUMBER**  
  JREC/176/15

- **APPROVAL DATE:**  
  20th August 2015

- **EXPIRY DATE:**  
  19th August 2016

This approval is based on the review and approval of the following documents that were submitted to the Joint Ethics Committee:

a) Completed application form  
b) Full Study Protocol  
c) Informed Consent in English and/or appropriate local language  
d) Data collection tool version:

After this date the study may only continue upon renewal. For purposes of renewal please submit a completed renewal form (obtainable from the JREC office) and the following documents before the expiry date:

a. A Progress report  
b. A Summary of adverse events.  
c. A DSMB report

OHRP IRB Number: IORG 00008914  
PARIKENYATWA GROUP OF HOSPITALS FWA: 00019350
• MODIFICATIONS:

Prior approval is required before implementing any changes in the protocol including changes in the informed consent.

• TERMINATION OF STUDY

On termination of the study you are required to submit a completed request for termination form and a summary of the research findings/results.

Yours sincerely

[Signature]

Professor M M Chidzonga
JREC Chairman
Annex 15: Medical Research council of Zimbabwe (MRCZ) Approval Letter

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

Ref: MRCZ/B/900 31 August, 2015

Ms Ester Muchenje
Department of Community Medicine
College of Health Sciences
University of Zimbabwe
Harare

RE: Factors Associated with Defaulting among Women Initiated on Option B+ in Urban Clinics - 2015

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has reviewed and approved your application to conduct the above titled study. This is based on the following documents (among others) that were submitted to the MRCZ for review:

- Research Protocol
- Informed Consent forms (English and Shona)
- Data Collection Tool, English and Shona

• APPROVAL NUMBER: MRCZ/B/900

This number should be used on all correspondence, consent forms and documents as appropriate.

• TYPE OF REVIEW: EXPEDITED

• EFFECTIVE APPROVAL DATE: 31 August, 2015

• EXPIRATION DATE: 30 August, 2016

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Website should be submitted three months before the expiration date for continuing review.

• SERIOUS ADVERSE EVENT REPORTING: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Website.

• MODIFICATIONS: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Website is required before implementing any changes in the Protocol (including changes in the consent documents).

• TERMINATION OF STUDY: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Website.

• QUESTIONS: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other:

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.

- You’re also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH