

EXPLORATION AND DESCRIPTION OF BARRIERS TO MALE PARTICIPATION IN ANTENATAL AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT) SERVICES IN MUMBWA DISTRICT, IN ZAMBIA.

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A mini-thesis submitted in partial fulfillment of the requirements for the Master's degree in Public Health (MPH) at the School of Public Health, University of the Western Cape, South Africa.

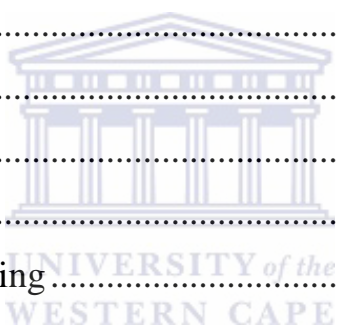
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KEY WORDS

Human immune deficiency virus

Acquired immune deficiency syndrome

Men's participation

Antenatal

Mother-to-child transmission

Prevention of mother to child transmission

Mumbwa district



ACRONYMS

AIC - AIDS information centre

AIDS – Acquired immune deficiency syndrome

ANC – Antenatal care or Antenatal clinic

ARVs – Anti-retroviral drugs

ART – Anti-retroviral treatment

CCT - Couple Counselling and Testing

CT – Counselling and Testing

CVCT – Couple Voluntary Counselling and Testing

CMMB – Catholic Medical Mission Board

DHMO – District Health Medical Officer

DHS – Demographic and Health Survey

DMO – Mumbwa District Office

DNA – Deoxyribonucleic acid

EGPAF – Elizabeth Glaser Paediatric AIDS Foundation

FGDs – Focus Group Discussions

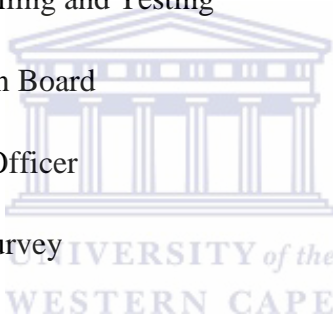
GBV – Gender Based Violence

GMAs - Game Management Areas

HCT – HIV counselling and testing

HDEC - Higher Degrees Ethics Committee

HIV – Human immune deficiency virus



IDI – In-depth interviews

IVCT – Individual Voluntary Counselling and Testing

KAP – Knowledge Attitude and Practices

LQAS - Lot Quality Assurance Sampling

MCH – Maternal and Child Health

MPH – Masters in Public Health

MTA – Men Taking Action

MTCT – Mother-to-child transmission of HIV

MoH – Ministry of Health

NAC – National AIDS Council

NDP – National Development Plan

NVP – Nevirapine

PEPFAR – President’s Emergency Plan for AIDS Relief

PMTCT – Prevention of mother-to-child transmission of HIV

RTIs - Reproductive Tract Infections

SF - Study short form

SMAG - Safe Motherhood Action Group

STIs – Sexually Transmitted Infections

TASO - The AIDS Support Organisation

UNAIDS - A Joint United Nations Programme on HIV/AIDS

UNFPA – United Nations Population Fund



UNICEF – The United Nations Children’s Fund

UNGASS - United Nations General Assembly Special Session for HIV and AIDS

UNZAREC - University of Zambia Research Ethics Committee

USAID - United States of America for International Development

UWC - University of the Western Cape

VCT – Voluntary Counselling and Testing

WHO - World Health Organisation

ZDHS – Zambia Demographic and Health Survey

ZEUHRP - Zambia Emory University HIV Research Project

ZNSF - Zambia National Strategic Framework

ZSBS - Zambia Sexual Behaviour Survey



ABSTRACT

The reproductive health of women is hugely dependent on the involvement of their male partners. Men also serve as gatekeepers to women's access to reproductive health services. Male involvement is an important recommendation for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) program as their participation in antenatal care and HIV testing has been found to decrease infant HIV infection and increase HIV free survival. Male involvement is not just about promoting men to accompany their partners to antenatal clinic, but for men to provide supportive roles in their families, and also to bring men into HIV preventive and care services. Male involvement in PMTCT is defined as the fathers' active involvement in attending antenatal care services and HIV testing during the antenatal period as well as the couple's acceptance of PMTCT if the mother is found to be HIV positive. Men are traditionally not directly involved in their partner's health in many sub-Saharan countries, although they most often make decisions about use of services. They may provide financial support but attending health services with their partner is not seen as part of the male's role. There are therefore huge challenges in efforts to get men involved in reproductive health services and there is a need to better understand how to promote male involvement in different settings. Male involvement in PMTCT was adopted by the Zambian Government in 1999 but not much is known on how best to initiate and develop male involvement in their partner's health.

This mini-thesis presents a qualitative study which was done in Mumbwa District at Nangoma Hospital and its catchment area after the introduction of a male involvement programme. The study aim was to explore and describe the attitudes, perceptions, knowledge and barriers to men's participation in antenatal care and PMTCT services. Eighteen semi-structured in depth interviews were conducted with eight women, six men and four health care workers. In addition two Focus Group Discussions (FGDs) were held, one with men (10 participants) and another with women (10 participants). The interviews were recorded, transcribed verbatim and translated into English for analysis. The thematic framework was used to analyse the data.

The study found that most participants (men and women) demonstrated a lack of adequate knowledge of activities that happen at antenatal care clinics. All participants perceived involvement in health care as not part of male roles. Participants reported that it was not culturally acceptable for men to attend maternal health care with women. Most participants stated that health system factors such as long waiting time impacted negatively on men's participation. Nearly all participants cited coercion by health workers to get male partners to become involved in antenatal care; this practice and its potential serious health consequences have not been documented before in the literature. It was learnt that community leaders were not involved in health care programmes aimed at involving men in antenatal care.

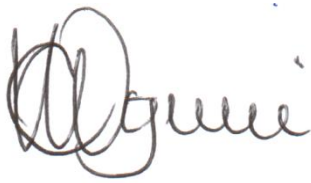
In order to change the cultural beliefs and mind sets of men towards getting involved in women's health issues; awareness on the importance of men participating in antenatal care and PMTCT services should involve community leaders who are the custodians of culture. It is important that health workers work with community leaders such as the chiefs, headmen, politicians and the clergy in disseminating information in the community that target traditional norms. The community should develop strategies to encourage men to attend antenatal clinics with their wives such as using them as models during the awareness campaign. In addition more people should be trained as community health workers to provide PMTCT messages and services in all the zones in Mumbwa district.

The government and policy makers have passed a law that male involvement should increase but it has not provided the strategies and the support to the health workers at the clinic level. Policy makers have an important role in assisting the success of this initiative and not expecting that it will just happen and get implemented.

DECLARATION

I declare that the work done in this research is my own work. This has not been submitted before to any University for any degree or examination and all the references made have been acknowledged as a complete reference.

Catherine M. Nguni.



Signed: -----



DEDICATION

To my children; Tiza, Skinner (jr), Taonga and my granddaughter Angel. During my studies, I have been very busy with my school work as well as my job, that I paid little attention to your needs. I dedicate this work to you for you are my dearest partakers. I therefore beseech each one of you to be inspired in your ambitions by this - my achievement.

To my dear late husband, Brigadier General Skinner Nguni, for the support and encouragement that you rendered to me ever since I started my studies up to the time I started collecting and analyzing data, when things got tough at the point of wanting to give up, you strengthened me and motivated me to go ahead and finish this work. For your sake honey, I had to work hard and finish this work. I appreciate every support that you gave me. I honour you my dear husband, may Your Precious Soul Rest in Eternal Peace, in Jesus Mighty Name. AMEN.

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Management and staff of Mumbwa District Office and Mumbwa community for having allowed me to do my research in Mumbwa. This fulfilled my research interests and I hope the work contained herein will in some way contribute to the better performance of the community members as well as their leaders in health projects.

All the respondents during my fieldwork for their contribution. It is upon these perceptions that I have based my results for this thesis and that is what makes the work original.

‘God richly bless you all!!!’

CHAPTER 1: INTRODUCTION

1.1 Background Information

1.1.1 Burden of HIV/AIDS

Although there have been real gains in the fight against HIV and AIDS in the last decade, the HIV epidemic is globally still one of the major public health problems. The UNAIDS 2010 report estimates that, globally, the rate of new infections dropped by 19%, and that 33 countries out of which 22 are in sub-Saharan Africa declined in HIV incidence by more than 25% between 2001 and 2009. Within the same period, there was a decrease in the number of children who acquired HIV from their mothers during perinatal and breastfeeding periods; from 500 000 in 2001 to 370 000 in 2009 (*UNAIDS*, 2010). The report also reveals that, of the 33.3 million people living with HIV globally, an estimated 23.5 million people are in sub-Saharan Africa, representing 69% of the global HIV burden, and 60% of people living with HIV in sub-Saharan Africa are women and girls (*UNAIDS*, 2010). About 90% of the mother-to-child transmission (MTCT) of HIV infection occurred in Africa (*WHO*, 2010) and a decline in transmission has also been reported by UNAIDS (2011), with new HIV infections in children 43% lower than in 2003, and 24% lower than in 2009. This is evidence that elimination of new infections in children is possible if PMTCT interventions are scaled up and women and their partners are motivated to access them (UNAIDS, 2011). This decline in infections among babies is indicating that this can even get better if male involvement in reproductive health including antenatal and PMTCT is improved.

With Zambia's population at 13 million and HIV prevalence rate at 14.3%, over 1.1 million people are living with HIV in Zambia (*ZDHS*, 2007; *CSO*, 2010). The national prevalence rate of HIV among pregnant women attending antenatal care (ANC) is about 16.4% in Zambia and it is estimated that, approximately 80,000 infants born annually are at risk of acquiring HIV from their mothers (*ZDHS*, 2007; *CSO*, 2010). The risk of mother-to-child transmission of HIV (MTCT) could be greatly reduced if all pregnant women with the support of their partners could start receiving antenatal care at the earliest possible time of their pregnancy, accept to test for HIV, and get enrolled into PMTCT if found HIV positive.

1.1.2 Challenges to Increasing Uptake of PMTCT Services

In high income countries, MTCT has been virtually eliminated because of availability of effective voluntary testing and counselling, increased access to antiretroviral therapy, safe delivery practices and safe use of breast-milk substitutes (*EGPAF, 2010; USAID, 2010*). If these interventions were used worldwide, they could save the lives of thousands of children each year especially in sub-Saharan Africa. As part of the strategy for virtual elimination of paediatric HIV in Zambia, the Ministry of Health has embarked on an ambitious plan to scale-up Prevention of mother-to-child transmission of HIV (PMTCT) services using different strategies such as encouraging pregnant women to start attending antenatal clinics early (at 12-14 weeks), providing counselling and HIV testing in maternal and child health (MCH) clinic, and promoting male involvement/participation in antenatal and PMTCT programmes (*MoH, 2010; Zambia Country Report, 2010; ZNSF, 2002-2010*).

The gender inequalities and the power that men have over women play a key role in deterring women from attending antenatal care in addition to societal stigma related to HIV and AIDS. For example, the 2005 Zambia Sexual Behaviour Survey (ZSBS) revealed that 75% of pregnant women attending ANC who accept HIV testing and counselling did not share their results with their spouses and nearly 90% of women who agree to be tested will not share their results if positive or accept to enrol in PMTCT because such a result or decision can lead to violent consequences and or divorce, and they may be shunned by family and community (*ZSBS, 2005*). This study also shows how unequal gender relations inhibit HIV testing and seeking care.

Involving men is not just inviting them to come to the clinic and having an HIV test done, it is more of engaging with them about their gendered behaviour. The primary reasons men are not involved in women's health is not merely health system issues, but rather issues located in the social world of people such as culture and the traditional role of men and women in childbirth and women's health (*Aarnio, Olsson, Chimbiri and Kulmala, 2009; Tonwe-Gold et al., 2009*). It is overcoming these barriers that will ensure men attend health services.

1.1.3 What is male involvement?

More women can attend antenatal care services and accept to test and enrol into PMTCT if their husbands approve and support them. Studies have shown that lack of male partner involvement is one of the major factors that are responsible for poor uptake of PMTCT services (Aluisio *et al.*, 2011).

Male involvement is an important recommendation in reproductive health and it may vary depending on the settings. For most, male involvement includes men supporting choices and rights of their female partners, or men doing something about their own reproductive and sexual behaviours as a way of protecting their partners such as the use of condoms (Lee, 1999). In PMTCT, male involvement refers to when pregnant women attend antenatal with their partners; and they are tested and counselled as a couple. Male involvement is measured by the number of “pregnant” couples undertaking the HIV test and received results.



1.1.4 Why involve men in antenatal and PMTCT services?

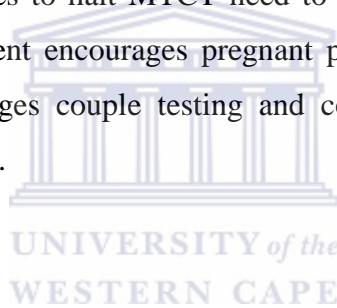
In 2007, the Catholic Medical Mission Board (CMMB) conducted a baseline survey to measure the utilisation of PMTCT services in selected Mission Hospitals in the nine provinces of Zambia, and the results were that 60% of pregnant women who attended antenatal clinics accepted to test for HIV and 70% of those who tested HIV positive accepted to take ARVs for PMTCT, while infant ARV uptake was at 60%. The survey also discovered that only 3% were tested and counselled as ‘pregnant’ couples (Sinkala, 2011). Infant ARV uptake is unacceptably low and also male involvement in antenatal care is dismally low. Male involvement in antenatal voluntary counselling and testing (VCT) has been associated with increased use of antiretroviral prophylaxis in their HIV-infected pregnant partners (Orne-Gliemann *et al.*, 2008; Pulitzer, Jones, Weiss and Shikwane, 2011).

In many societies men traditionally are not expected to perform the role of supporting women in antenatal care and other women health issues. This can possibly be the main barrier to male involvement because most people want to live by their culture. However, research in many African settings have shown that male involvement promotes women’s use of health services

(Byamugisha, Tumwine, Semiyaga and Tylleskar, 2010; Morfaw *et al.*, 2013) and it can improve uptake of antenatal care and of PMTCT interventions (Byamugisha, Tumwine, Semiyaga and Tylleskar, 2010; Morfaw *et al.*, 2013).

1.1.5 Why is male involvement critical for prevention of mother-to-child transmission of HIV (PMTCT)

Ninety percent of children who live with the HIV virus were infected through MTCT (*UNAIDS*, 2010). In 2009, UNAIDS called on the virtual elimination of mother-to-child transmission of HIV by 2015. Though HIV transmission to infants has drastically reduced, in order to attain UNAIDS vision of; zero new infections; zero discrimination and zero AIDS related deaths (the three zeros), strategies and services to halt MTCT need to be scaled up and uptake improved (*UNAIDS*, 2010). Male Involvement encourages pregnant partners to attend antenatal and get tested for HIV and also encourages couple testing and counselling and improve uptake of PMTCT (Byamugisha *et al.*, 2010).



1.1.6 Statement of the problem

The World Health Organization (WHO) PMTCT Strategic Vision 2010–2015, released in 2010 strongly recommends “increasing the involvement of male partners in PMTCT services (e.g. couples counselling, partner testing) as part of the strategy towards virtual elimination of paediatric HIV (*WHO*, 2010). However, it is a challenge to mobilize and get men meaningfully involved in antenatal care (ANC) and ultimately PMTCT services in low resource settings.

Male involvement provides an opportunity to couples testing and counselling. Disclosure to partner may not yield violence, a man may care for his partner if she tests positive and may support and encourage adherence to antiretroviral treatment (ART). The initiative of male involvement can contribute to the attainment of the WHO global targets on reduction of new infections among children, reduction in maternal deaths, and in under-five deaths due to HIV. In 2009, an estimated 23, 400 children were newly infected with HIV in Zambia (UNAIDS, 2012). It is indicated by UNAIDS, 2012 that if interventions are scaled up and Global Plan targets achieved, new child infections would reduce to 4, 400, an 81% decline in the number of new child infections from 2009. Making men meaningfully and adequately involved in antenatal care and PMTCT services can contribute significantly to the elimination of new HIV infections. However, since this is a new development in ANC and men traditionally are not part of ANC in the Mumbwa district, central of Zambia, it is important to understand what the barriers are to male involvement to assist in the development of responses to male participation in antenatal and PMTCT.

Decreasing HIV infections in children is a goal for the Zambian Government. The author worked in Mumbwa district where programs to promote male involvement in ANC were initiated. It was however considered important to understand barriers and facilitators to male involvement in PMTCT as these may inform services that can be developed for the program. A previous study in Zambia to evaluate Men Taking Action (MTA) program after three years of its implementation, showed increase in couple counselling from a baseline of 3% to 60% which is evidence that male involvement can work successfully in Zambia. This project was however only for couple counselling after HIV testing and did not include male involvement in PMTCT.

1.2 Study Aim

The aim of the study was to explore and describe barriers to male involvement in antenatal and PMTCT programmes in Mumbwa District, Lusaka, in order to increase uptake and participation of male partners/spouses to pregnant women with regard to ANC and PMTCT services.

1.3 Objectives

To explore barriers to male involvement in ANC and PMTCT services as reported by men

To explore barriers to male involvement in ANC and PMTCT services as reported by pregnant women attending ANC

To explore barriers to male involvement in ANC and PMTCT services as reported by service providers at health facilities

To assess factors that could motivate male participation in ANC and PMTCT and which can be incorporated into PMTCT package of care



CHAPTER 2: LITERATURE REVIEW

2.1 Men and use of health services

The World Health Organisation states that gender differences must be acknowledged and addressed if HIV and AIDS programmes are to be effective (WHO, 2003). Differences in HIV services uptake have been identified, with a growing number of studies highlighting that men are significantly less likely to get tested for HIV or enrol for and adhere to antiretroviral treatment (ART) (Obermeyer, Sankara, Bastien and Parsons, 2009; Chirawu *et al.*, 2010; Coetzee *et al.*, 2004). In South Africa, for example, a survey found that only one out of five people tested for HIV were male (Coetzee *et al.*, 2004).

An investigation into HIV testing in a multi-country HIV workplace programme in sub-Saharan Africa discovered that 22% of male workers compared to 28% of female workers, and 6% of male spouses compared to 18% of female spouses, were less likely to take advantage of the programme and get tested for HIV (Shisana & Simbayi, 2002; Van der Borgh *et al.*, 2010). Even where an equal proportion of men and women are found to make use of HIV testing services, men are observed to only test for HIV after becoming severely ill (Chirawu *et al.*, 2010). Men are known to be relatively poor in or delay uptake of HIV testing services while in many contexts women outnumber men in accessing HIV services (Chirawu *et al.*, 2010). This is demonstrated in the gender differences in the enrolment in HIV care with 45% of women and 37% of men enrolled onto an HIV care and treatment program in low- and middle-income countries by end of 2008 (WHO UNAIDS UNICEF, 2009).

Smith, Braunack-Mayer and Wittert (2006) looked at factors determining help-seeking and health service use among men, and they proposed socio-cultural and biological factors that account for the patterns in men's help-seeking behaviour and health service use. They reported that social construction of masculinity acts as an important influence on health and illness, and may both prescribe and limit men's lives (Smith, Braunack-Mayer & Wittert, 2006). Sociologists have also implied that specific behaviour associated with traditional forms of masculinity is likely to be hazardous to men's health (Smith, Braunack-Mayer & Wittert, 2006). Seymour-Smith, Wetherell, and Phoenix (2002) state that dominant masculine cultures and values may negatively affect patterns of illness and men's experiences and behaviour. Bearing pain or

difficulties (stoicism) and suppression of emotion are some values often associated with masculine gender role socialization, and adherence to patriarchal masculine characteristics, such as superiority, independence, self-reliance and dominance and may also act as a barrier to men appropriately accessing and using health services (Lee & Owen, 2002; Courtenay, 2000).

Cultural stereotypes also influence men to ignore screening and preventive health care, and to delay help-seeking for symptoms, which results in men underutilising health services aimed at early intervention (Lee & Owen, 2002; Courtenay, 2000). Subsequently, poor health-seeking behaviour results in poor health care use among men, which limits their access to information and restricts opportunities for health promotion interaction and primary care use (Van Buynder & Smith, 1995; Courtenay, 2003).

A study to assess gender difference in the utilization of health care services was conducted by Bertakis, Azari, Helms, Callahan and Robbins (1999) at the University of California Medical Center. The study was done with primary care resident physicians. A patient socio-demographic and health status was used as independent variables to investigate gender differences in the use and cost of the services. Five hundred and nine (509) new adult patients were randomly assigned to primary care physicians at the University Medical Center. Their use of health care services and associated charges were monitored for one year. Self-reported health status was measured using the Medical Outcomes Study Short Form-36 (SF-36). It is reported that the authors controlled for health status, sociodemographic information, and primary care physician specialty in the statistical analyses (Bertakis, Azari, Helms, Callahan and Robbins, 1999).

The results of the study showed that women had significantly lower self-reported health status and lower mean education and income than men. At the same time women had a significantly higher mean number of visits to their primary care clinic and diagnostic services than men. Mean charges for primary care, specialty care, emergency treatment, diagnostic services, and annual total charges were all significantly higher for women than men. However, there were no differences for mean hospitalizations or hospital charges. After controlling for health status, socio-demographics, and clinic assignment, women still had higher medical charges for all categories of charges except hospitalizations (Bertakis, Azari, Helms, Callahan & Robbins, 1999). The study concluded that women have higher medical care service utilization and higher associated charges than men. Although the appropriateness of these differences was not

determined, these findings have implications for health care (Bertakis, Azari, Helms, Callahan & Robbins, 1999) and shows that male behaviours related to their health is similar in developed and developing settings. This study was based in the United States and did not explore the reasons for the behaviour.

2.2 Men and use of reproductive health service

Gaikwad, Murthy, and Sudeepa, (2012) conducted a qualitative study on men's involvement in reproductive health of women among auto-rickshaw drivers in Bangalore rural India. A total of 96 married men were interviewed using a questionnaire. The aspects covered in the interview were awareness and practices related to reproductive tract infections/sexually transmitted infections/Human Immune Virus/Acquired Immune Deficiency Syndrome (RTIs/STIs/HIV/AIDS), family planning, antenatal care and treatment seeking behaviour for the reproductive health problems. The outcome of the study was that the majority (62.50%) of the men did not help their wives seek antenatal care. Only few (n=7, 7.29%) were aware of parameters (haemoglobin and urine albumin, blood pressure, foetal lie, foetal movements and foetal heart beats, test for syphilis and HIV) of antenatal care. There were 44 (45.83%) men who reported RTIs symptoms and only 32(72.73%) took treatment for their infections. Few (6.25%) men were aware of all family planning methods. There were 39 (40.63%) participants having extramarital sexual relations with prostitutes or other females, of which 25(64.10%) did not use condoms while engaging in the high risk sexual encounters. In addition (35.42%) were not aware of HIV/AIDS (Gaikwad, Murthy & Sudeepa, 2012). The study concluded that antenatal care and family planning are considered the primary responsibility of the women. The study results must be treated cautiously as the sample was small and the study may have been biased as the population included men who were at risk of engaging in sexual risk behaviours since their work involved travelling away from spouses/families.

As part of the wider research project in service-user interface in the context of antiretroviral treatment (ART); a study to explore obstacles and barriers to men's use of HIV services was conducted in the Manicaland Province of eastern Zimbabwe (Gregson, *et al.*, 2007; Skovdal *et al.*, 2011). Interviews conducted were: 19 individual and 4 group interviews with adults on

ARVs, 21 individual and 3 group interviews with carers for children on ART, and 18 individual and one group interview with health staff. Participants were recruited through openly HIV-positive community members and from hospital or clinic sites, and discussed the struggles they faced before accessing HIV services. Informants were approached in hospital and clinic waiting rooms and invited to participate. Health staff interviewed included primarily, HIV counsellors, pharmacists and a clerk (Skovdal *et al.*, 2011).

Skovdal *et al.*, 2011, reported that they found a clear and explicit version of hegemonic masculinity which emerged across the interviews such as: a ‘real man’ is strong, free of disease and in control. It also came out that a real man is sexually promiscuous and is a bread winner of the family (Skovdal *et al.*, 2011). Men are not only expected to abide by such representations, but also play an active role in constructing such representations by continually demonstrating their manhood (Skovdal *et al.*, 2011). The researcher agrees with the authors that such understandings and demonstrations of masculinity conflict sharply with the ART ‘patient persona’, which requires men to be concerned about their health and regularly present at the hospital; a space many men see as a ‘female space’ or take instructions from nurses and refrain from unprotected and extra-marital sex and alcohol, the latter being part of the masculine identity of taking risk.

The conclusion of the study was that men’s use of HIV services depend on; a) the social constructions of masculinity that characterise a context, b) the openness and ability of the context and men living within it to discuss and deconstruct hegemonic masculinities, and c) men’s ongoing negotiation between the ‘patient persona’ and social constructions of masculinity, helping them construct ART-friendly masculinities (Skovdal *et al.*, 2011).

Knowledge Attitude and Practices (KAP) survey done in 2007 by the Catholic Medical Mission Board (CMMB) as baseline to measure the utilisation of PMTCT services in selected Mission Hospitals in the nine provinces of Zambia, reviewed that 60% of pregnant women who attended antenatal clinics, accepted to test for HIV and 70% of those who tested HIV positive accepted to take ARVs for PMTCT, while infant ARV uptake was at 60%. It was also discovered that only 3% were tested and counselled as ‘pregnant’ couples (Sinkala, 2011). The study concluded that infant ARV uptake is unacceptably low and also male involvement in antenatal care is dismally low (Sinkala, 2011).

2.3 Challenges for male involvement

2.3.1 Known barriers

This section covers known barriers to male participation in antenatal and PMTCT services.

2.3.1.1 Men's perception and attitudes

Two studies done in Malawi and Uganda have shown the importance of male involvement in antenatal and intrapartum HIV counseling and testing. In Malawi, the authors interviewed 388 married men through 11 focus group discussions and a cross sectional survey to explore their perceptions of HIV in pregnancy and male involvement in antenatal HIV testing and counselling (Aarnio, Olsson, Chimbiri, & Kulmala, 2009). Similarly in Uganda, the authors conducted a study in a 200-bed capacity hospital in rural Uganda to compare acceptability, feasibility, and uptake of maternity and ANC PMTCT services between December 2004 and September 2005 (Homsy *et al.*, 2006). In Malawi the authors suggested that male involvement in antenatal HIV testing requires refocusing of information and health services to include men (Aarnio, Olsson, Chimbiri, and Kulmala, 2009). To avoid negative social outcomes for women, comprehensive and early involvement of men is essential (Aarnio, Olsson, Chimbiri, and Kulmala, 2009). While in Uganda the authors concluded that intrapartum HIV Counseling and Testing (HCT) may be an acceptable and feasible way to increase individual and couple participation in PMTCT interventions (Homsy *et al.*, 2006). Both studies show that male involvement improve PMTCT uptake.

The Zambia 2010 midterm United Nations General Assembly Special Session for HIV and AIDS (UNGASS) report on prevention of HIV transmission, based on the 2002 and 2007 DHS surveys and anecdotal evidence, has listed the following as perceptions and attitudes of men towards their involvement in PMTCT: men rarely attend ANC and maternity services where most PMTCT interventions are offered because they are not male friendly; women in Zambia refer to their male partner for reproductive health and resource allocation decisions; and that many couples do not disclose their HIV status to each other (UNGASS, 2010). These behaviours by men and women are deeply rooted in social- cultural beliefs and are gendered and would seriously influence efforts to increase male involvement in women's health.

A cross-sectional survey involving 388 men aged 18 years and above, whose spouses attended antenatal care at Mbale Regional Referral Hospital was conducted in the Mbale district, Eastern Uganda by Byamugishya *et al.*, (2010). The survey was complemented by eight focus group discussions and five in-depth interviews (Byamugishya *et al.*, 2010). Factors that hinder men's participation in the PMTCT programme were identified during the FGDs and were related to socio-cultural practices, social-economic and health system factors, as illustrated below:

2.3.1.2 Socio- Cultural practices

Traditional community perceptions have been reported as inhibiting male participation in antenatal care. Most men perceive antenatal care as a woman's affair and men seen going with their wives to antenatal clinics are perceived to be weaklings or being jealous (Byamugishya *et al.*, 2010). Culturally men are not allowed to get involved in women health issues, more especially in antenatal clinics and labour wards as these areas are culturally perceived as places for women. Similar findings were reported by Homsy *et al* and Msuya *et al* who reported that it is culturally a taboo and shameful for a man to be found where women go to give birth (Homsy *et al.*, 2006; Msuya *et al.*, 2008).

Two studies were done in Tanzania and Uganda to compare the uptake of HIV testing for pregnant women who tested as couples to those who tested without partners. In Tanzania a study aimed to describe the prevalence and predictors for male partner participation in HIV voluntary counselling and testing (VCT) was conducted at two primary healthcare clinics in Moshi urban, as well as the effect of partner participation on uptake of HIV perinatal interventions (Msuya *et al.*, 2008). Pregnant women ($n = 2654$) in their third trimester, participating in a prevention of mother to child transmission (PMTCT) program between June 2002 and March 2004 were encouraged to inform and invite their partners for HIV-VCT (Msuya *et al.*, 2008). HIV testing was done to the participating women and their partners. About 13% male partners came for HIV counselling and testing. A high proportion of 40% came after the woman had delivered (Msuya *et al.*, 2008). HIV-seropositive women whose partners attended were three times more likely to use Nevirapine prophylaxis, four times more likely to avoid breastfeeding and six times more likely to adhere to the infant feeding method selected than those whose partners didn't attend

(Msuya *et al.*, 2008). Women were more likely to bring their partner for VCT if they collected their own test results, were living with their partner, had a high monthly income and had expressed at enrolment the intention to share HIV results with their partner (Msuya *et al.*, 2008).

Between December 2004 and September 2005, authors monitored the acceptability of HIV testing, feasibility, and uptake of antenatal care and maternity services in a 200-bed capacity hospital in rural Uganda (Homsy *et al.*, 2009). Thirty-four women were found to be HIV seropositive through intrapartum testing. Women discharged from maternity ward with documented HIV status increased from 39% to 88% over the period, and only 2.8% of undocumented women had their male partners tested in the ANC in contrast to 25% in the maternity ward. Of all male partners who presented to either unit, only 48% accompanied wives and were counselled with them at the ANC, as compared with 72% in the maternity ward. Couples counselled together represented 2.8% of all persons tested in the ANC, as compared with 37% of all persons tested in the maternity ward (Homsy *et al.*, 2009).

Given the positive influence male participation has on the acceptance of perinatal, intrapartum and postpartum interventions, barriers to their participation must be identified so that more different approaches for promoting their [male] participation in reproductive health services are developed.

2.3.1.3 Social economic determinants of male involvement in PMTCT

A cross-sectional survey done in Uganda by Byamugishya *et al* (2010) with 388 men aged 18 years or above, whose spouses attended antenatal care at Mbale Regional Referral Hospital, was conducted to identify determinants of male involvement in the prevention of mother-to-child transmission of HIV. Socio economic factors were among the factors that were identified and several men claimed they could not divide time between looking for food to feeding the family and going to antenatal clinics with their wives. Some mentioned not having enough money to use for transport for two people. Low level of education, type of occupation (busy occupations with long working hours being an impediment), and lack of access to information on antenatal

and PMTCT services were sited to be some of the barriers to male involvement (Byamugishya *et al.*, 2010).

Another study done by Theuring *et al.* (2009) in Meya Region, Tanzania, to assess male attitudes regarding partner involvement into ANC and PMTCT included 124 participants in 6 FGDs. Barriers to male involvement in ANC and PMTCT mentioned by participants were; lacking information/knowledge, no time, low priority, the services representing a female responsibility and fear of HIV-test results (Theuring *et al.*, 2009). Both studies used similar methodologies and they yielded similar results. The studies also show that using qualitative methods to gain information from men was very useful as it encouraged men to express their views – issues that are not easily obtained in quantitative studies.

2.3.1.4 Health System factors

The health system has been shown to be critical on decisions to attend or not to attend for women overall but also for men. A qualitative study which included 16 FGDs with men and women conducted by Reece, Hollub, Nangami and Lane (2010) in the western Kenya to examine reasons for men's non involvement in PMTCT initiatives and other HIV-related services found health system barriers such as low quality couple's counselling, inflexible weekend clinic hours, community education regarding HIV-related services at clinics containing strong language and clinics not being male-friendly. In Byamugisha, Tumwine, Nalu and Tylleska (2010) study which was held in Mbale district in the Eastern Uganda cited similar health system barriers to male involvement which included the structural setup of antenatal clinics and health-workers not being client-friendly.

The limitation of the Byamugisha, Tumwine, Nalu and Tylleska, 2010 study was that the qualitative part did not target males who were spouses to pregnant women attending ANC but men were purposively selected from the AIDS Information Centre (AIC), the AIDS Support Organisation (TASO) and the four administrative divisions in targeted areas. Therefore it was possible that the views of the husbands of women who were attending antenatal clinics could have been different from the views of men whose spouses were not attending antenatal

purposely selected from AIC and TASO (Reece, Hollub, Nangami & Lane, 2010; Byamugisha, Tumwine, Nalu & Tylleska, 2010).

2.3.1.5 Gender Based Violence (GBV)

There is emerging evidence connecting the rapidly expanding HIV epidemic and GBV, particularly among young women (Maman, *et al.*, 2000). Gender-based violence refers to a range of harmful customs and behaviours against girls and women, including intimate partner violence, domestic violence, assaults against women, child sexual abuse, and rape. It generally derives from cultural and social norms that imbue men with power and authority over women (Goldberg, 2001). Current estimates indicate that between 8% and 70% of women worldwide have been physically or sexually assaulted by a male partner at least once in their lives (Heise, Ellsberg, & Gottemoeller, 1999). A recent systematic review of intimate partner violence during pregnancy in African studies shows that between 2-57% of women reported experiencing violence during pregnancy (Shamu, Abrahams, Temmerman, Shefer and Zarowsky, 2012).

In Zambia, domestic violence occurs across all socio economic and cultural backgrounds. In the Zambia Demographic and Health Survey, 5236 women from randomly selected households were interviewed to obtain information on experience of physical violence from age 15 (ZDHS, 2007). A prevalence of 47% of all women in the age group of 15-49 reported experiences of physical violence (ZDHS, 2007). The association between HIV and GBV has been demonstrated (Jewkes, Dunkle, Nduna and Shai, 2010) and women living with HIV who are in abusive relationship are not able to request their husbands to attend with them and testing positive may increase vulnerability for further violence (Wall, *et al.*, 2012; Mbonye, Hansen, Wamono and Magnussen, 2010; Kiarie *et al.*, 2006). However, couple counselling has been developed to assist women in disclosing their status in a supportive environment. However, this may be particularly difficult when women are in abusive relationships.

2.4 Why male involvement is important in HIV prevention

2.4.1 Male involvement programmes in Zambia

Mother-to-child transmission of HIV account for 21% of HIV infection during pregnancy (UNGASS, 2010). In Zambia, HIV infection in children aged less than 14 years is estimated at 10% and most are due to vertical transmission (MoH, 2009). The Ministry of Health established the PMTCT program in January 1999 in the effort to reduce the rate of HIV infection among infants and young children (MoH, 2009). By 2008 the number of antenatal care facilities scattered in all nine provinces of Zambia, providing counselling and testing to pregnant women reached 939 (MoH, 2009). The PMTCT package comes with promoting male involvement (UNGASS, 2010). In the recent past men were coerced to come with their partners to antenatal care clinics. It is anecdotal that health workers were refusing to attend to women who were not accompanied by their partners until the MoH issued a statement informing health workers to attend to all pregnant women regardless of them being accompanied by partners or not.

There are limited studies done in Zambia to explore factors that influence male involvement in PMTCT. Tshibumbu, 2006 conducted a study to evaluate PMTCT services in Mumbwa district. One hundred and twenty seven men participated in a study of a random selection of male spouses who tested for HIV without any consideration of HIV status of the women. The results were that 65% of men had knowledge about mother-to-child transmission of HIV and PMTCT of which only 14.2% had gone to PMTCT clinic with their partners and that only 17.3% had gone for HIV testing with their spouse at ANC/PMTCT clinic (Tshibumbu, 2006).

Several attempts have been made in Zambia, with regard to changing behaviours of men and women so that they can support each other in reproductive health services. Notable among the strategies used is the Men Taking Action (MTA) program being implemented by the Catholic Medical Mission Board (CMMB) at Mission Hospitals, located in rural areas; and the Couple Counselling and Testing (CCT) being implemented by the Zambia Emory University HIV Research Project (ZEUHRP) in Lusaka (Sinkala *et al.*, 2008; Allen *et al.*, 2007). The MTA program engages traditional leaders as agents of change to get men involved in PMTCT and VCT services; whereas the ZEUHRP mostly concentrates on training health workers and lay councillors in CCT. The MTA program was evaluated after three years of implementation and

the results showed successful increase in couple counselling and receiving results from a baseline of 3% to 60% in ANC settings and 92% of pregnant women testing and receiving results from a baseline of 60% while Family Health International Prevention, Care, and Treatment Partnership, Zambia with a program in Luapula Province has revealed successes in increasing the uptake of CCT to 70% (CMMB, 2010; Torpey *et al.*, 2010).

The MTA program is associated with communities being served by Mission Hospitals and the ZEUHRP targets people in urbanized areas. Both these target populations have different characteristics and the models being used to mobilize and involve men in PMTCT and VCT may not be applicable to the whole of Zambia. Therefore there is need to explore other social- cultural and gender related factors as well as other qualitative barriers that can influence partners to pregnant women to participate in ANC and PMTCT in order to maximize uptake of these services in Zambia.

Sinkala *et al.* (2008) have indicated that programmatic interventions that aggressively target men involvement in PMTCT, can dramatically improve HIV testing among pregnant women and increase enrolment into PMTCT services for those testing positive. Couple counselling as a strategy to improve uptake of interventions for PMTCT can also minimize adverse social outcomes associated with disclosure of HIV status by pregnant women. Semrau, Khun, Vwalika and Sinkala (2005), reveal that pregnant women who report as couples for antenatal care and receive HIV counselling and testing together are not more likely than those who come alone to report adverse social events associated with HIV partner disclosure.

2.5 Male involvement and PMTCT uptake

A number of studies have been conducted in Africa and other developing settings to show the effectiveness of male involvement in the uptake of PMTCT, HIV testing and uptake of ART. Controlled clinical trials and programmatic interventions such as couples counselling and testing with a focus of involving male partners/spouses to pregnant women in antenatal care and PMTCT have revealed that this strategy improves uptake and adherence to PMTCT interventions. Between 1999 and 2005, Alusio *et al* (2011) conducted a prospective cohort study in Nairobi, Kenya to investigate the relationship between male involvement in PMTCT and

infant HIV acquisition and mortality. HIV infected pregnant women were enrolled and followed with their infants for one year with infant HIV DNA testing at birth, at 1, 3, 6, 9 and 12 months. Women were encouraged to invite their husbands for prevention counselling and testing. Out of the 456 female participants, 140 (31%) partners attended the antenatal clinic. Eighty-two (approximately 19%) of 441 infants tested were HIV infected by one year of age. Adjusting for maternal viral load, vertical transmission risk was lower among women with partner attendance compared to those without and among women reporting versus not reporting previous partner HIV testing. The combined risk of HIV acquisition or infant mortality was lower with male attendance and report of prior male HIV testing when adjusting for maternal viral load and breastfeeding. The study concluded that including men in antenatal PMTCT services with HIV testing may improve infant health outcomes (Alusio *et al.*, 2011). While most of the other studies cited were cross sectional or qualitative, this longitudinal cohort study by Alusio *et al.*, (2011) confirms the long term benefits of male involvement.

Furthermore, Sripipatana, Spensely and Miller (2007) reviewed the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF) PMTCT supported sites in low resource countries and reported that at sites where with strong male involvement, uptake of testing among pregnant women and acceptability of antiretroviral drugs for PMTCT was very high in comparison to sites where there was suboptimal or lack of male involvement. Farquhar, Kiarie and Richardson (2004) studied the outcomes with regard to couple participation in PMTCT in Nairobi, Kenya and concluded that antenatal couple counselling increases uptake of interventions to prevent HIV-1 transmission.

As part of the President's Emergency Plan for AIDS Relief (PEPFAR) efforts to prevent mother-to-child transmission of HIV, IntraHealth International supported the MoH of Rwanda to establish PMTCT at 10 hospitals and health centres in Gitarama and Byumba provinces (IntraHealth, 2005). A system was developed in which partners were invited via letters from health staff. Community health workers were involved to sensitize the community and promote male involvement in antenatal, couple counselling and PMTCT (IntraHealth, 2005). IntraHealth revealed that at Kigoma Health Centre the partner testing rate grew from 10 percent in December 2002 to 88 percent in September 2004 (IntraHealth, 2005). At Byimana Health Centre partner testing increased from 53% in May 2004 to 78% in September 2004 (IntraHealth, 2005). IntraHealth further reports that men participating in PMTCT programs with their pregnant wives

have proven to contribute to increased uptake in HIV counselling and PMTCT with a success rate of 99% of pregnant women testing and receiving results while 95% testing as couples (IntraHealth, 2005).

However, knowledge about HIV and PMTCT by a male partner does not necessarily translate to participating in HIV services together with a spouse. A national community-based survey was conducted in Eritrea on women (15-49 years) and men (15-54 years) and two other population groups from October to December 2005 using the Lot Quality Assurance Sampling (LQAS) methodology. The survey took place in all six zones and 45 sub zones of the country. Nineteen (19) respondents from every population group were randomly selected for each to explore the level of knowledge on PMTCT (Berhane & Tesfazio, 2005). Results of the study were that although 81.8% of men and 75.5% of women knew that HIV can be transmitted from an HIV infected mother to the child, only 33.7% of men and 26% of women knew that the risk of transmission can be reduced (Berhane & Tesfazio, 2005). Men were more knowledgeable than women but were not more likely to participate. This study did not explore the reasons that impede men to participate in PMTCT services in spite of high knowledge.

As noted in the study done by Abiodun, Ijaiya and Aboyeji (2007) in Nigeria, one of the keys to men's involvement within prenatal HIV counselling and testing is the better understanding by men and women of couple relationships, attitudes and communication patterns between men and women, in terms of HIV and sexual and reproductive health.

2.6 Couple Counseling and PMTCT

Studies have shown that couple counselling yield good health outcomes not only for the child but for partners as well. Farquhar, Kiarie, and Richardson (2004), conducted a study in Nairobi to determine the effect of partner involvement and couple counselling on uptake of interventions to prevent HIV-1 transmission. Women attending antenatal clinics at a Nairobi clinic were encouraged to return with partners for voluntary HIV-1 counselling and testing (VCT) and offered individual or couple post-test counselling. Nevirapine was provided to HIV-1-seropositive women and condoms distributed to all participants (Farquhar, Kiarie & Richardson, 2004). The study found that among the 2104 women who accepted testing, 308 (15%) had

partners who participated in VCT, of whom 116 (38%) were counselled as couples. Although only 10% (30 women) of 314 HIV-1-seropositive women came with partners for VCT; they were 3 times more likely to return for Nevirapine ($P = 0.02$) and to report administering Nevirapine at delivery ($P = 0.009$). Nevirapine use was reported by 88% of HIV-infected women who were couple counselled, 67% whose partners came but were not couple counselled and 45% whose partners did not present for VCT (P for trend = 0.006). In addition the study found that HIV-1-seropositive women receiving couple counselling were 5-times more likely to avoid breast-feeding ($P = 0.03$) compared with those counselled individually. Partner notification of HIV-1-positive results was reported by 138 women (64%) and was associated with 4-times greater likelihood of condom use ($P = 0.004$) (Farquhar, *et al.*, 2004). The authors concluded that, partner participation in VCT and couple counselling increased uptake of Nevirapine and formula feeding. The study also demonstrated that antenatal couple counseling could play a very useful strategy to promote HIV-1 prevention interventions (Farquhar *et al.*, 2004).

In 2010, a randomized trial was conducted by Becker, Mlay, Schwandt and Lyamuya (2010) at three antenatal clinics in Tanzania. The study aimed to determine the acceptance and effectiveness of Couple Voluntary Counselling and Testing (CVCT) as compared to Individual Voluntary Counselling and Testing (IVCT). One thousand five hundred and twenty one (1,521) women attending antenatal clinics at the targeted clinics in Dar es Salaam were randomized to receive IVCT during that visit or CVCT with their husbands at a subsequent visit (Becker, *et. al.*, 2010). The results showed that the proportion of women receiving test results in the CVCT arm was significantly lower than in the IVCT arm (39 vs. 71%). HIV prevalence overall was 10%. In a subgroup analysis of HIV-positive women, those who received CVCT were more likely to use preventive measures against transmission (90 vs. 60%) and to receive Nevirapine for themselves (55 vs. 24%) and their infants (55 vs. 22%) as compared to women randomized to IVCT. The authors suggested that community mobilization and couple-friendly clinics are needed to promote CVCT (Becker, Mlay and Lyamuya, 2010).

Both studies show that couple counselling and testing contribute to accepting good health behaviour for HIV prevention; such as condom use, uptake of Nevirapine for PMTCT and choice of infant feeding. Couple counselling should be viewed as the introduction to the rest of child health and the parent's health as well.

Literature has shown unequivocally that male involvement in antenatal care provides a chance for both men and women to participate in couples counselling and testing for HIV, and this move can influence PMTCT intervention uptake by promoting dialogue between pregnant women and partners about methods to prevent mother-to-child and partner HIV transmission/re-infection. It is clear that the uptake for prevention is not the same if women test on their own and are required to notify male partners of the HIV positive status. In this latter scenario, women relay test results but do not necessarily provide additional information regarding specific interventions to prevent HIV transmission. If men came with their spouses for counselling and testing they would be informed of antiretroviral treatment for themselves/ their partner/ their unborn child as well as options of infant feeding and condom use. Furthermore, when partners present themselves as a couple for pre and post-test counselling, the counsellor tailors discussions to meet the couple's needs and facilitates interactions that are difficult to initiate among themselves.



CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter describes the methodology employed in the study. It outlines the research setting and study population; study design; sampling and recruitment procedure; characteristics of participants; data collection and analysis; limitations; rigor and ethical considerations.

3.2 Study design

The research was conducted using an exploratory qualitative approach. This methodology allowed for the investigation of male participation in health services including reproductive health, antenatal care and PMTCT and explored the attitudes, perceptions, knowledge and barriers of use to understand its impact on the uptake of antenatal and PMTCT services.

A qualitative research methodology was employed because of its inductive nature which allows more flexibility in investigating the study phenomenon. It allows the researcher to understand the diversity of the issue being studied, to generate in-depth information and assess how the issue relates to the broader social context (Kvale, 2000). In addition this methodology enabled the researcher to explore the phenomena of interest in the original language of the respondents, which ensures the respondents understand the questions in a position to express their views clearly and accurately in the language they well understand (Lincoln & Guba, 1985). Both in-depth interviews (IDI) and focus group discussions (FGDs) were used.

3.3 Description of the study setting

Mumbwa is a rural district situated 154 km west of the capital Lusaka in the Central Province of Zambia. It is accessed by the main tarred Lusaka-Mongu road that stretches from Lusaka west to Mongu, the capital of Western Province. Mumbwa district shares borders with Kaoma in the west, Itezhi-tezhi and Namwala in the south, and Chibombo, Luanshya and Kasempa to the north (Connect Africa, 2009). The district constitutes 25 percent of the central province, covering a

total land expanse of 23,800 square kilometres, of which 12,600 square kilometres are arable land and 11,200 square kilometres are national parks, game management areas (GMAs) and forest(Connect Africa, 2009).


The total population of the district is approximately 222,097, out of which 49.77% are women (ZDHS, 2007). The population relies on subsistence agriculture, predominantly maize and cotton, and there is one cotton ginnery, which employs a significant number of seasonal workers (Connect Africa, 2009).The district is rich in mineral deposits such as copper, gold, amethyst, magnetite and quartz. The district also attracts wildlife tourism to the Kafue National Park on its western border (Connect Africa, 2009).

The Sixth National Development plan 2011-2015 reported that, in Zambia the formal sector employment remained at 10% of total employment in 2008 (*NDP*, 2011-2015), relating to a high level of unemployment. The Living Conditions and Monitoring Survey in 2006 reviewed that 64% of Zambians were poor and this was more prevalent in rural than urban areas (80 and 34% respectively) (ZDHS, 2007). Most people in Mumbwa are engaged in self-sufficient farming, charcoal burning, small scale mining and fishing (Connect Africa, 2009). There are no social amenities and as a result people spend most of their time drinking alcohol. Most families are in polygamous marriages, which are acceptable as their custom.

The estimated HIV prevalence in Mumbwa district is at 10% while the National prevalence (for Zambia) is 14.3%. About 52.6% of people living with HIV in Mumbwa district are women (*NAC*, 2009).The district population is served by two hospitals, 26 health centres and three health posts (*NAC*, 2009). The two hospitals, the health centres and the health posts provide antenatal care services including syphilis and HIV testing and counselling. However, the villages are spaced out and to access a health service people often have to walk or cycle 15 to 20 kilometres to reach the nearest health facility. Public transport is also unreliable in this area. Most often women seek antenatal care services in their second trimester and home deliveries are more common than health center/hospital deliveries. For a pregnant woman to access antenatal care services she has to be accompanied by her husband otherwise the service is denied.

3.4 Study Population and Sampling

Health care services are concentrated in urban areas in Zambia with peri-urban and rural areas having poor access to health care. Mumbwa is a rural district with minimal health care services especially in reproductive health. This study was introduced to the Mumbwa District Medical Office management staff and after consultation it was decided that the study be conducted in Mumbwa at Nangoma Mission Hospital and its catchment area. Nangoma Mission Hospital was established in 1996 and it is run by the Roman Catholic Church. It serves a catchment population of 80,000 people, with HIV prevalence of 18% in the general population, and 9.5% among pregnant women. Among the services provided at the hospital are antenatal, PMTCT and antiretroviral services. Other services provided at Nangoma are labour and delivery including postnatal services, but because of traditional beliefs and long distances to the health facility most women seek antenatal services in the second trimester and most deliveries (60%) happen at home.



The study had three subgroups from which samples were drawn. The first sample was from women attending antenatal services and pregnant women at the maternity waiting home for women who lived far from the health facility, all the participants interviewed were married. All pregnant women attending antenatal care are educated in basic facts of HIV and AIDS and HIV testing is offered to them as opt out. A second group of women included those attending the child health clinics. These were mothers who brought their new born babies (up to three months old) for immunisation services. The second sample was men who are partners to pregnant women and partners to women who had given birth to a child in the last three months.

The third sample was of health staff and policy makers as key informants. The health staff included those who provide antenatal or PMTCT services as well as senior staff from the district management office who coordinated reproductive health services. The District Medical Officer in charge was involved in advocating for policy issues in the district.

Participants were sought from these different categories to get their views and diverse experiences in spouse (male) involvement in antenatal, PMTCT, family planning, and child care.

3.5 Inclusion criteria

Women: Only pregnant women attending the antenatal services despite were included to participate in in-depth interviews. Similarly, mothers who had given birth to a child in the last three months were included for the FGDs. All women were identified to participate in the interviews despite their HIV status because the researcher wanted to know if they accepted to test for HIV and participate in PMTCT if test positive.

Men: Male participants included male partners of the pregnant women and male partners of the mothers who had given birth to a child in the last three months participated in semi-structured interviews and FGDs.

Health staff: Only service providers and the senior staff from the Mumbwa District Office (MDO) were included for semi-structured in-depth interviews.



3.6 Accessing participants and sampling procedure

The researcher worked closely with the Mumbwa District Office to ensure their support of the study; they facilitated access to the study populations and helped in recruitment of participants, following the criteria provided by the researcher.

Women: The researcher approached ten women and introduced the study to them while they were waiting for services at the antenatal clinic, maternity waiting home and child health clinics. All the women except two agreed to be interviewed. At the maternity waiting home, the researcher spoke to a group of women and introduced the study and women volunteered to participate and completed informed consent forms.

Men: The men were accessed from antenatal and maternal and child health clinic registers and they were partners of pregnant women or women who had given birth to a child in the last three months. Permission was sought from women if their addresses listed in the clinic registers could

be used to invite their spouses and only women who accepted were the ones whose husbands were invited. We followed this method as men were generally not present at services. Some women took the invitation notes signed by the hospital administrator to their spouses while some invitation slips with the permission from women were taken to the identified men by members of the hospital committee. The method of inviting men was decided on during consultations with the management.

Staff: The health workers were accessed from antenatal/maternal and child health clinic who were the service providers, while senior management staff that coordinate reproductive health services at district level and participate in policy making were accessed from the DMO.

Focus Group Discussion for male partners together with interviews for informants was held on the 5th of April 2012, while the focus group discussion for mothers were done on the 6th of April 2012. The in-depth interviews for male partners were conducted on 1st May 2012 and for antenatal mothers on 20th May 2012.



3.7 Data Collection Methods

3.7.1 Semi-structured in-depth interviews

A total of 18 semi-structured in-depth interviews were conducted on 1st May and on 20th May 2012. Out of ten women eight accepted to be interviewed while two refused saying they needed to get permission from their husbands. Men were difficult to reach even through their wives, out of the ten men invited only six came. Four health care workers were also interviewed. An interview guide was developed for each set of interviews to ensure all the themes were covered (see appendix 3). All the interviews took place in the hospital setting. The interviews with the eight women were held at the antenatal department and at a maternity waiting home. Similarly the interviews with the six men were held at the antenatal department and the health worker interviews were held at the health facility. Informed consent was taken before interviews were conducted (Appendix 2). Only six of the ten men invited accepted the invitation to participate and attended the in-depth interviews.

All the interviews were conducted in a vernacular language that was commonly spoken and easily understood by participants, researcher and the research assistant, and were captured through note taking and audio-recording. After each interview the information from the audio-recorder was copied onto the laptop before it was deleted from the audio-recorder and only the researcher had access to the audio-recorder and the laptop. The researcher continued to conduct interviews until the information was saturated on all the themes (Glasser & Strauss, 1967).

3.7.2 Focus Group Discussions (FGDs)

Two FGDs (one each with men and one with women) were held in order to obtain different perspectives on specific issues. These were not the same participants that were involved in the semi-structured interviews. Each FGD consisted of 10 participants (10 spouses to pregnant women and 10 women who had given birth to a child within the last three months respectively). FGDs were conducted at private spaces in the community (the community hall) and a focus group discussion guide was used (Appendix 4). After explaining the purpose of the study; consent was sought from each participant and confidentiality was discussed. The researcher facilitated the discussion, and the discussions were captured using a tape recorder while the research assistant took notes. As for the in-depth interviews, the FGDs were conducted in vernacular (Tonga and Nyanja) on 5th and 6th April 2012. To keep the momentum of discussions, refreshments were served. The FGDs did not start on time as anticipated because participants arrived at different times because of travelling from distant areas. At the end of the FGD, participants were refunded transport money to and from the venue.

Full details of the study participants, their study code, gender, age and occupation are highlighted in Table 1 (see in the appendices). Table 2 below shows the number of participants and type of interviews done.

Table 2: Summary of Participants

Respondents	Data collection tool	Number of respondents
Pregnant women	In-depth interview	8
Partner to post-natal mothers who had given birth to a child in the last three months	In-depth interviews	6
Health workers involved in providing services in antenatal and PMTCT	In-depth interviews	2
Senior management staff coordinating reproductive health services in Mumbwa	In-depth interviews	2
Mothers who had given birth to a child in the last three months	Focus Group Discussions	10
Husbands to pregnant women	Focus group discussions	10
TOTAL PARTICIPANTS		38

3.7.3 Themes used in the study

The study examined the following aspects to barriers of male participation in antenatal care and in the prevention of mother-to-child transmission of HIV. These themes were developed from the literature review.

1. Respondents knowledge about antenatal care, PMTCT, and family planning
2. Perception/attitude of men towards participating in antenatal and in PMTCT
3. Barriers to PMTCT and
4. Use of services

3.8 Data Analysis

The data consisted of the interview transcripts from the semi-structured interviews and the extensive field notes that consisted of the combined notes taken during the FGD as well as notes developed after listening to the FGD recordings. Interviews were translated into English for those that were conducted in the local language. Analysis process followed using the thematic framework method (Ritchie & Spencer, 1993) described in more detail below. The researcher used different sources of collecting information in order to increase the validity of the study.

Familiarization

The researcher transcribed the data and thereafter read and reread the transcripts many times to identify key and recurrent themes. The researcher was aware of her reactions, prior assumptions and prejudices in order to avoid biasness in her perspective in this process. She interrogated these issues with her supervisors Dr. Shamu and Prof. Abrahams. The researcher tried hard to remain open, neutral and curious in the reading of the data with the help of her supervisors.

Thematic framework

All the key themes were identified by the researcher, and specific issues under each theme were drawn by which the data was examined and referenced. The end product of this stage was detailed indexes of the themes and sub-issues specific to research goals. The thematic framework was applied by systematically indexing all the data by annotating all transcripts in the margins.

Charting

A chart for each theme with columns for the different issues was formed. The data was rearranged by cutting and pasting the actual text in the chart and entering reference to the page and line numbers, this created charts that brought all the viewpoints made on a specific issue under a specific theme. The charting process involved considerable amount of abstraction and synthesis.

Mapping and interpretation

The charts were used to make sense of and interpret the data to extrapolate meaning at deep, essential levels. A range of opinions and diverse topics and multiple connections between

different issues and themes and how they might influence each other was observed and reflected upon. Contradictory information provided further pause for deeper insight and better understanding.

For triangulation; the researcher gathered data from three different populations namely; women, men and health staff. She also used in-depth interviews and focus group discussions to ensure validity of data.

3.9 Ethical Considerations

The researcher travelled to Mumbwa to meet the District Health Medical Officer (DHMO) and management staff to explain to them about the study she intended to carry out in Mumbwa. The researcher also provided them with the approval letter from the Zambia Ethics Committee which approves research proposals before any research/study is done in Zambia. Permission to interview the staff was approved by the DHMO.

The study was approved by the Higher Degrees Ethics Committee (HDEC) University of the Western Cape (UWC) and by the University of Zambia Research Ethics Committee (UNZAREC). The study was done according to the requirement of the two Ethics Committees. Transport refund was paid to FGD participants because some participants came from far places.

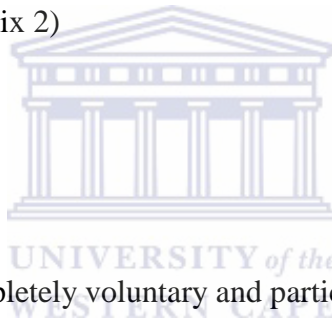
3.9.1 Risks to participants

Participation in the study was voluntary. Participants were told that they could exit the study at any time and that their decision to exit would not influence their accessing of any services from the clinic/hospital. Referrals to a psycho-social counsellor at a health facility were arranged if the researcher found that participants were in distress. Participants were each provided with an information sheet explaining the research study, and assuring them of confidentiality (Appendix 1).

The researcher negotiated with the staff to ensure that pregnant women received antenatal services on the day they attended for the interview.

3.9.2 Informed Consent

The researcher explained the research process to each participant in the in-depth interview and to participants in FGD in their language of choice. Information about the study was provided which included the aim, methods, anticipated benefits, potential risks and that they have a right to refuse to participate or to quit at any time. Questions were encouraged and were addressed. Each participant provided a signed informed consent only after the information had been given and before interviews were commenced. They were also requested to provide consent for the interviews to be recorded. (Appendix 2)



3.9.3 Voluntary participation

Participation in the study was completely voluntary and participants were told that they were free to withdraw at any time without any negative consequences. Each participant was given an opportunity to refuse to participate in the study to ensure that interviews involved only those who were genuinely willing to take part and were prepared to offer data freely. No participant was coerced to participate in the study. Participants were encouraged to be frank from the outset of each session.

3.9.4 Confidentiality

Confidentiality was maintained at all times during the interview process. No names were used on the data transcript. Numbers were used as codes to maintain anonymity. Data analysis was done by the researcher and all documents related to the study were kept in a locked cupboard to which

only the researcher had access. The data on the computer was not shared with any other person except supervisors and the researcher put a password on the computer for data protection.



CHAPTER 4: RESULTS

4.1 Description of Participants

Male participants were between the ages of 25 and 50 years while female participants were in the age range of 18 to 45 years. Participants had between one to six children and some stayed as far as 15 to 20 kilometres away from the health facility. Most men who participated in the study were peasant farmers; some were in casual employment at the cotton ginnery plant and a number of them were into charcoal burning and selling business in order to meet their basic needs. Most of the women were not in employment and looked after children and attended to crops in farms.

4.2 Perception and Attitudes

4.2.1 Men's perceptions of and their involvement in family planning issues

4.2.1.1 Use of family planning

Almost all the participants, both male and female agreed that decisions on family planning issues including what method of contraception a partner must use were traditionally made by men and this had not changed. This was justified on the basis of the men being household heads and breadwinners. One male respondent stated, *'It's a man who decides when to start family planning because he is the heard of the house, so he is the boss; he is the one who should know how many children he can manage to take care of'* (IDI Male 45 years).

Women spoke about consequences if they make decisions on use of contraception and without their husbands' permission. A woman said *'It's a man who decides when to start family planning; a woman cannot start family planning without permission from the husband, unless she is ready to be divorced'* (FGD F 26 years).

However, there were exceptions that showed some elements of gender equality and this was illustrated when a young man allowed his wife to use a family planning method of her choice, and he was the only man who said *'My wife was on family planning, she was receiving injections...my wife proposed and I accepted and supported her to go ahead because I saw that it*

was good so that our child can grow a bit more before we can have another child' (pm2). He allowed his wife to decide on the family planning method and he was also knowledgeable on the details of the method 'It's herself who decided, she was given types of family planning then she chose the one for injections...she was getting one injection after three months'(IDI M 26 years).

Becoming pregnant soon after marriage was an acceptable practice in this Zambian society. Pregnancy was in fact an important aspect of being a woman in this society and being barren was highly stigmatized *'because women are blamed if she does not become pregnant quickly after getting married...others are even divorced'(IDI M 25 years). The consequence of not accepting male dominance in the use of contraception is being chased away from a marriage, a man said 'other men want to be the ones to be deciding and women to be following what they decide no matter what; otherwise she can be chased for another woman who can accept to give the man a child' (IDI M 32 years).*

Health workers corroborated the view of the male domination in decision making to become pregnant by citing the ethnic group who practice polygamy and dictate family planning to their partners. Health workers said most men believe that women are for producing children, referring to a phrase in the bible which was quoted by a male health worker *'...Psalm 127 reads children are a heritage from the Lord; offspring a reward from him, like arrows in the hands of a warrior are children born in one's youth'.*

Only one man discussed the issue of vasectomy saying he would not use vasectomy as a means of family planning but he would rather have his wife go for bilateral tubal ligation (tying both the fallopian tubes so that she could not conceive) (BTL) *'hahahaha!...no, me I'm a man, maybe I can change my mind in future and decide to have a child outside marriage' (IDI M 45 years).*

4.2.2 Men's experiences and perceptions of attending antenatal with their pregnant partners

4.2.2.1 Why men attended

The current practice is that pregnant woman can only get antenatal care and services if she is accompanied by her husband and she would otherwise be denied access to care. However, most men are not willing to go with their wives to antenatal clinics, viewing antenatal care as an issue just for pregnant women. Health workers had to come up with strategies to get men to come with their wives and the most common one used is to deny services to those women who attend without their husbands. A man expressed his confusion when he said '*antenatal clinic was a place for women; men had nothing to do there. I just wanted to know why the health staff wanted me to go there*' (IDI M 28 years). Almost all participants especially women said it was difficult to convince their partners to go to antenatal clinics with them and support the initiative by health staff '*It was not easy to convince men to be going with their wives to the clinic that is the reason why they began to use force by refusing to attend to women who go to antenatal clinics without their husband*' (IDI F 35 years)

Almost all the participants; men, women including health workers reported that men accompanied their partners to antenatal clinic because they were pressurized to do so and that they would not have gone if it was not for the health staff who asked for them. A man reported that men did not traditionally attend the clinic because '*that place [antenatal clinic] is for women and not for me [men]*'. He further explained how in the past men never went with their wives to antenatal clinics saying, '*Noo...I shouldn't have gone there...to do what? That place is for pregnant women not for men, in the past no men were going with their wives to antenatal clinic*' (IDI M 30 years). The same man said he only attended the clinic because he wanted to find out why the clinic staff had asked for him to go there. Another man shared how he was adamant not to accompany his wife to the antenatal care clinic '*When My wife was pregnant she told me that I am required to go to antenatal with her...I totally refused...I thought ...haaa...me going to antenatal, why? She told me that it is a requirement that women have to go with their husbands otherwise she was not going to be seen...I still refused*'. He explained that his refusal meant his wife not having access to care and she reported him to her parents and they ordered him to go with his wife to the clinic '*until my wife went to report to her parents that I had refused to go*

with her to antenatal, then the mother (mother in law) came fuming and ordered me to go with my wife to antenatal clinic that's when I went' (IDI M 26 years). It was not easy for women to convince their husbands to accompany them but women did not give up easily and they persevered. A woman explained that her husband eventually agreed after she persisted. She explained the delay and only attending the antenatal clinic at 'five months'. She said 'men don't agree at the first time you request him to come...he will first give excuses...buying time thinking you will forget about it, this is what was happening to my husband...but I never got tired asking him until this time we went. She recommended that men who do not go to antenatal clinic with their wives should be penalized to pay money or a goat to the chief (traditional leader) 'If a woman goes to the clinic alone, the husband should be made to pay to the chief' (IDI F 18 years).

Some men attend antenatal clinics after they have had a discussion with the wife. A man [32 years old] shared how he had some discussions with his wife to attend antenatal care together and did not even fear HIV testing *'so we discussed with my wife and decided to go to antenatal together; when we arrived there, they taught us about HIV and tested us...then things were just ok, so we were very happy and we had free mind in that even when the third pregnancy came, we were aware of what to expect at the clinic' (IDI M 32 years).*

4.2.2.2 Impact of coercion

A male health worker stated that male involvement had improved tremendously because women are requested to come to the clinic with their partners. He also noted that the increase in men attending was not necessarily what it seems since women were desperate to be attended to. Women had to find ways to access care and they sought assistance from other men such as brothers, cousins, uncles to pose as partners. However, this created further problems because they would test as a couple but the results would show discordance. He said *'then we said...no...what's going on why are we having so many discordant couples'*. It was also discovered that men would come and linger around the clinic so that they could be hired by women who arrived without partners *'There are men for hire, men come and linger around the*

clinic if it is a booking day they will linger and ask women who come without a man if they wanted an escort ...then they would go in and pretend that they are a partner to the woman (inforb).

Health workers said after enquiring why men don't go to antenatal clinics with their wives; the common response given was that men refuse saying that it is a woman's work *'when we go round asking why men don't go with their wives to antenatal they say that men refuse, saying that, that is women's work, women are the ones who have a reason to go to antenatal...not men'*. They went on to say *'this has been a trend and belief so changing this belief will take some time'* (infora).

However a few men viewed attendance at the clinic with their wives as an extension of their role of provider and therefore escorting wives to ensure she gets seen by the health staff. A young man explained that he had gone to the clinic with his wife because he wanted to learn how to take care of his wife and the baby *'Yes, because I wanted to learn how to take care of her and the baby'* (IDI M 26 years). Another male participant explained that he wouldn't have gone to the antenatal clinic if it was not for the health staff to asked for him because he thought that *'antenatal was a place for women and that men had nothing to do there, the man's job is just to give directions and the wife follows...that's it'* (IDI M 30 years). Another man gave reasons as to why men don't want to go to the clinic with their wives mentioning the difficulties in taking time away from work, and others opt to go *'drinking beer other than go to the clinic'*.

Health workers said teachings at the clinic have positive effect on men and changed their behaviour. This was confirmed when men explained how they better understood the reasons for their attendance. A man said *'So, I made sure that my wife delivered at the clinic and she is exclusively breast feeding the baby just like we were taught...we are trying to follow all that we were taught at the clinic'* (IDI M 25 years).

4.2.2.3 Men's Perceptions, Experience and Benefits for accompanying partners to antenatal care

Despite the men's initial reluctance to accompany their partners to antenatal care, they reported positive experiences once they attended the clinic. Many had similar experiences of initially finding it difficult to accept to go with their wives to antenatal care but once at the clinic they felt relieved to find other men attending antenatal clinics with their wives and later on they appreciated the teachings and services offered at the clinic. A man [28 years old] said he felt 'scared' going with his wife but felt relieved to see other men with their wives *'Because I was not the only man there, so it was a bit light for me to be there... I was a bit scared because I did not know what to expect there...but after a while I became relaxed'*. He also said seeing other men with their wives and the teachings from health staff reduced his tension (IDI M 28 years). He further said *'I just wanted to know why the health staff wanted me to go there, but when I saw other men with their pregnant wives I was relieved, the nurse started telling us why men should be supporting their wives even in antenatal'*. The men's apprehension was also related to not knowing what to expect (pm5).

The men who have accompanied their wives in previous pregnancies or on previous antenatal visits spoke of the benefits of attending antenatal clinics to be for themselves, their wives and for their unborn child. Some men showed that they understood and supported women having to attend antenatal clinics *'pregnant women who attend antenatal [care] do well because, there, they are taught how to look after themselves when they are pregnant and how to take care of their babies when they are born'*(IDI M 28 years).

Some men also showed how their understanding of their role during pregnancy had been better understood such as how to look after a pregnant wife, how to prepare for the coming baby, medicines women receive at the clinic, how to avoid diseases and the importance of HIV testing. A man said he appreciated the teachings, he said *'I learnt a lot and saw the importance of antenatal'* (IDI M 28 years). Another said *'the health of the mother and that of the baby are checked to see if both are fine'* referring to the treatment of sexually transmitted diseases (STIs) including HIV treatment (FGD M Adult).

Women had most of their previous pregnancies without the partners' involvement at the clinic. An adult man shared his experience of going with his wife to antenatal care he said *'me...during the pregnancy of our sixth born that's when I decided to go with my wife to the clinic to start antenatal and we were both tested and I was happy to learn that we were both found without a disease'* (IDI M 45 years).

Men said it was important for a man to know about mother-to-child transmission of HIV so that they can work together in the prevention of HIV to the baby *'Fathers need a lot of education on the importance of HIV prevention from mother to the baby; it is the only way babies can be protected...fathers are decision makers in the home'* (FGD M adult).

Men gained wide knowledge on how different diseases affect women, such as malaria causing the placenta to be weak and allow HIV to be transmitted to the baby *'We were taught that malaria makes the placenta weak and germs can go to the baby through the placenta'* (FGD M adult).

Receiving health education from health staff caused a man to *'stop believing in cultural practices such as administering tradition medicine and he was ready to witness his wife giving birth'* (IDI M 45 years).

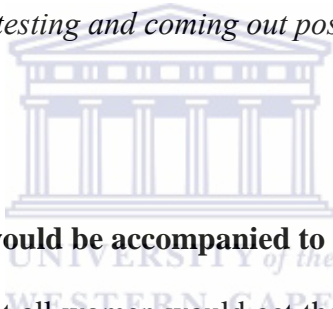
Almost all participants stated that the community view men who accompany their wives to antenatal as being weak and jealous and these are men that want to know, track and control the women's movements *'Haaa...some think that we are jealous men, who want to be everywhere, where the wife is'* (IDI M 26 years). It is also reported that men who attend clinics with wives are those who listens to whatever the wife says and want to know where ever the wife goes *'they are viewed as being under the rule of their wife and that they have been given some juju [charm or love portion] by their wives'* (IDI M 25 years).

Most participants explained that culture does not support men's involvement in women's health issues, saying it is considered a taboo *'It is a big taboo for men to get involved in women's health issues...it is not allowed'* (IDI F 22 years). Health workers corroborated that culture does not allow men to go with their wives to antenatal clinics otherwise such men are viewed as being under the rule of their wife and that they have been given some charm which confused them *'people said that men who go with their wives to the clinic they are viewed as being under the*

control of the wife, they say that they have been given some love portion which influence their thinking' (infora).

It is also a common view that men who accompany their partners to antenatal clinics have been given charm by their wives, the women would even be approached by other women whose husbands refuse to accompany them to antenatal clinic to ask what type of love portion they have given to their husbands *'They think the woman has given the husband some charm... some women will be coming to ask your wife what juju she has given you for you to be going with her to the clinic'* (FGD M Adult).

Although not mentioned by many, an additional barrier for men to attend antenatal clinics is the notion by the community that HIV was the reason why men accompanied wives to ANC (IDI M 45 years). Health workers reported a similar reason and said men feared HIV testing *'Well there is a fear of the unknown...a fear of testing and coming out positive'*.



4.2.2.4 Not all pregnant women would be accompanied to the clinic

Most participants explained that not all women would get the privilege of being accompanied to the clinic especially women mistresses. Men would not accompany women to antenatal clinic that they impregnate outside their marriage. Other reasons mentioned included not wanting to test for HIV; busy with doing work and if not working they were occupied with drinking beer. Long waiting time was cited as another reason why men do not accompany their partners to antenatal clinic.

A 32 year old man had different views about men who accompany their wives to antenatal saying he viewed them as men who are *'responsible and who loved their wives'*.

4.2.3 Cultural beliefs and practices of male involvement in women's health issues

Both men and women said their culture considered attending antenatal care as a taboo for men since men must not be present where women are giving birth and similarly it was said women do not like men to be where they are giving birth. Many beliefs of what happens to a man when he is present where women give birth were mentioned. It was said that unless the man bathes in traditional medicine, he could get ill *'If you want to be where a woman is giving birth you need to bath in traditional medicine'* (IDI M 28 years). Similarly if the waters [amniotic fluid] splashes on a man, he would get ill *'If a man is found in labour ward where a woman is giving birth and water that comes out splashes on him, then he will start getting sick'* (IDI M 25 years). It was also believed that witnessing a woman give birth can result in a man losing his appetite for sex *'It is believed that it is a taboo for a man to witness a woman giving birth, that can make him go blind and can lose appetite to ever make love to this woman'* (FGD M Adult). Losing appetite for sex was confirmed by a man who shared how his young brother could not make love to his wife for about eight months after he had seen her giving birth. The experience made him think that the birth canal would remain as large as he had seen it when the baby was coming out *'Loosing appetite for sex when you see a woman deliver is real, ... this happened to my young brother; there was no elderly woman to assist deliver his wife so he witnessed his wife deliver... so they continued living together until the baby was about 8 months he could not make love to his wife, he was saying he could not make love to his wife because he saw how big the way became when delivering the baby, he thought the way remained like that'* (FGD M adult).

Health workers confirmed that culturally men are not allowed to be found where women are getting health services like at antenatal and in labour ward *'traditionally it is a taboo for a man to be found where women are getting services that involve them'*. If a man witnesses a woman giving birth it is traditionally believed that he would go blind *'Traditionally they believed that a man who witnesses a child birth, that man would go blind'*. Health workers did not believe this myth and referred to male nurses who had been delivering women and who had not gone blind. However health workers acknowledge that these myths create challenges for them in providing services as women opted to deliver from home in fear of being delivered by male nurses *'women*

do not want to be delivered by male nurses, they prefer to deliver at home than come to the clinic and be attended to by a male midwife in labour'(inforb). Another male participant agreed and said *'some women prefer to deliver from home for fear of being delivered by male nurses, women feel ashamed to give birth in the presence of men'* (IDI M 30 years).

In general the community viewed men who get involved in women's health issues as being weak and they are perceived to think like women as well. They are also regarded as men who were not taught by elders and are considered as bad influence to other younger men (IDI M 28 years). Such men could be chased from the village because they would be considered as having brought shame to the elders in the village (IDI M 32 years). Though men are not allowed to get involved in women's health issues it is shown that they exert power over their health to the extent they decide for them to have an HIV test. A man said only when a woman is sick of malaria could a husband be expected to take her to the clinic and if she does not recover any time soon a husband could decide to take her for an HIV test to rule out HIV (IDI M 30 years). Men who were seen going to antenatal with their wives were thought of being under the control of their wives *'men who were seen going to antenatal with their wives they were thought of being under the control of their wives; they were thought of having been given charms by their wives'* (inforb).

There was however evidence of traditional beliefs being questioned by younger men who refused to accept cultural practices that are associated with HIV risks. A young man reported that some culture such as *'marrying a widow could pre-dispose you to getting HIV'* he went on to say *'No, us who are young fathers don't believe in this cultural practice, most of these things are dangerous...when you are sick they give you traditional medicine and do tattoos on you...haaa...1) tattoos are painful 2) we were taught that you can get HIV from sharing razor blades'* (IDI M 26 years).

4.2.4 Male involvement in the care/ health of children (fatherhood)

Men views of their roles of fatherhood resonated with what women said in their interviews and they all refer to the provider role of being a father. A man explained how involved he is in his children's health by ensuring that there is food for his children so that they can be strong and

grow well. He further stated that *'when anyone of them is sick I make sure he is taken to the clinic to get medicine either by my wife or myself'* (IDI M 45 years). It was clear that most men get involved in their children's health but at a decision making level and not more than this and would only take a child to the clinic if the wife cannot. They also ensured that the wife took the child to the under-five clinic *'when my child is sick I tell my wife to take him to the hospital...also I don't allow my wife to miss under-five clinic sessions for my son'* (IDI M 28 years). An alternative was also shown among young fathers. A young man shared how he enjoys taking his son to the clinic, including the children's clinic *'Hmm... I'm very much involved in my son's health; I even take him to the clinic for under five'* (IDI M 26 years). Another one said *'When any of my children is sick I make sure he is taken to the clinic so that he is given the right medicine...me...I even carry my child on my back and take him for under five clinic'* (IDI M 32 years).

Respondents believed that many wives, many children and much wealth is a measure of a successful father *'The man must be able to feed his children and dress them well; he should be a wealthy man with a lot of cattle and many children and may be with more than one wife, then he is considered as a successful man'* (IDI M 45 years). Men with few children and few cattle are considered poor and lazy and not worth to be called men *'Haaa...that one is a poor man, he is considered as a lazy person who is not worth to be called a man. They even suspect the few children not to be his...even if they look like him people will think that they look like their grandfather or their uncle'*(IDI M 45 years). The culture of many wives and children as an indication of wealth was explained by a young man who said *'culturally men are allowed to marry many wives, the main wives and male children are to work in the field to produce more food while girl children are to be married off for many cattle which are paid as dowry'*. Men with one wife and few children are considered as unsuccessful and they have less influence on the community (IDI M 32 years). Health workers corroborated the view of a man having many wives, many children and many cattle as being a successful father because the wives and children work in the field to produce a lot of food while he is drinking beer *'a man must marry as many women as he can and have as many children as he can so that the women and children will be the ones to provide labour in the fields while the man is out drinking somewhere'* (inforb). He went on to say a man with one wife and few children will not have much labour to produce a lot of food *'but with one wife and few children, who is going to provide labour so that*

they can have a lot of food? Most probably this family will not have enough, and the man will look like he has failed to provide for his family' (inforb).

The traditional reasons were also given by most men as to why they did not get involved in children's health issues '*Aaaah! Very few men take care of their children when they are sick; it is taken as woman's job' (FGD M Adult).*

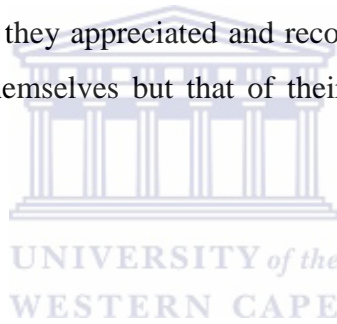
The results of this study show that even though men are traditionally not permitted to be were women are getting reproductive health services including antenatal, labour and delivery; culture give them power to rule over their female partner's fertility. They are considered providers of their families so they decide when a woman should conceive a child, and most men do not allow their wives to use family planning methods so women are having unplanned pregnancies which may contribute to mothers passing HIV to their babies



CHAPTER 5: DISCUSSION

5.1 Introduction

This study sought to investigate barriers to male involvement. Results show that male involvement in antenatal and PMTCT is a complex issue in Zambia. A number of factors to men's non-involvement include; a conception by both men and women that it is a taboo for a man to see a woman delivering a baby or to be found where pregnant women receive antenatal care, antenatal clinic attendance was not a male role, the community perceives that those couples attending antenatal care together are HIV infected, both women and men lack adequate knowledge on activities that happen at antenatal clinics; male involvement in family planning is only at decision level and demand for use of family planning by women is low. However, the study also found that once men attended the clinic and were informed about the reasons why they needed to accompany their wives, they appreciated and recognised the value of participating in reproductive health, not just of themselves but that of their spouses as well. The subsections below discuss the major findings.



5.2 Socio-cultural

The role of cultural taboos related to men's involvement in child birth was very prominent in all the interviews and FGDs and was discussed by almost all the participants. Many misconceptions and myths about misfortune that may happen to men when they are present at childbirth were discussed. This appears to be the main overriding reason men did not attend antenatal and PMTCT services with their spouses. This finding is similar to what Byamugishya *et al.* (2010), Homsy *et al.* (2006), Falnes *et al.* (2011) and Msuya *et al.* (2008) found in their studies. These appear to be very strong cultural codes and participants explained how men are ridiculed if seen to be going to the clinic with a wife. Such deep rooted cultural codes of behaviours are usually very difficult to resolve and it is no wonder that health workers used a strategy of coercion. However, the strategy to only see pregnant women if accompanied by a male partner can have serious health outcomes. This meant women whose husbands or partners were not willing to attend with them, widows and those separated or divorced after conception may end up at the clinic late in pregnancy. This could also lead to women not attending ANC at all and possibly

giving birth outside the health facility. In addition this study found that men do not attend with women who are not their main partners such as a pregnant mistress. These women are particularly vulnerable because they will never have a male partner to escort them. The dire need to have partners created by the demands from the health service certainly had other consequences – such as the men hiring themselves to women to pretend to be partners. The health workers recognised this when they saw the many discordant HIV results. Again these place huge questions on couple counselling in these services where treatment is denied to women that attend without a male partner. This practice by health workers and its potential serious health consequences have not been documented before in the literature. It is important that the health staff recognise the possible negative consequences of their policies and guidelines and consider alternative strategies which are less harmful, for example women without ‘official’ partners to be given a letter of support from a community leader so that they could receive a service.

5.3 Stigma of HIV

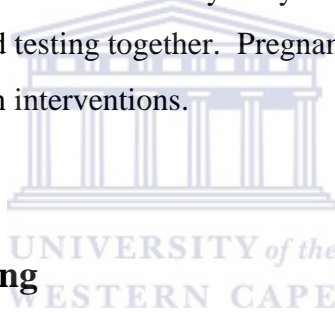
The perception by the community of any couple seen going to the clinic as having HIV causes a barrier to male involvement in antenatal care as no one wants to be associated with having HIV. Apart from culture compelling men not to attend antenatal as it is considered a taboo, it also appeared to play a role in some men’s unwillingness and inability to attend health services with wives as they were at work, they were drinking alcohol, and some did not have enough money for transport. These findings are similar to that of Byamugishya *et al.*, (2010), Homsy *et al.*, (2006) and Msuya *et al.*, (2008).

5.4 Inadequate knowledge

Most men and women do not have adequate knowledge on what goes on at antenatal clinics apart from having an idea that the health of the mother and that of the baby is monitored so that the delivery is safe and the baby is well. Knowledge about abdominal palpation, tablets given and tests done apart from HIV is not adequate. Though men find it difficult to go to the clinic with their partners, they appreciate the teachings and services provided by the health staff. Most men

interviewed claimed to have known about mother-to-child transmission of HIV through the information from the health staff. Similar to the studies done by Byamugishya *et al.* (2010), and Theuring *et al.* (2009), this study discovered that most men perceive getting involved in antenatal care as escorting the partner to the clinic so that she could be attended to, and also their provision for the mother and the baby's needs. However, the men interviewed had overwhelming positive perceptions of attending antenatal care with their wives, but this is mainly only after they had accompanied their wives.

Inadequate knowledge can promote myths and misconceptions which may hinder correct information flow, and will continue being a barrier to HIV services. Working with the Safe Motherhood Action Groups (SMAGs) would assist in information dissemination. Studies done by Farquhar *et al.* (2004) showed that male involvement encourages couple counselling and testing and enrolment into PMTCT. In this study only one man among the 16 interviewed appreciated going with his wife and testing together. Pregnant couple counselling may be a good strategy to promote HIV prevention interventions.



5.5 Low use of family planning

This study found that men played a very limited role in their wives reproductive health. The main role male partners played were decision making such as their wives fertility. The study showed women cannot use family planning without the husband's consent. The reasons for male control of fertility was related to men having the traditional role of the bread winner and carer of the family and he therefore makes decisions about how many children he can care for. It was a concern that when fertility was spoken about there was no reference to spacing or deciding on what the desired number of children would be. This is similar to what was reported by Gaikwad, Murthy and Sudeepa (2012). This finding of the very low use of family planning is a concern as this leads to unplanned and multiple pregnancies which can have a huge impact on a woman's health especially if she is HIV positive. In the study only one man out of the 16 male participants reportedly accepted his wife's proposal of starting family planning for spacing purposes to allow their child to reach a reasonable age before the next baby. In Zambia UNFPA (2013) reported that 55% of married women do not use family planning methods for fertility reasons. HIV

positive women are encouraged to use any form of planning method but with caution if they choose to use hormonal contraceptives for they affect the potency of ARVs (Robinson, Jamshid and Burke, 2012). HIV positive women on ARVs should be encouraged to use hormonal contraceptives together with female or Male condoms (UNAIDS/WHO, 2012). Preventing unintended pregnancy especially in HIV-positive women can significantly reduce mother-to-child transmission of HIV as well as improve the woman's overall health.

There is no doubt that male involvement in antenatal care is of benefit to all. Even this small qualitative study has shown that those men that eventually attended services found it beneficial and none of the men reported negative experiences. It is however important that this be implemented in a way that does not further harm the mother and her new born.

5.6 Coercion

Coercing men to attend antenatal with their wives is controversial. Some pregnant women are not married and may be impregnated by some ones husband. Women in abusive relationships will not ask their husbands to accompany them to antenatal, this has been reported to cause women come with other men posing as their husbands so they can access antenatal services.

5.7 Factors to motivate attendance

In this study most participants confirmed that men who went with their spouses to antenatal did so because the health staff requested them to do so, otherwise they wouldn't have gone. Both men and women participants supported by health workers proposed that SBCC be strengthened by involving the SMAG, community leaders such as the chief, the headmen, the clergy, and political leaders by training them in reproductive health issues so that they can become champions in Social Behaviour Change Communication (SBCC) in the community including work places, on the importance of men participating in reproductive health services. Traditional leaders being the custodian of culture and are respected in the community can assist to remove harmful/and or non productive tradition beliefs by getting involved in SBCC. Identify men who have appreciated accompanying their wives to the clinic to be role models and give testimonies

during SBCC. Waiting time should be reduced. Health staff should use polite language that will make everyone feel comfortable to listening.

Just like the findings in the studies done by Farquhar *et al.* (2004) participants in this study felt that if men are well sensitised by revered community leaders, they would support and encourage their wives to go to the clinic and access the services together.

5.8 Study Rigour

Many factors were taken into consideration to ensure the rigour of the study. The same researcher did the interviews which were all done in mother tongue language. Transcription was done immediately and the researcher developed field notes after each interview and after the FGD and used this in the analysis. The researcher did an open access software package (OpenCode) to manage the data and to do the coding and the sub coding. The supervisors coded a few interviews and this was compared with the student's coding and a second check was done by the supervisors when all the data were coded. This process ensured that researcher was consistent and the data was not misinterpreted. Quotes were used extensively to support the findings and sometimes many quotes from different participants were used to support a finding. The researcher also used triangulation by using data from the women, the men, and from the service providers and all these increased the rigour of this study.

5.9 Study Limitations

The study has a few limitations. It took almost 12 months for the University of Zambia Ethics Committee to approve the study and data collection began much later than the initial. The study struggled to reach men even through their wives. Only six out of ten men accepted the invitation via their wives to participate in the in-depth interviews. Eight out of ten women accepted to be interviewed while two said they needed to seek permission from their husbands. **Not including women that needed permission from their husbands may be problematic** as these women and their male partners may have particular views on PMTCT which is different to the group of women that did not need male partner approval. This study is also not representative of Zambia Health services as Mumbwa is a small rural district. In addition this is a qualitative study and

although it allows us to get in depth data it represent few voices and experiences. Also participants especially men may have said things that are social expected of them to say, such as repeating what they heard from health staff such as the benefits to attend and they repeated this to the researcher. The coercion from the health staff may also have played a role. The researcher did not only speak to women and men that accepted to test for HIV and enrol into PMTCT and therefore those who opted out views were not included. Similarly employed men were not really included as they did not want to miss a work day.

6.0 Conclusion and Recommendations

The practice of coercing men to attend should be reviewed by the service providers. This practice may have advantages if it has the effect for which it was intended, such as the male partner exposure to information and attending as a couple, but this practice also have many disadvantages, such as women coming to the clinic with hired men which contribute to high uptake of discordance and managing people who are not couples. In addition we have no idea to what extend this practice prevent women from using antenatal and delivery services at all. The findings of this study must be disseminated to service providers to ensure these practices are discussed and the consequences are considered as a health team. It is acknowledged that health workers are struggling to find ways to ensure the policy of increasing male involvement are initiated but it is also important to look at other possible strategies that will have less negative consequences. It is recommended that new strategies to increase male involvement be considered and that it is done in consultation with health workers, men and women.

The study showed that health information is lacking in particular health information directed to men as partners. It is important that such materials are developed in a cultural sensitive manner which will allow the transfer of knowledge on the benefits of family planning, antenatal care, PMTCT, and the importance of couple counselling and testing. Clinics and clinic staff should also be accommodative not just to women but to men as well if they want to attract men into health services. In addition services should review staff numbers at the clinic as long waiting times is a deterrent and a huge barrier for both men and women.

The study found that traditional gender norms were the biggest and most difficult barrier to male involvement in women's health. It is recommended that health workers work with community leaders such as the chiefs, headmen, politicians and the clergy in disseminating information in the community that target these traditional norms. The community should develop strategies to encourage men to attend antenatal clinics with their wives, for example, those who do not attend the clinic with the wife can be fined to pay the headman either an animal or money equivalent. In addition more people should be trained as Safe Motherhood Action Group to provide PMTCT messages and services in all the zones in Mumbwa district.

The government and policy makers have decreed that male involvement should increase but it has not provided the strategies and the support to the health workers at the clinic level. Policy makers have an important role in assisting the success of this initiative and not expecting that it will just happen and get implemented.



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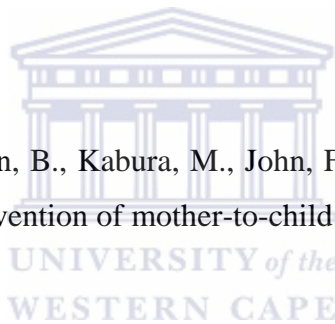
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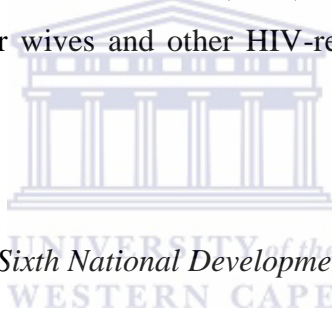
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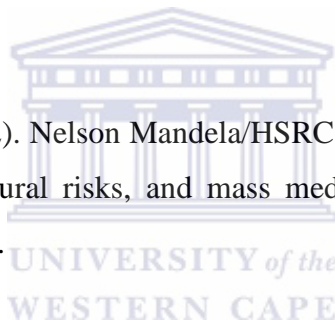
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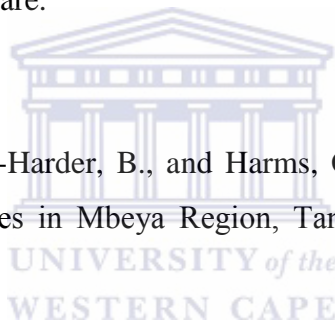
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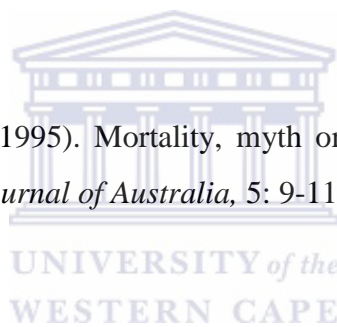
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APPENDICES



OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

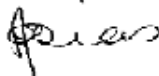
24 August 2011

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Mrs C Nguni (School of Public Health)

Research Project: Exploration and description of barriers to male participation in antenatal and prevention of mother-to-child transmission of HIV (PMTCT) services in Mumbwa district.

Registration no: 11/7/31



*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

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A place of quality,
a place to grow, from hope
to action through knowledge

All correspondence should be addressed

In reply Please quote:

NotMofH/

to:
The District Medical Officer



Telephone: 760 1 800197

Fax: 760 1 800197

REPUBLIC OF ZAMBIA
MUMBWA DISTRICT HEALTH MANAGEMENT TEAM
OFFICE OF THE DISTRICT MEDICAL OFFICER

P.O. BOX 830018

MUMBWA

26th September 2011

The Chairperson
Ethics Committee
University of Zambia
LUSAKA

Dear Sir/Madam

**RE: ~~RESEARCH ON BARRIERS AFFECTING MALE INVOLVEMENT IN~~
~~ANTENATAL/PMTCT SERVICES IN MUMBWA DISTRICT.~~**


With reference to the above mentioned, Mumbwa District Medical office has no objection in the research entitled exploration and description of barriers to make participation in antenatal and prevention of mother to child transmission of HIV (PMTCT) services in Mumbwa District, Zambia to be conducted.

Mrs Catherine Nguni will conduct the said study in collaboration with Mumbwa District Medical office.

Kindly assist her acquire ethical clearance to conduct this study.

Your assistance will be appreciated.

Yours faithfully


DR M C DUBE
DISTRICT MEDICAL OFFICER

Appendix 1

Table 1: Social demographic data of participants

Sex	Age	Occupation
Female In-depth Interviews		
Female	18	Housewife
Female	22	Housewife
Female	24	Housewife
Female	35	Housewife
Female	20	Housewife
Female	25	Housewife
Female	30	Housewife
Female	28	Housewife
Male In-depth interviews		
Male	45	Subsistent farmer
Male	26	Employed
Male	28	Subsistent farmer
Male	32	Subsistent farmer
Male	30	Employed
Male	25	Employed
Health Service In-depth interviews		
Female	45	Nurse
Female	28	Nurse
Female	42	District reproductive health coordinator
Male	45	District Medical Officer
Male Focus group discussion		
Male	Adult	Employed
Male	Adult	Employed
Male	Adult	Subsistent farmer
Male	Adult	Employed
Male	Middle aged	Subsistent farmer
Male	Adult (?50)	Subsistent farmer

Male	Adult	Employed
Male	Middle aged	Employed
Male	Middle aged	Subsistent farmer
Male	Adult	Subsistent farmer
Female Focus group discussion		
Female	20	Marketeer
Female	24	Housewife
Female	Middle aged	Housewife
Female	Middle aged	Marketeer
Female	18	Marketeers
Female	Middle aged	Housewife
Female	Middle aged	Housewife
Female	Adult	Housewife
Female	28	Marketeer
Female	26	Marketeer





Appendix 1



UNIVERSITY OF THE WESTERN CAPE

School of Public Health

Private Bag X17 • BELLVILLE • 7535 • South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872

PARTICIPANTS INFORMATION SHEET

Dear participant

Thank you for your willingness to hear about this research. What follows is an explanation of the research project and an outline of your potential involvement. The research is being conducted for a mini-thesis which is a requirement for a Masters Degree in Public Health; which I'm pursuing at the University of the Western Cape. If there is anything that you don't understand or not clear about, please do not hesitate to ask me. My contact details and that of my supervisors are recorded at the end of this memo.

TITLE OF THE RESEARCH

Exploration and description of barriers to male participation in antenatal care (ANC) and prevention of mother-to-child transmission of HIV (PMTCT) services in Mumbwa district, Zambia.

THE PURPOSE OF THE RESEARCH

The research is trying to explore, identify and describe barriers, facilitators/promoters to male participation in antenatal care and PMTCT services. It is hoped that with your participation, a better understanding of barriers, facilitators/promoters to male participation in antenatal and PMTCT services will be gained, with a view to contribute to the uptake of PMTCT. It is also hoped that the outcome of this research can contribute to the literature that can be used for further research programs.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

The study aims to explore and describe barriers to male involvement in antenatal care and PMTCT programme in Mumbwa District in order to increase uptake and participation of male partners/spouses to pregnant women with regard to PMTCT services.

Questions about awareness of HIV testing in antenatal, knowledge and perception of HIV medication to prevent HIV to the baby are some of the questions that will guide the discussion and the interview that I have for you. For any questions/clarifications you can get in touch with me on 260 977 636 318.

CONFIDENTIALITY

During the interview there will be no use of names. A code will be used instead of your name. The discussions between you and me will be confidential. I shall keep all records of your participation and our discussions including a signed consent which I will need to get from you once you accept to participate in this research study, under lock and key at all times and will destroy them probably a year after the research is completed. You will not be identified in the written reports as they contain no names.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Participation in this study is entirely voluntary, that is, you may or may not want to participate. If you choose to participate, you may stop at any time. You may also choose not to answer particular questions in the study that you feel uncomfortable with. If there is anything that you would prefer not to discuss, please feel free to say so.

BENEFITS AND COSTS

You may not get any direct benefit from this study. However, the information we will learn from participants in this study will contribute towards identifying barriers, facilitators/promoters to male participation in antenatal and PMTCT services which can guide on what targeted strategies can be implored at men to motivate them to get involved in antenatal care and PMTCT services; thus contribute to the increased uptake of PMTCT. Transport refund will be provided.

INFORMED CONSENT

Your signed consent (thumb print for those who cannot write) to participate and to be audio-recorded in this research is requested before I can proceed to interview you. I have included the consent form with this information sheet so that you can review the consent form and then decide whether you would like to participate in this study or not.

QUESTIONS

Should you have further questions or wish to know more, I can be contacted as follows:

Catherine Musakanya Nguni

Student No. 2657414

Cell No. +260 977 636 318

Telefax at work: 260 211 264 025

E-mail: catherenenguni7@yahoo.com

My supervisor's contact details are as follows:

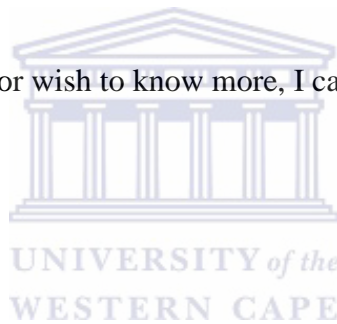
Dr. Simukai Shamu

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Co-Supervisor: Professor Naeemah Abrahams

Email: Naeema.Abrahams@mrc.ac.za



Appendix 3



UNIVERSITY OF THE WESTERN CAPE

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INFORMED CONSENT

Thank you for agreeing to allow me to interview you. I am..... a student at the School of Public Health, University of the Western Cape. As part of my Masters in Public Health, I am required to do a research study. I will be focusing on male participation in antenatal care and PMTCT services. I am accountable to Dr. Simukai Shamu who is contactable at +27 21 959 9494 or Fax: +2721 959 2872 or by email: shamuts@yahoo.com; 2931022@uwc.ac.za or at University of the Western Cape, Private Bag X17, Bellville 7535, South Africa.

THE TITLE OF THE RESEARCH IS:

Exploration and description of barriers to male participation in antenatal care and prevention of mother-to-child transmission of HIV (PMTCT) services in Mumbwa district, Zambia.

I have read/it has been read to me the information about this research study on the Participant's Information Sheet. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.

I voluntarily consent to be a participant and be audio-recorded in this research study and understand that I have the right to end the interview/recording at any time, and choose not to answer particular questions that are asked in the study.

My signature indicates that I'm willing to participate and be recorded in this research.

Participant's Name: _____

Participant's Signature/Thumb print: _____ Date: _____

Interviewer's Signature: _____ Date: _____



Appendix 4

In-depth interview between a researcher and participant

Date:

Place:

Male/Female:

Code:

Description of the setting in which the interview took place:

Note taker/operating tape recorder:

IDENTIFICATION

PMTCT is one of the interventions that have been put in place to control the spread of HIV from mother to child. Babies have a right to a HIV free life. It is felt that in order to increase up take to PMTCT, male involvement in ANC and PMTCT services is critical. This study aims to explore and describe barriers to male involvement in ANC and PMTCT.

You have been selected to participate in this survey and if you are willing to participate you will be required to sign a consent form. The information you will give us will be treated in confidence, shall not be revealed to any other person and is strictly for the purpose of this study.

Questions:

Researcher: What do you know about women attending the clinic when they are pregnant?

Participant:

Researcher: Tell me, what type of diseases are checked

Participant:

Researcher: Is it good for a pregnant woman to be going for antenatal? Please explain your answer.

Participant:

Researcher: Tell me what you think of those pregnant women who don't go to antenatal clinics.

Participant:

Researcher: Tell me, what causes some pregnant women not to go to antenatal clinics?

Participant:

Researcher: Tell me what you think can be done to make pregnant women be going to antenatal clinics?

Participant:



Researcher: Tell me who you think can be the best people to teach men.

Participant:

Researcher: What do you know about the prevention of HIV to the child during pregnancy?

Participant:

Researcher: Do you think it is important for men to know about this information? About a mother who has a disease of HIV passing the disease to their baby? Please explain your answer.

Participant:

Researcher: Tell me about testing for HIV at the clinic.

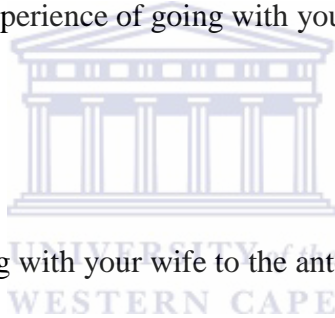
Participant:

Researcher: Tell me why testing should be done.

Participant:

Researcher: What has been your experience of going with your wife to antenatal?

Participant:



Researcher: How did you feel going with your wife to the antenatal clinic?

Participant:

Researcher: How does your community view men that accompany their wives to the clinic?

Participant:

Researcher: Tell me how your wife felt going with you to the antenatal clinic?

Participant:

Researcher: So if it was not a requirement for the clinic, where you still going to go with your wife to the antenatal clinic? Please give a reason/reasons.

Participant:

Researcher: Tell me about taking prevention medication for HIV during pregnancy?

Participant:

Researcher: Tell me what your culture say about men being involved in women's health issues?

Participant:

Researcher: Tell me about breastfeeding in your culture, what are the beliefs and practices about breastfeeding in your culture?



Participant:

Researcher: What if a woman has HIV/AIDS can she breast feed the baby? Please explain your answer?

Participant:

Researcher: Which health matters involving women are culturally accepted for men to get involved?

Participant:

Researcher: Do you agree on these cultural practices and beliefs? Please explain your answer.

Participant:

Researcher: Tell me how involved you are in your children's health?

Participant:

Research: How about taking them to under-five clinics, how involved are you?

Participant:

Researcher: Tell me about family Planning, what is family planning?

Participant:



Researcher: Tell me who decides on family planning and what family planning method to use?

Give reasons.

Participant:

Researcher: Culturally, are men allowed to be involved in deciding on family planning issues?

Please explain your answer.

Participant:

Researcher: Tell me your experience of your wife taking family planning?

Participant:

Researcher: How are discussions about getting pregnant made? Who decides when pregnancy should occur and why?

Participant:

Researcher: Tell me about your last baby, how did you discuss the pregnancy?

Participant:

Researcher: How is fatherhood and a successful father perceived in this culture?

Participant:



Researcher: Thank you very much for your time.

Appendix 5

A Discussion Guide for Focus Group Discussions (FGDs)

IDENTIFICATION

PMTCT is one of the interventions that have been put in place to control the spread of HIV from mother to child. Babies have a right to a HIV free life. It is felt that in order to increase up take to PMTCT, male involvement in ANC and PMTCT services is critical. This study aims to explore and describe barriers to male involvement in ANC and PMTCT.

You have been selected to participate in this survey and if you are willing to participate you will be required to sign a consent form. The information you will give us will be treated in confidence, shall not be revealed to any other person and is strictly for the purpose of this study.


Number of participants _____

Gender _____

Age group range _____

Venue _____

Date _____

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.

The researcher will lead the discussion by asking the group the following questions:

What knowledge do you have about ANC?

What do you think of a pregnant woman who attends ANC?

What do you know about PMTCT?

How do you perceive pregnant women who test for HIV?

What do you know about taking prevention medication for HIV during pregnancy?

What knowledge do you have about breastfeeding?

To what extent can a man get involved on health matters involving women (what is culturally accepted)?

Why is male involvement not acceptable in certain health matters concerning women (what will happen if man is involved)?

What knowledge do you have about VCT?

How do you/community perceive men who seek/access VCT?

How easy is it for a man to use a condom with his pregnant wife/intimate partner?

How are decisions to get pregnant made? Who decides when pregnancy should occur?

What are some of the cultural issues that surround male involvement in reproductive health?

How is fatherhood perceived in this culture?

Thank you very much for your participation

