

ASSESSING THE EFFECTIVENESS OF COMMUNICATION METHODS USED
FOR MALE INVOLVEMENT IN PREVENTING MOTHER TO CHILD
TRANSMISSION OF HIV IN SELECTED HEALTH CENTRES OF LUSAKA
DISTRICT

By

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**A Report Submitted in Partial Fulfilment of the Requirements for the Degree of
Master of Communication for Development**

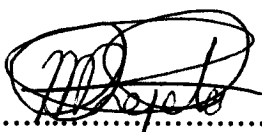
**The University of Zambia
2011**



DECLARATION

I, **Maurice Pengele** do solemnly declare that this report:

- a) Represents my own work;
- b) Has not previously been submitted for a degree at this or any other university;
- c) Does not incorporate any published work or material from another report.

Signed: 

Date: 8th April, 2011

ABSTRACT

This report is from a study whose principal objective was to assess the effectiveness of communication methods used for male involvement in Prevention of Mother to Child Transmission (PMTCT) of HIV activities in health centres of Lusaka district. The study undertook to find out how much the male folk knew about PMTCT and to what extent they were involved in PMTCT activities. It also established the types of communication methods used for men to know that their spouses were HIV positive and the necessary activities aimed at preventing the HIV virus from being passed on to the baby. Fortunately, a lot of women shared that their spouses knew that they were HIV positive and that most of them learnt about PMTCT from health centres and through interpersonal communication with their women. The study also revealed that some women were scared to inform their spouses that they were HIV positive. Actually, respondents expressed fear that low male involvement in PMTCT activities would hinder the uptake of key PMTCT services such as maternal and infant Antiretroviral (ARV) drugs, prevention of HIV re-infections, health centre delivery of HIV exposed babies, and infant feeding options and practices. Indeed, the study revealed that there were no robust communication strategies for active male participation in PMTCT activities. It is, therefore, recommended that there should be continuous sensitization on PMTCT targeted at men and this should be through the use of mass media and targeted discussion fora. Furthermore, male involvement communication efforts should concentrate on making men appreciate that it is their responsibility to ensure that their children are born HIV free. Lastly, but not the least, the fight for male involvement should be a continuous process aimed at ensuring that more and more men acquire knowledge in PMTCT and play their expected roles in reducing HIV prevalence in children.

DEDICATION

This document is dedicated to people who have had great influence on both my life and on my study program for this Masters Degree.

I dedicate this document to my late daughter, Natasha, who died suddenly on 3rd June 2009, the time I was preparing to start studying for this Masters Degree program. *My daughter Natasha, you were just too healthy and too young to die and I was just too young to lose a child in you. May your soul continue to rest in eternal peace.*

I also dedicate the document to all HIV positive mothers. Their anguish inspired me to venture into learning about how best communication methods could help their male spouses to get involved in PMTCT, and thereby lighten their mental, emotional, and physical burden. *May the responsibility of PMTCT not primarily be shouldered by women but by both men and women.*

Finally, I dedicate the document to all children who have acquired HIV from their parents through Mother to Child Transmission (MTCT) of the virus. *“Had your parents, either collectively or individually, taken PMTCT actions, you probably could not have acquired the virus”.*

I henceforth implore all men and women of good will to play their parental roles of ensuring that their off springs do not acquire the HIV virus through MTCT, and even if they so happen to acquire it, despite the efforts invested, then they should ensure that such children access appropriate care and treatment, so that they can grow up normally like any other.

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I am exceedingly grateful to my lecturer and supervisor, Dr. Elijah Bwalya who consistently provided valuable guidance until the finalization of this study report. To my other lecturers, Mr. Fidelis Muzyamba, Mr. Kenny Makungu, Dr. Isaac Phiri, Ms. Josephine Mapoma and Ms. Carole Chibbonta, I am very thankful for the unwavering encouragement and support.

I am greatly indebted to **mothers2mothers (m2m)** Zambia staff for having allowed me to be attached to their organization and do my research on male involvement in PMTCT using their project sites. Due credit also goes to **m2m** site staff who accepted to be hired and worked as data collectors during their free time. As enumerators, they accepted to be mobilized and capacitated at short notice, yet they remained energetic and cooperative in the entire data collection process. Great credit also goes to postnatal mothers of **m2m** support groups for their data feedback and patience as primary data sources in survey interviews and focus group discussions.

Nonetheless, the researcher apportions no responsibility on any of the parties herein mentioned for whatever misrepresentations, misconceptions and/or omissions.

Maurice Pengele

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8th April 2011

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome

AN – Antenatal

AZT – Azdovzine

CMMB – Catholic Medical Mission Board

CIDRZ – Centre for Infectious Diseases Research in Zambia

FGD – Focus Group Discussion

HIV – Human Immune Deficiency Virus

MCH – Maternal and Child Health

MTA – Men Take Action

MoH – Ministry of Health

m2m – mothers2mothers

NVP – Nevirapine

PLWHA – People Living with HIV/AIDS

PMTCT – Prevention of Mother-To-Child Transmission

UNGASS: United Nations General Assembly Special Session

USAID – United States Agency for International Development

PEPFAR – President’s Emergency Plan for AIDS Relief

PN – Postnatal

UNZA – University of Zambia

ZDHS - Zambia Demographic Health Survey

ZPCT – Zambia Prevention Care and Treatment

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1.0 Introduction

1.1.1 This document constitutes a report from an assessment of the effectiveness of communication methods used for male involvement in the Prevention of Mother to Child Transmission (**MTCT**) of HIV. It should be pointed out that, even though they do not get pregnant, men have a very crucial role to play in Preventing Mother to Child Transmission (**PMTCT**) of HIV. This kind of transmission from an HIV-infected mother to her child may occur during pregnancy, labour, delivery or breastfeeding, and in all these aspects, the male spouse should have a role to play in so far as PMTCT is concerned.

1.1.2 In order to ensure effective organization and ample access to relevant data sources, the researcher was attached to **mothers2mothers (m2m)** PMTCT program, an organization involved in implementing PMTCT activities. This organization was established in 2001 in Cape Town, South Africa, in response to a perceived gap in the services offered to pregnant women and mothers living with HIV and AIDS.

m2m provides PMTCT education, emotional support, assistance with disclosure of HIV status to partners and family, and guidance with choices on infant feeding. **m2m** has since expanded its services to other countries, including Rwanda, Kenya, Zambia, Malawi, Mozambique, Lesotho and Swaziland, with its vision of a world without HIV infected babies, where mothers with HIV/AIDS live long and healthy lives, raising their children and caring for their families. The goal is to reduce Mother to Child Transmission of HIV and thereby contribute to the long term reduction in the prevalence

of HIV among children. **m2m** Zambia implements PMTCT activities at Government health centres (hospitals, clinics and rural health centers) in Southern and Lusaka provinces. The organization uses HIV positive women called Mentor Mothers to provide PMTCT education and emotional support to their fellow women and couples through one-on-one and support group meetings. These women are first trained in PMTCT and HIV and AIDS before being deployed to work in particular health centers.

1.1.3 The aim of the study was principally to find out about the effectiveness of communication methods used for male involvement in PMTCT. It should normally be realized that if men do not come along to appreciate and support their spouses in implementing specific PMTCT actions, or the two agreeing on particular PMTCT social and medical related concerns, then the likelihood of having an HIV negative baby from these HIV positive parents would be drastically reduced. This study was therefore intended to delve into a very delicate but extremely important undertaking.

What should further be understood is that men might be in desperate need of information about PMTCT, but the specific type of information and manner in which such information is given to them might have a great bearing on whether the couple ends up with an HIV negative baby or not. For instance, the man first and foremost needs to know that his pregnant woman has tested positive for HIV; Once the man has been equipped with this basic knowledge, he then needs to be counseled that he should not continue having unprotected sex with his spouse in order to avoid HIV re-infection which might end him and his spouse with drug resistant HIV strains; Probably even before that, this man needs to know that it is important for him to also be tested for HIV, in case he is found to be negative so that he is advised on how to remain negative;

Mainly for the benefit of his expected baby, the man needs to learn about how HIV can be transmitted from his spouse to this “innocent” baby and how certain medical and psychosocial measures can prevent this from happening; and finally, this man needs to be told about how he and his spouse can live healthy and productive lives and continue to care for themselves and their families despite being HIV positive.

1.2.0 Background information

1.2.1 Description of study area

Lusaka is the capital and largest city of Zambia. It is located in the southern part of the central plateau of the country, at an elevation of 1300 m (4256 ft). According to the preliminary results of the 2010 National Census, the city has a population of 1,742,979 and is considered as one of the fastest growing (in terms of population) cities in Africa (<http://www.citypopulation.de/Zambia.html>).

It is a commercial centre as well as centre of government, and the four main highways of Zambia radiate north, south, east and west from it.

In terms of the pandemic, Lusaka is among those places most heavily burdened by HIV. Public-sector antenatal and delivery care occurs in 24 government clinics that are spread throughout the city. Each year, there are approximately 45,000 births in this system (*Central Board of Health, 2002*). In late 2001, the Zambian government began implementing services to prevent mother-to-child HIV transmission (PMTCT) in Lusaka and expanded this to all facilities in just over 2 years. From July 2002 to December 2006, the proportion of women attending antenatal care clinics who accepted HIV testing increased steadily from 71% to 94%. During that same period, the absolute

number of women testing positive for HIV also increased. However, as a proportion of those accepting testing, the number testing positive declined from approximately 24.5% (3rd quarter 2002) to 21.4% (4th quarter 2006). Yearly seroprevalence were 24.8% in 2002; 24.0% in 2003; 23.0% in 2004; 22.3% in 2005; and 21.6% in 2006 (*ZDHS, 2007*)

1.2.2 About Mother to Child Transmission of HIV

Mother-To-Child Transmission (MTCT) is simply the term used to describe how a mother may pass HIV, the virus that causes AIDS on to her baby. According to UNICEF (*2004:6*), about 35 per cent of all babies born to mothers with HIV, who do not receive the right medicine and care, contract the virus. UNICEF further indicates that there are three ways that a mother may pass HIV to her baby: (1) during pregnancy; (2) in childbirth and delivery; and (3) during breastfeeding. The UNAIDS and WHO (*AIDS epidemic update, 2008:5*) states that every minute of every day, a baby is born with HIV, passed on by their mother during pregnancy, labour or delivery.

In 2006, nearly half-a-million babies on earth were born with HIV. When with medicine and health care, more than 98 per cent of pregnant women with HIV do not pass the virus to their baby. Today, fewer than 10 per cent of pregnant women with HIV receive such medicine and care (*UNICEF, 2006:5*)

In resource rich countries, pregnant women are routinely tested for HIV as part of their standard antenatal care. If the expectant mother has HIV, securing a healthy future for her unborn baby is relatively straightforward. (This is not to underestimate the anxiety and uncertainty that any pregnant woman would feel on discovering that she has HIV).

With the package of care available, pregnant women in rich countries can be reassured by the knowledge that the likelihood of passing HIV on to their baby is very low.

The situation is different for women in poor countries. The fact that so many mothers are unaware that they can pass on HIV to their baby and the reality of the lack of treatment and care for children with HIV is a somber message. Yet there are grounds for hope. Effective steps are being taken now to prevent babies being born with HIV, and they are being implemented in some of the worst-hit countries. Successful approaches need to be rapidly expanded into nationwide programmes in order to ensure that children are born free, live free and stay free from HIV. The medical recommendations for the prevention of mother-to-child transmission (PMTCT) of HIV made by PMTCT programs are often difficult for women to implement because of community norms, values, and beliefs. For example, taking medication during pregnancy and using a breast milk substitute or exclusively breastfeeding and then early weaning are not normative practices for women. Many women are uncertain of the effect of these recommendations on their pregnancy and infant. Moreover, women may face stigma and other social costs if they follow providers' PMTCT recommendations (*WHO, 2006:1*).

Another barrier that interferes with the prevention of vertical transmission is that health providers are often overextended. According to the Times of Zambia Newspaper (*2nd March 2011*), by December 2003, about 2,000 Zambian nurses, enough to run the University Teaching Hospital (UTH) were discovered to be working in the UK as Zambian hospitals remained grappling with a critical shortage of nurses. The World Health Report (*2006:8*) states that the driving forces for migration by medical workers were various and included low remunerations, poor working conditions and absence of

career development schemes. The report further indicates that, in 2004 Britain had a nurse work force of which 43 per cent were foreign trained, and that some 25 per cent of the doctors employed in Canada and United States were originally trained abroad.

HIV services have been added to existing responsibilities even as the number of nurses has declined in most African health facilities. In numerous settings, there are not enough nurses and midwives to give needed information and support to patients because of high rates of migration for “greener pastures” in Europe, Australia and North America (*World Health Report 2006*:8). In high HIV prevalence settings, many providers themselves may suffer from AIDS-related illnesses. PMTCT programs have also found it difficult to follow up with women after delivery to address infant feeding, infant health, family planning, and women’s health. In many countries, once women deliver, most do not return to the antenatal care (ANC) or maternal child health (MCH) clinics where they received PMTCT services. This lack of participation in PMTCT-related programs during the postpartum period contributes to pediatric HIV infections. However, this can be reduced by improving the follow-up of HIV-positive mothers and their infants and fostering their utilization of health services.

1.2.3 Zambian PMTCT Context

In 2004, a National PMTCT Communication Strategy was developed as a result of an extensive series of meetings and discussions. A combination of health workers, neighbourhood health committee members, Central Board of Health (CBOH) and District Health Management Teams (DHMT) representatives, implementing partners, PMTCT experts and community health communicators developed this strategy through a

writing workshop held in March 2004 (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:3*).

The purpose of this document was to guide those involved in PMTCT activities throughout Zambia in addressing key issues, which affect the success of PMTCT interventions. This document was meant to be user-friendly and provide a simple framework for guiding communication activities. It was meant for health workers, DHMTs, implementing partners, CBOH and any other interested partner working in PMTCT. It was not meant to be a verbose document which sits on office shelves, instead, it was meant to be a living document which is put to use in each district and community wishing to undertake PMTCT activities.

PMTCT services were first introduced in Zambia in 1999 through the Ministry of Health in conjunction with UNICEF through a pilot project in Lusaka, Mbala and Monze to ensure both urban and rural sites (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:4*). The pilot project has expanded since that time into many more additional sites country wide.

While the expansion has progressed well, there remain a number of issues that have affected the success of PMTCT uptake and have hindered efforts to date. The PMTCT Communication Strategy identified some of such issues with their possible implications. Some of them could be outlined as follows:

- **Women and their partners have limited information on PMTCT** - The document indicates (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:4*) that PMTCT is still a relatively new concept for many young people

and the general populace. What this entails is that, while some information campaigns may have been underway for some time now, there are still many people that lack the basic information. This being the situation, it is highly likely that some people may only learn about PMTCT when confronted with a pregnancy, which could even be unplanned for. On this particular hindrance to do with poverty of PMTCT knowledge, men could be worst culprits.

- **Stigma surrounding HIV remains a problem and limits the success of PMTCT interventions** - Stigma is a barrier to couples going for VCT since HIV is still largely viewed as a death sentence by many people (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:5*). HIV is often associated with immoral behaviours which makes many people fear to be tested since they worry they will be seen as bad people and blamed if their result is positive. So they would prefer to remain ignorant of their HIV status.
- **Male involvement has been inadequate in PMTCT communication initiatives to date** – The National PMTCT Communication Strategy argues that programmes have largely focused on encouraging women to go for PMTCT services but have often left out men as critical decision-makers (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:5*). Indeed, if men are not informed of the benefits of PMTCT and clearly understand the risks to their children, they would not become a supportive force for PMTCT uptake and compliance.
- **Communities often don't speak openly about sexual matters or HIV/AIDS** – The Zambia National PMTCT Communication Strategy also cites cultural norms, as

often not allowing men and women to speak openly about sexual matters (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:5*). Such a scenario would definitely hinder communication about PMTCT and other reproductive health related topics.

- **Limited couple communication in general, and around sexual issues in particular, makes it difficult for women to make decisions about PMTCT, condom use, and others** - The Zambia National PMTCT Communication Strategy states that certain intimate topics are often not discussed between a man and a woman, as it is often not seen as acceptable for a woman to raise such issues (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:5*). For example, it may be difficult for a married woman to suggest condom use since it might be viewed as a lack of trust within the marriage. Worse still, in many cases women do not raise issues around HIV testing for fear their husbands will get upset.
- **HIV negative mothers may not be reached with HIV prevention messages where PMTCT services exist** - Traditionally there has been a predominant focus on HIV positive women within PMTCT service provision for many obvious reasons. But it is also important to see PMTCT as a chance to reach HIV negative women (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:5*). At present, there is a tendency to ignore HIV negative women instead of making a deliberate effort to get primary prevention messages to them.

- **Some cultural practices impede the success of PMTCT programmes –**
According to the Zambia National PMTCT Communication Strategy (*Zambia National PMTCT Communication Strategy: Mobilizing People for Action, 2004:6*), some cultural practices are counterproductive to the health of men and women in relation to the risk of contracting HIV. For example, widow inheritance, sexual cleansing and a tendency towards multiple partners may put men and women at greater risk for HIV infection.

1.3.0 Statement of the problem

One of the critical elements in the fight against HIV/AIDS is the Prevention of Mother-to-Child Transmission of the virus – both during and after pregnancy. The World Health Organization/Joint United Nations Programme on AIDS (2007:9) indicates that in resource-rich nations with access to short course antiretroviral (ARV) therapy and replacement feeding, pediatric AIDS has been virtually eliminated as transmission rates have been reduced to 1–2%. In resource-poor countries, however, this definitely is very far from being the case.

In Zambia for instance, 20% of all HIV transmissions is due to Mother-to-Child Transmission (MTCT), and it is the largest source of HIV infection in children below the age of 15 (*UNGASS, 2008:4*). A trend like this one if left unattended to presents a great threat to the future population of the country.

The Zambia Country Report to the UN General Assembly (2008:42), stated that despite the ever-widening availability of life-saving prevention therapies like short-course regimens of ARVs and initiation of Highly Active Anti Retroviral Therapy (HAART),

mother to child transmission rates in Zambia remained as high as 40%, without intervention. To make the situation even worse, existing health care systems, already overwhelmed, are often ill equipped to deal with the unique issues facing pregnant women and new mothers living with HIV.

According the ZDHS fact sheet (2007), the following is the context of the HIV/AIDS and MTCT situation in Zambia:

- Overall HIV prevalence - 14.3%; Among Women (aged 15-49) - 16.1%; Urban- 19.1%; Rural- 10.3% (almost twice as high in urban as in rural); Highest provincial prevalence: Lusaka (21%), Central (18%), Copperbelt (17%), and Western (15%), Southern (14.5%).
- Antenatal Clinic (ANC) prevalence - 21.2%; Infection rates are 4 times higher among young women than their male counterparts; ANC attendance: 93.4%; ANC testing: 48% (probable increase with opt out testing);
- Institutional Delivery: 46.5%; Percentage of HIV positive pregnant women accessing ART for PMTCT: 39.1%; and Increase in percentage of children under 6 months exclusively breastfed - 60%.

1.3.1 Causes and Contributing Factors

In this environment, HIV-positive women in PMTCT care face challenges which may inhibit successful prevention of HIV infection in their infants, including lack of knowledge about HIV and PMTCT and obstacles to attaining that knowledge; lack of women being empowered (knowledge, gender norms around decision making, affecting socio-economic standing); enormous stigma and discrimination which People Living

with HIV/AIDS (PLWHA) face from partners, friends and family; reluctance to undergo HIV testing, to disclose one's status or to adhere to PMTCT interventions which might reveal one's status because of stigma and discrimination, and reluctance of male partners to test, and by extension, support PMTCT interventions (such as primary prevention, alternate feeding options, etc); lack of access to antenatal and delivery services, anti-retroviral prophylaxis or related PMTCT treatments during delivery, or life-sustaining medical/ HIV care after delivery.

Other factors include low staffing levels and capacity and resources to provide PMTCT services, as health care worker capacity is not optimal to support more efficacious PMTCT regimens; the health system runs at 50% capacity, which compromises quality of care; health System heavily dependent on Community volunteer input, with challenges of burn out and high turnover; lack of widespread availability of critical technology and supplies: PCR testing, CD4 testing; fragmented continuum of care for mothers and infants; and lack of understanding about and support for women living with HIV/AIDS (*UNGASS, 2008:12*). These factors, in turn, dramatically undermine the likelihood of successful PMTCT outcomes for pregnant women/new mothers with HIV and their infants. Women facing dual medical and social challenges need both medical solutions and innovative social interventions.

1.4 Rationale of the study

The significance of this study was that it would bring out critical issues concerning communication methods used for male involvement in PMTCT. Throughout the cascade of PMTCT, it is clear that the involvement of the male spouse is very paramount.

For instance, a poverty stricken HIV positive pregnant woman would not alone chose a sustainable feeding method for her expected child without the help of her man; as needed, an HIV positive pregnant woman would not properly adhere to PMTCT ARVs if not supported by her spouse; as needed an HIV positive pregnant woman would not prevent HIV re-infection if the male spouse is not informed about the dangers involved in unprotected sexual intercourse for two HIV positive people as there is a risk of getting a drug resistant virus strain; an HIV positive pregnant woman, unwell and weak, may not afford to dismantle distance factors and deliver her baby at the health facility as required without the help of her spouse; and as needed, a baby born from an HIV positive mother may not receive ARV prophylaxis within 72 hours after birth without the active involvement of the father.

The question is about why there is **low** male involvement in PMTCT and how effective communication methods used for their involvement are in this very important HIV prevention program.

1.5 Outline of chapters.

Chapter one comprises the background to the study, the statement of the problem, the rationale of the study, study objectives and research questions. Chapter two, which is the methodology chapter, is constituted by methods used, the sampling procedure, data collection and data analysis methods. Chapter three is mainly concerned with conceptual and operational definitions, and the main theories underpinning the study. Chapter four deals with literature review. Data analysis and presentation of results are in chapter five.

Chapter six concentrates on the interpretation of results while chapter seven contains the conclusion and recommendations.

1.6.0 Main objective of the study

The main objective of this study was to assess the effectiveness of communication methods used for male involvement in the Prevention of Mother-To-Child Transmission (PMTCT) of HIV in selected health centres of Lusaka district, namely Chawama, Chipata, Kanyama, and George health centres.

1.6.1.0 Specific objectives

1.6.1.1 To identify communication methods used for male involvement in PMTCT activities.

1.6.1.2 To assess the effectiveness of communication methods used for male involvement in PMTCT activities.

1.6.1.3 To seek for communication methods that can help to enhance male involvement in PMTCT activities.

1.7.0 Research questions

1.7.1 What is the current situation of male involvement in PMTCT activities in Lusaka district health centres?

1.7.2 What communication methods are used for male involvement in PMTCT activities?

- 1.7.3** How effective are the communication methods used for male involvement in PMTCT activities in Lusaka district health centres?
- 1.7.4** What communication problems do women face in getting their men involved PMTCT?
- 1.7.5** What are the implications of low male involvement in PMTCT activities?
- 1.7.6** What could be done to improve communication for male involvement in PMTCT activities?

CHAPTER 2: METHODOLOGY

2.0 Introduction

This chapter consists of the research questions, sampling procedure, and data collection and analysis.

2.1.0 Sampling procedures

2.1.1 Selection of study areas: Simple random sampling was used to come up with four (4) public health centres selected out of the five (5) which have **m2m** PMTCT activities in Lusaka district. Selected health centres included Chipata clinic, Chawama clinic, Kanyama clinic, and George clinic health centres.

2.1.2 Selection of 116 HIV positive postnatal women for survey data: From 2 of the 4 health centres selected, 30 HIV positive postnatal women and 28 from the other 2 centres were purposively and conveniently selected based on them having gone through PMTCT experience, their availability and willingness to be interviewed. Support group registers were used to identify these participants with the help of the **m2m** Site Coordinators. These support group registers acted as sampling frames from which required numbers of women were picked using simple random sampling method, which involved picking every fifth client in the register rows. For those who were picked but were not available or willing to be interviewed, the process was repeated until the required sample size was attained. The sample size was set at 10% of the total number of HIV positive postnatal women who attended **m2m** PMTCT support group meetings. Normally, these PMTCT support group meetings were held every week.

2.2.0 Data gathering techniques

2.2.1.0 Quantitative data: This was collected through interviews with 116 postnatal HIV positive women with the help of **m2m** Mentor Mothers who were hired and trained for the exercise. Interviewees were randomly selected from **m2m** support group registers using simple random sampling.

2.2.1.1 Mentor Mothers, employed by **m2m** were HIV positive women trained to provide PMTCT education and support to HIV positive antenatal and postnatal women at health centres. It was therefore convenient and easy for these **m2m** women to help as data collectors from women they had been interacting with in their PMTCT support groups and one-on-one PMTCT education and emotional support sessions.

2.2.2.0 Qualitative data

2.2.2.1 Key Informant Interviews: These interviews were conducted by the researcher after reaching agreements and making appointments with identified key informant data sources that included PMTCT nurses in selected survey centres.

2.2.2.2 Focus Group Discussions (FGDs): These were conducted for two separate groups at Chipata and Chawama health centres, with the help of two research assistants. The two health centres were randomly picked from the four survey centres picked. This researcher moderated the discussions while the research assistants helped with note-taking and tape recording of the deliberations. Each of the two groups had 11 participants and these were HIV positive postnatal women randomly selected from **m2m** PMTCT support group registers.

2.2.2.3 Observation method: The researcher visited the 4 selected survey health centres to look at how PMTCT services are offered and what communication methods are used for male involvement.

2.2.2.4 Documentary reviews: Relevant PMTCT documents were used by the researcher to extract relevant data on PMTCT and male involvement issues.

2.3.0 Data analysis and interpretation

The analysis of quantitative data from the survey was done using the Statistical Package of the Social Sciences (SPSS). Analyzed data has been presented in charts and tables. As for qualitative data, analysis was done manually and presented in specific thematic areas according to research objectives and research questions and presented amidst quantitative findings through explanatory notes and reportable comments.

2.4.0 Limitations of the study

Time was inadequate to exhaustively undertake this study, especially in view of the use of triangulation. The other handicap was due to the fact that PMTCT was a relatively new portfolio in HIV prevention programs and as such there was not enough literature, and more so when it came to communication methods used for male involvement. The other fact that HIV/AIDS was a sensitive topic meant that stigma and privacy issues to a great degree affected data collection, as most data for the survey was based on the goodwill and availability of targeted data sources.

CHAPTER 3: CONCEPTUAL AND THEORETICAL FRAME WORK

3.0 Introduction

This chapter looks at the concepts and theories that were used in interpreting data obtained from the study. These are concepts and theories of communication relevant to the fight against HIV/AIDS through PMTCT.

3.1.0 Conceptual and operational definitions

The concepts defined and operationalised are in the following table:

Concept	Conceptual Definition	Operational Definition
3.1.1 Mother To Child Transmission (MTCT) of HIV	According to the WHO PMTCT Strategic Vision (2010-15:8), PMTCT is defined as HIV infection transmitted from an HIV-infected mother to her child during pregnancy, labour, delivery or breastfeeding is known as mother-to-child transmission	With regard to this study, the passing of the Human Immunodeficiency Virus (HIV) from the mother to the baby occurs during pregnancy, during labour and delivery, or during breastfeeding. In 2006, nearly half-a-million babies were born with HIV. With medicine and health care, more than 98 per cent of pregnant women with HIV do not pass the virus to their babies. Today, fewer than 10 per cent of pregnant women with HIV receive such medicine and care. According to the UNICEF, Children

		and AIDS: A stocktaking report (2006) about 40% of HIV-infected mothers in Zambia will transmit the virus to their babies if there is no intervention available.
3.1.2 Prevention of Mother to Child Transmission (PMTCT) of HIV	Prevention of Mother to Child Transmission (PMTCT) refers to: ☐ prevention of HIV infection in mothers; ☐ prevention of unwanted pregnancies; and ☐ prevention of HIV transmission to the infant by the HIV-infected mother (UNICEF, 2000:6). PMTCT therefore simply means stopping HIV from being passed from the mother to her baby Preventing HIV infection among new-borns requires a continuum of appropriate care for both the child and the woman from the period before the pregnancy to several years after the birth of the child.	With respect to this study, the risk of MTCT can be reduced to under 2% by interventions that include antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant in the first weeks of life, obstetrical interventions including elective caesarean delivery (prior to the onset of labour and rupture of membranes), and complete avoidance of breastfeeding (WHO PMTCT Strategic Vision, 2010-15:14). With these interventions, new HIV infections in children would become increasingly rare.

3.1.3 Exposed baby	A baby born from an HIV positive mother (CDC, 2007:4)	To be exposed for a child means the mother is HIV positive and if proper adherence to PMTCT requirements is not observed even this child may get HIV.
3.1.4 PMTCT Uptake	This refers to the number of women who access or offer to take up PMTCT services as required (<i>PMTCT Intelligence Report, 2001:5</i>)	PMTCT uptake with regard to this study includes the following: The number of pregnant women who get tested for HIV in the PMTCT setting; the number of women who receive ARV prophylaxis for PMTCT; the number of HIV positive pregnant women who deliver from health facilities, and the number of exposed babies who are given short course ARV prophylaxis for PMTCT.

3.1.5 Antenatal Woman	Antenatal woman can simply be referred to a pregnant woman. According to Wise, H (1976:596). Pregnancy is the carrying of one or more off-springs, known as a foetus or embryo, inside the womb of a female. Childbirth usually occurs about 38 weeks after conception; i.e., approximately 40 weeks from the Last Normal Menstrual Period (LNMP) in humans. The World Health Organization defines normal term for delivery as between 37 weeks and 42 weeks.	Pregnant women in Zambia are normally expected to undergo routine HIV counseling and testing for PMTCT and those tested HIV positive are expected to take up PMTCT actions.
3.1.6 Postnatal Woman	A woman who has given birth is referred to as a postnatal woman. The postnatal period begins immediately after the birth of a child and then extends for about six weeks. During this period, the mother's body returns to pre-pregnancy conditions	Every HIV positive woman who delivers a baby needs to adhere to PMTCT requirements including getting the baby to receive infant PMTCT ARVs; appropriate infant feeding options; and infant HIV diagnosis

	as far as the uterus size and hormone levels are concerned (<i>Farlex, 2008:17</i>).	
3.1.7 Male involvement	This means men take part in activities that are aimed at helping to prevent mother to child transmission of HIV (<i>Maman, S et al., L, 2008:14</i>).	With respect to this study, male involvement looks at a situation where men are knowledgeable about PMTCT, they test for HIV with their pregnant women, they support their women and exposed babies to adhere to and access available PMTCT services.
3.1.8 Status disclosure	This refers to a situation whereby an HIV positive pregnant woman shares her HIV positive status with her spouse after being tested positive during routine HIV testing at the antenatal clinic (<i>Clifford. L, 2001:14</i>)	When a pregnant woman tests HIV positive at the antenatal clinic, the spouse may not be aware of the situation and he may need to be informed about it, and if it is the wife who tells it to him, that is disclosure and it may have its own consequences depending on the communication paradigms involved
3.1.9 Communication	There are varied definitions of communication. According to	In this study, communication implies several approaches of exchanging

	Wrench, J. S et al., (2008:74), communication is a sharing process where a source shares his/her message with a receiver via a certain channel in order to influence the receiver's thoughts and actions. For the purpose of this study, communication has simply been defined as "the sending, giving, or exchanging of information and ideas," which is often expressed nonverbally and verbally. Non-verbal communication is the act of saying what's on your mind without speaking words. Verbal communication is the act of saying what's on your mind with words. Communication is not a one way street. It is a process of exchange between the source and the receiver.	ideas and information among different players in PMTCT with a bias towards getting men involved in PMTCT activities. This is because the study strictly attempts to investigate the messaging challenges faced in getting men involved in PMTCT services. It should essentially be stressed here that men need information about the HIV positive status of their pregnant spouses and about the specific PMTCT actions necessary to prevent the HIV virus from being transmitted from the mother to the child. But the method and manner this information is communicated to men determines whether one succeeds or not
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3.1.10 Effectiveness	Effectiveness means the capability of producing an effect. It relates to getting the right things done (<i>Drucker, PF, 2006:27</i>).	The kinds of communication methods used to involve men in PMTCT are supposed to be so effective that men can actively participate in PMTCT. Issues considered here include communication methods used to invite men to health facilities for purposes of PMTCT involvement, communication methods used to teach men about specific measures that are needed to ensure that there is no mother to child transmission of HIV.
1.1.11 Infant PMTCT Anti-Retral Viral Therapy (ART)	In simple terms, this refers to the therapy given to an HIV exposed baby in order to prevent HIV transmission from the mother (<i>WHO, 2006:28</i>).	The recommended regimen for exposed babies is Azdovzine (AZT) for seven days from birth. For women who receive less than four weeks of ART before delivery, the AZT dose for the babies should be extended to four weeks.
3.1.12 Maternal	The kind of short course ARVs given to a pregnant woman in order to	All pregnant HIV positive women need to receive appropriate short

PMTCT ART	prevent the virus from passing from the mother to the child (<i>WHO, 2006:26</i>).	course ARVs.
3.1.13 Infant feeding options	The type of feeding method chosen for a baby.	The choosing of a feeding method should be done by both parents; especially for HIV positive parents and this should be done during pregnancy. The available infant feeding options include exclusive breastfeeding, exclusive replacement feeding and mixed feeding and each of these has merits and demerits

3.2.0 Main communication theories underpinning the study

The following communication theories were identified to be relevant to this study:

3.2.1 Social penetration theory: According to this theory, as human relationships develop, they penetrate deeper and deeper into private and personal matters. This exposes vulnerabilities, so trust has to be developed along the way. Penetration goes through a number of stages as follows:

1. Orientation stage: - This involves playing safe with small talk and simple, harmless clichés like ‘Life’s like that’, following standards of social desirability and norms of appropriateness;

2. Exploratory affective stage:- At this stage, people start revealing themselves to each other, expressing personal attitudes about moderate topics such as government and education. This may not be the whole truth as they are not yet comfortable to lay themselves bare. They are still feeling their way forward. This is the stage of casual friendship, and many relationships do not go past this stage;

3. Affective stage: - At this stage they start to talk about private and personal matters. They may use personal idioms. Criticism and arguments may arise. There may be intimate touching and kissing at this stage;

4. Stable stage: - The relationship now reaches a plateau in which personal things are shared and each can predict the emotional reactions of the other person; and

5. De-penetration: - When the relationship starts to break down and costs exceed benefits, then there is a withdrawal of disclosure which leads to termination of the relationship (*Altman, I. et al., 1987:257-277*).

The **relevance** of this theory to the study is that when it comes to disclosure of HIV positive status by someone, it should be to someone the discloser trusts and expects to receive or share supportive efforts and/or mutual benefits from the same. For example, an antenatal (pregnant) woman who tests HIV positive as a PMTCT service mandatory requirement would find it easier to disclose the HIV positive status to her spouse if their relationship is **stable** and **strong** enough. The relationship should have reached the

Stable stage. At stage 4, the relationship has reached a plateau in which personal things are shared and each can predict the emotional reactions of the other person. What is likely to be the case is that male involvement in PMTCT would be low in relationships that are not stable and /or long term. If a married man impregnates a girl friend before their relationship gets to the stable stage and this woman is tested HIV positive at the antenatal clinic, it is questionable as to whether this married man would offer all the necessary support with regard to PMTCT. Probably the woman may not even disclose to him that she has tested positive for HIV, depending on how she understands the man. Therefore, entrusting this woman with the communication responsibility for the involvement of the spouse in PMTCT may not be an effective method.

3.2.2 Communication pragmatics/interactional view: This theory posits that "Relationships within a family system are interconnected and highly resistant to change. Communication among members has both a content and relationship component. The system can be transformed only when members receive outside help to reframe the relational punctuation." The Theorist is Watzlavick, Beavin, & Jackson and the theory was developed in 1967 (*Griffin, 1967:494*).

This theory has many implications for everyday life. Since families often suffer from miscommunication, this theory is able to explain why such things take place. The suggestion of the theory to reframe problems in order to gain a better understanding of what is going on seems like sound and practical advice, and the relevance of the theory is that a man and his wife may be having a difficult time talking to one another about

PMTCT or reproductive health issues but may need the help of an external person such as a Psychosocial Counselor.

3.2.3 Activation theory of information exposure - The theory states that an individual will seek to satisfy their need for stimulation and information when attending to a message, before they seek to fulfill their need for information alone. The theorists are Lewis Donohew, Phillip Palmgreen, & J. Duncan (1980; p47, 295-303). Activation Theory of Information Exposure explains how individuals seek messages that fulfill their cognitive need for information as well as their need to be entertained.

Ideas and implications for this study could be that this theory is very helpful to those in advertising and persuasion. As they develop messages for individuals, it is important for them to meet the cognitive and emotional needs of their audiences. PMTCT has to do with marketing strategies to persuade men to get involved in PMTCT activities, instead of putting emphasis only on women, simply because men do not get pregnant.

3.2.4 Theory of planned behaviour /reasoned action: Ajzen and Fishbein (1980:179-211) formulated the theory of reasoned action (TRA). This resulted from attitude research from the Expectancy Value Models. Ajzen and Fishbein formulated the TRA after trying to estimate the discrepancy between attitude and behaviour. This TRA was related to voluntary behaviour. Later on behaviour appeared not to be 100% voluntary and under control, this resulted in the addition of perceived behavioural control. With this addition the theory was called the Theory of Planned Behaviour

(TPB). The theory of planned behaviour is a theory which predicts deliberate behaviour, because behaviour can be deliberative and planned.

The *relevance* of the theory here was that it provided useful information for the development of communication strategies. Examples of items which could be researched with the theory of planned behaviour are whether to check oneself for HIV and whether to use condoms when having sex for primary HIV prevention or prevention of re-infection.

3.2.5 Health belief model: According to Rosenstock et al., (1966:94-127), the Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS.

The HBM is based on the understanding that a person will take a health-related action (for example use condoms) if that person:

1. Feels that a negative health condition (for example, HIV) can be avoided,

2. Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (for example, using condoms will be effective at preventing HIV), and
3. Believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived *susceptibility*, perceived *severity*, perceived *benefits*, and perceived *barriers*. These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action*, would activate that readiness and stimulate overt behaviour.

3.2.6 Diffusion of innovation theory – According to Rogers, E (1983:150), diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. He states that diffusion is a special type of communication concerned with the spread of messages that are perceived as new ideas. Rogers further indicates that an innovation, simply put, is “an idea perceived as new by the individual.” Even in the context of this study, an innovation can be taken to be an idea, practice, or object that is perceived as new by an individual or other unit of adoption. The characteristics of an innovation, as perceived by the members of a social system, determine its rate of adoption. The four main elements, according to Rogers (1983:150-283) in the diffusion of new ideas are: (1) The innovation; (2) Communication channels; (3) Time; and (4) The social system (context). The characteristics which determine the rate of adoption of an innovation are: (1) Relative

advantage; (2) Compatibility; (3) Complexity; (4) Trialability; (5) Observability to those people within the social system.

The *relevance* of this theory was that PMTCT was an innovation and so was the need for male involvement and the rate at which these got accepted would depend on various factors and such factors needed to be clearly understood and plans made accordingly.

CHAPTER 4: LITERATURE REVIEW

4.0 Introduction

To ensure that there was a consolidated background to the study, it was essential to review information on related research studies that had been conducted by other researchers, with focus on PMTCT in general and communication for male involvement in particular. It is important to again stress the fact that this study was underpinned by the assumption that **men** had a critical role to play in Preventing Mother to Child Transmission (PMTCT) of HIV and as a result the effectiveness of communication methods used for their involvement needed proper investigation. The following pieces of literature were considered for review:

4.1 Women Create Opportunities for Male Involvement in PMTCT

At Mombasa's Likoni Health Centre, Women Fighting AIDS in Kenya (WOFAK), a People Living with HIV (PLHIV) Organization, creatively reached out to men and increased their involvement in Prevention of Mother-To-Child Transmission (PMTCT) activities funded by USAID through AIDS, Population, and Health Integrated Assistance (APHIA II) program.

According to the programme (*FHI, 2010:7*), that was a significant accomplishment because men did not typically participate in such activities in that part of Kenya. The WOFAK staff spoke with the mothers about HIV, the importance of knowing one's status, and living positively with the virus. They counseled HIV-positive pregnant

women one-on-one, stressing the importance of having their partners tested and becoming involved in the care. Clients whose partners accompanied them on subsequent visits needed not wait in the queues. Apart from escorting the HIV-positive clients to ensure they were registered in the pre-ART register and linking them to support groups, WOFAK staff also conducted home visits to talk to the male partners of clients who consented to be visited. Because of these innovations, loss to follow-up among HIV-diagnosed mothers significantly decreased, and the ability to identify and counsel HIV-discordant couples (those whose HIV status differs) improved. Consequently, about 6-10 of the partners of the approximately 15-20 HIV-positive women in antenatal care accompanied the women each month, compared to none two years before.

4.2 Male Involvement in Preventing Mother-to-Child Transmission of HIV in Rwanda (2005): According to this success story from a USAID funded program (<http://africastories.usaid.gov>), among the greatest challenges facing providers of preventing mother-to-child transmission (PMTCT) services is reaching sexual partners of HIV-positive women and persuading them to receive HIV counseling and testing. As part of President George W. Bush's Emergency Plan effort to prevent mother-to-child transmission of HIV in Rwanda, IntraHealth International helped the Ministry of Health in Rwanda to establish and support PMTCT services at 10 hospitals and health centres in Gitarama and Byumba Provinces, serving a total population of 77,454. In each of these facilities, IntraHealth integrated partner involvement activities with PMTCT services increased, leading to significant gains in the rate of partner testing in a short period of time.

According to this program, the success of the PMTCT partner involvement initiative could be attributed to three principal activities:

- (1) A system in which sexual partners were invited discreetly (via letters from health facility staff) to accompany women to prenatal visits and receive voluntary counseling and testing;
- (2) The involvement of men in the reproductive health services provided to their spouses, such as prenatal counselling; and
- (3) A community-provider partnership approach that promotes male partner involvement by challenging attitudes and behaviours of men that compromise their own health as well as the health of their women and children.

Partner involvement grew dramatically as a result of these activities. At Kigoma Health Centre in Gitarama Province, the partner testing rate grew from 10 percent in December 2002 to 88 percent in September 2004. In fact, the trend in Kigoma was that the majority of women's sexual partners started to accompany their spouses to the PMTCT counselling sessions without receiving a written invitation letter. In Gitarama Province, the Byimana Health Centre - which only began providing PMTCT services in May 2004, reported that 78 percent of partners were agreeing to test by September 2004, up from 53 percent in the first month of the activity. And at Kinihira Health Centre in Byumba Province, 57 percent of partners were consenting to be tested by September 2004, only six months after the initiation of PMTCT services and male involvement activities (the rate of partner testing in the first month of services was 16 percent).

Additionally, IntraHealth PMTCT interventions at the 10 sites supported by the Emergency Plan achieved high rates of counselling and testing for women: 99 percent of 12,379 women attending prenatal care were counselled, and 95 percent of women counseled accepted an HIV test. By maximizing identification of HIV-positive pregnant women and systematically reaching out to their male partners, this project was making a direct contribution to the President Emergency Plan for AIDS Relief goals and encouraging a norm of male participation in the continuum of HIV/AIDS services offered at health centre (<http://africastories.usaid.gov>).

4.3 This was a report presented by Kindyomunda Rosemary Mwesigwa, Uganda AIDS Commission, 7th August, 2003 and revealed the following:

The report presented the following challenges:

- Involvement was very low yet men played a key role in family decision-making
- Barriers to male involvement identified were: Cultural norms (dominance and socio-economic status); Low level education for both; Polygamy: attention to wives; Social and political support structures; Unfriendly health facilities; unsuitable timing; health worker attitudes to men; lack of family approach to MCH service delivery.

The following were the strategies suggested by Kindyomunda, et al., (2003) for improvement of male involvement in PMTCT:

- Innovation in male involvement strategies: identification of types of men: the many indifferent/uninformed, some hostile ones and a few supportive ones
- Sensitize health workers, leaders and communities
- Involve men in health education through antenatal clinics
- Establish male friendly clinics

4.4 Evaluation of the National Prevention of Mother-to-Child Transmission of HIV Pilot Project of the Ministry of Health and Family Welfare (*Chingono, A.; Chandiwana, B.; Kambabrami, R, 2002*) - The objectives of the evaluation were to: assess achievements, determine strengths, weaknesses, opportunities and threats, assess project acceptability and accessibility, establish reasons for low PMTCT uptake, assess establishment of partnerships, look into management issues, and make recommendations on future management of the project required, including policy-related aspects.

Among the findings and conclusions, interviewed counsellors were of the opinion that community sensitization, male involvement, provision of free formula feeds, widespread nurse training, targeting decision makers within households, involvement of other sectors in community mobilization and a sustained education strategy would have facilitated the uptake of PMTCT services by clients. Regarding male involvement, counsellors suggested a number of strategies including the introduction of 'man-friendly ANC', extending opening hours for PMTCT services into the weekend to accommodate working men, workplace-based sensitization and education sessions, and the development and distribution of IEC materials targeted at, and relevant to men.

4.5 Zambia's Luapula Province Sees Increase in Male Involvement in PMTCT

According to Family Health International (*FHI, 2008:10*) this was a U.S. President's Emergency Plan for AIDS Relief (PEPFAR) partner, the Health Communication Partnership (HCP) success story. They stated that an increasing number of men proved that they could be true partners in the fight against HIV/AIDS in Zambia, where they pointed out that the HIV epidemic continued to disproportionately devastate women and

girls. In their presentation they mentioned that in Luapula Province, husbands and boyfriends had started going with their pregnant partners to antenatal clinics and encouraging their wives to get health checkups before giving birth.

They shared that when Daniel Chipeleka, 30, learned that his wife Miriam was pregnant with their fifth child, he went with her to Chembe Rural Health Centre, located just north of Mansa town on the Congolese border. In 2005, Daniel became a believer in proactively taking care of his own health and his family's health after becoming a participant in the Safe Motherhood Action Group, a project initiated by a U.S. President's Emergency Plan for AIDS Relief (PEPFAR) partner, the Health Communication Partnership (HCP). As a participant in this group, Daniel learned about his important role in making sure that his wife delivered a healthy baby. Daniel got tested for HIV with his wife and learned more about preventing the transmission of the deadly virus from mother to child. He said, "Coming to the health facility with my wife will help us know of our HIV status, and thereafter plan our future together."

The HCP presentation concluded that through their program, nearly 70 women were tested and counselled at the antenatal care clinic each month, and 75% of the clients who attended the clinic at the health centre came with their spouses (zambia.usembassy.gov/pepfar-pmtct.html).

4.6 Redefining Male Involvement in PMTCT - This was a presentation by Suzanne Maman, Allison Groves, Elaine Smith, Nduduzo Makhanya, Montsooe Pakkies, Sibekizelo Msomi, Dhayendre Moodley; The University of North Carolina at

Chapel Hill, The University of KwaZulu-Natal (*Maman, S. et al., 2008*). According to their presentation male involvement had been narrowly defined as follows: Most studies measured male involvement as: Attendance at clinic appointments by men; Uptake of testing by men. They stated that male involvement in PMTCT was associated with numerous **benefits**, including greater uptake of testing; greater uptake of antiretrovirals; increased condom use; increased communication; and support for infant feeding choices.

They identified the following as **barriers** to male involvement in PMTCT: ANC clinics perceived as women's spaces; Hospital policies that restrict access to clinics by males; Perception that pregnancy and child-rearing are women's responsibilities; Societal stigma; and time constraints. They proposed the following **strategies** to increase male involvement: Offering VCT for men at alternative times and locations; Routine offer of testing for men at labour/delivery; sending letter of invitation to invite male participation; Social marketing and community mobilization.

4.7 South Africa HIV/AIDS Antenatal Post-Test Support Study (SAHAPS) -

This was a formative research for a Randomized Controlled Trial (RCT) designed to evaluate the efficacy of HIV post-test support for pregnant women (*Maman, S. et al., 2007:61-63*). It involved qualitative research in antenatal clinic. 46 interviews with women who had received ANC services at the clinic were conducted. This analysis limited to the interviews with 30 HIV positive women. There was also observation of PMTCT services. Male involvement was considered across the following topics: HIV testing and disclosure decisions; Infant feeding decisions; Family planning decisions. Interviews were conducted in Zulu, transcribed, translated, and computerized for analysis.

Results revealed that on their men's reaction to pregnancy, majority of women described their partner's reaction to the pregnancy as positive. Reaction to pregnancy did not vary depending on men's awareness of the women's HIV status. Men who did not respond positively had concerns related to: Stability of their partnerships; how they would support the child; and how news of the pregnancy would be received by their family. Women's reactions to pregnancy were more ambivalent, as only 2 women described their reaction as happy, and the remaining were upset, surprised, or resigned.

In terms of male involvement in pregnancy, less than a quarter of women reported that their partner attended a clinic appointment with them during pregnancy or post-partum. Women described other ways men were involved and supportive as in providing transportation to clinics, reminding women to attend clinic, providing women food during clinic visits, reminding women to take medications, and providing psychosocial support to women.

On male involvement in infant care, women also described ways that men were involved with infant care: basic care of children, encouraging women to test the baby, transportation to the clinic for baby visits, buying formula for infants, buying clothes and other material things for children, and providing emotional support to women.

Some women chose not to involve their male partners, as a third of women had not disclosed their status to their partners, and thus had not involved them in decisions related to PMTCT. Reasons for non-disclosure included fear of consequences - two men threatened to kill their partners if they tested positive, unsure how to tell male partners,

men generally uninvolved in women's lives and thus women felt the decisions were theirs alone.

Strategies to engage men should include the need to start where couples are. Find ways that men are already involved; build on these natural systems of support; and tailor approaches to accommodate women living in abusive relationships. They also proposed the need to promote greater involvement within ANC: Counselling and support of women through testing and disclosure process; and within the community: Mobilize men to encourage responsibility for the health and well being of their partners and children.

4.8 Factors influencing involvement of men in Prevention of Mother-to-Child Transmission (PMTCT) of HIV programmes in Mambwe district, Zambia

This was a study conducted by Desire Dinzela Tshibumbu (2006). It aimed at assessing the factors influencing the low involvement of men in the prevention of mother-to-child transmission (PMTCT) of HIV programmes in Mambwe district, Zambia. The factors studied were grouped as knowledge and awareness, socio-cultural, programmatic and demographic characteristics.

A quantitative, exploratory study was used and 127 men were interviewed. The major findings were: Knowledge of PMTCT was the strongest factor which was positively associated with the level of men's involvement in PMTCT. Socio-cultural and programmatic factors were found to negatively influence men's involvement (although weakly); and among the demographic characteristics, age and level of education were positively associated with an increase in the level of involvement, while the duration of

the relationship with the female partner was negatively associated with the level of men involvement.

4.9 Male involvement in PMTCT services in Mbeya Region, Tanzania

This was a study by Theuring, S; Mbezi, P; Luvanda, H; Jordan-Harder, B; Kunz, A; Harms, G. According to their study (*Theuring, et al., 2009*), throughout all stages of programmes for the prevention of mother-to-child-transmission of HIV (PMTCT), high dropout rates were common. Increased male involvement and couples' joint HIV counselling/testing during antenatal care (ANC) seemed crucial for improving PMTCT outcomes. The study assessed male attitudes regarding partner involvement into ANC/PMTCT services in Mbeya Region, Tanzania, conducting 124 individual interviews and six focus group discussions. Almost all respondents generally supported PMTCT interventions.

Mentioned barriers to ANC/PMTCT attendance included lacking information/knowledge, no time, neglected importance, the services representing a female responsibility, or fear of HIV-test results. Only few perceived couple HIV counselling/testing as disadvantageous. Among fathers who had refused previous ANC/PMTCT attendance, most had done so even though they did not perceive a disadvantage about couple counselling/testing.

The contradiction between men's beneficial attitudes towards their involvement and low participation rates suggested that external barriers played a large role in this decision-

making process and that partner's needs should be more specifically addressed in ANC/PMTCT services.

4.10 How implementing PMTCT services expand HIV prevention and care - This was a Horizons Operations Research Report on HIV/AIDS (*Horizons 2003*) and shares the following findings:

Increasing Male Involvement - Involving male partners can make a real difference in improving uptake of PMTCT services by women. When outreach efforts successfully engage men, they are far more likely to support women at critical turning points: deciding whether to take an HIV test, returning for test results, taking antiretroviral drugs, and practicing safer infant feeding methods.

One of the most compelling findings for the evaluation team was that attempts to involve male partners were most successful when they provided information about HIV and PMTCT directly to men outside of the antenatal or maternal/child health clinic setting, which many men perceived as the exclusive realm of women. For example, in rural Keemba and Monze, Zambia, program staff approached male leaders to promote PMTCT among the men in their communities, which had led to higher levels of male involvement in PMTCT decision-making and in uptake of VCT services. Providing men directly with information confirmed their important role in such decisions and removed the onus of responsibility from women for bringing up PMTCT. According to Kankasa, et al., (2008), it was often easiest to reach men in the more traditional and close-knit communities rather than in large urban areas. Dr. Chipeco Kankasa of the PMTCT Working Group and a principal investigator for the Horizons PMTCT study in Zambia

further stated that there was a recognizable leadership structure in place, usually headed by a man, through which programs could communicate health and prevention messages to men.

Similarly, PMTCT program managers in Kenya developed strategies to inform male partners about PMTCT services such as providing community education on PMTCT in places where men congregated, organizing support groups for men and directly inviting men to the clinic for HIV counselling and testing ([http://www.popcouncil.com/horizons/newsletter/horizons\(7\)_2.html](http://www.popcouncil.com/horizons/newsletter/horizons(7)_2.html)).

CHAPTER 5: DATA ANALYSIS AND PRESENTATION OF FINDINGS

5.0 Introduction

This chapter deals with the analysis and presentation of findings obtained from the study which was conducted in Lusaka district. The sample consisted of one hundred and sixteen (116) respondents.

All respondents were HIV positive mothers with children aged 0 to 2 years old. These were women who had been receiving PMTCT education and emotional support from **mothers2mothers** through PMTCT support groups and one-on-one sessions in health centre of Lusaka district where **m2m** was operational. The idea was to talk to HIV positive women who had gone through PMCT experience so that they share on how their male spouses were informed about PMTCT interventions that needed to be implemented so that their babies did not get the virus.

5.1.0 Background characteristics of respondents

The background characteristics of respondents were as follows:

5.1.1 Age groups of respondents

Out of the total 116 (100%) respondents, 58 (50%) were in the active reproductive age group of 26-35 years of age. This was followed by those aged 16-25 years at 39 (33.6%). Next was 36-45 years at 12 (10.3%); followed by those below 16 years of age at 5 (4.3%); and finally those aged above 45 years were at 2 (1.7%).

Table 1: How old are you?

Age Group	Frequency	Percent (%)
Below 16 years	5	4.3
16 – 25	39	33.6
26 – 35	58	50
36 – 45	12	10.3
45+	2	1.7
Totals	116	100

Source: Field Data

5.1.2 Age of spouse to the respondent (father to the youngest child)

Of the 116 respondents, the majority (78.4%) said their spouses were aged 25-44 years; 11.2% (13) below 25 years; 9.5% (11) with 45-60 years old spouses; and only 1 (0.9%) respondent said the father to her baby was above 60 years old.

Table 2: How old is your spouse (Father to the youngest child)?

Age of Spouse	Frequency	Percent (%)
Below 25 years	13	11.2
25 - 44	91	78.4
45 - 60	11	9.5
60+	1	0.9
Total	116	100

Source: Field Data

5.1.3 Marital status of respondents

Of the 116 respondents, the majority (87%) were married, 6.9% (8) were single and on separation respectively; 6% (7) were widows; while 5.2% (6) were divorced.

Table 3: What is your marital Status?

Marital status	Frequency	Percent (%)
Single	8	6.9
Married	87	75
On Separation	8	6.9
Divorced	6	5.2
Widowed	7	6
Total	116	100

Source: Field data

5.1.4 Education level of respondents

21 (18.1%) respondents had never been to school; 41 (35.3%) had basic education; 45 (38.8%) had high school education; and only 9 (7.8%) had been to college.

Table 4: What is your education level?

Education of respondents	Frequency	Percent (%)
Never been to School	21	18.1
Basic Education Level	41	35.3
High School Education Level	45	38.8
College Education Level	9	7.8
Total	116	100

Source: Field Data

5.1.5 Respondents length of relationship with the father of the youngest own child

Of the 116 respondents, 49 (42.2%) said they had been in relationships with fathers of their youngest children for above 5 years; 29 (25%) for 1-2 years; 23 (19.8%) for 2-5 years; and for less than 1 year 15 (12.9%) of the 116 respondents.

Table 5: How long were you in the relationship with the father of the youngest child?

Length of relationship	Frequency	Percent (%)
Less than 1 year	15	12.9
1 - 2yrs	29	25
2 - 5yrs	23	19.8
5+	49	42.2
Total	116	100

Source: Field Data

5.1.6 Residential areas of respondents

77 (66.4%) said they came from high density residential areas; 31 (26.7%) were from medium density areas; and 8 only 8 (6.9%) came from low density residential areas.

Table 6: In which residential area do you live?

Residential area	Frequency	Percent (%)
Low Density	8	6.9
Medium Density	31	26.7
High Density	77	66.4
Total	116	100

Source: Field Data

5.1.7 Household main source of income

Of the 116 respondents, 75 (64.7%) depended on informal employment for their household livelihood while 41 (35.3%) had formal employment as their main source of household income.

Table 7: What is the main source of your household income?

Household source of income	Frequency	Percent (%)
Formal employment	41	35.3
Informal employment	75	64.7
Total	116	100

Source: Field Data

5.2.0 PMTCT knowledge, communication and practices

In order to inquire about the knowledge of PMTCT by respondents, the survey had various questions to do with how, when and where they and their spouses accessed particular PMTCT knowledge. The idea was to identify communication dynamics at play in various PMTCT actions and outcomes, with focus on male involvement.

5.2.1: Respondents having heard about PMTCT ever

As the table below shows, out of the total 116 respondents, 112 (96.6%) said they had heard about PMTCT. Only 4 (3.4%) had never heard about PMTCT.

Table 8: Have you heard about PMTCT?

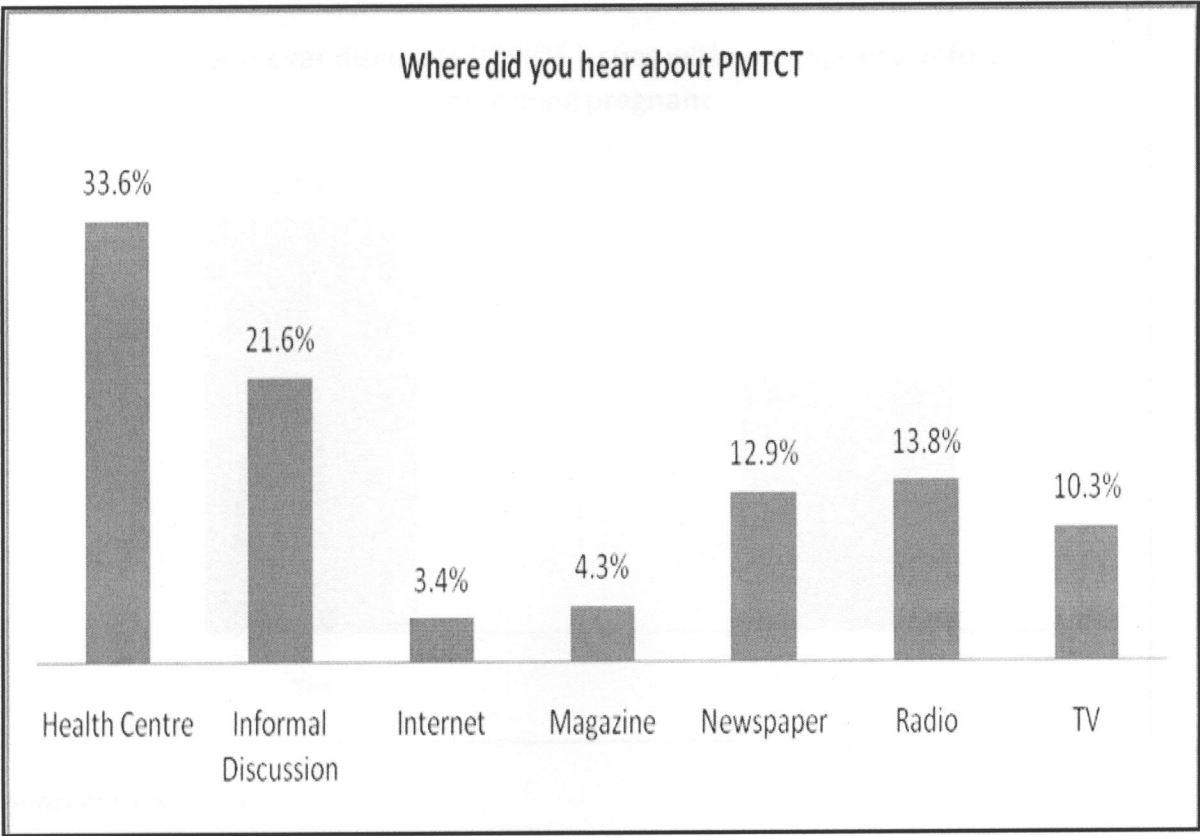
Response	Frequency	Percent
Yes	112	96.6%
No	4	3.4%
Total	116	100%

Source: Field Data

5.2.2: Where respondents had heard about PMTCT

Majority of respondents (33.6%) mentioned that they heard about PMTCT from discussion fora at health centres; 21% from informal discussions; and the rest from various forms of mass media, with radio accounting for the highest at 13.8%.

Figure 1: Where did you hear about PMTCT?

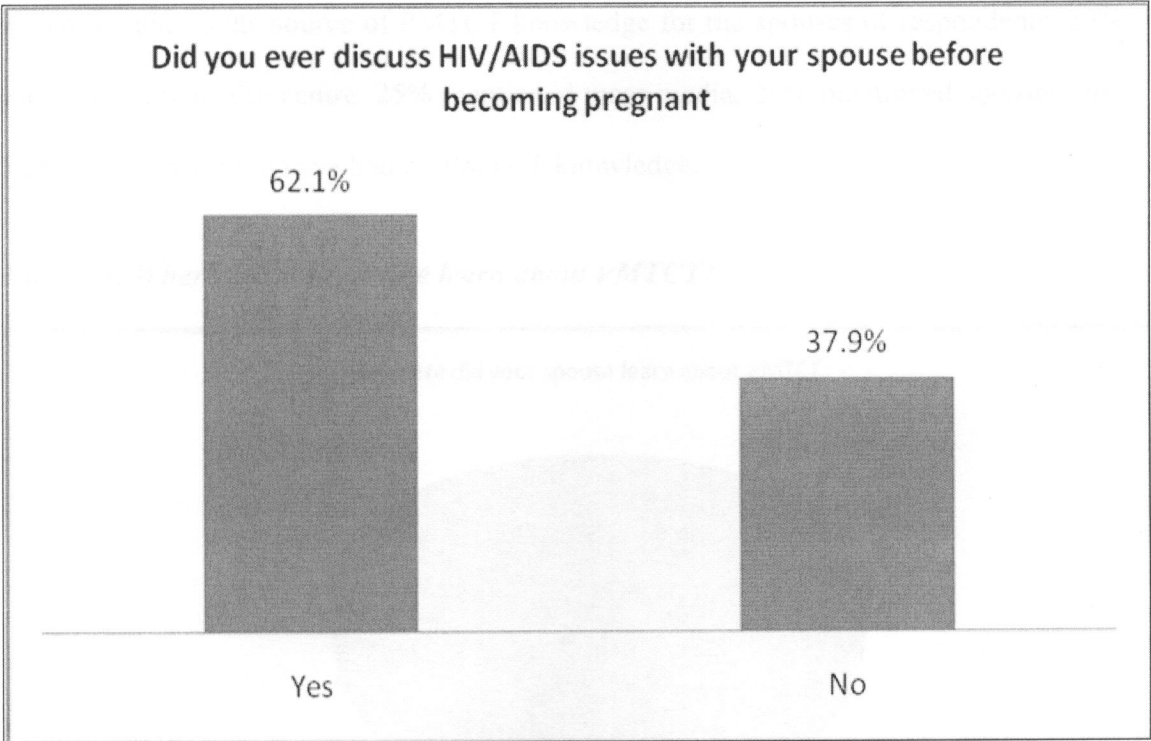


Source: Field Data

5.2.3 If couples ever discussed HIV/AIDS issues before pregnancy

It was encouraging to note that more (62.1%) respondents said they discussed HIV/AIDS issues with spouses before becoming pregnant, compared to 37.9% who did not.

Figure 2: Did you ever discuss HIV/AIDS issues with your spouse before pregnancy?



Source: Field Data

5.2.4 If spouses of respondents knew about PMTCT

Male spouse knowledge of PMTCT is very crucial for their participation in PMTCT activities. Of the 116 respondents, 84 (72.4%) said their spouses had heard about PMTCT while 27.6% (32) respondents said their spouses did not know about PMTCT.

Table 9: Does your spouse know about PMTCT?

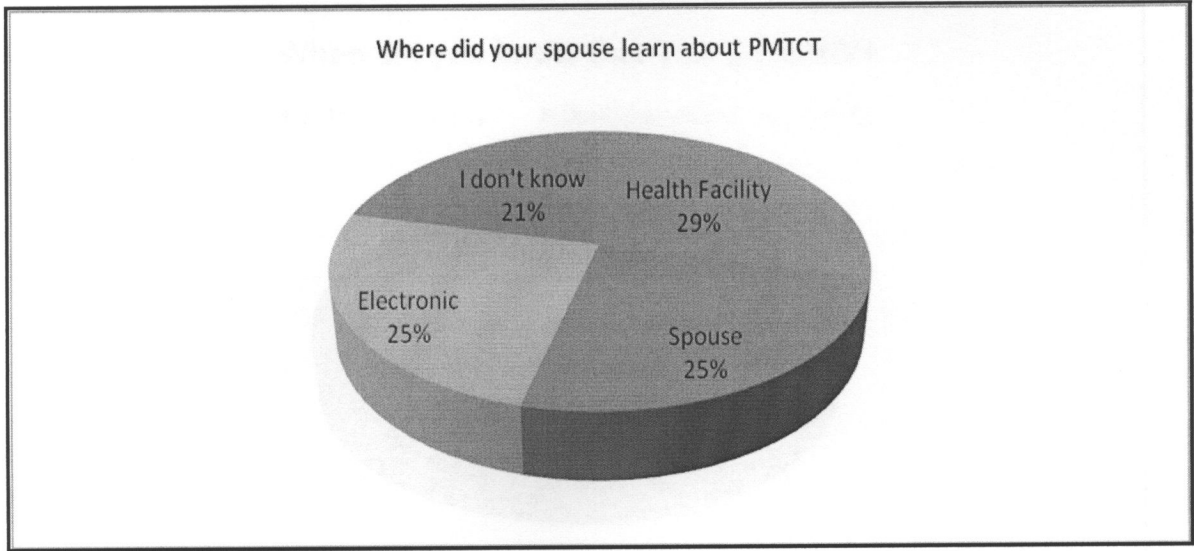
Response	Frequency	Percent
Yes	84	72.4
No	32	27.6
Total	116	100.0

Source: Field Data

5.2.5 Where spouses of respondents learnt about PMTCT

When it came to the source of PMTCT knowledge for the spouses of respondents, 29% mentioned the health centre, 25% mentioned mass media, 25% mentioned spouses, and 21% were reported to have had no PMTCT knowledge.

Figure 3: Where did your spouse learn about PMTCT?



Source: Field Data

In terms of specific media where spouses learnt about PMTCT, radio accounted for the highest as 46.2% of respondents mentioned it, followed by print media such as posters, magazines, brochures, billboards and others at 36.5% (19), with TV at 17.3% (9).

Table 10: What was the specific media source of PMTCT knowledge by your spouse?

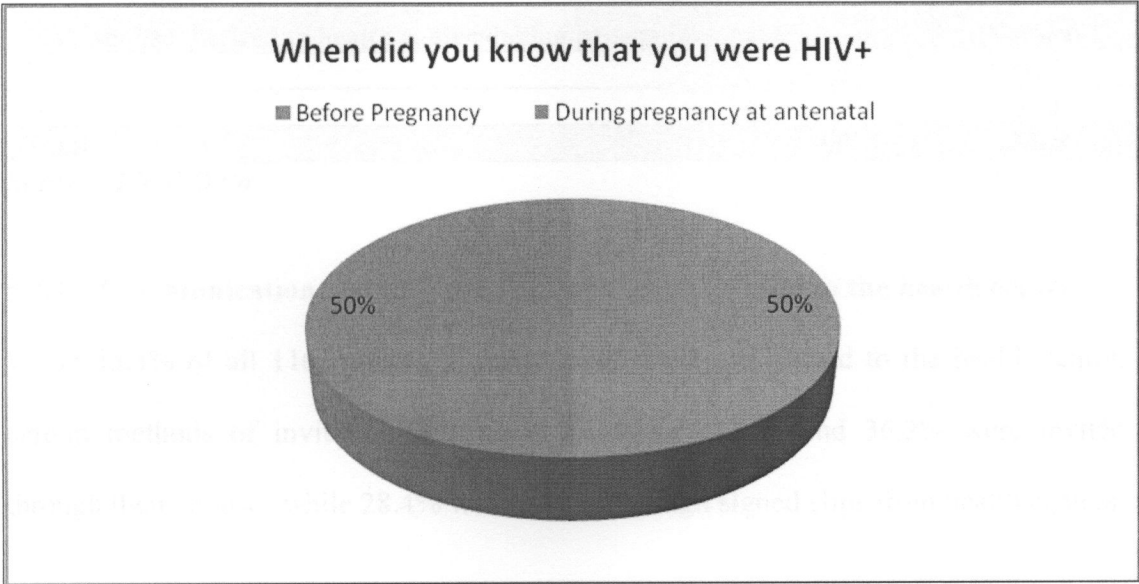
Source of knowledge	Frequency	Percent
Radio	24	46.2
TV	9	17.3
Print media	19	36.5
Total	52	100%

Source: Field Data

5.2.6 When respondents knew that they were HIV positive

Of all the 116 respondents, half of them (50%) were aware of their HIV status before they became pregnant while the other half 50% (58) knew they were HIV positive when they went for their routine antenatal clinic visits.

Figure 4: When did you know that you were HIV positive?



Source: Field Data

5.2.7 If their spouses were involved when respondents went to the antenatal clinic

Of the 116 respondents, 62% (73) said their spouses were involved when they attended their antenatal clinics while 37.1% (43) said their spouses never involved themselves.

Table 11: When you went to the antenatal clinic, was your spouse ever involved?

	Frequency	Percent
Yes	73	62.9
No	43	37.1
Total	116	100.0

Source: Field Data



5.2.8 If spouses of respondents were ever called to the health centre

Of the 116 respondents, 75 (64.7%) said their spouses were invited to go to the health centre when they were pregnant. 41 (35.3%) said their spouses were not ever invited.

Table 12: Was your spouse invited to the health centre when you were pregnant?

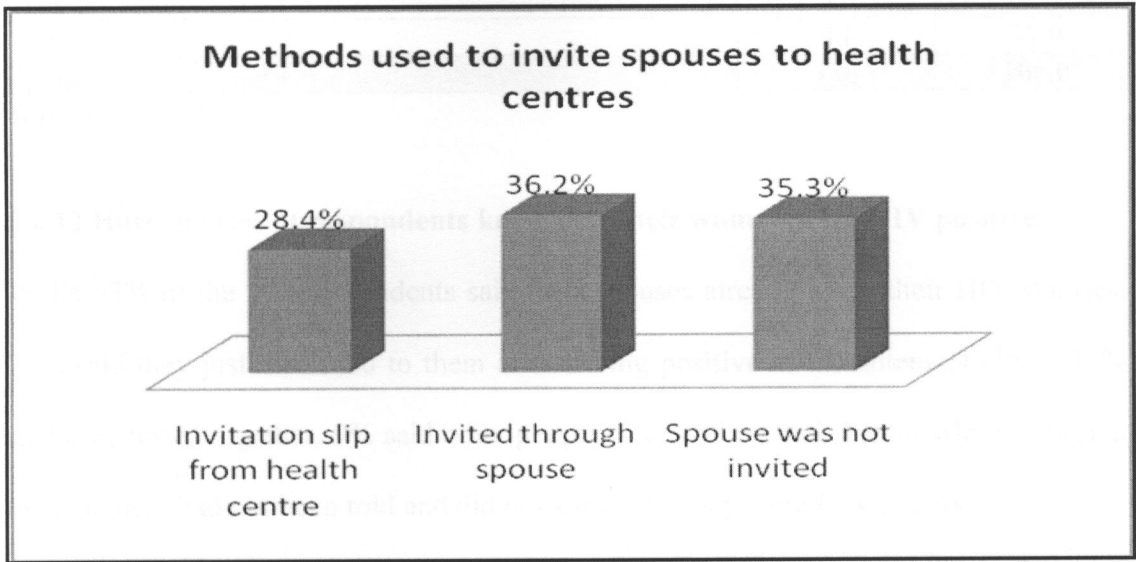
Male spouses invited to health center during pregnancy	Frequency	Percent
Yes	75	64.7
No	41	35.3
Total	116	100.0

Source: Field Data

5.2.9 Communication methods used to invite male spouses to the health centre

While 35.3% of all 116 spouses of respondents were not invited to the health centre, certain methods of invitation were used for those invited and 36.2% were invited through their spouses while 28.4% were invited through signed slips from health centres.

Figure 5: What method was used to invite your spouse to the health centre?



Source: Field Data

5.2.10 If spouses of respondents came to the health centre after being invited

For those 75 spouses who were invited to come to the health centre, either through their spouses or invitation slips from health centres, 35.3% (26) showed up while 64.7% (49) never showed up and this was a very sad state of affairs.

Table 13: Did your spouse come to the health centre after being invited?

	Frequency	Percent
Yes	26	35.3
No	49	64.7
Total	75	100.0

Source: Field data

5.2.11 When spouses of respondents knew that their women were HIV positive

Out of the 116 respondents, 62.1% (72) said that they already knew that they were HIV positive before pregnancy while 37.9% (44) did not.

Table 14: Did you as a couple already know your HIV status before pregnancy?

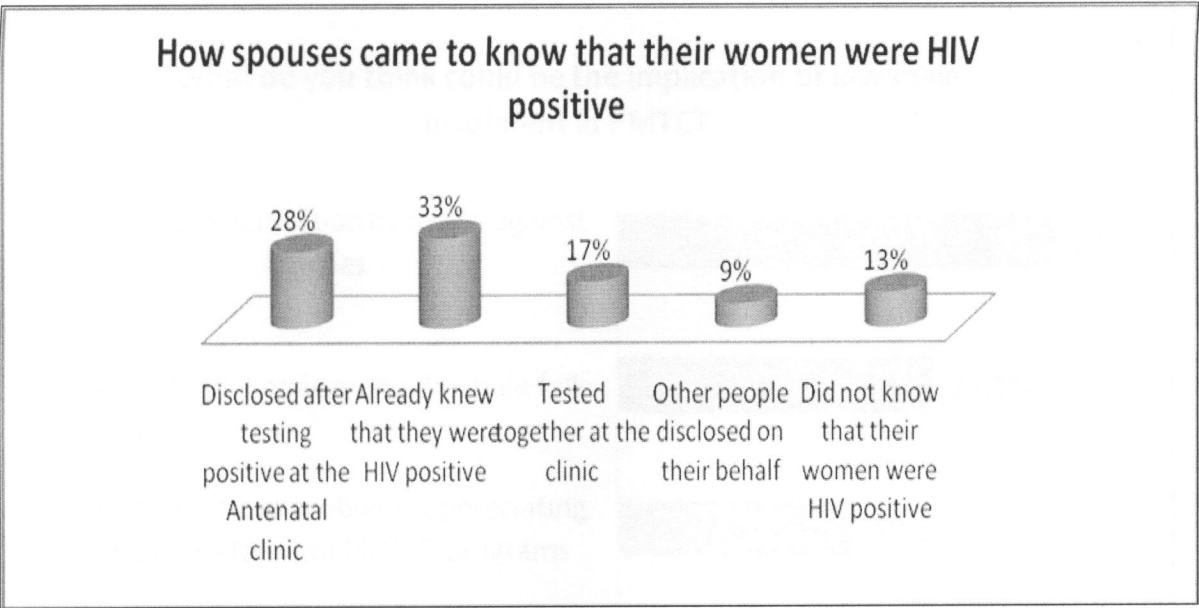
We already knew our HIV status before pregnancy	Frequency	Percent
Yes	72	62.1
No	44	37.9
Total	116	100.0

Source: Field data

5.2.12 How spouses of respondents knew that their women were HIV positive

While 33% of the 116 respondents said their spouses already knew their HIV statuses, 28% said they just disclosed to them after testing positive at the antenatal clinic. 17% said they tested together, 9% said other people disclosed on their behalf while 13% said their spouses had not been told and did not know that they were HIV positive.

Figure 6: How did your spouse come to know that you were HIV positive?

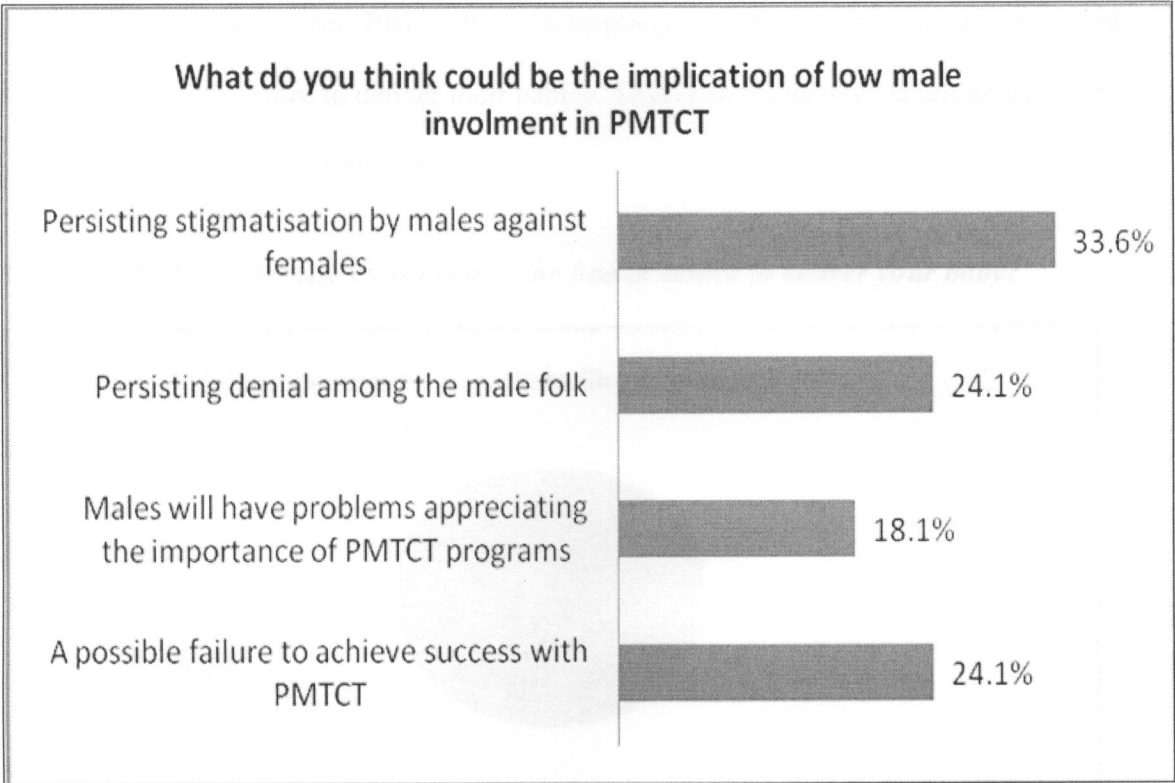


Source: Field Data

5.2.13 Implications of low male involvement in PMTCT

Asked to state what they thought could be the implications of low male involvement in PMTCT, 33.6% said there would be persistent stigma by males against women, followed by 24.1% who said there would be persistent denial among the men folk. The other 24.1% said there would be a possible failure to achieve desired PMTCT outcomes while 18.1 said males would have problems appreciating the importance of PMTCT.

Figure 7: What could be the implications of low male involvement in PMTCT?



Source: Field Data

5.2.14 If the child was delivered in a health centre

With regard to the importance of health centre delivery for HIV exposed babies, out of 116 respondents, a huge majority of 112 (96.6%) said they delivered their babies at health centre while only a paltry 3.4% said their babies were not delivered at health centres.

Table 15: Was your baby delivered in a health centre?

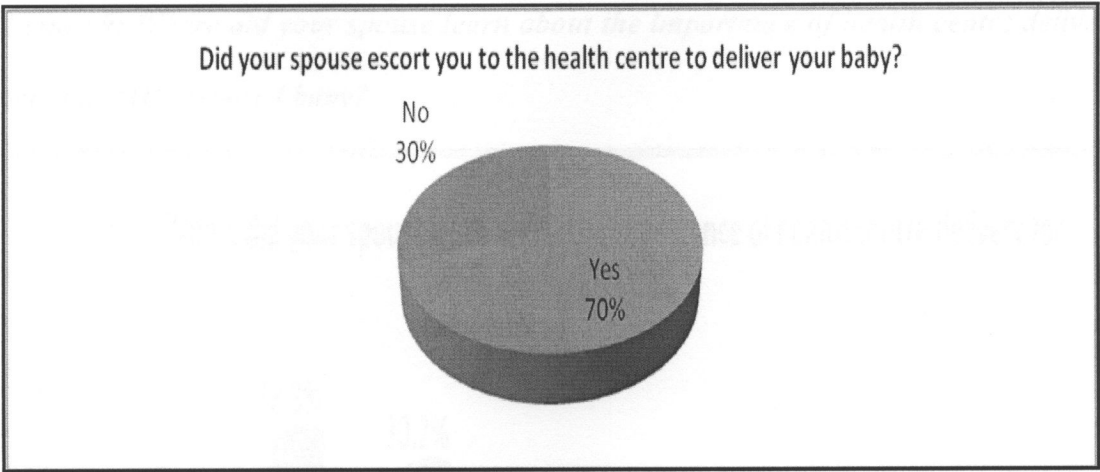
Response	Frequency	Percent
Yes	112	96.6%
No	4	3.4%
Total	116	100

Source: Field Data

5.2.15 If spouses escorted them to health centres to deliver their babies

As the figure below shows, 70% of the 116 respondents said that their spouses escorted them to the health centre to deliver their babies. This is an impressive result as only 30% were not escorted by their spouses.

Figure 8: Did your spouse escort you to the health centre to deliver your baby?



Source: Field Data

5.2.16 If spouses knew about the importance of health centre delivery

Knowledge of the importance of health centre delivery for their HIV positive pregnant spouses is very critical if their men are to offer the needed support. Of the 116 respondents, 86.2% (100) said their spouses knew about the importance of health facility delivery for HIV exposed babies and only 16 (13.8%) were said not to know.

Table 16: Did your spouse know about the importance of your health centre delivery?

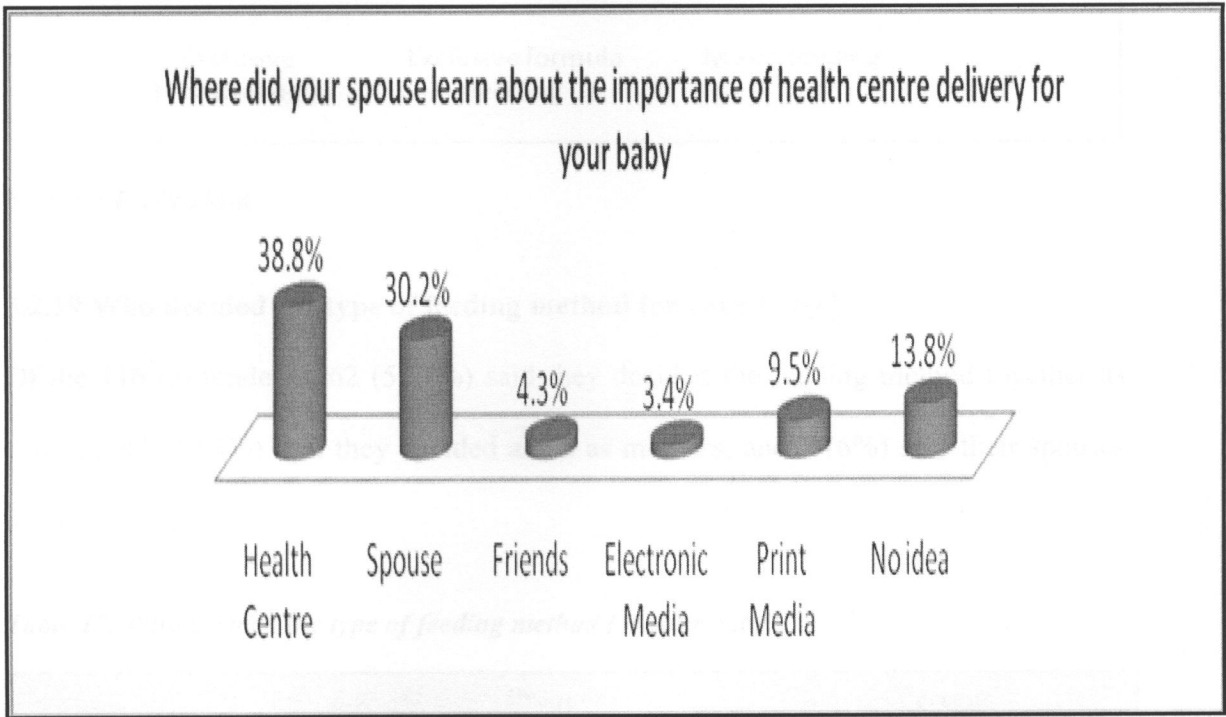
Response	Frequency	Percent
Yes	100	86.2
No	16	13.8
Total	116	100.0

Source: Field Data

5.2.17 Where spouses learnt about the importance of health centre delivery

Of all the 100 respondents whose spouses had learnt about the importance of health centre delivery, 38.8% learnt it from the health centre, 30% from their spouses, 9.5% from print media, 4.3% from friends, 3.4% from electronic media, and the other 13.8% had no idea where spouses had learnt about the importance of health centre delivery.

Figure 9: Where did your spouse learn about the importance of health centre delivery for your HIV exposed baby?

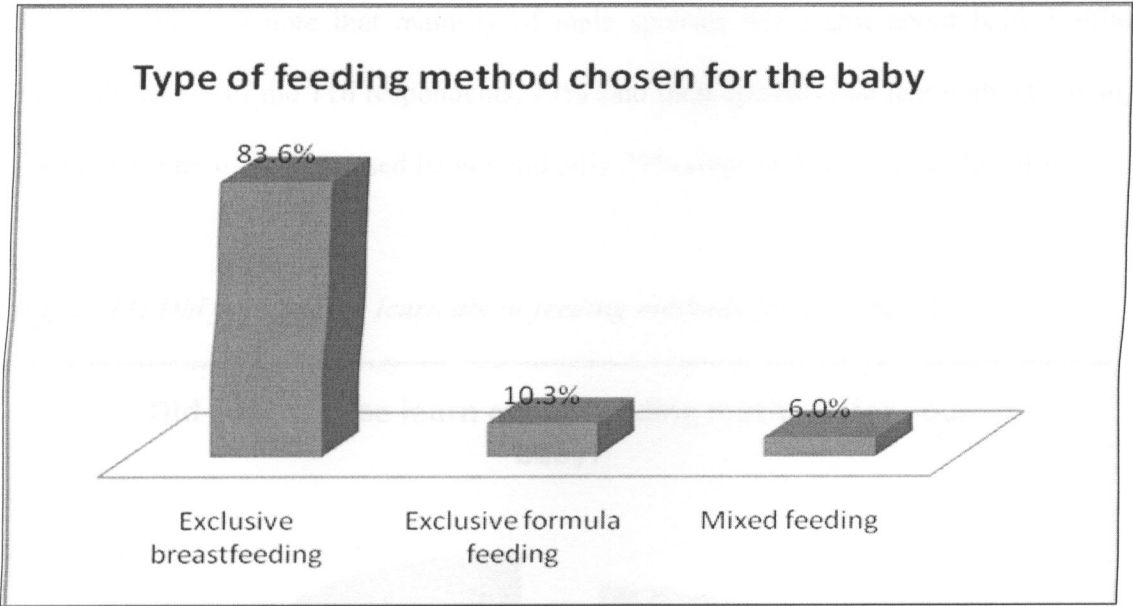


Source: Field Data

5.2.18 Type of feeding method chosen for the baby

Out of the 116 respondents, 83.6% said they had opted for exclusive breastfeeding, 10.3% chose exclusive formula feeding while 6% chose mixed feeding.

Figure 10: What type of feeding method did you choose for your baby?



Source: Field Data

5.2.19 Who decided the type of feeding method for your baby?

Of the 116 respondents, 62 (53.4%) said they decided the feeding method together as couples; 47 (40.5%) said they decided alone as mothers; and 7 (6%) said their spouses made the decision.

Table 17: Who decided the type of feeding method for your baby?

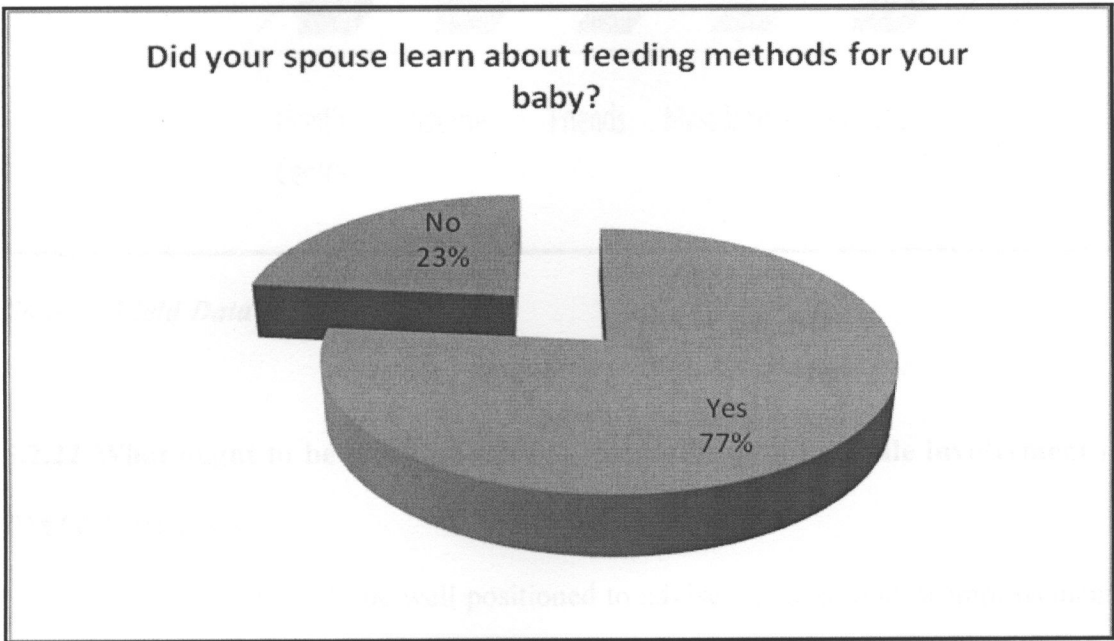
	Frequency	Percent
Mother	47	40.5%
Father	7	6.0%
Couple	62	53.4%
Total	116	100.0%

Source: Field Data

5.2.20 If spouses had learnt about feeding methods for their babies

It is gratifying to note that majority of male spouses had learnt about baby feeding methods, as out of the 116 respondents, 77% said their spouses had learnt about feeding methods for their HIV exposed babies and only 23% were said not to have learnt it.

Figure 11: Did your spouse learn about feeding methods for your baby?

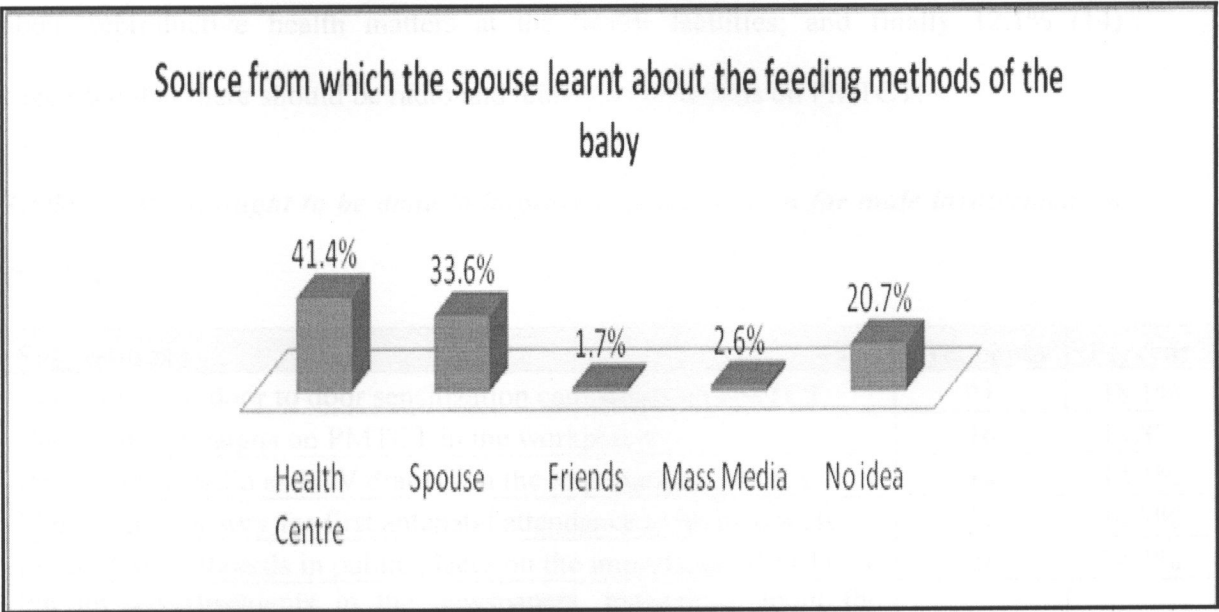


Source: Field Data

5.2.21 Where spouses learnt about feeding methods for their HIV exposed babies

Of the 77% who had learnt about feeding methods for their babies, majority of them (41.4%) learnt about it from the health centres; 33.6% from their spouses; 2.6% from mass media; 1.7% from friends and 20.7% did not know.

Figure 12: Where did your spouse learn about feeding methods for your babies?



Source: Field Data

5.2.22 What ought to be done to improve communication for male involvement in PMTCT activities

HIV positive women could be well positioned to advise on what kind of improvements needed to be made to enhance communication for male involvement in PMTCT.

It is encouraging to note that of all the six suggestions respondents gave, majority of them (24.1%) called for putting up of posters/billboards in public places on the importance of PMTCT; followed by 18.1% (21) who called for community or door to door sensitization campaigns on PMTCT; 17.2% (20) suggested putting up advertisements in newspapers and magazines about the importance of PMTCT; 14.7% (17) demanded that the government should make it compulsory for first antenatal attendees to go as couples; 13.8% (16) called for carrying out campaigns on PMTCT in

workplaces, as some men usually claim to be at work and cannot afford to go and learn about reproductive health matters at the health facilities; and finally 12.1% (14) suggested that there should be radio and television programs on PMTCT.

Table 18: What ought to be done to improve communication for male involvement in PMTCT?

Suggestions	Frequency	Percent
Community or door to door sensitization campaigns on PMTCT	21	18.1%
Carry out campaigns on PMTCT in the workplaces	16	13.8%
Broadcast on radio and TV dramas on the importance of PMTCT	14	12.1%
Make it compulsory for first antenatal attendance to be by couple	17	14.7%
Put posters/billboards in public places on the importance of PMTCT	28	24.1%
Put up advertisements in the newspapers, magazines about the importance of PMTCT	20	17.2%
TOTAL	116	100.0%

Source: Field data

5.2.23 Communication methods not effective for male involvement in PMTCT

Asked about what communication methods were not effective for male involvement in PMTCT, 70 (60.3%) of the 116 respondents said there was lack of compulsory means to educate males about PMTCT; 31 (26.7%) said there was lack of sensitization among the male folk concerning the importance of PMTCT; and 15 (12.9%) said none involvement of males in first antenatal clinic visits affects communication effectiveness for male involvement in PMTCT.

Table 19: What communication methods are not effective for male involvement in PMTCT?

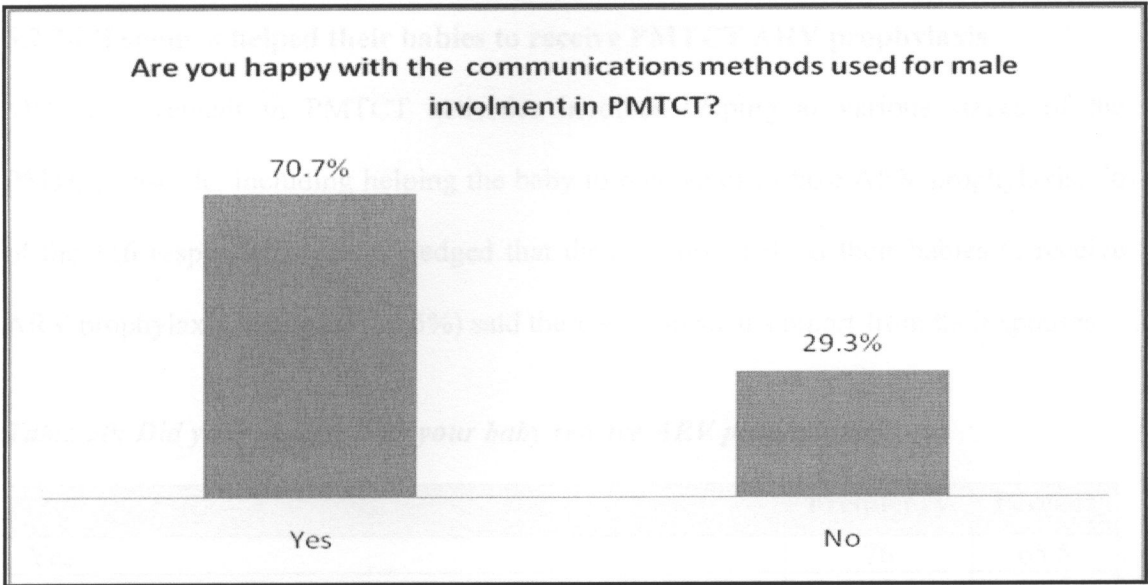
Response	Frequency	Percent
Lack of compulsory means to educate males about PMTCT	70	60.3
Lack of sensitization among the male folk	31	26.7
None involvement of males in first antenatal clinic visits	15	12.9
Total	116	100.0

Source: Field Data

5.2.24 If respondents were happy with communication methods used for male involvement in PMTCT

Asked what they thought about current communication methods used for male involvement in PMTCT, 70.7% said they were happy while 29.3% said they were not happy, as the figure below shows.

Figure 13: Are you happy with the communication methods used for male involvement in PMTCT?

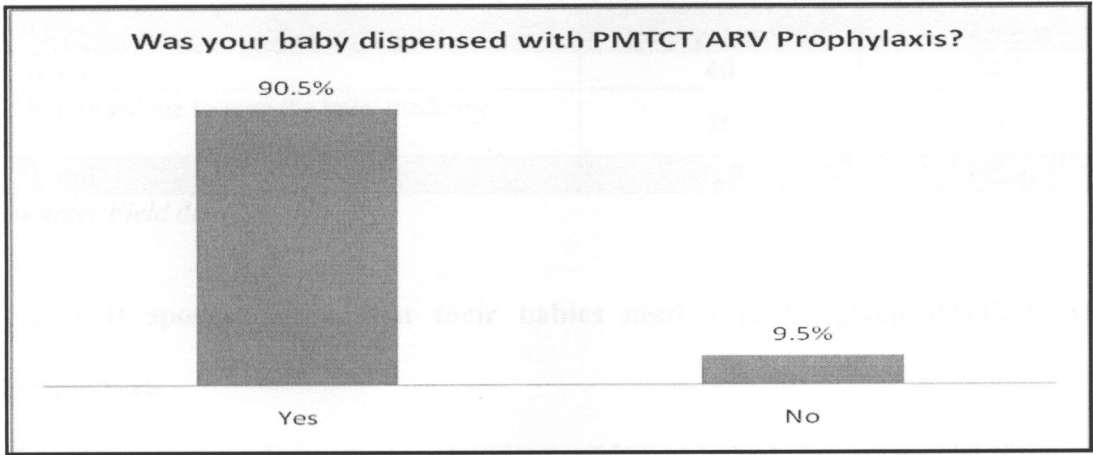


Source: Field Data

5.2.25 If babies of respondents were dispensed with PMTCT ARV prophylaxis

Baby ARV prophylaxis is very key in the prevention of mother to child transmission of HIV and it is very encouraging to note that a great majority of respondents (90.5%) said their babies received this drug while only 9.5% said they did not.

Figure 14: Was your baby dispensed with PMTCT ARV prophylaxis?



Source: Field data

5.2.26 If spouses helped their babies to receive PMTCT ARV prophylaxis

Male involvement in PMTCT activities involves helping at various stages of the PMTCT cascade, including helping the baby to receive or to take ARV prophylaxis. 76 of the 116 respondents acknowledged that their spouses helped their babies to receive ARV prophylaxis, while 40 (34.5%) said there was no such support from their spouses.

Table 20: Did your spouse help your baby receive ARV prophylaxis?

	Frequency	Percent
Yes	76	65.5
No	40	34.5
Total	116	100.0

Source: Filed data

5.2.27 Roles which spouses played in helping their babies receive ARV prophylaxis

Asked about what roles their spouses played, 40 (34.5%) of the 116 respondents said their spouses never played any roles, while 76 (65.5%) said their spouses reminded them to give babies the medicines, as the table below show.

Table 21: What role did your spouse play in your baby taking ARV prophylaxis?

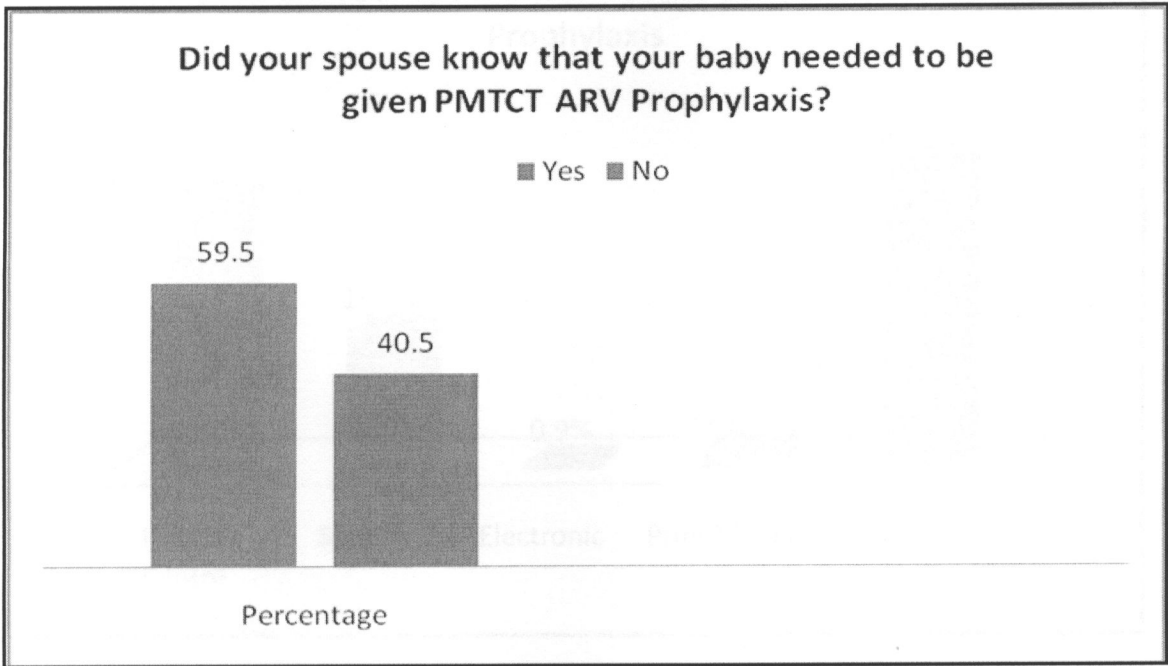
	Frequency	Percent
Nothing	40	34.5
Reminded me to give the baby medicine	76	65.5
Total	116	100.0

Source: Field data

5.2.28 If spouses knew that their babies needed to be given PMTCT ARV prophylaxis

Knowledge that the baby needs to be given ARV prophylaxis is very crucial if the male spouse is to be involved in helping the baby to access the drug. It is indeed sad to note that only 59.5% of the respondents said their spouses knew that their babies needed to be given PMTCT ARV prophylaxis, while 40.5% did not.

Figure 15: Did your spouse know that your baby needed to be given PMTCT ARV prophylaxis?

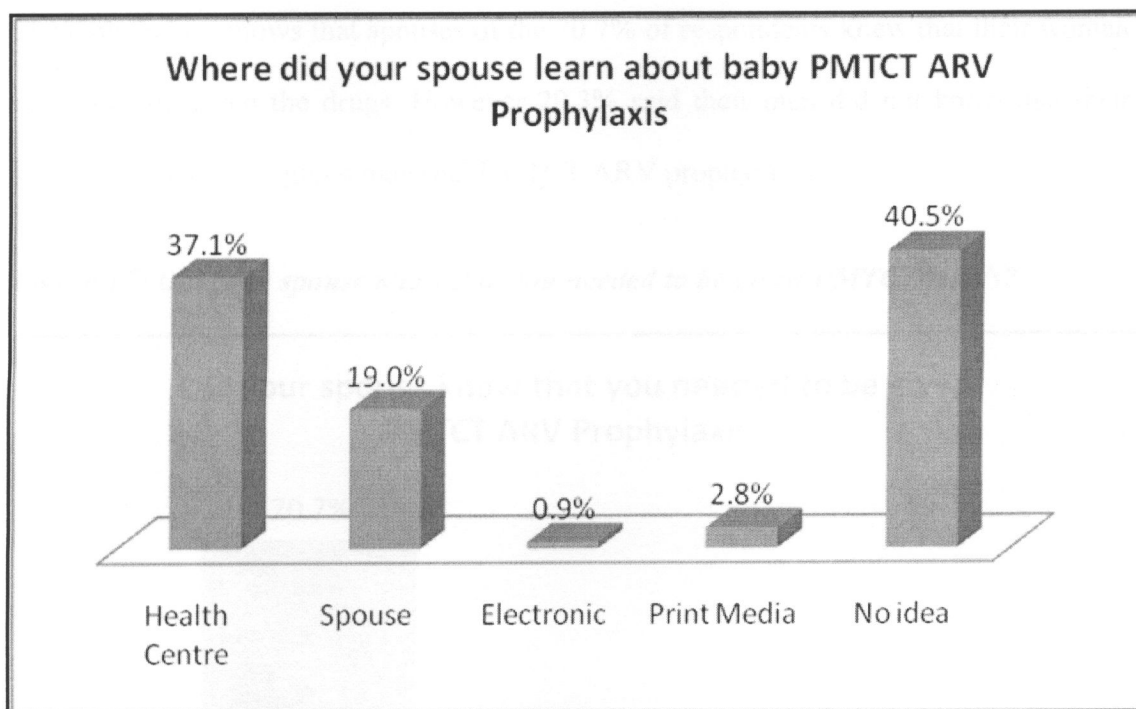


Source: Field data

5.2.29 Where spouses learnt about baby PMTCT ARV prophylaxis

For those respondents whose spouses knew about baby ARV prophylaxis, the study was interested in finding out where they acquired this knowledge from. Majority of the respondents (40.5%) said they had no idea where their spouses learnt about baby ARV prophylaxis; 37.1% said they learnt from the health centres; 19% from their spouses; 2.8% from the print media and 0.9% from electronic media.

Figure 16: Where did your spouse learn about baby PMTCT ARV prophylaxis?



Source: Field data

5.2.30 If respondents were given PMTCT ARV prophylaxis for their pregnancies

Taking maternal PMTCT ARV prophylaxis during pregnancy helps to reduce chances of HIV transmission from mother to child during pregnancy, labour, and delivery or even during breastfeeding. Of the 116 respondents, 105 (90.5%) said they were given PMTCT ARV prophylaxis for their pregnancies. Only 11 (9.5%) indicated not to have been given the drug.

Table 22: Were you given PMTCT ARV prophylaxis for your pregnancy?

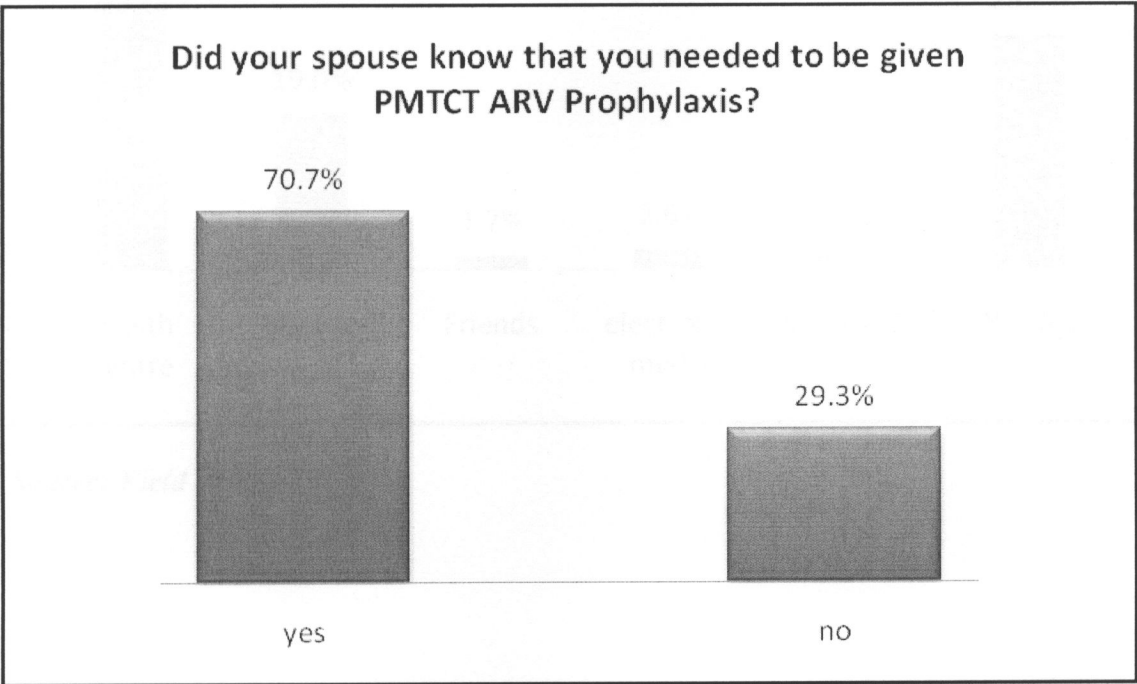
	Frequency	Percent
Yes	105	90.5
No	11	9.5
Total	116	100.0

Source: Field data

5.2.31 If spouses knew that respondents needed to be given PMTCT ARVs

The table below shows that spouses of the 70.7% of respondents knew that their women needed to be given the drugs. However 29.3% said their men did not know that their spouses needed to be given maternal PMTCT ARV prophylaxis.

Figure 17: Did your spouse know that you needed to be given PMTCT ARVs?

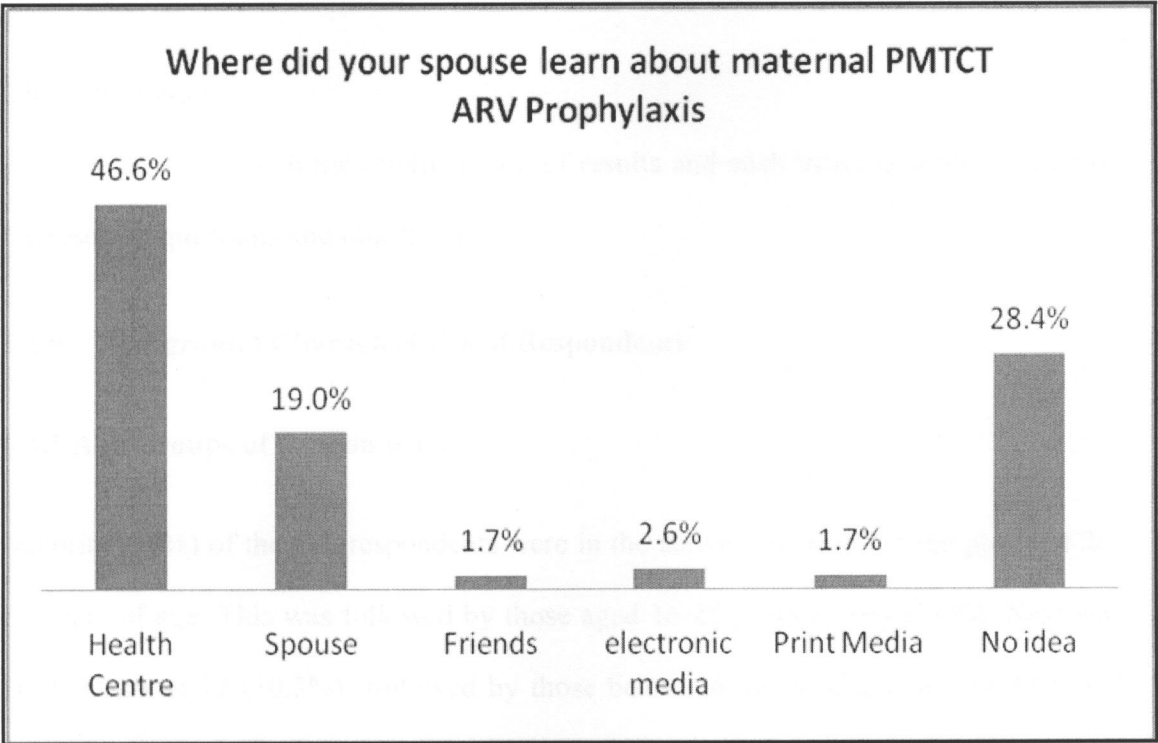


Source: Field data

5.2.32 Where spouses of respondents learnt about maternal PMTCT ARVs

Of the 70.7% of 116 respondents who said their spouses knew that they needed to be given maternal PMTCT ARV prophylaxis, majority (46.6%) said they learnt this from the health centres; followed by 28.4% who said they had no idea where their spouses learnt about it; 19% said they learnt from their spouses; 2.6% from the electronic media; 1.7% each from friends and print media.

Figure 18: Where did your spouse learn about maternal PMTCT ARV prophylaxis?



Source: Field data

CHAPTER 6: INTERPRETATION OF DATA

6.0 Introduction

This chapter deals with the interpretation of results and such interpretation is based on the research questions and objectives.

6.1.0 Background Characteristics of Respondents

6.1.1 Age Groups of Respondents

Majority (50%) of the 116 respondents were in the active reproductive age group of 26-35 years of age. This was followed by those aged 16-25 years at 39 (33.6%). Next was 36-45 years at 12 (10.3%); followed by those below 16 years of age at 5 (4.3%); and finally those aged above 45 years were at 2 (1.7%).

Overall, what this entails is that the survey had a good mix of respondents in terms of age groups, guaranteeing that women in the reproductive age group were adequately represented. What is somehow worrying about the above age statistics is that 4.3% (5) of these postnatal HIV positive women were aged below 16 years of age. Such a scenario points not only to the unfortunate prevalence of teenage pregnancies but also to the need to design PMTCT communication methods appropriate to such age groups, most of whom might still be in school and are clearly defilement victims according to Zambian laws. Their young age and circumstances surrounding their teenage pregnancies might overshadow the need for them to access PMTCT services.

Actually, teenage mothers, especially defilement victims (those aged below 16 years) might find it very difficult to get their spouses involved in PMTCT activities. What should basically be emphasized is the fact that PMTCT communication methods should be tailored according to target age groups, whether for female or male clients.

6.1.2 Ages of spouses to respondents (fathers to their youngest children)

The survey was interested in knowing the age distributions for the fathers of the youngest children of the respondents. As part of criteria to qualify to be interviewed, the HIV positive women were supposed to have babies aged 2 years old or below.

Of the 116 respondents, the majority (78.4%) said their spouses were aged 25-44 years; 11.2% (13) below 25 years; 9.5% (11) with 45-60 years old spouses; and only 1 (0.9%) respondent said the father to her baby was above 60 years old.

The essence of this background information was that it would be helpful in designing appropriate communication methods for male involvement in PMTCT based on what could be relevant to specific age groups. Indeed, not all particular communication tools might be appropriate for varying age groups.

What might be suitable for fathers aged below 25 years might not be suitable for fathers aged above 60 years of age. For instance, an open air musical concert aimed at promoting condom use in PMTCT setting might attract more young people below 45 years than those aged above 60 years old.

6.1.3 Marital Status of Respondents

The survey was interested in tracking the marital status of respondents, in the sense that the nature of the relationship might have a bearing on the level of male involvement in PMTCT. It was gratifying to note that majority of respondents (116) were married (87). Marriage or a stable relationship might provide ample platform for the couple to venture into reproductive health talks and PMTCT discussions and consequently get the male spouse involved in influencing PMTCT outcomes; 6.9% (8) of the respondents were single and on separation respectively; 6% (7) were widows; while 5.2% (6) were divorced.

For the divorced and separated ones, this could have happened after their men learnt that they had HIV, as one mother at Chawama clinic in the **focus group discussion** complained, that: *“I was four months pregnant when I told my husband that I had tested HIV positive at the antenatal clinic and that he also needed to go and get tested for HIV”*. The woman said upon hearing this, her **“former”** husband got upset, beat her up and chased her from their matrimonial home and that until the day of this discussion, with the child now aged 1 year and 2 months, they had not reconciled and the man had since moved in with another woman.

6.1.4 Education attainment of respondents

The level of education might have a bearing on understanding and interpretation of PMTCT messages, including communication dynamics for male involvement. Out of the 116 respondents, 21 (18.1%) indicated not to have been to school; 41 (35.3%) had basic

education; 45 (38.8%) had high school education; and only 9 (7.8%) had been to college. The scenario presented here requires that PMTCT communication messages are designed by taking into account literacy levels and consequently comprehension capacities of varying target groups, so as to make them less complicated.

Actually, according to the “**Diffusion of Innovation Theory**” (Rogers, 1983:150-283), complexity of an innovation is one of the characteristics that would determine the rate of adoption of such an innovation. Indeed, PMTCT is considered to be an innovation in HIV prevention.

6.1.5 Respondents length of relationship with the father of the youngest child

Of the 116 respondents, 49 (42.2%) said they had been in relationships with fathers of their youngest own children for above 5 years; 29 (25%) for 1-2 years; 23 (19.8%) for 2-5 years; and for less than 1 year 15 (12.9%) of the 116 respondents.

According to the **Social Penetration Theory** (Altman, I, et al., 1981:257-277), as human relationships develop, they penetrate deeper and deeper into private and personal matters. This exposes vulnerabilities, so trust has to be developed along the way. When at **Stable stage**, the relationship reaches a plateau in which personal things are shared and each can predict the emotional reactions of the other person. Indeed, and in congruency with this theory, longer relationships are more likely to foster ample platform for disclosure and male involvement.

6.1.6 Residential areas of respondents

The survey had interest in knowing the nature of residential areas where respondents lived. Of the 116 respondents, 77 (66.4%) said they came from high density residential areas; 31 (26.7%) were from medium density areas; and 8 only 8 (6.9%) came from low density residential areas.

6.1.7 Household Main Source of Income

Of the 116 respondents, 75 (64.7%) depended on informal employment for their household livelihood while 41 (35.3%) had formal employment as their main source of household income.

The source of household livelihood has a bearing on how much time couples would spend together and their collective participation in accessing reproductive health services, including PMTCT.

For instance, some women shared in the **focus group discussion** at Chipata clinic that their husbands always claimed to be too busy with work for them to come to the health centre. One of them even repeated what her husband had told her, *“If I don’t go to work and instead escort you to the health centre then my salary will be deducted because I cannot be given time off as a Security Guard. I may even end up being fired and we’ll not be eating antenatal since I’m the bread winner in this house.”* After that response, the woman never again asked him about escorting her to the health centre.

6.2.0 PMTCT knowledge, Communication and Practices

In order to inquire about the knowledge of PMTCT by respondents, the survey had various questions to do with how, when and where they and their spouses accessed particular PMTCT knowledge. The idea was to identify communication dynamics at play in various PMTCT actions and outcomes, with particular focus on male involvement.

6.2.1: Respondents having heard about PMTCT ever

The survey sought to find out if respondents had ever heard about PMTCT. This was intended to gauge if they really understood and /or remembered PMTCT as an HIV prevention intervention they had experienced. Having heard about PMTCT would also entail higher probability of learning about PMTCT services and consequently accessing PMTCT services and taking up particular PMTCT actions. Out of the total of 116 respondents, 112 (96.6%) said they had heard about PMTCT. Only 4 (3.4%) had never heard about PMTCT. What this entails is that knowledge of PMTCT among postnatal women with babies up to two years old is very high. However, the research was interested in further investigating from where these women had heard about PMTCT. So the next question had to do with that.

6.2.2: Where respondents had heard about PMTCT

The source of PMTCT knowledge for clients may determine how that knowledge would impact on PMTCT actions performed by the respondent. Majority of respondents (33.6%) mentioned that they heard about PMTCT from discussion fora at health centres;

21% from informal discussions; and the rest from various forms of mass media, with radio accounting for the highest at 13.8%.

Clearly, mass media appears to play a very small role in PMTCT. Focus group discussants attributed this to: Inadequate PMTCT programmes on radio and television; Lack of money to buy newspapers which they also accused of containing very little on PMTCT; Low literacy levels, hence unable to read and understand English, and suggested more use of vernacular languages. They also said that even though they owned radio and television sets, their men were never home often times to use them.

The finding that the majority of respondents acquired their PMTCT knowledge from discussion fora at health facilities was an indication that such fora could provide good platform for intensified PMTCT education.

This researcher visited all health centres to observe how PMTCT education was conducted for antenatal and postnatal mothers and it was discovered that there were special group education presentations given to clients on specific topics including PMTCT and generally HIV/AIDS. These sessions were conducted by nurses and other non medical and non uniformed personnel. Some of these sessions even had men in attendance, except they were not as many as their female counterparts.

6.2.3 If respondents ever discussed HIV/AIDS issues with spouses before pregnancy

Communication is considered to be a very important tool in any interpersonal relationship, because without it, it would not be easy to resolve problems or plan things together. This applies even in matters of reproductive health, where couples who seriously discuss matters are more likely to plan for their future together, they can plan whether or not to have a pregnancy, and even when to, if they choose so. They may even end up in disagreement, but they will have communicated their thoughts and feelings to each other, anyway.

It is encouraging to note that more (62.1%) respondents said they actually discussed HIV/AIDS issues with spouses before becoming pregnant, compared to 37.9% who did not. However, with reference to the importance of spousal dialogue around issues of reproductive health and particularly HIV/AIDS related, this 37.9% (44 of the 116 respondents) is just too high. What this means is that HIV positive couples might get pregnant without knowledge of their HIV status. They may, therefore, have not planned and prepared for PMTCT services, and such a scenario would pose challenges in taking up key PMTCT actions such as infant feeding options, maternal and infant ARV prophylaxis, health centre delivery, among others.

Focus group discussion participants at Chawama health centre shared that some women might have difficulties discussing reproductive health matters with their men for fear of being misunderstood in one way or another, such as being suspected to be sexually too active and adventurous. This they said might lead to mistrust and loss of confidence in them.

6.2.4 If spouses of respondents knew about PMTCT

Male spouse knowledge of PMTCT is very crucial for their participation in PMTCT activities, but how this knowledge is communicated to them might even be more crucial.

Of the 116 respondents, 84 (72.4%) said their spouses had heard about PMTCT while 32 (27.6%) respondents said their spouses did not know about PMTCT. The 32 out of 116 respondents whose spouses did not know about PMTCT is not impressive because it means that despite having HIV positive spouses and babies exposed to HIV, they did not

know about how the HIV virus could be prevented from getting to the baby. These men were totally in the dark and would have no role to play in PMTCT for their babies because they had been blacked-out by their spouses. Definitely spouses had their own reasons for not disclosing that they were HIV positive and that their babies were exposed to the HIV virus.

From the **focus group discussion** at Chawama health centre, some women indicated that it was not always easy to disclose to their spouses that they were HIV positive because that might cause a lot of problems for them in marriage, including serious beatings, abandonment or divorce. One woman from the group, who constantly kept saying marriages were not easy to come by remarked that, *“Especially if the owner of my pregnancy is a married man, I would just keep him in the dark, or else he might leave me and get stuck to his wife or find another woman so it is better not to tell him that I am HIV positive so that he continues supporting me and his child”*.

As a key informant, one PMTCT Nurse at one of the study health centres also shared that *“We have had HIV positive women who delivered their babies here and pleaded that they did not want their spouses to know that they were HIV positive and that their exposed babies would be on infant ARV prophylaxis”*. So they would even use different bottles to put NVP syrup for their babies just to make sure that their spouses did not discover what type of medicine their babies were taking.” This is a very sad state of affairs because if the father does not know that his baby is HIV exposed he would not be in a position to help in any areas of PMTCT care and support, such as choice and enforcement baby feeding methods and PMTCT ARV prophylaxis adherence.

6.2.5 Where spouses of respondents learnt about PMTCT

When it came to the source of PMTCT knowledge for the spouses of respondents, 29% mentioned the health centre, 25% mentioned mass media, 25% mentioned spouses, and for 21% they said they did not know their PMTCT knowledge source.

Concern is about those 21% spouses said to have no PMTCT knowledge, because it means they would have no role to play in influencing PMTCT decisions. It is however encouraging to note that majority of spouses learnt about PMTCT from the health facilities, more than from their spouses and mass media. This should be encouraged because if the male folk can frequent health facilities to acquire knowledge on reproductive health, it would lessen the burden of educating them by their spouses, who in some cases might be scared to talk about such matters with their men. But the challenge still remains with how these men should be invited to the health centres.

In terms of specific media where spouses learnt about PMTCT, radio had the highest as 46.2% (24) of respondents mentioned it, followed by other print media such as posters, magazines, brochures, billboards and others at 36.5% (19), with TV at 17.3% (9).

Observations by this researcher also revealed that really posters on PMTCT were not visible at visited health centres. It was also evident that billboards had nothing on PMTCT. Of course, it is not all aspects of PMTCT that can be captured on posters or billboards, but specific aspects of it such as infant feeding or maternal and infant PMTCT ARV prophylaxis, just to ensure that many people could read and learn.

6.2.6 When respondents knew that they were HIV positive

Of all the 116 respondents, half of them (50%) were aware of their HIV status before they became pregnant while the other half 50% (58) knew they were HIV positive when they went for their routine antenatal clinic visits. What comes out clearly here is that there is a huge proportion of women who conceive without knowing their HIV status and only to learn about it when faced with a routine requirement to be tested by virtue of being pregnant. It is however gratifying to note that a lot of respondents already knew they were HIV positive before conceiving. What this points to is that these respondents could find it easier to access PMTCT services and take up necessary PMTCT actions because chances are high that their pregnancy might have been planned, with full knowledge of their HIV positive status.

Actually, PMTCT **key informant** nurses interviewed confirmed that a lot of women came to know their HIV positive status when tested at the antenatal clinic. One of the nurses further explained that for such women it often became difficult to get them to accept their HIV positive results and help them plan how to involve their male spouses in taking up all necessary PMTCT actions as couples. This nurse actually acknowledged that the presence of **m2m** staff at their health centre had helped a lot in the provision of PMTCT education and emotional support to a lot of HIV positive mothers, saying they appeared to indentify well and comfortably with their fellow HIV positive **m2m** Mentor Mothers who were there to share their own personal experiences as they taught them.

6.2.7 If their male spouses were ever involved when respondents went to the antenatal clinic

Of the 116 respondents, 62% (73) said their spouses were involved when they attended their antenatal clinics while 37.1% (43) said their spouses never involved themselves.

What should be pointed out here is that male involvement in PMTCT requires that the male spouse shows interest in going with his pregnant woman for at least one antenatal clinic visit. When such interest is shown, it is likely that the man would also test for HIV and the woman would not be troubled by the challenge of how to disclose her HIV positive status to him, because probably they could even be tested together, get their results at the same time and receive the counselling together as a couple.

Additionally if the male spouse gets involved during antenatal, there would be adequate preparation and agreements for the rest of the PMTCT actions before their HIV exposed baby is delivered. Such prior and very critical actions might include the choice of feeding method, where the baby should be delivered from and associated maternal and infant ARV prophylaxis.

Having learnt from health authorities through **Key informant interviews** that antenatal clinics were conducted every day from Monday to Friday at all the study health centres, this researcher visited all centres to go and **observe** what actually obtained in relation to male involvement in antenatal attendance. The presence of male spouses was actually very low. But one MCH nurse shared that, *“First antenatal bookings never attracted many male spouses, unless when they went back with male spouse invitation slips which required couples to be tested together for HIV.”* She, however, stated that even without coming with their spouses, antenatal women were still attended to because they gave reasons as to why they could not come with owners of their pregnancies.

6.2.8 If spouses of respondents were ever called to the health centre

It would not be fair to just blame the male folk for not showing up at the health centre to escort their pregnant women for antenatal services without first knowing if they were ever invited. Traditionally, antenatal clinics are known to be facilities only for women and if a man ever has to go there, they have to be invited somehow. But even if they happen to be invited, it does not mean that they would easily cooperate. They might somehow be suspicious of the invitation.

Out of the 116 respondents, 75 (64.7%) said their spouses were invited to go to the health centre when they were pregnant. 41 (35.3%) said their spouses were not ever invited. Despite being a higher percentage, and while those invited were more, the figure was not impressive at all because out of this number some of them may have absconded. Also, the method used to invite them might determine their decision on whether to attend or not. Even the number of those not invited was too high at 35.3%, because what

this means is that their participation in PMTCT activities might be very minimal or might not even be there.

During a **key informant interview**, a nurse from Chawama health centre shared that *“Even though it was a requirement for pregnant women to attend initial antenatal bookings with their spouses, it was not easy to implement that because very few of them are able to come with their men and they give all sorts of excuses”*. She further mentioned that some of them even came for their first antenatal bookings late so they could not be delayed further by being turned away just because they did not come as couples.

From the **focus group discussion**, most mothers said it was not easy for them to invite their men to the health centre because they would always claim to be too busy as bread earners. A focus group discussion participant at Chipata health centre even remarked that, *“Me I managed to bring my husband here when I was told to come with him, but he left and went back to work after having waited to be attended to for over an hour and he since never came back and I never invited him again”*.

This researcher visited all study health centers to **observe** activities related to male involvement in PMTCT. The presence of men escorting their pregnant women for first antenatal bookings was very low; meaning most women simply came on their own.

Checking for any information displays on PMTCT in study health centres, they were very few, and in most cases not even there. Worse still there was no print media display anywhere talking about the importance of male involvement in PMTCT.

6.2.9 Methods used to invite male spouses to the health centre

While 35.3% of all 116 spouses of respondents were not invited to go to the health facility, certain methods of invitation were used for those invited and 36.2% were invited through their spouses while 28.4% were invited through invitation slips from health centre staff.

It is actually impressive to note that health staff can find time to send invitation slips to spouses of their clients. However, the number invited through this method is not very impressive at 28.4%, but what should also be realized is that a slip from health staff might be considered to be a sign of respect to the invitee and probably doing a lot more of such might increase on turn out and male involvement generally. Indeed, invitation through spouses is higher, but how effective it is, is another question because in some cases, men may not take seriously invitations made through their spouses and may come up with all sorts of excuses. What is most worrisome is to note that a lot of spouses of respondents (35.3%) were not even invited, as this presents a sad scenario whereby those not invited may have a very limited or no role to play in PMTCT activities.

6.2.10 If spouses of respondents came to the health centre after being invited

For those 75 men who were invited to come to the health centre, either through their spouses or invitation slips from health staff, 35.3% (26) showed up while 64.7% (49) never showed up and this is a very sad state of affairs. If so many were invited and they never showed up, then it means that such spouses would not access couple counselling services and would be less likely to actively take part in enforcing PMTCT actions in collaboration with their women.

6.2.11 When spouses of respondents came to know that their women were HIV positive

One of the most challenging steps concerning male involvement in PMTCT is on how to communicate to the male spouse that his pregnant woman is HIV positive. This is especially so because the pregnancy itself is a sign that there was unprotected sexual intercourse. But this becomes more difficult if the couple did not know their HIV status before pregnancy.

Out of the 116 respondents, 62.1% (72) said that they already knew that they were HIV positive before pregnancy while 37.9% (44) said they did not know their HIV statuses.

It is highly likely that if couples knew their HIV status before pregnancy and agreed to have the pregnancy, chances of male involvement in PMTCT would be assured. There would be no communication challenges associated with HIV status disclosure since partners already know their status. They would therefore just get to the next stages of male involvement such as feeding plans, health centre delivery, maternal PMTCT ARV prophylaxis and ARV prophylaxis for the baby.

6.2.12 How spouses of respondents came to know that their women were HIV positive

While 33% of the 116 respondents said their spouses already knew their HIV status, 28% said they just disclosed to them after testing positive at the antenatal clinic. 17% said they tested together, 9% said other people disclosed on their behalf while 13% of the respondents said their spouses had not been told and did not know that they were HIV positive.

When and how the male spouse learns about the HIV positive status of his woman would determine his reaction and level of involvement in PMTCT activities. If the woman chooses to disclose to her spouse on her own, she really must understand her spouse very well and be able to anticipate his reaction because this might attract violent reactions or resentment in some cases. One would actually argue that such type of disclosure might be considered unfair on the part of the male spouse because it is an indirect way of telling him that he too is HIV positive, without getting him psychologically prepared through HIV pre-test and post test counseling, which the woman would have already benefitted from at the antenatal clinic. The other unfortunate sign is on the 13% of respondents who said their spouses did not know that they were HIV positive. Of course, the percentage is low but it would be necessary to understand that if the man does not know about the HIV positive status of his woman, it would be impossible for him to support PMTCT activities with his woman because there is even no starting point, and in this case knowledge of HIV status is the foundation stage.

6.2.13 Implications of low male involvement in PMTCT

Male involvement in PMTCT is considered to be a very critical component in the successful implementation of PMTCT services. Without male involvement, definitely various challenges would be faced, including psychosocial or socio-economic ones.

Asked to state what they thought could be the implications of low male involvement in PMTCT, 33.6% said there would be persistent stigma by men against women, followed by 24.1% who said there would be persistent denial among the men folk. The other

24.1% said there would be a possible failure to achieve desired PMTCT outcomes while 18.1% said males would have problems appreciating the importance of PMTCT.

In the **focus group discussion** at Chawama health centre, participants confirmed that, indeed, the lack of male involvement in PMTCT might hinder a lot of things. However, the women complained that it was not always easy to get the male folk involved in PMTCT activities. One woman remarked as follows: *“We all want our men to be involved in PMTCT activities, but sometimes their involvement might even cause more problems in marriage which might even endanger the life of the baby more”*. This woman further elaborated that *“If when pregnant I disclose to my man that I am HIV positive and then he divorces me, then the baby and I will suffer in a lot of ways, including lack of proper nutrition since he is our bread winner”*. The group argued that poor nutrition may lead to low CD4 count and increased viral load which may easily contaminate the breast milk with HIV and put the baby at risk of getting the virus through breastfeeding.

Indeed, while these focus group discussants contended that male involvement in PMTCT was important, they also felt that it was not in all situations that it could be helpful because some men might be too brutal and uncooperative for the noble cause. They suggested that for such types of men, it would be better not to even involve them.

6.2.14 If the child was delivered in a health centre

HIV positive pregnant women are always advised to deliver their babies at health centres by qualified health personnel. This is because there are dangers of HIV transmission

from mother to baby during delivery if the delivery is performed by unqualified personnel, where chances of blood contact between mother and baby might be high.

Actually, according to the **Zambia Demographic and Health Survey (2007 page 133-134)**, increasing the number of births delivered in health facilities is an important factor in reducing deaths arising from the complications of pregnancy. Definitely, the expectation is that if a complication arises during delivery, skilled health workers can manage the complication and/or refer the mother to the next level.

The ZDHS (2007) indicates that Lusaka province has the highest proportion of health facility deliveries at 76% while Northern province has the lowest at 26%.

What the field data shows is that the proportion of births occurring in a health centre increases steadily with certain client characteristics, definitely, one of which is the need for HIV positive pregnant women to deliver their babies at health centres. This is also a sign that health personnel in Lusaka are doing a commendable job in educating HIV positive pregnant women on the need to deliver their babies at health centres.

Out of the 116 respondents, 112 (96.6%) said that they delivered their babies at health centres and this is a very good result.

6.2.15 If spouses escorted them to health centres to deliver their babies

Health centre delivery for HIV positive pregnant women is a very important PMTCT action. This action requires the support of the male spouse because the HIV positive pregnant woman might be physically in-ambulant and hence too weak to take herself

there or she may have no transport money to get to the health centre to deliver her baby. Male involvement at this stage is, therefore, very critical. 70% of the 116 respondents said that their spouses escorted them to the health centre to deliver their babies. This is an impressive result as only 30% were not escorted by their spouses.

Indeed, **observation** by this researcher at health centres revealed that a lot of women were in the company of men when leaving health centres after giving birth. They were also accompanied by their fellow women, some of whom could have been their mothers, aunties, sisters or friends, but of course there was a presence of men.

Even the **key informant** nurse at Chipata health centre confirmed the high presence of men who either escorted or went to collect their spouses after delivery.

6.2.16 If spouses knew about the importance of health centre delivery of babies

Knowledge of the importance of health centre delivery for their HIV positive pregnant spouses is very critical if their men are to offer the needed support. Of the 116 respondents, 86.2% (100) said their spouses knew about the importance of health centre delivery for HIV exposed babies and only 16 (13.8%) were said not to know.

6.2.17 Where spouses learnt about the importance of health centre delivery

Of all the 100 respondents whose spouses had learnt about the importance of health centre delivery, 38.8% learnt it from the health centre, 30% from their spouses, 9.5% from print media, 4.3% from friends, 3.4% from electronic media, and the other 13.8% the women had no idea where they had learnt about the importance of health centre delivery.

Therefore, health centre and spousal dialogue were very key communication tools in informing men about the importance of health centre delivery for HIV exposed babies. Mass media did not appear to be significant a tool in this endeavour and such a scenario is most unfortunate, because it is only through the use of mass media that a lot of people could simultaneously be informed about key PMTCT messages and the need for male involvement.

6.2.18 Types of feeding methods chosen for babies of respondents

The choice of baby feeding methods for HIV exposed babies is a very important PMTCT action because HIV transmission from mother to the baby might occur during breastfeeding if certain precautions are not taken. For instance, if exclusive breastfeeding is chosen and the pregnant woman has a CD 4 count below 350, she is supposed to be commenced on HAART, so that by the time she delivers her CD4 count might have risen and the viral load reduced so much that there would be little chance of the HIV being found in the breast milk or any other bodily fluids including blood. The higher the CD4 count, the lower the viral load.

The lack of financial resources makes some couples or mothers not to opt for exclusive formula feeding (use of formula milk) where contact with breast milk is totally done away with. For this method, if mother to child HIV transmission never occurred during pregnancy or during delivery, it means the baby would not get the virus through breast milk. Some opt for mixed feeding, which is very dangerous for HIV exposed babies. Because of the various food chemicals, it increases chances of infection because the

baby's stomach is too soft and can easily develop cracks through which the HIV, possibly from breastmilk might pass.

Out of the 116 respondents, 83.6% said they had opted for exclusive breastfeeding, 10.3% chose exclusive formula feeding while 6% chose mixed feeding.

6.2.19 Who decided the type of feeding method for your baby?

The choice of a feeding method for the baby should involve the male spouse for it to be effective. If for instance, the male spouse does not know that his baby is being exclusively breastfed, he might give the baby other foods, or even water and that ends up as mixed feeding, which is extremely dangerous to HIV exposed babies.

On the other hand, if the man is not involved and the woman chooses exclusive formula feeding, she has to prepare a lot of money to be buying formula milk almost every week for at least the first six months of the life of the baby. If the father of the baby is involved in choosing a feeding method, he is likely to plan for that choice, enforce the implementation of it and definitely stick to it for the recommended timeline.

Focus group discussants from both Chipata and Chawama health centres contended that, indeed, it was important for the father to be involved in choosing the type of feeding method for the baby. They said it was important for the couple to agree and plan together based on their resource base so that they pick on a kind of feeding method they would be able to sustain.

One mother at Chawama health centre revealed to the group that *“I had planned to exclusively breastfeed my baby without consulting my husband but just two days before delivery my husband said he would manage to buy formula milk and that’s what we fed the baby for the first six months and the baby is now almost 2 years old and HIV negative”*

The other woman from the Chipata focus group discussion commented that *“It would be most unrealistic for any woman not to involve her spouse in the choice of a feeding method for her HIV exposed baby even if that man is poor and he is not the main income earner for the home”*

Out of the 116 respondents, 62 (53.4%) said they decided the feeding method together as couples; 47 (40.5%) said they decided alone; and 7 (6%) said the spouses made the decision.

6.2.20 If spouses had learnt about feeding methods for their babies

For the male spouse to help in choosing a feeding method, he first has to learn about the types of feeding methods available and their merits and de-merits.

Of the 116 respondents, 77% said their spouses had learnt about feeding methods for the HIV exposed babies and only 23% were said not to have learnt about the same. It is gratifying to note that majority of the spouses had learnt about baby feeding methods.

6.2.21 Source where spouses learnt about feeding methods for their HIV exposed babies

Of the 77% who had learnt about feeding methods for their babies, majority of them (41.4%) learnt about it from the health centres; 33.6% from their spouses; 2.6% from mass media; 1.7% from friends and 20.7% had no idea where their spouses learnt it from.

6.2.22 What ought to be done to improve communication for male involvement in PMTCT

HIV positive women could be very well positioned to advise on what kind of improvements could be made to enhance communication for male involvement in PMTCT. It was encouraging to note that of all the six suggestions respondents gave, majority of them (24.1%) called for putting up of posters/billboards in public places on the importance of PMTCT; followed by 18.1% (21) who called for community or door to door sensitization campaigns on PMTCT; 17.2% (20) suggested putting up advertisements in newspapers and magazines about the importance of PMTCT; 14.7% (17) demanded that the government should make it compulsory for first antenatal attendees to go as couples; 13.8% (16) called for carrying out campaigns on PMTCT in workplaces, as some men usually claim to be at work and cannot afford to go and learn about reproductive health matters at the health facilities; and finally 12.1% (14)

suggested that there should be radio and television programs on the importance of PMTCT.

Focus group discussions came up with almost the same suggestions presented above, although they added that PMTCT topics and related issues should be promoted through preaching about them in churches and in schools as part of education curriculum, so that young people could start learning about PMTCT early enough. They also suggested for employers to permit men to escort their pregnant women for their first antenatal clinics.

6.2.23 Communication methods not effective for male involvement in PMTCT

Asked about whether communication methods were not effective for male involvement in PMTCT, 70 (60.3%) of the 116 respondents said there was lack of compulsory means to educate males about PMTCT; 31 (26.7%) said there was lack of sensitization among the male folk concerning the importance of PMTCT; and 15 (12.9%) said none involvement of males in first antenatal clinic visits affects communication effectiveness for male involvement in PMTCT.

Focus group discussion participants at both Chawama and Chipata health centres said that invitation slips for men to accompany their pregnant women at antenatal clinics were not taken seriously because even when men refused to go, for all sorts of reasons, *their women were still attended to. They claimed that this in some way diluted the significance of male involvement in PMTCT activities.*

Key informant nurses also confirmed this, but they argued that it would not be easy to deny women antenatal services just because their men refuse to come with them because in the end it might put the baby in more danger of acquiring the HIV virus.

6.2.24 If respondents were happy with communication methods used for male involvement in PMTCT

Asked what they thought about current communication methods used for male involvement in PMTCT, 70.7% said they were happy while 29.3% said they were not happy, arguing that not enough was being done to get the male folk actively involved in PMTCT activities. They said when men gave excuses that they were too busy to escort their spouses to health centres for reproductive health services, no further efforts are made to ensure that they abide.

6.2.25 If babies of respondents were dispensed with PMTCT ARV prophylaxis

Baby ARV prophylaxis is very key in the prevention of mother to child transmission of HIV and it is very encouraging to note that a great majority of respondents (90.5%) said their babies received this drug while only 9.5% said they did not.

6.2.26 If spouses helped their babies to receive ARV prophylaxis

Male involvement in PMTCT activities involves helping at various stages of the PMTCT cascade, including helping (or at least showing interest) the baby to receive ARV prophylaxis.

76 (65.5%) of the 116 respondents acknowledged that their spouses helped their babies to receive ARV prophylaxis, while 40 (34.5%) said there was no such support from their spouses.

6.2.27 Roles which spouses played in helping their babies receive ARV prophylaxis

Where there is effective communication for male involvement in PMTCT, the male spouse would help concerning when and how to take the drugs.

Asked about what roles their spouses played in this, 40 (34.5%) of the 116 respondents said their spouses never played any roles, while 76 (65.5%) said their spouses reminded them to give babies the medicines.

6.2.28 If spouses knew that their babies needed to be given PMTCT ARVs

Knowledge that the baby needs to be given ARV prophylaxis is very crucial if the male spouse is to be involved in helping the baby to access the drug.

It is indeed sad to note that only 59.5% of the respondents said their spouses knew that their babies needed to be given PMTCT ARV prophylaxis, while 40.5% did not. What is most worrying about this state of affairs is that it is either the men did not know that their babies were HIV exposed or they did not know what needed to be done to HIV exposed babies, or both.

6.2.29 Where spouses learnt about baby PMTCT ARV prophylaxis

For those respondents whose spouses knew about baby ARV prophylaxis, the study was interested in finding out where they acquired this knowledge from.

Majority of the respondents (40.5%) said they had no idea where their spouses learnt about baby ARV prophylaxis; 37.1% said they learnt from the health centres; 19% from their spouses; 2.8% from the print media and 0.9% from electronic media.

It is clear from these statistics that the media plays a very insignificant role in teaching men about baby PMTCT ARV prophylaxis.

6.2.30 If respondents were given PMTCT ARV prophylaxis for their pregnancies

Taking PMTCT ARV prophylaxis during pregnancy helps to reduce chances of HIV transmission from mother to child during pregnancy, labour, and delivery or even during breastfeeding.

However, if the male spouse is not aware of this need or does not just support it, there might be lack of adherence to taking the drugs.

Fortunately, out of the 116 respondents, 105 (90.5%) said they were given PMTCT ARV prophylaxis for their pregnancies. Only 11 (9.5%) indicated not to have been given the drug.

6.2.31 If spouses knew that respondents needed to be given PMTCT ARVs

Knowledge that his spouse needs to be given maternal PMTCT ARV prophylaxis, might inspire the man to support his spouse in accessing the drug.

70.7% of respondents knew that their women needed to be given the drugs. However 29.3% said their men did not know that their spouse needed to be given maternal PMTCT ARV prophylaxis.

6.2.32 Where did your spouse learn about maternal PMTCT ARV Prophylaxis?

Of the 70.7% of the 116 respondents who said their spouses knew that they needed to be given maternal PMTCT ARV prophylaxis, majority (46.6%) said they learnt this from the health centres; followed by 28.4% who said they had no idea where their spouses learnt about it; 19% said they learnt from their spouses; 2.6% from the electronic media; 1.7% each from friends and print media.

Clearly, and very unfortunate indeed, the media plays a very small role at 4.3%.

Focus group discussions from both Chipata and Chawama health centres revealed that indeed most spouses of respondents learnt about maternal ARV prophylaxis from health centres and from other sources they as wives did not know. One of the focus group discussion participants shared that *“Initially, my husband did not know anything about PMTCT drugs, but after visiting the health centre with him he developed a lot of interest in it and even started teaching me”*.

6.3 Conclusion

Communication methods used for male involvement in PMTCT have no clear framework for effective implementation. However, the actual implementation of PMTCT activities in Lusaka district health centres have been well done, in the sense that a lot of women mentioned to have accessed all the key PMTCT services.

The first objective of the study sought to identify communication methods used for male involvement in PMTCT activities. The methods used to inform male spouses about specific PMTCT issues included interpersonal communication between spouses, discussion fora at health centres, mass media and private discussions with friends. Results have shown clearly that interpersonal communication between spouses and with health staff has been a major method than mass media.

Clearly, the mass media appears to play a very small role in PMTCT promotion, with most respondents from focus group discussions saying there were not so many PMTCT programmes aired on radio and television and even when such are presented, time is not appropriate for most men as they may be out for work or return late home. As for newspapers, respondents said most of their men could not afford to buy newspapers regularly, which they also said do not contain so much information on PMTCT. Moreover, most electronic and print media messages are in English, a language respondents said could not be understood by a lot of them and their spouses.

As for the effectiveness of communication methods used for male involvement in PMTCT activities, it was encouraging that most male spouses who had learnt about PMTCT had helped their spouses in implementing key PMTCT actions. But it was also saddening that some women chose not to let their spouses know that they were HIV positive because they feared that consequences might be too harsh for them.

The survey also sought for communication methods that could help to enhance male involvement in PMTCT activities and what was revealed was that there was great need to intensify activities and strategies deliberately aimed at enhancing PMTCT knowledge

among the men folk. This should be through targeted education through mass media, interpersonal communication and stringent government policies aimed at compulsory involvement in certain reproductive health activities.

CHAPTER 7: GENERAL CONCLUSION AND RECOMMENDATIONS

7.0 Chapter seven is the last chapter of this report and it is divided in two parts. The first part deals with the general conclusion while the second part is a presentation of recommendations derived from the findings.

7.1 GENERAL CONCLUSION

It was important for this study to be conducted in view of the significance of male involvement in PMTCT and the ultimate contribution of PMTCT to the overall prevention of HIV, especially in children below the age of 15 years.

Male involvement in PMTCT is very important in the sense that there are various PMTCT outcomes whose successful realization depends on couples working on them together or the male spouse supporting his woman in implementing particular PMTCT actions. In all these facets, communication plays a very critical role. Where there are effective communication methods for male involvement, PMTCT outcomes are likely to be enhanced. When PMTCT outcomes are enhanced, it would mean low rates of mother to child transmission of HIV, hence low prevalence of HIV among children below the age of 15 years, and consequently low overall HIV prevalence in the long run.

The main objective of this study was to assess the effectiveness of communication methods used for male involvement in the Prevention of Mother to Child Transmission (PMTCT) of HIV.

Indeed, when it comes to the current communication methods used for male involvement, the study discovered that to a large extent there are no robust interventions that are specifically targeted at enhancing communication methods for male involvement in PMTCT. Results have shown clearly that most (29%) of the respondents indicated that their spouses learnt about PMTCT at health centres; followed by learning from spouses at 25%; mass media 25%; and those whose spouses did not have PMTCT knowledge at 21%. What is worrying most is that if without health centre and spouse notification as sources of PMTCT knowledge (54%), only 25% may have had PMTCT knowledge when their HIV positive women conceived. The implication is that 75% of the spouses of respondents may have known nothing about PMTCT prior to their women becoming pregnant. Mass media should be made to play a much bigger role in promoting PMTCT knowledge among men.

As far as the main objective of the study was concerned, communication methods used for male involvement in PMTCT are not just ineffective but also not given adequate attention and systematic implementation strategies.

As for the specific objectives, the study endeavoured to identify communication methods used for male involvement in PMTCT activities and what came out was that there were four main methods used to involve men in PMTCT. The first one was the health facility, where spouses of pregnant HIV positive women were invited to go and learn about PMTCT; secondly it was where women themselves shared with their spouses what they already knew about PMTCT; thirdly, men learnt about PMTCT from mass media; and fourthly were through private conversations with friends. Each one of

these methods had both merits and de-merits, but what should matter most is for male spouses to be aware well in advance that interventions exist for PMTCT, instead of learning about them amidst tempers and emotional upheavals.

The other specific objective of the study was to seek for communication methods that could help to enhance male involvement in PMTCT activities. What clearly came out was that, indeed there existed potential methods that could help enhance communication for male involvement in PMTCT. Suggestions identified by the survey included community or door to door sensitization campaigns on PMTCT; Carrying out campaigns on PMTCT in workplaces; Broadcasting on radio and television dramas on the importance of PMTCT; Making it compulsory for first antenatal attendance to be by couples; Putting posters/billboards in public places on the importance of PMTCT; and putting up advertisements in newspapers and magazines about the importance of PMTCT.

7.2 RECOMMENDATIONS

Recommendations are based on specific findings of the study and presented to relevant PMTCT stakeholders.

To the government, through the Ministry of Health, National AIDS Council, and other HIV/AIDS oriented organizations, the following are the recommendations:

- Design robust and specific messaging strategies targeted at men of reproductive age groups or younger so that they do not wait until their women are pregnant for them to come and learn about PMTCT and their role in it.
- Intensify campaigns for voluntary counselling and testing so that more people know their HIV status even before entering into marriage or before becoming pregnant.
- Organize debate contests for students about PMTCT in schools and colleges.
- Print Information, Education and Communication (IEC) materials such as fliers and brochures and distribute them cheaply or for free in busy places such as learning institutions, market places, churches and sports centres. These are easy and fast to look at and dispose of, so they would be appropriate.
- Reach out to men who claim to be too busy by following them in their work places or social clubs.
- The government should introduce a policy requiring couple attendance for first antenatal visits so that couples could be tested for HIV together and receive the PMTCT instructions together as one. This policy should be incorporated into the

labour laws of Zambia so that employers observe it as a right of a worker and as such no penalties should be inflicted upon a worker.

- The government should collaborate and work hand in hand with communication services providers so that PMTCT messages could be posted on cell phones of individual customers. The internet can as well be tapped for this purpose, especially the social networks.

To the media, the following are the recommendations:

- Ensure to give prominence to PMTCT issues and the critical role men play in it. For example there should be specific PMTCT messages on radio and television just before and after the main news.
- Even newspapers should provide columns for those writing about PMTCT.
- Search for success stories in PMTCT and the role of men in it and share them with wider audiences through special newspaper articles and radio and television programmes in vernacular languages to cater for audiences with low literacy levels.

To other researchers, the following are the recommendations:

- From where this study has left off, undertake studies in this area as it is wide and very important in so far as long term HIV AIDS fight is concerned.

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APPENDICES

APPENDIX 1

INTERVIEW QUESTIONNAIRE FOR POSTNATAL WOMEN

Questionnaire Number: _____

Date: Health Facility: Interviewer:

SECTION A

1. Age of respondent: (1) *Below 16 years* ☐ (2) *16-25 years* ☐ (3) *26-35 years* ☐
(4) *36-45 years* ☐ (5) *above 45 years* ☐
2. Age of baby (*youngest own child*): (1) *Below 6 months* ☐ (2) *7-12 months* ☐
(3) *13-18 months* ☐ (4) *19-24 months* ☐ (5) *above 24 months* ☐
3. Age of spouse (*father of your youngest child*): (1) *Below 25years* ☐ (2) *25-44years* ☐
(3) *45-60years* ☐ (4) *Above 60 years* ☐ (5) *No idea* ☐
4. Marital status respondent:
(1) *Single* ☐ (2) *Married* ☐ (3) *On separation* ☐ (4) *Divorced* ☐ (5)
Widowed ☐
5. How long have you/or were you in the relationship with the father of youngest own child?.....
(1) *Less than 1 year* (2) *1-2 years* (3) *2-5 years* (4) *Above 5 years*
6. Education of respondent:
(1) *Never been to school* ☐ (2) *Primary* ☐ (3) *Secondary* ☐ (4) *College* ☐ (5)
University ☐

7. Residential area: (1) *Low density* ☐ (2) *Medium density* ☐ (3) *High density* ☐

8. Household source of income: (1) *Formal employment* ☐ (2) *Informal employment* ☐

Please specify:.....

9. Average household monthly income in *Zambian Kwacha*:

(1) *Above K5 Million* ☐ (2) *K4 - K4.9 Million* ☐ (3) *K3 - K3.9 Million* ☐

(4) *2-2.9 Million* ☐ (5) *1-1.9 Million* ☐ (6) *500,000-900,000* ☐ (7) *Below 500,000* ☐

SECTION B

10. Have you heard about PMTCT? (1) *Yes* ☐ (2) *No* ☐

11. If you have heard about PMTCT where did you hear about it from? (1) *Health center* ☐

(2) *Spouse* ☐ (3) *Friend (s)* ☐ (4) *Electronic Media* ☐ (5) *Print media* ☐ (6) *Other....* ☐

12. Have you gone through PMTCT experience? 1. *Yes* ☐ 2. *No* ☐

13. Did you ever discuss HIV/AIDS issues with your spouse before becoming pregnant?

1. *Yes* ☐ 2. *No* ☐

14. Does your spouse know about PMTCT? 1. *Yes* ☐ 2. *No* ☐

15. If yes to 17, where did your spouse learn about PMTCT? (1) *Health facility* ☐ (2) *spouse* ☐

(3) *Friend (s)* ☐ (4) *Electronic Media* ☐ (5) *Print media* ☐ (6) *No idea* ☐ (7) *Other* ☐

16. When did you know that you were HIV positive? (1) *Before pregnancy* ☐ 2. *At antenatal during pregnancy* ☐ 3. *Other,* ☐ *specify:*

17. When you went to the antenatal clinic, was your spouse ever involved? 1. Yes ☐
2. No ☐

18. Was your spouse ever called to the health facility concerning your pregnancy or child? 1. Yes ☐ 2. No ☐

19. If yes to 18, what method was used to invite your spouse to the clinic?

1. Invitation slip from clinic ☐ 2. Invited through spouse ☐ 3. Other ☐

20. Did your spouse show up at the clinic after being invited concerning your pregnancy or child? 1. Yes ☐ 2. No ☐

21. How did your spouse come to know that you were HIV positive?

1. We already knew our HIV status before pregnancy ☐
2. I disclosed to him after testing at the antenatal clinic ☐
3. We tested together at the antenatal clinic ☐
4. Other people disclosed to him on my behalf, ☐
5. He does not know that I am HIV positive ☐

22. Was your child delivered in a health facility? 1. Yes ☐ 2. No ☐

23. Who escorted you to the health facility to deliver your baby?

1. Spouse ☐ 2. Other people ☐ 3. No one ☐

24. Did your spouse know about the importance of health facility delivery for your baby? 1. Yes ☐ 2. No ☐

25. If yes to 30, where did your spouse learn about the importance of health facility delivery for your baby? (1) Health facility ☐ (2) Spouse ☐ (3) Friend (s) ☐ (4) Electronic Media ☐ (5) Print media ☐ (6) No idea ☐ (7) Other ☐

26. What type of feeding method did you chose for your baby?

1. Exclusive breastfeeding ☐ 2. Exclusive formula feeding ☐ 3. Mixed feeding ☐

27. Who decided the type feeding method for your baby? 1. Mother ☐ 2. Father ☐ 3. Couple ☐

28. Did your spouse learn about feeding methods for your baby? Yes ☐ No ☐

29. If yes to 28, where did your spouse learn about feeding methods for your baby?

(1) Health facility ☐ (2) Spouse ☐ (3) Friend (s) ☐ (4) Electronic Media ☐ (5) Print media ☐ (6) No idea ☐ (7) Other, ☐

30. Was your baby dispensed with PMTCT ARV prophylaxis? 1. Yes ☐ 2. No ☐

31. Did your spouse help your baby receive ARV prophylaxis? 1. Yes ☐ 2. No ☐

32. Did your spouse know that your baby needed to be given PMTCT ARV prophylaxis? 1. Yes ☐ 2. No ☐

33. If yes to 32, where did your spouse learn about baby PMTCT ARV prophylaxis?

(1) Health facility ☐ (2) Spouse ☐ (3) Friend (s) ☐ (4) Electronic Media ☐ (5) Print media ☐ (6) No idea ☐ (7) Other ☐

34. Where you given PMTCT ARV prophylaxis for your pregnancy? 1. Yes ☐ 2. No ☐

35. Did your spouse know that you needed to be given PMTCT ARV prophylaxis?

1. Yes ☐ 2. No ☐

36. If yes to 35, where did your spouse learn about maternal PMTCT ARV prophylaxis?

(1) Health facility ☐ (2) Spouse ☐ (3) Friend (s) ☐ (4) Electronic Media ☐ (5) Print media ☐ (6) No idea ☐ (7) Other ☐

37. Are you happy with the communication methods used for male involvement in PMTCT? (1) Yes ☐ (2) No ☐

38. If no to 37, what communication methods are not effective for male involvement in PMTCT?

.....

39. What do you think could be the implications of low male involvement in PMTCT?

.....

.....

.....

40. What do you think should be done to improve communication for male involvement in PMTCT?

.....

.....

END OF INTERVIEW

**THANK YOU VERY MUCH FOR YOUR ATTENTION AND
COOPERATION!**

APPENDIX 2: GUIDING FRAMEWORK FOR FOCUS GROUP DISCUSSION

Questions	Responses	Quotable Quotes
1. What are your views about the current level of male involvement in PMTCT activities?	low male involvement	
2. What specific roles do you think men can play in PMTCT activities?	invite men to participate	
3. What communication methods are used to invite men to take part in PMTCT activities at health facilities	communication sites?	
4. How can men be made to play roles in choosing a feeding method for their HIV exposed baby?		
5. How can men be made to play roles in ensuring that their spouses deliver from health facilities?	FOR DOCUMENTARY REVISION	
6. Do men have a role to play in getting their spouses receive PMTCT ARV prophylaxis and how can they be involved in this?	role in PMTCT involvement in PMTCT	
7. Do men have a role to play in getting their exposed babies receive PMTCT ARV prophylaxis and how can they be involved in this?	involvement in PMTCT ment in PMTCT	
8. What do you think could be the implications of low male involvement in PMTCT activities?	there to enhance male involvement	
9. What do you think could be done to improve on communication methods for male involvement in PMTCT activities?	involvement in PMTCT	

APPENDIX 3: FRAMEWORK FOR KEY INFORMANT INTERVIEWS

Questions	Responses
1. What are your views about the current level of male involvement in PMTCT activities?	
2. What could be the communication reasons for low male involvement in PMTCT activities?	
3. What communication methods are used to invite men to participate in PMTCT activities at health facilities?	
4. What do you think could be done to improve communication methods for male involvement in PMTCT activities?	

APPENDIX 4: GUIDING FRAMEWORK FOR DOCUMENTARY REVIEWS

Questions	Answers
1. What are the current levels of male involvement in PMTCT activities?	
2. What could be the reasons for low male involvement in PMTCT activities	
3. What could be the implications of low male involvement in PMTCT activities?	
4. What could be done to improve male involvement in PMTCT activities?	
5. What deliberate communication strategies are there to enhance male involvement in PMTCT?	

APPENDIX 5: GUIDING FRAMEWORK FOR OBSERVATION DATA

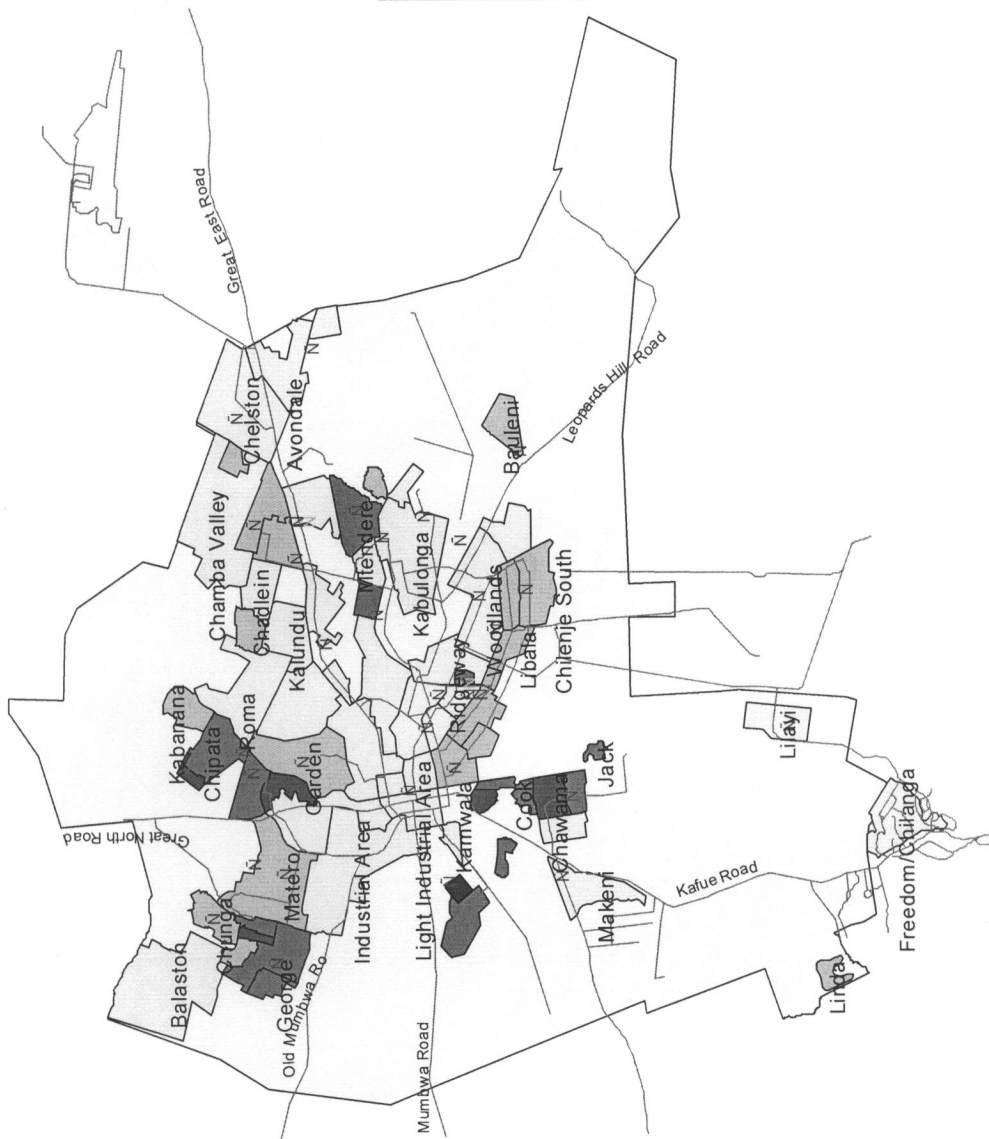
Questions	Answers
1. Are there men coming to antenatal clinic with their spouses?	
2. Are there men coming with their spouses to deliver in health facilities	
3. Are there men attending PMTCT support group meetings	
4. Are advertisements in health facilities or any other public places aimed at encouraging male involvement in PMTCT activities?	

APPENDIX 6

MAP OF LUSAKA DISTRICT SHOWING PUBLIC HEALTH FACILITIES

(The map of Lusaka district health centres on the next page in landscape)

HEALTH FACILITIES IN LUSAKA



Health Facilities

Health Centres

N

Clinic

N

Hospital

Population density

5,294 - 77,941

77,941 - 198,274

198,274 - 387,517

387,517 - 628,438

628,438 - 1,483,185

Roads

District boundary