

**Factors influencing male's involvement in prevention of mother to
child transmission (PMTCT) services in Kibaale District, Uganda**

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Abstract

A qualitative study to explore the factors influencing male's involvement in PMTCT services in Kibaale District, Uganda

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Globally, approximately 600,000 infants each year are born with HIV infection in Sub-Saharan Africa as a result of mother to child transmission (MTCT) (UNAIDS, 2001). Whereas there is significant progress in reduction of mother to child transmission of HIV in Uganda, the Western Region of Uganda has low rates of PMTCT service utilization. The progress has been hampered by many factors including low male involvement (MOH, 2005). The main objective of this study was therefore to identify some of the factors that discourage men from participating in PMCT services in this region. The study was conducted in Kibaale District in the Western Region of Uganda for a period of one month in mid 2009.

Data was collected using a qualitative methodology. The tools that were used for data collection were key informant in-depth interviews and focus group discussions (FGDs) guides. Data was collected from PMTCT service providers, women of reproductive age group and men whose partners had given birth during the last year (2008).

For the focus groups, a purposive sample of men and women who had some children born in 2008, followed by random sampling from the list of potential subjects was used to select participants. The study sample comprised of three FGDs of women who had given birth in year 2008 and male partners of women who had also given birth in 2008. Each FGD consisted of eight participants. One FGD was with women only, the other with men only, while the third was with both men and women.

The discussions were audio recorded, transcribed and analyzed using thematic content analysis. Information from FGDs and key informant interviews were analyzed using several key themes that included knowledge about aspects of PMTCT services, traditional beliefs as well as cultural practices affecting male involvement in PMTCT.

Findings from the study were: all participants were highly knowledgeable about the magnitude of HIV/AIDS problems in the community. However, this knowledge did not translate into high level of utilization of the HIV/AIDS services in the region including PMTCT. The study revealed that there were quite a number of barriers to male involvement in PMTCT services raised by participants. Some of the barriers mentioned were: limited accessibility of PMTCT services, inconveniences involved in seeking the services, limited incentives at service outlets, cultural practices and norms, fear of being identified with HIV/AIDS, limited use of PMTCT guidelines and policies, poor clinical infrastructural settings, and stigma associated with HIV/AIDS in the community. In addition some men did not believe that mothers can transmit HIV before and after birth.

Given the fact that PMTCT is already stigmatized in the community and there are few men generally seeking care in health units, interventions need to concentrate more on a behavioral change. Stigma and fear of HIV testing seemed to be the most reported barriers by almost all the participants and this can be best addressed through engagement with community leaders and community workshops focusing on changing the current behavior of men and their support towards PMTCT, Maternal and Child Health as well as Reproductive Health in general.

Based on these findings of the study, recommendations were made on that the PMTCT awareness be intensified especially in communities to reach more men, the PMTCT services be offered on a daily basis, training of other cadres to assist ANC providers with PMTCT programmes be done, male involvement in information, education and communication (IEC) materials be intensified, the PMTCT policies and guidelines were to be made available and used at all health units.

Findings and recommendations of this study were to be presented to all stakeholders in PMTCT and were hoped to facilitate the current revision of the PMTCT guidelines in the country as well as identifying new strategies.

Key Words

HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome,
Prevention of Mother to Child Transmission (PMTCT) of HIV,
Male involvement,
Socio-cultural factors,
Traditional beliefs,
Kibaale district,
Confidentiality,
Antenatal Care



Declaration

I declare that “A qualitative study to explore the factors influencing male’s involvement in PMTCT services in Kibaale District, Uganda” is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Signed by: _____

Prosper .T. Behumbiize

This _____ date of _____ 2009



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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care/Clinic
ARVs	Antiretrovirals
AVSI	Associazione Volontari Servizio Internazionale
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
IDIs	In-depth Interviews
LC	Local Council
MoH	Ministry of Health
MPH	Master's in Public Health
MTCT	Mother-To-child Transmission
NGO	Non Governmental Organization
OPD	Out Patient Department
PATH	Programmes for Appropriate Technology in Health
PMTCT	Prevention of Mother-To-Child Transmission
RH	Reproductive Health
UNAIDS	United Nations AIDS
UNICEF	United Nations International Children's Emergency Fund
UWC	University of Western Cape
VCT	Voluntary counseling and Testing
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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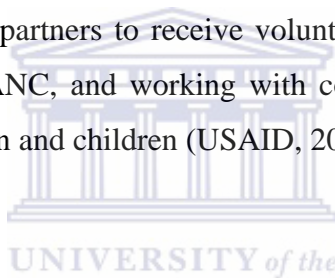
Operational Definitions

Male involvement

Male involvement in PMTCT services in this study is defined as a process through which males participate and help others (including spouses and friends) to participate in PMTCT. It is also defined as a process through which males take part in PMTCT matters that include the making of decisions and providing resources for seeking PMTCT services. However, there are different understandings of what is meant by ‘male involvement’ across the different cultures and study contexts. According to Lee (1999), male involvement in reproductive health can be viewed in the context of males’ roles in support of both themselves and their partners in meeting reproductive health needs, choices and rights or the way men modify their sexual behavior and active involvement in policy and programme formulation. For USAID models, male involvement in PMTCT may mean inviting male partners to receive voluntary, counseling and testing (VCT), involving them in all phases of ANC, and working with communities to promote more male involvement in the health of women and children (USAID, 2005).

Key stakeholders

There are quite a good number of key stakeholders in PMTCT and these include the Ministry of Health - the main provider of health services in the region, local health bodies and other agencies providing HIV/AIDS services and all whose study guidance is important. All have a good understanding of the PMTCT services delivery and were critical in guiding the research process. Formal and informal meetings were held with these key stakeholders to exchange information and build mutual understanding. The research protocol was presented to these teams, research problem and questions reviewed, working guidance and permission sought, study updates and findings shared as well as the way forward on interventions from this study’s findings agreed upon.



Chapter 1: Introduction and Orientation to the Study

1.1 Introduction

Globally an estimated 2 million HIV-positive women become pregnant every year and 20% to 30%, in absence of prevention of mother to child transmission (PMTCT) programmes, infect their children with HIV (UNAIDS, 2007). PMTCT can be more effective in reducing HIV infections among infants when it is sought early in pregnancy and continues through delivery and infant care. According to the Ministry of Health (MoH) in Uganda; mother-to-child transmission (MTCT) is one of the major modes of HIV transmission among children. Studies have shown that 90% of the children aged below 15 who die from AIDS acquire HIV through MTCT (Phoolcharoen & Detels, 2002; UNAIDS, 2000).

Recognizing the importance of PMTCT, the Government of Uganda (GoU) through the Ministry of Health (MoH) and with support from development partners has for the past 6 years accelerated HIV prevention to reduce HIV infections through a range of prevention interventions. PMTCT programmes form an important component of the overall HIV prevention strategy (MOH, 2005). Uganda PMTCT encourages couple HIV counseling and testing (MoH, 2004). There has also been an increase in the service delivery outlets from 280 in 2005 to 568 in 2007 country wide.

Uganda was the first country in Sub-Saharan Africa to initiate PMTCT services in January 2000 and has been able to increase the number of positive women receiving ARVs from 12% in 2005 to 34% in 2007 (UNAIDS, 2007). Scaling up has occurred rapidly throughout Uganda in over 78 districts countrywide (Onyango, 2004). However, low involvement of men in PMTCT services has been a major concern to both health care providers and policy makers. Several studies in Uganda have reported lack of male involvement as a major challenge to PMTCT uptake (Mugenyi, Kabasinguzi, & Ali, 2004; Bajunirwe & Muzoora 2005; Onyango & Magoni 2001). Most women needed to consult their spouses first before taking an HIV test and if found positive, the decision to participate in PMTCT services had to be made by their spouses (Bajunirwe, & Muzoora 2005).

According to the Uganda AIDS Commission report, it is believed that about 15-21% of HIV transmissions in Uganda are through mother-to-child transmission and is between 40-60% in Western Uganda (UAC, 2007). MTCT risks could be dramatically reduced if all pregnant women together with their male partners were accessing HIV counseling and testing services and the prevention of mother-to-child transmission (PMTCT). Without any intervention, the infection/transmission rate ranges between 20-45% among newborns (De Cock *et al*, 2000). Furthermore, lack of male involvement has been repeatedly reported by different studies in developing countries as a major challenge for successful PMTCT programmes (Tsague, Njom, & Zoung-Kanyi, 2005; Nuwagaba-Biribonwoha, Mayon-White, Okongo, & Carpenter, 2007; Perez, Zvandaziva, Engelsmann, Marchand, & Dabis, 2005).

1.2 Background to the study

Currently the status of male involvement in PMTCT activities in Kibaale district is not well known. The level of knowledge by men on issues pertaining to mode of HIV transmission especially MTCT is also not well understood. Men play dominant roles in decision taking regarding women's reproductive health, health education, HIV counseling, testing and giving ARVs to mothers. Programmes for women alone may not reduce the rate of infection among newborns because of their inability to make critical decisions like using condoms, HIV testing, drug taking and infant feeding options (UNAIDS, 1999).

Realizing that men are key stakeholders in reproductive health, there has been an increasing global interest to increase male involvement in reproductive health (PATH, 2005). It is very important to involve men because they influence women's access to health services through control of finances, and decisions (Greene, 2002). This study therefore attempted to understand the reasons behind low involvement of males in the specific context of Western Uganda.

The drive to reduce HIV transmission to children in developing countries has been mostly promoted through safe sex, couple VCT and provision of antiretroviral therapy. To ensure that the mothers and their children benefit from the therapies that prevent HIV infections, HIV testing during pregnancy is encouraged, particularly in the context of couple-based VCT (Greene, 2002).

Positive male involvement in PMTCT interventions has been recognized to result in increased uptake and success of HIV prevention by women world wide (Clark, 2001; Greene, 2000; Rutenberg, Kalibala, Baek & Rosen, 2003). However, the majority of PMTCT sites in Uganda have continuously experienced low involvement of men and very little is known on how to enhance male involvement. In Kibaale district, less than 10% of men escort their wives to hospitals and less than half are willing to take an HIV test (MoH, 2005). In order to increase male involvement and participation, there is need to gain in-depth knowledge and understanding of the factors limiting male participation in this district.

The findings will inform and guide the District Health team and PMTCT stakeholders in designing appropriate information, education and communication materials to increase male participation. This information is also hoped to be used by the MoH to change public health practice and policies regarding men involvement in Reproductive Health (RH).

1.3 Study setting

1.3.1 Location, geography and climate

Kibaale district is located in the mid-Western part of Uganda, bordering Mubende and Kiboga districts to the East, Hoima to the North, Kabarole to the West, Bundibugyo to the Southwest and the Democratic Republic of Congo to the West. It also borders with Lake Albert in the East, making fishing one of the economic activities undertaken by the residents. The total land area for the district is 4,400 sq km with a population density of 98 per sq km, while 319 sq km is covered by water bodies. The Kibaale district is 120 km away from Hoima, which is a major commercial centre and an administrative headquarters for the Bunyoro kingdom (KDLG, 2007).

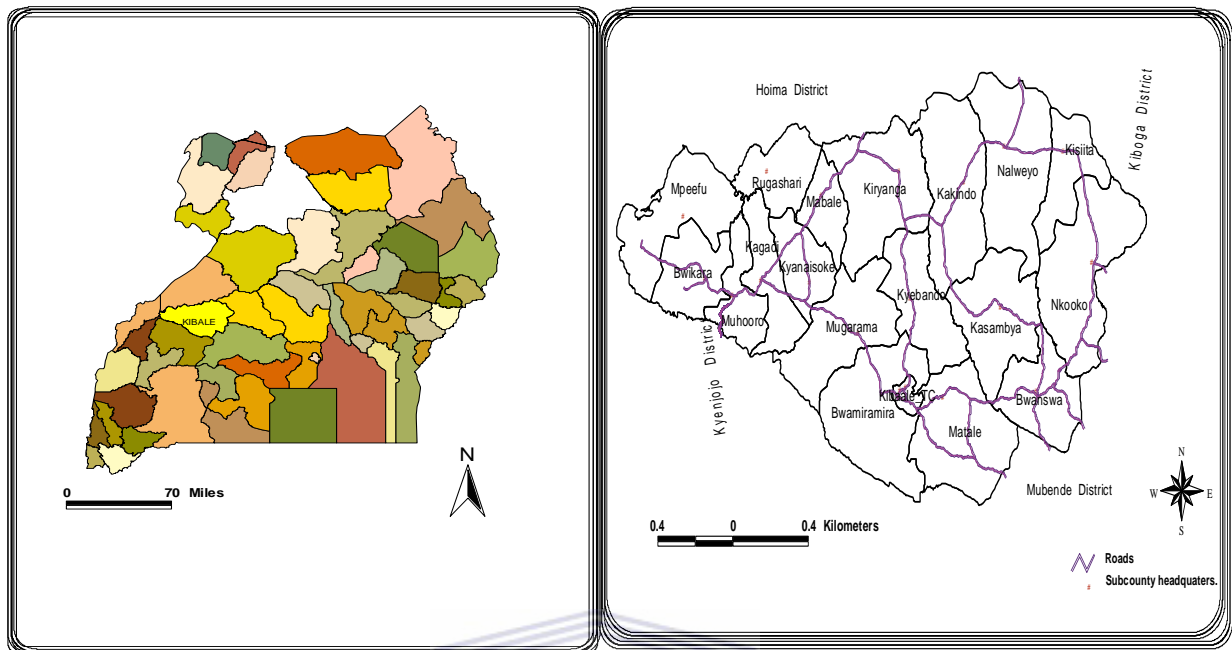


Figure 1: Map showing Kibaale district

According to the Population and Housing Census carried out in 2002, Kibaale district had a population size of 412,427 out of which 51% were females. The district has a high population growth rate of 5.2% per annum higher than the national figure of 3.2% mainly due to high fertility rate of 7.8 children per woman and the influx of settlers from other districts of Kabarole, Kasese, Rukungiri and Kabale (Uganda Population and Housing, 2002).

Kibaale district is extraordinary in terms of its location, climatic conditions and relief. It lies in the lower green belt with extremely low altitude of 2040 ft above sea level. The district experiences extreme harsh weather conditions ranging from high temperatures of 30⁰C in December to lower temperatures of 15⁰C in April. It experiences moderate and high rainfall patterns varying from 1000 mm – 1500 mm per annum and in most cases floods (KDLG, 2007).

1.3.2 Administrative structure

The district was created in 1991 out of Hoima district. Administratively, the district consists of three counties; Buyaga, Buyanja, and Bungangaizi, 18 sub-counties, two town councils namely Kibaale and Kagadi, 82 parishes and 931 villages (local council I). The district has a Health Department also divided into 3 Health Sub-Districts (HSDs) of Buyanja, Buyaga, and Bugangaizi. Uganda is operating centralized management system, so that the district administration acts as a conduit for the central government to reach the community (UBOS, 2002).

1.3.3 Culture, religion and languages

Kibaale district is one of the three districts that constitute Bunyoro Kingdom. The other districts are Masindi and Hoima. The major ethnic group is the Banyoro (48.1%) though a large group of Kiga (31.4%) tribe who were resettled by government from densely populated areas of Kigezi also live in the district (Kibaale District Profile, 2000; UBOS, 2002).

The main languages spoken are Runyoro, Rukiga and Luganda. People often mix these languages when trying to communicate in Kibaale district. However, in the rest of the country districts, English is the official language (UDHS, 2006). People in the Kibaale district mainly follow patrilineal type of marriage whereby a man pays 'enjugano' bride price to the parents of the wife and the wife then lives at the husband's home. The enjugano can be paid in form of money or livestock (KDLG, 2007).

Catholicism is the predominant religion in the district, though also Bisaka believers constitute a sizeable proportion of the district population. Other faiths like the Protestants, Seventh Day Adventists (SDA) and Moslems are not existent in significant numbers like the Catholics and Abaikiriza (*a religion founded by one man called Owobusobozi Bisaka and its headquarters is at Kapyemi in Muhorro Parish Kibaale District. The followers of Bisaka are called Abaikiriza*) (UBOS, 2002).

1.3.4 Economy

Kibaale district is endowed with very good soils, and a hard working population. Luckily the district has not experienced a lot rural-urban migration like most of the rural communities in the country and thus, most of the young men and women have not yet moved out of the rural areas. Substance farming is the main activity in Kibaale district. The major economic activities include small scale agriculture and crops grown include coffee, tobacco, rice, cotton, Irish potatoes, cereals, groundnuts and cassava. There is some fishing at the shores of Lake Albert though not on a large scale basis as well as, brewing of alcohol, especially *waragi* a local gin. Poverty is rampant and employment opportunities limited thus people primarily depend on agriculture (Kibaale District Profile, 2000; UBOS, 2002).

1.3.5 Literacy

The district has one of the highest levels of literacy (69%) as compared to the 68% of the whole country. However males are more literate than females, whereby the literacy level for males is at 76% as compared to females whose literacy level is 61% (UDHS, 2006).

1.3.6 Services and road infrastructure

Service facilities and road infrastructure in the district are lacking and in some cases, very inadequate or even in dilapidated or obsolete state. There are 36 health facilities in the district comprising of one hospital at Kagadi, that is 4 health centre IVs, 17 health centre IIIs, and 15 health centre IIs. However, only 4 health facilities in the district render PMTCT services. It should be taken into consideration that more than 46% of the country's population live more than 8 Km from the health facility (MoH, 2004). It is also logical to conclude that more than 46% of the people in Kibaale live more than 8 km from health units where they get services once they are pregnant. However, the actual distance is likely even longer for PMTCT, since there are only four health units offering PMTCT.



Figure 2: A poster hangs in one of the clinic in Kibaale

The district is linked to other parts of the country through a network of roads and within the district, only feeder and district roads are existent. However, these road networks become impassable during the rainy season and usually in bad state of repair during most of the year.

1.3.7 Kibaale health indicators and health units

Infant mortality rate is estimated at 90 per 1000 live births almost same as the national of 88/1000 and maternal mortality at 550 per 100,000 live births close to 505/100000 national. The leading cause of mortality is malaria which accounts for 42.6, followed by diarrhea (8%) and acute respiratory infections. HIV/AIDS is the 4th cause of death and being responsible for about 3.2% of deaths (MoH, 2002).

Table 1: A comparison of health indicators for Kibaale and Uganda compared (2000)

Health Indicators	Kibaale	Uganda
Infant mortality rate	90/1000	88/1000 live births
Child mortality rate	140/1000	152/1000 live births
Maternal mortality rate	550/100000	505/100000 live births
Total fertility rate	7.3	6.3 children per woman
Population growth rate	5.2%	3.2%
Life expectancy	49.1 years	48.1 years

Source: Uganda population and housing census 2002. world population reports.

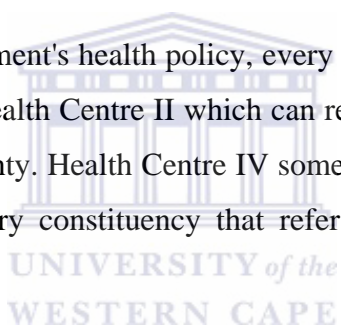
Table 2: Distribution of health units (Government and NGO) by county

Buyaga HSD	
Kagadi Hospital (Govt) *	Muhorro Government HC II
St Ambrose Charity IV (NGO)	Muziizi HC II (Tea Estate)
Muhorro (NGO) HC III (Govt)	Mpeefu A HC II (Govt)
Bwikara HC III (Govt)	Kahunde (NGO) HC II
Mpeefu B HC III (Govt)	Mugalike (NGO) HC II
Kyaterekera HC III (Govt)	Kyabasara HC II (Govt)
Isunga HC III (Govt)	Galiboleka HC II (Govt)
Mabaale HC III (Govt)	Kiryanga HC III (Govt)
Rugashali HC III (Govt)	
Bugangaizi HSD	
Kakindo HC IV (Govt) *	Kigando HC II
Kasambya HC III (Govt)	Magoma (NGO) HC II
Nkooko HC III (Govt)	Kabuubwa HC II
Nalweyo HC III (Govt)	Mukoora HC II
Kisiita HC III (Govt)	Mpasaana (NGO) II
Igayaaaza HC II (Govt)	

Buyanja HSD	
Kakumiro HC IV (Govt) *	St Denis Nsinga (NGO)
Kibaale HC IV (Govt) *	Nchwanga (NGO) HC II
Bujuni (NGO) HC III	Matale Government HC II
EMESCO (NGO) HC III	Bukuumi (NGO) HC II
Nyamarwa HC III (Govt)	Bubango HC II (NGO)
Kyebando HC III (Govt)	
Mugarama HC III (Govt)	
Kyabasaija HC III (Govt)	

*** Facilities offering ANC, HIV/AIDS care and treatment and PMTCT services**

According to the Ugandan government's health policy, every parish - lowest administrative level is supposed to have at least one Health Centre II which can refer complicated cases to next level Health Centre III at every sub-county. Health Centre IV sometimes referred to as a mini-hospital serves a county or a parliamentary constituency that refers cases to hospital found in each district.



HIV testing and PMTCT services are only offered at Kagadi Hospital, Kibaale Health Centre IV, Kakumiro HC IV and Kakindo HC IV. These are the only health units with a laboratory technicians trained in sero testing and managing the mother to child HIV transmission prevention program (MTCT). However, there are other outreach private VCT services in the district.

1.3.7 Trends in HIV/AIDS prevalence in Kibaale district

The HIV/AIDS surveillance system in Kibaale district is quiescent. Consequently, the district lacks reliable data on HIV/AIDS prevalence that are representative of the whole population. However, the prevalence rate of HIV infection stands at 7.4% for the year 2001 (MoH, 2002). According to available data from the district, the most affected age group is that between 25 and 45 years. The trends in the prevalence can be seen in the table below over the years:

Table 3: Kagadi hospital HIV/AIDS antenatal sentinel surveillance

% HIV Prevalence	1997	1998	1999	2000	2001	2002
Kagadi Hospital	10.3	11.5	11.0	10.5	7.4	6.4

Source: National HIV/AIDS surveillance report 2003 – ACP/MOH.

1.3.8 PMTCT service utilization in Kibaale district

PMTCT; HIV/AIDS counseling and testing services and care are available to all pregnant women including men in Kibaale district. These services are offered in only four health units, but the plan is to extend them to 16 more sites by 2012 (Kibaale Strategic Plan 2008-2012, January 2008). Implementation of PMTCT is currently supported by the Ministry of Health and other development partners which include Elizabeth Glaser Pediatric Foundation (EGPAF), and a community non governmental organization (NGO) – Kibaale District Network of People Living with HIV/AIDS.

There are currently policies and guidelines on PMTCT in the country and a process of updating them is ongoing. These policies require that each pregnant woman visiting for an antenatal check-up be offered HIV/AIDS counseling and testing and if found positive, ARVs administered to her. The district has a PMTCT coordination unit, which facilitates the coordination of PMTCT activities across its health units. This is supported by both the Ministry of Health and other development partners in PMTCT that are providing training, resources and other logistics to the programme.

1.4 Problem statement

There are number of infants who become HIV positive through maternal transmission of the HIV virus that can occur during pregnancy, birth, and during breastfeeding. Most programmes have largely focused on encouraging women to come for PMTCT services but have often left out men as critical decision-makers. If men are not informed of the benefits of PMTCT and clearly understand the risks to their unborn children, they will not become a supportive force for

PMTCT uptake and compliance (Greene, 2002).

1.5 Aim and objectives

1.5.1 Major Aim

The main aim of this study was to explore factors affecting male involvement in uptake of PMTCT services in Kibaale district, Western Uganda.

1.5.2 Specific objectives

1. To determine the existing knowledge, attitudes and practices of participants on male involvement in PMTCT.
2. To determine the factors affecting male involvement in Kibaale District, Western Uganda

1.6 Significance of the study

The idea of involving men in reproductive health is rapidly gaining credibility. In Uganda males in company of their pregnant partners are advised to go for ANC at every visit. This is essential for reducing the risk of HIV infection both for couples and their unborn children. Women who test HIV positive at their ANC visits are advised about how to prevent transmission of HIV to their babies. However, the majority of the males because of their attitudes and practices do not accompany their wives to ANC so as to get PMTCT services. This study will hereby establish the factors limiting males from getting involved in PMTCT services in Kibaale district Uganda. The findings will help policy makers and planners to identify how to improve male involvement in PMTCT services which should help decrease HIV transmission to infants. .

Chapter 2: Literature Review

2.1 Introduction

This chapter reviews the literature related to this study. It includes the ideas and findings of other researchers on what is known about the research problem and what still needs to be researched. Literature in this study includes the global situation of HIV/AIDS, the previous studies undertaken to determine factors influencing male involvement in reproductive health in Africa, socio-cultural factors, factors contributing to the low uptake of Voluntary Antenatal HIV Counseling and Testing by men, and attitudes of men and women towards PMTCT services.

2.2 Global HIV/AIDS situation

Nearly about 25 million people world-wide have died of HIV/AIDS since 1981 when the first case was recorded, and the disease is still growing to be the biggest challenge to public health. By the end of 2008, close to 33.4 million people were living with HIV world-wide, of which 2.1 million were children and 15.7 women (UNAIDS, 2009). In 2007, an estimated number of 2.5 million people were infected with HIV, 85% of which were in the reproductive age and about 2.1 million dying as a result of HIV-related illnesses (UNAIDS, 2007). Sub-Saharan African accounts for about 90% of the world's infected population and HIV still remains the leading cause of death (UNAIDS, 2007). MTCT is the most significant source of HIV infection in children under the age of 15 (UNAIDS, 2000:81). Although the rate of infection among children has declined, an estimated 2.5 million children were reported to be living with HIV, a number that places a huge burden on families and health systems (UNAIDS, 2007). An estimated number of children living with HIV/AIDS in Uganda is currently estimated at 100,000 (Uganda AIDS Commission, 2008).

2.3 HIV/AIDS and women

Women and children are the most disadvantaged groups and take up the biggest burden of HIV/AIDS as they continue to experience high rates of new infections as well as suffering from HIV-related illnesses and deaths (UNAIDS, 2006). More than 17 million women world-wide are today living with HIV and infection among them is on the rise in every region of the world (UNAIDS, 2006). Globally, the percentage of women living with HIV has remained stable at

50% over the past year, but the rate of infection among women has been increasing across different regions and countries especially the Sub-Saharan countries (UNAIDS, 2008). Uganda is one of the countries experiencing high infection rates among women with a ratio of 1:5 male to female infection rate in the 15-19 years age group. Out of the cumulative 56,451 adult cases reported in 2003, 30,347 (75.2%) were female while 24.8% were male (STD/AIDS Control Programme, 2003 Report).

By the end of the year 2003, the rate of infection among women was three times more than that of men, (UNAIDS, 2003). According to Michael (2007), the infection rates of men increased after the age of 25 but nonetheless, remained below those of women until the age 35, and then death among women pulled down the female prevalence rate. This then implies that the proportion of HIV infected women of child bearing age will continue to increase thereby increasing the number of infants likely to be born with HIV or to acquire HIV through MTCT after birth. It also means that women will have AIDS related illnesses at a younger age than men unless they receive ART. In household surveys in seven countries in the Sub-Saharan Africa, results revealed that more deaths occur among women than men and on average women die younger than men (UNAIDS, 2002). This has enormous implications on the care of upcoming generations as the burden of orphan care increasingly falls upon grand parents.

HIV prevention among partners, preventing unwanted pregnancies among HIV positive women and provision of antiretroviral drugs to HIV positive pregnant women including their babies coupled with safe delivery practices and proper infant feeding practices are some of the strategies recommended by UN in preventing the transmission of HIV to infants (WHO, 2001).

Women's dependence on men, their inability to make certain decisions, and the effects of social and cultural factors on them, increase their risks and vulnerability to HIV exposure, and at the same time limiting their chances for seeking health services. The social-cultural and economic determinants of women's HIV infections greatly differ from those of men because of the central positions and roles of men in relationships and families (WHO, 2003). Thus a person's gender would in one way or the other determine the extent to which one can ably access available HIV/AIDS treatments and coping up with the burden of the disease. A study analyzing

HIV/AIDS knowledge level across sexes in 23 developing countries revealed that HIV/AIDS transmission

and prevention is higher among men than women (Gwatkin & Deveshwar-Bahl, 2001). Therefore, there is a great need to integrate gender issues and challenges into HIV/AIDS programmes since most of such programmes tend to overlook gender issues in their design and implementation. Successful integration requires a clear understanding that economic, social and cultural dimensions exist between men and women at all levels other than in service delivery only. Gender equity programmes especially in HIV seem to be increasing the burden of women and increasing the blame (Tallis, 2000).

2.4 Mother to child transmission of HIV/AIDS

Mother to Child Transmission of HIV is a process that takes place when HIV passes from a mother to her baby during pregnancy, delivery or through breast feeding. UNAIDS estimated that 800,000 children were infected in 2001, almost all through the transmission of the virus from their mothers during pregnancy, childbirth, or breastfeeding. Of these cases, seven of each eight children live in the Sub-Saharan Africa while the remainder lives in South and Southeast Asia (UNAIDS, 2001). Although Uganda has seen adult HIV prevalence falling from an average of 18% in 1992 to 7.0% in 2005 (UNAIDS, 2006) without treatment, the risk of MTCT is estimated at 5-10% during pregnancy, labour, and delivery while through breastfeeding, it is estimated at 10-20% (MOH, 2004).

2.5 Male involvement in PMTCT programs

2.5.1 Benefits of involving men PMTCT

“Women are unable to stop the spread of HIV/AIDS alone” (Tallis, 2000:64). There are a number of challenges that HIV/AIDS programmes are facing in involving men although the benefits of such programmes outway the challenges. Successful involvement means that gender inequalities are challenged, power imbalances in effecting behavioral change are reduced and gender issues are integrated into the HIV/AIDS programmes (Tallis, 2000). Male involvement is associated with improved social support that comes with the ability for men to provide advice on HIV testing, money for transport and other necessities required during pregnancy,

accompaniment to ANC and encouragement. A study comparing differences in husband involvement in maternal health in the past versus the present revealed that gender relations had improved and that husbands were more caring, supportive, and involved than in the past (Carter, 2002).

2.5.2 Male knowledge and information about PMTCT/VCT services

VCT is a crucial entry point to PMTCT services. All pregnant women should be given an opportunity to know their HIV status (WHO, 2001). Knowledge and awareness of a programme influences its uptake and success (Glanz, Rimer, & Lewis, 2002). PMTCT information is usually provided during antenatal care where men are marginalized and provided with little information (Ntabona, 2002; Burke, Rajabu, & Burke, 2004). Often, there are limited avenues through which men can access reproductive health information. According to a survey involving organizations and individuals involved in HIV/AIDS with interests in male initiative programmes in Kenya, lack of adequate information on PMTCT was one of the major hindrances that influence men's participation (Munene & Gathenya, 2004). Another study in rural Southern India found that full involvement and engagement of men right from counseling to treatment give them an opportunity to better support their spouses (Alexandra, Anand, Ambikadevi, Aruna, Prasanna, Jubin, Divya, Padma, Avinash and Shetty, 2006).

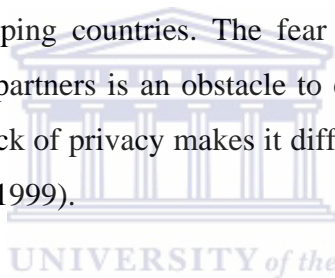
2.5.3 Socio-cultural influences on male involvement in PMTCT

African men have been found to hold onto certain traditional cultural beliefs which inhibit their active involvement in reproductive health programmes. Traditionally, men have the pride of always being consulted in matters of family health, yet are very hesitant in seeking medical care (PATH, 2005). A cross-sectional survey conducted in 6 hospitals in Zimbabwe showed that a majority of women declined routine HIV testing mainly because they required partner's consent (Freddy, Zvandaziva, Engelsmann, Dabis, 2006). A similar study in rural Southern India found that social and cultural barriers such as fear of their partners and parents deter pregnant women from accessing PMTCT services (Alexandra, Anand, Ambikadevi, Aruna, Prasanna, Jubin, Divya, Padma, & Avinash, 2006). Furthermore a study in Tanzania, reported that source of information and who relays it seemed to affect utilization since men still regard themselves as 'bringers' of health information to the family and usually trusted information more from health

workers than their female partners (Burke, Rajabu, Ramadhani, & Burke, 2004). In addition, men prefer receiving information from their fellow men (Burke, Rajabu, Ramadhani, & Burke, 2004).

2.5.4 Programmatic factors influencing male involvement in PMTCT

Reproductive health programs like family planning and PMTCT are generally designed and implemented solely for women and men feel neglected and unwelcome at these service outlets. According to PATH (2005), men's views need to be included when designing reproductive health programs like PMTCT so as to include male service providers, convenient hours, and male-friendly clinics. Studies in Tanzania and Kenya found out that men are always marginalized when it comes to PMTCT services (Burke, Rajabu, Ramadhani, & Burke, 2004; Rutenberg, Kabibala, Mwai & Rosen, 2003). Stigmatization still remains a major barrier to accessing HIV services in developing countries. The fear of being discriminated against by family members, community and partners is an obstacle to entering PMTCT programmes. The openness of PMTCT clinics and lack of privacy makes it difficult to maintain confidentiality thus limiting male involvement (Berer, 1999).



Unlike women, working men are not granted antenatal leave and according to Lee (1999), long working hours and inconvenient clinic hours also limit men's participation on reproductive health issues. A study in India revealed that change in working hours like opening on Saturdays and providing travel services could increase male attendance (Samuel, 2006).

2.5.5 Accessibility and availability of PMTCT services influence on male involvement

PMTCT services have been globally prioritized in HIV prevention. However, in many countries, particularly developing countries, PMTCT services are not widely available or not available at all. Several key factors like lack of transport and poverty are also bottlenecks to male involvement in PMTCT services. Limited access to radio and television (TV), print and electronic media coupled with high illiteracy levels means that few men have access to quality reproductive health information including PMTCT. In addition, high transportation costs in poorly maintained roads limit access of PMTCT health centers. A study in Eastern rural Uganda showed that availability of VCT services and counseling services were the major barriers of

PMTCT implementation and men are less likely to seek these services (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006).

2.6 Male involvement in general maternal and child health and reproductive health

There have been noticeable changes in the reproductive support to women by men especially in family planning decisions when men are fully involved. Communication as an important aspects of ensuring women receive their reproductive health service cares has also improved. According to Ngong, Becker, Haws & Wegner (1999)'s report, the involvement of men in reproductive health improves health outcomes for both men and women and also ensures that women's partners are educated and positively supported in all reproductive health concerns. Men seem to have a great influence on women's reproductive health and play a big role in improving their reproductive well-being. Patient issues have to be considered when designing reproductive health (RH) programmes that address improved sexual and RH for both men and women, and thus generating men's support for women's RH actions and at the same time promoting health sexual behavior. Tawiah's (1997) study on factors affecting contraceptive use in Ghana revealed that the discussion of family planning with partners and husband-wife communication were positively associated with the use of contraceptives.

2.7 Strengths and weaknesses of reviewed studies

Most of the reviewed studies used women or men alone as respondents instead of combining them. However one major strength of the studies is the fact that they were carried out in different sites and countries and present variations of norms across cultures.

2.8 Conceptual framework

After the review of literature from several studies, books and reports, there are various factors that may independently predict factors affecting male involvement in PMTCT services. These include socio demographic factors, cultural factors, programmatic related factors and policy/guideline issues as is outlined and presented below (Fig.3).

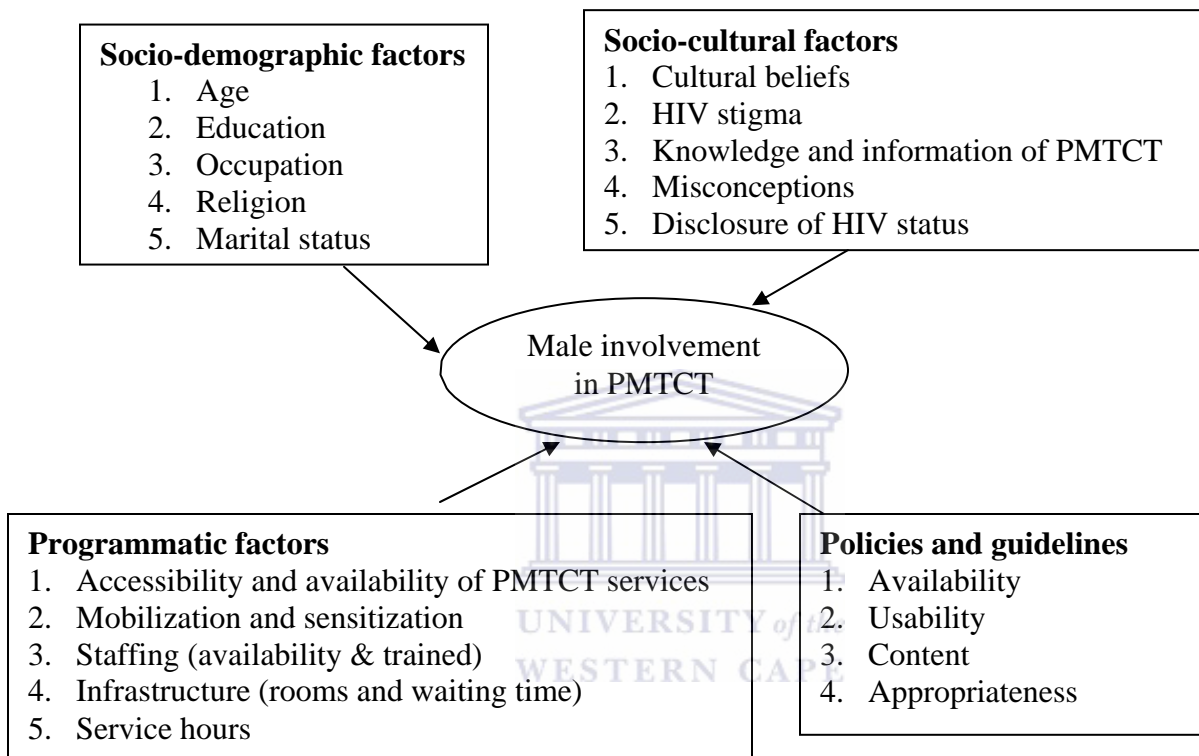
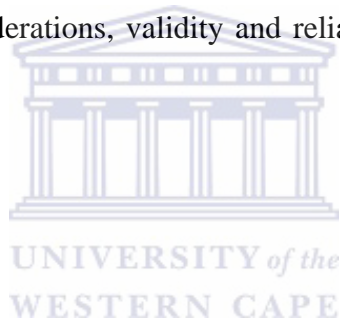


Figure 3: Study conceptual framework

2.9 Conclusion

This chapter covered a review of previous research studies related to HIV/AIDS global situation, HIV/AIDS in women, MTCT, PMTCT services in Kibaale District of Uganda, male involvement in PMTCT and other reproductive services. The literature clearly showed that male involvement in reproductive health issues especially PMTCT is low and interventions are hence required to avert the situation. From the reviewed literature, knowledge and attitude, social-cultural factors and programmatic factors are some of the barriers for men to be involved in PMTCT services. Apart from unpublished program reports, there is limited published literature from Uganda on factors affecting male involvement in PMTCT services and therefore this would be the focal point of this current study. Hence the next chapter shall be focusing on the research methodologies, which employed qualitative methods, that were used to conduct the study, and these will cover: the study design, the study setting, sampling methods, data collection and data analysis procedures, ethical considerations, validity and reliability as well as the limitations of the study.



Chapter 3: Research Methodology and Study Design

3.1. Introduction

In this chapter, the processes and methods used to conduct the study are explained. The chapter covers the processes from study identification to data collection and specifically focusing on: study design, setting of the study, study population, procedures used in selecting the participants for the interviews, sampling design, data collection and analysis, strategies to ensure trustworthiness of the data, ethical consideration, study limitations as well as the work plan (Burns & Grove, 1995).

3.2 Study design

This is a descriptive study design employing qualitative research methodology that utilizes in-depth interviews and focus group discussions (FGD). Qualitative methods were chosen because of their usefulness in exploration of people's views and experiences (Kitzinger, 1994). The research employed two data collection strategies: semi structured interviews, and focus groups discussions. According to Blink (1999), the personal contact with respondents produces descriptive data and presents it in the respondents' own words, views and attitudes towards the research topic (*i.e.* male involvement in PMTCT).

Findings from a qualitative study reveal patterns of feelings and emotions that underlie communities and women's and men's otherwise quantifiable knowledge about HIV and mother to child transmission of HIV. The strategy elicits information about factors that may influence attitudes or behaviour. Sensitive topics such as sexuality are also easily discussed in qualitative methods which use focus group discussions because once the "ice is broken" by one participant, others will start to open up (Kitzinger, 1995). The other advantage of qualitative methods is that they can be participatory, democratic and empowering (Kitzinger, 1994). This may result in development of new perspectives and attitudes that are health promoting (Kitzinger, 1995). Use of open-ended questions in both in-depth interviews and group interviews allows participants to express themselves in their own vocabulary that would be difficult in close-ended questions characteristic of quantitative methods.

3.3 Study setting

The study was conducted in three primary health units offering PMTCT services in Kibaale District, Western Uganda. The district has one 100 bed district hospitals which act as a referral centres for 3 primary health care clinics. Kibaale district has 43 primary health care units, 1 hospital, 4 health center IVs, 18 health centre IIIs and 20 health centre IIs. Out of these, only the hospital and 4 health centre IVs offer PMTCT services. This means that the majority of the pregnant women in need of PMTCT services have to be referred to these units.

3.4 Study population

The study population for FGDs included women and men aged between 21 and 49, living in Kibaale district, married or in relationship and have or their partner have given birth in the year 2008. Nurses at the antenatal clinic (ANC) and local community leaders helped in identifying participants.

For in-depth interviews, participants were identified based on their involvement and experience in ANC and these included;

- Senior midwife; a nurse who manages the ANC
- PMTCT In-charge; an appointed nurse/clinical officer who oversees PMTCT services in the clinic.
- HIV/AIDS counselor; a person responsible for HIV/AIDS Voluntary Counseling and Testing.
- District PMTCT focal person

3.5 Sampling and sample size

The study employed a 'purposeful sampling' to get 'information-rich' males, females and PMTCT In-charges in Kibaale District's selected health units. This is a type of a non-probability sampling approach in which subjects are selected because they are identified as knowledgeable regarding the subject under investigation (Frankel & Devers, 2000b). The researcher establishes certain criteria thought to be representative to the target population and deliberately selects subjects according to such criteria (Burns & Groove, 1993).

The study area Kibaale district was purposefully selected because the researcher comes from this region and has a close working collaboration with the district and Ministry of Health's HIV/AIDS qualities of care service and improvement programmes. The health units were selected because they offer PMTCT services and are representative of the majority of health units in Uganda. 12 male and 13 female participants for the FGB were purposefully selected from three communities; firstly, 8 men were purposefully selected from a community nearby the clinic, a second FGD was then conducted with 8 women in the furthest community from the health facility, and the third FGD was conducted with 4 men and 5 women midway from the furthest community and the health facility. Participants having given birth in the last 12 months were sought.

The researcher was guided by the ANC nurses and local council level I chairpersons to identify men and women who participated in the study. For the women, an ANC register for women who had attended the clinic and delivered there during the year 2008 was used to randomly select 16 participants. Their names and addresses were used to trace their respective local leaders who were given participation letters of invitation (Appendix VIII) to pass on to them. For men, the local leaders were asked to name those men whose partners had given birth in 2008 and 16 invitation letters were also sent to them.

For in-depth interviews, the study deliberately selected knowledge-rich participants (Burns & Groove, 1993). Three health facility service providers were also purposefully selected from three health units providing PMTCT services based on their experience and interactions with the ANC and PMTC services. In addition, the district PMTCT focal person was also interviewed.

3.6 Data collection tools and methods

3.6.1 Training and pre-testing tools

A semi-structured questionnaire for in-depth interviews was designed and translated to the local language, Runyankole/Runyolo. Training was provided to research assistants in a one-day workshop on both FGDs and Key Informant interview guides. This helped internalize and refine tools. The pre-test was conducted in one of the health units (Kakindo Health Centre IV and

Kakindo county) within the catchment area. This unit also offers PMTCT services and has similar resources limitations like the other three.

3.6.1 Data collection method

Four in-depth interviews were conducted with key informants who included ANC, PMTCT service providers and District PMTCT focal person at their respective offices. All participants were given an appointment date and time to attend the discussions sessions through invitation letters. In all cases, interviews took place at the facilities with prior booking for time convenience. A brief explanation of the aim of the study and confidentiality related issues kicked off the interview. At the end of the interview, debriefing was carried out and some questions asked to ensure completeness. Each interview lasted for about one hour and was tape-recorded and in addition, hand-written notes also taken.

Three focus group discussions were conducted: one with males alone, the other with females alone and one with both males and females. Topics discussed were similar to the ones for in-depth interviews aided by relevant probing questions. Each focus group session began with a welcome followed by a brief introduction of the research project and settings of the ground rules. Among these rules was confidentiality assurance, for the fact that the session was being tape-recorded, and that there were no wrong or right answers and that all individual opinions were important and had to be respected. It was emphasized that participation was voluntary and individuals had a right to terminate their participation at any time. After the completion of the introduction, questions were then posed and the discussions proceeded.

Each participant was given an opportunity to speak until the information saturated was reached and no new ideas were emerging. One research assistant acted as a moderator while the other recorded responses on the flip chart. The researcher took notes as well as tape-recording the outcomes. The discussions were held in the local language in order to facilitate understanding among the participants and at the same time increasing the effectiveness of the whole process. An attendance list capturing age, sex and educational level was used in registration. A summary of the main views and checks for completeness were made at the end each discussion. Each

participant was given Ugandan Shilling 15,000/= (USD 7) as compensation for transport and their time spent during the interview and this was well appreciated by all the participants.

3.7 Data management and analysis

This study used thematic analysis where analysis begun immediately after the discussions. This helped in refining questions and identifying new avenues of inquiry. The transcripts were read repeatedly and first coded independently by the researcher and the facilitator in order to capture the range and diversity of the participants' perceptions followed by a comparison amongst them at the end of each session. The researcher analyzed content and elicited recurring themes related to the reasons of low male involvement in PMTC service through listening to tapes, reading transcriptions and studying field notes. Audio-taped and written notes were reviewed and transcribed to develop a comprehensive list of factors related to low male involvement.

According to Bailey (1997), qualitative data analysis is the process of systematically organizing any materials used in the survey such as field notes, interview transcripts and taped recorded notes so as to be able to address the research questions. Key issues, concepts and themes were categorized accordingly in order to obtain detailed meaningful indexed data for analysis. Themes were based on those aspects identified in the review of literature before data collection (Bailey, 1997) and those of particular interest were as follows: knowledge about the magnitude of HIV problems in the area, knowledge about PMTCT services, attitudes of participants towards PMTCT services, opinions about participants' impressions of reasons for low male involvement in PMTCT, social cultural issues and recommendations for improving male involvement. The data were presented in the form of general concepts illustrated with quotations linking back to literature available. All data collection tools were then kept locked.

3.8 Strategies to ensure trustworthiness of data

In order to ensure that the data was trustworthy, issues relating to the soundness of data were addressed. Soundness of data was maintained through measures addressing the following aspects: credibility, transferability, and conformability of the data (Lincoln & Guba 1985).

Credibility is the degree to which research conclusions are sound and are provided through a detailed description of the research setting and methodology. Hence in order to improve credibility, data was also recorded using a tape recorder. In addition, credibility was also enhanced by using different methods of data methods, (triangulation), which were: in-depth interviews and focus group discussions with different groups (Mays & Pope, 2000). Transferability or generalisability relates to the extent to which the findings can be generalized to other settings. In this case, it was provided through detailed and rich descriptions of the contexts (Smalling 1992). Clear statements of the theoretical basis of the research were also made so that other readers could determine the extent to which the results might be applied to other settings.

Dependability refers to the degree to which the reader can be convinced that the findings did indeed occur as the researcher states they did. This was achieved through rich and detailed descriptions that showed how certain actions and opinions were rooted in and developed out of contextual interactions. Confirmability refers to the extent to which the data confirms the general findings and not simply the products of the researcher's bias. This was achieved by comparing the findings and interpretations to the wider literature and also done by giving feedback of the findings at the end of the interview to the participants and checking whether they agreed with them.

3.9 Ethical considerations

The study involved human subjects and therefore, relevant permission was sought and obtained from relevant ethical committees, political leaders, and participants themselves. Approval to carry out the study was sought from UWC Research and Ethics Committee. Permission was also obtained from the District Health Officer's office in Kibaale district, the District Local Council and In-charge of the concerned Health Units. Participation in the study was voluntary for all male and female subjects as well as the key informants.

A written informed consent explaining the objectives, the benefits and potential risks of the study (Appendix II) in the local vernacular and English languages was obtained from each participant. The document sought consent to participate and also to audio tape recording. Participants were informed of their right to withdraw from the study at any time and assured that withdrawal would

not affect their health care in any way or the other. Respondents' dignity, privacy and confidentiality were assured throughout the study period and because of the sensitiveness of the topic, anonymity was ensured and all notes and tapes were to be kept under lock. The information provided was treated confidentially and would only be used for study purposes. Respondents were assured that they were free to ask questions and that their names were not to appear anywhere in this study report.

3.10 Study limitations

The study sample size was small due to the limited time and funds for the research. The Banyoro cultural norms prohibit people from discussing about their cultural practices with persons they consider "outsiders". Therefore, there was a general lack of enthusiasm among men and women during FGDs and especially on issues of cultural practices pertaining to PMTCT. However, pilot focus discussion was conducted to pretest the tools so as to ascertain whether they were appropriate; role plays and discussions on the questions were also conducted until a level of comfort was reached. Training was also conducted to ask questions in a culturally sensitive manner. The presence of tape recorders could have had an affect on the behaviour of the respondents who could have felt inhibited in the presence of a recording device.

3.11 Work plan and budget

The research was carried out during the period of May 2009 to June 2009 and thereafter, the final study report submitted to School of Public Health at the end of Nov 2009. Funding for the study was secured from the Centers for Disease Control and Prevention, Uganda.

Chapter 4: Results and Discussions

4.1. Introduction

In this chapter, analysis of data will be discussed according to the identified themes, categories and subcategories. Both in-depth interviews and focus group discussions were conducted within the period of two weeks, 08 – 20 June 2009. All the participants met the inclusion criteria: women who had given birth or men whose spouses/partners had given birth in the year 2008 and living in Kibaale district

Three focus group discussions were conducted. The participants consisted of 13 women and 12 men out of the 16 women and 16 men invited respectively. Only 2 women and one man refused to attend while one woman and three men never showed up. Of the 25 participants, 11 were married, 8 were cohabiting and 6 were not married. An outlined FGD guideline was used to collect the data as well as probing techniques during discussions. Data gathering was based on the opinions of both men and women. The FGDs were conducted within Kibaale District. The venues for discussions and interviews were conducive; isolated rooms with less disturbances and noise.

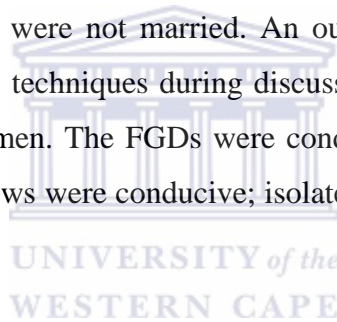


Table 4: Demographic profile of the study participants (FGDs)

Age		
Age group	Frequency	Percent
20-25	6	24.00
26-29	6	24.00
30-35	8	32.00
36-39	2	8.00
40-45	2	8.00
46-49	1	4.00
Sex		
Sex	Frequency	Percent
F	13	52.00
M	12	48.00
Religion		
Religion	Frequency	Percent
Catholic	15	60.00
Moslem	2	8.00
Pentecostal	5	20.00
Protestant	3	12.00
Education level		
Educ level	Frequency	Percent
Primary level	17	68.00
Secondary level	4	16.00
Teacher Grade 3	1	4.00
None	3	12.00
Occupation		
Occupation	Frequency	Percent
Business	5	20.00
Chair LC	1	4.00
Peasant	16	64.00
Porter	2	8.00
Teacher	1	4.00

The majority of the participants (52%) were in the age group above 35 years. In relation to education, 68% of the participants had only primary level education while 4% of the participant had grade three teacher level of training. Not surprising, the majority (64%) of the participants were peasant farmers who financially depended on selling produce from their small scale agricultural farming and the brewing of local beer.

The results of the indepth interviews and FGDs are reported using the following 4 main categories of themes based on study objectives, which were further divided into sub-categories based on themes generated from the data:

1. Knowledge about the HIV/AIDS problem in the community,
2. Knowledge about PMTCT services in the district,
3. Opinions of participants' reasons for low male involvement in PMCT services,
4. Suggestions for improved male involvement in PMTCT services

4.2. Participation

In all FGDs, female participants were more open than men and freely shared their experiences and opinions. The women were first shy but later opened up, and there was a general feeling that men were reluctant to seek PMTCT services, which was evidenced by the fact that they had little to discuss during the research process.

4.3. Knowledge of PMTCT services

Participants especially women were all aware of the availability of PMTCT services in the district and in which health units they could seek these services for free. They appreciated the fact that if sought together as couple/partners, PMTCT services would be beneficial and taken up widely..

“During antenatal check ups, we get HIV testing and we are given a dose to prevent infecting the baby. We are also told not to deliver from villages ” A new mother also added: *“When you are counseled and tested with your partners, it eases the problem of disclosure, support and adhering to instructions and guidance of the health provider”.*

“It’s good to come with our spouses and get counseling and testing together, and if we are infected, then we can start on drugs together and we could even stop producing.if am unable to come for drugs he can bring them for me”

ANC nurses reported that they offered a wide range of PMTCT services at their clinics and had the capacity of extending them to the communities if they had the resources. In their clinics, these registered nurses and midwives during routine antenatal care, carried out HIV counseling and testing as well as providing ARVs, delivery and feeding information.

“Yes PMTCT services are available here and we have adopted the new PMTCT guidelines recommendations; we offer VCT, ARVs, Infant Dry Blood Spot (DBS) testing, counseling on infant feeding, male involvement and all these services are free”

Participants who had or knew their friends that had accessed PMTCT services from these health units appreciated the treatment they received and perceived that most of the times, PMTCT effectively worked.

“I have seen a mother who took back her child for VCT after 6 and 8 months and the child was HIV free yet that mother is HIV positive, the drugs are effective”

“Drugs are effective because we have seen some people who have gone through that process and the babies are free from HIV”. Acclaimed one mother

The majority of the women recognized the importance of PMTCT services and knew where to get them. As it can be noticed from phrases above, PMTCT services were quite known to the majority of the female participants.

4.4. Reasons for low male involvement in PMTCT services

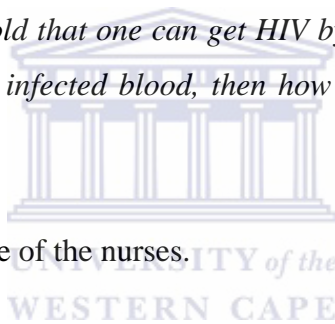
Low male involvement in PMTCT services is a challenge in the country and even in this district. A number of socio-economical, cultural and service related factors were raised by participants as

barriers to the low male involvement in PMCTC services. For effective PMTCT results, men needed to support their partners and participate in all those services.

4.4.1 Knowledge and information about mother to child transmission of HIV and the impact of HIV

The magnitude of the HIV problem in the community was asked from both key informants and FGDs participants and generally, all participants were aware of the magnitude of the HIV/AIDS problems in their community and that it needed everyone's attention. They had a demonstrated clear knowledge that pregnant mothers could also pass on HIV/AIDS to both their unborn and born infants though the majority of men were not aware of the different mechanisms of mother-to-child transmission. The following statement confirms this;

“... we have always been told that one can get HIV by having sexual intercourse with an infected person or sharing infected blood, then how do the innocent babies get it from their mothers....”



This was further emphasized by one of the nurses.

“Most of the men we have interacted with in the clinic don't believe that mothers can infect their babies before birth and after birth”.

Participants also shared clearly their understanding of HIV/AIDS; what it is, how it is spread among adults, the nature of the effects it causes to individuals, families, communities and the nation as a whole. This is clearly illustrated in the quotes below;

“...it kills, brings poverty since the infected don't work, loss of parent creates orphans who don't attend school, children headed household.....”

“HIV is a very big problem in this community, we know very many people suffering from it and being in the township there is high immorality rate and prostitution”

The district boosted a massive HIV/AIDs campaign through IEC materials, radio adverts and talk shows as well as youth group community dramas. However, when asked from where PMTCT services were offered, one participant in the men's group said;

“I hear that they test for HIV in women and babies only. That's all I know.”

Accordingly, male participants seemed not to possess concrete information on the services provided by the PMTCT clinics apart from HIV testing.

In contrast, the majority of the female participants were well aware of the services and even went ahead to mention most of them. They mentioned the services provided by PMTCTs as provision of HIV testing and administration of anti retroviral (ARV) drugs to pregnant mothers during pregnancy, labour and immediate post partum period.

“We are offered counseling and testing, prophylaxis with nevirapine and seprine, dry blood spot for the new born babies, infant feeding options, HIV testing for babies after 18 months and 3 months” Another woman added; *“We are told to exclusively breast feed for only 3 months if we can manage”*.

4.4.2 Sources of information

It was interesting to note that men still considered themselves as 'bringers' of health information and yet they had very little knowledge about PMTCT services. They had only got bits of information through radios, TVs/videos and community meetings. This was reflected by several respondents as follows:

“I heard about PMTCT over the radio, but not enough information was given since they were referring us to the health units for more information and I don't have time to go there since am not sick”.

Most of the information was being provided in the ANC where men could not attend yet most of women could share information. One health providers said;

“We carry out a lot of talks about MTCT and PMTCT during the antenatal visits both in general group morning sessions and individual sessions, and we encourage women to talk to their husbands but most of them tell us that they fear them, they are not interested and some don’t stay with them, so it’s a big problem to get these messages to men”.

It could also be assumed that the sources of information were inadequate in most of the communities. It was also revealed that some women feared talking to their husbands and thus were not able to share the information they got from the PMTCT centres. Therefore, campaigns should be planned to target the entire population and especially men.

4.4.3 Service related factors

Service related factors such as availability, convenience of services and attitude of the health providers could also affect men’s decision to utilize PMTCT services.

4.4.3.1 Accessibility of PMTCT services

Participants especially those who dwelled far from health units that offered PMTCT services experience problems in accessing those services. The terrain and road network in this area made it very difficult for even the few that could rather walk to the centers.

“Transport costs are high, me, I use a bicycle; me, I foot; me, I use ‘boda boda’...”

Accessibility to most of these health units was mainly by a taxi or a hired motorcycle referred to as “boda boda” and the cost ranged from 3-5 US Dollars, but then, such forms of transport were very uncomfortable for pregnant women. Since the majority of the people in this district were solely depending on selling produce and brewing local beer, they therefore found the cost of transport to be quite high. Furthermore, most of those people had no formal employment and their incomes being that low, they again felt that they could not afford to pay such an amount of money for transport and especially for two people for couple service seeking.

Most of the health units did not have ambulances which could help in cases of deliveries and even for the transportation of those people that were not capable of meeting the running costs of transport. The majority of the health units were situated 30 - 50 km away from the villages they served. Key informants also mentioned that transport to reach out to the community and carry out sensitisation programmes was also a contributing factor to the low utilization and awareness among the community members. They mentioned the lack of fuel to run a generator or transport for those who could not afford to come to the clinic. In order for them to come to the clinic at no cost, the community members had either to walk or carry their pregnant women on bicycles.

“When majority of them calculate all this trouble and costs involved, they are discouraged to come to the health unit”. “Opening hours are not friendly, but if it’s a serious man, he can wait”. Narrated by one of the health providers.

Even when they visited the clinic, the queues of people waiting for the service were too long because the facilities and the health workers were also few. Some men had no patience to wait all day unlike their female counterparts. This was further confirmed by one of the nurses:

“The time which women spend here when they come for ANC may discourage men as they claim they have a lot to do and have no time to waste”.

It appeared that there were very few health workers with skills and competencies in delivering PMTCT services and that there were no dedicated staff for PMTCT. Limited quality time during couple counseling and testing could be a barrier that led to low male involvement. More emphasis therefore needed to be placed on training more cadres and appropriate staff allocation into the health units. This was emphasized by a District PMTCT focal person.

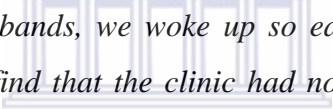
“The fact that we have few PMTCT outlets and limited manpower, staff is overloaded with work and can’t execute appropriate services that would encourage more men to attend ANC and thereby involve themselves in PMTCT services.

“I think the time we spend seeing couples is not adequate to exhaust all the PMTCT information that men would require. You can’t spend a lot of time with one couple when there is a long line of clients waiting”. Supplemented by health workers.

“The workload here is too much, we sometimes mind about clearing the long lines thereby providing little information”

4.4.3.2 Convenience of PMTCT services

The participants were asked to comment on the opening hours and whether there was privacy during the HIV/AIDS counseling and testing sessions. Women mentioned that they found no problem since the services were offered at ANC, the opening hours were sometimes not convenient and there were few health providers to see the many women who clouded at these health units:



“When I went with my husbands, we woke up so early and reached the clinic after 2 hours of traveling only to find that the clinic had not yet opened. We lined up and the only available nurse served me after 4 hours of waiting while my husband was bored and had left me alone and gone to town to check on his friend.”

The feeling was that women were aware of the limited health providers in these health units, who were trying their level best to deliver the services. One participant proclaimed:

“Services are convenient and it also depends on the time you come to the health unit, now it was made easy – ANC services are daily unlike the previous days when it used to be one day a week and there is a lot of confidentiality assured and kept by the health providers.”

Another one added. *“They don’t go around the village telling everyone that you are HIV positive even when you are very sick and they need to visit you at home”*

This was further emphasized by one of the health providers *“Sometimes we find ourselves on duty alone and in the process delay to offer the services and this can chase away patients especially men.”*

However and on contrary, men revealed that the services were not convenient

“It is not convenient because VCT at Kagadi hospital is only on Tuesday and Thursday with very many people so when you test positive they are likely to know from your facial expression. Me, I was escorting a patient and other patients started talking about me that I have HIV.”

“The sick are mixed with those testing for the first time which is not good because when people see you coming from that place they also think you are sick.”

It was revealed that the infrastructure especially the waiting area and counseling rooms were inadequate and thus privacy was not maintained at all times. Further probing also revealed that the opening hours were not convenient for most of the men and most of them would prefer after work hours and weekend.

“The working days are not convenient for some colleagues of ours who work in schools and have to work Monday to Friday and also the fishermen and tree-cutters who are not around most of the time in the weekday. At least Saturday and Sundays would work best.”

4.4.3.3 Attitudes of service providers

The participants were asked to describe the attitudes of health providers at the health units they were seeking PMTCT services. Some of the participants especially women expressed their satisfaction with the attitudes of the health providers,

“The nurses at the ANC are very welcoming and considerate, they take good care of you especially if you are HIV positive, but when it comes to delivery, they can even slap you in the labour ward.... They abuse”.

Some male study participants were not comfortable with opposite sex service providers. They indicated willingness to attend sessions of opposite sex but were not willing to disclose some issues.

“I cannot reveal my other sexual partners to a female nurse”. Another one said “I can’t undress myself in front of a female nurse to check my private part”.

“Men are not comfortable being seen by women much as they try to be friendly.” Added one midwife.

Though it did not come out clearly from females, it was clear that males would prefer being served by fellow men. They seemed to be very uneasy with the so many female dominated PMTCT clinics in the district. It is very necessary for health seekers to confide in the health providers and be treated with respect.

4.4.3.3 Lack of incentives

Three of the four of the key informants expressed the need for government to put in place incentives that could attract more men in PMTCT services. This would be in form of gifts and other recreational facilities as expressed by one of the service providers.

“I wish the government could come up with incentives like mosquito bed nets, purification water jerricans and delivery hampers to give to men when they come to clinic with their spouses, facilitate men’s clubs, and introducing video shows at the clinic as they wait”.

They revealed that promotion of first service priority given to women who come with their partners was not enough and was not fair sometimes for the limited service outlets and the long distance these women would have trekked in the district.

4.4.3.4 Policies and guidelines

Apart from one health unit, all the other had old versions of the guidelines available and seemed to be using them. They knew some basic procedures of PMTCT services: to carry out pre-test and post-test counseling, administering ARVs to mothers and babies, infant feeding options and follow-up infant HIV tests. It also appeared that participants had less information on male involvement. Their opinions are described below:

“I have not seen a copy of these guidelines here and I don’t use it in this clinic, I only use the knowledge that I got from the PMTCT training workshop.”

“We only have an old copy of the guideline, which don’t have any information of male involvement, so what we have applied is what we got from colleagues who work with research projects in other health centers”. Added another health provider

Physical check of these policies, guidelines and job aides revealed that the health providers in these units did not have some of them and even those that did have them, kept them under lock and key and never referred to them. It was also revealed that some recommendations were not appropriate for rural settings like this district. Therefore, it was difficult for health workers to implement some policy guidelines targeting male involvement especially for a free service like PMTCT. Health workers found it difficult to deny services to women who came alone in health units and also had no resources to carry out community outreaches targeting families. In urban areas however, the same guidelines would work well;

“It is very difficult for us to refuse pregnant mothers services when they come alone for ANC, sometimes giving priority to couples is sometimes unfair for women travelling long distances.

“Door-to-door HIV/AIDS counseling and testing is a very good initiative especially in getting more men tested and involved in PMTCT, but we don’t have resources to carry out this in our community”.

4.4.3.5 Infrastructure and staffing

In all the clinics, there was insufficient infrastructure to offer PMTCT services, especially in terms of offering counseling services. Counseling sometimes took place in treatment rooms and cloth-curtained rooms where confidentiality was very limited.

“The staff is not enough, we have only three nurses who can work in the ANC clinic and only two of us have been trained in HIV/AIDS management and one trained in PMTCT. On every Tuesday and Thursday, we have only one staff or two offering both ANC and PMTCT. So this causes delays in service provision and thereby chasing away men”

“The antenatal room used to work well before introducing PMTCT as there little confidentiality to be maintained, but now women, especially when they come with husbands, feel uneasy to open during counseling sessions.”

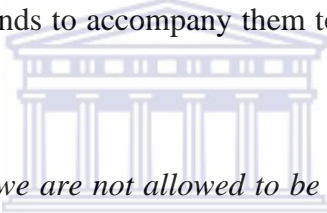
The shortage of staff in health units could also affect PMTCT services. During the research, all clinics had one or two staff members who were carrying out PMTCT services. These health providers were also expected to provide all other out-patient department (OPD) services in the health units. The district PMTCT coordinator revealed that several posts were available but had not been able to fill them because the majority of the health providers did not want to work in rural areas like Kibaale.

4.4.4 Socio-cultural factors

According to Khan (2000), regardless of which health service, there are a number of socio-economic and cultural factors acting as barriers to the utilization of services by men. When asked to give their opinions on the factors that contributed to low male involvement in PMTCT services, participants in both IDIs and FGDs had very interesting reasons.

4.4.4.1 Traditional family norms and taboos

PMTCT being something new among different traditions, there seemed to be little known by participants. However, traditional beliefs in child delivery still hold and required to be followed. Some participants were concerned that the family values were being abused by health providers. Traditionally, mother in-laws were meant to help with deliveries with the help of Traditional Birth Attendants and pregnancy was no man's business. Therefore, it made it difficult for pregnant women to ask their husbands to accompany them to hospital later on to accept an HIV test. One woman said:



“According to our culture, we are not allowed to be the first to propose ideas, you have to wait for the husband to say and you add. So if he doesn't know about PMTCT, its very difficult for me to start taking him that we go for an HIV test or am not going to breastfeed the baby.”

“Traditionally, women are supposed to breastfeed their children up to the age of two and more and sometimes you are told not to breastfeed at all or only for 3 months and stop. So this becomes confusing for women who are forced by their husbands to or not to stop breastfeeding.”

They further explained that men were not questioned by their wives and were therefore free to do whatever they wanted. They felt that if other men saw them escorting their wives, they would think that they were bewitched or were possessed by devils and then they would be rejected by other men.

“Men go for testing in hiding because they are not under anyone’s control.” Another woman added: “mine got tested but did not tell me. I got the information from our neighbor”.

Participants further explained that men who were not legally married and sometimes not staying with their partners found it very difficult to escort those women to the clinic. The situation was even worse when the pregnant woman was a girlfriend of a married man or was an inherited wife.

“I cannot go with my girlfriend to the clinic for an HIV test or even escort her for delivery. What if my wife finds out, then she would divorce me.” Another male added.

“It is very difficult for men to be seen in the company of women they inherited from their late brothers/neighbors or a clan mate. This would automatically mean that the former deceased husband would have died from HIV and you therefore have it”

“Some men have more than one partners, so when it comes to escorting them to the hospital, they fail to choose on who to go with and end up lying to all of them and not going there at all.”

4.4.4.2 Fear of knowing their HIV status

Some participants expressed the problem of finding out that there were HIV positive and living in fear of death. They revealed that most women and men feared to test for HIV as that could lead to family breakages and abandonment of homes.

“Some women fear to test because of their husbands. When they tell their husbands, then their families break. They also throw away the drugs.”

Some of them did not want to be known as people living with HIV/AIDS. They rather preferred keeping their sero-status unknown;

“They are these men who have many wives and girl-friends. They fear testing because they are not sure of who gave them HIV if they find out that they are positive.” (From a midwife at one on the health units).

When people find out that they are HIV positive, they react differently some lose hope in life, others break down and even some commit suicide.

4.4.4.3 Stigma related to HIV/AIDS

Uganda has been known to be in lead in fighting HIV/AIDS and therefore stigma has not been a big problem in most of its communities. However, a lot of stigma is attached to HIV/AIDS in this District. Most participants reported that the community still treated people living with HIV/AIDS unfairly. Most of the times, men blamed women if the couple was found to be HIV-positive.

“Some men test secretly either in different health units to those that their spouses are attending or private clinics and don’t even disclose to their spouses. When they are found to be positive, they even take drugs secretly without their spouses, families and community knowing.”

According to the male participants, PMTCT has received a lot of stigma in the community that men who had been ‘too’ supportive or involved with their wives pregnancy issues were labeled to having HIV/AIDS like one man described below;

“With all the talks going around, when you are seen with your wife going or at the ANC clinic, they automatically conclude that you have HIV, otherwise what would be taking you to the clinic if you are not going to pick AIDS drugs.”

It could be as well concluded that HIV/AIDS stigma was still being seen as a problem in this district and this might have created fears for women and men to access PMTCT services. In an attempt to remain unknown and unnoticed, people refused to get tested for HIV/AIDS at these

health units. In addition to stigma, the issues of disclosure to partners, families and relatives were cited as contributing to low male involvement in PMTCT services.

4.4.4.4 Male health seeking behavior

The culture and practice about male general health seeking behavior especially in other reproductive health services like family planning, ANC, and STDs appeared to be a less significant, though still important, barrier to husbands involvement in PMTCT. Among the participants, male health seeking behavior was a big challenge for some men. One midwife felt that low moral of men seeking other health services was a major obstacle. She explained:

“You see in this area, they are few men who generally come to the hospital and even when they come they don’t adhere very well with the medication. Take an example of child immunization, its only women who bring the children. So, we are struggling with even getting them (men) to come for PMTCT.”

And even some women also acknowledged the difficulty their husbands found in seeking health service, such as this:

“My husband does not like going to the hospital, he fears medication and even when they give it to him, he throws it away. He fears infections so much that if you tell him to go with him to the hospital, he will think of injections that he would rather take local herbs.”

Concerning the male health seeking behavior, Kibaale district was experiencing low male uptake of health services including HIV/AIDS. Majority of the health statistics reported more women accessing services than men of which was an indication that they were few men accessing health services in this district.

4.5. Suggestions for increased male involvement

Participants were requested to suggest ways in which more males could be encouraged and attracted into the PMTCT services. Both key informants and FGD participants gave suggestions

that should be implemented by the government, health providers, health seekers and communities.

4.5.1 Increasing awareness at community level

All the participants in FGDs suggested that there was need to sensitize the community about PMTCT services and its benefits through their community leaders. They expressed their feelings that community leaders (Local Council Chairpersons in villages) were very important people in the community and had a mandate to disseminate this information during the local community meetings. One participant proclaimed:

‘Train local leaders to sensitize their communities so that they can talk about these issues in the meetings, because when they call for meetings, its men who attend mostly and women are sometimes not allowed to attend these village meetings.’

“Through chairpersons, men should be sensitized and get tested there and then. They can be called to come in meeting and when they find they are to be tested, they can’t run away after enough counseling. Yes, it is good to just call them like you are telling them that there is a meeting because if you tell them earlier that you are going to test them, they will not come. Some will even stop on the way.”

There seemed to be a consensus that more awareness was needed to know the importance of PMTCT and also to educate more men and clear the existing misconceptions about PMTCT services. Participants wanted to see more information given in outreach sessions on PMTCT and especially VCT at village meetings, funerals and in public places.

4.5.2 Bring services nearer to the communities

Participants felt that the current four health units offering PMTC services were not enough for the sparsely population, mountainous and forest district. They also felt that overcrowding of mothers and long distances could be contributing a lot in discouraging men from attending PMTCT services with their partners. Community outreach and house-to-house HIV testing should also be included in the programmes since they are the ones where men feel freely to

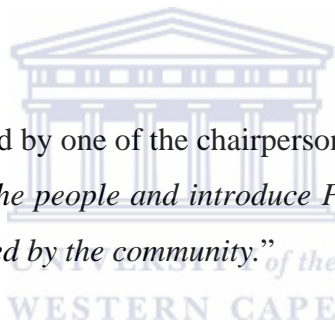
attend. They should be promoted in corroboration with community leaders to ensure sustainability. This could reduce on the costs and time spent by both men and women while seeking PMTCT services.

This was further emphasized by the health providers who expressed the fear that they might be providing sub-standard services because of the huge number they handled. This is in line with the VCT guideline that encouraged community Voluntary Counseling and Testing even in homes.

“We don’t have facilitation to carry our community VCT and PMTCT, like going to communities and hold rally whereby we invite men and women to test for HIV afterwards, following up on women in their homes and helping them to disclose and taking medication”

This was further emphasized by one of the chairperson’s request in the group;

“Bring services nearer to the people and introduce PMTCT services in the lower health units that are easily accessed by the community.”



4.5.3 Compulsory male participation

Nearly all participants and service providers suggested that it should be made compulsory for all pregnant women to be escorted by their partners to ANC during pregnancy in order to get every male involved.

“Set a policy that women who don’t come with their spouses don’t be provided with the services and once they are sent away, they will tell their husbands that they have been denied services because they have not come with them.”

One woman suggested.

“We wish the health workers can give us letters to take to our husbands inviting them to come with us and these can be passed through our chairmen and those who refuse should then be forced by the leaders.”

Most of the service providers were not in agreement with it, though it is being implemented in some of the hospitals outside their district.

4.5.4 Need for the health units to recruit and train male service providers

The male participants suggested that male PMTCT service providers should be recruited to handle men who are not comfortable with female service providers. Apparently, all the PMTCT service providers were females and according to some of the participants, they revealed that they were not able to disclose their sexual relationships and behaviors which was an important intervention. This made men unwilling to take the test because they were sometimes shy. One of the health providers mentioned that;

“All PMTCT services are offered by females here, majority of men don’t feel free with female health providers when discussing safer sex and their sexual activities.”

It was revealed that majority of the ANC service providers has limited skills in handling PMTCT services and were in need of HIV/AIDS management training.

4.6 Conclusion

This chapter covered the results and findings of the study. The next chapter will then present detailed discussions of the research findings comparing them to the already known or unknown findings. It will also cover conclusion and recommendations drawn from the main issues of this study.

Chapter 5: Discussion, Conclusion and Recommendations

5.1. Discussion

5.1.1 Knowledge about HIV/AIDS problems in Kibaale district

This study's main aim was to explore the factors influencing male's involvement in PMTCT services in Kibaale District, Uganda so as to facilitate the process of designing appropriate interventions and measures to attract more men into the PMTCT program. For men to actively and fully participate in PMTCT programme, it was important to find out whether they were fully aware that HIV/AIDS was a real problem in their community.

All the participants both in the FGDs and key informants regarded HIV/AIDS as a problem in their community and the same sentiments were even made by children as well. Some of the problems raised were death, poverty in families, orphans, child-headed homes and poor growth among children. In a review of district reports (HMIS data in DHO's office Kibaale-2007) and other studies carried out in this area, all these issues were evident. The participants were able to reveal that PMTCT services were beneficial and that it was a good practice to seek the services as a couple.

In Uganda, men and women with comprehensive knowledge about HIV/AIDS was 35.8% and 28.3% respectively while knowledge about MTCT was 73.3% among men and 62.5% among women in the age group 15-49 years (UAC, 2008:4). This is in agreement with findings of this study.

5.1.2 Knowledge about MTCT and PMTCT

Participants were also asked on whether they were aware that pregnant mothers could transmit HIV/AIDS to their babies. Being knowledgeable about vertical transmission may influence one's PMTCT seeking behavior, uptake and adherence to counseling guidance especially among men. For the success of the PMTCT prevention strategy, pregnant mothers together with their partners need to be well-versed with this information. Apart from some of the female participants, the study revealed that majority of the male participants lacked basic information on the different modes of MTCT and PMTCT services. These findings are similar to those of Munene &

Gathenya (2004) that was based on mobilizing men's support in PMTCT in Kenya. According to their study that involved 127 participants, both key informants and FGDs had a 66.67% reported low male involvement in PMTCT gave limited knowledge as one of the reasons for such a low male participation/support for the PMTCT in Kenya. Similar findings were also observed in studies in India and Tanzania (Alexandra, Anand, Ambikadevi, Aruna, Prasanna, Jubin, Divya, Padma, Avinash and Shetty, 2006; Burke, Rajabu, Ramadhani, & Burke, 2004). Therefore it is important to provide opportunities for men to also get this information so that they can appropriately support their partners in PMTCT. Women will keep accessing PMTCT services but men will not find a reason to support them.

Lack of or insufficient knowledge about a health service may hinder an individual from taking effective action including participation. One may not expect men to accompany their partners when they are not aware of the programmes. Therefore, the campaigns needed to be conducted in order to create awareness in the entire community and particularly for men.

5.1.3 Reasons for low male involvement in PMTCT

The low male involvement (seeking HIV counseling and testing with partners, supporting drug administration, reinforcing social norms regarding breast feeding and playing an important role in supporting formula feeding if opted) can be attributed to factors such as limited accessibility of PMTCT services, inconveniences involved in seeking the services, poor attitudes of service providers, limited incentives at service outlets, cultural practices and norms, fear of being identified with HIV/AIDS, limited use of PMTCT guidelines and policies, poor clinical infrastructural settings, and stigma associated with HIV/AIDS in the community.

5.1.3.1 Limited accessibility of PMTCT services

Most of the females were aware of the PMTCT services and where to seek them in the district though they revealed that they were not easily accessible and some of the reasons given were; transport costs, time involved and limited service outlets. The advantages of having health services readily accessible include time and cost-saving, and having quality time with service providers thus improving efficiency. A study in South Africa on factors influencing the utilization of PMTCT also revealed that physical access to a health facility was one of the major

factors affecting PMTCT utilization (Peltzer, Skinner, Mfecane, Shisana, Nqeketo & Mosala, 2005:38). There was also evidence to suggest that men were not comfortable with the opening hours due to the nature of their jobs.

It was also revealed that there were other compelling reasons for requiring more service outlets especially for men to take an HIV test and seek PMTCT service in clinics where they were not known and for men with multiple sexual partners to have different options. These results are similar to those from a study in Eastern rural Uganda that showed that availability of VCT services and counseling services were the major barriers of PMTCT implementation and men were less likely to seek these services (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006).

5.1.3.2 Inconveniences involved in seeking PMTCT services

It is important for health providers to get feed back on the services they offer and how they offer them. Addressing the inconvenience patients face as they seek health services can serve as opportunities for improved service delivery and attracting more patients especially men. Participants revealed that one was taking a lot of time at the health units and the waiting areas were too exposed to the public. It was also mentioned that no matter how much confidentiality was assured by the health providers, the infrastructure itself could not permit it. Patients were crowded in the small waiting areas and were therefore able to listen to all counseling sessions in the treatment rooms. The opening hours seemed not feasible to the majority of the men who had the responsibility of taking care of the families and going to work throughout the week.

These findings concur with those found by the study in Uganda assessing the challenges faced by health in implementing PMTCT (Nuwagaba-Biribonwoha, Mayon-White, Okong & Carpenter, 2007:4). In this qualitative study the majority of health units were experiencing staff shortages, increased workloads, shortage of private space for counseling, and little motivation among health workers.

5.1.3.3 Attitudes of service providers

With an already stigmatized disease like HIV/AIDS, a service provider's attitude is most likely to affect the number of return clients on particular services. Regarding the attitude of health

workers, participants seemed to have some reservations on commenting about them and particularly the female participants. Women expressed their satisfaction with most of the service providers in PMTCT. This actually concurred with findings from the South African PMTCT utilization study that revealed that majority of the women were motivated to return to services because of the good attitudes of health providers (Skinner, Mfecane, Henda, Dorkenoo, Davids, Gumede & Shisana, 2003:33).

5.1.3.4 Limited incentives to men at service outlets

Most of the participants and key informants were supportive of the idea of introducing incentives at ANC to attract more males into the clinics. It was noted that even though the priority was given to women who came with their spouses/partners, participants and PMTCT service providers felt it was not enough and were calling for more incentives in order to attract more men. There was also an impression that PMTCT service providers needed some motivation to keep up with the growing numbers of women and their partners in their clinics. Motivating service providers with reduced workloads was also reported in a study in Kenya where women were experiencing limited quality time and sympathy from the service providers during PMTCT service delivery (Painter, Diaby, Matia, Lin, Sibailly, Kouassi, Ekpini, Roels & Wiktor et al, 2004).

5.1.3.5 Cultural practices and norms

Cultural practices and norms also affect men's participation in pregnancy-related activities as perception of male and female roles in different communities differ. Participants acknowledged that these cultural practices existed but had little influences on male involvement in PMTCT services. The challenges cited however, were in circumstance when a man impregnated a relative or clan mate or an inherited wife, he would then not be allowed to claim responsibility and thus not able to escort the pregnant woman for PMTCT services. Traditionally, culture dictates one man one wife unless one is a Moslem, so men who had extra marital relationships found it very difficult to support all the women when it came to seeking HIV-related services like PMTCT.

Adhering to some of the infant breast feeding options were also seen to be difficult especially for men to accept and then permit their wives not to breast feed in a cultural manner. Gupta's (2000)

MTCT study revealed that encouraging women not to breast feed their infants presented obstacles because some cultures treated women who do not breast feed as bad mothers. Limited couple communications and inability to openly communicating about sexual matters was common among couples in this region and this also hindered PMTCT services. This scenario was also found to be true in a family planning study in Nepal (Sharan & Valente, 2002).

5.1.3.6 Fear of an HIV test positive outcome

Fear for both men and women to take an HIV/AIDS test during pregnancy appeared to be a significant barrier to the realization of supportive behaviors played by spouses and the community. People could not stand the pain and suffering one undergoes once found to be HIV positive, which include among others, divorce, suicide and family and community neglect. However, some participants also revealed that it was important for one to find out his/her HIV status and if sick, to start on ARVs that had proved to improve the lives of many patients. This outcome was in agreement with the situation analysis of PMTCT services in Cape Town that revealed that men blamed women if the couple was found to be positive and also women fearing to be tested and refused to disclose their statuses to their spouses (Skinner, Mfecane, Henda, Dorkenoo, Davids, Gumede & Shisana, 2003:24). Hence this therefore calls for measures to promote positive living and improving the lives of people living with HIV/AIDS through universal access to ARVs, income generating activities and extending hospice services in the community.

5.1.3.7 Limited use of PMTCT policies and guidelines

Male involvement in PMTCT services in Uganda is in its earliest stages and therefore, there are limited guidelines and policies regarding male involvement. However, it was evident that majority of the services providers did not have them or even use them as confirmed by the physical checks. The process of staff rotation in the ANC clinic implied that some untrained staff offered PMTCT and required using these guidelines as they provided the service.

PMTCT development partners and the PMTCT district focal person needed to ensure that health providers were trained in order to improve the quality of services provided particularly

orientation on policy and focus on new effective methods of service delivery. PMTCT policies and guidelines on male involvement also need to be clearly defined for health providers.

Similar policy-related findings were also revealed in a qualitative study on barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal (Britta, 2006). The study revealed that policy maker's bias has been a major barrier in including men in reproductive health services.

5.1.3.8 Poor infrastructural settings

Major concerns of the participants were that the PMTCT service outlets were in bad states regarding privacy as counseling and waiting spaces were not adequate. The limited financial and infrastructural resources in the health service outlets meant that they were unable to provide extra services targeting males in PMTCT. However, this was not something new about health service delivery in resource-limited countries like Uganda. Similar findings were revealed by a study evaluating challenges faced by health workers in five hospitals implementing PMTCT programmes in Uganda in 2003 (Nuwagaba-Biribonwoha, Mayon-White, Okong & Carpenter, 2007). In their study, all the five hospitals reported shortage of key PMTCT staff (counselors, midwives and laboratory personnel) and space shortages with limited privacy. There is therefore a carefully great need to integrate HIV/AIDS services with reproductive health services. Under this approach, ANC would be allocated more space and HIV counseling and testing then routinely offered to both men and women seeking antenatal care.

5.1.3.9 Stigma associated with HIV/AIDS in the community

Most of the participants expressed the fear of being stigmatized by their families and communities. They mentioned possibilities of being isolated, insulted and excluded from family and community events if they were found to be HIV positive. Men and women expressed the fears that their partners or families would not support them in case they were HIV positive. Despite that fact that Uganda has been successful in its HIV prevention programme in the Sub-Saharan Africa, stigma still affects HIV testing and seeking care for the infected persons (Ministry of Health ART Performance Report, 2000).

The participants also indicated that the majority of people living with HIV/AIDS were being discriminated against in the community. Therefore, community awareness and education campaigns were essential towards the success of male involvement in PMTCT. These would enforce the role men play in PMTCT because they influence their partner's health seeking behavior. Public information campaigns, community out-reach and health interventions have been able to avert the stigma that used to exist with family planning in the 1980s (Bessinger & Bertrand, 2001:69).

MCH and RH share common target clients, an attempt to offer these services together with HIV/AIDS care would expand opportunities for accessing HIV/AIDS services; increase efficiency and cost effectiveness of programs thus addressing health care workers shortages. Integration would imply taking every opportunity while seeing MCH and RH clients to offer them HIV counseling and testing. This integration can lead to reduction of stigma associated with stand-alone services like PMTCT. Integrated services have been found to promote male participation and increase opportunities for sexual communication between partners. A study in South African revealed that vertical programs rarely encourage men and women access health care together or in the same place (Immo, Audrey, Natashia, MacPhail, & Rees, 2007).

5.2 Conclusion

Although all participants were knowledgeable about HIV and its impact and women were knowledgeable about PMTCT, most men did not believe that mothers could infect their babies before and after birth.. There were quite a number of barriers to male involvement in PMTCT services raised by participants. Some of the barriers mentioned were: limited accessibility of PMTCT services, inconveniences involved in seeking the services, female gender of service providers, limited incentives at service outlets, cultural practices and norms, fear of being identified with HIV/AIDS, limited use of PMTCT guidelines and policies, poor clinical infrastructural settings, and stigma associated with HIV/AIDS in the community.

Given the fact that PMTCT is already stigmatized in the community and there are few men generally seeking care in health units, interventions need to concentrate more on a behavioral change. Stigma and fear of HIV testing seemed to be the most reported barriers by almost all the participants and this can be best addressed through engagement with community leaders and community workshops focusing on changing the current behavior of men and their support towards PMTCT, Maternal and Child Health as well as Reproductive Health in general.

5.3 Recommendations

The following recommendations can be made based on the findings drawn from this study:

- Since most participants were highly in agreement with more sensitization, the undertaking of a wider community education so that more men can be persuaded to participate in their partners' maternity care and accessing PMTCT services needs to be considered. In addition, IEC materials seemed to be inadequate especially around male involvement and these need to be widely circulated in health units and communities.
- Addressing infrastructural health service issues and the timing of services to facilitate the involvement of working men may be vital. Allocating more convenient space to ANC and early or evening service delivery could attract more males in the health units.

- Training more health providers to serve couples, conduct couples counseling and provide male-friendly PMTCT services may also be necessary. If service providers and the community are not well-informed about PMTCT or equipped with skills to work with communities, they may not be able to adequately and correctly support clients especially men.
- Integrating other reproductive health services such as STI, child immunization, family planning, voluntary counseling and testing, and prevention of mother-to-child transmission with antenatal and postnatal care for men to participate actively in PMTCT may be of necessity. Currently, PMTCT is treated like a vertical program and needs not to stand alone, it needs to be integrated. This could also further be addressed by encouraging partnership and coordination of different implementing players in HIV/AIDS service provision in the district. It may also greatly reduce the stigma of stand alone PMTCT attendance.
- To further destigmatize the community, encourage supportive structures at facility and community levels. Men's post-test clubs, positive living clubs and breastfeeding mother's clubs can help in counseling, care and support. This can also encourage behaviors among men and women that can support and protect their children from HIV/AIDS.
- Involve men and the community in policy development stages. Currently, the majority of the policy recommendations are aimed at encouraging more women to access PMTCT service while men are left out. Communities are sometimes not involved and consulted when new programmes are being introduced and this often presents some rigidity and sometimes resistance in their uptake.
- Encourage more open discussions about sexual matters in communities and families. Currently, sex education is still limited in schools and families and seems to be hindering talks about HIV/AIDS and PMTCT even among married couples. Traditional and cultural leaders need to be involved and educated about man's role, HIV/AIDS and PMTCT. In addition to this, cultural norms about breast feeding need to be addressed too. Men and

women need to be encouraged to talk, especially sexual matters like condom use and family planning.

- Introduce community-based PMTCT services which may include door to door HIV testing and community education. It is important for families and communities to understand the different components and services of PMTCT so that they are able to support men and women. Myths and misconceptions around PMTCT need to be openly addressed at both family and community levels.



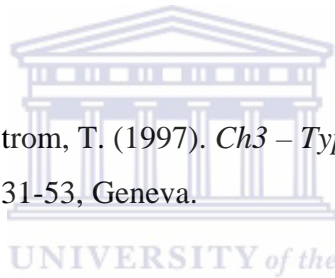
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APPENDIX I: IN DEPTH INTERVIEW GUIDE FOR ANC SERVICE PROVIDERS

1. What is your designation; how long you have worked in this facility?
2. Do you carry out PMTCT services in this health unit?
3. Are all services on the PMTCT package free?
4. Do you know if there is any policies on PMTCT?
5. Do women attend ANC? What stage of their pregnancy do most of them come in?
6. Do the husbands come with there wives for ANC?
7. What do you think are the main reasons for men not coming with their wives?
8. What measure can you put in place to attract men in PMTCT?
9. What do you do if a couple attends ANC; any incentives in place to encourage them come back or others to come with their spouses?
10. In your own thinking, could it be possible that the services or health workers here may be a reason for poor PMTCT service and male involvement?
11. Can you please tell me your working hours?
12. How many staff are on duty each day?

APPENDIX II: FOCUS GROUP DISCUSSIONS GUIDE FOR IN THE VILLAGE

Focus group Discussion

Introductory steps

Topic/Step	Comments/Action points
Introduction	<ul style="list-style-type: none">• Facilitator introduces self, the participants and the research topic• Explain how long the session is expected to run
Focus group/Key informant objectives	<ul style="list-style-type: none">• Explain briefly the objectives of the discussion
Participants Consent	<ul style="list-style-type: none">• Read the consent statement to participants and Proceed with the questions

1. **HIV/AIDS problem**

- How is HIV/AIDS transmitted in children?
- Do you think there is an HIV/AIDS problem in children in your community? If yes to what extent?

2. **Knowledge about PMTCT:**

- Do you think a mother who is HIV positive can transmit the AIDS virus to her child? If yes how?
- Have you heard about the government's programs for Prevention of Mother to Child Transmission of HIV?
- Are these services offered at Kibale/Kagadi/Kakindo/Kakumiro health centre?
- Can you describe what is involved in PMTCT services?
- Do you think that all HIV positive pregnant women should be tested for HIV and if positive offered that drug?
- Do you think that the drugs given are effective?
- Would you encourage your partner to access ARVs if he/she was found HIV positive?

- What are the ways you think men should support their partners in to prevent passing HIV to their infants?
 - *For men only:* Would you participate in the program if you partner was invited you to escort her to the clinic? If no why
 - *For women only:* Would you feel comfortable if your partner escorted you to the clinic? If no why
 - What are some reasons people would give for not wanting to participate in the PMTCT program?
3. Social-cultural factors influencing men:
- a. Should women be tested without the knowledge of their husband? If no why?
 - b. What seems to prohibit men from getting involved in PMTCT (probe for granting permission to women to test for HIV, accompanying females, taboos, use of condoms,
 - c. who should get PMCT information first
 - d. who are PMTCT services are meant for?
 - e. Is it a taboo for women or men to test for HIV in this area?
4. Programmatic factors influencing men in PMTCT services:
- a. Do you think PMTCT service is a good service? (i.e screening pregnant women and giving them ARVs, advising on the options of infant feeding).
 - b. *For men only;* Do you feel comfortable attending ANC sessions with your spouses at the health facility? If not why? (Probe for privacy, opening hours and service providers)
 - c. Do you find attending PMTCT services at Kibale/Kagadi/Kakindo/Kakumiro Health Centre convenient to you (probe for; opening days, confidentiality, distance from home, likeness to be attended to by opposite sex, willingness of services provides to attend to men)
5. Level of involvement:
- a. *For women only:* When you go for ANC, do get counseled and then tested for HIV? If no why?

- b. *For women only*: Do you discuss the counseling and HIV testing with your partners? If yes what do you discuss?
 - c. *For men only*: If you partner tested positive for HIV, would be willing to support her? If yes how?
6. Suggestions for improvement/Recommendations

What do you think should be done to get more men involved in PMTCT?

Solicit for any other additional action points in addressing male involvement in PMTCT.

Thank you for your time



List of participants for Focus Group Discussion

The male involvement in PMTCT study and its objectives have been explained to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this assessment and understand that I have the right to withdraw from the discussion at any time without in any way affecting my seeking of medical care at this facility. This research project involves making audio recording to help not miss out any of the information you provide and will be kept under lock after analysis. [

	Study ID	Age (yrs)	Sex	Marital status	Religion	Education Level	Occupation
1							
2							
3							
4							
5							
6							
7							
8							

 Moderator's name Signature of Moderator Note Taker's name Signature of Note taker

 Date

 Place

Appendix III



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail:

INFORMATION SHEET **FOCUS GROUP PARTICIPATION**

Project Title: A qualitative study to explore the factors influencing male's involvement in PMTCT services in a Western Region of Uganda

What is this study about?

This is a research project being conducted by Prosper Behumbiize from the University of the Western Cape. We are inviting you to participate in this research project because you live in this village and you are one of the families that have had a child in 2008. The purpose of this research project is to explore factors influencing male involvement in antenatal health services in Kibale district.

What will I be asked to do if I agree to participate?

You will be asked to participate and share your experiences in a group discussion. You will also be tape-recorded so that we do not miss all the relevant information you share. The discussions will take about 1-2 hours with short breaks in between. You are free to accept to participate or decline from participating. If you agree to participate, you can also withdraw anytime in the course of the discussions. If you refuse to participate or withdraw, you will continue to receive the care you normally receive from the health unit without any problems.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, all interview notes and audio recording will be kept locked after analysis and will only be accessed by the researcher. No names will be used in the final research report.

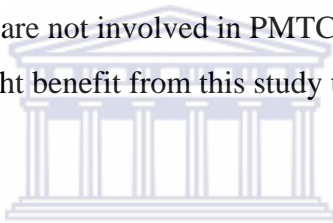
If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no known risks associated with participating in this research project. Participation will not mean you are HIV positive.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about reasons why men are not involved in PMTCT service in the district. We hope that, in the future, other people might benefit from this study through improved understanding of male involvement in PMTCT.



Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

There are no immediate advantages or benefits to you personally if you participate in this study. But other families with similar problems might benefit in future as a result of what you will share. Sometimes people feel relieved when they share their concerns. If this happens to you, it might be of benefit. Since sharing information that is private and talking about health workers and services runs a risk of feeling guilty once other people access the information, in this study all the information will be kept confidential. No names will be used during the focus group discussion.

What if I have questions?

This research is being conducted by Prosper Behumbiize from Department of Community Health at the University of the Western Cape. If you have any questions about the research study itself, please contact Prosper Behumbiize at 0772 762707 or email ptb3000@gmail.com.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Professor David Sanders

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535

Telephone #: +27-21-959-2809

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



Appendix IV



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

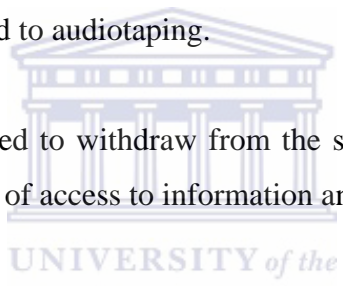
Tel: +27 21-959, Fax: 27 21-959

E-mail:

CONSENT FORM FOR FOCUS GROUP PARTICIPATION

I have been told of this study and I understand the objectives of the study as the eventual improvement in the health of our people. I also understand that participation in this study is by choice, without coercion and agreed to audiotaping.

I have understood that I am allowed to withdraw from the study at anytime I fell like and my withdrawal will not affect my right of access to information and health services in the district.



I also understand that I should keep information discussed in this focus group confidential and that I should not share it outside of this group so as to respect the privacy of my fellow focus group participants.

.....
Witness's signature (Research Assistant)

.....
Participant's signature/thumbprint

Researcher.....

Date.....

Appendix V



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail:

INFORMATION SHEET **IN-DEPTH INTERVIEWS**

Project Title: A qualitative study to explore the factors influencing male's involvement in PMTCT services in a Western Region of Uganda

What is this study about?

This is a research project being conducted by Prosper Behumbiize from the University of the Western Cape. We are inviting you to participate in this research project because you live in this village and you are one of the families that have had a child in 2008. The purpose of this research project is to explore factors influencing male involvement in antenatal health services in Kibale district.

What will I be asked to do if I agree to participate?

You will be asked to participate and share your knowledge and experiences in an interview. Notes will be taken during the interview so that we do not miss all the relevant information you share. The discussions will take about 1 hour. You are free to accept to participate or decline from participating. If you agree to participate, you can also withdraw anytime in the course of the discussions. If you refuse to participate or withdraw, you will continue to receive the care you normally receive from the health unit without any problems.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, all interview notes will be kept locked after analysis and will only be accessed by the researcher. No names will be used in the final research report.

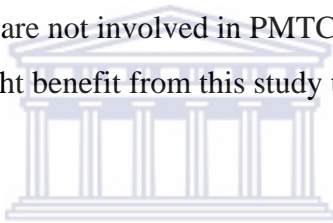
If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no known risks associated with participating in this research project. Participation will not mean you are HIV positive.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about reasons why men are not involved in PMTCT service in the district. We hope that, in the future, other people might benefit from this study through improved understanding of male involvement in PMTCT.



Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

There are no immediate advantages or benefits to you personally if you participate in this study. But other families with similar problems might benefit in future as a result of what you will share. Sometimes people feel relieved when they share their concerns. If this happens to you, it might be of benefit.

What if I have questions?

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Appendix VI



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail:

CONSENT FORM FOR IN-DEPTH INTERVIEWS

I have been told of this study and I understand the objectives of the study as the eventual improvement in the health of our people. I also understand that participation in this study is by choice, without coercion and agreed to audiotaping.

I have understood that I am allowed to withdraw from the study at anytime I fell like and my withdrawal will not affect my right of access to information and health services in the district.

.....
Witness's signature (Research Assistant)

.....
Participant's signature/thumbprint

Researcher.....

Date.....

APPENDIX VI: Permission to Carry out Research for (Ministry of health, Stakeholder and ANC clinics)

Behumbiize Prosper

CDC-Uganda

P.O. Box 22616

Kampala

Uganda

To:

.....

.....

Dear Sir/Madam,

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY

IN KIBALE DISTRICT

I am a Master Degree student in my final MPH year at the University of the Western Cape, South Africa. As a requirement for the study, I am expected to carry out research study and I have chosen exploring the factors influencing male involvement in PMTCT services to gain an insight of the low uptake of PMTCT in Western Region of Uganda. My target population will be partners of women seeking visiting ANC clinic in the region.

Since I am dealing with a sensitive topic – HIV, confidentiality will be highly ensured and will I share with you the outcomes and recommendations to inform your policy and guidelines. I humbly request your office to grant me permission to conduct the study. Attached is a copy of the research proposal, which has been approved by the Research Committee at the University of the Western Cape.

Your kind response will be highly appreciated.

Yours sincerely

.....

Behumbiize Prosper

APPENDIX VIII: Participant Invitation letter

Behumbiize Prosper

CDC-Uganda

P.O. Box 22616

Kampala

Uganda

To:

.....
.....
.....

Dear Sir/Madam,

RE: AN INVITATION TO PARTICIPATE IN A RESEARCH STUDY IN KIBALE DISTRICT

My name is Behumbiize Prosper. I am a Masters of Public Health in the University of Western Cape, School of Public Health, I am conducting a research study as part of the requirements of my Masters Degree in Public Health and I would like to invite you to participate in a Focus Group Discussion.

I am studying factors influencing low male involvement in PMTCT services in Kibaale District. If you decide to participate, you will be asked to participate in a group discussion about male involvement in PMTCT services. In particular, you will be asked questions about reason for low male involvement in PMTCT services n Kibaale District. The meeting will take place at starting at 10:00PM and should last about one hour.

Participation is confidential. Study information will be kept in a secure location at the University of South Carolina. The results of the study may be published or presented at professional eetings, but your identity will not be revealed. So, please do not write your name or other identifying

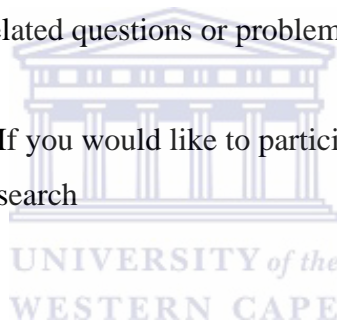
information on any of the study materials. Others in the group will hear what you say, and it is possible that they could tell someone else. Because we will be talking in a group, we cannot promise that what you say will remain completely private, but we will ask that you and all other group members respect the privacy of everyone in the group.

You will receive 15,000/= to reimburse you for your time and travel expenses (Transport and lunch). Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering. Participation, non-participation or withdrawal will not affect your seeking of health services.

We will be happy to answer any questions you have about the study. You may contact me at (0772 762707) if you have study related questions or problems. I

Thank you for your consideration. If you would like to participate, please inform your Local leader who will then inform the research

With kind regards,



Behumbiize Prosper

Box 22616, Kampala C/O School of Public Health, UWC

0772 762 707