

**FACTORS INFLUENCING MALE INVOLVEMENT IN
PREVENTION OF MOTHER-TO-CHILD TRANSMISSION
(PMTCT) OF HIV:
A CASE STUDY OF LUSAKA DISTRICT**

BY

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DECLARATION

I, Nora Lipenda do declare that this dissertation represents my work, has not been previously submitted for a degree at this University or any other University in the world and does not incorporate any published work or material from another dissertation.

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DEDICATION

I dedicate this paper to my late father and mother, Philemon and Beatrice Lipenda. Your undying love keeps me going.

CERTIFICATE OF APPROVAL

The dissertation of **NORA LIPENDA** is approved as fulfilling part of the requirements for the award of the degree of **Master of Arts in Population Studies** at the University of Zambia.

EXAMINER

1.
2.
3.

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ABSTRACT

One of the ways of HIV transmission is from the mother to her unborn child during pregnancy, delivery and breastfeeding, otherwise known as Mother-to-Child-Transmission of HIV. Efforts to curtail this form of transmission of HIV have been made by the government and stakeholders through the Prevention of Mother-to-Child Transmission (PMTCT) of HIV programme. Though uptake has been visible in some quarters, the challenge to capture every pregnant woman to first test for HIV and then enroll for uptake if found positive is great. One reason given for shunning such services has been lack of male involvement (GHAP, 2009). This study examined factors that influence male involvement in PMTCT in Lusaka district. The survey was conducted among 200 male residents in Chelstone, Avondale and Chainda between January and March 2013. Information on trends of PMTCT among residents was obtained from Chelstone and Chainda clinics Maternal and Child Health (MCH) staff. Results revealed that knowledge influences attitude and thereby increases involvement. Stigma and fear of knowing their status are deterring factors among men to go for Voluntary Counselling and Testing (VCT) with their spouses during antenatal care. It is clear from the results that men would choose not to undergo VCT with their spouses but would rather support them through PMTCT services once they test positive for HIV. Lack of confidentiality during couple counselling and among health care givers is another reason men choose to stay away but support their spouses even though they themselves would not go for an HIV test.

It is therefore imperative that efforts be made to encourage men to take part in VCT and not only sit back and watch their spouses undergo the process. The government and other stakeholders should endeavour to improve the situation by instituting HIV and AIDS programmes in the workplace that must include aspects of the importance of partnership in reproductive and family health. Also, health care givers should encourage men in their communities to be fully involved in pregnancy and birth preparedness by promoting facility based deliveries where men are encouraged to be present without fear of stigmatization. Healthcare providers must disseminate information on PMTCT in workplaces as well as communities. If most of these approaches are to work right, stakeholders must improve on the healthcare workforce to improve the ratio of practitioner to patient.

LIST OF ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
APHIA	AIDS Population Health Integrated Assistance
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV /AZT	Anti-Retroviral
CBoH	Central Board of Health
CDC	Centre for Disease Control
CHTC	Couples HIV testing and counselling
CT	Counselling and Testing
CSO	Central Statistical Office
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
GHAP	The Global HIV and AIDS Program
HAART	Highly Active Anti-Retroviral Treatment
HCT	HIV Counselling and Testing
HCCT	HIV Couple Counselling and Testing
HIV	Human Immune Virus
IEC	Information Education & Communication
MCHC	Maternal and Child Health Care
MTCT	Mother-to-Child Transmission
MDG	Millennium Development Goal
MoH	Ministry of Health
NAC	National HIV and AIDS/STI/TB Council
NGO	Non-governmental Organisation
NVP	Nevirapine
PEPFAR	President's Emergency Plan For AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
STI	Sexually Transmitted Infections
TV	Television
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund

USAID	United States Agency for International Development
VCT	Voluntary Counselling & Testing
WHO	World Health Organization
WHOSIS	World Health Organisation Statistical Information System
ZDHS	Zambia Demographic Health Survey
ZDV	Zidovudine

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CHAPTER ONE

INTRODUCTION

1.1 Overview

Since the early 1980s when the first case of HIV infection was diagnosed in the United States of America, HIV has grown into a serious global pandemic. The World Health Organisation, (WHO) (2004), says that HIV and AIDS is a serious threat to mankind and its impact will extend to future generations. In the year 2003, about 33 million adults and children were living with AIDS in the world, of which 2.7 million were recorded in 2002 alone, (WHO, 2004). According to the joint United Nations programme on HIV and AIDS (UNAIDS) and WHO (2004:2), young people, particularly the female ones are at the centre of the global epidemic. A study conducted by the United Nations Population Fund (UNFPA, 2006), indicated that over 1 billion youths (aged 15 to 24 years) worldwide are living with HIV infection.

Among the many ways in which HIV and AIDS is transmitted is from an infected mother to her unborn child – Mother-To-Child-Transmission (MTCT). In Africa about 8 percent of the adult population aged between 15 to 49 years are HIV positive, with estimates of MTCT rates in the range of 25 to 45 percent (UNAIDS/WHO, 2001).

Zambia with a population of over 13 million, is one of the countries hardest hit with the HIV and AIDS epidemic in the world. Although the basic knowledge about HIV and AIDS stands at 99 percent among the adult population (aged 15 to 49), according to the 2007 Demographic and Health survey, the national prevalence rate reduced only slightly from 15.6 percent in 2001/2002 to 14.3 percent in 2007, (CSO ZDHS, 2007). A higher proportion of those who

are HIV positive is among women with a proportion of 17.8 percent compared to 12.6 percent among men (CSO, CBoH, 2007:236).

The prevalence rate of HIV and AIDS among the pregnant women attending antenatal is the largest in Southern Africa and the prevalence gaps are growing wider (UNAIDS/WHO 2004). The MTCT rates in the country are nearly 40 percent with an estimated 25 to 30 percent occurring during pregnancy and delivery and 10 to 15 percent occurring through breastfeeding in the absence of Prevention of Mother-to-Child Transmission of HIV and AIDS (PMTCT) programmes (MoH and NAC, 2001).

Like many other nations in the region and the world, the Zambian government together with civil society has embarked on anti- HIV and AIDS campaign programmes aimed at informing the nation about the negative consequences of HIV and AIDS. Among these programmes is the Prevention of Mother-to-Child Transmission of HIV. Mother-to-child transmission (MTCT) occurs when the HIV virus is passed from a mother to her baby during pregnancy, birth, or breastfeeding. Thus the Prevention of Mother-to-Child Transmission (PMTCT) programme aims to reduce this risk of transmission (UNAIDS, 2002).

According to a study conducted on PMTCT in Zambia in 2003, overall, 96 percent of the respondents knew that HIV and AIDS could be transmitted from the mother to child. The main source of PMTCT information was from health workers (89 percent), and 5 percent from spouses. Peer-education was said to be an effective source of PMTCT information. This information is most common among women than men with a proportion of 76.6 percent to 59.8 percent. It was also revealed that most of the mothers have come to know that an HIV positive woman can obtain a drug during labour to prevent mother-to-child transmission. They also indicated that some syrup is given to the child after birth. Such information is vital for effective control of HIV and AIDS infection (Malungo, 2006).

The statistics above indicate that there is need to do more in as far as dissemination of information about PMTCT services is concerned. With the rate of knowledge among men being low, challenges in utilization of these services arise as men are heads of households and decision makers.

The national programme for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV follows the World Health Organisation (WHO) endorsed four-prong approach: primary prevention of HIV, with a focus on pregnant women; prevention of unwanted pregnancies among HIV positive women or women of unknown status; prevention of HIV transmission from infected mothers to their babies; and care and support to HIV infected families (NAC, 2009). Among the PMTCT activities that government, in collaboration with various stakeholders supports is; counselling and testing, including couple counselling; and male involvement.

Zambia first piloted the PMTCT programme in 1999, and it expanded rapidly due to support and commitment of the government and its development partners (UNAIDS 2009). The National AIDS Council (NAC, 2004) reports that 40 percent of babies born to HIV infected mothers are infected with the virus. In recent years, the evidence in support of feasible interventions to reduce MTCT of HIV has been growing. In 1994 research showed that 3 months treatment with the drug Zidovudine (ZDV) for the mother at the end of the pregnancy and at the time of labour as well as 6 weeks treatment for the infant, while not breastfeeding would reduce MTCT by two thirds (WHO, 1998). However the absence of men in antenatal care and HIV testing during the visit to the health centres is proving to be a big challenge in administering PMTCT services to some women that test positive to HIV (WHO, 2009). The role of men in the prevention of HIV transmission is pivotal to changing the course of the epidemic (UNAIDS, 2009). Data gathered during the consultative process of developing the

National Strategy for the Prevention of HIV and STIs (NAC, 2009), indicate that male involvement in HIV programmes is minimal. Field visits conducted in areas where “male taking action” programmes are implemented, and men have been involved in the design, implementation and evaluation of HIV programmes, revealed better results (NAC, 2009).

Similarly, when men participate in the Prevention of Mother-to-Child Transmission (PMTCT) their knowledge of HIV increases, their behaviour becomes supportive and their receptiveness to HIV testing increases (Mayumi, 2007). Also, men can prevent primary HIV infection to women by practicing safe sex through condom use and also by being faithful to one uninfected faithful sexual partner (NAC, 2009).

Rouw (2002), reports that traditionally, in many low and middle income countries, men do not participate in Reproductive or Maternal and Child Health Care Services with their partners. The inadequate male involvement and participation has been cited as one of the reasons for poor programme uptake. Traditionally, antenatal (ANC) and postnatal care have been viewed as tasks for a woman. The historic institutionalization of reproductive health as “women’s spaces”, and reproductive health as women’s work, has generally produced health services that are not welcoming of men and couples (WHO, 2012). From 27 June to 22 July 2002, the Global PMTCT E-list discussed the issue of male involvement- concerns and ways to overcome the obstacles, (Rouw, 2002).

The world over, multiple efforts have been implemented that encourage men to accompany their wives to antenatal and to undergo HIV testing. Zambia is not an exception to this call. However, challenges still arise when it comes to PMTCT services as this is attributed to the absence of men in obstetric/ PMTCT care for their partners, (Msuya *et al.*, 2008). There should be a strong recommendation of scaling up PMTCT services to enable delivery of HIV-negative babies in line with previous commitments (to reduce HIV and AIDS among

children), made through Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and the Maputo Plan of Action (The Post, February 15, 2012).

According to the Cambridge International Dictionary of English (1999), knowledge is understanding of or information about a subject which has been obtained by experience or study and which is either in a person's mind or possessed by people generally. As such, Knowledge has to do with information, education and communication (IEC). When men receive information concerning PMTCT from media, health workers or peers what do they do with it? They get to know the terminology and how HIV is transmitted from mother-to-child. They are told about precaution and prevention of HIV; and in case of HIV in a pregnant spouse they are aware of the necessary measures in PMTCT. The question remains as to whether they adhere to this information or not. It is a fact that knowing about Mother-To-Child transmission alone is not enough to curtail the HIV in unborn children and infants. As such attitudes of men after knowing are cardinal to the vice; hence their standing on the subject at hand would determine their practices.

Attitude is feeling or opinion about something or someone, or a way of behaving that follows from this (Cambridge International Dictionary of English, 1999). It can be said therefore that attitude is the state or standing of one after being exposed to certain beliefs or information. Attitude can be shaped by societal standing and level of education as well as peer influence. After reading about or being told and having heard about PMTCT, how do men receive this information and what do they really do with it? Do they put it to practice or they discard it as mere knowledge?

Application of knowledge is important in bringing out expected results. So the men that have heard and learnt about PMTCT are expected to exhibit behaviour in line with HIV prevention strategies to both their spouses and unborn children

This study therefore, examined male involvement in PMTCT. It particularly assessed knowledge, attitudes and practices of married men in PMTCT and antenatal care of their spouses.

1.2 Statement of the problem

According to Global Fund (WHO 2009), HIV transmission from mother-to-child contributes largely to HIV prevalence among children. The problem has been attributed to lack of male involvement in maternal care, (Msuya et al. 2008). As primary decision makers, men are supposed to be incorporated so that women do not refrain from seeking important health care needs when pregnant, as many believe that issues of HIV counselling and testing should be consensual among couples (NAC, 2009). By being a part of their spouses'/partners antenatal care and HCT programmes, men would learn more and adhere to the health needs of their families.

Since men are decision makers in most households and relationships, especially marriage; their involvement in antenatal care for their partners would foster a positive adherence to Knowledge hence treatment of HIV among pregnant women (Rouw, 2002). According to the ZDHS (2007), men have knowledge about PMTCT, but nothing is known about their involvement in practices concerning PMTCT. Hence the importance of this study aimed at assessing levels of male involvement in PMTCT in Zambia.

One of the reasons of low PMTCT uptake is lack of male involvement (Mutale *et al.* 2010). This was found out during the study in Cameroun through a campaign to encourage men to accompany their spouses for HIV testing and counselling during their antenatal visits. Examples of Tanzania and Cameroun which show documentation on this subject indicate that where men are fully involved in their spouses' antenatal care there has not been a challenge

in uptake of PMTCT services compared to those women whose men have shunned accompanying their wives for antenatal. According to the World Health Organization, male involvement has been recognized as a priority area of intervention within this woman-centered approach (WHO, 2012). Though not fully investigated in Zambia, in countries where this investigation has been done, data indicate that where PMTCT programmes have involved men positive results have been obtained. Robey *et al.* (1998), reports that men are accustomed to making reproductive health decisions even without the permission from their wives; for example when to have sex, how many children to have and how many wives to marry. At the community level men have an influence on cultural norms that guide individual and community behavior, such as sexual cleansing and how information about HIV and AIDS is interpreted (ZDHS, 2007). Despite the key roles males have, there is limited documentation to show that men are involved in PMTCT services in Zambia. It is on this premise that the study was carried out to investigate factors that influence male involvement towards PMTCT in antenatal care of their spouses.

1.3 Research objectives

1.3.1 General objective

The general objective of this study was to investigate factors that influence men in PMTCT in Lusaka district.

1.3.2 Specific objectives

To address the general objective the following specific objectives were examined among others;

1. To ascertain knowledge of men towards antenatal care of their partners in Lusaka district.

2. To examine attitudes of men about PMTCT services in Lusaka district.
3. To establish current levels of male involvement in PMTCT practices in Lusaka district.
4. To identify the socio-cultural factors that may influence men's involvement in PMTCT practices in Lusaka district.
5. To examine the level of couple counselling in PMTCT.

1.3.3 Research questions

1. How much do men know about HIV transmission from the mother to her child?
2. What are the attitudes of men concerning PMTCT services?
3. To what extent are men involved in PMTCT services in Lusaka district?
4. What social-cultural factors influence men's involvement in PMTCT?
5. To what extent do men accompany their spouses for antenatal care and HIV

Counselling and Testing?

1.4 Significance of the study

NAC (2009) reports that one out of 10 new infections of HIV occurs in children aged 0-14 years; of which most are vertical transmissions from mother-to-child. It is argued that some pregnant women do not adhere to PMTCT services when they test positive due to fear of victimisation and abandonment by their spouses and partners alike (Chomba *et al.* 2011). It is therefore justified that knowledge on PMTCT must not only be limited to pregnant women who access health facilities during antenatal care, but also improve dissemination of information on MTCT in order to encourage men access health facilities and thereby encourage their spouses in utility of PMTCT services.

This study is important in that it sought to investigate knowledge, attitude and practices of men towards PMTCT of HIV. This is because one of the prominent ways of transmission of HIV among infants and children is through vertical transmission from mother-to-child.

It is with a view that the study will contribute knowledge to the government and health fraternity, and help in influencing the government, stakeholders and partners in framing policies that encourage male participation in PMTCT services as they are very critical. They could start by making Maternal and Child Health (MCH) an all inclusive family health facility so that men fully participate in antenatal care for their spouses. A report by the World Health Organisation (2012:58) says, 'Perhaps the most significant obstacles are the conceptual and policy barriers that inadvertently support men's exclusion from PMTCT and other reproductive health services'. With this in place the rate of HIV transmission from mother to child will be reduced or better still halted. This would overall reduce HIV infection in the country.

1.5 Hypotheses

- Involving men in Prevention of Mother-to-Child-Transmission of HIV will improve utilization of PMTCT services.
- Male involvement in Prevention of Mother-to-Child-Transmission will foster positive attitudes towards HIV couple counselling and testing (HCCT) in PMTCT services.
- Knowledge of HIV transmission among men would encourage their involvement in PMTCT services.

1.6 Operational definitions of factors influencing male involvement in PMTCT

In assessing male involvement in PMTC the study assessed different factors as variables. The interplay of these variables has influence on how the men respond to issues pertaining to PMTCT in antenatal of their spouses/partners.

1.6.1 Attitude as a factor influencing male involvement in PMTCT

Socioeconomic status has influence on one's attitude; these include level of education attained, place of residence and income earned. People exposed to certain environments and those who dwell among the affluent in society would have a different perspective about PMTCT compared to those that are of low socioeconomic status. They could be influenced either negatively or positively as income and education play a very critical role in one's life. When one has advanced education their understanding of issues in life is different from those with low education (Falnes, *et al.*, 2011). Their thinking is broader whether right or wrong. Similarly, high income levels determine the how, when, where and what kind of health services to acquire compared to not having a choice or alternative due to low or poor income status.

Socio-cultural characteristics are attributes of one's attitude. How society strives to survive in their environment has to do with their norms and beliefs in life; especially to sex roles and responsibilities. Questions of who should go to antenatal clinic and obtain such services will arise. Some communities view antenatal care and maternal health care as a woman issue and any male involvement would raise suspicion or questions about the man's behaviour. For some it could be that he is jealous and others would think he is under his wife's submission. These too are bound to bring about influence on how society appreciates the utilization of PMTCT.

1.6.2 Knowledge as a factor influencing male involvement in PMTCT

Knowledge of information is cardinal to PMTCT programmes. People have acquired knowledge about PMTCT from health workers, media and other forms of literature, and this, in some ways, affects their attitudes and practices. One's age, level of literacy and residence could play a significant role in how they receive and understand this information. Peer influence plays a very important role here. How exposed are they and what is the level of their understanding of issues pertaining to PMTCT? Are they willing to learn more and share, or are they encouraging or discouraging their peers and/or the community to learn more and be positive towards the programme? The government and stakeholders alike, have made efforts to disseminate information to the public in various forms; Information Education Communication, (IEC) materials. Basing on one's age, residence and level of literacy one would both learn and adhere or not at all, to the importance of such programmes.

In South Africa, a study carried out by Montgomery, *et al.*, (2006) revealed that many men identified traditional gender roles and the fear of losing respect as a significant deterrent to participating in care and support activities. They identified a number of obstacles. In one group men said that some men would see them doing work traditionally performed by women as an "affront to their dignity". Others said that many men simply did not have the knowledge or skills necessary to provide support or to be more involved in domestic activities and would not want to risk being seen as ignorant or incompetent; while others were afraid that their involvement in care and support activities might create a perception that they themselves are HIV positive, which might lead to stigma and social exclusion.

Dr Francois Venter, head of the South African HIV and AIDS clinician's society, makes the point that government has a critical role to play in increasing men's use of HIV services (WHO, 2004). This was in view of the cultural norms that societies seem to still hold on to

that maternal health care is a woman issue. NGO's alone cannot fight the barrier that holds back many men in reproductive and maternal health programmes. As such knowledge, attitude and practices are fundamental to achieving success in male involvement in PMTCT. The efforts of civil society and government are necessary to breaking barriers and achieving success in this programme.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

It must be made very clear that literature with specificity to Zambia on the subject is very scanty; as such most literature review was derived from the regional perspective. The limited literature from Zambia was also derived.

2.1 Regional perspective

Most studies conducted on PMTCT have centred on women and their attitudes towards testing and uptake of antiretroviral drugs to prevent transmission to the unborn child. In Northern Tanzania a study revealed that pregnant women showed reluctance to undergo HIV testing (Msuya SE *et al.* 2011). They attribute this to the fact that men are not involved in antenatal care and their mere finding out that their spouses underwent HIV counselling and testing, and the subsequent uptake of PMTCT services, would lead to their abandonment and divorce. Pregnant women having a partner with a history of a sexually transmitted infection (STI) and having a partner who had another sexual partner in the previous year were positively associated with a preference to avoid HIV testing. While the presence of a partner living at home or feeling able to ask their partner to go for an HIV test preferred to do an HIV test. According to Msuya SE *et al.* (2011), the major concern of women was for the reaction of their male partners to the possibility of a positive HIV test and low confidence in the confidentiality of HIV testing.

Mayumi *et al.* (2007), report that in Dar-Es-Salam, Tanzania most pregnant women in the study conducted had tested for HIV and few had not. It was revealed that participants' general knowledge of HIV was high, but specific knowledge of MTCT was relatively low.

The analysis brought to light that, frequencies of antenatal clinic visits, awareness of MTCT and intensive family support were significantly and inversely associated with the refusal of HIV testing.

In Cameroon, multiple efforts have been implemented that encourage men to follow their wives to obstetric/PMTCT care and to undergo HIV testing. However, only 18 percent show participation in this area. Mutale *et al.* (2010) state that men's participation in PMTCT is affected by socio-cultural barriers centred in tribal beliefs and traditional gender roles. They further listed the barriers identified and they included the belief that pregnancy is a "woman's affair", the belief that a man's role is primarily to provide financial support for the woman's care; the man's perception that he will be viewed as jealous by the community if he comes to the clinic with his pregnant wife; and cultural gender-based patterns of communication.

HIV counseling and testing (HCT) for pregnant women has largely been organized on an individual and sex-specific basis in PMTCT programmes, typically ignored by male partners (CDC, 2007). However, a couple's approach to HCT and antenatal care facilitates communication about HIV status, reduces one of the major barriers to acceptance of ARV prophylaxis by mothers for themselves and their newborns, as well as encouraging adoption of preventive behaviours within couples to reduce HIV incidence during pregnancy (Bakari, *et al.* 2000).

Centre for Disease Control (CDC, 2007), says the need for male involvement in the PMTCT process has been increasingly encouraged to improve adherence to ARV prophylaxis though no randomized clinical trials of the influence of male partners as key contributors to acceptance and PMTCT uptake have been conducted. It further states that HCT and prevention strategies for couples in stable relationships could also strengthen HIV prevention efforts in Southern Africa, where the majority of HIV infections occur in stable relationships.

Prevention programmes to increase male involvement in Tanzania and Botswana have met with some success, for instance, Tanzania found male involvement increased Nevirapine (NVP) uptake, Botswana utilized a media campaign and increased male involvement from 4 percent to 11 percent (Msuya, *et al.* 2008). In Cote d'Ivoire, prenatal couple counselling and testing improved couples' communication on sexual risks among both HIV positive and negative women. In Kenya, partner participation in HCT and couples counselling increased Nevirapine and formula feeding uptake among women attending antenatal clinics and partner attendance from 3 percent to 15 percent (Bakari *et al.* 2000). However, while PMTCT attendance by both members of a couple is feasible, uptake remains limited by lack of male participation highlighting the need to increase communication within the couple about reproduction and sexual health (UNAIDS, 2008).

Men's attitudes regarding involvement in PMTCT and antenatal care (ANC) programmes have been linked to cultural barriers, including the perception that male participation in ANC/PMTCT services is superfluous and that ANC is "a woman's responsibility", (Rouw, 2002).

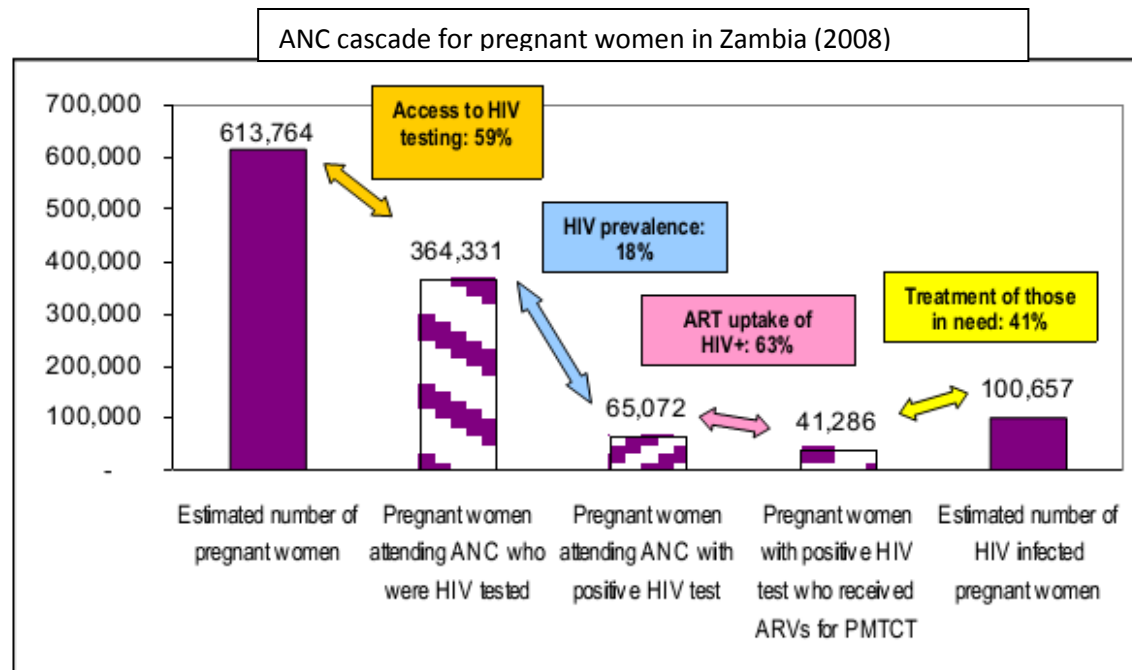
2.2 The Zambian perspective

Previous research in the US and Zambia has found that a gender specific group, sexual behaviour intervention designed to increase couples communication, *the Partner Project*, enhanced the acceptability and use of sexual barrier products (male and female condoms) among HIV positive men and women (Stringer *et al.* 2005). The Partner Project, currently being implemented in the community health clinics across Zambia by CDC Zambia, has achieved 95-100 percent retention of enrolled couples over 6 months and 90-95 percent over 12 months and maintained comparative levels of participation by both men and women throughout the intervention.

This indicates that male attitudes towards PMTCT in Zambia are not any different from those found within the region. WHOSIS, (2005) report that, “in most cases women are often reluctant to participate in PMTCT programmes because of fear of disclosure and abuse from their partners. Global form, WHO (2009), states that access of pregnant women to counselling and testing (CT) within PMTCT services is 59 percent, and access to ART of pregnant women diagnosed HIV positive is 63 percent. It further reports that in 2008, only 20,407 male partners of 491,234 ANC clients attending knew their status (4 percent). These results are worrying as it shows that men (96%) do not get to know their HIV status in the event that their spouses are pregnant. From among the women that tested positive to HIV, results show that not all were captured for treatment of PMTCT. Figure 2.1 shows these results. We need to ask ourselves why this is so and bear in mind that even those that are put on PMTCT might not fully benefit as their spouses have not been tested and the possibility of re-infection is high.

The question here is why are these men not willing to test for HIV? Is it because they are not told or in case sensitized correctly? Are they using their spouses as a measure for their own status or are they scared of the HCT process?

Figure 2.1 ANC cascade for pregnant women in Zambia (2008)



Source: WHO (2009) – Monitoring and reporting on the health sector response to HIV/AIDS

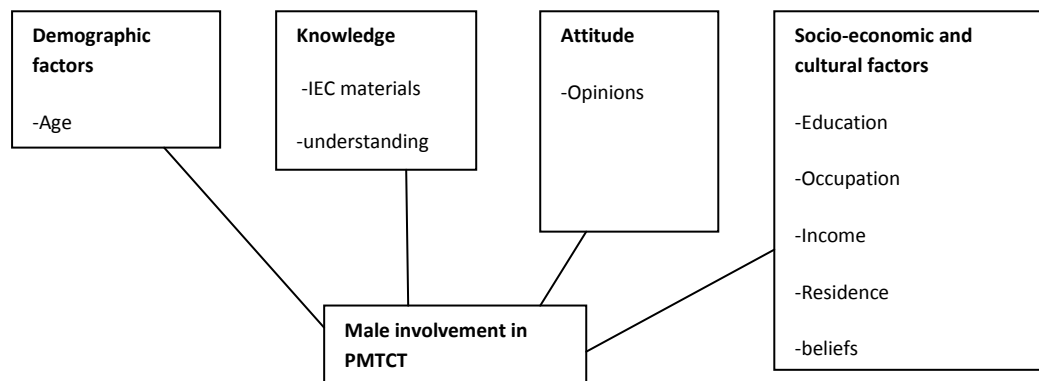
Most women that have tested positive have faced abandonment and discrimination from their partners and community (Stringer *et al.*, 2005). Women who cannot disclose their positive diagnosis may have a harder time enrolling in PMTCT programmes or in choosing exclusive feeding options. This could explain the reason why only 41,286 pregnant women were put on ARVs for PMTCT when there were 65,072 pregnant women who tested positive for HIV. In any case there are over 100 thousand pregnant women estimated to be HIV positive. In Uganda a study demonstrated that male partners' attitudes are important in a woman's reported willingness to accept HIV testing. In a survey by Bajunirwe (2005), it was revealed that the perception that the husband would approve of a mothers' decision to test for HIV was the strongest predictor of whether the mother had the intention of testing or not. Research has also shown that involvement of men in PMTCT services will help improve access among

pregnant women. A study in Kenya and South Africa revealed that this is attainable (UNAIDS, 2009).

2.3 Conceptual framework

The conceptual framework used in this study provides a basis for a detailed analysis of the factors that influence male involvement in PMTCT of HIV. These factors bring about attitudes and practices of men towards the subject.

Figure. 2.2 Conceptual Framework of factors that influence male involvement in PMTCT



Male involvement in PMTCT of HIV is core to HIV prevention and treatment. Studies carried out so far in African countries like Cameroun and Tanzania, and the world over reveal that a number of factors have been attributed to male involvement in PMTCT. Fundamental factors are demographic characteristics, socio-economic and cultural characteristics of the respondents. These characteristics are controlled by age, education, income, cultural beliefs, residence and occupation. These immediate variables are cardinal to assessing factors that influence male involvement towards PMTCT in their societies.

Residence as an immediate variable can have influence on how one perceives HIV and support towards the spouse in the event of a pregnancy and antenatal care. This may be in

low density or high density residential areas. The way a community generally views the idea of escorting a spouse for antenatal care and taking part in HIV couple counselling and testing (HCCT) can have a very big imprint on how the man will behave when it comes to his spouse being pregnant.

The age of a man may determine his attitude towards information received on PMTCT. It could be that the younger ones would be freer and more expressive compared to the older men or vice versa. The freedom and excitement that comes with pregnancy and responsibility can encourage some men to be fully involved in antenatal care and all the maternal health issues of their spouse; while others might just feel responsible for provision of finances and paternity but not inclined to be a part of maternal duties.

Occupation brings about the relationships one has and the exposure to different life issues. Income brings about empowerment to do things that one might otherwise not do in its absence, like movement from one place to another and accessing quality healthcare that may be absent in some health centres. Depending on the age of the man and the level of education attained ones' attitude and practices towards PMTCT can be shaped. It could be that the higher one goes in education the more assertive they are towards HCCT, or maybe those that are less educated will be more assertive. Cultural norms and beliefs are more inclined to ones' level of education and residence. Behaviour and attitude may be shaped by these. The kind of information availed to the people in different areas, be it residential or workplace, may be received differently by different kinds of people in communities they live.

The interaction of these variables can sway men's attitudes either positively or negatively towards their involvement in PMTCT.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

The chapter explains how the study was conducted. It contains information on the study design, definition of the study population, methods of sampling and data collection used; and the development of the research instruments.

3.1 Types and sources of data.

The study used both primary and secondary data. Primary data included information obtained directly from respondents and observations to ascertain factors influencing male involvement in PMTCT of HIV in Lusaka district. Secondary sources of data included the ZDHS, published materials by various authors, literature from the internet and Newspapers.

3.2 Study design

The study used both qualitative and quantitative methods of collecting primary data. In collecting qualitative data, Focus Group Discussions (FGDs), in-depth discussions and observations were used. Focus Group Discussions and observations were conducted on male participants during couple counselling sessions and simultaneous opinions and experiences of respondents on their involvement in PMTCT were obtained; while in-depth discussions were done with some health care providers to obtain key information on their experiences with male involvement in antenatal care and PMTCT.

In quantitative method, semi structured questionnaires were administered to participants to examine their knowledge, attitudes and practices regarding PMTCT and HIV. The

demographic data on age, education and occupation were collected in order to establish the levels of participation in PMTCT among the respondents. If it so happened that a sampled household had no male (married or cohabiting), this was omitted but went to another one at the same sampling interval. The questionnaire emphasized on identifying barriers to men's participation in PMTCT programmes and obtaining HIV counselling and testing.

Secondary data, especially on men's knowledge about PMTCT services, was obtained from the ZDHS and other sources.

3.3 Study Area and Ethics

Lusaka was chosen as a study area because it has the highest prevalence rates of HIV in the country. According to the Zambia Demographic Health survey (CSO *et al.*, 2009), the HIV prevalence rate for Lusaka was 20.8 percent of which the prevalence rate between women and men was 22.2 percent and 20 percent respectively.

The study was community-based and the sampling frame (based on probability proportion to size), and random covered low density (Avondale and Chelstone) and high density (Chainda) residential areas within Lusaka. The choice of the residential areas was purposive because they encompass populations with different socio-demographic characteristics but have access to Chainda and Chelstone health facilities, which offer reproductive and maternal health care services. No participant identifying information was collected as pertaining to ethical issues. The study was cleared by the ethical committee and informed consent was obtained.

3.4 Description of sample population

The residential areas have serially arranged housing units and systematic sampling was used to select the sample size population. A sampling element was chosen at every fifth housing

unit. A sample of 200 married men (legally or cohabiting), aged 15 years and above, at the time of study, were targeted. However the study only managed to capture men from the age of 24 because of the later marriage age in urban areas. The study targeted married men because there's no known study which has focused on male involvement in PMTCT so far. Most studies have targeted either women or a combination of women and men; and their adherence. Sixty five households were randomly sampled from Avondale and Chelstone (low density) residential areas, while Chainda (high density) had a population sample of 70 households. This was in order to obtain various experiences concerning PMTCT based on the differing socio-demographic characteristics of the residents. Five health care workers from both Chelstone and Chainda clinics were interviewed to get information on their experiences with male involvement in antenatal care and PMTCT.

3.5 Research instruments

Questionnaires were used to collect quantitative data while interview guides and Focus Group Discussions were used in collecting qualitative data. The questionnaire had both open ended and closed questions and was administered to married or cohabiting men. The use of open ended questions was to allow free expression among participants.

In-depth interviews were done with health care workers to get information on their experiences with men that attend antenatal services and HIV couple counselling and testing in pregnancy. Focus Group Discussions were conducted among men who attended couple counselling and HIV testing sessions at Chainda clinic.

3.6 Data Processing and Analysis

Qualitative data collected were processed and analysed thematically following independent variables in the study. Quantitative data collected was processed using Statistical Packages in the Social Sciences (SPSS). Descriptive statistics, logistic and multiple regression were used to obtain statistical information. Frequency tables and graphs were run in both SPSS and Excel to obtain percentages and proportions of the sampled population for interpretation and analysis.

3.7 Study limitations

The study proved a challenge in identifying male participants in due time as most were absent from households for work and other economical errands. However with persistence most of them participated in the study.

3.8 Characteristics of respondents

Respondents' background information is very critical to this study as its analysis helps to determine the knowledge, attitudes and practices that may affect their involvement in PMTCT. It is upon these variables that the factors that influence male involvement can be evaluated.

Some demographic and socio-economic characteristics of the respondents that may directly or indirectly influence male involvement include age, residence, education attainment, occupation and income level.

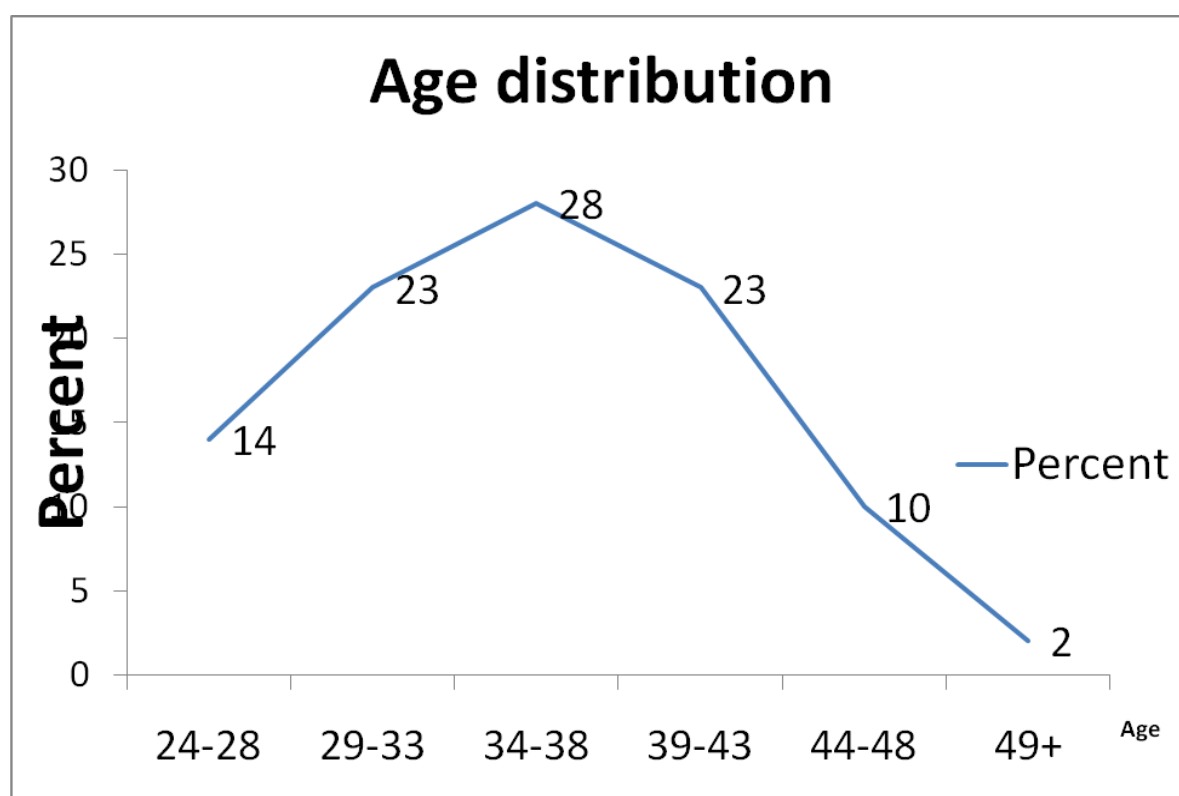
3.9 Background characteristics

3.9.1 Demographic and socio-economic characteristics of respondents.

The study captured a population of 200 married men distributed equally among the study sites. They were ranging in the age group between 24-49+ years. Figure 3.1 shows the age distribution of the respondents.

From the graph in Figure 3.1, it can be seen that the majority of the participants in the study are aged between 34 and 38 years giving a percentage of 28, while those aged 49+ years had a 2 percent participation rate. The age groups between 29-33 and 39-43 had 23 percent participation rate each, while those aged 24-28 had 14 percent and the 44-48 age group had a participation rate of 10 percent.

Figure 3.1 Percent Age distribution of respondents.



Source: PMTCT study 2013.

Statistics of their age, education attainment status, employment status and that of their spouses, as well as the number of children they have is shown in Table 3.1. The Table shows

that 33.3 percent and 66.7 percent in high and low residential areas respectively have achieved higher education. A total of 22 participants had secondary education with 22.7 percent and 77.3 percent in high and low residential areas respectively. A total of 113 participants were employed in the civil service (37.2 percent and 62.8 percent in high and low residential areas respectively). The private sector had 22.9 percent and 77.1 percent participants in respect of high and low residential areas.

All participants had children except for one who recently married. A total of 90 of the respondents had between 3-4 children, 88 had at least 1-2 children, and 21 percent had more than four children at the time of the survey.

Of all the participants, 35 percent came from Chainda and 65 percent were from Chelstone and Avondale with a participation rate of 32.5 percent each

Table 3.1 Percentage of demographic and socio-economic characteristics of married men

Characteristics	Residence				Total
Age	High density		Low density		count
24-28	13	(46.4)	15	(53.6)	28
29-33	21	(45.7)	25	(54.3)	46
34-38	21	(37.5)	35	(62.5)	56
39-43	10	(21.7)	36	(78.3)	46
44-48	4	(20.0)	16	(80.0)	20
49+	1	(25.0)	3	(75.0)	4
Employment status					
Civil servant	42	(37.2)	71	(62.8)	113
Private sector	8	(22.9)	27	(77.1)	35
Business man	8	(29.6)	19	(70.4)	27
Other	12	(48.0)	13	(52.0)	25
Education attainment					
Primary	9	(90.0)	1	(10.0)	10
Secondary	5	(22.7)	17	(77.3)	22
Higher	56	(33.3)	112	(66.7)	168
Number of children					
Between 1-2	40	(45.5)	48	(54.5)	88
Between 3-4	24	(26.7)	66	(73.3)	90
More than 4	5	(23.8)	16	(76.2)	21
None	1	(100.0)	0	(0.0)	1

Source: PMTCT study 2013

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 Knowledge of Prevention of Mother-to-Child Transmission of HIV

Knowledge about PMTCT is very important among men if they are to make informed decisions to have children free from HIV, and a health mother to care for them. If the men, who are fathers to the children born and/or yet to be born lack the knowledge, decisions concerning PMTCT might not be comprehensive. As decision makers in relationships and households they need to be well aware of their spouses/partners and their own HIV status. Information on knowledge of PMTCT was collected by asking participants questions such as *(a) If they knew the services offered in PMTCT, (b) If they had ever discussed PMTCT with their spouse and (c) and if they knew ways in which HIV is transmitted from Mother-to-Child.*

The information on knowledge of PMTCT is presented in Table 4.1

Table 4.1 shows that when respondents were asked if they knew the services offered in PMTCT the age groups 29-33 and 34-38 had 91.3 percent and 76.8 percent responses respectively. When asked if they had ever discussed PMTCT with their spouses 63.0 percent and 67.9 percent said they did, and as to whether they knew the ways of MTCT all (100 percent) in each of the two age groups said they did. In the age group 39-43, 89.1 percent said they knew the services offered in PMTCT, 76.0 percent had discussed PMTCT with their spouses and 100 percent knew the ways of MTCT. The age group 24-28 had the following responses to the same questions; 78.6 percent knew about the services offered in PMTCT, 57.1 percent had discussed PMTCT with their spouses and 96.4 percent knew ways of MTCT.

Table 4.1 Count and Percent distribution of responses of married men on Knowledge about PMTCT

	Services offered in PMTCT		Ever discussed PMTCT with spouse		Ways of MTCT		
	Yes	No	Yes	No	Yes	No	
Age							
24-28	22(78.6)	6(21.4)	16(57.1)	12(42.9)	27(96.4)	1(3.6)	28
29-33	42(91.3)	4(8.7)	29(63.0)	17(37.0)	46(100.0)	0(0.0)	46
34-38	43(76.8)	13(23.2)	38(67.9)	18(32.1)	56(100.0)	0(0.0)	56
39-43	41(89.1)	5(10.9)	35(76.0)	11(23.9)	46(100.0)	0(0.0)	46
44-48	16(80.0)	4(20.0)	17(85.0)	3(15.0)	20(100.0)	0(0.0)	20
49+	3(75.0)	1(25.0)	4(100.0)	0(0.0)	4(100.0)	0(0.0)	4
Total count	167(83.5)	33 (16.5)	139 (69.5)	61(30.5)	199 (99.5)	1(0.5)	200
Employment status							
Employed							
Self employed	124(83.8)	24(16.2)	103(69.6)	45(30.4)	147(99.3)	1(0.7)	148
	43(82.7)	9(17.3)	36(69.2)	16(30.8)	52(100.0)	0(0.0)	52
	167 (83.5)	33 (16.5)	139(69.5)	61(30.5)	199 (99.5)	1(0.5)	200
Education attainment							
Primary	6(60.0)	4(40.0)	6(60.0)	4(40.0)	9(90.0)	1(10.0)	10
Secondary	19(86.4)	3(13.6)	13(59.1)	9(40.9)	22(100.0)	0(0.0)	22
Higher	142(84.5)	26(15.5)	120(71.4)	48((28.6)	168(100.0)	0(0.0)	168
	167(83.5)	33(16.5)	139(69.5)	61(30.5)	199(99.5)	1(0.5)	200
No. of children							
1-2	71(80.7)	17(19.3)	61(69.3)	27(30.7)	87(98.9)	1(1.1)	88
3-4	81(90.0)	9(10.0)	62(68.9)	28(31.1)	90(100.0)	0(0.0)	90
Over 4	14(66.7)	7(33.3)	16(76.2)	5(23.8)	21(100.0)	0(0.0)	21
None	1(100.0)	0(0.0)	0(0.0)	1(100.0)	1(100.0)	0(0.0)	1
	167 (83.5)	33(16.5)	139 (69.5)	61(30.5)	199(99.5)	1(0.5)	200

Source: PMTCT study 2013.

4.2 Knowledge of PMTCT services offered to mothers and ways of Mother-to-Child-Transmission of HIV.

Participants in the survey were asked if they knew ways in which HIV can be transmitted from mother-to-child and drugs/services offered to HIV-positive pregnant mothers. Responses were varied and multiple in some cases, thus the totals in responses are more than the total of participants. Almost all participants knew at least one or more ways of HIV

transmission from mother-to-child. About 8.5 percent said MTCT occurs during pregnancy, 80 percent said it occurs during delivery and 67 percent said transmission occurs during breastfeeding. However, a higher percentage rate (91.5 percent) had no knowledge that MTCT occurs during pregnancy, about 33 percent did not know about transmission of HIV during breastfeeding and 20 percent had no knowledge of transmission of HIV during delivery. Table 4.2 shows the responses.

Table 4.2 count and percent of responses married men on Stage at which Mother-to-Child Transmission occurs.

Stage	Yes		No		Total
During pregnancy	17	(8.5)	183	(91.5)	200
During delivery	160	(80.0)	40	(20.0)	200
During breastfeeding	134	(67.0)	66	(33.0)	200
Total	311	(51.8)	289	(48.2)	600 (100)

Source: PMTCT study 2013

Having knowledge about services offered in PMTCT is important for easy understanding of the whole subject in terms of access and utilization. Overall 31 percent of the respondents knew of one or more services offered during PMTCT and 69 percent claimed to have no knowledge of any services at all. However, a greater percentage of the knowledgeable (74.0 percent), knew mainly about counselling. This was followed by 38 percent ARV prophylaxis/Nevirapine, 8.5 percent Zidovudine and 4 percent AZT/HAART.

The responses are shown in Table 4.3.

Table 4.3 count and percent of responses of married men about knowledge of services offered in PMTCT.

Service offered	Yes		No		Total
AZT/HAART	8	(4.0)	192	(96.0)	200
Zidovudine	17	(8.5)	183	(91.5)	200
ARV/Nevirapine	76	(38.0)	124	(62.0)	200
Couselling	148	(74.0)	52	(26.0)	200
Total	249	(31)	551	(69)	800 (100)

Source: PMTCT survey 2013

4.3 Sources of information about PMTCT

Dissemination of information about PMTCT is cardinal to prevention of HIV to infants and reduction of both infant and maternal mortality. It was therefore important to ask the participants about where they got to hear about PMTCT from. Responses were varied and multiple as such the totals are in some cases different from the total number of participants.

Table 4.4 shows that 74 of respondents got their information about PMTCT from health personnel and the least source of information (11%) is from community health workers. ‘Other’ sources of information include HIV and AIDS work place programmes, spouses/partners, and workshops with total of 7.5 percent in each of the selected demographic and socio-economic activities. Friends account for 13.7 percent among those highly educated, 27.3 percent among those with secondary education and 10.0 percent only for primary education. Radio/TV is second in offering information on PMTCT among the highly educated with 35.1 percent and residents of Chainda with 48.6 percent. The age group 34-38 has its highest rate of participants (39.3 percent) getting information from the radio and the least are those aged 44-48 with 30.0 percent.

Table 4.4 Count and percent distribution of male respondents' source of information on PMTCT by selected demographic and socio-economic characteristics.

Source of information	Radio/TV	Friends	Health personnel	Community health worker	Other	Not applicable	Total
Age							
24-28	9 (32.1)	4 (14.3)	12 (42.9)	10 (7.1)	1 (3.6)	0 (0.0)	28
29-33	13 (28.3)	10 (21.7)	18 (39.1)	4 (4.3)	3 (6.5)	0 (0.0)	46
34-38	21 (39.3)	6 (10.7)	17 (32.1)	5 (8.9)	3 (5.4)	2 (3.6)	54
39-43	15 (32.6)	3 (6.5)	20 (43.5)	1 (2.2)	6 (13.0)	1 (2.2)	45
44-48	6 (30.0)	6 (30.0)	5 (25.0)	1 (5.0)	2 (10.0)	0 (0.0)	20
49+	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	4
Residence							
High density	34 (48.6)	6 (8.6)	23 (32.9)	4 (5.7)	2 (2.9)	1 (1.4)	70
Low density	33 (25.4)	24(18.5)	51 (39.2)	7 (5.4)	10(10.0)	2 (1.5)	130
Education							
Primary	3 (30.0)	1 (10.0)	4 (40.0)	2 (20.0)	0 (0.0)	0 (0.0)	10
Secondary	5 (22.7)	6 (27.3)	9 (40.9)	0 (0.0)	2 (9.1)	0 (0.0)	22
Higher	59 (35.1)	23 (13.7)	61 (36.3)	9 (5.4)	13 (7.7)	3 (1.8)	168
Employment status							
Employed	50 (33.8)	19 (12.8)	54 (36.5)	7 (4.7)	15(10.1)	3 (2.0)	148
Self/employed	17 (32.7)	11 (21.2)	20 (38.5)	4 (7.7)	0 (0.0)	0 (0.0)	52

Source: PMTCT study 2013.

4.4 Men's attitude towards PMTCT

In order for some women to access PMTCT services and utilize them fully, it is cardinal for their spouses to have a positive attitude towards access and utilization of these services. Most men's attitudes towards this subject are believed to be shaped by their religion, education, occupation and cultural beliefs (Maharaji, 2001). The study reveals that religion has the lowest percentage rate on influencing male attitude towards PMTCT as 29.5 percent of the Catholics indicate that PMTCT services are important in clinics, where as 46 percent of protestants attest to that and 24.5 percent of other faiths agree. The same rate of respondents, with respect to each faith, agrees that pregnant women need to undergo HIV Counselling and Testing (HCT).

The majority of those with higher education (84 percent) view that PMTCT is important in clinics. Eleven percent and 5 percent of those who agree have acquired secondary and primary education, respectively. With regards occupation, 73 percent of the employed think that pregnant women should undergo HCT, and 26 percent of the self employed feel the same way. The study reveals that 49.5 percent of the employed attest that current PMTCT services are adequate, while only 13.5 percent of the self employed agree to this sentiment.

However when asked if they would be willing to be involved in PMTCT activities 56.5 percent of the employed and 22.5 percent of the self employed expressed interest and willingness to be involved. Lack of involvement among some respondents was due to time factor and others stated that they had no opportunity, or had not been availed information on how to get involved.

Table 4.5 Percent of responses on married men's attitudes towards PMTCT services with selected socio-demographic characteristics.

	Religion Catholic protestant other	Education status Primary Secondary Higher	Employment status Employed Self/employed
Do you think PMTCT services in clinics are important?	59(29.5) 92(46.0) 49(24.5)	10(5.0) 22(11.0) 168(84.0)	148 (74.0) 52(26.0)
Do you believe that pregnant women should undergo HIV counselling and testing?	56(28.2) 92(46.0) 49(24.5)	10(5.0) 22(11.0) 168 (84.0)	148(74.0) 52(26.0)
Do you think the current PMTCT services are adequate and comprehensive?	36(18.0) 52(26.0) 36(18.0)	4(2) 13(6.5) 109(54.5)	99(49.5) 27(13.5)
Do you feel more needs to be done concerning access and delivery of PMTCT services in health centres?	53(26.5) 86(43.0) 41(20.5)	7(3.4) 15(7.5) 158(79.0)	136(68.0) 55(27.5)
Would you be willing to be involved in activities concerning PMTCT?	43(21.5) 75(37.5) 40(20.0)	8(4.0) 21(10.5) 129(64.5)	113(56.5) 45(22.5)
Would you accompany your spouse for HIV testing in antenatal care	57(28.5) 88(44.0) 46(23.0)	8(4.0) 22(11.0) 161(80.5)	139(69.5) 52(26.0)

Source: PMTCT survey 2013.

All participants in the survey, irrespective of their age, admitted that PMTCT services are important in clinics. Apart from the 1.8 percent and 2.2 percent respondents in the age groups 34-38 and 39-43 respectively, all said it is important for pregnant women to undergo HCT. As to whether current PMTCT services are adequate and comprehensive in clinics, 71.7 percent of the age group 39-43 said they are and the 46.4 percent of the age group 24-28 said they are not. When asked whether they would accompany their spouses for HCT in antenatal care 95.7 percent and 95.4 percent of the respondents in high and low residential areas respectively, said they would.

Table 4.6 below shows more information about male attitudes towards PMTCT with specificity to residence and age.

Table 4.6 Results for male attitudes towards PMTCT by residence and age.

	Do you think PMTCT services are important in clinics?		Do you believe that pregnant women should undergo HCT?		Do you think current PMTCT services are adequate and comprehensive?			Do you feel more needs to be done concerning access and delivery of PMTCT services in health centres?		Would you be willing to be involved in activities concerning PMTCT?		Would you accompany your spouse for HCT in ante natal care?		Total count
	Yes	No	Yes	No	Yes	No	DK	Yes	No	Yes	No	Yes	No	
Age														
24-28	100.0	0.0	100.0	0.0	50.0	46.4	3.6	82.1	17.9	82.1	17.9	92.9	7.1	28
29-33	100.0	0.0	100.0	0.0	56.5	39.1	4.3	91.3	8.7	89.1	10.9	97.8	2.2	46
34-38	100.0	0.0	99.5	0.5	66.1	32.1	1.8	94.6	5.4	76.8	23.2	96.4	3.6	56
39-43	100.0	0.0	99.5	0.5	71.7	23.9	4.3	84.8	15.2	69.6	30.4	91.3	8.7	46
44-48	100.0	0.0	100.0	0.0	70.0	30.0	0.0	95.0	5.0	90.0	10.0	100.0	0.0	20
49+	100.0	0.0	100.0	0.0	50.0	50.0	0.0	100.0	0.0	25.0	75.0	100.0	0.0	4
Totals	200	0	199	1	126	68	6	180	20	158	42	191	9	200
Residence														
High density	100.0	0.0	98.6	1.4	62.9	37.1	0.0	85.7	14.3	81.4	18.6	95.7	4.3	70
Low density	100.0	0.0	99.2	0.8	63.1	32.3	4.6	92.3	7.7	77.7	22.3	95.4	4.6	130
Totals	200	0	198	2	126	68	6	180	20	158	42	191	9	200

Source: PMTCT study 2013

Information on practices about PMTCT was obtained from respondents by asking them whether they had ever participated in PMTCT activities. They were also asked if they would go for HIV Counselling and Testing in the event that their spouses tested positive to HIV during antenatal, and whether they would use a condom during sexual intercourse. Table 4.8 below shows count and percent of responses on practices about PMTCT.

4.5 Practices of men about PMTCT

Results show that the age group 39-43 had a higher participation rate (47.8 percent) followed by the 44-48 age group with 45 percent participation rate. The pattern is similar when asked whether they had ever gone back to test for HIV other than the time they tested during antenatal. Close to eighty percent (78.6) of those aged 24-28 said they never went back, while 67.4 percent and 66.1 percent of the age groups 29-33 and 34-38, respectively, had never gone back for another test. When asked if they would use a condom if they and/or their partners tested HIV positive, the 29-33 year age group responses were as follows; 71.7 percent said yes, 2.2 percent said no and 26.1 percent said they did not know whether they would use a condom or not.

With regards to residence only 30 percent of those in high density areas had ever actively engaged in PMTCT activities, while 37.7 percent of those in low density areas had ever participated in PMTCT activities.

At least 79.2 percent of those in high density residential area said that they would use a condom in the event that their spouse and/or they tested positive to HIV, and 83.1 percent of those in low density residential areas would. On whether they would consider having an HIV test before considering getting pregnant 75.7 percent of those in high density areas said yes and 78.5 percent of those in the low density areas agreed.

From among the employed and self-employed 32.4 percent and 42.3 percent participated in PMTCT respectively. When asked if they had ever gone back to test for HIV, 30.4 percent

and 34.6 percent of the employed and self-employed respectively, agreed to have re tested for HIV.

Table 4.7 Percent distribution of married men's responses on practices about PMTCT by selected socio-demographic characteristics

	Have you ever participated in PMTCT activities?		Other than the time you went for antenatal have you ever gone back as a couple to test for HIV?		Would you use a condom if your spouse and/or you tested positive for HIV?			Would you be willing to do an HIV test with your spouse before considering getting pregnant?			Would you go for HCT in the event that your wife tested HIV positive during pregnancy?			Total count
	Yes	No	Yes	No	Yes	No	DK	Yes	No	DK	Yes	No	DK	
Age														
24-28	39.3	60.7	21.4	78.6	60.7	0.0	39.3	78.6	14.3	7.1	92.9	7.1	0.0	28
29-33	28.3	71.7	32.6	67.4	71.7	2.2	26.1	78.3	15.2	6.5	93.5	4.3	2.2	46
34-38	26.8	73.2	33.9	66.1	87.5	3.6	8.9	78.6	19.6	1.8	96.4	3.6	0.0	56
39-43	47.8	52.2	39.1	60.9	89.1	0.0	10.9	69.6	23.9	6.5	100.0	0.0	0.0	46
44-48	45.0	55.0	15.0	85.0	75.0	5.0	20.0	85.0	15.0	0.0	100.0	0.0	0.0	20
49+	0.0	100.0	50.0	50.0	100.0	0.0	0.0	100.0	0.0	0.0	100.0	0.0	0.0	4
Total count	70	130	63	137	159	4	37	155	36	9	193	6	1	200
Residence														
High density	30.0	70.0	35.7	64.3	72.9	2.9	24.3	75.7	21.4	2.9	95.7	2.9	1.4	70
Low density	37.7	63.3	29.2	70.8	83.1	1.5	15.4	78.5	16.2	5.4	96.9	3.1	0.0	130
Total count	70	130	63	137	159	4	37	155	36	9	193	6	1	200
Education status														
Primary	30.0	70.0	40.0	60.0	60.0	0.0	40.0	60.0	30.0	10.0	70.0	20.0	10.0	10
Secondary	50.0	50.0	18.2	81.8	59.1	0.0	40.9	50.0	45.5	4.5	100	0.0	0.0	22
Higher	33.3	66.7	32.7	67.3	83.3	2.4	14.3	82.1	13.7	4.2	97.6	2.4	0.0	168
Total count	70	130	63	137	159	4	37	155	36	9	193	6	1	200
Employment status														
Employed	32.4	67.6	30.4	69.6	80.4	2.7	16.9	81.1	14.2	4.7	95.9	4.1	0.0	148
Self employed	42.3	57.7	34.6	65.4	76.9	0.0	23.1	67.3	28.8	3.8	98.1	0.0	1.9	52
Total count	70	130	63	137	159	4	37	155	36	9	193	6	1	200

Source: PMTCT survey 2013.

Participants were further asked if they had ever escorted their spouses for antenatal care and if they had received HIV Counselling and Testing on PMTCT. Findings in Table 4.8 above show that age groups 29-33 and 39-43 had 67.4 percent and 73.9 percent respectively, which are the highest in escorting their spouses for antenatal. This was followed by the age group 24-28 with 64.3 percent, 34-38 had 60.7 percent, 44-48 had 55 percent and those aged 49+

had 25 percent. However not every one of them who escorted their spouse for antenatal received HIV Counselling and Testing (HCT). Results show that among the 73.9 percent in the age group 39-43 only 52.2 percent received HCT, while those aged 29-33 had 54.3 percent receiving HCT. Further, 57.1 percent in the age group 24-28 received HCT, 51.8 percent of those aged 34-38 underwent HCT, 40 percent of the 44-48 age group received HCT and non aged 49+ underwent HCT.

For PMTCT services to be fully utilized by women they need support from their male partners and this starts from the onset of the pregnancy. Men can only know what is happening to their pregnant partners when they fully support them through the pregnancy and this includes antenatal care. Table 4.8 shows responses to these questions by various socio-demographic characteristics.

Table 4.8 count and percent responses of married men on practices about PMTCT

	Have you ever escorted spouse for antenatal care		Did you receive HCT on PMTCT			Total count
	Yes	no	Yes	no	not applicable	
Age						
24-28	18(64.3)	10(35.7)	16(57.1)	3(10.7)	9(32.1)	28
29-33	31(67.4)	15(32.6)	25(54.3)	5(10.9)	16(34.8)	46
34-38	34(60.7)	22(39.3)	29(51.8)	5(8.9)	22(39.3)	56
39-43	34(73.9)	12(26.1)	24(52.2)	9(19.6)	13(28.3)	46
44-48	11(55.0)	9(45.0)	8(40.0)	3(15.0)	9(45.0)	20
49+	1(25.0)	3(75.0)	0(0.0)	1(25.0)	3(75.0)	4
Total count	129	71	102	26	72	200
Employment status						
Employed	94(63.5)	54(36.5)	77(52.0)	16(10.8)	55(37.2)	148
Self employed	35(67.3)	17(32.7)	25(48.1)	10(19.2)	17(32.7)	52
Total count	129	71	102	26	72	200
Education attainment						
Primary						
Secondary	4(40.0)	6(60.0)	4(40.0)	0(0.0)	6(60.0)	10
Higher	12(54.5)	10(45.5)	10(45.5)	2(9.1)	10(45.5)	22
	113(67.3)	55(32.7)	88(52.4)	24(14.3)	56(33.3)	168
Total count	129	71	102	26	72	200
No. of children						
1-2	57(64.8)	31(35.2)	47(53.4)	10(11.4)	31(35.2)	88
3-4	58(64.4)	32(35.6)	47(52.2)	10(11.1)	33(36.7)	90
Over 4	14(66.7)	7(33.3)	8(38.1)	6(28.6)	7(33.3)	21
None	0(0.0)	1(100.0)	0(0.0)	0(0.0)	1(100.0)	1
Total count	129	71	102	26	72	200

Source: PMTCT study 2013

Participants were asked if it was justified for men to refuse to escort their spouses for antenatal care and were asked to give reasons for their responses. Table 4.9 shows responses to these questions by various socio-demographic characteristics. The results to these questions were varied and multiple in as such percent responses may be higher than the number of respondents. Among age groups about 10.7 percent of the 24-28 age group said it was justifiable not escorting their spouses for antenatal, while 8.7 percent of the 39-43 age

group equally agreed. With regards education, over 95.8 percent of the highly educated participants said it was not justified as it was the responsibility of both parents to ensure spouse and unborn child were doing well. At least 6.5 percent of the 39-43 age group justified that antenatal care was a woman's issue and men were not required to be present.

Table 4.9 responses to why some men do not escort their spouses for antenatal by selected socio-demographic characteristics.

	Is it justified that men should refuse to accompany their spouses for antenatal care?		Why do you think so?			
	Yes	No	Responsibility of both parents	Not necessary	It's a woman issue	Total count
Age						
24-28	3 (10.7)	25 (89.3)	27 (96.4)	0 (0.0)	1 (3.6)	28
29-33	2 (4.3)	44 (95.7)	45 (97.8)	0 (0.0)	1 (2.2)	46
34-38	3 (5.4)	53 (94.6)	53 (94.6)	3 (5.4)	0 (0.0)	56
39-43	4 (8.7)	42 (91.3)	43 (93.5)	0 (0.0)	3 (6.5)	46
44-48	1 (5.0)	19 (95.0)	19 (95.0)	1 (5.0)	0 (0.0)	20
49+	0 (0.0)	4 (100.0)	4 (100.0)	0 (0.0)	0 (0.0)	4
Education						
Primary	5 (50.0)	5 (50.0)	6 (60.0)	2 (20.0)	2 (20.0)	10
Secondary	1 (4.5)	21 (95.5)	21 (95.5)	1 (4.5)	0 (0.0)	22
Higher	7 (4.2)	161 (95.8)	164 (97.6)	1 (0.6)	3 (1.8)	168
Occupation						
Employed	8 (5.4)	140 (94.6)	142 (95.9)	1 (0.7)	5 (3.4)	148
Self employed	5 (9.6)	47 (90.4)	49 (94.2)	3 (5.8)	0 (0.0)	52
Number of children						
1-2	7 (8.0)	81 (92.0)	83 (94.3)	2 (2.3)	3 (3.4)	88
3-4	5 (5.6)	85 (94.4)	87 (96.7)	2 (2.2)	1 (1.1)	90
Above 4	0 (0.0)	21 (100.0)	21 (100.0)	0 (0.0)	0 (0.0)	21
None	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1

Source: PMTCT study 2013

4.7 Factors encouraging male involvement in PMTCT and HCT.

Generally questions on factors that may encourage male involvement in PMTCT were asked. The responses were varied but not very different. The study revealed that men were motivated to participate in PMTCT activities based on the knowledge that they are bound to have HIV free children (52.5 percent) in the event that they themselves as parents tested positive to HIV. They realize that this was only achievable by seeking advice from healthcare

providers. Support from health personnel as a factor encouraging male participation received only 13.5 percent. And protecting the spouse from eventual death during or after pregnancy (maternal death) had a 20.5 percent rate.

Tables 4.10 and 4.11 below show the statistical distribution of these responses.

Table 4.10 Count Percent responses of men on factors encouraging couple counselling in PMTCT

Factors encouraging couple counselling						
	To access PMTCT services	To prevent partner re-infection	Assertiveness	Positive attitude of healthcare givers	Don't know	Total
Age						
24-28	12 (42.9)	4 (14.3)	7 (25.0)	4 (14.3)	1 (3.6)	28
29-33	12 (26.1)	7 (15.2)	15 (32.6)	9 (19.6)	3 (6.5)	46
34-38	17 (30.4)	17 (30.4)	8 (14.3)	11 (19.6)	3 (5.4)	56
39-43	12 (26.1)	11 (23.9)	15 (32.6)	8 (17.4)	0 (0.0)	46
44-48	6 (30.0)	2 (100.0)	6 (30.0)	6 (30.0)	0 (0.0)	20
49+	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)	4
Total count	61	42	52	38	7	200
Residence						
High density	18 (25.7)	14 (20.0)	20 (28.6)	16 (22.9)	2 (2.9)	70
Low density	43 (33.1)	28 (21.5)	32 (24.6)	22 (16.9)	5 (3.8)	130
Total count	61	42	52	38	7	200
Education						
Primary	4 (40.0)	0 (0.0)	1 (10.0)	5 (50.0)	0 (0.0)	10
Secondary	5 (22.7)	5 (22.7)	7 (31.8)	5 (22.7)	0 (0.0)	22
Higher	52 (31.0)	37 (22.0)	44 (26.2)	28 (16.7)	7 (4.2)	168
Total count	61	42	52	38	7	200
Occupation						
Employed	47 (31.8)	31 (20.9)	36 (24.3)	28 (18.9)	6 (4.1)	148
Self employed	14 (26.9)	11 (21.2)	16 (30.8)	10 (19.2)	1 (1.9)	52
Total count	61	42	52	38	7	200

Source: PMTCT study 2013.

Table 4.11 percent responses of married men on factors encouraging male participation in PMTCT.

Factors encouraging male involvement in PMTCT activities in the community						Total count
	Knowledge of not producing an HIV positive child	Support from healthcare personnel	To access ARVs	To protect spouse from dying during pregnancy/delivery	Don't know	
Age						
24-28	14 (50.0)	3 (10.7)	2 (7.1)	7 (25.0)	2 (7.1)	28
29-33	29 (63.0)	5 (10.9)	3 (6.5)	6 (13.0)	3 (6.5)	46
34-38	25 (44.6)	7 (12.5)	1 (1.8)	16 (28.6)	7(12.5)	56
39-43	28 (60.9)	8 (17.4)	4 (8.7)	5 (10.9)	1 (2.2)	46
44-48	7 (35.0)	2 (10.0)	3 (15.0)	7 (35.0)	1 (5.0)	20
49+	2 (50.0)	2 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	4
Total count	105	27	13	41	14	200
Residence						
High density	27 (38.6)	7 (10.0)	7 (10.0)	26 (37.1)	3 (4.3)	70
Low density	78 (60.0)	20 (15.4)	6 (4.6)	15 (11.5)	11(8.5)	130
Total count	105	27	13	41	14	200
Education						
Primary	1 (10.0)	3 (30.0)	3 (30.0)	3 (30.0)	0 (0.0)	10
Secondary	13 (59.1)	5 (22.7)	1 (4.5)	2 (9.1)	1 (4.5)	22
Higher	91 (54.2)	19 (11.3)	9 (5.4)	36 (21.4)	13(7.7)	168
Total count	105	27	13	41	14	200
Occupation						
Employed	82 (55.4)	19 (12.8)	8 (5.4)	28 (18.9)	11(7.4)	148
Self employed	23 (44.2)	8 (15.4)	5 (9.6)	13 (25.0)	3 (5.8)	52
Total count	105	27	13	41	14	200

Source: PMTCT study 2013.

4.7 Factors discouraging male involvement in PMTCT and Couple Counselling.

Table 4.12 below shows count and percent distribution of responses by age, residence, education and occupation. It was observed that out of 62 respondents 28.4 percent of the age group 39-43 felt discouraged to attend couple counselling sessions due to stigma and 23.8 percent did so because of inaccurate results from health centres. About 22.6 percent shunned couple counselling due to fear of knowing their status and hence stigma. Only 11.1 percent said they had no knowledge as to why some men stayed away from couple counselling and HCT.

Table 4.12 Factors discouraging male involvement in couple counselling

Factors discouraging couple counseling						
	Fear	Inaccurate results from health centres	Stigma	Lack of knowledge	Don't know	Total count
Age						
24-28	7 (11.3)	4 (9.5)	15(22.4)	1 (5.6)	1 (9.1)	28
29-33	14 (22.6)	11 (26.2)	12(17.9)	3 (16.7)	6 (54.5)	46
34-38	18 (29.0)	15 (35.7)	13(19.4)	8 (44.4)	2 (18.2)	56
39-43	14 (22.6)	10 (23.8)	19(28.4)	2 (11.1)	1 (9.1)	46
44-48	6 (9.7)	1 (2.4)	8 (11.9)	4 (22.2)	1 (9.1)	20
49+	3 (4.8)	1 (2.4)	0 (0.0)	0 (0.0)	0 (0.0)	4
Total count	62	42	67	18	11	200
Residence						
High density	16 (25.8)	16 (38.1)	28(41.8)	5 (27.8)	5 (45.5)	70
Low density	46 (74.2)	26 (61.9)	39(58.2)	13 (72.2)	6 (54.5)	130
Total count	62	42	67	18	11	200
Education						
Primary	3 (4.8)	3 (7.1)	2 (3.0)	0 (0.0)	2 (18.2)	10
Secondary	9 (14.5)	5 (11.9)	8 (11.9)	0 (0.0)	0 (0.0)	22
Higher	50 (80.6)	34 (81.0)	57(85.1)	18 (100)	9 (81.8)	168
Total count	62	42	67	18	11	200
Occupation						
Employed	46 (74.2)	31 (73.8)	54(80.6)	12 (66.7)	5 (45.5)	148
Unemployed	16 (25.8)	11 (26.2)	13(19.4)	6 (33.3)	6 (54.5)	52
Total count	62	42	67	18	11	200

Source: PMTCT survey 2013.

Table 4.13 below shows factors discouraging male involvement in PMTCT in the community. The study indicates that the age group 44-48 had 8 (40%) participants who said men are not involved in PMTCT activities due to fear of knowing their status. Among the age group 29-33, 15 (32.6%) said that men are not involved due to lack of knowledge

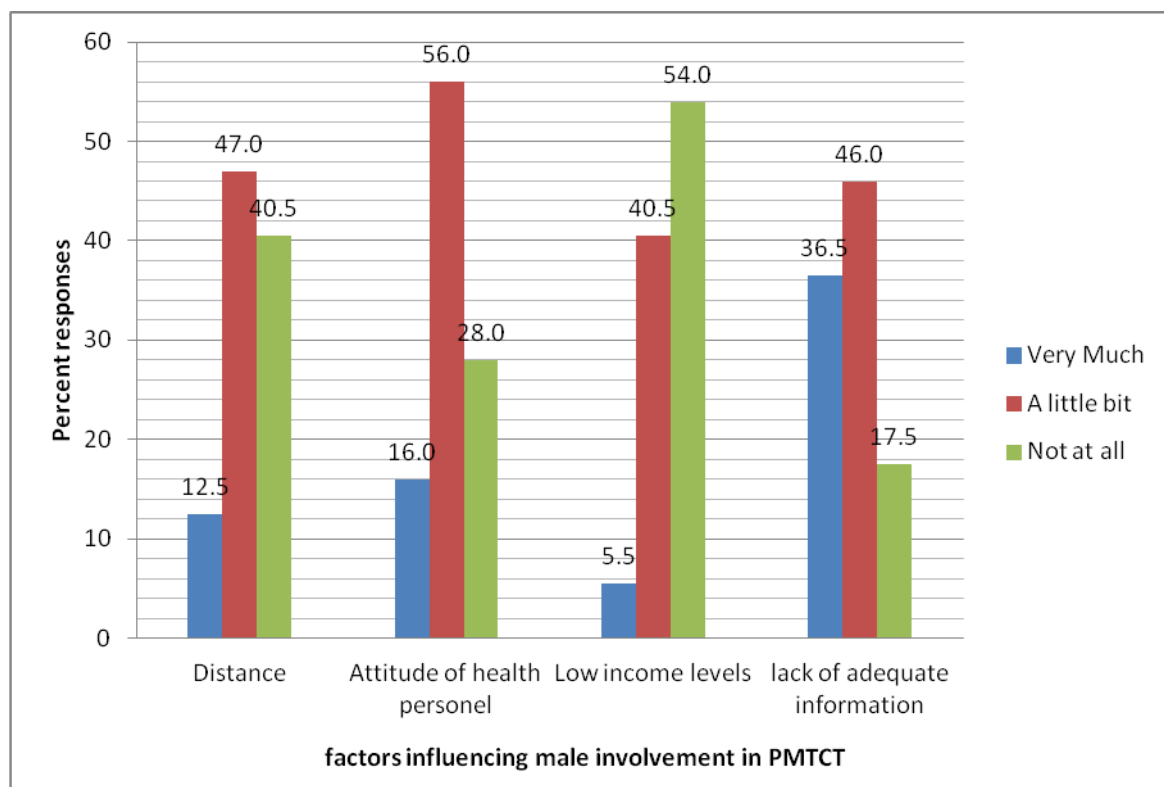
Table 4.13 Factors preventing male involvement in PMTCT in the community

Factors preventing male involvement in PMTCT services in the community							
	Fear of knowing their status	Lack of knowledge	Stigma	Gender bias/woman issue	No time	Don't know	
Age							
24-28	10 (35.7)	6 (21.4)	6 (21.4)	2 (7.1)	4 (14.3)	0 (0.0)	28
29-33	8 (17.4)	15 (32.6)	6 (13.0)	4 (8.7)	11(23.9)	2 (4.3)	46
34-38	20 (35.7)	11 (19.6)	6 (10.7)	10 (17.9)	9 (16.1)	0 (0.0)	56
39-43	12 (26.1)	14 (30.4)	7 (15.2)	9 (19.6)	4 (8.7)	0 (0.0)	46
44-48	8 (40.0)	2 (10.0)	4 (20.0)	0 (0.0)	6 (30.0)	0 (0.0)	20
49+	1 (25.0)	2 (50.0)	1 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	4
Total count	59	50	30	25	34	2	200
Residence							
High density	25 (35.7)	16 (22.9)	7 (10.0)	10 (14.3)	11(15.7)	1 (1.4)	70
Low density	34 (26.2)	34 (26.2)	23(17.7)	15 (11.5)	23(17.7)	1 (0.8)	130
Total count	59	50	30	25	34	2	200
Education							
Primary	3 (30.0)	1 (10.0)	0 (0.0)	0 (0.0)	6 (60.0)	0 (0.0)	10
Secondary	5 (22.7)	10 (45.5)	5 (22.7)	1 (4.5)	1 (4.5)	0 (0.0)	22
Higher	51 (30.4)	39 (23.2)	25(14.9)	24 (14.3)	27(16.1)	2 (1.2)	168
Total count	59	50	30	25	34	2	200
Occupation							
Employed	49 (33.1)	31 (20.9)	23(15.5)	22 (14.9)	22(14.9)	1 (0.7)	148
Unemployed	10 (19.2)	19 (36.5)	7 (13.5)	3 (5.8)	12(17.0)	1 (1.0)	52
Total count	59	50	30	25	34	2	200

Source: PMTCT survey 2013

Figure 4.1 below presents variables influencing male involvement in PMTCT. Fifty four percent of the participants said low income levels had no bearing in discouraging male involvement, 40.5 percent said it had a little impact and only 5.5 percent said it had a big impact. With regards to having inadequate information on PMTCT, 36.5 percent said this had a great impact, 46 percent said it had a little impact and 17.5 percent said it had no impact at all. Lack of adequate information has the highest percentage of respondents (36.5) saying it has a great impact on how males respond to PMTCT activities. Attitude of health personnel and distance have 16 and 12.5 percent of the respondents respectively saying they have a great impact in influencing male involvement in PMTCT. However a larger percentage of the respondents said low income levels (54), attitude of health personnel (48), and distance (40.5) had no bearing on how men responded to PMTCT services. Figure 4.1 below shows responses to the extent some factors influence male involvement in PMTCT.

Figure 4.1 Factors influencing male involvement in PMTCT



Source: PMTCT study 2013

Multiple regression analysis was run to assess the attendance level of men in HCT during antenatal care of their spouses. At less than 10 percent the results of a multiple regression model on variables that would influence men to attend HCT with their spouses during antenatal visits show that the level of education (.097) and occupation (.050) make a unique significant contribution to the dependent variable, while age (.273) and income (.310) have no significant contribution on men accompanying spouses and receiving HCT on PMTCT of HIV during antenatal. The results are shown in Table 4.15 below.

Table 4.14 Variables assessing the attendance level of men in HCT during antenatal care.

Variables	Unstandardised-coefficients		Standardized coefficients	t	Sig	95% confidence interval (CI) for B	
	B	Std error	Beta			Lower bound	Upper bound
Level of school attended	-15.126	9.066	-.166	-1.669	.097	-33.006	2.753
Monthly income	-9.168	9.011	-.095	-1.017	.310	-26.940	8.604
Age of respondent	2.866	2.610	.077	1.098	.273	-2.280	8.013
occupation	-17.249	8.745	-.161	-1.972	.050	-34.496	-.003

Source: Field data 2013.

Multiple regression analysis was done to assess the variables that would encourage condom use among men in the event that they and/or their spouses tested positive for HIV. The results of the multiple regression model at less than 10 percent show no significant relationship between the variables and condom use. However there is a weak positive correlation between highest level of school attended, monthly income, and age of respondent, occupation and willingness of condom use in the event of an HIV positive test of either a spouse and/or the

respondent. Residence has a negative correlation on condom use. Table 4.16 presents the results of the multiple regression.

Table 4.15 Results for variables that may affect condom use.

Variables	Unstandardised co-efficients		Standardized co-efficients	t	sig
	B	Std error	Beta		
1 (constant)	.076	.269		.283	.778
Residence	-.079	.072	-.082	-1.105	.271
Level of school attended	.014	.093	.016	.154	.878
Monthly income	.089	.091	.093	.983	.327
Age of respondent	.018	.027	.050	.691	.491
occupation	.087	.088	.082	.988	.324

Source: Field data: 2013

The chi square results show that at less than 10 percent there is significance association between occupation and knowledge that MTCT can be reduced by a woman taking special drugs, participating in PMTCT and going with the spouse for antenatal care. However, residence shows no significance association with any of the said variables as the values .834, .351 and .299 are larger than the significance value of 0.1.

Table 4.16 Chi square result analysis for male involvement in PMTCT

Variables	Chi sq	
	Residence	Occupation
Do you know that MTCT can be reduced by a woman taking special drugs?	.834	.075
Ever participated in PMTCT activities?	.351	.265
Did you ever go with spouse for antenatal?	.299	.746

Source: Field data 2013

4.8 Views of men on male involvement in PMTCT

Two Focus Group Discussions and few random interviews were conducted on men that were present at the clinics for HCCT and under five visits. Various questions concerning their involvement in their partners' antenatal welfare and later the wellbeing of their children were asked. Various views were obtained and most of them were positive. When asked why they were present at their partners' first visit at antenatal one man responded:

It is important as a couple to know our HIV status. We are told of the benefits of knowing first hand and receiving necessary treatment in the event of a positive test in pregnancy. There is no need of having a sick child when we have the information on prevention.

When further asked if all men thought the same way despite having the knowledge of PMTCT in antenatal care another man said:

It's not an easy decision to make. Testing for HIV is a matter of life and death. It takes a lot to gather up the courage and come to the clinic for this exercise. We have had relationships before marrying and there's no way of knowing whether one is negative or positive. Many of us are actually scared of the outcome.

Another man said:

We live in a society that is so traditional when it comes to gender roles. Coming with your spouse to the clinic is some cases looked at as a weak thing to do or that you are jealous. Society expects the man to provide for the spouse and not to tag along at hospitals even when there's nothing really serious with your wife.

General observation showed that the couples that come for HCCT in antenatal care are counselled as a group and then later go in as couples to test for HIV and await their results. The researcher views this as a deterrent to male involvement. The system does not give privacy to the clients that come through for HIV testing. Besides there are other patients that go to the clinics for various treatments; all these get to see and know who is testing for HIV.

This view was expressed by some men saying:

Most men fear to come through because of the openness of the exercise. We live within the same community and even if we don't know each other personally we feel exposed. The freedom of knowing you are positive and living among others is compromised as we feel everyone knows your status even when they don't.

A health care provider agreed to these sentiments saying:

Our clinic facilities are not well laid out. We do realize the element of fear and stigma but there's not so much we can do. Some men have come here with their spouse for HCCT in antenatal but after counselling they have left without testing, because they fear to be exposed. However most of those that come do test. Among few that end up not testing it's mainly because they fear to know their status.

Another nursing staff said:

Some men have come before with their spouses for antenatal. However they've find themselves seated among women and felt awkward about the whole situation. They have ended up leaving without even seeing and talking to the health care providers.

One man openly admitted that there was no need for him to test for HIV when his wife is mandated to test during pregnancy.

If she tests positive it means we are both positive and then we will decide whether to start treatment or not.

Another man expressed fear especially when it came to discordance. He said:

If my spouse tests negative and I test positive it is not a good thing. This will expose me as having been unfaithful. It will bring problems in the home. There is also stigmatization that may come from the family and even friends.

Generally the results show a high rate of male adherence to PMTCT activities. Most knowledge concerning PMTCT activities is from health care providers then followed by radio and TV. Men may be willing to accompany their spouses in most cases but are hindered by the layout of the healthcare facilities which have no privacy.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

The general objective of this study was to investigate factors that influence male involvement in PMTCT in Lusaka district. From the findings it was observed that knowledge has a very big impact on male involvement. This in turn influences their attitudes and practices.

5.1 knowledge of about PMTCT

Knowledge about PMTCT is cardinal to bring about an increase in male involvement. The middle aged group of 34-38 years, had more knowledge about PMTCT, followed by the 29-33 year age group. This shows that those who are less than 29 years old have less knowledge about PMTCT and hence affecting their participation. The number of children one has does influence male involvement. Participants with between 3-4 children have more knowledge on PMTCT and a high participation rate in PMTCT activities. This was followed by those with between 1-2 children. The participants with over 4 children know very little about PMTCT despite having a higher rate of escorting their spouses for antenatal care. This is a contrasting effect as it is expected that when one has more children the rate of exposure to PMTCT and antenatal care should be higher than those with less children.

5.2 A comparative analysis of HCCT in antenatal care for PMTCT at Chelstone and Chainda clinics

Statistics show that 62 (48%) of the participants in the low density areas get their information on PMTCT from health care providers followed by radio/TV, while this is the opposite for those in high density residential areas with most getting information from radio/TV followed by healthcare personnel, (see Table 4.4). The study indicates that there is a high rate of

antenatal attendance from among the participants in high density residential areas compared to those in low density residential areas. Information collected from health care personnel clearly attests to this. According to authorities at Chelstone clinic, there is a challenge with male partners in accompanying their spouses for counselling and HIV testing in antenatal care. Despite the efforts to encourage pregnant women to come along with their male counterparts for testing at their first antenatal visit, most will return alone with excuses from their partners.

In responding to a question why there is poor attendance of men in HCCT at Chelstone clinic a nursing staff said:

We do tell the women to come with their spouses for first HCT in antenatal but they always come back without their husbands.

Their excuses span from them being busy at work to not having time to attend to such programmes.

Chelstone clinic has less than 5 percent attendance in couple counselling a month. The low rate of attendance is attributed to the stigma that comes with a positive test of HIV, and others give excuses about being busy with work. However, men encourage their spouses to go ahead with HCT and eventually PMTCT in the event that they test positive for HIV during pregnancy. Their reaction to a positive HIV test in their spouses is usually calm and supportive and there is no resistance from the female folk in HCT despite the absence of their male partners.

In an interview with the nursing staff as to whether the women do face resistance and abuse from their spouses once they test positive for HIV the response was:

There are very few of such situations. If anything there is only one such case we know of at our health facility. Men are supportive even if they do not test for HIV themselves.

Auvinen *et al.* (2013), say that ‘barriers to male participation are linked to a male partner himself, to health care services and to society.’ This means men have it in their minds that PMTCT is a woman’s issue and not a man’s’ responsibility; health care facilities are not designed to accommodate men so they could feel comfortable, and society on the other is more traditional when it comes to reproduction and maternal health care. It is therefore, imperative that more and different approaches to encouraging men’s presence during HCT are considered. The absence of men during HCT in antenatal care at Chelstone clinic could prove to be a barrier to achieving 100 percent PMTCT in the area as men are not tested and do not get to know their HIV status.

If a female tests positive to HIV she can start medication, the man on the other hand may not bother to undergo HIV testing and therefore bring about re-infection to the woman and the unborn child. According to an HIV and AIDS activist, Kasune Zulu, ‘most couples living with HIV re-infect each other by having unprotected sex’ (Post newspaper, August 2013). In the event that the female tests negative to HIV it may not be known whether the male partner is equally negative. If it so happened that the man is positive, the pregnant woman will be exposed to the virus and eventually infect the unborn child, especially if she does not go for the second and/or third tests of HIV in antenatal care. Peltzer, *et al.* (2011), say that ‘the continuation of unprotected high risk sex during the middle to later stages of pregnancy may go undetected for the purposes of PMTCT unless women are re-tested just prior to delivery.’ A male partner can prevent his spouse and infant from being exposed to HIV by preventive behaviour in their relationship (being faithful to their spouse) and by utilizing health care

services. Men who go for voluntary counselling and testing (VCT) with their spouses can better plan their future together and take care of their children.

Despite challenges in couple counselling at Chelstone clinic, the picture is different and more positive at Chainda clinic. The clinic boasts of a near 100 percent participation in couple counselling during antenatal. During these sessions men attest to knowledge of ways of transmission of HIV from one partner to another. Knowledge on ways of transmission of HIV from mother-to-child was varied with the majority having heard about transmission during delivery and pregnancy. Few knew about transmission during breastfeeding. When asked how the clinic manages to achieve such a high level of attendance in couple counselling the health care provider said:

We ask the women to go back and come with their spouses for the first antenatal visit so that they are counseled and tested together. When they say they cannot come because they are busy we ask them to come on Saturdays when they are not working. With that we have been able to capture most couples.

An on the spot check of these couple counselling sessions revealed a high level turn out of men in HCCT on Saturdays compared to the assigned days for antenatal and HCT during the week. The men were very cooperative and responsive to couple counselling as they participated in the counselling process. When asked why they attend to these sessions with their spouses when other men would prefer to stay away altogether some responded saying:

It is important to adhere to calls from health care givers and be supportive of my spouse. If I choose not to undergo HCCT of

HIV in pregnancy it means I am an irresponsible husband.

*It is important that we know our status and take precaution
as we are told by health staff.*

Another male participant said:

*When my wife said I was needed at the clinic I thought there
was something wrong with the pregnancy. But coming here I
realize the importance of HCCT in pregnancy. Why plan to
have a child when you know he may not live long enough
for us to enjoy a health parenthood? Now that I know that there
are preventive measures I will encourage other men to attend
HCT with their spouses for their own good.*

5.3 Attitudes and practices of men towards PMTCT

With the knowledge on HCT and PMTCT men get from health centres, they are ready to support spouses through PMTCT in the case of a positive test for HIV. In addition, they are ready to use preventive measures such as enrolling for uptake of Anti retroviral drugs and condom use in the event that they and/or their spouses tested positive for HIV during pregnancy. Whereas some studies have shown that a lower education level is associated with likelihood to request for HIV testing, this study showed the opposite. From Table 4.5 under findings it was observed that 4 percent of the respondents with primary education would accompany their spouses for HCT in ante natal care as well as willingness to be involved in PMTCT activities, while 64.5 percent of the highly educated would be willing to be involved in PMTCT activities 80.5 percent said they would accompany their spouses for HCT in antenatal care. Only 10.5 percent and 11 percent of those with secondary education would be

willing to involved in PMTCT activities and accompany their spouses for HCT in antenatal care respectively. It can be said therefore that education helps shape attitudes of men in PMTCT. In this case, the higher one goes in education the more positive their attitude is towards involvement. Similarly, a study from Uganda showed that those having at least a post-primary education were more likely to choose to test compared to those with lower education. Another study among Hispanic farm workers in South Florida showed that participants with at least twelve years of education were four times more likely to test compared to those without the same education, (Fernandez *et al.* 2005). In a Vietnamese study low education was associated with not returning for results after having tested, (Okuonzi *et al.* 2000).

‘Men’s attitudes towards women also influence condom use’, (Auvinen *et al.* 2013). Condom use among couples poses a challenge as there are questions about fidelity and trust. Observations revealed that men are hesitant about condom use with their spouses especially when they know that they are faithful and HIV negative. They said if they tested positive they would consider using a condom especially if their spouses were pregnant.

Findings from this study (Table 4.7) reveal that overall, 79.5 percent of the respondents would use a condom in the event that they and/or their spouses tested positive for HIV. In total 2 percent, said that they would not and only 18.5 percent said they were not sure if they would use a condom or not. The main reason given for this was that just knowing about their HIV status is scary enough and thinking about condom use would be the least of their worries in an environment riddled with stigma. ‘All over the world HIV has been stigmatised, making it difficult for people living with HIV to access testing, treatment, care and counselling or even to act on a diagnosis or get advice and treatment, for fear of being judged,’ ([http://dx.doi.org/10.1016/50968-8080\(07\)29029-9](http://dx.doi.org/10.1016/50968-8080(07)29029-9)). According to NAC (2009), the Zambian

youths may have knowledge about HIV and AIDS, but stigma still remains an important hindrance towards applying that knowledge to their own personal risk assessment for behaviour change. In comparison to all the age groups, the age group 24-28 had a low response rate of 60.7 percent in condom use, while the highest was 89.1 percent among the 39-43 age group.

Reacting to the issue of condom use in case of a positive HIV test one man argued that:

There is no way I can be negative and my wife positive. Questions will arise as to where she got the virus from. In any case if we are both positive there is no need for condom use. This is a very delicate issue and we are talking about sexual matters here.

Another man in responding to the same question said that:

There is no need for me to respond to that question because my sexuality, status and whether I would use a condom or not is a private matter and must not be violated by anyone.

It is clear that even though people may know about their HIV status, in marriage condom use will remain a very sensitive subject that either party will find challenging to discuss and later use.

Male attitude towards PMTCT breeds about their practices. PEPFAR, (April, 2013), says that an increasing number of men realise that they can be true partners in the fight against HIV and AIDS in Zambia, where the HIV epidemic continues to disproportionately devastate women and girls. This was in a report of the survey conducted in Luapula Province, under the Safe Motherhood Action Group, where it was observed that, husbands and boyfriends have started to travel with their pregnant partners to antenatal clinic visits, encouraging their

wives to get health checkups before giving birth. Another study reveals that cultivating a male friendly approach in antenatal care is urgent to protect infants from contracting HIV (Auvinen, *et al.* 2013).

From the findings in this survey, Table 4.7 reveals that 78.6 percent of the respondents aged 24-28 admitted willingness to undergo HCT with their spouses before considering getting pregnant, and the 39-43 age group had 69.6 percent response in this category. With regards to participating in activities concerning PMTCT, besides accompanying spouses and undergoing HCT, 47.8 percent of the age group 39-43 said they have been involved in PMTCT activities. Among the 49+ age category none has ever participated in PMTCT activities other than escorting their spouses for antenatal. These include sensitization in the community, workplace HIV and AIDS programmes facilitation and counselling of peers. Overall the participation percentage rate is less than half, clearly indicating that more needs to be done in information dissemination and education to scale up numbers of participants in the exercise. It was also seen that 69.5 percent (Table 4.2) discussed PMTCT with their spouses which is a very encouraging factor as open communication in HIV and AIDS matters is cardinal to prevention and protection

One of the participants in the study said that:

I escort my wife every time she is pregnant and also attend the four sessions of antenatal care because it is the responsibility of both of us.

Another man said:

*I love my wife too much to let her bear the burden by herself.
I make sure whenever I am requested for at the clinic I go.
We have attended HCT together the two times she has been*

pregnant. And I am happy I did it.

According to WHO (2012), men who participate in PMTCT are in more committed relationships, they were also more likely to have previously discussed HIV testing with their partner and willing to confide in their partner if they tested HIV seropositive than men who did not present to the clinic.

One younger man in the couple counselling session argued that:

I am only here because my wife told me that the nurses said she would not be attended to in her antenatal care if I did not accompany her. Since it is the first time she is pregnant I decided I should come and hear for myself why I was needed. I will not however test for HIV; I would not dare do that. (Siningayese kuchita test ya HIV ine iyayi).

Those that have never participated in PMTCT activities said the reasons they were inactive was because they had never been availed information of such activities taking place (13 percent), the greater majority had had no opportunity (36 percent), and others had no time for such activities (25.5 percent). However 79 percent said they would be willing to be involved in PMTCT activities once they knew how.

One of the interesting findings in this study was that even medical practitioners are not expectant of men to be involved in PMTCT. During the survey, while attending one of the PMTCT technical working group committee meetings, a challenge was posed why most PMTCT programmes conducted by various NGOs excluded fathers', one doctor replied:

We do not follow up men because they are not just up to the task. Even if we asked them they would not come. They believe it is the job of a woman to carry a child to full term, deliver and take care of it.

Our concentration is on the mothers. Men are only there to make us pregnant that's all. You won't find anything concerning PMTCT on men.

Health practitioners must realize that their forward thinking attitude could be the main reason why men are in some cases totally absent in PMTCT. If they could realize that an assertive mind towards bringing men to the table on issues of reproductive health and HIV, the many challenges being faced now in their efforts to scale up PMTCT of HIV would be reduced. Men could be absent in some cases because they feel left out in the whole setup of reproductive health and family where even the facilities in gynecology are designed in a feminine manner.

5.4 Factors influencing male involvement in PMTCT.

The survey considered knowledge, attitude and practices as key to the study. Among all three factors knowledge has a positive bearing in some men on involvement in PMTCT. It is the way knowledge is obtained that brings about attitude and finally practices. Though the rate of knowledge is very high among participants (99 percent), attitudes are different with others not fully embracing the importance of impartiality in HCT in antenatal with their spouses. A high participation rate is as a result of knowing that as parents they are more likely to have an HIV free child and overcome maternal fatality. The knowledge that they can access drugs for both themselves and the pregnant mother gives hope for a healthy child and an opportunity to enjoy fatherhood. According to one Kenyan study, male involvement reduced the risks of vertical transmission and infant mortality by more than 40 percent compared with no involvement, (IRIN January, 2012). They realize that taking precaution and preventive measures in avoiding partner re-infection is an advantage for both parents.

Lack of involvement among others is attributed to lack of knowledge. Though they may know how HIV is transmitted from one partner to another as well as the possibility of

infection from pregnant mother to child, they are not drawn to the cause for PMTCT. Fear is a great enemy among men. There is still an element among some people that they are better off not knowing their HIV status. This is usually coupled with stigma to which 33.5 percent of respondents attest to as a reason why some men shun couple counselling. Health care providers are said to divulge information of their status to others and so they lose confidence in going for HCT. Data from South Africa indicate that men are significantly less likely than women to use voluntary counselling and testing (VCT) services and account for only 21 percent of all clients receiving VCT (Peacock, 2003). Further Msuya *et al*; (2008) asserts that men believe that seeking health services is a sign of weakness. In this study, it was revealed that 12.5 per cent of the participants reported that some men were not involved in PMTCT because they believed that it is a woman's issue. Gender bias is at play here though many do not support the assertion. A smaller number of participants said they were not involved in PMTCT due to time factor. Most of their time is taken up by work and other income generating activities to sustain their families.

Inaccurate results from healthcare providers are another factor that discourages male involvement in PMTCT. The element of discordance is not understood by many people in society. Observations during couple counselling show that men are likely to violently bolt out of the relationship if their spouses tested positive for HIV and it turned out they tested negative. According to Beatrice Misoga, PMTCT programme officer with the AIDS Population Health Integrated Assistance (APHIA Plus) in Kenya, gender-based violence is more common in discordant relationships where the man is HIV-negative. "Male involvement has helped realize success with PMTCT programmes where it has been applied because prevention of mother-to-child transmission is a family issue, but yes, there have been challenges in certain aspects like the possibility of gender-based violence targeting women

and more so in a situation where the male partner is not willing to be part of it", (IRIN, 2013 p23). The situation obtaining in Kenya is not different from the picture at home. Information from MCH at both Chelstone and Chainda clinics reveals that gender violence is there in discordant couples, though very few cases have been recorded. Both Chainda and Chelstone clinics have recorded only one such case each. It is therefore important that with such situations occurring, though rare, in order to preserve the benefits of male involvement in PMTCT, health clinics had to become more aware of the counselling needs of men.

Inaccuracy of results does not only occur in discordant couples. There is also a situation where results may not be clear the first time an HIV test is done. When a second test is asked for at the second visit of antenatal and a woman tests positive, tensions will arise in a home especially if the man was not a part of the HCT session. When the spouse reveals the results to him he may refuse to go for the second test himself and accuse the spouse of cheating, hence abandonment. During one couple counselling session one man was so adamant about the possibility of discordance. He said:

Having a positive HIV test for my spouse and a negative in my case is unacceptable. Where will she have got the virus from when I am negative and know very well that I am faithful. That will bring a lot of questions and certainly a problem I would not tolerate.

With such cases occurring some women choose to opt out of PMTCT programmes and only return when it is time to give birth. Thus they will have missed out on the benefits of PMTCT and having an HIV negative child. Even though such cases were rare in this study, it is important to give constant information and messages targeting men on the need to be part of prevention of mother- to- child transmission programmes. This will ensure a hundred percent

achievement of participation and reduction of both infant and maternal mortality due to HIV and AIDS in the country.

Distance and income proved not to be deterrent factors in male involvement. Only 12.5 percent of the respondents said distance to health care centres had a great influence in preventing men to seek health care, while 47 percent said it had little impact. Only 5.5 percent of respondents said low income levels had a much negative influence on male involvement and 40.5 percent said it had a little bit of a negative influence, (Figure 4.1) Though this has no significant effect on male involvement it does have some constraints on the general health system of the nation. According to a UNAIDS report, in developing countries where virtually all HIV MTCT now occurs, constraints related to health system infrastructure, availability of trained personnel, and availability of resources are an inescapable part of decision-making. Information on the economic value of alternative PMTCT strategies can contribute to the design of evidence-based policy (UNAIDS Report on the global AIDS epidemic 2010). A Mid-wife at Chelstone clinic attests to this:

The setup of health care facilities does discourage most men to attend to couple counselling sessions. There is no privacy or seclusion of individuals. They are seen going in and out of the counselling rooms by other patients that have come to seek medical care. This is what they fear and would try at all cost to avoid so that they are not stigmatized against by society.

In comparison to high income countries, the decrease of MTCT of HIV through preventive measures, such as alternative feeding practices in the case of an HIV positive mother, in low income countries is low. The challenge is mainly in obtaining affordable and accessible

breast milk substitutes (Tudor *et al.* 2011). This is despite the impressive progress in the introduction and scale-up of programmes for PMTCT of HIV as an integrated component of antenatal care. An on the spot observation checklist revealed that some low income earners had a challenge in exclusive breastfeeding and/or feeding substitutes. One man who had come with his wife for their six week child results of an HIV test said that:

If our son is positive we will continue with breastfeeding though it might be difficult as he grows older. I am not working and my spouse works as a maid. We survive by people helping us out with food from time to time.

5.5 Challenges in provision of PMTCT services at Chainda clinic

Chainda clinic which has a high participation rate in couple counselling does not offer PMTCT services other than HCT. Once couples have been counseled and tested positive for HIV they are referred to Chelstone clinic or other clinics like Mtendere and Kalingalinga for PMTCT care. This is very risky as some clients may not reach the service provider and could just stay away. Moreover there is no record keeping between the health facilities to show whether all those referred have reached the next health centre for treatment. Apart from that Chainda clinic has no maternity wing and all births occur at either Chelstone clinic or other nearby health centres. This makes it even more difficult to assess levels of PMTCT for those women captured as HIV positive. Willingness to accept PMTCT programmes is high among the couples but the basis for monitoring those that test and later uptake is worrying. Despite these challenges, once mothers have delivered their babies they do return to Chainda clinic for under five care, and the clinic still offers a successful HCT and antenatal care programme.

5.6 Provision of PMTCT services at Chelstone clinic

On the other hand Chelstone clinic, which has less than 5 percent couple counselling participation rate a month, has a near 100 percent retention of all women who test positive for HIV in PMTCT programmes despite the absence of their male partners. However the reality still remains that men should change their perceptions towards maternal health care and get involved in their spouses reproductive health needs. Men play an important role in terms of women's risk of acquiring HIV and prevention in terms of condom use in the couple relationship (Msuya *et al*; 2006 and Farquhar *et al*; 2007). Behavioural change among men is cardinal to this cause.

This discussion has brought to the fore information that men have knowledge concerning PMTCT, though they may be absent in the entire process of antenatal and HCCT at health care centres. It is however important that they should be encouraged to be present at these forums to help prevention and protection of HIV from the mothers to their children.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter looks at the conclusions drawn after the analysis of the findings in this study. Though this was a case study, it is plausible that the picture painted at the two health centres and the residential areas concerned are a reflection of what is obtaining in the country.

6.1 Conclusions

In this study men have been seen to be supportive of their spouses' PMTCT programme even though most of them have not been a part of the HCT process in some cases. In other instances men (over 60 percent) have been part of the HCT process and perhaps will have equally enrolled in the treatment process. The question of whether this experience will have changed their sexual behaviour will still arise.

According to (UNAIDS, 2011), women's decision-making about their pregnancies and health are deeply influenced by their partners, communities and social norms and beliefs regarding HIV and AIDS. This survey reveals that communication between couples is lacking in about 30 per cent of the participants. The 69.5 percent overall rate of couples who have discussed PMTCT issues is not satisfactory in achieving the reduction of both infant and maternal mortality due to HIV and AIDS. The issue of communication in a couple is cardinal to achieving male involvement in PMTCT. Its absence brings about fear to open up especially on the part of a woman. Women will most likely not communicate to their partners the results in HCT/antenatal care if they are not in an open relationship where norms and beliefs are guided by tradition. According to a survey in Uganda, the perception that the husband would approve of a wife's decision to test for HIV was the strongest predictor of whether she had the intention of testing or not (Bajunirwe *et al.* 2005). During this study it was discovered that

in some cases women have not enrolled in the uptake of PMTCT services after they have tested positive for HIV in antenatal for fear of victimization from their spouses. In one study conducted by Homsy *et al.* (2007), partner's consent was the principal reason of opting out of HIV testing. However with almost all women who attend antenatal care testing for HIV men are in most cases accepting their results and encouraging their partners in the uptake of PMTCT services.

Testing for HIV ordinarily is voluntary. Though men may support HCT of their spouses in antenatal care, they do not subscribe to voluntary counselling and testing of HIV. As observed in the findings 99 percent of respondents would support their spouses test for HIV in antenatal care but only 31 percent have gone for couples HIV testing and counselling (CHCT) in the absence of a pregnancy. Findings from this study reveal that overall 79.5 percent rate of men said they would use a condom if they or their partners tested positive for HIV (Table 4.7). The rest either would not or they were not sure about the possibility of using a condom. From this we can assert that partner participation may increase spousal communication about HIV and sexual risk.

Male involvement should be a comprehensive case with all stakeholders bridging the gap of gender bias in reproductive issues. Most PMTCT programmes by various nongovernmental organizations (NGOs) focus on women only. Leaving out the focal person, the man, in the equation is not helping improve the cause - to fight MTCT in communities today. Men's duty should not only end with making women pregnant and providing finances. It should go beyond the moment of fertilization through to the delivery room and post natal care. Such an attitude will propel great success in PMTCT, thereby reducing infant and maternal mortality rates due to HIV.

In Zambia the scale-up of PMTCT services in health centres is officially high and many pregnant women have been captured and enrolled in the uptake of these services. Efforts made to encourage couple counselling in PMTCT have equally been recognized by the Ministry of Health through Global fund (UNAIDS/WHO, 2010).

The picture painted among the participants in this study is encouraging with regard testing for HIV in pregnancy and uptake of services. Whether there is a behavioural change in men and adherence to counselling tips for those that have attended remains to be seen. This can only be obtainable when the rate of HIV in pregnant women and infants is reduced, thus reducing both mother and child mortality rates to HIV in the country. Further, the idea by some men in using their spouses' HIV test results as a measure of their own status should be discouraged by bringing to their understanding issues of serodiscordancy in couples as well as behavioural change in issues of sexuality. The world health organization (WHO) states that, men's use of women as proxies for their own HIV testing suggests limitations in men's understanding of the dynamics of transmission and serodiscordancy (WHO, 2012).

6.2 Recommendations

In order to increase male involvement in PMTCT services in the nation, there is need for the government and stakeholders to realize that what is currently obtaining is not plausible in achieving zero rate of maternal and infant mortality rate to HIV. In view of the findings to this study the following recommendations are made. It is with a hope that if implemented the challenges that arise in some pregnant women's refusal to undergo HCT in antenatal care as well as refusal of uptake of PMTCT services will be curtailed; and further increase the proportion of men attending HCT/antenatal care and reproductive family health in the country.

- Information on HIV and AIDS programme which include aspects of importance of partnership in reproductive and family health should be incorporated in the workplace as a way of involving men in PMTCT.
- Healthcare providers must go all the way out in disseminating information on MTCT/HCT in workplaces as well as communities through door-to-door campaign and sensitization among community members.
- Adequate social behavioural knowledge of HIV prevention within the dynamics of couple relationships should be disseminated through print and electronic media.
- Health care givers must encourage men in their communities to be fully involved in pregnancy, birth-preparedness by promoting facility based deliveries where men are encouraged to be present.
- The government and developing partners should promote family centred approaches in health centres which will encourage exclusive couple counselling and testing in health centres unlike the all inclusive form of HCT.
- Given that most men do escort their spouse for antenatal care though they may not be present inside the health facility, a PMTCT health information desk should be setup outside or at the entrance of the health facility to capture the reluctant men who might be waiting for or leaving their spouses.
- Increase human resource in PMTCT/antenatal care to improve the ratio of practitioner to patient so that health care providers get to know more about the dynamics and qualities of their clients' relationships.
- Health centres should embrace an all inclusive PMTCT facility where HCT/antenatal care, family planning and reproductive health as well as sexuality and behavioural change in a couple are encouraged.

- There is need to introduce a follow-up register programme for HIV positive clients referred to other health centres for PMTCT services as a way of capturing and monitoring them.

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Appendix 1: Questionnaires

QUESTIONNAIRE SERIAL NO.....

THE UNIVERSITY OF ZAMBIA

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

DEPARTMENT OF POPULATION STUDIES

RESEARCH TOPIC: FACTORS INFLUENCING MALE INVOLVEMENT IN PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV - A CASE STUDY OF LUSAKA DISTRICT.

SECTION A: PRELIMINARY QUESTIONNAIRE INFORMATION

NO.	BACKGROUND INFORMATION	RESPONSE/ CATEGORIES	
Q01	Province	.....
Q02	District	.....
Q03	Residence, High density 1/ Low density 2	.....
Q04	Health facility usually accessed	.....
Q05	Residence where health facility is located	.....
Q06	Distance to health facility you usually access	.....
Q07	Mode of transport to health facility	.....
Q08	Date of interview	.....

SECTION B: RESPONDENTS BIODATA

NO.	Questions and filters	Coding category	Skip to
Q09	How old were you on your last birthday?		
Q10	What is your marital status?	Single .....1 Married .....2 Divorced .....3 Separated .....4 Widowed .....5	
Q11	What type of marriage are you in?	Monogamous .....1 Polygamous .....2	
Q12	Which tribe do you belong to?	.....
Q13	What is your religion?	Catholic .....1 Protestant.....2 Muslim .....3 Other, specify.....8	
Q14	Have you ever attended school?	Yes.....1 No.....2	To Q16
Q15	What is the highest level of school you attended?	Primary.....1 Secondary .....2 Higher .....3	
Q16	What is your occupation?	Civil servant.....1 Private sector .....2	

		Business man .....3 Other, specify .....8	
Q17	What is your monthly income?	Less than K500 000 .....1 Between K500 000 and K1000 000 .....2 Above K1000 000 .....3	
Q18	What is your spouse's employment status?	Employed .....1 Unemployed.....2 Self-employed .....3	
Q19	What is your spouse's occupation?	Civil servant .....1 Private sector.....2 Business woman .....3 Other, specify .....8	
Q20	How many children do you have?	.....

SECTION C: KNOWLEDGE

Q21	Has your spouse ever been pregnant?	Yes.....1 No.....2	To Q27
Q22	Is she pregnant now?	Yes .....1 No.....2 Not sure .....9	
Q23	How many months pregnant is she?	.....

Q24	At the time your spouse was pregnant did you ever go with her for antenatal care?	Yes .....1 No .....2	To Q27
Q25	If yes: how many times?	.....
Q26	If YES: Did you receive HIV counselling as a couple at the centre on how to prevent transmission of HIV from the mother to her unborn child?	Yes .....1 No .....2	To Q28
Q27	If not-have you ever received information on how you can prevent transmission of HIV from the mother to her unborn child?	Yes .....1 No.....2	
Q28	Have you ever heard of prevention of mother to child transmission (PMTCT) of HIV?	Yes .....1 No .....2	To Q31
Q29	If yes, where did you hear about PMTCT from?	Radio/TV .....1 Friends .....2 Health personnel .....3 Community health personnel .....4 Other specify .....8	
Q30	What kinds of services are offered in PMTCT of HIV?	AZT-.....1 HAART-.....2 ZUDOVIDINE-.....3 ARV PROPHYLAXIS-.....4 NEVIRAPINE-.....5	

		COUNSELLING .....6 Other specify.....8	
Q31	Have you ever discussed PMTCT of HIV with your spouse?	Yes .....1 No .....2	
Q32	In what ways can HIV be transmitted from the mother to child?	During pregnancy.....1 During delivery .....2 Breastfeeding .....3 Don't know .....4	
Q33	Do you think PMTCT services are necessary in antenatal care?	Yes.....1 No .....2	
Q34	Why?	..... ..... ..... ..... ..... ..... .....
Q35	At what stage is a pregnant woman tested for HIV in antenatal care?	Months	
Q36	Do you know that the risk of mother to child transmission of HIV can be reduced by the woman taking special drugs during pregnancy?	Yes .....1 No .....2	
Q37	Would you encourage your spouse in the uptake of PMTCT services once she tests HIV positive?	Yes.....1 No .....2	

Q38	What are some of the risks of not accessing PMTCT services during pregnancy?	Low birth weight.....1 An unhealthy infant.....2 An HIV positive infant.....3	
Q39	Do you think inadequate knowledge among men affect their involvement in PMTCT?	Yes .....1 Not at all.....2 A little bit .....3	To Q41
Q40	If yes; to what extent?	..... ..... .....

SECTION D: ATTITUDE TOWARDS PMTCT SERVICES AND UPTAKE

No.	Questions and filters	Coding categories	
Q41	Do you think PMTCT services in clinics are important?	Yes .....1 No .....2	
Q42	Why?	..... ..... .....
Q43	Do you believe that pregnant women should undergo HIV counselling and testing?	Yes.....1 No .....2 Other.....8	
Q44	Why?	..... ..... ..... .....
Q45	Do you think the current PMTCT services are adequate and comprehensive?	Yes .....1 No .....2	

Q46	How would you rate the level of sensitization and mobilization for PMTCT services in your community?	Good .....1 Very good .....2 Excellent .....3 Poor .....4 Very poor .....5 Don't know .....7	
Q47	Do you feel accessing PMTCT should be a woman issue?	Agree .....1 Strongly agree.....2 Disagree .....3 Strongly disagree .....4	
Q48	Is it justified that men should refuse to accompany their spouse for antenatal care?	Yes .....1 No .....2 Other .....8	
Q49	Why do you think so?	..... ..... ..... .....
Q50	How do you look at the attitude of health personnel towards PMTCT of HIV in pregnant women?	Good.....1 Very good .....2 Not good .....3 Not very good .....4	

Q51	Do you feel more needs to be done concerning access and delivery of PMTCT services in health centres?	Yes .....1 No .....2 Other .....8			
Q52	Would you be willing to be involved in activities concerning PMTCT of HIV?	Yes .....1 No .....2 Other.....8	To Q54		
Q53	In what way?	..... ..... ..... ..... ..... .....		
Q54	Why not?	..... ..... ..... ..... ..... .....		

Q55	Would you accompany your spouse for HIV testing in antenatal care?	Yes .....1 No .....2	To Q57
Q56	Why?	..... ..... .....
Q57	What would be the main reason for not escorting your spouse for HIV testing in antenatal care?	No time .....1 Lack of transport .....2 Financial difficulties.....3	

		Not necessary .....4	
		Health attendants' bad attitude ...5	
		Others, specify .....8	

SECTION E: PRACTICES

Q58	Have you ever participated in PMTCT activities?	Yes.....1 No .....2	To Q62
Q59	IF YES: What activity have you ever been involved in?	Accompanying Relative/spouse for antenatal .....1 Sensitizing the community .....2 Other, specify .....8	
Q60	What prompted you to get involved?	..... ..... ..... .....
Q61	How often are you involved?	.....
Q62	If NO: Why?	..... ..... ..... .....
Q63	Has your spouse ever tested for HIV as part of her antenatal care?	Yes.....1 No .....2	To Q67
Q64	Did she get the test result?	Yes .....1 No .....2	To Q67
Q65	Did she share with you the results?	Yes .....1	

		No .....2	
Q66	What was your reaction and why?	..... ..... ..... .....
Q67	What advice would you give to a friend or relative whose spouse is pregnant concerning health care?	Go to a health centre.....1 Seek help from community health worker.....2 Other specify.....8	
Q68	How did you react when you were told to test for HIV together with your spouse at antenatal?	Happy .....1 Not happy.....2 Worried.....3 Other specify.....8	
Q69	Other than the time you went for antenatal, have you ever gone back as a couple to test for HIV?	Yes .....1 No.....2	
Q70	Why?	..... ..... .....
Q71	Where was the test done?	Govt hospital.....1 Govt health centre.....2 Mission hospital.....3 Private clinic/hospital.....4 Other specify.....8	
Q72	Would you use a condom if your spouse and/or you tested positive for HIV?	Yes.....1 No.....2 Not sure.....9	

Q73	Why?	..... ..... .....
Q74	Would you be willing to do an HIV test with your spouse before considering getting pregnant?	Yes.....1 No.....2 Not sure.....9	
Q75	Have you ever come across an HIV positive pregnant woman who refused the uptake of PMTCT services?	Yes.....1 No.....2	To Q77
Q76	What reason did they give for refusal of uptake of PMTCT services?	Lack of spousal support.....1 Unfair treatment from health care givers.....2 Inadequate information on PMTCT.....3	
Q77	Would you go for HIV counselling and testing in the event that your spouse tested HIV positive during pregnancy?	Yes.....1 No.....2 Not sure.....9	
Q78	Why?	..... ..... .....
Q79	Out of 10 couples who go for PMTCT, how many do you think would go for counselling, Testing and care?	..... ..... ..... .....
Q80	What are the main reasons/factors that encourage men to get involved in PMTCT services in this community?	..... ..... ..... ..... .....

Q81	What factors prevent men to be involved in PMTCT services in this community?	..... ..... .....
Q82	What factors encourage couple counselling of HIV?	..... ..... ..... .....
Q83	What factors discourage couple counselling of HIV?	..... ..... ..... .....
Q84	Who makes health care decisions in your home?	Myself.....1 My spouse.....2 My spouse and I together.....3 Others, specify.....8	
Q85	To what extent do the following factors affect male involvement in PMTCT? 1. distance 2. attitude of health personnel 3. low income levels 4. lack of adequate information on PMTCT	Very much .....1 Not at all.....2 A little bit.....3	

Thank you for your time and participation.

Appendix: 2

Interview guide for Healthcare personnel

UNIVERSITY OF ZAMBIA

Factors influencing male involvement in PMTCT of HIV

1. What is the level of HCCT in antenatal care in this clinic?
2. How much do men know about PMTCT?
3. What are you doing as a clinic to facilitate the presence of men during HCT in antenatal care?
4. What are the perceptions of men in issues concerning reproductive health?
5. How is couple counselling done in this clinic?
6. What is the attitude of men during couple counselling sessions?
7. Are the current PMTCT services in clinics adequate?
8. What should be done to improve the levels of male involvement in PMTCT and reproductive health?
9. What is the retention rate of pregnant women who test positive for HIV in PMTCT?
10. Have you had any experiences of women who denied enrolling for PMTCT?
11. What reasons did they give for refusing uptake of these services?
12. Do you carry out any community sensitization on PMTCT?

Appendix: 3

Interview guide for in-depth discussion

UNIVERSITY OF ZAMBIA

Factors influencing male involvement in PMTCT of HIV

1. Have you ever heard of PMTCT?
2. Where did you hear about it from?
3. How often have you attended couple counselling sessions and why?
4. Have you done an HIV test together with your spouse during pregnancy?
5. How do you feel about using condoms in the event that any one of you in marriage tests positive for HIV?
6. Do you think it is a good thing for men to refuse to accompany their spouses for HCT in antenatal care?
7. Do you believe that PMTCT is a woman issue?
8. Are you satisfied with the way healthcare providers conduct HCCT in pregnancy?
9. What in your view would be a better way to encourage men to participate in PMTCT?
10. Is income in anyway a barrier to men's presence in PMTCT?
11. What do you think is the reason why some men fail to be part of HCT in antenatal?