

FACTORS INFLUENCING MALE PARTNER INVOLVEMENT IN THE MOTHER-TO-CHILD TRANSMISSION OF HIV PLUS (MTCT-plus) PROGRAMME IN GOBABIS DISTRICT, NAMIBIA: A QUALITATIVE STUDY.

By

Felix Kwenda

A mini-thesis submitted in partial fulfilment of the requirement for the Masters in
Public Health (MPH) degree



University of the Western Cape
Faculty of Community and Health Sciences
School of Public Health
Supervisor: Dr Thubelihle Mathole
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Abstract:

Background: Although great strides have been made in reducing mother-to-child transmission of HIV (MTCT) in Namibia, the universal target of less than 5% by 2015 has not yet been achieved. In an effort to scale-up services in the programme, a comprehensive family centred approach which broadens HIV prevention activities and considers HIV as a family disease was instituted. However its success has been affected by low male partner participation in the programme.

Study aim: To investigate factors influencing male partner involvement in MTCT-plus programme in Gobabis District, Omaheke Region, Namibia.

Study design and data collection: This was a cross sectional descriptive study that was conducted using a qualitative research methodology. Data was generated through focus group discussions (FGDs) and in-depth interviews. Four same sex FGDs were conducted with men and pregnant women. The study participants were HIV positive pregnant women and HIV positive women in their postnatal period purposefully selected from the PMTCT clients. A few male participants were partners of the female participants and other men conveniently sampled from the community. Seven in-depth interviews were conducted to gather information from key informants who were programme managers and midwives. Thematic analysis was used for the data analysis.

Results: Men were generally knowledgeable and appreciated the importance of participating in the MTCT-plus programme but the majority of them did not participate. They cited several barriers to actively supporting their partners. Men's participation in the MTCT-plus programme was affected by lack of trust in the health workers and cultural practices that shift the role of taking care of their partners to the biological parents. The other barriers included HIV related stigma, unfriendly environment at the antenatal care clinics, time and work related constraints, having many sexual partners and gender and power imbalances in relationships that affect patterns of communication on HIV related matters.

Discussion: Participation in the MTCT-plus programme is well supported by men. However, few men put this into practice because of complexities surrounding their specific role in women reproductive health issues, as well as cultural practices and health facilities organizational structures that preclude men from participation in the MTCT-plus programme. Given the positive attitude by men towards participation in this programme, creating a male friendly space within the MTCT-plus programme and empowering men to participate in them should be prioritized for the programme to achieve its goals.

DECLARATION

I, the undersigned, hereby declare that the work contained in this mini-thesis entitled **FACTORS INFLUENCING MALE PARTNER INVOLVEMENT IN THE MOTHER-TO-CHILD TRANSMISSION OF HIV PLUS (MTCT-plus) PROGRAMME IN GOBABIS DISTRICT, NAMIBIA: A QUALITATIVE STUDY** is my own original work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

Felix Kwenda

Date: November 2012



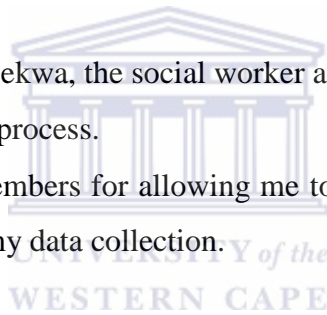
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KEY WORDS

- Mother-to-child transmission (MTCT-plus) plus programme
- Pregnant women
- Male partner involvement
- HIV/AIDS
- Reproductive health
- Antenatal care
- Men's knowledge, attitudes and beliefs
- Institutional barriers
- Gobabis district



ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral treatment
ARVs	Antiretroviral drugs
CDC	Centre for Disease Control and Prevention
FGD	Focus group discussion
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDC	Infectious Disease Clinic
MCH	Maternal and Child Health
MOHSS	Ministry of Health and Social Services
MTCT	Mother to Child Transmission of HIV
OPD	Out-patients Department
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV
RMT	Regional Management Team
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

TABLE OF CONTENTS	PAGE
Title	i
Abstract	ii
Declaration	iii
Acknowledgements	iv
Key words	v
Abbreviations	vi
Table of contents	vii - ix
CHAPTER 1: INTRODUCTION AND BACKGROUND	
1.1 Introduction	1
1.2 HIV/AIDS and MTCT-plus programme in Namibia	1
1.3 The Gobabis District MTCT-plus programme	3
CHAPTER 2: LITERATURE REVIEW	
2.1 The meaning of men's involvement	5
2.2 Benefits of men involvement in PMTCT programme	5
2.3 Factors affecting Men's Involvement in PMTCT programmes	7
2.3.1 Socio-economic factors	7
2.3.2 Cultural practices and men's belief and perceptions	7
2.3.3 Women's fear of victimization and HIV stigmatization	8
2.3.4 Institutional barriers	8
2.4 Conclusion	9
2.5 Problem Statement and Rationale for the study	
2.6 Study aim	10
2.7 Objectives of the study	10
CHAPTER 3: STUDY METHODOLOGY	
3.1. Study design	11
3.2. Study setting	11
3.3. Study population	11
3.4. Sampling technique and Research Participants	12
3.5. Data collection methods	13

3.5.1. Key informant interviews	13
3.5.2. Focus group discussions	13
3.6. Data analysis	16
3.7. Rigour	16
3.8. Study limitations	17
3.9. Ethical considerations	17

CHAPTER 4: FINDINGS

4.1 Findings	19
4.2. Factors influencing male partner participation in the MTCT-plus programme	19
4.2.1. General attitude and knowledge about MTCT-plus programme	19
4.2.2. Cultural and traditional practices	20
4.2.3. Lack of trust and confidence in health workers	22
4.2.4. HIV related stigma	23
4.2.5. The problem of multiple sexual partners	24
4.2.6. Work commitments	25
4.2.7. Unfriendly environment at health facilities	26
4.2.8. Teenage pregnancies	28



CHAPTER 5: DISCUSSION

5.1. HIV disclosure issues and knowledge about MTCT-plus programme.	29
5.2. Cultural practices' influence on male participation in MTCT-plus programme	30
5.3. Institutional barriers and HIV-related stigma	31
5.5. Men's sexual behaviour and teenage pregnancies	32

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions	34
6.2. Recommendations	35

REFERENCES	36
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APPENDICES

Appendix 1: Participant information sheet	45
Appendix 2: Deelnemer Inligtingsblad	47

Appendix 3: Informed Consent	49
Appendix 4: Toestemming vorm	51
Appendix 5: Consent Form on Confidentiality	53
Appendix 6: Toestemming Vorm vir Vertroulikheid	55
Appendix 7: Key Informant Interview Guide	56
Appendix 8: Interview Guide for Focus Group Discussions	58

LIST OF TABLES

Table 1: Characteristics of participants	15
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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

Prevention of mother-to-child transmission of HIV (PMTCT) programme forms an integral component of the overall HIV prevention strategy worldwide (WHO, 2006). According to UNAIDS (2010), an estimated 2.5 million children less than 15 years were living with HIV and the majority of these were in sub-Saharan Africa. The majority of children who live and die of HIV infection acquire it through mother-to-child transmission (MTCT). MTCT accounts for up to 90% of all HIV transmission in children less than six years old (Rutenberg et al, 2003; Global HIV/AIDS Programme, World Bank, 2003). It was estimated that 25 - 45% of children born to HIV positive mothers will acquire the HIV infection during pregnancy, labour and delivery or through breastfeeding, if no active intervention is put in place (CDC, 2007; WHO, 2008). This percentage has been reduced to less than 2% with the use of antiretroviral (ARV) drugs as well as other core PMTCT interventions such as safe breastfeeding methods in the developed world (Cooper et al, 2002). Such interventions require the involvement of male partners especially in sub-Saharan Africa where women make decisions regarding their reproductive health in consultation with their partners (Biratu and Lindstrom, 2006).

Male involvement in maternal and child health care (MCH) as caring fathers and decision makers is central to improving reproductive health and to the incremental process of achieving gender equity (Greene et al, 2006). Men play an important role in women's reproductive health matters such as PMTCT, family planning and treatment of sexually transmitted infections (STIs). Furthermore the involvement of men in MCH creates an opportunity to address men's set of unmet reproductive health needs. Failure to realise the full benefits of HIV prevention programmes has prompted the need to scale up involvement of men in reproductive health matters. In sub-Saharan Africa, where HIV prevalence rates are highest in the world, male involvement in women's reproductive health matters has been generally low (Greene et al, 2006; Kumar, 1999).

1.2 HIV/AIDS and MTCT-plus programme in Namibian

In Namibia, HIV/AIDS is ranked the most important public health problem because of its high morbidity, mortality and socio-economic burden. The national adult HIV prevalence rate is currently at 13.1%, and 17.3% among pregnant women (MOHSS, 2010). The HIV prevalence rate among children is not known since sentinel surveys are only conducted on

adults. In Gobabis district where the study was undertaken, the HIV prevalence rate among pregnant women was 15.6% (MOHSS, 2010).

The Government of Namibia embarked on a number of HIV prevention and treatment programmes in an effort to combat this disease burden (MOHSS, 2004; MOHSS, 2008). The country adopted the WHO (2006) four-pronged strategy to prevent mother-to-child transmission of HIV. This includes: 1) prevention of HIV infection among parents to be; 2) prevention of unwanted pregnancies in HIV infected women; 3) prevention of HIV transmission to their infants and 4) treatment, care and support of infected women, their children, partners and families. The Namibian government also made it a policy that all HIV/AIDS services are easily and freely available to the people in all state health facilities (MOHSS, 2007).

The four-pronged strategy to prevent mother-to-child transmission of HIV is part of the MTCT-plus initiative which calls for a family centred approach to HIV care and treatment (Betancourt et al, 2010). A family centred approach to HIV care and treatment regards pregnant women attending Antenatal care (ANC) as an entry point for promoting voluntary counselling and testing and for providing lifelong care and treatment for HIV/AIDS disease to families. The approach broadens HIV prevention activities and considers HIV as a family disease thereby avoiding the pitfalls of biomedical interventions which only focuses on the pregnant mother (Betancourt et al, 2010). The MTCT-plus initiative also strives to strengthen local health capacity in decreasing stigma and empowering people living with HIV/AIDS (WHO, 2010).

The Namibian PMTCT national coverage is currently estimated to be 75% (MOHSS, 2011). Transmission rates of HIV to the new born babies have remarkably gone down, from 33% in 2002 when the programme started, to 12.7% in 2009 (MOHSS, 2011). The substantial progress in providing PMTCT has been attributed to the massive campaign for the programme and a lot of resources allocated for the broader maternal and child health care (MCH). Mobile services were also put in place to cater for the difficult to reach population. Difficult to reach population includes people who lead a nomadic way of life and those who reside in areas which are difficult to access due to poor infrastructure. Although available, mobile services are poorly utilised because of poor road infrastructure and communication networks. The Universal Access target of MTCT rates of less than 5% by 2015 has however

not yet been achieved. Male partner involvement in the MTCT-plus programme has been acknowledged as a key pillar in government efforts to reduce HIV transmission rates. In an effort to boost the campaign to eliminate mother-to-child transmission of HIV, a campaign to involve men was launched by the first lady in March 2011 (MOHSS, 2011). Nationally only 3% of men are estimated to participate in ANC clinic HIV counselling and testing (MOHSS, 2011). From personal experience men in Namibia generally shun participation in all MCH activities.

1.3 Gobabis District MTCT-plus programme

In Gobabis district, participation in the MTCT-plus programme by pregnant women has been reasonably high at all antenatal clinics. The “opt-out” testing strategy facilitated the acceleration of the MTCT-plus uptake. However men in this district generally do not participate in women’s reproductive health activities. According to the 2011 District Annual Report, 99% of pregnant women who attended ANC were counselled and tested for HIV (MOHSS, Omaheke Region Annual report, 2011). Those who tested positive accepted to participate in the programme, although some were lost to follow up. Despite high participation by women in this programme, male partner involvement is low. In 2011, Gobabis District only managed to report less than 10% of pregnant mothers who participated in the MTCT-plus programme with their male partners (MOHSS, Omaheke Region Annual report, 2011). It is against this background that this research was conducted to investigate factors that might contribute to low male partner involvement in the programme.

Gobabis district is located in Omaheke region. Omaheke region is divided into seven political constituencies. The Gobabis constituency is located at the centre of the region and serves as the administrative and commercial town for the region. Omaheke is a commercial cattle farming area and part of it is rural. Most households are classified as low income. At the time of the study, Omaheke region had a population of 83 000. The population is multi-tribal, with different cultural and traditional beliefs. Cross-tribal marriages take place. Some couples prefer cohabitation instead of marriage (LaFont and Hubbard, 2007). There are five main tribes (Herero, Tswana, Damara-Nama, Oshiwambo and the San). The Herero tribe constitutes the bulk (39%) of the Omaheke population. The San community stays mostly in the rural and farming areas and constitutes only 7% of the population (Central Bureau of Statistics, 2005). Afrikaans is the unifying language spoken by most of the people.

Gobabis State hospital is the only referral centre for the whole region. It has a full staff complement of doctors, nurses, physiotherapists, radiographers, pharmacists and social workers. There are 13 clinics dotted around the region to serve the rural and farming area population. Primary Health Care (PHC) and MTCT- plus services are available and accessible at all state health centres and clinics. Services are provided by nurses and community counsellors on daily basis. A doctor visits these clinics on outreach services once every month. Because the region is so vast and sparsely populated, mobile clinics were set up and made available to people who stay far away from health facilities. Mobile clinics operate from each of the 13 health centres. Use of MCH services by the women in Omaheke region has generally been high with 90% of women delivering at a health centre and attended to by a skilled health worker (MOHSS, 2007).



CHAPTER 2: LITERATURE REVIEW

2.1 The meaning of men's involvement

The meaning of men's involvement varies from source to source and depends on the context in which it is applied. Terms such as "men's participation, men's involvement, men's responsibility, men as partners and men in sexual and reproductive health" have widely been used (Drennan, 1998, Green et al, 2002, Green et al, 2006). Their purpose is to describe a complex process of social and behavioural change that is needed for men to play more responsible roles in reproductive health (Drennan, 1998). Men's involvement can be viewed from a programme perspective. It may mean men supporting choices and rights of their female partners, or men getting involved in the programmes for their own sexual and reproductive health needs, or as a way of protecting their sexual partners (Lee, 1999). Some men may choose to accompany their partners to the ANC clinics and get involved in counselling and testing for HIV. Others opt not to accompany their partners to the clinic. They may instead support their partners in coping with the stress of living with HIV. While some may pay for their partners' health care, others provide transport for their partners to get to the clinic (Ruterburg, 2002).

In this study, male involvement in reproductive health programmes means men's readiness to provide support to their female partners in all MTCT-plus programme activities that are aimed at improving family health. These include providing moral or financial support, accepting counselling and testing, becoming ARV treatment supporters for their partners, promoting the use of prophylactic ARV drugs and getting involved in the choice of baby feeding options.

2.2 Benefits of men involvement in PMTCT programme

Men's involvement in women's reproductive health programmes has been of much interest especially after the 1994 International Conference on Population and Development (ICPD) in Cairo. After the launch of the PMTCT programme in the late 1990s, there was renewed interest in male involvement in women's reproductive health programmes. This was prompted by the realisation that men play an important role in the implementation of programmes such as PMTCT, family planning and treatment of STIs (Clark, 2001; Ntabona, 2002; Green et al, 2006)

The role of men in women's reproductive health is well recognised in that it improves the health of their families and themselves (Greene et al, 2006; Lee, 1999). It is crucial because men influence women's access to health services through their control of finances, transportation and health care decisions (Greene, 2002). This is very important especially in the African context where there is rapid spread of HIV and where men's involvement in reproductive health is viewed with negative stereotypes because of cultural norms and taboos (Kumar, 1999). It is therefore difficult to implement MTCT-plus interventions without male partners' understanding and consent.

The success of PMTCT programme as an effective HIV prevention strategy has long been reported in many countries such as Uganda, Kenya, Haiti and Namibia (PEPFAR, 2004). Since the launch of the programme, many studies have been conducted in various parts of the world on the involvement of the male partner in the implementation of these programmes (Reece et al, 2010; Theuring et al, 2009; Nkuoh et al, 2010; Msuya, 2008). This was prompted by the realisation that male partner involvement improves adherence to PMTCT programmes during antenatal care (CDC, 2007; Clark, 2001) which ultimately results in decreased likelihood of HIV transmission from mother to child (Aluisio et al, 2011). Furthermore the PMTCT programme has also opened the door for MTCT-plus initiative which involves comprehensive family-centred health care and provision of enhanced HIV-specific primary and preventive care (Betancourt et al, 2010).

WHO (2006) advocates for a four-pronged strategy to prevent mother-to-child transmission of HIV. This includes: 1) prevention of HIV infection among parents to be; 2) prevention of unwanted pregnancies in HIV infected women; 3) prevention of HIV transmission to their infants and 4) treatment, care and support of infected women, their children, partners and families. This strategy, which was also adopted in Namibia, requires the involvement of men. Pre-existing level of communication within the couple around sexual and reproductive health issues influences the acceptability of prenatal HIV counselling and testing and the choice of infant feeding practice (Biratu and Lindstrom, 2006; Bakari et al, 2000; Kiarie et al, 2004).

Despite these benefits, the involvement of male partners in MTCT-plus programmes was also shown to be non supportive. A literature review conducted on male participation in PMTCT revealed that non supportive descriptions of male partner participation included lack of discussion on HIV related matters, HIV-related intimacy violence, and abandonment or fear of abandonment (Auvinen, Souminen and Valimaki, 2010). For example in Durban, South

Africa, Maman and others (2011) showed that direct threats and experiences with violence caused some HIV positive women to fear partner involvement.

2.3 Factors affecting Men's Involvement in PMTCT programmes

2.3.1. Socio-economic factors

The socio-economic status of people affects their health seeking behaviour as well as gender and power relations. The range of factors which limit male participation in women's reproductive health matters include time constraints, lack of financial resources and decision-making relating to health care (Reece et al, 2010). For example due to financial constraints, some men may not afford to accompany their partners to the ANC, in cases where access to health services involves transport costs and user fees. In a study in Tanzania, Msuya and others (2008) found that some of the main predictors of male partner participation in ANC activities were high income and staying with the partner. It was also shown in the same study that women who stayed with their partners collected their own HIV results and expressed interest in sharing their status with their spouses.

2.3.2 Cultural practices and men's beliefs and perceptions

Male participation in women's reproductive health has been viewed with negative stereotypes in many African societies because of cultural norms and taboos (Kumar, 1999). The prevailing cultural practices that encourage men to be aggressive in sexuality and not to treat their partners as equal partners have shaped men's perceptions and attitude regarding participation in women's reproductive health (Baker, 2005). Some men believe that pregnancy and the PMTCT programme is a woman's affair, where men have no role to play (Theuring et al, 2009, Nkuoh et al, 2010, Falnes et al, 2011). They also believe that men's role is primarily providing financial support for the woman's care.

A research conducted in Kenya in 2009 indicated that men have a belief that they lack necessary skills to support their partners during pregnancy. The same study also showed that men have a perception that female nurses were opposed to male participation in PMTCT activities (Reece et al, 2010). Some perceptions which affected male participation in PMTCT programme highlighted in other studies were that they were viewed as jealous by the community if they accompanied their wives to the antenatal clinic (Nkuoh et al, 2010).

2.3.3 Women's fear of victimization and HIV stigmatization

The MTCT-plus programme regards the pregnant women as an entry point for a family centred HIV care. It is women who get tested first in the MTCT-plus programme. They are then asked to divulge their HIV status and to invite their male partners to participate in the MTCT-plus programme. A recent study in four African countries namely, Burkina Faso, Kenya, Malawi and Uganda showed that despite women's satisfaction with PMTCT services, HIV disclosure to male partners is still a problem (Hardon et al, 2012). In some cases women even consult their partners first for approval of the HIV test (Bajunirwe and Muzoora, 2005). Because of fear of abandonment and or HIV related intimacy violence, some women chose not to involve their partners in the programme. As a result of this fear and lack of disclosure some women prefer not to inform their partners about the programme (Reece et al, 2010). There is also fear of stigmatisation and social isolation by men if they engage in HIV related activities. In Uganda a study showed that mistrust in marriage was a reason why men do not accept couple HIV counselling during antenatal care since they perceived their marriages as unstable and distrustful, making the idea of couple testing unappealing because of the conflicts it could give rise to (Larsson et al, 2010). Some men know the benefits of getting involved in the MTCT-plus programme but are precluded from participating due to fear of an HIV test (Reece et al, 2010; Theuring et al, 2009).

2.3.4 Institutional barriers

Studies have shown that men know about the MTCT-plus programme and are willing to participate (Reece et al, 2010; Theuring et al, 2009, Nkuoh et al, 2010). However the contradiction between men's beneficial attitudes towards their involvement and low participation rates suggest that external roles play a major part in their decision making process (Theuring et al, 2009). Institutional or organisational obstacles might be the major contributor of low male participation. The environment at most ANC clinics which is predominantly female was shown to be a contributing factor for low male participation in MTCT-plus programmes (Falnes et al, 2011). The biased gender representation of ANC workers may make men feel uncomfortable to accompany their pregnant wives to the clinic. For example, a research conducted in Kenya in 2009 indicated that men have a perception that female nurses were opposed to male participation in PMCT activities (Reece, 2010). The attitude of health workers has been shown in some studies to stop men from attending ANC activities (Theuring et al, 2009; Falnes et al, 2011) In addition, poor MTCT-plus counselling

offered at ANC may also affect the disclosure of HIV status to partners if the partner did not participate in the counselling process (Kadowa and Nuwaha, 2009; Ismail and Ali, 2009)

2.4 Conclusion

Benefits of male partner involvement in MTCT-plus are well known. Factors cited as contributing to low male partner involvement in this programme are mainly socio-economic, traditional beliefs, lack of knowledge and institutional barriers. Although some studies have been done on factors associated with low male partner involvement in PMTCT programmes, some gaps in this field still exist. For example, from the data base searched, there was no published research that targeted male partners of HIV positive women who do not turn up for MTCT-plus services. The study was one of the first one to be conducted in Gobabis district with focus on the utilisation of MTCT-plus services by men.

2.5 Problem Statement and Rationale for the study

The MTCT-plus initiative calls for a family centred approach to HIV care and treatment. In addition to reducing mother-to-child transmission of HIV, the initiative aims to promote voluntary counselling and testing as well as provide lifelong care and treatment for HIV/AIDS disease to families (WHO, 2003). Since the programme started in 2004, Gobabis district MTCT-plus programme has reported yearly between 6% and 9% of HIV positive pregnant mothers who participate in the programme with their partners (MOHSS, Omaheke Region Annual report, 2011). Strategies such as use of mass media and partner invitation cards have been tried but failed to raise the percentage of HIV pregnant women who participate in the programme with their male partners.

Men play an important role in women's reproductive health matters such as PMTCT, family planning and treatment of STIs. Male partner participation in MTCT-plus programme improves their health as well as that of their families (Greene et al, 2006). Such an initiative is important because it broadens HIV treatment and prevention measures to include other family members instead of narrowly focussing on MTCT biomedical interventions on the pregnant women during the perinatal period (Betancourt et al, 2010). In Gobabis District, HIV prevalence rose from 13.1% in 2008 to 15.6% in 2010 despite the national HIV prevalence rate among pregnant women remaining constant at 17.3% within the same period (MOHSS, 2008; MOHSS, 2010). One of the reasons explaining this rise in HIV prevalence was attributed to the failure to effectively implement the MTCT-plus programme. It was assumed that the MTCT-plus programme would assist in identifying a lot of sexually active

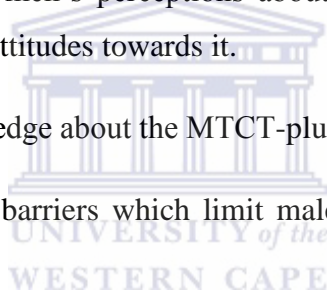
men who were not aware of their HIV status. If men know their HIV status, they are likely to practice safe sex behaviour resulting in mitigation of the spread of HIV. The Omaheke region and Gobabis district AIDS committees expressed concern about this situation. The study was conducted to investigate factors that might be contributing to low male partner involvement in the MTCT-plus programme in Gobabis District. The information elicited from the study will be used to provide recommendations aimed at increasing male partner participation in the MTCT-plus initiative.

2.6 Study aim:

To investigate factors influencing male partner involvement in MTCT-plus programme in Gobabis District, Omaheke Region, Namibia.

2.7 Objectives of the study

1. To identify and describe men's perceptions about the MTCT-plus programme and how this influences their attitudes towards it.
2. To establish men's knowledge about the MTCT-plus programme.
3. To identify and describe barriers which limit male participation in the MTCT-plus programme.



CHAPTER 3: STUDY METHODOLOGY

3.1. Study Design

This study was conducted using a qualitative research design because of the nature of the problem that was being researched. When conducting a qualitative study, the researcher purposefully avoids controlling the research conditions and concentrates on recording the complexity of situational context and interrelations as they occur (Marshall and Rossman, 1995). The main factors associated with low male partner involvement in PMTCT programmes as outlined by other studies have been attributed to cultural and social traditions as well as institutional or organisational obstacles that influence men's perceptions about the programme. Exploring these perspectives through in-depth interviews and FGDs constitutes a critical step for developing strategies to increase male partner participation in the programme. This was most appropriate in a community such as that of Gobabis District which consists of different tribes with different socio-cultural backgrounds and traditional beliefs.

3.2. Study Setting

The study was done in Gobabis district in Omaheke Region which is on the south-eastern part of Namibia. The population of the region was 83 000 during the time of the study. It is multi-tribal, with different cultural and traditional beliefs. Cross-tribal marriages take place. Gobabis is a small and only town which is located at the centre of the region.

The study was conducted in two sites within Gobabis town (Gobabis State Hospital and Epako ANC clinic). The two sites provide MTCT-plus services. These sites were conveniently sampled because the researcher worked at these sites and hence had easy access to them. Gobabis State Hospital is the only referral centre in the region. The hospital has a full staff complement. Epako Clinic serves as the PHC clinic for the town and peri-urban population.

3.3. Study Population

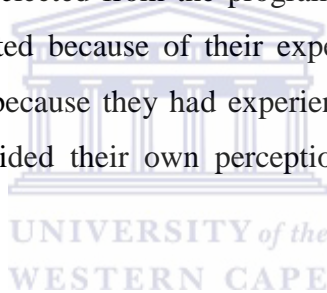
The study population consisted of three sets of participants. This included women aged 18 and older attending the MTCT-plus programme, men aged 18 and older and midwives and regional and district health management personnel. The first set was comprised of key informants running the programme. These respondents were selected because of their expert

knowledge in the field of HIV and MCH. They were purposefully selected from the regional and district health management teams and ANC midwives.

The second set of participants comprised of HIV positive pregnant women and other women in their post-natal period. All women participants were aged between 18 and 45 years. The third set was made up of men. Some of these men were partners of women participating in the MTCT-plus programme. The study also included ordinary men sampled at the hospital out-patients department (OPD) in order to solicit their insights into the programme. All male participants were above 18 years.

3.4. Sampling technique and Research Participants

Purposive sampling method was used in this research. In most qualitative research studies, sampling of participants aims to select information-rich cases for in-depth study to examine meanings, interpretations, processes and theory (Coyne, 1997). Seven key informant interviewees were purposefully selected from the programme management teams and from midwives. Midwives were selected because of their experience in MCH. Key informants were important in this research because they had experience and crucial information about the programme. They also provided their own perceptions on the reasons for low male partner turnout in the programme.



Women who participated in the FGDs were systematically recruited from PMTCT registers at two antenatal clinics in Gobabis town (Epako clinic and Gobabis state hospital). Every second woman in the ANC PMTCT register (which normally has 12 – 18 women per month) who gave consent to participate was selected to make up 19 participants for the two FGDs. This group was very important because they provided information based on their personal experiences on gender and power relations as well as reasons as to why some male partners were not participating in the programme.

Male research participants were partners of women participating in the MTCT-plus programme and some men conveniently sampled from the hospital out-patients department. Some of the male participants were participating in the programme with their female partners, while others were not. Women in the MTCT-plus programme were asked to provide the names of their partners so that research assistants could make a follow up to request them to participate in the study. Only seven men who were partners of female participants gave consent to participate. The other group of male participants were purposively sampled at the

hospital outpatients department. These men were not participating in the MTCT-plus programme. They were randomly selected on two particular clinic days for their consent to participate in the study. The study had 7 key informant interviews, and 4 focus group discussions; each with at least 8 - 10 people. Each FGD consisted of people of the same gender.

3.5. Data collection Methods

The researcher collected data through key informant interviews and FGDs. All FGDs were conducted by the researcher with aid of two trained research assistants (one male and one female) who were HIV community counsellors.

3.5.1. Key informant Interviews

Individual interviews with seven key informants (HIV programme managers and midwives) were conducted by the researcher in English after obtaining their consent (Interview Guide, Appendix 4). Interviews with three programme managers were conducted in their respective offices at Omaheke Regional offices. Four midwives from two health facilities were interviewed. All key informants were conversant in the English language. Time spent on interviews ranged from 35 to 40 minutes. The interviews were all tape-recorded. The purpose of the interviews was to gather information on activities of the MTCT-plus programme and how it is promoted. They were also intended to solicit key informants' experiences and perceptions on the involvement of men in MTCT-plus programme.

3.5.2 Focus Group Discussions

The two research assistants who were community counsellors were trained in qualitative interviewing skills and in facilitation of FGDs before the study was conducted. This was because the researcher did not speak Afrikaans although he understood it. The advantage of using these research assistants was that they had experience and knowledge about the MTCT-plus programme. They were working at the HIV rapid testing sites. They also had some skills and experience in HIV group counselling. Research assistants were fluent in Afrikaans which was the medium of exchange during FGDs. Research assistants were from the same region with the respondents but working in different facilities.

The study had four FGDs which were all conducted in Afrikaans language. The language was understood and spoken by all the participants (Interview Guide for Focus Group Discussions Appendix 5). However some participants felt more comfortable to express their views in their

own languages. The two research assistants were conversant with these languages. All the FGDs were conducted at Gobabis hospital because the two selected research sites are close to each other. The researcher was part of the FGDs in order to direct the focus of the discussion and to note non verbal communication of the participants. While the male research assistant was taking notes, the female research assistant assisted the researcher in translation during the group discussion with female participants. The roles of the research assistants were exchanged during FGDs with male research participants.

The first two FGDs comprised of HIV positive women participating in the MTCT-plus programme. There were five pregnant women and four women in postnatal period in the first group. The second group had 6 pregnant women and 4 women in the postnatal period. Their ages ranged from 19 years to 36 years. The last two FGDs were also conducted with men only. There were seven men who were partners of women who had previously participated in the women's FGDs. 12 men were men conveniently selected from the hospital OPD. The men were aged between 24 and 51 years. Time spent on FGDs was between 50 minutes and 1 hour. All FGDs comprised of people from different tribes. This was because cultural differences shaped men's participation in women's reproductive health. Table 1 below summarizes participant characteristics.

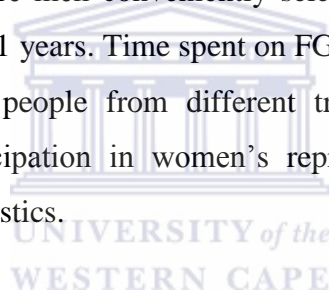


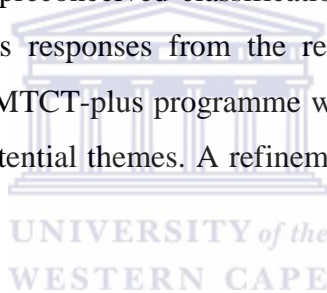
Table 1. Participant characteristics

Participant characteristic	Women		Men	
	<i>n</i>	%	<i>n</i>	%
Tribal Identity				
Herero	6	26.3	3	15.8
Tswana	4	21.0	4	21.0
Damara-Nama	7	36.8	6	31.6
Oshiwambo	2	10.0	5	26.3
San	0	0.0	1	5.2
Marital Status				
Married	4	21.0	5	26.3
Cohabiting	7	36.8	7	36.8
Single parent	6	31.6	1	5.2
Other	2	10.0	6	31.6
Partners of participant in FGD				
Yes			7	36.8
No			12	63.2
Employment Status				
Employed (full time/part time)	6	31.6	14	75.7
Unemployed	13	68.4	5	26.3
Living with HIV				
Yes	19	100	7	36.8
No	0	0	3	15.8
Unknown	0	0	9	47.4
Key informants				
Programme managers	3	42.8		
Midwives	4	57.2		

3.6. Data analysis

The analysis of data was a continuous process and started during data collection process. Thematic analysis was used for data analysis. This method offers an advantage in that it is a flexible and useful data analysis method which can provide a rich and detailed account of data (Braun and Clarke, 2006). After the key informant interviews and FGDs, the tape recorded interviews were transcribed and translated. The data collected from the field consisted of field notes and transcriptions of key informant interviews and FGDs.

The first step in analysing transcribed data and field notes involved repeatedly reading the data. Each line and sentence was read and analysed searching for words and phrases that had similar meaning. Trends on which words were mostly repeated and what meaning they held to various participants in relation to research objectives and questions were noted. A process of coding and categorizing the contents of these data was done through use of participants' own words and phrases without preconceived classification. This assisted the researcher to establish the meaning of various responses from the respondents. The recurring themes related to men's involvement in MTCT-plus programme were identified through the process of sorting different codes into potential themes. A refinement of the themes was done at the end.



3.7. Rigour

There were several ways in which rigour was ensured in this qualitative study. Different sources of data were used in this study. In-depth interviews were conducted with key informants who were programme managers. Focus group discussions were held with both men and women from different tribes. This ensured a diversity of the sources of the information. Two data collection methods were used. Three investigators were involved in the research. Key points were summarised at the end of each FGD to verify whether the researcher's understanding and interpretation of participants' perceptions were accurate. Research assistants went through intensive training and orientation on the research.

The audit trail was done through taking notes and having a diary of personal thoughts and feelings for personal monitoring. Throughout this study the researcher gave an account of his background and acknowledged and described his beliefs and biases. The beliefs and biases were documented in a separate diary and regularly revised throughout the research for personal monitoring. This was done to ensure credibility of the research findings. The

supervisor was updated regularly as the research progressed. Another way of ensuring rigour was through debriefing during Regional Management Team (RMT) meetings with fellow doctors and colleagues in public health during the process of research and data analysis.

3.8. Study limitations

The sample size was a limitation in this study because the researcher conducted only four FGDs and seven key informant interviews to satisfy the needs of the mini-thesis. The sampling strategy was not meant to be representative of the population. Research participants were sampled from within Gobabis town and the peri-urban area. These participants might have been more informed about the programme compared to those staying in rural areas. Socio-economic status and literacy level of the selected participants might also have been higher as well hence affecting their health seeking behaviour. Since there is a wide cultural diversity in Gobabis district more group discussions could be needed to reach a level of data saturation. Hence the results could not be generalised to the population of Gobabis District. Since the researcher is not conversant in local languages other than Afrikaans, some information could have been lost through the use of translators. Research assistants were from the same region with the respondents. This might have made some respondents uncomfortable to share their experiences and perceptions. During interviews, ethnocentrism could have played a part as evidenced by some key informants who became defensive when discussing issues concerning their tribes. It was also difficult to get participants from the San community since they contribute a small percentage of the population. The other reasons could be that HIV prevalence rate among them is low and that their health seeking behaviour is poor.

3.9. Ethical Considerations

When conducting any research that involves humans as participants, the main ethical issues to be considered include; the voluntary nature of participation, obtaining informed consent, risk reduction for participants, ensuring confidentiality and privacy of participants and institutional ethical approval (Polit and Beck, 2004). Since this research involved complex issues around HIV disease, which is a highly stigmatised disease, participants were well informed about the research and assured of confidentiality for them to participate voluntarily (Participant Information Sheet Appendix 1). It was emphasised that the FGDs were going to focus on reasons why some men are not participating in the programme, and not on participants' personal lives.

All participants were given an information sheet explaining the research and its purpose, requesting their participation and assuring them of confidentiality. Participation in the study was voluntary. All women participants approached agreed and consented to participate in the study. Out of the twelve male partners of women participants, only seven men agreed to participate. Participants were allowed to withdraw from the study at any time. All participants were over the age of 18 years and signed consent forms before each FGD and interview (Consent form Appendix 3 and 4). FGDs participant also signed confidentiality statements (Consent on Confidentiality Appendix 5 and 6). Besides snacks and drinks served after FGDs, no other compensation was given to participants. The findings of the FGD and KI interviews are stored in a code-controlled computer. Data files are kept in a lockable cabinet. Ethical clearance was obtained from the Gobabis Regional Management team (RMT), Namibia Research Council and the University of the Western Cape ethical clearance committee.



CHAPTER 4: FINDINGS

4.1. Findings

Men in this study were generally knowledgeable and supportive of participation in the MTCT-plus programme but only a few participated in the programme. Men's participation in women's reproductive health issues is affected by cultural practices, HIV related stigma, health facility organisational barriers, multiple sexual partners and work commitments. Study findings highlight the nature of complexities that emanate from cultural practices and its interference with HIV related prevention and treatment programmes. Health facility related barriers were the unfriendly staff attitude and clinic set up which was reported as unfriendly to men. HIV related stigma still remains a big challenge for men to participate in MTCT-plus programmes. Men however cited other reasons such as work-related commitments as the reason for not coming to the ANC clinic instead of HIV related stigma. The habit of multiple sexual partners was a significant barrier which made it difficult for men to accompany their partners to ANC clinic. The problem of inter-generational relationships that result in teenage pregnancies was another barrier for male participation in the MTCT-plus programme.

4.2. Factors influencing male partner participation in the MTCT-plus programme

Different themes emerged from the discussions representing factors that were identified as most influential on the likelihood that a male partner would get involved in the MTCT-plus programme. Although there was general consensus on most themes by research participants, some notable differences arose across tribes, type of spousal relationship and age groups were observed.

4.2.1. General attitude and knowledge about MTCT-plus programme

Almost all male participants knew about the MTCT-plus programme in general but were not knowledgeable about all its core interventions. The interventions mentioned by men were use of the ARV prophylaxis and avoiding breastfeeding. Some of the interventions were wrongly interpreted. For example, avoiding or early cessation of breastfeeding was generally associated with HIV. The general attitude and support towards the programme was mirrored in FGD statements such as;

“I don’t think anybody can claim that they don’t know about HIV these days. We all know that pregnant ladies are given the tablets (ARV) so that the baby does not get the infection (HIV)”;

“I know about it (PMTCT) because everybody is talking about it. When you see a lady not breastfeeding a baby then she must be in the programme”.

When asked about the source of information for the MTCT-plus programme, some men indicated it was from their partners. It turned out that the majority of men were aware that pregnant women were tested for HIV as part of routine ANC. Most men were supportive of their partners being tested for HIV and showed interest in knowing the results of their partners. As one male participant mentioned,

“Obviously I will ask her about it (HIV status) when she comes back (from ANC) because I would like to know”.

Women participating in the FGDs indicated that it was easy for them to disclose their HIV status because their partners asked for the HIV results in most cases. When asked on how easy disclosure was, most women agreed with one participant who said,

“He knew I was going to the (ANC) clinic and I was going to be tested. When I came back he was the first one to ask me about the test results. I simply handed him the (ANC) card”.

It also turned out that the electronic and print media as well as health education given at health facilities and mobile health clinics were men’s important source of information about the programme. Comments such as these showed that men were knowledgeable and that there were various sources of information about the MTCT-plus programme.

“We see these things everywhere we go. At the clinics, post office, municipality offices, everywhere pictures (of couples undergoing counselling) are pasted on walls”.

According to these participants, information about the programme was abundant.

4.2.2. Cultural and traditional practices

Some of the male respondents felt that they are dissuaded from taking a role in the reproductive health of their partners because of cultural practices. In the Otjiherero and Tswana cultures (which are the predominant tribes in Omaheke), it is the responsibility of the pregnant woman’s own biological mother to take care of her during the first pregnancy, especially towards the delivery period and a month after delivery. As evidenced by one key informant who said,

“In my tribe (Herero), I have to look after my daughter in my own house when she delivers the first baby. When the boyfriend (husband or fiancé) visits to see the baby he is not even allowed to enter the house...”

The male partner is not supposed to get in contact with his partner from a month prior to delivery up to a month post natal. However a man can still accompany his female partner to the ANC earlier before her own mother takes over care during the later part of the pregnancy. Such a practice is observed even on the subsequent pregnancies unless the women gets married and stays with her husband. The same sentiments about this cultural practice were echoed by the Herero and Tswana women participants in the FGDs. This cultural practice is not observed among the Damara-Nama and Oshiwambo tribes who instead stay with their pregnant partner until she gives birth. As confirmed by one Oshiwambo women,

“In the North (Ovamboland), we don’t have this practice anymore, of my mother staying with me when I am pregnant. My mother only comes to see me when I am seriously sick ...”

However, when a Damara-Nama or Oshiwambo man marries a Herero woman (cross-tribal marriage), her mother will take care of her during the later stages of her pregnancy until a month after giving birth. This cultural practice is prevalent in Omaheke region. It has made men believe that pregnancy and other reproductive health matters are a ‘women issue’. It has also made them to believe that it is a taboo for them to get involved in women’s reproductive health matters. When asked whether that practice affected their participation in MTCT-plus programme, one male respondent put it as follows,

“...I also want to be there (ANC consultation and delivery rooms), but surely how can I stand besides my mother in law when my wife is being attended to. I would rather hire a taxi for them to go to the clinic, after all they tell me to go out when the moment (delivery time) comes”.

By being physically distanced from their partners during pregnancy and soon after delivery, a lot of men felt that it is difficult for them to discuss and support their partners on issues related to reproductive health and HIV care. Instead of getting involved directly in the MTCT-plus together with their partners, men claimed that they rather offered financial support for transport and other health related costs.

The midwives also agreed that the old cultural practice stopped men from participating in the MTCT-plus programme. One of the midwives commented,

“Among Coloureds and Whites, there is no such a practice that is why ninety percent of them always come with their partners...”

However women felt that men could still play a more supportive role even under those circumstances. For example, during early pregnancy, a man can still accompany his partner to the ANC for booking and for couple HIV counselling and testing. Moreover, with subsequent siblings, men can actively participate more in the programme since there is minimal interference from other family members. As one mother narrated,

“... men just give silly (sic) excuses, ...this is now my third (pregnancy) and still he does not come with me, the first one (pregnancy,) he was not coming because I was staying with my own mother at the farm who wanted to teach me how to take care of the baby...”

Another barrier to male participation in the MTCT-plus programme that came out from the FGDs was the community perception on men accompanying their partners to ANC clinic which was described as negative. Both male and female participants expressed concern about comments from the community if a man was seen accompanying his partner to the ANC clinic. Although all participants viewed it as a good idea, it was reported that the community saw it differently. A man who is seen with his wife at the ANC clinic made community doubt his manhood and was regarded as ‘weak’. Such a man was perceived as having lost control over his partner.

4.2.3. Lack of trust and confidence in health workers

Both men and women participants consistently indicated that they did not trust midwives and community counsellors in the MTCT-plus programme because of the perception that these health workers will fail to maintain confidentiality. Gobabis is a small town and a lot of people know each other’s personal lives. Participants indicated that some health workers were even related to them. Most midwives and community counsellors grew up and stayed in the same residential area as participants of the MTCT-plus programme. One male respondent had this to say,

“Imagine I come and get tested by these guys (community counsellors) and I am (HIV) positive, then the same day I see him at the bars drinking and chatting with his friends who also know me, what will go through my mind, what will they be discussing, obviously my status...?”

Key informants interviewees echoed the same sentiments, as commented by one midwife, *“The problem here is that, our town (Gobabis) is so small, such that a lot of them (men), because we know them very well, they think that we will go out there in the community and reveal their HIV status to other people, yet that is not true”*

This lack of trust and confidence in the health workers made men to believe that their positive HIV status may be revealed if they come to the ANC clinic with their partners. Men alleged that health workers were curious to know the partners of women who were HIV positive especially if they personally know the pregnant women. One male participant made an allegation and narrated,

“These people (community counsellors and midwives) when they see that a lady is pregnant and HIV positive they would really want to know, who made her pregnant and who gave her the disease. They then go to the location and make stories. Its better if she goes alone and then they won’t even know that it’s me.”

Men suggested that it was better for them to go to the private doctors who they trusted. When asked to invite their partners by midwives, women attending the MTCT-plus programme indicated that their partners refused to come because of lack of trust and confidence in the health workers.

4.2.4. HIV Related stigma

Fear of an HIV test was described by women as one of the main deterrent factors in influencing male partner participation in the programme. The programme managers consistently agreed that men were dissuaded from participating in the programme because of the stigma related to HIV. According to the midwives, every woman recruited into the MTCT-plus programme is asked to invite her partner for HIV counselling and testing. Women described this fear of HIV test by their partners as being a significant factor in preventing them from securing help in activities related to the programme such as support on adherence to ARV prophylaxis and breastfeeding choices. When asked why men are afraid of an HIV test one respondent answered,

“Instead of going for the HIV test on his own, he relies on my own (HIV) status... that is why the moment you leave the (ANC) clinic, an sms (short message service) will come asking “what did they say? Because he is afraid to be tested himself”

The majority of women participants claimed that they had revealed their status to their partners because their partners had shown interest in knowing the results. Men also agreed that they knew that all women attending ANC clinic were tested for HIV. Women in the FGDs indicated that they managed to overcome the fear of an HIV test because of the desire to have an HIV free baby. As one woman explained,

“With us (women), we have no option but just to accept the test because you want to give birth to a baby with no HIV”

On the contrary most men expressed willingness to go for HIV couple counselling and testing. However none of the participants had done it with their partners. The few men who were participating in the programme were tested individually, without their partners. Men denied that they were afraid of the HIV test but were not comfortable with being asked a lot of questions during couple counselling sessions. Some reasoned that there was no need for them to go for the test if their partners' status was already known. It was assumed by some men that the HIV status of a pregnant woman tested for HIV is automatically the same status of the male partner. Very few men believed in discordant HIV status. For example one man showed 'neglected importance of attending services' by saying,

“If she is tested and the result is known, then why should I rush to go and get tested? I can always go some other time when I am free because nothing will change.”

Meanwhile other men believed that their female partners had an obligation to go for the test and to comply with the prescribed HIV treatment or prophylaxis because it is a woman's responsibility to ensure that she delivers a healthy baby. Such deep-seated ideas about gender roles were found to be major obstacles to male participation in the MTCT-plus programme.

4.2.5. The problem of having more than one sexual partner

Both male and female participants in the FGDs concurred that men's willingness to participate in MTCT-plus programme was affected by the number of sexual partners they had. Women emotionally complained that, their partners tend to have other sexual partners. Most women (even those cohabitating) indicated that they did not mostly stay with their partners and that they were not married to them. Within marriages, men were still accused of having extramarital affairs. Because of such men's behaviour, women indicated that their partners did not want to escort them to the ANC clinic for fear of being exposed because the clinic and hospital were public places. They indicated that if a man accompanies one of the partners and not another, problems may arise between girlfriends. One woman emotionally said:

“How on earth do you expect someone with four or five girlfriends to take one of them to the clinic (ANC), he knows that he will create havoc if the other girlfriends come to know about it”

Key informants also expressed concern over the high number of non marital relationships. Such relationships were alleged to impact negatively on the efforts to reduce the spread of HIV. One midwife lamented the situation,

“We have a big problem here (in Namibia). Men don’t want to marry, yet they want to have children. They only want to get married when they are old. That’s why they end up having children from different women”.

According to the midwives, the few participants in the MTCT-plus programme who came as partners were legally married and staying together. Fifteen out of the 19 HIV positive women participants in the FGDs were not legally married. Economic hardships and social decay were among the reasons why men did not want to get married. When asked to comment on how spousal relationships influenced men’s perception about participating in the MTCT-plus programme, some men felt that they had no moral obligation to do so if one is not legally married to the woman. One of the male participants said,

“...yes, I might be the one who made her pregnant, but she is not my wife, so why should I be forced to come with her to the clinic...”

Women also argued that it was particularly challenging to engage partners in the MTCT-plus programme whom they were not staying with. A few women were also afraid of being blamed of bringing the HIV disease in the relationship and hence were contented in coming alone to the clinic rather than risking their relationships.

4.2.6. Work commitments

Working men specifically indicated that work commitments made it very difficult for them to accompany their partners to the ANC clinic. Men alleged that their employers declined to release them to accompany their partners to the ANC particularly because they will not appear sick. As one male participant commented,

“These Boers (employers) will not just let you go for no reason. He will subtract my working hours because I am a contract worker”

Another challenge which men faced when asking for some time away from work was discussing their HIV status with employers. Men indicated that it was particularly difficult to convince their employers when asking for some time away from work without talking about HIV. As explained by one male participant,

“If I tell him that I want to take my wife to the clinic, he will ask me, why? I can’t tell him that I am HIV positive. He might chase me away if he knows about it”

A lot of men thought that they risked losing their jobs if their HIV status was known by their employers. The men stated that the present system where health workers use word of mouth to invite them to the clinic does not work with their employers. They suggested that their

partners get invitation letters from ANC that could be presented to employers in order for them to get some time away from work.

4.2.7. Unfriendly environment at health facilities

Participants expressed concern over the unfriendly environment at the ANC clinic where MTCT-plus activities services are offered. The problems which participants raised with health care facilities can be divided into two, the clinic and hospital set up and the perceived staff attitude which was described as rude. It was evident from the discussion that participants were not happy with the midwives' bad attitude. This included shouting at or even insulting patients and blaming them for their HIV status. Men also indicated that they were afraid of being embarrassed by the midwives. However midwives argued that the system did not allow men to be present especially in the delivery rooms because of shortage of space. For example one male participant alleged that he was chased away from the delivery room when he accompanied his girlfriend to the labour ward.

“The young nurse told me to go out and was shouting at me saying ‘can’t you see there are naked women all over, what’s so special about your girlfriend”

It was alleged that such unfair patient treatment was mostly perpetrated by young female midwives. One female participant said,

“These young nurses are very rude. If you book late, they insult you. They ask “where were you all this time” If you are HIV positive it is even worse, they start asking a lot of questions”.

According to participants in the FGDs, such comments demonstrated that some health workers were impatient and not sensitive to patients' concerns. Some participants reported that they were blamed for reporting late to ANC and hence starting ARV prophylaxis late in pregnancy because of transport problems. Besides precluding men from accompanying their partners to ANC clinic, participants felt that this rude staff attitude also resulted in delay in seeking health care even by the pregnant women. Because of this perceived rudeness by health workers, men were ashamed of coming with their partners to participate in the MTCT-plus programme. Men suggested that male nurses be deployed to ANC as well. As suggested by one male participant,

“Why is it that there are only ladies in ANC, we also want male nurses because it will be easy for me to ventilate my feelings if I am talking to a man.”

Men felt that male nurses are better disposed to treating them better when they come for ANC with their partners.

The set up at the clinic which separated pregnant women from other patients on ANC days was cited as one of the reason which prevented men from attending ANC activities. Men felt uncomfortable to sit among a group of women attending ANC. Such a set up demonstrated some of the challenges in the institutional organisation and lack of services integration which all worsened HIV stigma. As shown by one man's comment,

“Imagine I am the only man seated on that bench (waiting place), and all around me are just pregnant ladies...people these days know too much... pictures of these things (of couples undergoing HIV counselling and testing) are all over the walls, they will automatically say, that one with his pregnant girlfriend is HIV positive, what is he doing here”

Women were of the opinion that a separate arrangement for them was convenient in that it ensured that they were helped on time. That system also ensured that they received due care and attention as pregnant mothers as opposed to being attended to together with other patients.

Women were against being sent from one room to the next if they needed HIV counselling and testing. Comments such as these expressed women's frustration with the existing system, *“Why should you be moved from one room to the next, from there to that one..., it's better if they just do everything in one room...”*

“The nurses can still do the test and give us the medicine. We don't want other people to see us going to that room (HIV rapid test room).”

In this way, participants felt that their confidentiality was being compromised. Most participants suggested integration of all HIV services (including MTCT-plus offered to pregnant women) with other health services in order to avoid social stigma of HIV.

The other problem men cited was that a considerable amount of time is spent at the clinic whilst waiting to be attended to. Working men were reported to be generally impatient. Midwives also agreed that there was delay in attending to ANC patients because of staff shortage. As one midwife complained,

“We really appreciate men's presence but, remember some days (ANC) are so busy and I will be alone with for example with thirty pregnant women, it will be impossible for me to attend to all of them with their partners”

Another challenge which midwives faced was that couples in the MTCT-plus programme needed more attention in counselling on ARV prophylaxis, breastfeeding choices and coping with living with HIV. It was apparent that more staff was needed to scale up services in the MTCT-plus programme.

4.2.8. Teenage pregnancies

The midwives and programme managers expressed concern over the high number of teenage pregnancies and how it affected male participation in the MTCT-plus programme. It was evident from the interviews with midwives that a significant number of the participants in the MTCT-plus programme were single teenage mothers.

“If you look at our region, we are among the highest in terms of teenage pregnancies. Twenty five percent of girls already have kids by the age of nineteen, yet they are still at school”.

Key informants disclosed that majority of these young mothers were impregnated out of relationships with elder man. As a result it was difficult for the teenage mothers to discuss their HIV status and to ask the elder men to accompany them to the ANC clinic. Midwives reported that elder men accepted responsibility but were shy to accompany their young partner to the clinic. This situation was compounded by the campaign from the Namibian women and child protection unit to report to the police all pregnancies of mothers below 16 years of age. As one midwife explained,

“A significant number of our PMTCT clients (HIV positive pregnant women), are young girls who not even married, and impregnated by old men,... these elder men, you will never see them here (at ANC clinic). They are afraid because they think that we report them to the police”.

Although it is assumed that this policy will mitigate the problem of teenage pregnancies, it has unintended consequences which highlight lack of input from the health ministry. Men were of the opinion that this policy is detrimental in the long term.

Chapter 5: Discussion

The purpose of this study was to investigate factors that influence male partner participation in the MTCT-plus programme in Gobabis District. Participation in the MTCT-plus programme was well supported by men in this study. Men were generally knowledgeable about the programme. However, few men put this into practice because of complexities surrounding their specific role in women reproductive health issues, HIV related stigma and some health facility organisational barriers. Study findings highlight the nature of complexities that emanate from cultural practices and its interference with HIV related prevention and treatment programmes. For example in this study men indicated that their role as care givers to their partners was taken away from them because of cultural practices. At the centre of health facility organisation barriers was the unfriendly staff attitude and poorly organised clinic set up which was reported as male unfriendly. HIV related stigma still remains a big challenge for men to participate in MTCT-plus programmes.

There were limitations in sampling, data collection process and analysis in this study. The study was done in a context which is similar to other settings especially in sub Saharan Africa hence these research findings can be transferred to other contexts. However, it is crucial to bear in mind that attitudes concerning culturally sensitive issues such as gender roles and reproductive health matters are to be seen in their particular background, and findings might not be transferrable to different contextual settings. The findings of the study were generally comparable to results from earlier researches done in the same field. Some particular differences were however noted. An understanding of the complexities and challenges encountered in engaging men in MTCT-plus activities constitutes a critical step in developing strategies for reducing the HIV disease burden (Bolu et al, 2007).

5.1. HIV disclosure issues and knowledge about MTCT-plus programme.

Men in Gobabis district were generally knowledgeable about the MTCT-plus programme and other ANC activities. Such knowledge mainly came from their partners. In Malawi, it was shown that HIV disclosure is effective and feasible and constitutes an important step in engaging male partners in MTCT-plus activities (Brown et al, 2011). In this study, the majority of men knew that pregnant women are tested for HIV as part of routine ANC. This made it easier for most women to disclosure their status because their male partners were

curious to know about the HIV results. This is in contrast to other studies where men's failure to participate in the programme is attributed to failure by the partners to disclose their HIV status (Hardon et al, 2012; Falnes et al, 2011). Problems with HIV disclosure to partners was observed in teenage pregnancies. In such relationships it might have been difficult for the teenage mothers to discuss their HIV status with their elder partners and to accompany them to the ANC clinic probably because of the age difference.

Other important sources of information for men's knowledge about the MTCT-plus programme were electronic and print media as well as health education given at health facilities and mobile health clinics. These sources of information have been shown to offer better opportunities for increasing male involvement in women's health reproductive health matters (Bolu et al, 2007). Besides the knowledge about the programme, men also appreciated the benefits of being engaged in it. These findings are consistent with earlier studies done in settings such as Kenya, South Africa and Nepal; regarding men's attitudes on getting involved in women's reproductive health and other HIV care related activities (Reece et al, 2010; Mullany, 2006; Peacock, 2003).

5.2. Cultural practices' influence on male participation in MTCT-plus programme

In relation to cultural practices among the Tswana and Herero tribes, it was the responsibility of the mothers of the pregnant women to offer care to their daughters until a month after delivery. This cultural practice is not peculiar to Tswana and Herero tribes in Namibia only. In Zimbabwe if a woman gets married and falls pregnant for the first time, she is sent back to her own parents towards delivery period so that her own mother takes care of her till delivery (Mathole and Shamu, 2009). For men, such a practice imparts negatively on their perception about their role in women reproductive health matters. In this study, for example some men specifically indicated that this cultural practice distanced them from their partners particularly at a time when they thought their support was needed most. This traditional practice swayed men's perception into believing that it is a taboo for them to be involved in women's reproductive health matters. Women however dismissed that reasoning by men as an excuse for not accompanying them to ANC clinic. Despite the distance imposed by culture between the men and their partners, most men believed that their financial support was needed. This finding supports the results from other studies done in Cameroon and Tanzania, which showed that men believe that their primary role was that of offering financial support for transport and obstetric care costs (Theuring, 2009; Nkuoh et al, 2010).

5.3. Institutional barriers and HIV-related stigma

Studies have shown that HIV related stigma is one of the most significant barriers for both men and women's acceptance to be enrolled into the MTCT programmes (Bajunirwe and Muzoora, 2005, Bakari et al, 2000). Women in this study said that they managed to overcome the fear of an HIV test because of the desire to have an HIV free baby. Men's fear of an HIV test was mainly reported by women in the FGDs. Although men did not express any fear of an HIV test and showed willingness to support their partners in the MTCT-plus programme, very few men actually put it into practice. By showing interest in their female partner's HIV test results and yet avoiding the HIV test themselves, men proved that they were afraid of the HIV test. This finding complies with other studies which showed that despite men's supportive attitudes in participating in women's reproductive health matters, HIV related stigma presented a significant barrier for them to behave accordingly (Magagula and Mkhathshwa, 2008; Reece et al, 2010). The challenge which health workers now face is influencing men's positive attitudes in to health service-seeking behaviour.

One of the strongest factors which influence a person's health seeking medical advice is trust in health delivery system and health workers (Galdas et al, 2005). Besides bringing patient satisfaction, trust is also built on the premise that the health worker maintains confidentiality in the patient's sickness. Men in this study consistently indicated that they were not comfortable with being attended to by staff at ANC clinic. They alleged that midwives and community counsellors knew their personal lives since Gobabis is a small town. The reason may be that most midwives and community counsellors stay in the residential area with the patients. Some participants in the FGDs were related to the health workers. This perception led men to lose confidence and trust in the ability of the health workers to maintain confidentiality of their HIV status. Participants suggested that health workers especially community counsellors should behave as role models in society so as to gain trust from their patients. In addition, men suggested that they would prefer to be attended to by doctors in whom they trusted.

The study also tried to identify some institutional barriers to male participation in the MTCT-plus programme. Health workers' attitudes emerged as one of the main obstacle to male involvement in the programme as highlighted in other studies (Peacock, 2003; Larsson et al, 2010). Although health workers' bad attitude was an experience alleged by women participants, men also gave the same excuse for not coming to the ANC. It is therefore crucial

that health workers' attitudes be improved when formulating policies to increase men's health seeking behaviour. In addition to changing staff attitudes, it is important to adjust the ANC clinic set up in order to improve patients' privacy. In this study men even suggested a revision of the staff establishment to accommodate more male midwives in order to make men feel more comfortable at the ANC clinic. As was shown in one study in Kenya (Reece et al, 2010), a set up that is not male-friendly can make men believe that ANC clinic is a female domain.

5.5. Men's sexual behaviour and teenage pregnancies

The study findings highlight some complexities that exist in sexual relationships outside marriage settings and how it impacts negatively on men's attitudes towards being involved in women's reproductive health matters. Married men explicitly expressed an interest in supporting their partners in couple counselling and testing. Despite their willingness to support their partners in couple counselling and testing, more than half the unmarried men in the FGDs believed that they had no obligation to do it because they were not married to them. This is despite the fact that these men knew that they were responsible for the pregnancy. This underscores the findings in some studies which showed that a marriage relationship offered women, a better opportunity for them to communicate openly and discuss HIV care and other health matters such as STI's (Brown et al, 2011; Msuya et al, 2008).

Marriage rates in Namibia have generally been going down in both the rural and urban settings. According to Pauli (2007), marriage is generally no longer regarded as a normative frame for childbearing and lately there has been an increase in non-marital birth rates (LaFont, 2007). It was evident from the FGDs with women that the situation of not being married and not staying with their partners made their partners prone to having multiple sexual partners. Such a practice is seen as contributing to the spread of HIV. It was then difficult for men in more than one relationship to accompany one of his partners to the ANC clinic. If he accompanies one partner, problems might arise from other girlfriends. This can apply in both formal and informal relationships. Nkuoh and others (2010) showed in a similar analysis in Cameroon showed that a polygamous relationship created problems for men to take their wives for ANC. Women who were in non-marital relationships were of the opinion that if they were married and staying with their partners, the problem of multiple sexual partners would be mitigated.

Another study finding was that teenage pregnancies act as a barrier to male participation in the MTCT-plus programme. The problem of teenage pregnancy is a major concern in Namibia. Overall, fifteen percent of teenagers in Namibia will have started childbearing by the age 19 (MOHSS, 2007). Omaheke region has one of the highest teenage pregnancy rates which is around 27%. These pregnancies usually result from young girls coerced into having sexual relationships with elder men (UNICEF, 2006). Because of intricacies involved in such a relationship when the pregnant girl is HIV positive, the man responsible for the pregnancy is not forthcoming when invited to ANC clinic. Given the gravity of the problem of teenage pregnancies and HIV more effort from different sectors and other social networks is needed to mitigate the problem. For example, the campaign proclaimed by the Namibian women and child protection unit to report to the police all pregnancies of girls less than sixteen years so that the partner can be prosecuted will go a long way in reducing teenage pregnancies.

This study included collection of data from different tribes in the southern part of Namibia and the findings of the study were most certainly influenced by the unique cultural and traditional practices of the people in this region. The patriarchal nature of this society has obviously shaped men's behaviour and attitude towards engaging in women's reproductive health matters. The rise in teenage pregnancies and non marital relationships has demonstrated some cultural changes and the nature of complexities arising from gender and power imbalances in such relationships and how it affects patterns of communication on HIV related matters. The findings highlighted in this study suggest a revision of the current strategies on male spousal engagement in women reproductive health matters. While the study findings provide insights for HIV care and treatment programmes, the future challenge now seem to lay in conducting research that is particularly focusing on the unique gender and culture-based issues that have a direct impact on the success HIV prevention programmes and efforts to engage males in women's reproductive health care.

CHAPTER 6: CONCLUSION and RECOMMENDATIONS

6.1 Conclusion

Most men demonstrated good knowledge and appreciated the benefits of being involved in the MTCT-plus programme. Such knowledge was acquired mainly from their partners, electronic and print media as well as health education. It was clear that men's supportive attitudes are not reflected in their health seeking behaviour yet their involvement in the broader maternal and child health care as caring fathers and decision makers is central to improving reproductive health. A number of barriers to male participation in the MTCT-plus programme were identified. Of note were the cultural practices and traditional beliefs which distanced men from their partners during pregnancy and soon after delivery. This practice created in men a perception that care for their partner was limited and hence their minimal involvement in women's reproductive health matters. Although it is difficult to change these cultural practices, more health education and policy changes that are culturally sensitive are needed to improve male participation in the programme. HIV related stigma was another significant barrier to male participation in the MTCT-plus programme. The fact that men denied fear of an HIV test and supported the idea of couple counselling is enough evidence to the existence of some institutional obstacles to their participation in the programme. The main institutional barriers included male-unfriendly environment set up and health workers attitude which dissuaded men from attending ANC. It is therefore imperative to put in place policies that support male involvement in women's reproductive health as well as improve attitudes of health workers. The problem of teenage pregnancies and the habit of multiple sexual partners needs a multi-disciplinary approach. It is important to address these issues because they are intrinsically linked with unsafe behaviour and practices which lead to the spread of HIV. More emphasis in behaviour change and reproductive health education is needed in order to mitigate these problems. As in other study findings men's work commitments poses a challenge when their presence and support is needed at ANC clinics. These research findings underscore the need to incorporate other important social networks in order to increase male participation in women's reproductive health matters.

6.2. Recommendations

- a. Revision of the current health education on women's reproductive health in order to accommodate issues that are culturally sensitive and context specific so as to reduce the negative influence of traditional beliefs and cultural practices on the role of men in the MTCT-plus programme.
- b. ANC clinics should be more male user friendly. This includes improving the privacy and confidentiality of patients to reduce HIV related stigma. A gender balanced staff establishment is needed at ANC clinics.
- c. Refresher courses and training are needed to improve health workers attitude so that they are more sensitive to men's presence at ANC clinics.
- d. A multi-disciplinary approach is needed to solve the problem of teenage pregnancies and HIV among the youth. This involves engaging other ministries such as education, youth and culture, NGO's and faith based organisations.



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APPENDICES

Appendix 1: Participant Information Sheet



UNIVERSITY OF THE WESTERN CAPE School of Public Health



Private Bag X17 • BELLVILLE • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

Participant information Sheet

Dear Participant

I am Felix Kwenda, 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 mini-thesis which is a requirement for the completion of the course. The following is an explanation of the research project and an outline of your potential role in the study. This research is being conducted for a mini-thesis. In case you do not understand anything in this information sheet, please feel free to contact me for clarification. My contact details and those of my supervisor are at the end of this information sheet.

Title of Research

Factors influencing male partner involvement in mother-to-child transmission of HIV plus (MTCT plus) programme in Gobabis District, Namibia: A qualitative study.

Purpose of the study

This research will be focusing on factors influencing male partner participation in the mother-to-child transmission of HIV (MTCT-plus). MTCT plus programme is intended to reduce the transmission of HIV from the mother to the new born baby as well as offering comprehensive HIV prevention, care and treatment to families. The main aim of the research is therefore to describe factors that influencing male partner participation in this programme in Gobabis District.

Description of the study

The study will be conducted using in-depth interviews with programme managers and midwives. Focus group discussions will be conducted with women who are in the MTCT plus programme and men, some of whom are partners of the women in the programme, and

others sampled from the community. It is your opinions about the research topic that will be the centre of discussion and/or the interview that I will have with you.

Confidentiality

The purpose of this research is for my mini-thesis. Your name will not be published anywhere. At all times I will keep the source of information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep the records of your participation including your signed consent form locked away at all times. I will then destroy them after the research is completed. The contents will be used for the purposes referred above only.

Voluntary participation and withdrawal

Participation in this research is voluntary and safe. It is only the opinions and ideas you give that will appear in the mini-thesis report. I would also like to assure you of confidentiality. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will no negative consequences if you prefer not to answer a question. You are free to withdraw from the study without giving a reason at any stage of the research. Your refusal to participate or withdrawal from the research will not adversely affect you in any way.

Informed consent

You will be asked to give consent for you to participate in the research before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review it and then decide whether you would like to participate in this study or not.

Contact details

In case you do not understand anything please feel free to contact me on the following contact details (Cell: 081 3821184, Work: 062 566200, e-mail: taona@iway.na). I am also accountable to Dr Thubelihle Mathole who is my supervisor at University of the Western Cape. Her contact details are +27 21 9592173 (cell no: +27 79 3247638, fax +27 959 2872) or by e-mail at tmathole@uwc.ac.za.

Appendix 2: Deelnemer Inligtingsblad



UNIVERSITY OF THE WESTERN CAPE School of Public Health



Private Bag X17 • BELLVILLE • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

Geagte Deelnemer

Ek is Felix Kwenda, 'n student aan die Soph, Universiteit van die Wes-Kaap. As deel van my Meestersgraad in Openbare Gesondheid, ek moet 'n mini-tesis, wat 'n vereiste is vir die voltooiing van die kursus te doen. Die navorsing sal fokus op die redes wat verband hou met lae manlike maat deelname in die moeder-na-kind-oordrag van MIV (MNKO-plus)-program. Die navorsing sal uitgevoer word in Gobabis-Distrik.

Titel van navorsing

Faktore wat die manlike maat betrokkenheid in die moeder-na-kind-oordrag van MIV-plus (MNKO plus) program in die Gobabis-Distrik, Namibië: 'n kwaliteit studie.

Doel van die studie

Hierdie navorsing sal fokus op faktore wat verband hou met lae manlike maat deelname in die moeder-na-kind oordrag van MIV (MNKO-plus). MNKO plus program is daarop gemik om die oordrag van MIV vanaf die moeder na die pasgebore baba sowel as wat omvattende MIV-voorkoming, sorg en behandeling aan gesinne te verminder. Die hoofdoel van die navorsing is dus faktore wat die manlike maat beïnvloed in deelname in hierdie program in Gobabis-Distrik.

Beskrywing van die studie

Die studie sal gedoen word met behulp van in-diepte onderhoude met die program bestuurders en vroedvroue. Fokus Groep gesprekke met vroue wat in die MNKO PLUS-program en mans, van wie sommige vennote van die vroue in die program, en ander wat bemonster is uit die gemeenskap gedoen word. Dit is jou mening oor die

navorsingsonderwerp wat die middelpunt van bespreking en / of die onderhoud wat ek met jou sal hê.

Vertroulikheid

Die doel van hierdie navorsing is vir my mini-tesis. Jou naam sal nie oral gepubliseer word nie. Te alle tye sal ek die bron van die inligting vertroulik en verwys na u of u woorde deur 'n skuilnaam of uitgevinde naam wat ek kies. Ek hou die rekords van jou deelname, insluitend jou getekende toestemmingsvorm weggesluit te alle tye. Ek sal hulle dan vernietig na die navorsing voltooi is. Die inhoud sal gebruik word vir die doeleindes soos hierbo beskryf.

Vrywillige deelname en onttrekking

Deelname aan hierdie navorsingsprojek is vrywillig en veilig. Dit is net menings en idees wat jy gee wat in die mini-tesis verslag sal verskyn. Ek wil jou ook graag verseker van vertroulikheid. As daar enigiets wat jy sou verkies om nie te bespreek nie, voel asseblief vry om dit te sê. Ek sal nie aanstoot neem nie, en daar sal geen negatiewe gevolge wees nie en indien u verkies om nie 'n vraag te beantwoord. Jy is vry om te onttrek van die studie, sonder om 'n rede op enige stadium van die navorsing te verskaf. Jou weiering om deel te neem of 'n onttrekking uit die navorsing sal nie afbreuk aan julle op enige manier maak nie.

Ingeligte toestemming

Jy sal gevra word om toestemming te gee vir jou om deel te neem in die navorsing , voordat ek voortgaan om 'n onderhoud te voer. Ek het die toestemming vorm met hierdie inligtingstuk ingesluit sodat jy in staat sal wees om dit te lees en dan besluit of jy graag deel wil neem in hierdie studie of nie.

Kontakbesonderhede

In die geval dat jy niks verstaan nie voel asseblief vry om my te kontak by die volgende kontakbesonderhede (Sel: 081 3.821.184, Werk: 062 566.200, e-pos: taona@iway.na). Ek doen ook verantwoording aan Dr. Thubelihle Mathole wat my promotor aan die Universiteit van die Wes—Kaap is. Haar kontak besonderhede is +27 21 9592173 (Sel no: +27 79 3.247.638, Faks +27 959 2872) of per e-pos by tmathole@uwc.ac.za.

Appendix 3: Informed Consent



UNIVERSITY OF THE WESTERN CAPE School of Public Health



Private Bag X17 • BELLVILLE • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

INFORMED CONSENT

Date of Interview

Interviewer

Place of Interview

Research Title:

Factors influencing male partner involvement in the mother-to-child transmission of HIV plus (MTCT-plus) programme in Gobabis District, Namibia: A qualitative study.

As was mentioned in the Participant information sheet, your participation in this research is entirely voluntary. Refusal to participate or withdrawal from the study will not result in penalty or any loss of benefits to which you are otherwise entitled.

If you choose to participate, you may stop at any time. You may choose not to answer any questions that you feel are uncomfortable with you. If there is anything that you would prefer not to discuss, please feel free to say so.

The information that will be collected from this interview will be kept strictly confidential.

If you choose to participate in this research, your signed consent is required before I proceed with the interview.

I have read and understood the information about this research on the participant information sheet. All the queries I have were answered to my satisfaction.

I voluntarily consent to be a participant and to be tape recorded in this research. I have understood that I have the right to end this interview at any time, and choose not to answer any questions that I am not comfortable with.

I also undertake to keep what will have been discussed during the FGD confidential.

My signature below confirms that I am willing to participate in this research

Participant Name (Printed)

_____ Consent date _____

Participant signature

Researcher Conducting Informed Consent (Printed)

Signature of Researcher Date



Appendix 4: Toestemming vorm



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

Ingeligte toestemming

Datum van onderhoud..... Onderhoudvoerder.....

Plek van onderhoud

Ondersoek Title:

Faktore wat die manlike maat betrokkeheid in die moeder-na-kind-oordrag van MIV-plus (MNKO plus) program in die Gobabis-Distrik, Namibië: 'n kwaliteit studie.

Soos genoem in die Deelnemer inligtingsblad, is jou deelname aan hierdie navorsing heeltemal vrywillig. Weiering om deel te neem of die onttrekking van die studie sal nie lei tot 'n boete of enige verlies van die voordele waarop jy geregtig is nie.

As jy verkies om deel te neem, kan jy ook enige tyd ophou. Jy kan kies om nie enige vrae wat jou ongemaklik laat voel te beantwoord nie. As daar enigiets is wat jy sou verkies om nie te bespreek nie, voel asseblief vry om dit te sê.

Die inligting wat versamel word, sal streng vertroulik gehou word.

As jy verkies om deel te neem in hierdie navorsing, is jou ondergetekende toestemming nodig voordat ek kan voortgaan met die onderhoud.

Ek het die inligting gelees en vertaan die navorsing op die deelnemer inligtingsblad. Alle navrae wat ek het sal ek tot my bevrediging beantwoord.

Ek stem vrywilliglik in om 'n deelnemer te wees en op band opgeneem te word na die navorsing aangeteken is. Ek het verstaan dat ek die reg het om hierdie onderhoud enige tyd te beëindig, en kies om nie enige vrae waarmee ek nie gemaklik is te beantwoord nie.

Ek onderneem om dit vertroulik te hou en sal dit tydens die Fokus Groep Bespreking ook vertroulik bespreek .

My handtekening bevestig hieronder dat ek bereid is om deel te neem in hierdie navorsing

Deelnemer Naam (gedrukte)

_____ Toestemming Datum _____

Deelnemer handtekening

Ondersoeker Uitvoer van ingeligte toestemming (gedrukte)

Handtekening van navorser Datum



Appendix 5: Consent Form on Confidentiality



UNIVERSITY OF THE WESTERN CAPE School of Public Health



Private Bag X17 • BELLVILLE • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

CONSENT ON CONFIDENTIALITY

Research Title:

Factors influencing male partner involvement in mother-to-child transmission of HIV plus (MTCT-plus) programme in Gobabis District, Namibia: A qualitative study.

As was mentioned in the Participant information sheet, your participation involves sharing information with other research participants during focus group discussion. Refusal to participate or withdrawal from the group discussion will not result in penalty or any loss of benefits to which you are otherwise entitled.

The focus group discussion that you will be participating in will focus on factors that influence men's participation in the MTCT-plus programme. It will not focus on the lives of individuals participating in the debate. You are therefore required to keep the information shared during the group discussion confidential. The researcher will also keep the information that will be collected from this discussion strictly confidential.

If you choose to participate in the focus group discussion, your signed consent is a guarantee that you will keep information shared during group discussion confidential.

I voluntarily consent to be a participant and to be tape recorded in the group discussion. I have understood that I have to keep what will be discussed during the FGD confidential.

My signature below confirms that I will not divulge the information shared during the focus group discussion to anyone.

Participant Name (Printed)

_____ Consent date _____

Participant signature

Researcher Conducting Consent on Confidentiality (Printed)

Signature of Researcher

Date



Appendix 6: Toestemming Vorm vir Vertroulikheid



UNIVERSITY OF THE WESTERN CAPE

School of Public Health

Private Bag X17 • BELLVILLE • 7535 • South Africa

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



Ondersoek Title:

Faktore wat die manlike maat betrokkenheid in die moeder-na-kind-oordrag van MIV-plus (MNKO plus) program in die Gobabis-Distrik, Namibië: 'n kwaliteit studie.

Soos genoem in die Deelnemer inligtingsblad, behels u deelname deel van inligting met ander deelnemers aan navorsing tydens fokusgroep bespreking. Weiering om deel te neem of onttrekking van die groepbespreking sal nie lei tot straf of 'n verlies van voordele waarop u andersins geregtig.

Die fokusgroepbespreking waar aan u sal deelneem sal fokus op faktore wat 'n invloed op manlike se deelname aan die MNKO-PLUS-program. Dit sal nie fokus op die lewens van individue wat deelneem aan die debat. Dit word van u verwag wat tydens die groepbespreking bespreek word vertroulik te hou. Die navorser sal ook die inligting wat uit hierdie bespreking versamel word streng vertroulik hou.

As u kies om deel te neem in die fokusgroepbespreking, u getekende toestemming is 'n waarborg dat u die inligting wat gedeel word tydens groepbespreking vertroulik sal hou.

Ek gee vrywillig toestemming om 'n deelnemer te wees en om opgeneem te word in die groepbespreking. Ek het verstaan dat wat bespreek word vertroulik te hou.

My handtekening hieronder bevestig dat ek nie sal openbaar wat bespreek gedeel word tydens die fokusgroepbespreking nie.

Deelnemer Naam (Gedruk)

Datum

Deelnemer handtekening

Appendix 7

Key Informant Interview Guide

The following is the interview guide that will be used with key informants of the MTCT plus programme. Each participant will be asked to fill in a form for socio-demographic data. Interview guide will contain an introduction (including informed consent), a set of questions, and closing comments, as illustrated below:

KEY INFORMANTS INTERVIEW GUIDE

Introduction

1. Introducing myself
2. Signing of the informed consent form.

Questions

1. Can you please explain, what has been your experience of being involved the Gobabis district MTCT plus program?
2. District monthly PMTCT reports are always showing less than 10% of HIV pregnant women participating in the program with their male partners. What are the strategies currently in place to increase male partner involvement in the MTCT plus program?
3. Which of these strategies would you consider to be the key ones for the success of the programme? Please explain.
4. What has worked well so far? Please elaborate.
5. In your opinion, what do you think are the main reasons for the low male partner turnout in the programme? Please explain.
6. To what extent do you think men are aware of the MTCT plus program in Gobabis district? Please elaborate
7. Omaheke region is known for its multi-tribal population and cultural diversity, what role does that factor play in shaping men's attitude towards their involvement in the MTCT plus program? Please explain why.
8. May you please elaborate on the beliefs that you think men have towards getting involved in this program?

9. To what extent do gender and power relations influence men's attitudes towards participating in the program? Please explain your opinion putting into consideration the existence of cross-marriages in this region.

10. What are some of the institutional barriers within the health care settings e.g. antenatal clinics, voluntary and counselling centres that may preclude men from participating in the programme?

11. In your opinion, in what way does the female biased gender representation of ANC health workers affect men's attitudes towards the programme?

12. What mechanisms have you put in place to ensure that the antenatal clinics are friendly to male partners if they are to get involved in all the activities of the programme?

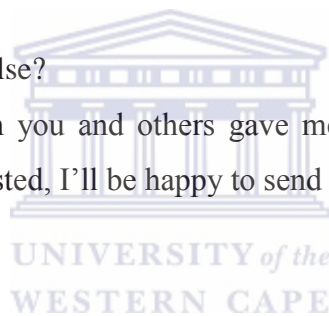
13. What strategies would you deploy to increase involvement of men in the programme? Please provide a justification for your response.

14. What recommendations do you have for future efforts such as these?

Would you like to add anything else?

I'll be analyzing the information you and others gave me and submitting a report for my mini-thesis. Should you be interested, I'll be happy to send you a copy to review.

Thank you for your time.



Appendix 8

Interview Guide for Focus Group Discussions

Introduction

1. Introducing the research team member
2. Signing of the informed consent form
3. Research participants to fill in socio-demographic form.

Interview Process

1. Eliciting the participants' thoughts on the subject of MTCT plus program in Gobabis district. This will bring forth their opinions that they have been waiting to share in the discussion.
2. The themes brought in the focus group discussion are then explored one by one. Participants are asked to comment on their individual feelings and experiences regarding each topic under discussion and on the MTCT plus as a program. The participant's response is followed as each issue is explored and examples requested if need arises
3. When an issue has been explored adequately and exhausted, the next item is tackled. In the process probing for connections between items is done. Once a domain has been adequately explored, then a move to the next domain is done with a proper introduction and explanation.

Issues to be covered

1. Participants to share their knowledge about MTCT plus programme.
2. Traditional/cultural beliefs about men's roles in women reproductive health
3. Socio-economic factors
4. Gender and power relations in relationships
5. Cross-tribal marriages
6. Cohabitation
7. Institutional barriers

Closing

Is there anything more you would like to add? I'll be analyzing the information you and others gave me and submitting a report for my mini-thesis.

Thank you for your time.