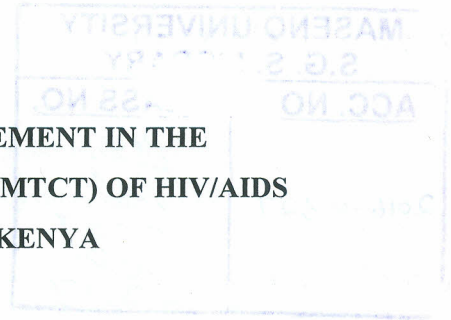


**FACTORS AFFECTING MALE PARTNERS' INVOLVEMENT IN THE
PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV/AIDS
IN ASEGO DIVISION, HOMA BAY COUNTY, KENYA**



BY

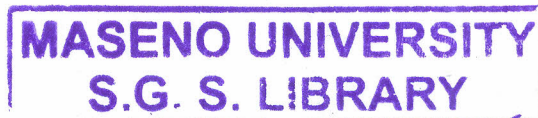
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**A RESEARCH REPORT SUBMITTED IN PARTIAL FULFILLMENT
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Abstract

HIV/AIDS pandemic has far-reaching social, economic, health and population effects. In addition to the harms directly inflicted on HIV-infected individuals and the households in which they live, AIDS has had indirect effects that are nevertheless real and substantial on communities and the whole of society. According to UNAIDS (2013), over 1700 children become infected with HIV worldwide each day with over 95% of them getting it through mother-to-child transmission and this called for the introduction of Prevention of Mother to Child Transmission (PMTCT) program as a global strategy to curb such escalating vertical transmissions. While both the partners (husband and wife) are responsible for a pregnancy, key decision making role in the families is often a male preserve and despite this fact, reviewed literature indicates little involvement of male partners' in PMTCT. This study is aimed at investigating the factors influencing male partners' involvement in PMTCT program with specific emphasis on male partners' knowledge and awareness on PMTCT, socio-cultural and programmatic factors and providing recommendations that are specific to the context of Asego division on how to increase male partners' involvement and consequently increasing PMTCT uptake and reducing maternal transmission of HIV/AIDS. This study was guided by the Health Belief Model adapted from Glanz, Rimer & Lewis' Related Behavior Theory and adopted cross-sectional descriptive design. Data was collected from 48 households among the 108 households from which children had completed the 18 months of follow-up at the Homa Bay District ANC in 2012 (HBDH Monthly Activity Report; Dec 2012). Purposive sampling was used to identify the 108 households from the patient register on the basis of completion of 18 months of follow-up; stratified sampling was employed to categorize households with children who turned HIV positive and those who turned HIV negative and simple random sampling finally conducted to identify proportionate representation from the two categories with data collected using structured questionnaires and direct observation methods. Qualitative data was analyzed using content analysis to capture the opinions and perceptions on male involvement while quantitative data was analyzed using SPSS 20 and results presented using frequency tables, pie charts and cross tabulations. The study findings revealed that male partners' involvement in PMTCT is largely influenced by strong fears of HIV positive results other than knowledge deficit of PMTCT and cultural influence. There is therefore a great need to design culturally appropriate and gender sensitive programmatic interventions that can address the reasons why men are discouraged to accompany their wives to the ANCs.

CHAPTER ONE: INTRODUCTION

1.1 Background Information

The question of whether men should be involved in women's reproductive health services started to attract a lot of interest especially after the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Women's Conference in Beijing (Drennan, 1998; Lee, 1999). This increased interest followed the realization by all stakeholders of the many roles men can play in the success of these services (Munene & Gathenya, 2004).

According to UNAIDS, PEPFAR, UNICEF, WHO (2013), Prevention of Mother to Child Transmission Programs (PMTCT) form an important component of the overall HIV prevention. Even though the involvement of male partners in this program has been associated with an increased uptake of PMTCT interventions by women, it remains one of the major challenges faced by program implementers (Rutenberg, Kalibala, Baek & Rosen, 2003). In Sub-Saharan Africa where HIV prevalence is highest, women are most affected with an average of 13 infected women for every 10 infected men. This difference is even more marked among young people (15-24 years) with three out of four people living with HIV being female (UNAIDS, 2013). The high HIV prevalence in women of childbearing age threatens child survival and development as 0.9% of children aged 18 months to 14 years corresponding to an estimated 104,000 children were infected with HIV in Kenya (KAIS, 2012). From a human rights perspective, governments and UN agencies have an obligation to support action to prevent infants from becoming infected.

Mother to child transmission of HIV, also called vertical transmission of HIV, is a very important mode of HIV transmission for children. Since the initiative for the PMTCT was launched in 1998, it has become clear from the increasing scientific evidence and recent results that it is possible to make a difference. According to Phoolcharoen and Detels (2002), the majority of children who die of HIV/AIDS acquire the infection through MTCT, and most of these children live in the developing world. According to UNAIDS (2013), during the year 2012 there were about 2.3 million children under 15 years living with AIDS in the world, and the vast majority of these were in sub-Saharan Africa. According to Rutenberg *et al.* (2003), MTCT is associated with up to 90% of all HIV infection in children up to six years.

It is estimated that without any intervention, about 35% of children born to HIV-infected mothers will be infected with the virus (UNAIDS, 2013). This percentage has reportedly been reduced to levels as low as 2% in developed countries with the advent of antiretroviral drugs and the implementation of core PMTCT interventions (Newell, 2001; Phoolcharoen & Detels, 2002).

In Kenya, the PMTCT program has witnessed an increase in the PMTCT sites to about 4,000 out of the 4,400 ANC providing facilities (NASCO, 2012). The PMTCT data now indicate that the rate of MTCT is falling below 10% down from a high of 27% five years ago (UNAIDS, 2012). The benefits of involving men in women's reproductive health services and PMTCT in particular are well recognized and have been advocated by many (Clark, 2001; Newell, 2001). They play key roles in reproductive health issues as individuals, family members and community decision makers. Therefore, reaching them is 'key' to making PMTCT more widely accepted and used as they can prevent primary HIV infection to women by practicing safe sex through condom use and also by being faithful to one uninfected sexual partner.

The benefits of male partners' involvement in PMTCT cannot be overemphasized. Women need social support from their male partners if they are to access and adhere to PMTCT services (Newell, 2001). World Health Organization (2009) also argue that social support plays a crucial role in enabling women to make important decisions pertaining to PMTCT, and adhere to the course of the intervention, improve uptake and continuation of family planning methods and provide family-centered care and treatment. This is supported by Theuring, Luvanda & Jordan-Harder (2009) who see male partners' involvement as crucial in the success of PMTCT because, behind every pregnancy, there is a man. They argue that men can play a big role in PMTCT because they are decision makers in matters of sexual and reproductive health (SRH). They also argue that men are opinion leaders, breadwinners and policy makers not only in their own homes but also in the communities they live. All these attributes influence women's behaviour towards PMTCT services. Unsupportive partner attitudes are likely to create a barrier to women's participation in PMTCT programs. However, reports from various PMTCT sites still show generally low involvement by male partners, with its negative impact on the level of uptake of interventions in this program by women (Lee, 1999; Rutenberg, Kabibala, Mwai & Rosen, 2002). This

lack of involvement by male partners deprives women of their partners' care and support in coping with the HIV infection, in taking antiretroviral therapy and in making appropriate infant feeding choices (UNICEF, 2001).

1.2 Statement of the Problem

Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012 of which about 25 million are living in Sub-Saharan Africa and about 2 million of them are children below the age of 15 years accounting for about 90% of all the HIV-infected children worldwide (UNAIDS, 2013). Over 1700 children become infected with HIV worldwide each day with over 95% of them getting it through mother to child transmission (UNAIDS, 2012). In Kenya for instance, children aged between 18 months and 14 years infected with HIV were estimated at 104,000 in 2012 due to low uptake of PMTCT services (KAIS, 2012).

Male partners' involvement in PMTCT has been associated with increased uptake of interventions by women (Theuring *et al.*, 2009). However, various PMTCT sites in the country, including HBDH continue to experience low levels of male partners' involvement. In spite of the noted low male partners' involvement, data on the beliefs, needs, priorities, and roles of males in the PMTCT program are limited and not fully documented (Munene & Gathenya, 2004). This paucity of information limits the development of appropriate strategies that may enhance male involvement in PMTCT programs, with a potential to increase the safety of both their female spouses and their unborn babies. In order to help the country devise policies and reasonable strategies to address this bottle-neck, there is an immediate need to investigate the factors associated to male partners' low involvement. This is the core objective of this study.

1.3 Research Questions

This study was set to unearth the factors affecting male partners' involvement in PMTCT programs in Asego Division, Homa Bay County, Kenya. In order to ascertain this, it adopted the following research questions:

- 1) What is the influence of male partners' knowledge and awareness about PMTCT on their level of involvement in PMTCT programs in Asego Division, Homa Bay County, Kenya?
- 2) What is the influence of socio-cultural factors on male partners' involvement in PMTCT program in Asego Division, Homa Bay County, Kenya?

- 3) What is the influence of PMTCT programmatic factors on male partners' involvement in PMTCT program in Asego Division, Homa Bay County, Kenya?

1.4 Research Objectives

1.4.1 General Objective

The general objective of this study was to examine the factors influencing male involvement in PMTCT program in Asego Division, Homa Bay County, Kenya.

1.4.2 Specific Objective

The specific objectives intended to be addressed by this study were to;

- 1) Assess how male partners' knowledge and awareness on PMTCT influence their involvement in PMTCT programs in Asego Division, Homa Bay County, Kenya.
- 2) Investigate how socio-cultural factors affect male partners' involvement in PMTCT programs in Asego Division, Homa Bay County, Kenya.
- 3) Examine how PMTCT programmatic factors influence male partners' involvement in PMTCT programs in Asego Division, Homa Bay County, Kenya.

1.5 Justification of the Study

Male involvement is an important determinant of PMTCT uptake. However male involvement in PMTCT is influenced by socio-cultural norms, beliefs, attitudes and perceptions of the various communities. In order to improve male involvement in PMTCT in a given community, it is important to understand the perceptions, attitudes and beliefs towards the involvement of male partners in PMTCT, the cultural norms influencing male involvement in PMTCT, and the culturally acceptable strategies that can be adopted in order to improve male involvement in PMTCT.

In spite of the noted low male partners' involvement, data on the beliefs, needs, priorities, and roles of males in the PMTCT program are limited and not fully documented (Munene & Gathenya, 2004). The findings of this study is therefore intended to help in providing information on how to effectively involve male partners as increasing male partners' involvement in these programs will increase PMTCT service uptake by women. As indicated by Theuring *et al.* (2009), increased uptake of PMTCT services will ultimately contribute to a reduction in new paediatric HIV infections, which is the ultimate goal of PMTCT thereby reducing HIV related

morbidity and mortality among children and women, leading to the achievement of the fourth, fifth and sixth Millennium Development Goals.

The findings of this study shall also serve as baseline information for comparison purposes in future studies on related topics. Exploratory analysis of data collected in this study may also generate hypotheses for examination in further studies.

1.6 Scope and Limitation of the Study

The study was limited to male partners' involvement in the core PMTCT interventions included in the third prong of PMTCT or MTCT preventive interventions for HIV-infected pregnant women which covers the period before birth and after birth. However, the study was not interested in the status of the male partners.

Among the limitations realized in this study included; the small sample size which is likely to have a bearing on the generalization of the findings to the entire 963,794 people of Homa Bay County. Moreover, being that socio-cultural factors are in most cases specific to a given ethnic group, Luo in this context, the generalization of the findings of this study were also limited to the Luo culture and may therefore not be relevant to the neighboring Suba, Kuria, Kisii and Luhya communities.

1.7 Theoretical Framework

This study used the Health Belief Model adapted from Glanz, Rimer & Lewis' Related Behavior Theory. Glanz *et al.* (2002) denotes that The Health Belief Model is a psychological model that attempts to predict the health behavior by focusing on the attitudes and beliefs of individuals. The HBM was developed in 1950 as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs. Since then, the HBM has been adapted to explore variety of long-and-short-term health behavior, including sexual risk behavior and the transmission of HIV/AIDS.

In general, it is now believed that people will take action to ward off, to screen for, or to control an ill-health condition if they regard themselves as susceptible to or the severity of the condition, if they believe it to have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing

either the anticipated barriers to (or cost of) taking the action are outweighed by its benefits.

According to the model, behavior depends mainly on two variables: the value that individual places on a particular goal and the individual's estimation on the likelihood that the given action will achieve the goal. When these variables will be conceptualized in the context of the health related behavior, the correspondences will include the desire to prevent mother to child transmission and the belief that a male partners' involvement as an action is effective in reducing vertical transmissions.

The HBM consists of the following variables:

A. **Perceived Threat:** Consists of two parts as perceived susceptibility and perceived severity of a health condition.

Perceived Susceptibility as a construct refers to one's perception of the risk of contracting a health condition. In the case of a medically established illness, the dimension has been reformulated to include acceptance of the diagnosis, personal estimates of susceptibility and susceptibility to illness in general.

Perceived Severity refers to the seriousness of contracting an illness or leaving it untreated and facing the possible medical, clinical and social consequences such as death, disability and the effects of the condition on work, family life and social relation.

The combination of both susceptibility and severity are labeled the perceived threat by this model.

B. **Perceived Benefit:** This refers to the believed effectiveness of given available alternatives in reducing the disease threat. The perceived barrier of acting refers to the negative aspects of preventive behavior, such as inconvenience, high costs, unpleasantness, etc.

C. **Cue to Action:** In various early formulations of the HBM, the concept of cues that trigger actuation was discussed. Hochbaum (1958), for example, thought that readiness to take action (perceived susceptibility and perceived benefits) could only be potentiated by other factors, particularly by cues to instigate action, such as bodily events, or by environmental events, such as media publicity. He did not,

however, study the role of cues empirically. Cues to action may ultimately prove to be important, but they have not been systematically studied. Indeed, while the concept of cues as a trigger mechanism is appealing, it has been difficult to study in explanatory surveys; a cue can be as fleeting as a sneeze or the barely conscious perception of a poster.

D. Other Variables

Diverse demographic, socio-cultural factors (e.g. sex, age and race), psychological variables (e.g. personality, social class) and structural variables (e.g. knowledge about the disease, prior experience with the disease) may affect the individual's perception and thus indirectly influence health related behavior. Specifically, socio-demographic factors, particularly educational attainment, are believed to have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits and barriers.

The Health Behavior Model asserts that people who feel threatened by an illness and believe that the benefits of taking an action outweighing the barriers are more likely to perform the preventive behavior. In terms of male involvement in prevention of mother to child transmission of HIV/AIDS, the HBM assumes that the male partners who perceive the threat of vertical transmission to their children, perceived benefits of taking HIV test more than barriers of taking HIV test, have more knowledge about HIV/AIDS and have internal or external cues of the action are more likely to be supportive to their spouses in seeking ANC services.

A diagrammatic representation of the adopted Conceptual Framework

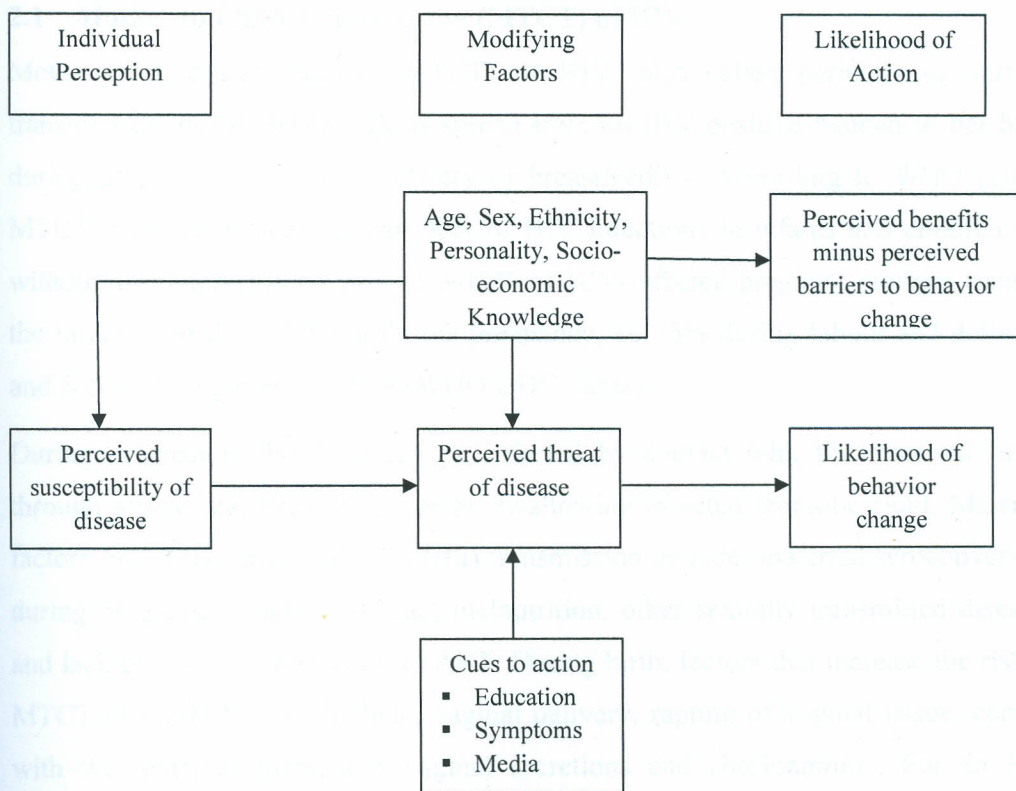


Figure 1: Health Belief Model Components and Linkages

Source: Glanz, (2002)

CHAPTER TWO: LITERATURE REVIEW

2.1 Mother to Child Transmission (MTCT) of HIV

Mother-to-child transmission (MTCT) of HIV, also called perinatal or vertical transmission, occurs when HIV is spread from an HIV positive woman to her baby during pregnancy, labor and delivery or breastfeeding. According to WHO (2010) MTCT contributes to more than 90% of HIV infections in infants and children and without any interventions, around 5-10% of HIV-infected pregnant mothers transfer the infection to their children during pregnancy, 10-15% during labour and delivery, and 5-20% during breastfeeding (WHO/CDC, 2008).

During pregnancy, the fetus can be infected by contact with the maternal blood through a placental hemorrhage or by swallowing infected amniotic fluid. Maternal factors which increase mother-to-fetus transmission include: maternal seroconversion during pregnancy, high viral load, malnutrition, other sexually transmitted diseases and lack of or poor compliance to ART. During birth, factors that increase the risk of MTCT of the HIV virus include; vaginal delivery, rupture of vaginal tissue, contact with the maternal blood and vaginal secretions and chorioamnitis. For an HIV positive woman not being treated for HIV, the chance of passing the virus to her child is about 25% during pregnancy, labor and delivery because of the greater exposure to maternal secretions during the delivery process secondary to prolonged rupture of membranes.

After birth, the most significant risk factor is breastfeeding. There is an additional 12% chance of transmission of HIV if the mother adopts mixed feeding within the first six months of delivery. Scientists hypothesize that an infant's immune response is triggered by the introduction of new foods, attracting white blood cells to the gastrointestinal tract and increasing targets for the HIV viruses to spread infection (WHO, 2004).

The table below summarizes the risk factors associated with increased MTCT as adapted from the guidelines for prevention of mother-to-child transmission of HIV in Kenya.

Table 1: Factors associated with increased mother-to-child transmission of HIV

<p>Maternal factors</p>	<ul style="list-style-type: none"> • Viral load, advanced HIV disease • Low CD4 count, • New HIV infections in the mother • Viral, parasitic and other infection of placenta • Nutritional deficiency (iron foalte, Vitamin A, and Zinc deficiencies) • Breast conditions (nipple fissures, cracks, mastitis and breast abscess)
<p>Infant factors</p>	<ul style="list-style-type: none"> • First infant in multiple birth • Preterm low birth weight • Prolonged duration of breastfeeding • Mixed breastfeeding • Oral lesions in the infant
<p>Obstetric and delivery practices</p>	<ul style="list-style-type: none"> • Rupture of membrane for more than 4 hours (routine artificial rupture of membrane) • Birth canal injury during child birth(Instrumental assisted delivery unless absolutely indicated) • Ante-partum procedures • Birth canal injury during child birth(Instrumental assisted delivery unless absolutely indicated) • Ante-partum procedures (Amniocentesis and external cephalic version) • Invasive procedures (routine episiotomy and fetal scalp monitoring) • Delayed infant cleaning and eye care • Routine infant airway suctioning • Vaginal delivery • Prolonged labour

Adapted from MOH Guidelines on PMTCT 2002

2.2 Prevention of Mother to Child Transmission (PMTCT)

HIV may be transmitted to the infant during pregnancy, at the time of delivery, and through breastfeeding (Family Health International, 2003). For a known HIV-infected mother who becomes infected in the antenatal period, the additional risk of transmission of HIV to her infant through breastfeeding has been estimated at 14%; it may reach 29% for mothers who acquire HIV in the postnatal period (Newell, 2001).

The factors that may increase the risk of prenatal transmission include: high maternal viral load; recurrent sexual transmitted diseases (STDs); malaria; Vitamin A deficiency; preterm delivery; vaginal delivery; duration of rupture of membranes longer than four hours; placental disruption; invasive procedures during delivery (like vacuum extraction, episiotomy, use of forceps); breastfeeding and mixed feeding (Family Health International, 2003; Phoolcharoen & Detels, 2002).

The majority of children who are infected with HIV were infected through MTCT or vertical transmission (Rutenberg *et al.*, 2003). Without any appropriate interventions, about a third of children born to HIV-infected women are likely to be infected (Phoolcharoen & Detels, 2002). According to Newell (2001), these children who acquire HIV through this mode of transmission face severe morbidity and mortality, especially in settings where specialized care is not available.

In countries where PMTCT interventions have been fully implemented, rates of transmission from mother to child have been estimated to be as low as 2% (Newell, 2001). In developing countries such as those in sub-Saharan Africa, where PMTCT interventions are not always available and prolonged breast-feeding is a norm, the rates are still estimated to be as high as 25-35% (Rutenberg *et al.*, 2003).

A declaration by the UN General Assembly Special Session on HIV/AIDS (UNGASS) held in June 2001 reflected this position, setting a goal for 20% and 50% reductions in paediatric HIV infection by 2005 and 2010 respectively, through provision of PMTCT services to 80% of pregnant women accessing antenatal care (WHO, 2003). To achieve this ambitious UNGASS goal, WHO and the UN have recommended a comprehensive, four-pronged strategic framework for preventing MTCT of HIV, encompassing:

Prong 1: Targeted primary HIV prevention among women of child bearing age

Prong 2: Prevention of unintended pregnancies among HIV-positive women

Prong 3: Prevention of infection from HIV-positive mothers to infants

Prong 4: Provide care and support of women, their children, and families infected and affected by HIV/AIDS

2.2.1 Primary Prevention of HIV Infection

Preventing HIV in women, particularly young women, and their partners is the best way to ensure that secondary transmission to infants does not occur (WHO, 2003).

This could be achieved through implementation of behavioural change communication, scaling up of HIV-testing and counseling, improvements in case detection and management of STIs, making blood supply safer, and addressing contextual factors that increase women's vulnerability to HIV (e.g., schooling, economic dependency, cultural and social practices) (FHI, 2004). WHO emphasizes at least four areas to address primary prevention efforts in the context of PMTCT programs and they include; expansion and intensification of HIV prevention efforts, strengthening of links between programs to prevent MTCT of HIV and other HIV prevention efforts, focusing on HIV prevention during pregnancy and lactation lastly the promotion of male participation in PMTCT (WHO, 2003).

2.2.2 Prevention of Unintended Pregnancy among Women Living with HIV

That more than 50% of all births in some countries are due to unintended pregnancies indicates the great potential of contraception to prevent thousands of cases of vertical HIV transmission (FHI, 2004). USAID-funded analysis of the costs and benefits of adding family planning services to PMTCT programs found that in PEPFAR focus countries, family planning can double the cost effectiveness of PMTCT services in averting new paediatric HIV infections (WHO, 2003). The contribution of family planning services integrated into HIV care services to PMTCT is therefore not to be underestimated.

2.2.3 Prevention of HIV Transmission from infected Women to their Infants

The third prong is based on what are considered as key PMTCT interventions (FHI, 2003). In the broader sense, prevention of transmission of HIV infection from infected women to their children will involve a range of strategies and activities, including improved availability, quality and use of MCH services; HCT in the context of PMTCT services; antiretroviral chemoprophylaxis for PMTCT; infant feeding counseling and support; and safer obstetric practices (FHI 2004; WHO, 2003).

Among these interventions, three are considered to be core PMTCT interventions; these are VCT, ART and counseling for infant feeding options. VCT is considered by some as the most important intervention for PMTCT (Newell, 2001). According to Rutenberg *et al.* (2002), the importance of VCT in PMTCT lies in the fact that it has the potential to reach large numbers of women who may already be infected with HIV or at high risk of becoming infected. According to the Horizon Program (2002),

experiences from a number of PMTCT sites have shown that VCT in PMTCT is a key to successful male partners' involvement, especially when it takes the form of couple counseling. This view is also supported by Clark (2001), who considers VCT programs which work with couples to be more successful than those working with women alone.

Another core intervention considered important is the use of ARVs in PMTCT. Giving ARVs to pregnant, HIV-infected women is associated with a significant decrease in the rate of MTCT by reducing transmission during pregnancy and childbirth (Clark, 2001).

A third core intervention considered to be important is counseling and support for appropriate choice of infant feeding option. Although important, this intervention is also considered as one of the most demanding and challenging components of PMTCT programs (Rutenberg *et al.*, 2003). Persuading HIV-infected mothers to accept replacement feeding can be difficult because of affordability, lack of clean water, and lack of sources of energy for sterilization; or because of fear of stigmatization (Newell, 2001).

2.2.4 Treatment, care and support for HIV Positive Mothers and their Infants

Providing mothers and their family with care, treatment and support is a natural development of PMTCT programs. Most Mothers, when offered HIV-testing, would initially ask, "what can you do for my baby?", but soon expect interventions for their own health also (WHO, 2003). This interest could then extend to other members of the family, including the partner. According to WHO (2003) and FHI (2004), there are several justifications for care, treatment and support of HIV-infected mothers and their families.

This prong meets the ethical obligation to treat mothers and family members when ART is indicated, which in turn positively influences the support and use of PMTCT services. It would also improve both the survival and quality of life of parents, thereby enhancing survival of their HIV exposed infant. Through facilitation of HIV status disclosure, this prong supports medical follow up of parents and HIV exposed infants; initiation of pediatric ART when indicated; and adherence to ARV regimens and infant feeding choice. This prong therefore offers a more efficacious intervention to prevent MTCT as antiretroviral treatment, when indicated, significantly decreases the

maternal viral load and the risk of MTCT as compared to short course ARV prophylaxis.

2.3 Male Partners' Involvement

Male partners' involvement in women's health programs has been a source of much interest in the recent years, even though its meaning continues to vary from source to source. According to Lee (1999), male partners' involvement can be viewed from program perspectives and may mean men supporting choices and rights of their female partners, or men doing something about their own reproductive and sexual behaviour as a way of protecting their partners. For Rutenberg *et al.* (2002), male partners' involvement may mean many things, depending on the couple and community; some men may choose to go to the clinic with their female partners, get involved in counseling and be tested for HIV, while many choose not to visit the clinic, but instead support their partners in coping with HIV in other ways, pay for their partner's healthcare and/or provide transport for their partner to reach the clinic.

According to Drennan (1998), the topic of male partners' involvement is also complicated by the wide range of terms used in the literature to qualify it. This terminology includes: men's participation, men's responsibility, male motivation, male involvement, men as partners, and finally men and reproductive health. He emphasizes that the terminology used does not matter as long as the purpose is to describe the process of social and behavioural change that is needed for men to play more responsible roles in reproductive health services.

A further challenge is posed by the difficulty of measuring male partners' involvement. According to the Horizon Program (2003), measuring the ideal degree of involvement is very difficult because male involvement is so couple-specific.

2.3.1 Male Involvement in Prevention of Mother to Child Transmission of HIV

In 2008 mother to child transmission of HIV accounted for 390,000 new infections among children below 15 years of age in Sub-Saharan Africa. According to the Inter-Agency Task Team, male involvement is a critical component of the PMTCT program. Male involvement is necessary for improving women's uptake of core PMTCT services; it is a key contributor to community acceptance and support of PMTCT. It has been linked to greater uptake of testing, greater uptake of antiretrovirals, increased condom use, increased communication and support for

infant feeding choices. Male involvement is critical for primary prevention of HIV and for avoiding unintended pregnancy (UNAIDS 2012).

In spite of the acknowledged contribution of male involvement in increased uptake of PMTCT services, actual involvement of male partners in PMTCT programs in several countries of Sub-Saharan Africa is low and programs report difficulties in attracting the involvement of male partners (Burke, Rajabu & Burke; 2004). The involvement of male partners in PMTCT programs has been extensively studied and attributed to a wide range of factors: In Zambia, male involvement in PMTCT was influenced positively by increasing age of the male partner, and increasing level of knowledge of PMTCT (Tshibumbu, 2006). The participation of men in carrying out sustainable HIV/AIDS interventions in rural Uganda was influenced by socio-economic, cultural and limited access to accurate information (Kavuma, Onyango & Pariyo, 2004) while in Kenya, failure to recognize the community leadership of men, men as channels of information for other men, involving men from initiation of PMTCT program, woman centered services and leaving men who accompanied their partners with inadequate services hindered male involvement in the PMTCT programs (Mbuyi, Vaz, Callens, Behets & Kokolomami, 2004).

2.3.2 The significance of Male Partners' Involvement

Nzioka (2000) posits that male partners' commitment and participation is critical to ensuring full engagement of pregnant women and mothers in PMTCT, and thus maximizing the benefits thereof. Male involvement in PMTCT/MCH is important for at least three main reasons: Firstly, it influences women, as some males care about their partners and support them while others stand in their partner's way or make decisions on the partner's behalf. Thus, male readiness and active participation in PMTCT/MCH can determine whether women can adhere to the recommendations to prevent MTCT. Secondly, males are also important as clients themselves, as they make the decision of whether or not to use male condoms. They also have concerns regarding STIs, HIV infections and MTCT of HIV that deserve the attention of the healthcare system and providers. Thirdly, decisions on matters of reproductive health including PMTCT, e.g. infant feeding, occur within relations that affect both males and their partners (WHO, 2007; UNESCO, 1998).

Involving men is important because men do influence women's access to health services through their control of finances, women's mobility, means of transportation, and health care decisions (White, Greene & Murphy, 2003). Lee calls this role the "gate keeping" authority of men. For Kumah (1999), the need to involve men, as defined by the ICPD and the Beijing Conferences, is even more crucial in the African context, because of the rapid spread of the HIV/AIDS pandemic and because of cultural norms and taboos which reinforce negative stereotypes about male involvement in reproductive life issues. These factors call for responsible sexual and reproductive behaviour by both men and women if HIV/AIDS is to be controlled (Rutenberg *et al.*, 2003).

Nzioka (2000) is in support of this as he outline that male partners have a high potential to impact on pregnant women's health-seeking behaviour in a range of reproductive health issues, including prenatal care utilization, uptake of HTC and PMTCT services. He also noted that communication with the partner plays a vital role in women's uptake of HIV-testing at MCH clinics and subsequent PMTCT interventions; therefore, encouraging women to engage in a discussion about testing with their partners may be a feasible intervention to improve couples' participation in PMTCT (Theuring *et al.*, 2009).

Several other African studies have also proven the influence males may have on HIV test uptake. Studies conducted on ANC attendees in developing countries (Uganda, Nigeria, Zimbabwe, Namibia, Kenya, Tanzania and Ethiopia) revealed that pregnant women declined HIV tests either because they wanted to consult their male partners prior to the testing or were afraid of their reaction and rejection should they test positive (Lee, 1999). While the benefits of men involvement seem to be indisputable, Kumah (1999) mentions opposing views in some circles that consider male partners' involvement as a way of increasing male partners' control over women's reproductive life. Their argument is that as men are already involved in all major human activities, why should they acquire more control over women's reproductive life as well?

In general, the potential benefits of male participation in sexual and reproductive health and PMTCT include expanded rights for women, better communication between partners, joint and informed decision-making within households, and improved family health, including reduction of risk of paediatric HIV infection (Walston, 2005).

However, Clark (2001), while of favorable opinion regarding participation of males in reproductive health programs and services, recommends consideration be given to tackling two important potential caveats, i.e., a “paternalistic” approach that jeopardizes women’s interest, and “subtraction of resources from women’s programs”. He instead states that male participation should always protect women’s interest and bring additional resources into existing women’s programs. On the same line, the Population Council Annual Report (2001) states that programs should be equally sensitive to those women who want their partners’ participation in reproductive health issues and those who do not.

2.4 The influence of Knowledge and Awareness on Male Partners’ Involvement

Awareness and knowledge about PMTCT programs is important for male partners’ involvement; men need information about reproductive health issues and their possible role in these services and how they can access them (Kumah, 1999). In a qualitative study on factors influencing male partners’ involvement in Tanzania, Burke, Rajabu and Burke (2004b) found that men felt marginalized by the inadequacy of access to information as they received second-hand information through their wives. In Pakistan, Kamal (2002) found that even women identified lack of information among men as a serious issue and wished that dissemination programs could also be held for their male partners. In a study in India and South Africa, the Population Council (2005) found that when men are informed and involved from the beginning through couple counseling, they provide a better support for their female partners. For Burke *et al.*, (2004), the level of ignorance amongst men in most PMTCT settings is so significant that very few are even aware that their female partners have been tested during their antenatal care and are enrolled in PMTCT programs. It is clear that providing reproductive health information to men has many benefits, as it is associated with an increase in the uptake of interventions by women (PATH, 1997).

2.5 The influence of Socio-cultural perceptions on Male Partners’ Involvement

According to Burke *et al.*, (2004), all cultures have values that give meaning and provide guidance to humans as they interact with their social world. These values and beliefs influence men and women living in the same society about what are considered appropriate roles and responsibilities for each gender (Drennan, 1998).

According to Kumah (1999), these values and perceptions are sometimes reinforced by social institutions like traditional and religious groups in the community. A number of cultural factors which limit male partners' ability to take an active role in reproductive health have been reported in the literature. PATH (1997) reports on the unfavourable social and religious climate in some societies where sexual matters are not discussed openly and men may feel uncomfortable talking about reproductive health needs with their partners and health workers. Kumah (1999) and Drennan (1998) mention that some cultural norms and taboos in Africa reinforce negative stereotypes about male involvement in reproduction matters, and some even condone abuses of women's reproductive rights by men. According to Kumah (1999), although gender is considered culture-specific, there is consistency across cultures in the difference between women's and male partners' roles, access to resources, and decision-making authority. In Zimbabwe, Rutenberg *et al.*, (2002), report on male involvement projects which revealed cultural beliefs reinforcing the community perception of men who publicly supported their wives by accompanying them to the clinic as "weak" or "bewitched". In Tanzania, Burke *et al.* (2004) found that because of cultural norms, men preferred to receive information about PMTCT from fellow men who were their peers or older, and in gender-specific groups. According to White *et al.* (2003), social, gender-related issues also affect men as they may engage in high-risk behaviours more frequently than women in order to meet the perceived expectations of social norms.

2.6 Programmatic factors influencing male partners' involvement in PMTCT

Programmatic factors can also be a barrier to male partners' involvement in reproductive health services. According to PATH (1997), reproductive health services are designed to meet women's and children's needs and these results in men not considering these programs as a source of information and help for them. Furthermore, because service providers are mostly females, they may be biased towards female related services (PATH, 1997). According to Rutenberg *et al.* (2002), PMTCT programs have done very little to involve men, this despite acknowledging their key roles and positive experiences in other reproductive health programs like family planning services.

According to these authors, antenatal and mother and child health clinics are women's spaces that cannot be easily adapted to accommodate men. Kamal (2002) is of the

opinion that men want to make use of the existing public health care facilities, but the way these facilities function is not very conducive to their utilization because of constraints related to the time schedule, the attitude of the health care providers, and the expenses involved. In Tanzania, Burke *et al.* (2004) found that men considered themselves marginalized by PMTCT programs.

Another issue to be considered is the lack of privacy in many antenatal settings which makes it difficult to maintain confidentiality and so discourages both women and men from taking the test, for fear of stigmatization (Newell, 2001). The manner in which PMTCT services are provided and organized can therefore be a limiting factor to male partners' involvement.

Bajunirwe and Muzoora (2005), in their study on barriers to the implementation of PMTCT programs in Rwanda, found that 72% of rural women were of the opinion that husbands should be consulted before testing for HIV in PMTCT. They also found that among the women living with their husbands, the majority (89%) informed their partners about their going to the antenatal clinic on that day. Also, the majority of these women (71%) thought that their husbands would accept being tested for HIV. Women who thought they should consult their husbands before being tested were less likely to accept the test compared with those who thought they did not need to consult their husbands. Women who thought their husbands would allow them to test were more likely to accept the test than those who thought their husbands would not approve.

Burke *et al.* (2004) also found that there was similar thinking among men themselves, who believed that women should be expected to seek permission from men before VCT, otherwise there would be conflict. Nzioka (2000) found similar opinions in the Kenya, where the fear of male partners had a negative effect on the uptake of PMTCT interventions among HIV infected women, to the point that women who were single accepted the PMTCT package more frequently than those who had a male partner. However, in Zambia, Tshibumbu (2006) found that a good percentage of women were able to share their HIV test results with their male partners (69%). But among those who did not share, fear of partner reactions was the concern most raised.

In terms of feeding options in PMTCT, Kiarie, Richardson, Mbori-Ngacha, Nduati & John Stewart (2004), in their study on infant feeding practices of HIV infected women

in Kenya; found that male partners had a considerable influence on the feeding options chosen by women. The low use of replacement feeding in HIV-infected women (30%) was also explained by reasons which included fear of loss of confidentiality and the negative attitudes of partners and the family. It was also found in the same study that although partner knowledge of the HIV status of the woman was a factor influencing feeding decisions, a supportive partner attitude was very important for women.

Rutenberg *et al.* (2003), while reviewing the first 18 months of the implementation of a rural PMTCT program in Zimbabwe, found that although the majority of women interviewed suggested that partners should be tested, only 23% of partners accepted the test and very few returned for their results. Similar findings are reported by Semrau, Khun, Vwalika, Kasonde, Sinkala, Kankasa, Shutes, Aldrovandi, & Thea (2005) in Zambia, where only 10% of women were able to encourage their husbands' participation in PMTCT. Burke *et al.* (2004) found that men were willing to participate in PMTCT programs when there were incentives like ARVs and when sources of information flow respected gender and cultural norms.

In a qualitative study on factors influencing male-partners' involvement in PMTCT in Tanzania, Burke *et al.* (2004) found that the source and the order of information flow on new programs like PMTCT were important for the involvement of men. Men consider themselves traditionally as bringers of health information to the family. If information on PMTCT interventions is first given to women, this information is less trusted by men.

Men prefer to receive the information directly from health workers and in gender-specific groups, because cultural norms do not encourage mixing of men and women when discussing reproductive health issues. Similar findings are reported by Horizon Program (2003) in a study conducted in Zambia and Kenya on feasibility and acceptability of PMTCT. The study found that attempts to involve male partners are most successful when information about PMTCT is provided directly to men and preferably outside the antenatal clinic setting, which is perceived by men as exclusive to women.

This lack of friendliness of PMTCT clinics to men was again identified as a barrier by Horizon Program (2002) in another multi-sites study in which it was found that in

Kenya, female clients at the ANC clinic considered men as intruders, and that clinics were usually closed at the times when working men could most easily access them. The findings also report the perceptions among many men that male involvement is for the benefit of women and not men.

The study by Burke *et al.* (2004) also revealed that men did not like to attend the local PMTCT clinic and would prefer to be tested at a distance from home for fear of lack of confidentiality at their local clinic, and of stigma and discrimination. Nzioka (2001), in a qualitative study in Zambia and Botswana on women, communities and PMTCT, reported that community members (including men) had opinions, beliefs, and values that directly affected their decisions about participating in programs such as PMTCT. They also reported that men were less informed than women about MTCT and this disparity in knowledge could be attributed to the place and manner in which information is usually shared, mostly by female health workers at antenatal clinics, where men are unlikely to be found.

**IEBC REVISED HOMA BAY TOWN CONSTITUENCY
COUNTY ASSEMBLY WARDS**

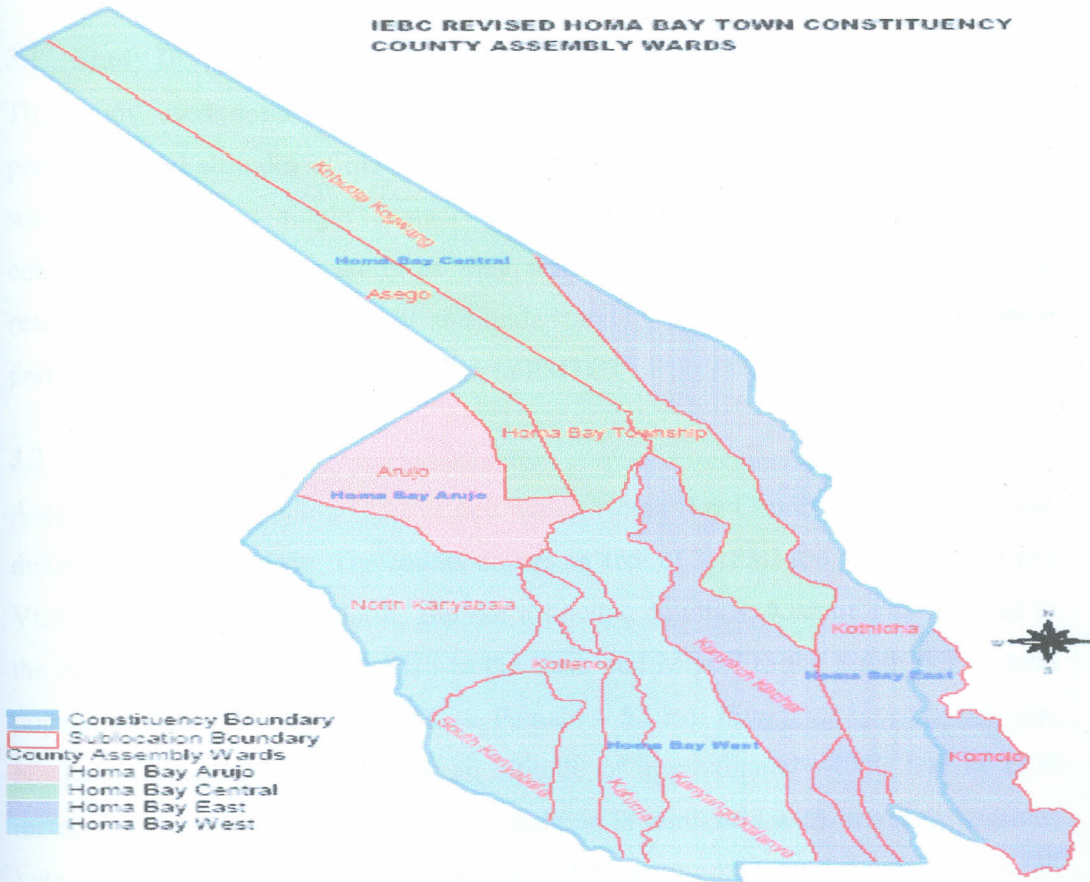


Figure 2.1: Map of Homa Bay Town Constituency

Source: IEBC Constituency Boundaries Map 2012

3.3 Study Population

According to Babbie (2007), this is the group from which the sample is actually selected. This study's population included all the 108 households within Asego division from which the woman had received PMTCT services and the child being followed up have received the final Polymerase Chain Reaction (PCR) test done at 18 months without any consideration to the outcome of the test.

3.3.1 Inclusion and Exclusion Criteria

The inclusion criteria for the study population included all the households with a woman and a child who have been followed up in the MCH for PMTCT services and the child's final HIV status at 18 months known. The household members must have also been residing within the jurisdiction of Asego Division, Homa Bay County for the entire period of follow-up in the PMTCT Program.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Study Design

This study used descriptive cross sectional design as information on behaviors, perception and attitudes of male partners in relation to their involvement in PMTCT was collected at a single contact with respondents. These two designs were concurrently used in the study as they were perceived to be able to enable the researcher to gain a deep insight and understanding of the factors influencing male partners' involvement and participation in PMTCT.

3.2 Study Area

Asego Division is an administrative unit within Homa Bay County located in the now defunct Nyanza Province. The county covers an area of 3,183.3 km² and borders Lake Victoria to the West and North, and the following counties; Kisumu and Kericho to the North East, Nyamira and Kisii to the East, and Migori to the South with a total population of 963,794 (Male – 48 %, Female – 52 %). (<http://sofikenya.com/homa-bay-county/>). The division lies at an altitude of approximately 4000 feet at 1330 meters above sea level and its climatic condition is semi- arid with two rainy seasons; long rains which falls between the months of March and May while short rains fall between September and November with approximately measurements of 1180 millimeters. Its daily temperature falls between 26-28°C. The division has one of the highest poverty levels in the country of 50.2% with infant mortality rates being 137 deaths per 1000 live births. It also has a total population of 90,442 distributed as per the table below in terms of age;

Table 3.1: Population Distribution by Age in Homa Bay County

Age	0-14 years	15-64 years	65+ years
% age of the total	48.1 %	48.2 %	3.7 %

Source: 2009 Census Report

However, the child's final HIV status after the 18 months' period of follow-up and the household members' tribe, educational levels, occupation, political or religious affiliations will not be considered as a criterion for inclusion or exclusion into the study.

3.4 Sample Size and Sampling Technique

According to Mulwa (2008), a study should be conducted on a sample which is neither too large nor too small, as these would lead, respectively, to wastage and unmanageable data, and wastage and non-conclusive data. The sample size for this study were 48 households, proportionately distributed between each category from those households with children who turned HIV negative or positive after the 18 months of intervention in the PMTCT program. This sample size was arrived at following the sampling formula outlined in Ahuja (2005) which states that;

$$n = \frac{N}{1+n(e)^2}$$

Where, N is total accessible population, 108 HHs, and 'e' is the confidence level of 95% for this study.

This study used purposive, stratified and simple random sampling procedures. Purposive sampling technique was used to identify the 108 households with children who had completed the 18 months of follow up at the Homa Bay District Hospital ANC. Stratified sampling technique was then used to segregate from among the 108 purposively sampled households, those with children who were HIV negative (25) and those with children infected with HIV (83). Simple random sampling technique was finally employed to proportionately identify the actual sampling units (households) from both the two strata (37 HIV positive and 11 HIV negative) that formed the sample size for the study.

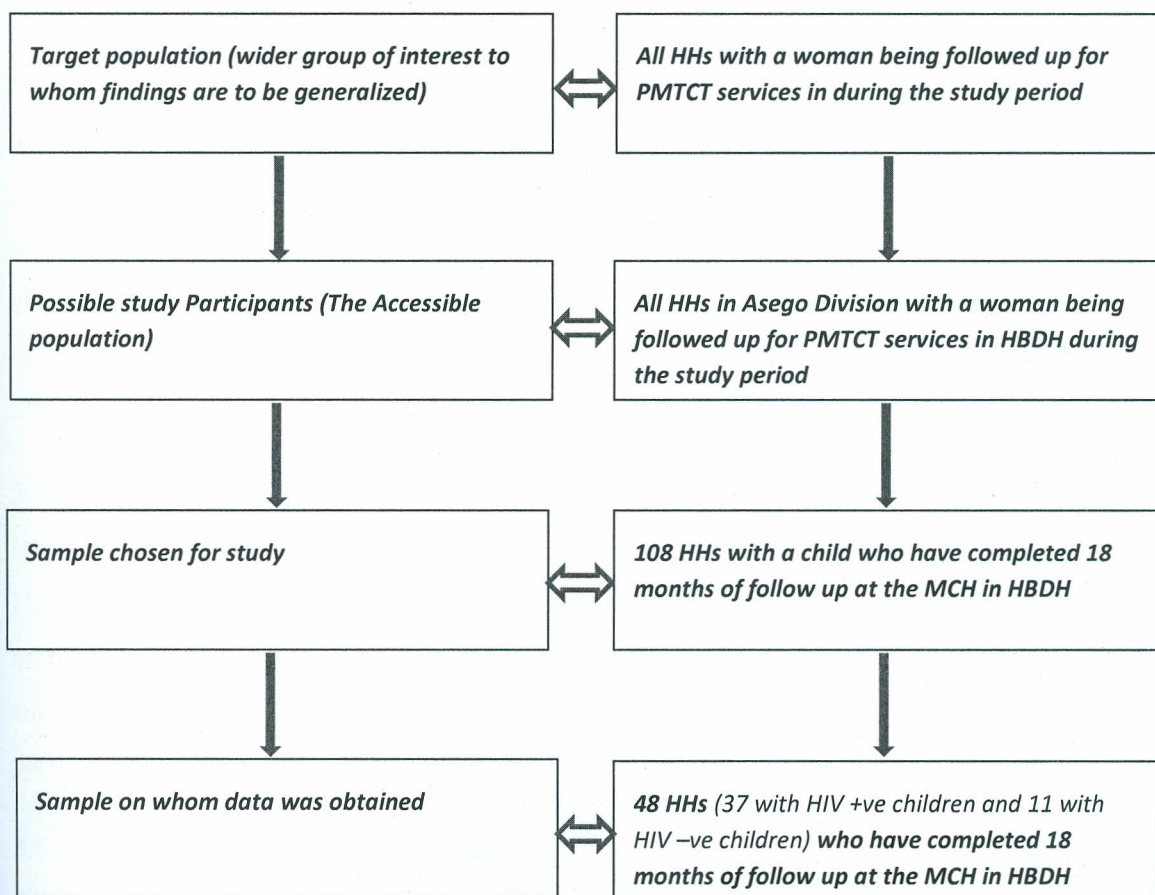


Figure 3.2 Schematic Representation of the sampling procedure

(Adapted from Polit & Beck 2010)

3.5 Data Collection Methods

3.5.1 Questionnaires

The data collection method for this study was face to face interview using a structured questionnaire administered in the respective sampled households by the trained research assistants who will be community unit members initially trained as interviewers.

One advantage of structured interviews is that all respondents are asked exactly the same set of questions in the same sequence and this increased the objectivity of the collected data (Fisher & Foreit, 2002). Other advantages of this approach included an increase in the response rate and a higher questionnaire completion rate (Babbie & Mouton, 2001), and the reduction of administrative costs and difficulties of assembling all respondents in one place. It also assists in reducing difficulties related

to low literacy levels of respondents which were a factor in this study (Burns & Grove, 2005).

The advantages of using community unit members as data collectors included their experience in collecting data for other health programs and conducting home visits in the community, the fact that they come from the same community and thus share characteristics with respondents, their knowledge of the area and understanding of local culture, and their availability for the entire data collection period (Polit & Beck, 2004).

3.5.2 Direct Observation

Direct observation was also used during physical visits to the MCH/PMTCT clinic at Homa Bay District Hospital with an objective of having a glance of the number of men accompanying their wives to the clinic and their level of involvement during such visits as well as programmatic arrangements that hinder or promote male partners' involvement.

3.6 Data Analysis and Presentation

All the data items were given codes, rechecked and entered in SPSS and analyzed using descriptive statistics. The analyzed data was then presented using frequency distribution tables, bar graphs and pie charts. Correlation analysis was also conducted to assess the relationship between male partners' involvement and the different factors, to measure the level of influence of each. Qualitative data was analyzed using content analysis to capture the opinions and perceptions on male involvement.

3.7 Ethical Considerations

The entire process of this study was guided by various ethical considerations ranging from voluntary participation, informed consent by the respondents, seeking permission from the concerned authorities to undertake the research and assuring the respondents of confidentiality and privacy as discussed below;

Before conducting the interviews, the participants received information in a simple form of the local language regarding the nature and purpose of the study and their rights to decide freely whether to participate, to refuse to respond to any questions they did not wish to, and to withdraw from the interview at any time. Furthermore, participants were reassured that refusal to participate in the study would not

compromise in any way the services offered to self, partner or the newborn. Participation in this research study was purely voluntary and no induction was provided to the respondents to lure their participation.

After provision of adequate and relevant information about the study as described above, written consent was obtained from each study participant prior to the administration of the interview. Those who volunteered to participate signed on the front page of the questionnaire bearing the consent form. Participants who could not sign were assisted by the researcher to put their left thumb print on the section meant for signing. To ensure confidentiality and privacy of the respondents, the interviews were conducted at the respondents' households in a place/room where both visual and auditory privacy was guaranteed at its maximum. Moreover, there were no personal identifiers written on the questionnaire in order to ensure anonymity so that the responses were not linked to these identifiers.

The researcher also sought for written permission to conduct the study from the relevant government line ministries and the Maseno University's School of Graduate Studies (SGS). In accordance with academic propriety and convention, and to avoid the risk of plagiarism, the researcher properly acknowledged in the text and in the listing of references, all primary and secondary sources referred to in this dissertation as per the APA (6th edition) referencing style. No information obtained from secondary sources was used without cross-referencing the original source.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS

4.1 Study Findings

The participants interviewed for the study were from 48 households and table 4.1 below shows the respondents' distribution in terms of age. 8.3% of the respondents were 19 years and below, 39.6% were in the age group of 20-29 years and 52.1% were in the age group of 30-39 years.

Age Distribution of Respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 19 years and below	4	8.3	8.3	8.3
20-29	19	39.6	39.6	47.9
30-39	25	52.1	52.1	100.0
Total	48	100.0	100.0	

Source: Survey Data

An equal number of respondents were interviewed with different levels of education (Table 4.2). This was to show if the level of education had an influence in the knowledge one has over PMTCT and HIV/AIDS. However, there is slight difference in the level of education of the people who participated in the study. The study revealed that 35.4% of the respondents never attended school, 33.3% attended lower primary, 18.8% attended upper primary and the remaining 12.5% attended secondary school.

Table 4.2: Respondents' distribution on Level of Education

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never attended school	17	35.4	35.4	35.4
Lower primary	16	33.3	33.3	68.8
Upper Primary	9	18.8	18.8	87.5
Secondary	6	12.5	12.5	100.0
Total	48	100.0	100.0	

Source: Survey Data

In terms of marital status, the finding showed that 10.4% of the respondents who participated in the interview were single, 81.2% were married and the other 8.3% were divorced or separated (Table 4.3). Marital status of the respondents was of importance since the study focused on male partners' involvement in PMTCT yet single mothers would not be in a position to give the influence their child's father have towards PMTCT. This study had a majority of married respondents who voluntarily accepted to participate in the study.

Table 4.3: Distribution of Respondents' Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	5	10.4	10.4	10.4
	Married	39	81.2	81.2	91.7
	Divorced/Separated	4	8.3	8.3	100.0
	Total	48	100.0	100.0	

Source: Survey Data

4.1.1 Influence of Knowledge and Awareness

The findings revealed that the level of knowledge amongst respondents about PMTCT interventions was above average. The majority of the respondents (75.6%) had already heard about PMTCT, 6.7% refuted hearing of such a program and the remaining 17.8% did not know whether they have heard of PMTCT program or not. This is of importance because it reflects the knowledge individuals have over PMTCT services offered.

Donought chart showing distribution of respondents with respect to knowledge and awareness on PMTCT

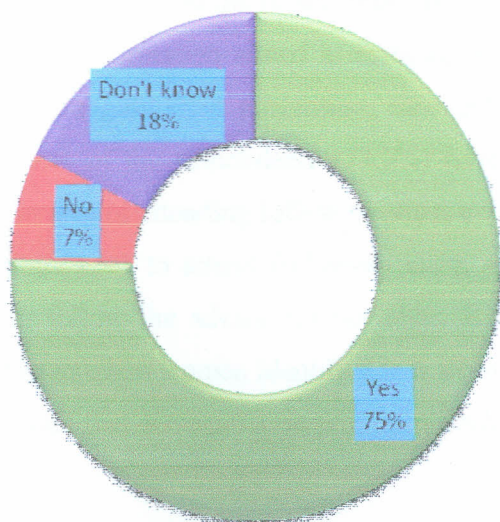


Figure 4.1: Responses on Knowledge and Awareness on PMTCT

Source: Survey Data

All respondents (100%) were aware that PMTCT services were offered at Homa Bay District Hospital's ANC as well as other government hospitals at no cost. 50% of the respondents knew that mother to child transmission of HIV can occur during pregnancy, during labour and delivery and after birth through breastfeeding, 33.3% did not have this knowledge while 16.7% were uncertain (Table 4.4). Most of the respondents (71.7%) were also aware that giving ARVs to the mother and the child reduce chances of transmission of HIV to the child. The study also revealed that all the respondents (100%) rated the risk levels associated with deliveries conducted by traditional birth attendants as opposed to trained health workers in the hospitals as having high risks of HIV transmission.

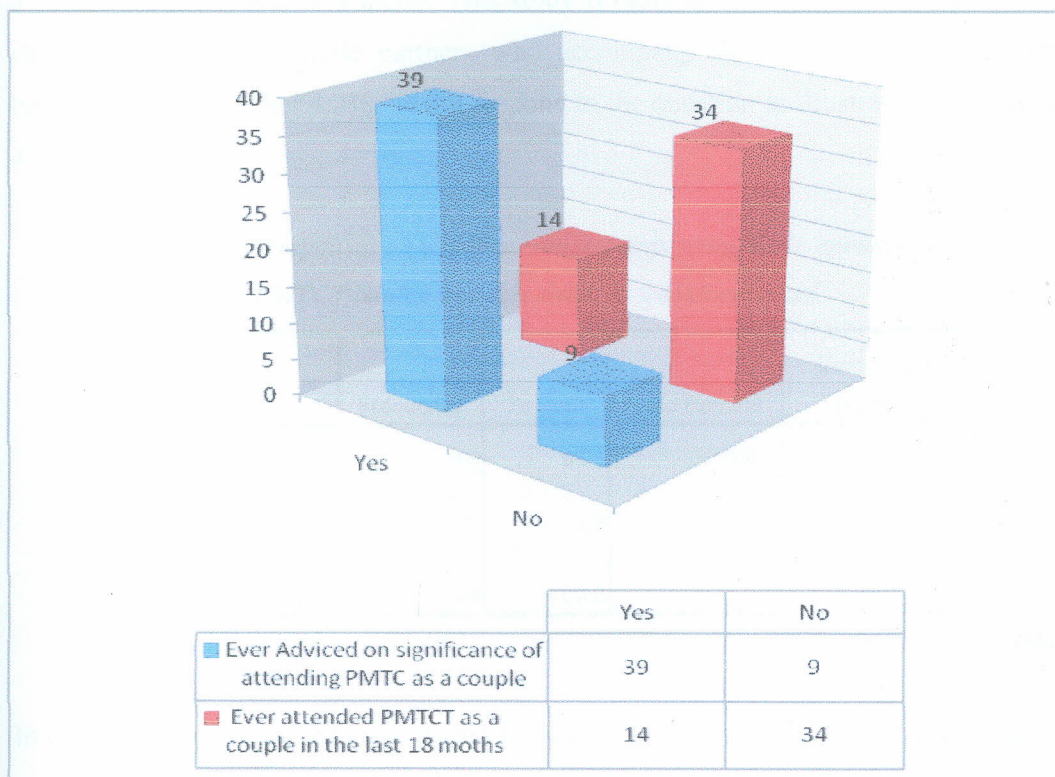
Table 4.4: Responses on when MTCT can occur

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	24	50.0	50.0	50.0
No	16	33.3	33.3	83.3
Don't know	8	16.7	16.7	100.0
Total	48	100.0	100.0	

Source: Survey Data

Awareness regarding importance of attending anti-natal care with couples has been created severally by the clinic staff and the media. This practice is important since it equips people with relevant information aimed at realizing an Aids-free generation through continuum of care ranging from prevention, care and treatment. This study reveals that, a great number of the respondents (73.9%) have been advised by the clinical staff on the importance of attending follow-up visits as a couple. 26.2% refute being advised by the clinic staff to attend follow-up visits as a couple. The main reasons behind failure to follow the advice are not clear. It could be what Kamal (2002), found out in Pakistan when women identified lack of information among men as a serious issue and wished that dissemination programs could also be held for their male partners.

While 73.9% of the respondents admitted that they have received advice on the significance of attending ANC services as a couple, only 29.2% of the entire respondents have ever accompanied their partners to the clinics throughout the eighteen months of follow up.



Source: Survey Data

Figure 4.2: Bar graph showing responses on those advised to attend PMTC as a couple vs those who ever attended within the 18 months of follow up in PMTCT clinic

The findings in this study suggest that an increase in knowledge and awareness about PMTCT may have a positive influence on male partners' involvement in PMTCT. The Population Council (2005) also found in India and South Africa that when men are informed and involved from the beginning, they provide a better support for their female partners, which is also in accordance with the theory of Diffusion of Innovation (DOI) which postulates that the adoption of programs by recipients is influenced by knowledge and awareness (Glanz *et al.*, 2002).

4.1.2 Influence of Socio-cultural Factors

In this study, participants noted that people no longer observe traditional practices when it comes to issues of child bearing. However, their responses to subsequent questions showed that they still embrace some cultural norms and values pertaining to what a man and woman should and should not do within marriage. For instance, social roles accorded by the society to the male are far from care and support for child birth. If a male person is seen associating with such kind of duties they were regarded as outcasts, bewitched or a taboo. This study reveals that 95.8% of the respondents strongly disagree that male partners who accompany their spouses to ANC are bewitched and the other 4.2% did not respond to the question as illustrated in the table 4.5 below.

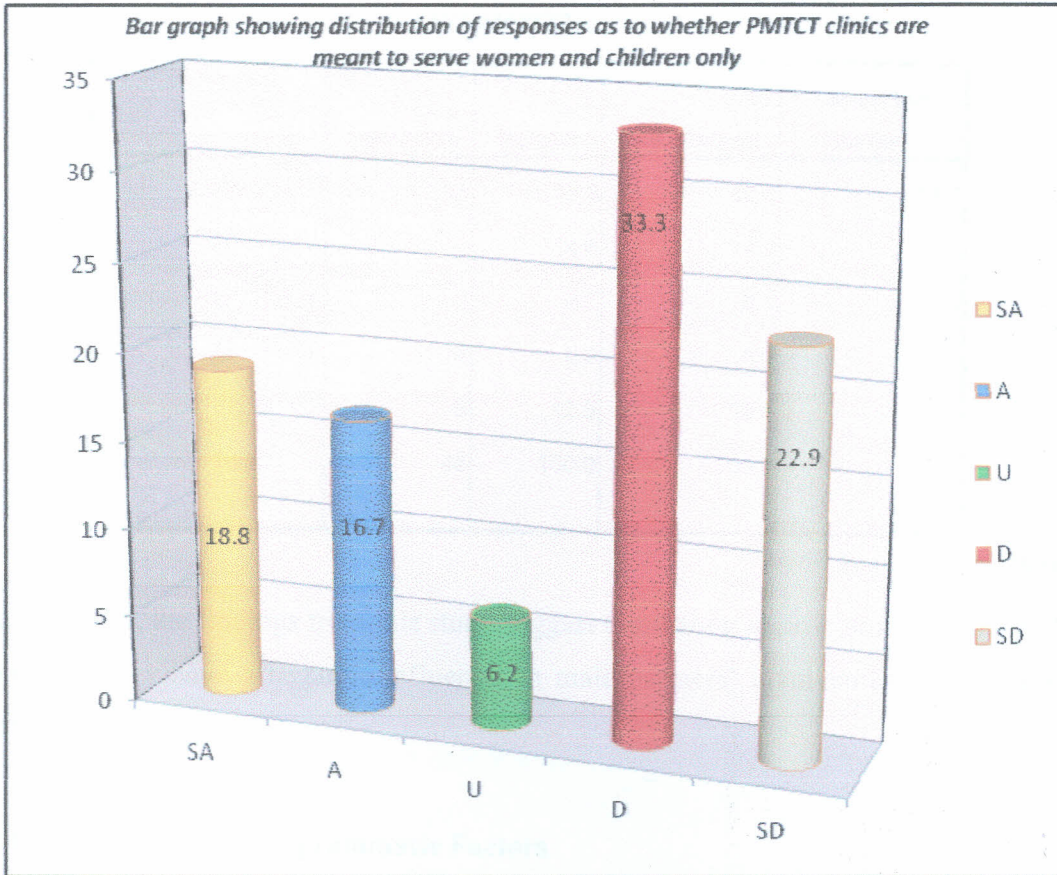
Table 4.5: Responses on whether men accompanying their spouses to PMTCT clinics are perceived as weak/bewitched

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SD	46	95.8	100.0	100.0
	No Response	2	4.2		
Total		48	100.0		

Source: Survey Data

In the African culture ANC has always been considered to serve women and children only. These values and beliefs influence men and women living in the same society about what are considered appropriate roles and responsibilities for each gender (Drennan 1998). This study contradicts the African values as the respondents report a

disagreement (33.3%) towards the idea of looking at PMTCT clinics as a place for women and children. 22.9% strongly disagree with the idea, 18.8% strongly agree with the idea, 16.7% agree and the remaining 6.2% were uncertain about the concept as illustrated in the below graph.



Source: Survey Data

Figure 4.3: Responses on whether PMTCT clinics are for women and children only

Opinions given by the respondents revealed that the majority of the respondents are of the opinion that women should seek permission from their male partners before testing for HIV (66.9%), that it is better to postpone HIV testing to post-delivery as pregnancy itself is stressful (55.1%), and that it is better to live with unknown HIV status than live depressed with positive HIV status known (69.3%). Burke et al (2004), in Tanzania, found that men did not like to receive second-hand information through their wives on PMTCT. The majority of households in this study supported that men should accompany their pregnant wives/partners to ANCs (59.6%), and that men and women should undergo couple counseling and HIV testing at the same time

at ANCs (59.1%) while strongly opposing the idea that a positive HIV test result of a female partner proves that she is unfaithful (91.1%) and that if a pregnant woman is found to be HIV positive, she should be divorced immediately (100%).

Table 4.6: Responses on whether men should accompany their spouses to ANC/PMTCT clinics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SA	28	58.3	59.6	59.6
	A	7	14.6	14.9	74.5
	U	3	6.2	6.4	80.9
	D	4	6.2	6.4	87.2
	SD	6	12.5	12.8	100.0
	Total	48	100.0	100.0	

Source: Survey Data

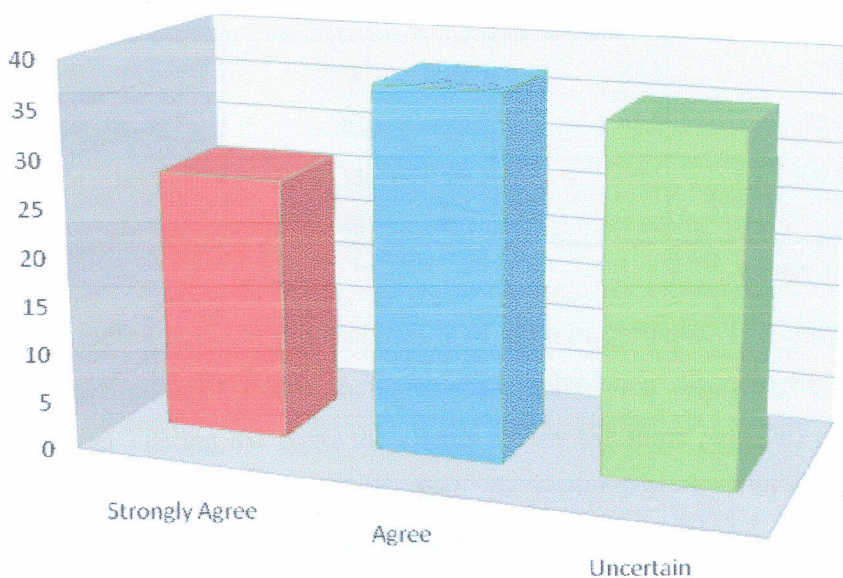
In summary, the findings from this study suggest that strong socio-cultural beliefs and opinions may have a negative influence on male partners' involvement in PMTCT programs.

4.1.3 Influence on Programmatic Factors

In this sub section, findings regarding programmatic factors that influence male partners' involvement in PMTCT are presented.

Programmatic factors can also be a barrier to male partners' involvement in reproductive health services. This study reveals that most men fail to be actively involved in PMTCT activities including accompanying their partners to the clinic because of the time these services are scheduled. Men are culturally endowed with the bread-winning role in most households and during the ANC appointments; they are always at their places of work-whether formal or informal. A question on whether PMTCT clinic timings should be revised to include weekends and evenings was posed and analysis of the responses revealed that more than a quarter (37.5%) of the respondents agree with the idea while 27.1% strongly agree and the other 5.4% are uncertain about this idea as illustrated in bar graph below.

Distribution of respondents with respect to opening of PMTCT clinics in the evenings and over the weekend



	Strongly Agree	Agree	Uncertain
Series3	27.1	37.5	35.4

■ Strongly Agree ■ Agree ■ Uncertain

Source: Survey Data

Figure 4.4: Bar graph showing respondents' opinion on timings for opening of PMTCT clinics

According to Nzioka (2000) reproductive health services provision in Kenya are designed to meet women's and children's needs and are therefore male biased thus resulting in men not considering these programs as a source of information and help for them. This study's finds concurs with Nzioka's observation as it also reveals that there is need for proper set up of reproductive health facilities to accommodate men. Table 4.7 below illustrates that 43.2% of the respondents agree with the idea of setting up male PMTCT clinics, 29.5% of those interviewed are uncertain over this issue and the remaining 27.3% strongly agreed with the idea. Rutenberg *et al.* (2002) also argues that, PMTCT programs have done very little to involve men despite acknowledging their key roles and positive experiences in other reproductive health programs like family planning services.

Table 4.7: Responses on the need to set up males only PMTCT clinics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SA	13	27.3	27.3	27.3
	A	20	43.2	43.2	70.5
	U	15	29.5	29.5	100.0
Total		48	100.0		

Source: Survey Data

Privacy at the reproductive health facilities is of great importance. The current set-up of most PMTCT clinics, HBDH inclusive, has really been discouraging to many clients since after visiting the ANC the clients follow the same path full of a crowd waiting for services. This study reveals that, the respondents had an almost equal percentage distribution over this issue. Table 4.8 shows that, 22.2% of the respondents strongly agreed with this matter, the other 22.2% disagreed, 20% of those interviewed agreed with the concept, 17.8% strongly disagreed and the other 17.8% were uncertain over the matter. This is in line with Newell (2001) who reports that another issue to be considered is the lack of privacy in many antenatal settings which makes it difficult to maintain confidentiality and so discourages both women and men from taking the test, for fear of stigmatization. This means that the manner in which PMTCT services are provided and organized can therefore be a limiting factor to male partners' involvement.

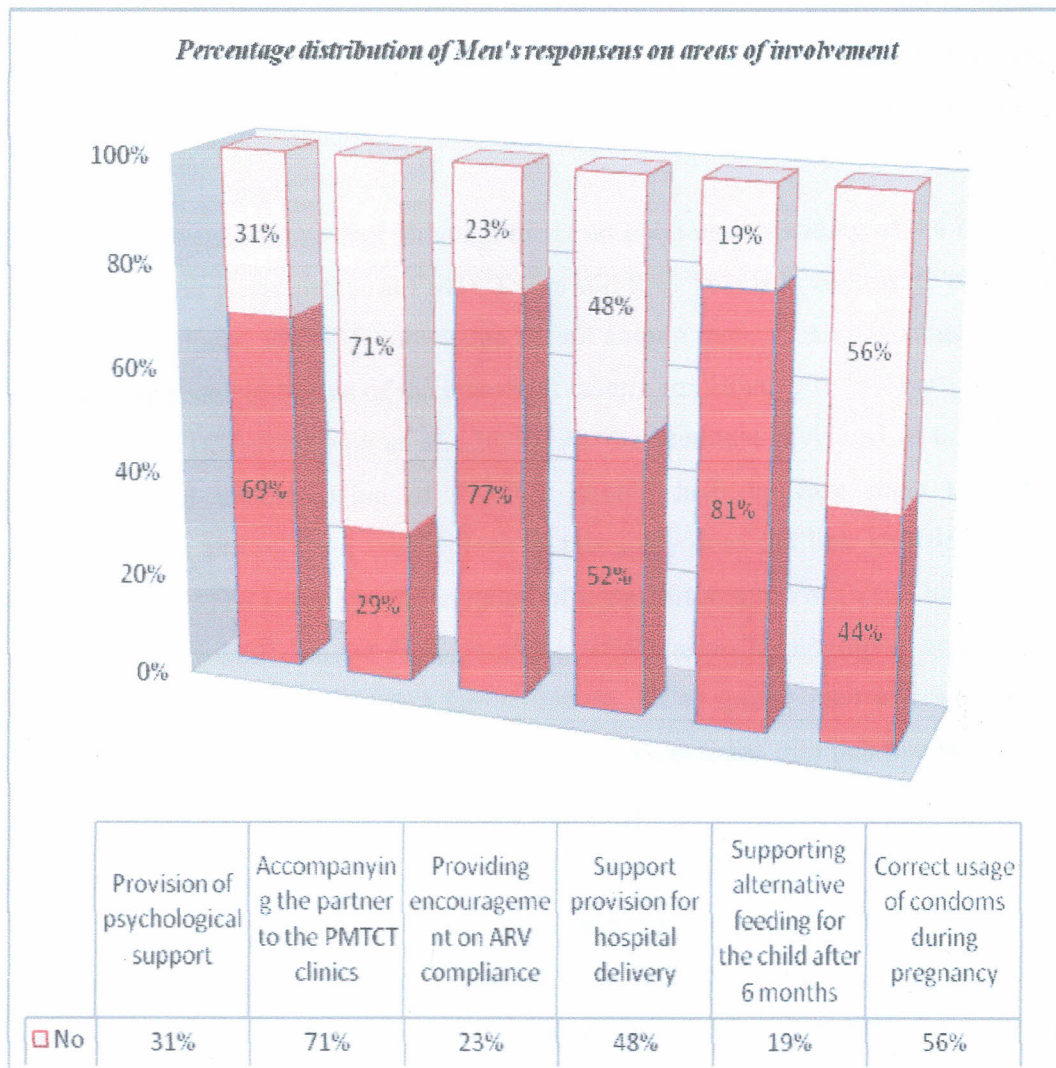
Table 4.8: Responses on the need to set up entry and exit points at the PMTCT clinics

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SA	11	22.2	22.2	22.2
	A	9	20.0	20.0	42.2
	U	8	17.8	17.8	60.0
	D	11	22.2	22.2	82.2
	SD	9	17.8	17.8	100.0
Total		48	100.0		

Source: Survey Data

The majority did not find gender separation at PMTCT clinics to be important (65.3%), and 78.7% of the couples were ready to be attended by either male or female health workers. The findings are contrary to those of Burke *et al.* (2004) who found out that because of cultural norms, men preferred to receive information about PMTCT from fellow men who are peers or older and in-gender-specific groups.

The majority of the respondents agreed that male partners have a role to play in reducing vertical transmission of HIV and their responses varied in different capacities as is represented in the below bar graph.



Source: Survey Data

Figure 4.5: Bar graph showing Male partners' perceived areas of involvement

4.2 Discussion of the Study Findings

This section provides a critical evaluation of key study findings. These findings are discussed according to the study objectives.

In this study, generally male partners had a better understanding of what PMTCT is all about than expected. The majority of men knew about Mother to child transmission of HIV, the timing of MTCT and how MTCT can be prevented. They knew that there are high risk levels of MTC on obstetrics conducted by the traditional birth attendants. They also demonstrated to be knowledgeable about the benefits of PMTCT services. In theory, this should have a positive influence on male partners' involvement in PMTCT because according to the Diffusion of Innovation Theory, the adoption of programs by recipients is influenced by knowledge and awareness (Peacock, 2003).

This study however, found that although men had good understanding of the benefits of PMTCT, their participation in PMTCT was still low. This is in contrast to previous studies which found PMTCT knowledge deficit among men. This knowledge deficit has been suggested to be one of the important factors contributing to low participation of men in PMTCT (Theuring *et al.*, 2009). As the literature reviewed in this study suggests, good understanding of PMTCT should help increase male partners' participation in PMTCT but the findings of this study does not link knowledge and awareness of PMTCT to high participation of male partners in PMTCT. This finding correspond very well with the findings of the 2004 Malawi Demographic and Health Survey (MDHS) which identified knowledge of AIDS among men and women in Malawi to be almost universal but translating this knowledge into positive behaviour change such as testing for HIV to be a great problem.

In terms of the influence of socio-cultural factors on male partners' involvement in PMTCT, the only thing that majority of the respondents reported that male partners did not approve of is spouse testing for HIV without their prior knowledge and/or approval and considered such women as being unfaithful and material for divorce. Other than this, almost all males approved their spouses' participation in PMTCT. However, translating this supportive attitude into practice, for instance accompanying the pregnant spouses to ANC and getting tested for HIV, remains a significant task for the majority of male partners. Different reasons have been suggested in theory for this contradiction. One of such reasons has been traditional gender roles and perceived

community norms and expectations where male partners are expected to be engaged in economic productive work that will bring food on the table and women in reproductive work (Nkouh, Meyer & Nkfusai, 2011).

The findings of this study however, seem not to strongly correlate with this point of view because as the majority of the respondents in the study put it, people no longer observe or subscribe to traditional beliefs and practices because men are being exposed to gender, maternal and HIV and AIDS related information through the church, radio and other forms of social media.

Although there has been this traditional and cultural paradigm shift as evidenced by the responses from households which reported to have shed out these traditional beliefs, male partners still find it difficult to freely accompany their pregnant spouses to ANC and get tested together but they will accept the spouse to access this service and use the wife's HIV result (whether positive or negative) as a reflection of their HIV sero status. Thus the study seem to suggest that there should be another reason (s) other than knowledge deficit of PMTCT and traditional and cultural factors that are influencing men of this area in getting involved in PMTCT more especially on accompanying pregnant spouse to ANC.

This study also found that negative attitude and perceived rude behaviour of PMTCT service providers towards clients hamper male partners' participation in PMTCT. 29.5% of the responses mentioned that there are some nurses at the hospital who ill-treat pregnant women as such their male partners are reluctant to accompany them to the hospital for they do not want to see their pregnant women being ill-treated in their presence. This finding also resonates with studies in Uganda (Kavuma *et al.*, 2004). For this reason there is need to design programs specific for PMTCT service providers that aim at improving their negative attitudes towards their clients or patients.

Another substantial factor related to programming of PMTCT that affect male partners' involvement in PMTCT turned out to be health education songs. Responses from some male partners revealed that nurses make them sing along with their spouses before the PMTCT service providers start their work. This makes them to feel embarrassed, uncomfortable and branded the whole thing as childish. In view of these programmatic factors, there is great need to make the whole PMTCT site male

friendly that accommodate and respect the needs of pregnant women and those of their spouses. As observed by Theuring *et al.* (2009) ANC facilities in a more male-friendly way might be a reasonable reaction to the predominant, obstructive societal assumption that ANC is an exclusively female domain.

CHAPTER FIVE: SUMMARY, CONCLUSION & RECOMMENDATIONS

5.1 Summary

This study revealed that despite having good understanding of PMTCT and having moved away from being influenced by traditional norms and beliefs, the majority of male partners still found it difficult to respond positively to the call of accompanying their pregnant spouse to ANC. The study also found out that male partners' participation in PMTCT was also being negatively affected by programmatic factors. PMTCT service providers' rudeness towards pregnant women and forcing their male partners to join women in singing health promotion songs were said to be putting men off from accompanying their pregnant women to the ANC. However, the policy by Homa Bay District Hospital of enforcing men to accompany their spouses to the ANC was helping to encourage male partners to get involved in PMTCT and there is need to continue enforcing this policy.

5.2 Conclusion

Men are key decision makers in many societies and families in sub-Saharan Africa; they make important decisions that affect the health of their family members positively or negatively. Literature reviewed in this study has shown that male partner involvement in PMTCT is very important for successful implementation of the program as it can increase uptake of PMTCT services by HIV positive pregnant women. Literature has also shown that countries which are doing well in PMTCT program have already adopted male partner involvement while the biggest challenge being faced by many countries is low participation of male partners in PMTCT services which translates to low uptake of PMTCT interventions and increase in mother to child transmission of HIV.

There is need for more research studies in Sub-Saharan countries to find innovative strategies that do not only consider male partners as mere supporters of women in PMTCT services but rather as active participants. Such strategies should also incorporate ways of changing retrogressive socio-cultural practices which instills in the mindset of African men the perception that motherhood and PMTCT are women's domain that do not deserve a collective responsibility by their male counterparts. Providing the public with accurate, simple, consistent and current information regarding PMTCT and HIV through available channels coupled with a male friendly

PMTCT service warrants a priority attention as it will address knowledge and awareness gaps about PMTCT and AIDS as well as help shun the retrogressive socio-cultural factors which thwart male participation. Print and electronic media, billboards and posters, and opinion/religious leaders are some of the vehicles through which simplistically framed information on PMTCT and HIV can reach the community. Community based volunteers and health care cadres at community level could also bring the agenda closer to the community. Promotion messages focusing not only on male partners' role in PMTCT but also the benefits of participation to themselves and the family should also get into the community.

This study has equally noted it worth to highlight that policy makers, program managers, health service providers and whoever party involved in PMTCT programs should keep in mind that any effort to improve engagement of male partners in PMTCT should at the same time ensure that the reproductive right of women are protected in full.

5.3 Recommendations

On the basis of the findings of this study, the investigator suggests the following recommendations:

- Information about PMTCT program should be given to all men and in particular to those in a relationship with women in reproductive age. This information could be provided through couple counseling or campaigns through the media to increase the knowhow of the general public on mother to child transmission of HIV and how couples can synergize their efforts to minimize cases of vertical transmission. There is also the need to identify men whose active involvement in PMTCT resulted into their children successfully completing the 18 months of follow-up at the ANC with a final outcome of HIV negative result and train them in interpersonal communication. They can help in deepening fellow men's understanding of the benefits associated men supporting their spouses in the uptake of PMTCT services.
- The researcher has found it justifiable to recommend that in order to reduce the negative influence of socio-cultural beliefs and opinions among men, context specific and cultural sensitive messages should be formulated and disseminated through health education on reproductive health and PMTCT so

that the retrogressive yet valued socio-cultural practices which form major predisposing factors to vertical transmission are identified by the communities and collectively shunned away.

- This study further recommends that ANC's should be made 'friendlier' to men and the service providers should ensure that programmatic adjustments are done including revision of protocols so that male partners are involved from the beginning in every PMTCT intervention

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