

**EXPLORING MALE ATTITUDES ON INVOLVEMENT IN ANTENATAL CARE:
THE CASE OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV
IN ATHI RIVER SUB-LOCATION OF MAVOKO CONSTITUENCY, MACHAKOS
COUNTY**

BY

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DECLARATION

I declare that this project is my original work and has not been presented for an award of a degree in any other university.

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This project has been submitted for examination with my approval as the supervisor.

Signature: _____

Date: _____

Dr. Owuor Olungah

DEDICATION

I feel deeply honored in dedicating this work to my family members: Nelly Ongweny, my dearest mother whose support and prayers throughout my education has been unconditional even in her old age; to my beloved husband Symmon Kidero for his unwavering encouragement and my dearest children Paul, Laura and Doris, for their immense support and bearing with my intellectual absence when I had to sacrifice my time away from them to complete the project.

I also salute my house help Eunice, who took charge of my house and family while I was busy with my education and research.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
APHIA	AIDS Population Health Integrated Assistance
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centre for disease control
CSP	Children in need of Special Care
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
FGDs	Focus Group Discussions
FHI	Family Health International
HCT	HIV Counseling and Testing
HIV	Human immunodeficiency virus
HRW	Human Rights Watch
IRIN	Integrated Regional Information Networks
KDHS	Kenya Demographic and Health Survey
KIHBS	Kenya Integrated Household Budget Survey
KIIs	Key Informants Interviews
KNBS	Kenya National Bureau of Statistics
MCH	Maternal and child health
MDGs	Millennium Development Goals
MTCT	Mother-to-child transmission
NASCOP	National AIDS and STI Control Program
NGO	Non-Governmental Organizations
NVP	Nevirapine
PMTCT	Prevention of mother-to-child transmission
TA	Thematic Analysis
UN	United Nations
UNAIDS	United Nations Global Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary HIV Counseling and Testing
WHO	World Health Organization

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ABSTRACT

This study explored male attitudes on involvement in antenatal care (ANC) with specific reference to the prevention of mother-to-child transmission (PMTCT) of HIV in Athi River sub-location of Mavoko Constituency, Machakos County in Kenya. The objective was to explore the factors that encourage or hinder men in participating in ANC and PMTCT, given that previous research has indicated that their involvement plays a key role in ensuring the well-being of their HIV positive spouses, the expected baby and the community and nation at large. Involving men in PMTCT is now part of national and international policy guidelines.

The study adopted the descriptive and explanatory design and data was collected through FGDs and KIIs between August and November, 2013. Overall, a total of four FGDs were conducted composed of women attending ANC and PMTCT without their spouses, women attending ANC and PMTCT programs with their spouses, men whose wives are enrolled in PMTCT programs but were not accompanying them and men who accompanied their wives to ANC and PMTCT programs. Two KIIs interviews were conducted for three doctors and three nurses. Data collected from the two methods included male attitudes, perceptions and concerns towards male involvement and participation in ANC and PMTCT and factors that hinder or encourage male involvement.

Thematic Analysis was used to analyze the qualitative information. The study findings indicate that though some men are involved in ANC and PMTCT, majority of them were not, sighting deterrents such as interference with their income generating activities, social and cultural beliefs, men's superiority complex, ignorance, more focus on women in the health facilities, barriers in reproductive health and negative attitudes of health personnel.

A majority of the men were of the opinion that paying for the services was involvement enough and no further participation should be expected from them. They noted that to enhance their involvement, it would be important to decrease the amount of time spent in the health facilities, enhance awareness and sensitization of men on values the whole family would derive from their involvement and participation, create awareness on retrogressive social and cultural norms, and implement a comprehensive training of health personnel in handling delicate medical issues such as HIV and AIDS. In conclusion, there is an urgent need to distribute and make available the government policies and strategies that relate to ANC, HIV and PMTCT to all who need them.

1.0 CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Between 1983 and 1985, 26 cases of AIDS were reported in Kenya (AIDS Newsletter 1986). Towards the end of 1986, there was an average of four new AIDS cases being reported to the World Health Organization each month. This totaled to 286 cases by the beginning of 1987, 38 of which had been fatal. One of the Kenyan government's first responses was to publish informative articles in the press and to launch a poster campaign urging people to use condoms and avoid indiscriminate sex. A year later in 1987, the Minister of Health announced a year-long health and education program, funded by a £2 million donation from high-income countries. By 1987, HIV appeared to be spreading rapidly among the population – an estimated one to two percent of adults in Nairobi were infected with the virus (AIDS Newsletter 1987).

Since 2000, Prevention of mother-to-child transmission (PMTCT) efforts in Kenya have rapidly expanded. There are now more than 3,397 health facilities offering PMTCT services (United Nations General Assembly Special Session (UNGASS) 2010). In 2011, an estimated sixty seven percent of pregnant women living with HIV received the most effective anti-retroviral regimen for preventing the transmission of HIV to their babies (UNAIDS, 2012). Prevention services for pregnant women must continue to grow as HIV transmission from mother-to-child is still high. For example, an estimated one in five babies born to HIV-infected mothers are infected with HIV and PMTCT services are still only available in half of the country's health facilities (WHO/UNAIDS/UNICEF, 2011). An estimated 220,000 children were living with HIV in 2011, with approximately 13,000 new child infections that year, most of which were probably as a result of mother-to-child transmission (UNAIDS, 2012). It is believed that these high rates account for the high infant mortality rate in Kenya (UNAIDS, 2012).

A national campaign to stop new HIV infections among children by 2015 and keep their mothers alive was announced on 16th November, 2011 by the then Kenyan Minister for Public Health and Sanitation Beth Mugo. The new initiative is part of a commitment made by Kenya at the 2011 United Nations General Assembly High Level Meeting on AIDS in New York, and marks an important milestone in the national AIDS program in Kenya (UNAIDS, 2012).

From the foregoing, this study sought to assess male attitudes and opinions on involvement and participation in ante-natal care and PMTCT and explored men’s perceptions in Athi River sub-location of *Mavoko* Constituency of Machakos County. Research has shown that without treatment, around half of all babies born with HIV will die before their second birthday. Also, in most countries of the world, dominant social norms present pregnancy and maternity care as women’s domain and accompanying male partners can be stigmatized (Rutenberg *et al.*, 2003). In addition, sex-specific vulnerabilities such as violence against women may prevent women from considering/desiring the involvement of their partners within prenatal HIV counseling and testing. It has however, been noted that "Male involvement has helped realize success with PMTCT programs where it has been applied because prevention of mother-to-child transmission is a family issue, but yes, there have been challenges in certain aspects like the possibility of gender-based violence targeting women and more so in a situation where the male partner is not willing to be part of it" (IRIN PlusNews 2012).

This diagram below shows the different stages that a woman must progress through to complete a PMTCT program.

Table 1.1: PMTCT Progress



Source: AVERT.org

1.2 Statement of the problem

Despite progress made in the provision of services to prevent mother-to-child transmission of HIV, access to appropriate diagnostics and/or treatment for pregnant women still remains inadequately low. According to UNAIDS, the percentage of treatment-eligible pregnant women living with HIV who were receiving anti-retroviral therapy for their own health in

2011 was an estimated thirty percent. PMTCT implementation faces organizational constraints and the deteriorating quality of existing health services. The low coverage of prenatal HIV counseling and testing is also explained by personal and social perceptions of HIV infection, and particularly by the poor place given to men within PMTCT program. In sub-Saharan Africa studies, pregnant women have reported the need to first consult their partner and for him to approve their decision before undertaking HIV testing (Bajunirwe *et al.*, 2005; Perez *et al.*, 2004; Kowalczyk *et al.*, 2002 and Semrau *et al.*, 2005).

The study by Alusio *et al.* in 2011, presents biological evidence for a beneficial effect from male partner engagement with HIV health services on the prevention of pediatric HIV in East Africa. The “efficacy” of male partner involvement for women’s or children’s HIV prevention outcomes, whether behavioral or biological, has never been experimentally tested. Although findings from studies of female initiated methods of PMTCT, HIV counseling and testing (HCT) promotion, family planning and HIV treatment suggest that the inclusion of men or support of male partners encourages women’s prevention method uptake (Straten *et al.*, 2007 and Montgomery *et al.*, 2010).

Efforts to include male partners in HIV prevention for women have focused primarily on engaging men to support their female partners in adopting a prevention strategy, without also offering broader consideration for men’s own health needs or of a social agenda aimed at achieving greater sex equality, both of which might ultimately reduce female risk as well (Peacock *et al.*, 2009 and Higgins, *et al.*, 2010). The pre-existing level of communication within the couple around sexual and reproductive health issues influences the acceptability of prenatal HIV counseling and testing (Bakari *et al.*, 2000). Men seem to influence the perceptions (grounded or not) of women who evaluate their personal and social risks before using prenatal HIV testing services. Yet, the place of men in the promotion and implementation of PMTCT has been very small to date. First, the structural and conceptual basis of PMTCT programs has not contributed to a family approach to prenatal HIV counseling and testing. PMTCT, integrated within mother and child health services, which are rarely male-friendly, has excluded de-facto men (Misiri *et al.*, 2004).

In spite of the low male involvement, data on attitudes, perceptions, opinions and roles of males in the PMTCT programs are limited in Kenya. There is need for research in Kenya to find innovative strategies that do not only consider male partners as mere supporters of

women in PMTCT services but rather as active participants. Such strategies should also incorporate ways of changing the mind set of African men of perceiving motherhood and PMTCT as women's domain but rather as a collective responsibility. There is need for research to explore the feasibility and importance of male partner involvement in PMTCT services. Few studies have also been done to explore male involvement in PMTCT in sub-Saharan Africa. This research therefore, aimed at filling this gap by establishing the attitudes and opinions on male involvement in ANC and PMTCT in Athi River sub-location with the aim of identifying factors that hinder or promote their involvement. The inquiry was guided by a set of research questions listed below.

1.3 Research Questions

1. What are the attitudes, perceptions and concerns towards male involvement and participation in ANC and PMTCT?
2. What are some of the factors that hinder or encourage male involvement and participation in ANC and PMTCT?

1.4 Research Objectives

1.4.1 General objective

The main objective of this research was to assess the attitudes and perceptions of males of reproductive age, on involvement and participation in ANC and PMTCT, in Athi River sub-location of *Mavoko* Constituency, in Machakos County.

1.4.2 Specific objectives

1. To assess male attitudes, perceptions and concerns towards male involvement and participation in ANC and PMTCT.
2. To assess the factors that hinders or encourages the involvement of males in antenatal and PMTCT care programs.

1.5 Justification of the study

Throughout all stages of programs for the prevention of mother-to-child-transmission of HIV (PMTCT), high dropout rates are common. Increased male involvement and couples' joint

HIV counseling/testing during antenatal care (ANC) seem crucial for improving PMTCT outcomes (Stephanie *et al.*, 2009). Male partner involvement in antenatal voluntary HIV counseling and testing (VCT) has been shown to increase uptake of interventions to reduce the risk of HIV transmission in resource-limited settings (Katz *et al.*, 2009). Since no research has been conducted in Athi River sub-location on male involvement in ANC and PMTCT, the assessment of what men in this area feel about this topic and what factors encourage or hinder them from participating, can go a long way in forming strategies on male involvement.

“In a previous study, it was observed that the involvement of male partners in antenatal VCT was associated with increased uptake of interventions to prevent vertical and sexual HIV transmission” (Farquhar *et al.*, 2004). Couple VCT was shown to have greater benefits than accompanying the female partner for individual VCT, and further analysis found that couple counseling was similar in terms of cost-effectiveness for preventing MTCT to standard antenatal VCT (John *et al.*, 2008). Unfortunately, few men accompany their partners to antenatal clinics and even fewer participate in couple counseling when it is available (Farquhar *et al.*, 2004 and Homsy *et al.*, 2006). There is limited research about men’s involvement in VCT and the antenatal setting in the developing world from the male perspective (DeGraft-Johnson *et al.*, 2005; Gage & Ali, 2005; Machekano *et al.*, 2000; and Sangiwa *et al.*, 2000). Much of the research on male involvement in antenatal care and MTCT has relied on women’s reports regarding their male partners and has addressed male characteristics and behaviors associated with women’s participation in MTCT prevention services (Cartoux *et al.*, 1998; Msuya *et al.*, 2006; Painter *et al.*, 2005; and Urassa *et al.*, 2005). An understanding of male participation in this study may help to identify novel methods for increasing male involvement in antenatal VCT and improve uptake of interventions to prevent vertical and sexual HIV transmission.

From the foregoing, it is clear that there is an information gap in relation to study of men with regard to their feelings, concerns and attitudes of their involvement in ANC and PMTCT. It is for this reason that this study targeted both males and females of reproductive age in Athi River sub-location to assess their attitudes and perceptions on involvement and participation in ANC and PMTCT and determined ways of improving their participation and mitigating the hindrances that prevent men from participating. Research geared towards men, and not only women, will go a long way in understanding just what their perceptions are and what can be

done to ensure they fully participate in ANC and PMTCT. It is hoped that the outcome of the study will inform both policy and improve the interventions aimed at enhancing male involvement.

1.6 Scope and Limitation of the Study

The study was conducted in Athi River Sub-Location of *Mavoko* Constituency, in Machakos County, Eastern Kenya. The study population was limited to women attending ANC and PMTCT programs without their spouses, women attending PMTCT with their spouses, men whose wives have enrolled in PMTCT programs but are not accompanying their wives and men who accompanied their wives.

The study also employed non-probability sampling known as convenience or purposive sampling. This therefore, meant that the researcher only targeted individuals who are available rather than selecting from the entire population. The limitation of this approach was that some members of the population had no chance of being sampled, and the sample may actually not be representative of the entire population.

1.7 Definition of Key Terms

Antenatal Care: Antenatal care is the clinical assessment of mother and fetus during pregnancy, for the purpose of obtaining the best possible outcome for the mother and child. Efforts are made to maintain maternal physical and mental wellbeing, prevent preterm delivery, to determine whether the mother-to-be is HIV positive, to anticipate difficulties and complications at delivery, to ensure the birth of a live healthy infant, and to assist the couple in preparation for parenting. Antenatal care traditionally involves a number of ‘routine’ visits for assessment, to a variety of healthcare professionals, on a regular basis throughout the pregnancy.

Assessment: This is a process that the study conducted to make a judgment or form an opinion on male attitudes on involvement in ANC and PMTCT.

Attitude: The way male and female partners think, feel or behave towards the involvement of males in PMTCT.

HIV: AIDS is a disease caused by a virus called HIV. Both the virus and the disease are often referred to together as HIV/AIDS. People with HIV have what is called HIV infection. As a result, some will then develop AIDS. HIV is found in the body fluids of an infected person (semen and vaginal fluids, blood and breast milk). The virus is passed from one person to another through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their babies during pregnancy, delivery and through breast feeding. HIV is not a disease but a condition that weakens the body immunity and exposes it to different opportunistic infections. There is currently no cure for HIV/AIDS.

Involvement: To take part in or to make somebody take part in the PMTCT program.

Male Partner: A father to a pregnancy in which one or both parents are HIV positive.

Mother-to-Child Transmission: It is possible for an HIV-infected mother to pass the virus directly before or during birth, or through breast milk. Breast milk contains HIV, and while small amounts of breast milk do not pose significant threat of infection to adults, it is a viable means of transmission to infants.

PMTCT: Refers to a four-pronged strategy for stopping new HIV infections in children and keeping mothers alive and families healthy. PMTCT begins before pregnancy with primary HIV prevention and family planning; includes prophylaxis or treatment during pregnancy; and extends beyond childbirth to include treatment, care and support for mothers and infant prophylaxis, feeding, diagnosis, care and treatment to age 18 months.

Transmission: HIV can be transmitted from an infected person to another through blood, semen, vaginal secretions and breast milk.

1.8 Study Assumptions

- There are negative attitudes and perceptions towards male involvement and participation in ANC and PMTCT.
- Certain factors hinder or encourage male involvement and participation in ANC and PMTCT programs.

2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviewed the existing literature on the basis of the specific objectives of the study. It also includes the theoretical framework that guided this inquiry, as well as the conceptual framework.

2.2 Background on HIV and AIDS

An estimated 1.6 million people are living with HIV, around 1.1 million children have been orphaned by AIDS and in 2011, nearly 62,000 people died from AIDS-related illnesses (UNGASS 2011). Whilst many people in Kenya are still not being reached with HIV prevention and treatment services, access to treatment is increasing. Seventy two percent of adults who need treatment are receiving it, with around 200,000 additional people on treatment in 2011 than in 2009. Unfortunately, as with many countries, the proportion of eligible children receiving antiretroviral treatment is much lower. This demonstrates that Kenya still has some way to go in providing universal access to HIV treatment, prevention and care (UNAIDS, 2012).

In sub-Saharan Africa, an estimated sixty percent of people living with HIV are women, mostly in the reproductive age group. In the absence of appropriate interventions, HIV infection in women translates directly to infant and child infections. Each year, approximately 1.4 million women living with HIV become pregnant. Among antenatal clients in sub-Saharan Africa, the proportion of women living with HIV ranges from five percent to as high as thirty percent—and HIV among childbearing women is the main cause of infection among children (UNAIDS, 2010).

2.3 Male attitudes, perceptions and concerns towards male involvement and participation in Antenatal Care (ANC) and Prevention of Mother-to-Child Transmission (PMTCT) Programs

According to the 2008–09 KDHS, almost all Kenyan adults have heard of HIV and AIDS, but knowledge of HIV prevention measures is lower. Only seventy one percent of women age 15–49 and seventy eight percent of men age 15–49 know that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful, uninfected partner. Prevention knowledge is higher among those with higher levels of education. Eighty seven percent of

women and men know that HIV can be transmitted by breastfeeding. However, only about two-thirds of women and men know that the risk of mother-to-child transmission can be reduced by taking drugs during pregnancy. Many Kenyans still have misconceptions about HIV and AIDS. Only seventy two percent of women and seventy seven percent of men know that HIV cannot be transmitted by mosquito bites (KDHS, 2008-2009).

Most Kenyans know where to get an HIV test (ninety two percent). However, only fifty seven percent of women and forty percent of men have ever been tested and received results. In the 12 months before the survey, twenty nine percent of women and twenty three percent of men took an HIV test and received the results. More than half of women who were pregnant in the two years before the survey were offered and received HIV testing during antenatal care. HIV testing during antenatal care is much more common in urban areas (seventy three percent) than rural areas (fifty two percent) and is highest among women with secondary and higher education (seventy four percent). The vast majority (ninety two percent) of Kenyan women receive some antenatal care (ANC) from a skilled provider, most commonly from a nurse/midwife (sixty three percent). Only fifteen percent of women, however, had an antenatal care visit by their fourth month of pregnancy, as recommended. Almost half of women (forty seven percent) received the recommended four or more visits. Two-thirds of women took iron supplements during pregnancy; only seventeen percent, however, took intestinal parasite drugs. Only forty three percent of women were informed of signs of pregnancy complications during an ANC visit (KDHS, 2008-09).

Christopher Mukabi, a local peer educator, says male support groups have proved useful in improving the way couples deal with an HIV diagnosis - "Bringing men together in male support groups and then using these groups to convince them to get into PMTCT programs can help deal with some of the challenges, but stigma and alcoholism are still problems in getting men involved." The aim of the *Zingatia Maisha initiative* - Swahili for "carefully consider life" - a program of the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF), is to get men more involved in PMTCT. Since 2006, the *Zingatia Maisha* program has enrolled 15,000 men in western and eastern Kenya. This initiative that encourages men to visit exclusively male clinics is gaining popularity in western Kenya and increasing male participation in PMTCT programs (IRIN/PlusNews, 2013).

A study from Kenya revealed that where women are supported and accompanied by their male partners, they are more likely to consistently visit antenatal clinics (IRIN/PlusNews, 2009). Few men usually accompany their wives on visits to antenatal clinics for fear of being ridiculed by peers. However, it has been shown that when male partners are involved, both partners can get tested for HIV, know their status, and therefore improve the baby's chances of a healthy survival (UNAIDS, 2012). Following a strict infant feeding method is a key part of PMTCT; yet such methods are often contrary to traditional feeding methods, which may involve supplementing breast milk with porridge or other solids. However, if both parents are involved in strict infant feeding method prescribed in PMTCT, diversions from the chosen infant feeding method are less likely.

Furthermore, if couples are counseled and tested together then there is less potential for blame and recrimination. Counselors can emphasize the man's responsibility for protecting the health of his partner and family, and can promote the use of PMTCT and other services, resulting in much higher rates of treatment uptake (UNAIDS, 2012; Semrau *et al.*, 2005; Farquhar *et al.*, 2004; UNICEF, 2003).

More than ninety percent of infant and young child infections occur through mother-to-child transmission, either during pregnancy, labor and delivery, or breastfeeding. The risk of transmission varies at different stages ranging from five percent to ten percent during pregnancy, ten percent to twenty percent during labor and delivery, and ten percent to twenty percent through mixed infant feeding. The lives of mothers and their babies - can be saved, through a combination of HIV testing and counseling, access to effective antiretroviral prophylaxis and treatment, safer delivery practices, family planning, and safe use of breast-milk substitute. Mother-to-child transmission of HIV has been virtually eliminated in industrialized countries, but remains a problem in Africa. In 2008, for every one child living with HIV in North America and Western and Central Europe, there were nearly 800 children infected with HIV in sub-Saharan Africa (UNFPA, 2010).

Investments made to protect mothers from HIV and babies from becoming infected is a moral responsibility of all governments (UNAIDS, 2012). Eliminating new HIV infections among children and keeping their mothers alive is not, and should not be, just about pills. It is first and foremost about protecting the health, dignity and security of mothers living with HIV and their children (UNAIDS, 2012).

Mother-to-child transmission (i.e., vertical transmission) of HIV is almost completely preventable through a set of interventions referred to as prevention of mother-to-child transmission (PMTCT). PMTCT begins during antenatal care (ANC) when the woman is tested for HIV and receives the result that she is HIV positive. The recommendation in sub-Saharan Africa is for the woman to then take medication throughout pregnancy, during labor, and the postnatal period while exclusively breastfeeding. The infant must also undergo periodic HIV testing and take medication to prevent transmission of the virus while he/she is breastfed.

PMTCT was introduced as a comprehensive package of interventions known as Prevention of mother-to-child transmission program with an aim of reducing mother to child transmission (MTCT). PMTCT program consists of a range of interventions, including improved antenatal services, opt-out HIV counseling and testing for pregnant women, antiretroviral drug prophylaxis for HIV positive pregnant women and newborns, referral to support groups, and counseling on options for safer infant feeding practices. Comprehensive PMTCT program also includes continued follow-up and treatment for HIV positive mothers and their children, especially for the first 18 months of the child's life (WHO, 2011) and (Malawi Ministry of Health PMTCT training module, 2007).

To ensure PMTCT programs successfully prevent HIV transmission from mother-to-child, PMTCT and antenatal services must be available, efficient and accessible; mothers must be able to access antenatal services early and be retained on PMTCT programs from beginning to end. In reality, however, and due to a range of interacting factors, many women do not follow this essential pathway (UNAIDS, 2012). Despite clear benefits of earlier PMTCT regimen initiation, delayed initiation of ANC contributes to late maternal HIV diagnosis and suboptimal PMTCT, resulting in preventable infant infections. Furthermore, lack of male involvement in ANC has been associated with lower maternal adherence to PMTCT interventions and increased in-utero transmission to infants born to women infected during pregnancy. Poor linkages between services result in late infant HIV diagnosis (UNAIDS, 2012).

Swift progress will depend on strong leadership from national governments, and on the committed support of foreign donors and non-governmental organizations. It will also require sustained advocacy from campaigners and the media. The programs that are provided need to ensure that they are reaching as many women as possible. This means addressing not just

practical issues, but also social, cultural and personal factors. People's attitudes towards HIV are central to the success or failure of PMTCT.

In recent years, efforts to widen access to antiretroviral treatment have caught the attention of politicians, non-governmental organizations and the global media. Apart from some large donors and organizations that worked closely with national governments to improve access to PMTCT services, PMTCT and the health of mothers remained largely out of the spotlight until 2011. With this renewed commitment, it seems feasible that increasing numbers of countries will add their names to the already growing list of low-and middle-income countries reaching the eighty percent coverage target of antiretroviral for PMTCT (WHO/UNAIDS/UNICEF, 2010).

2.4 Contributing factors towards involvement of males in HIV Testing & Counseling, ANC and PMTCT care programs

Mother-to-child transmission of HIV (MTCT) accounts for over ninety five percent of all pediatric HIV infections worldwide. There is limited research into the area of gender-based violence following HIV-testing, but a presentation by the NGO, the Sonke Gender Justice Network, at the 2010 International AIDS Society conference in Vienna, Austria, reported that women's experiences upon disclosing their status to their male partners were often "complex and positive": some studies reported violence levels of up to fourteen percent, while others stated that about half of HIV-positive women said their partners reacted supportively to the disclosure (IRIN/PlusNews, 2012).

In 2009, Human Rights Watch (HRW) cautioned the Kenyan government to ensure that human rights were protected during a large-scale home-based counseling and testing program; HRW noted that HIV-positive mothers - among them girls under the age of 18 - sometimes suffered violence, mistreatment, disinheritance, and discrimination from their husbands, in-laws, or their own families. Some women, too fearful of the repercussions of revealing their HIV status to their husbands, opt out of PMTCT programs altogether. According to Beatrice Misoga [PMTCT program officer, AIDS Population Health Integrated Assistance/APHIA], to preserve the benefits of male involvement in PMTCT, health clinics have to become more aware of the counseling needs of men. In August 2009, the Kenyan government introduced the more effective combination therapy to replace single-dose Nevirapine to prevent mother-to-child transmission and also emphasized the importance of

male involvement in PMTCT programs (IRIN/PlusNews, 2009). In 2010, the government also introduced a Kshs. 240 million campaign to encourage partner testing, exclusive breastfeeding and to deliver antiretroviral treatment to more children who need it ((IRIN/PlusNews, 2012).

Interventions that focus on women only as if they were single and living alone, and do not take into account their couple relationship, are likely to be counter-productive by placing women in an impossible situation. Couple approaches to PMTCT and general HIV and AIDS prevention and care need to be further documented and implemented. Involving men is increasingly being promoted as a key element in the prevention of mother-to-child transmission of HIV, and while its benefits are well-documented - in one Kenyan study, it reduced the risks of vertical transmission and infant mortality by more than fourteen percent compared with no involvement - it can occasionally lead to domestic discord and even violence (IRIN/PlusNews, 2012).

The 1994 international conference on Population and development in Cairo and the 1995 international conference on women in Beijing organized by UN, called for global attention to the importance of involving men in reproductive health programs because of their influence on women's health (United Nations Population Information Network, 1994 and United Nations Division for the Advancement of Women ,1995). In 2002, the World Health Organization (WHO) formulated recommendations advising couple HIV testing in settings with high HIV prevalence (WHO, 2002). WHO's 2010-2015 PMTCT Strategic Vision, emphasizes the need to involve male partners in scaling up PMTCT services in sub-Saharan Africa. WHO introduced the policy guidelines based on the assumption that couple testing would help increase spousal support for women to use PMTCT services, create opportunities for secondary prevention by counseling both men and women about HIV, and increase the uptake of testing and identification of HIV infected persons (WHO, 2010).

Positive Factors:

Men's role in HIV prevention is pivotal to changing the course of the epidemic. When men participate in PMTCT programs, their knowledge of HIV increases, and their behavior becomes supportive, and their receptiveness to HIV testing increases. In Cameroon, Africa, multiple efforts have been implemented that encourage men to "follow" their wives to

obstetric/PMTCT care and to undergo HIV testing. However, only eighteen percent of men have participated in this care (Nkuoh *et al.*, 2010).

A study conducted in Ivory Coast revealed that men, who were involved in PMTCT programs played an active role in applying the advice received, particularly related to exclusive breast feeding and early weaning. Studies in Kenya found that women accompanied by their partners for HIV testing were three times more likely to return for antiretroviral prophylaxis. Couple post-test counseling was also associated with an eight-fold increase in post-partum follow up, as well as greater antiretroviral utilization and formula feeding (Betancourt *et al.*, 2010 and Farquhar *et al.*, 2004).

In Uganda, male involvement is associated with beneficial health outcomes such as first trimester antenatal visits, abstinence from smoking and alcohol consumption, reduction in low birth weight infants as well as positive influence in the uptake of HIV testing and preventive interventions for vertical and sexual transmissions of HIV (Tweheyo *et al.*, 2010). In another study in Kenya, the combined adverse outcome risk of vertical transmission and infant mortality was significantly lower with male partner involvement. The combined risk for either vertical transmission or mortality was forty five percent lower with male antenatal attendance (Aluisioet *et al.*, 2011).

At male health centers, HIV-positive men form support groups and both positive and negative men are counseled on the importance of accompanying their partners for antenatal visits. The men also receive education on issues that are usually taboo for men such as the importance of exclusive breastfeeding for HIV-positive mothers. As well as referring men to the male clinics, the *Zingatia Maisha* program has attempted to make clinics more male-friendly by giving priority to women who attend with their male partners and to men who bring their children. "When you are working in a patriarchal society such as this, it is important to take the route of least resistance, and that is to make antenatal and post-natal clinics male friendly and thus increase the demand for the services," said Faith Oriwo, a field officer with EGPAF. In PMTCT program, men are encouraged to accompany their pregnant wives to antenatal clinics in order to be counseled and tested for HIV together. Men are also encouraged to be supportive to their pregnant wives if found HIV positive and to encourage them to adhere to all PMTCT protocols (Kalembo *et al.*, 2012).

The available data are edifying. In Zambia and Kenya, where pregnant women were offered individual or couple HIV counseling, couple HIV counseling improved the uptake of HIV testing, antiretroviral prophylaxis and alternatives to prolonged and mixed breastfeeding, and no increased risk of adverse social events was reported compared with individual counseling (Farquhar *et al.*, 2004 and Semrau *et al.*, 2005). Men are the decision makers in many of the African settings where PMTCT is offered (Akarro *et al.*, 2011). Without working with men, change would be very difficult or impossible (Sternberg and Hubley, 2004). Literature shows that risk behaviors change dramatically among couples where partners are aware of their HIV serostatus (Medley *et al.*, 2004). One major factor that prevents some women from accepting HIV testing is the need to seek their partner consent or assent (Omatayo *et al.*, 2007).

Most men consider accompanying their wives to ANC/PMTCT a good practice. Yet fewer men actually do this, because they feel that the provision of finance for ANC registration and delivery fees is their most important role in supporting their wife's pregnancy. Health care workers should encourage individuals and community leaders to build upon the traditional value of financial responsibility, expanding a man's involvement to include supportive social roles in obstetric care, PMTCT, and HIV testing (Nkuoh *et al.*, 2010). When men take action to prevent HIV infection, they can change the course of the epidemic. And the very actions that prevent HIV infection also promote the sexual and reproductive health of both women and men (UNPF, 2008).

In many African countries, widespread testing of women for HIV infection remains an elusive goal, with their primary access to HIV testing and education occurring at antenatal care (ANC) visits and through PMTCT programs (Population Council, 2009). HIV testing of men also remains challenging, with an estimated six point one percent of men in sub-Saharan Africa having ever been tested for HIV and receiving the results (www.who.int/entity/hiv/mediacentre/universal_access_progress_report_en.pdf). One strategy to increase HIV testing and counseling in men is to include male testing in ANC. Yet barriers often prevent the inclusion of the woman's husband in ANC/PMTCT care (King, 2009). Although studies have shown an improvement in men's and women's basic knowledge of HIV since 2005, the levels identified in 2007 remain well below the global goals (WHO, 2008).

Negative Factors:

Men's participation in ANC/PMTCT is affected by socio-cultural barriers centered in tribal beliefs and traditional gender roles. The barriers identified included the belief that pregnancy is a "woman's affair"; the belief that a man's role is primarily to provide financial support for the woman's care; the man's perception that he will be viewed as jealous by the community if he comes to clinic with his pregnant wife; and cultural gender based patterns of communication. Men's fear of having an HIV test has been shown to present barriers to their obtaining HIV testing and to women's health care (Bwirire *et al.*, 2008 and Magagula & Mkhathshwa, 2008). Several factors have been found as barriers to male involvement. These include; culture, health system, socio-economic factors, lack of information, poor communication, stigma and lack of confidentiality (Murphy, 2007; Chinkonde *et al.*, 2009; FHI, 2011; Pulerwitz *et al.*, 2010; Njuguna and Blystad, 2010; and Skinner *et al.*, 2005).

Literature shows that there is low male partner involvement in PMTCT services in many sub-Saharan countries (Pignatelli *et al.*, 2006 and Larsson *et al.*, 2010). In sub-Saharan Africa, male participation rate levels in hospital settings vary between twelve point five percent and eighteen point seven percent (Ditekemena *et al.*, 2011). In Malawi, male partners do not often come forward to test for HIV with their wives, this has contributed to drop outs and non-compliance at many levels of PMTCT services (Malawi, Ministry of Health, 2008; Murphy, 2007 and Chinkonde *et al.*, 2009). In Tanzania, male involvement in reproductive and child health services is low, estimated at five percent and lower in urban areas (Family Health International, 2011).

Before the introduction of PMTCT, it was observed that a lot of pregnant women were shunning HIV testing because they had no consent from their husbands. Those who had courage to go for test, if tested positive were afraid to disclose their sero-status to their husbands because they thought their husbands would accuse them of infidelity or even face divorce. Some HIV positive women who had courage to inform their husbands faced divorce, violence or accused of infidelity, some were not even allowed to continue with PMTCT interventions. This resulted in low uptake of PMTCT services by HIV positive women. Male partner involvement in PMTCT was then introduced with an aim of combating these problems and consequently increasing uptake and adherence to PMTCT interventions

by HIV infected women (WHO, 2010 and Malawi Ministry of Health, PMTCT training module, 2007).

Most clinics are dominated by female staff and patients, which can be off-putting for men. Health workers are still often reluctant to encourage male attendance in prenatal care, and in certain settings, men have been forbidden in prenatal wards (Mullany, 2006). In 2004, a review estimated that between three point five and fourteen point six percent of pregnant women reported negative consequences of HIV status disclosure (Medley *et al.*, 2004). More generally, over the past decades, reproductive health programs have aimed at ensuring that women have control over their own body and that their reproductive and sexual choices are free from male domination (Fathalla *et al.*, 2006).

According to a survey administered in Cameroon to identify men's knowledge and attitudes regarding ANC, PMTCT, and HIV in 2010, many men in the region had supportive attitudes about participating in ANC/PMTCT. Almost sixty percent of men had been tested for HIV and had some knowledge, though incomplete, of HIV and HIV testing. Expanding men's role to include other types of social support faces cultural barriers. These barriers also make expectant women uncomfortable in seeking additional support from their husbands (Nkuoh, 2010).

2.5 Theoretical Framework

Social Network Theory (SNT)

History and Orientation

The term 'social network' was first coined in 1954 by John Arundel Barnes. Barnes (September 9, 1918 – September 13, 2010) was an Australian and British social anthropologist. Barnes, among others, is known to be the first to use the concept of social networks in a scientific context. This was in 1954, in the article "Class and Committees in a Norwegian Island Parish, "Human Relations", in which he presented the result of nearly two years of fieldwork in Norway. His anthropological studies ranged from New Guinea to Norway. His interests and writings extended across the social and political sciences and beyond. Barnes (1954) was the first to describe patterns of social relationships that were not

explained by families or work groups. Cassel (1976) found a relationship with health. Social support served as a “protective” factor to people’s vulnerability on the effects of stress on health. Social networks are closely related to social support. Social Support and Social Networks are concepts that describe the structure, processes and functions of social relationships. Social networks can be seen as the web of social relationships that surround individuals.

The Social Network Theory looks at social behavior not as an individual phenomenon but through relationships, and appreciates that HIV risk behavior, unlike many other health behaviors, directly involves two people. With respect to sexual relationships, social networks focus on both the impact of selective mixing (i.e. how different people choose who they mix with), and the variations in partnership patterns (length of partnership and the overlap). Although the intricacies of relations and communication within the couple, the smallest unit of the social network, is critical to the understanding of HIV transmission in this model, the scope and character of one’s broader social network, those who serve as reference people, and who sanction behavior, are key to comprehending individual risk behavior (Auerbach, 1994).

Core Assumptions and Statements

Social Support is associated with how networking helps people cope with stressful events. Besides it can enhance psychological well-being. Social support distinguishes between four types of support (House, 1981). *Emotional support* is associated with sharing life experiences. It involves the provision of empathy, love, trust and caring. *Instrumental support* involves the provision of tangible aid and services that directly assist a person in need. It is provided by close friends, colleagues and neighbours. *Informational support* involves the provision of advice, suggestions, and information that a person can use to address problems. *Appraisal support* involves the provision of information that is useful for self-evaluation purposes: constructive feedback, affirmation and social comparison.

Social relationships have a great impact on health education and health behavior. There is no theory adequately explaining the link between social relationships and health. Closely related to health components of social relationships are social integration, social network and social support (Berkman *et al.*, 2000). *Social integration* has been used to refer to the existence of social ties. *Social network* refers to the web of social relationships around individuals.

Social support is one of the important functions of social relationships. Social networks are linkages between people that may provide social support and that may serve functions other than providing support (Glanz *et al.*, 2002).

Scope and Application

For promoting health, different interventions can be used. Therefore being able to understand the impact of social relationships on health status, health behaviors and health decision making are very important. Identification of the importance of networks or training of people in networks is applications of the approach of social support.

According to UNAIDS report on Sexual behavioral change for HIV of 2009, programs using this theory to guide them would investigate:

- **The composition of important social networks in a community:** This study sought to investigate what role male attitudes and opinions in ANC and PMTCT play in the family and in the larger community. Do their attitudes and opinions help to promote or hinder both the female and male involvement in ANC and PMTCT?

- **Whether the social network provides the necessary support to change behavior:**

The research sought to understand whether couples opinions on what role each spouse play to support change in behavior in as far as both couples participation in ANC and PMTCT is concerned had any bearing on uptake. What advantages do the couples experience or anticipate when there is change in behavior and both couples are involved in ANC and PMTCT?

- **Whether particular people within the social network are at particularly high risk and may put many others at risk:** This was to find out how the couple's attitudes shape positively or negatively the HIV infection rate and how this plays a role at the exposure of both mothers and children.

2.5.1 Relevance of the theory to the study

Social Networks Theory is especially relevant to women's HIV status disclosure, which has been associated with significant improvements in PMTCT utilization (Peltzer *et al.*, 2011 and

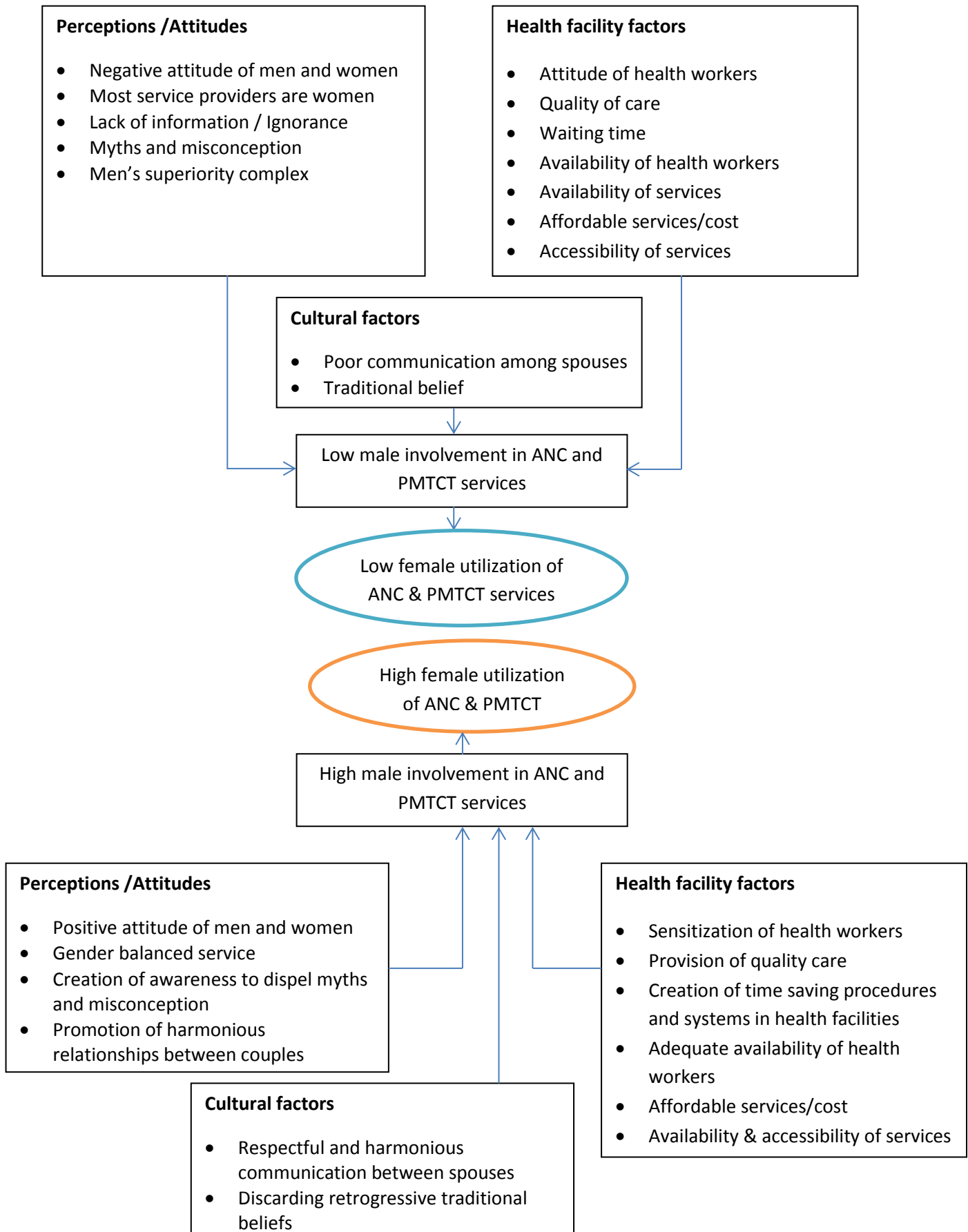
Theuring *et al.*, 2009). Social integration refers to the social ties that affect women's decision making (Glanz *et al.*, 2008).

Ujiji *et al.* (2011) found that the type of relational ties that exist between the HIV pregnant woman and her network determines disclosure of an HIV diagnosis. Social influence describes how the actions of others affect women's thoughts and actions towards PMTCT (Glanz *et al.*, 2008). Lastly, social undermining is the expression of negative affect or criticisms from others that may hinder pregnant women's utilization of PMTCT (Glanz *et al.*, 2008). For example, pregnant women are often reluctant to disclose HIV status for fear of family exclusion (Msellati, 2009).

Social stigma and discrimination are widely discussed as perceived barriers to PMTCT. In addition, fear of partner's reaction or fear of violence/conflict with the woman's partner may also prevent women from utilizing these services. Thus, theories regarding social networks and social support are useful in understanding the interpersonal influences on HIV-positive pregnant women's decision-making and health-seeking behaviors.

2.6 Conceptual framework factors affecting male involvement in ANC and PMTCT

Figure 2.1: Conceptual framework



The factors that affect male involvement in ANC and PMTCT services may be categorized into cultural factors, socio-economic, health facility factors, inter-spouse communications, and perceptions men have on these services in the community.

Cultural factors include traditional beliefs which endear some couples to trust traditional medicine compared to modern medicine and poor communication among couples which stems from traditional beliefs that men are the heads of the households, their word is law and cannot be questioned. Health facility factors include lack of privacy and confidentiality, comfort and poor attitude of health workers, adversely affect men's capacity to be involved in ANC and PMTCT services.

Perceptions men have on these services range from ignorance, lack of information, myths and misconceptions and men's superiority complex. The time taken in the health facilities is also a deterrent for most men because they compare this with time taken away from income generating activities. Low male involvement in ANC and PMTCT will lead to low utilization of these services by expectant women and their infants, which will lead to high maternal and infant morbidity/mortality.

3.0 CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter covers an overview of the research site including a map, population details, constituency size, and an outline on health and development. Details of the research design, study population, sampling procedures and data collection and analysis methods are also included. Due to the sensitive nature of the study, ethical considerations have also been covered in this section.

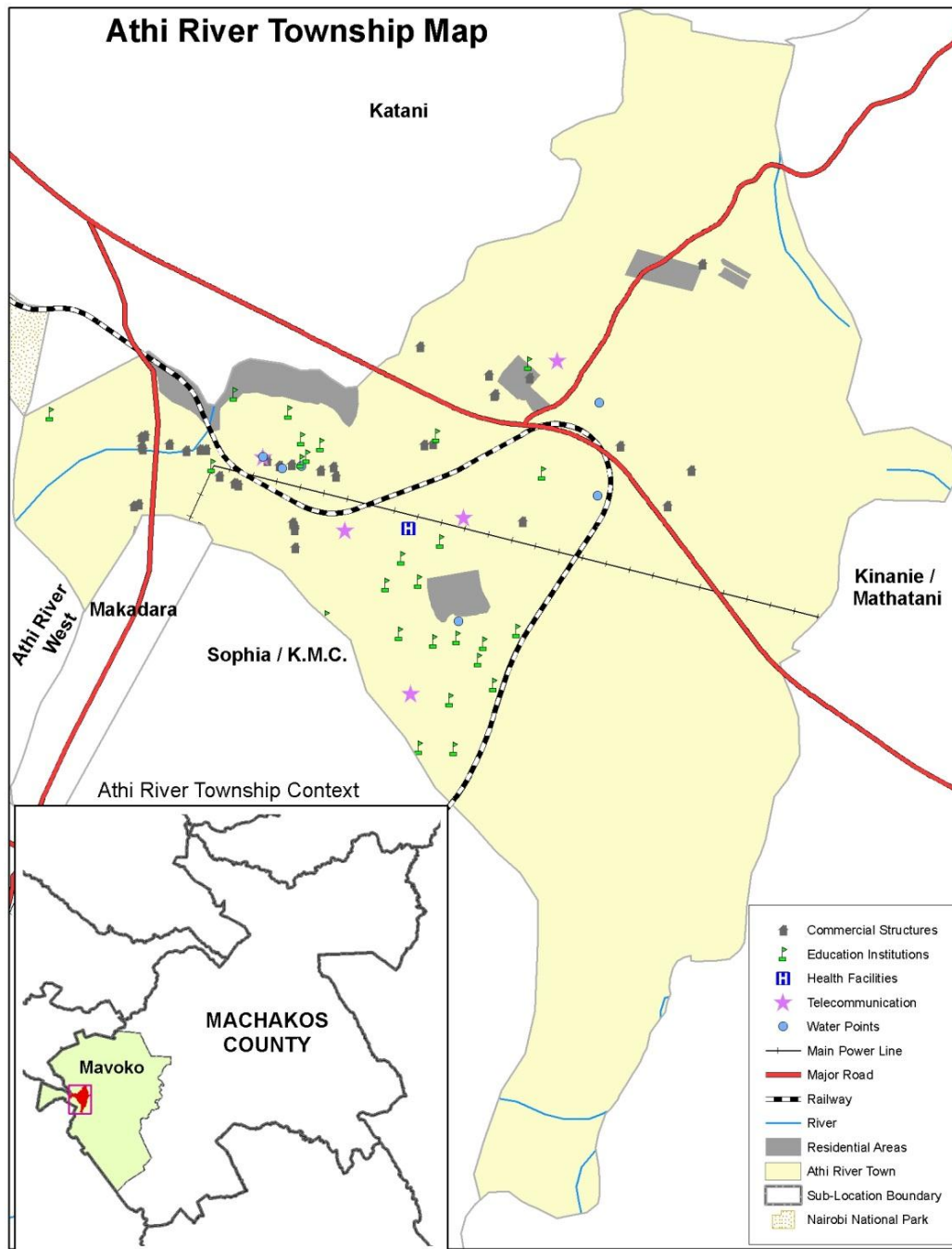
3.2 Research Site

This study was conducted in Athi River Sub-location of Mavoko Constituency in Machakos County, in Eastern Kenya. According to the Kenya 2009 Census Report, Machakos County has a total of 543,139 males and 555,445 females, with an overall total population of 1,098,584, and covers an area of 5,953 square kms. Mavoko Constituency covers an area of 843.2 square kms with a population of 139,502. The Population density is 177 per square kms. Athi River is a town outside Nairobi, Kenya and is also known as Mavoko. The town hosts Mavoko municipal council and headquarters of Mavoko division which is part of the Machakos County. The County is relatively industrialized, with six cement factories located within its vicinity and is also a growing residential area due to its proximity to the capital. The town is named after Athi, the first part of the Athi-Galana river system. Athi River town is adjacent to and three kilometers from Kitengela town, but is part of the Machakos County, while Kitengela belongs to Kajiado County in the expansive Rift Valley (<http://softkenya.com/town/machakos-county/>).

Machakos County General Information

According to KNBS (2009), Machakos County had a population of 1,098,584, with a surface area of 6,208km² with a density of 177 people per km². The poverty rate, based on KIHBS is fifty nine point six percent with a share of urban population of fifty two percent. The urban population in largest towns stands at Kangundo-Tala 218,557, Machakos 150,041, Mavoko 137,211, Kathiani 3,365 and Masii at 2,501.

Map 3.1: Map of Athi River Sub-Location Mavoko Constituency



USAID/Kenya GIS Facility, Nairobi – (Ochieng, T., 2013)

3.2.1 Residents of Athi River Sub-location

Athi River is a cosmopolitan town with various Kenyan communities represented. In as far as Akamba people are the dominant tribe in Athi River, Kisiis, Kikuyus, Luos, Maasais and Taitas are also represented. The research collected data from various health facilities in Athi

River, namely, Athi River Medical Services, Athi River Health Centre and Shalom Community Hospital.

3.2.2 Health Issues

The biggest challenge facing the County is the increasing cases of HIV and AIDS in spite of the awareness level of over eighty five percent. It also faces the challenges of providing medical care for the infected and support for the affected. Currently, the County estimates that there are over 15,000 children who are in need of special care (CSP) and this number is expected to rise due to the increasing number of HIV and AIDS orphans. HIV prevalence is fifteen percent with about fifty percent of hospital bed occupancy occupied by people suffering from HIV and AIDS related diseases (<http://softkenya.com/town/machakos-county/>). The highest prevalence is found in Machakos town and its environs, and the urban areas along Mombasa road. However, other townships and growing trading centers e.g. Matuu and Wamunyu, are registering equally increasing HIV and AIDS incidences because they are associated with high numbers of long-distance truck drivers and commercial sex workers. HIV in Machakos County was first diagnosed in June 1989 when 4 males and 5 females tested HIV positive (<http://softkenya.com/town/machakos-county/>). In December of the same year, 42 cases had been reported and since then the numbers have continued to increase. According to the Kenya AIDS Indicator Survey of 2009, Coast province had the fewest estimated number of HIV-infected adults taking cotrimoxazole, estimated at 6,000 persons, followed by Eastern province with an estimated 9,000 persons taking cotrimoxazole.

The most common diseases in the area are malaria, flu, diarrhoea, HIV and AIDS, and tuberculosis. In recent years, there has been a notable increase in respiratory diseases, which is likely to be the result of high levels of air pollution and dust from the area's industries. The middle- and high-income groups rely on the town's private clinics, whereas the poorer groups are forced to use the government-run health clinics only for outpatients. The council needs to establish more health clinics, including mobile clinics, to ensure better access to health care, as well as to improve the awareness of the most common diseases and how to prevent and treat them (UN Habitat, 2010).

According to the KNBS (2009), fully immunized population below one year in 2010/2011 is fifty four point three percent. In 2009/2010, tuberculosis in every 10,000 people was twenty four percent, while HIV positive and antenatal care patients in 2010 were four point two

percent. The population with primary education was sixty nine point seven percent, and with secondary education being fourteen point six percent.

3.2.3 Hospitals and Health Centers dealing with PMTCT

The following are the health facilities in the study area that deal with PMTCT:

- Athi River Health Centre
- Athi River Community Hospital
- Shalom Community Hospital
- Athi River Medical Services Ltd.
- Makadara Healthcare Clinic

3.3 Research Design

The research adopted the descriptive and explanatory design. Social researchers ask two fundamental types of research questions, namely: What is going on? (Descriptive research) and why it is going on? (Explanatory research). The study sought to describe what is going on in as far as male attitudes and opinions are concerned towards ANC and PMTCT, and explain why and how there is a relationship between male involvement in ANC and PMTCT and the increase in couple's uptake in these programs. Good description provokes the 'why' questions of explanatory research. Answering the 'why' questions involves developing causal explanations. In this study, causal explanations argue that couples participation in ANC and PMTCT is affected by male attitudes and perceptions in these programs.

The study used qualitative research methods that included key informant interviews and focus group discussions to collect data. Experiences of both the men and women from diverse backgrounds were shared along the objectives. Male participants were recruited into the study through their wives. Pre-prepared interview guides were used to gather the data and were structured in a flexible fashion to allow the group and individuals to take the discussion in any direction they deem fit but at the same time not losing track of the original topic of discussion.

3.4 Study Population

The study population in this research included all males and females of reproductive age in Athi River sub-location of Machakos County. The inclusion criteria that was used identified women and men who are attending ANC, and those who are enrolled in PMTCT programs. Another inclusion criterion was the consent of the targeted participants. This criterion excluded males and females of reproductive age who were not attending ANC, those that were not enrolled into PMTCT programs, and those who were already attending these programs but did not assent to participate in the study.

3.5 Sample Population and Sampling Procedures

The study used purposive and convenience (judgmental) sampling, which is a non-probability sampling method in selecting the FGD participants. Sometimes it is appropriate to select a sample on the basis of knowledge of a population and the purpose of the study. This means that you select those members of the community who you think will provide you with the best information. The researcher sought the consent of the doctors and nurses in the health facility to approach the FGD participants through the exit method, after they had come for the scheduled ANC and PMTCT service days. The participants, who agreed to participate in the study, were then requested to ask their spouses if they could also accept to be interviewed. They were then grouped into various categories namely: women attending ANC and PMTCT without their spouses, women attending the services with their spouses, men whose wives have enrolled for the services but do not accompany their wives and men who accompany their wives. Four FGD sessions were conducted with six participants from each of the mentioned categories.

The key informants were equally purposively selected on the basis of their expert knowledge in the subject matter. They included three doctors and three nurses, who are involved in these programs. Each of them was individually interviewed. The researcher approached the health facilities during specific scheduled times for ANC and PMTCT services, sought the consent of the doctors and nurses, and interviews were arranged with those who consented to participate in the study.

3.6 Data Collection Methods

The researcher used two data collection methods namely; focus group discussions and key informant interviews. The researcher also considered the strength of the interactive nature of qualitative research.

3.6.1 Key Informants Interviews (KIIs) – Doctors and nurses

The key informant interviews were conducted with three nurses and three doctors, who are experts, knowledgeable and experienced in ANC and PMTCT. The KIIs guide used to direct the sessions is included in Appendix five. The interviews with key informants helped to explore the knowledge; attitude and behavior related to male involvement in ANC and PMTCT.

3.6.2 Focus Group Discussions

Four focus group discussions were conducted with the different categories of participants as follows:

- Group one: women attending ANC and PMTCT without their spouses,
- Group two: women attending the services with their spouses,
- Group three: men whose wives have enrolled for the services but do not accompany their wives and
- Group four: men who accompany their wives for ANC and PMTCT services.

All the four FGDs consisted of six participants from each of the mentioned categories. All the participants were in monogamous marriages.

The researcher using the discussion guide facilitated the FGDs. One research assistant took hand written notes during the FGDs.

3.7 Data analysis and presentation

This study was a qualitative research, whereby the information obtained from participants was not expressed in numerical form. The emphasis was on the stated experiences of the participants and on the stated meanings they attach to themselves, to other people, and to their environment (Psychology Press Ltd., 2004).

The data processing and analysis method used in this study is Thematic Analysis (TA), which is a descriptive presentation of qualitative data. Qualitative data may take the form of interview transcripts collected from research participants or other identified texts that reflect experientially on the topic of study. A satisfactory TA portrays the thematic analysis of interview transcripts (or other texts) by identifying common themes in the texts provided for analysis (Anderson, 1997). The researcher organized the data in relation to the overall objective of the study, as well as the research questions. The FGD and KII interview notes were analyzed separately and key verbatim quotes from participants as well as the informants were collated.

3.8 Ethical concerns

The complexities of researching people's lives and bringing these accounts into the public are enormous. The personal nature of qualitative research requires the researcher to pay attention to several considerations. The researcher sought approval from the management of the health centers and informed consent from the participants, which was addressed by giving them verbal and written information about the aims and development of the research. To ensure privacy and confidentiality due to the stigma associated with HIV, no participants' identifying information was captured. The researcher gave participants an opportunity to ask for clarification and raise any issues of concern with the research prior to signing of the consent forms. Codes were used to replace names to ensure that no one will be able to identify the participants from any report published about the research.

Due to the public nature of FGDs, participants were handled sensitively and allowed to express themselves without coercion. The researcher spelt out the participant's rights, such as right of withdrawal and right of information before commencement of the study.

4.0 CHAPTER FOUR: MALE ATTITUDES ON INVOLVEMENT IN ANC AND PMTCT

4.1 Introduction

This chapter presents data obtained from the participants during the focus group discussions and key informant interviews. The details of both the discussions and interviews are included as well as analysis of the data to support the discussions of the study. The health facilities visited were Athi River Medical Services, Athi River Health Centre and Shalom Community Hospital.

4.2 Male attitudes and perceptions on involvement in ANC and PMTCT

The study sought to find out how the participants classified a “good husband”. The FGDs consisting of women, whether accompanied by their spouses or not, indicated that a good husband is the one who provides for his wife financially and supports the wife morally irrespective of the HIV status, encourages the wife to follow the PMTCT program and accompanies her to check their HIV status and to the ANC.

The FGD consisting of men who accompanied their spouses to the clinic was of the view that this is their duty and responsibility. They indicated that their role as good husbands was to fully participate in their spouses’ pregnancy and ensure safe delivery. Their voices can be captured by two of them who said:

“As a responsible man, it is my duty as a good husband to ensure that I am fully involved in my wife’s pregnancy to ensure both her and the unborn child are safe. This I would do by accompanying her for clinics and helping her with household chores, such that at the time of birth, she is not exhausted.” (A father of two in his mid-thirties).

“I have to be involved as a man to see how I can keep my wife and child safe and healthy. I will give my full support if we are advised not to breastfeed the baby. I think as a man, if I am not supportive, then my child may be HIV-positive”. (32 year old father of one).

The key informants further indicated that whenever the couple attend clinic together, they encourage them to assist each other and to ensure that the pregnancy becomes bearable. One doctor noted thus:

“We are always keen in ensuring that all the couples who attend clinic, get an opportunity to learn more about the pregnancy, ANC, PMTCT and the whole burden of child birth. All the men are advised to show their support as good husbands by assisting their wives in whichever way possible” (Nurse, Shalom Community Hospital).

A few participants from the FGDs with men who do not accompany their wives to the health facilities were of the opinion that providing financial support towards pregnancy and prenatal care, as well as other financial needs in the home, is enough to be classified a good husband.

A woman not accompanied by her spouse indicated that:

“It would be important for my husband to accompany me for ANC and PMTCT, for him to understand the challenges associated with pregnancy and what is required before I deliver. This would enable him understand the kind of support I need”. (27 year old woman expecting her first child).

It was important to find out if the men accompany wives when they visit ANC. According to the findings, majority of the women participating in the FGDs consisting of women not accompanied by their husbands indicated that the men did not accompany their wives when they visit ANC. On the other hand, the participants in the FGDs consisting of men who accompany their wives reiterated that they accompany their wives to the ANC and PMTCT and participate fully in what is required. One male participant said:

“I love my wife and accompanying her to the health center is a role I am very proud of and I undertake proudly as a loving and caring husband and also as a good father to my unborn baby”. (35 year old father of two).

The FGD consisting of men, who do not accompany their wives, noted that they do not accompany their wives because they believe that providing physical and financial support is enough and accompanying them to the health centers was not necessary.

The key informants further indicated that most men shy away from participating in ANC and PMTCT despite the high awareness of the availability of these services. However, some nurses differed with this perception, saying that awareness is low. Two were quoted saying:

“Men stubbornly do not come because they are aware of what is taking place; when a mother comes and you ask them where their partners are, they say he dropped me here and left. We tried to talk to some men and they said, ‘we are tired of health personnel pushing us on these issues..... HIV is now a normal condition’”. (Nurse, Athi River Medical Services).

“In as much as we have tried to create awareness by inviting men and women for awareness sessions, many people do not attend and are not interested. Many do not really understand what we are talking about - so there is lack of awareness”. (Nurse, Athi River Health Centre).

In Cameroon, Africa, multiple efforts have been implemented that encourage men to “follow” their wives to obstetric/PMTCT care and to undergo HIV testing. However, only eighteen percent of men have participated in this care (Nkuoh *et al.*, 2010).

The nurses interviewed emphasized that male partners are involved in PMTCT if they participate in every stage of the PMTCT program. This participation would have to start from attending health education talks and understanding pregnancy needs of their partners, to couple counselling HIV testing and mutual disclosure. These would then be followed by taking the lead in making relevant PMTCT decisions and supporting the female partner to successfully implement these decisions.

Men are also encouraged to be supportive to their pregnant wives if found HIV positive and to encourage them to adhere to all PMTCT protocols (Kalembo *et al.*, 2012).

“Men are involved in making the women pregnant hence they must be involved all through the pregnancy. They must accompany their wives for ANC and PMTCT when advised. They should also participate in health education talks, counseling, testing, and when results are released. They should also be involved in any treatment options advised by the doctors, such as infant feeding options, referral of cases that can't be managed at the health unit, etc.” (Nurse, Shalom Community Hospital).

From the KIIs, one of the doctors interviewed from Athi River Medical Services said:

“A HIV positive expectant woman and her husband need to attend health education talks and understand the pregnancy needs of their partners. This would encourage couple counseling, HIV testing and mutual disclosure. Infected mothers should also attend regular PMTCT seminars at community halls and churches and participate in regular free medical check-ups”.

From the FGD consisting of men who do not accompany their wives to the clinics, majority of them had not heard of prevention of mother-to-child transmission of HIV. However, the other participants, especially women, had heard of this through their attendance to ANC and PMTCT programs and other awareness and sensitization programs in the media. This finding indicates that there is still some level of ignorance on this topic. The response was the same for another question related to this, which sought to find out whether the participants had heard about the use of some drugs to reduce the transmission of HIV from an infected mother to her child. The same participants, who had not heard of prevention of MTCT of HIV, also had not heard about these drugs.

From the KIIs, the awareness creation in ANC and PMTCT programs has been stagnant in the recent past because the attendance and retention rates for ANC and PMTCT services has dropped. The health stakeholders have reduced the sensitization of these services. Majority of the men in all the FGD categories mentioned that the major reason why people in this community do not take advantage of these hospital services that help prevention of mother-to-child transmission of HIV virus, is because of fear of stigma. They also said that there is no privacy at the ANC and PMTCT sections at the health centers and some of the health workers were not confidential.

The men indicated that if their expectant wife was advised by the doctor to take a particular drug to prevent HIV transmission to her baby, they would react negatively if they did not know her status. However, if they were aware of her status, they would react positively and encourage her to take the drug.

Two male participants who had accompanied their wives said:

“If it will protect the baby I will support her...of course I would encourage anything that will benefit her and the baby”. (33 year old father of one)

“The best option is for government to provide free medication to expectant HIV positive women. This would encourage men to support their wives and ensure MTCT of HIV does not occur. Nobody wants to discourage his wife from taking the ARV drugs. It is only lack of money, but when the medicine is free nothing will stop her from taking it”. (35 year old father of two).

A few of the male participants felt that some men would not support the use of the drugs by their wives. The reasons varied from lack of awareness to poverty.

“Another reason why men would not support their wives is that some people make a lot of false allegations against antiviral drugs. Some will say it will kill you, people say myths that will discourage the positive people to take it, especially those who believe in traditional medicine. Some of them are not well educated”. (Father of three in his mid-thirties).

Female participants in the FGDs were asked if there were any reasons that would prevent an expectant woman from taking the drugs that help prevent HIV transmission to her baby. Reasons most frequently mentioned were family influence, lack of money, side effects, as well as a carefree attitude.

“The spouse can prevent her from taking the drugs. Some don’t believe the hospitals. I know of a woman like that. She almost died before her spouse allowed her to be taken to hospital.” (33 year old mother of two).

Male participants in the FGDs felt that they would trust health workers, their in-laws, religious leaders and employers for accurate information on their wives’ pregnancy and prevention of mother-to-child transmission of HIV.

4.3 Factors hindering male involvement in ANC and PMTCT

The study sought to find out the factors that discourage men from accompanying their wives to the ANC and PMTCT. From the findings, majority of the men in the FGD consisting of men who do not accompany their wives indicated that men felt it was the responsibility of women to attend ANC but not men. Some men feared the HIV test, while others felt that they were busy providing a source of livelihood to their families and did not have time to visit the health centers. One such participant was quoted saying:

“According to me, it is not necessary accompanying my wife to go to the clinic, but to facilitate her financially”. (30 year old first time father to be).

According to the FGDs consisting of women who were not accompanied to the clinics, men were perceived as negligent and sometimes stubborn, considering that they claimed to always be busy, yet would rather engage in leisure activities than participate in noble activities, such as accompanying their wives to the health centers. It was also mentioned that some men would drop their wives at the health centers and then leave.

The key informants further indicated that the perceptions and attitudes of some people in the community is that PMTCT is a female oriented service which would economically deprive day to day life provisions, if men were to be actively involved. There is high male superiority complex, which negatively affects male involvement. Most male spouses feel superior to their female partners and often exert control, power and authority towards their wives. This factor promotes disharmony in their relationship. One of the informant doctors interviewed, pointed out that men’s superiority complex, as well as societal acceptance of HIV positive people and stigmatization of those infected, are a hindrance to male involvement.

Among the less prevalent factors, some men believe that PMTCT encourages the use of condoms within married couples. Their disagreement with such PMTCT recommendations prevents male participation and involvement. There is also some impression from the men that prenatal HIV testing for pregnant women, as recommended by the PMTCT programs, was in fact a late occurrence. Their belief was that couples should be encouraged and given the opportunity to test in advance before making decisions on child bearing. This would control the number of couples who are HIV positive and only realize when the baby is already on the way.

The cost of managing an infected person is also high especially in poor households. During the KIIs, one of the doctors from Shalom Community hospital said:

“The most frequently reported barrier for male involvement in antenatal care is the perception that antenatal care was a woman’s activity, and it was thus shameful for a man to be found in such settings. This cultural barrier in itself without any other external influence demotivated men from attending antenatal care and getting involved in PMTCT.”

This perception was closely linked to other obstacles noted during the FGDs with women from both categories and men who do not accompany their wives, such as societal ridicule for men who accompanied their wives for ANC. These men are ridiculed as being jealous, over-protective of their wives and lacking of self-confidence. This has continuously dissuaded men from getting involved.

Another cultural barrier noted during FGDs with both women categories, was the fact that in most African cultures, women are not allowed to lead. In these settings, it is inconceivable for a woman to tell a man what to do, and worse still for him to consent to what she says. This cultural norm forbids women from taking decisions at home on matters such as antenatal care and HIV counselling and testing and thus served as a major obstacle to women's efforts of involving their spouses in PMTCT. Men are the decision makers in many of the African settings where PMTCT is offered (Akarro *et al.*, 2011). Without working with men, change would be very difficult or impossible (Sternberg and Hubley, 2004).

In all the FGDs, there was consensus that the reluctance to learn one's HIV status was a major limiting factor to male ANC/PMTCT involvement. This reluctance was grounded in many theories the most common of which was the fear of being HIV positive. For others, this reluctance was associated with the shame of learning one's HIV status especially if it turned out to be positive. In some, reluctance was a demonstration of men's 'stubborn nature, while in other cases it was that men did not want to participate in ANC/PMTCT activities. One male from the FGD consisting of men who do not accompany their wives said:

“For me, it is not necessary to go for HIV testing because what I do not know does not harm me. I am better off not knowing and moving on with my life, than get tested and confirm that I am HIV positive. This knowledge is what will kill me quickly because of worrying.” (32 year old father of two).

Another barrier captured from all the FGDs and KIIs, was that the timing of ANC/PMTCT activities was in conflict with men's normal daily activities. Men simply did not have the time to participate in ANC and receive the knowledge necessary to implement PMTCT strategies. A further barrier was the perception by men that they simply did not see any benefits in testing for HIV and getting involved in PMTCT. Hence the whole exercise was deemed to be futile.

An interesting barrier noted during the FGDs with all categories of participants, was that to men, PMTCT involvement was a man's perception of his own health. Most men deemed themselves to be in good health and this was the major limiting factor for ANC/PMTCT involvement. Since HIV testing is the gateway into any PMTCT program, the self-perception of good health was a limitation to this portal of entry. Another perception noted especially by the men is that most of them believe that if their wives participated in ANC, receive HIV testing and are found to be negative, then it follows that they are also free from the virus. Men's fear of having an HIV test has been shown to present barriers to their obtaining HIV testing and to women's health care (Bwirire *et al.*, 2008) and (Magagula & Mkhathshwa, 2008).

One participant in the FGD category of men who do not accompany their wives said:

“There is no need for me to attend ANC because it is obvious that when my wife attends, she will be taken through the compulsory HIV counseling and testing, and if the results are negative, then I will rest easy assured that I am also safe.” (30 year old father of one).

Another consensus finding in both the FGDs and KIIs was financial barrier. The lack of finances and consequently the avoidance of the burden of health care, hindered men from attending antenatal care and upholding PMTCT. In some cases, men lacked the money to accompany their partners and pay for health care.

From the KIIs with one nurse from Athi River Medical Services, it was noted that where couples did not have a helping hand in the home, the problem of childcare when both parents are away often comes up, limiting the involvement of both partners in ANC and PMTCT. The nurse stated that in the case where both parents were to go for antenatal care, there would be no one left at home to look after the other children. In both the FGDs with women who are not accompanied and men who do not accompany their wives for ANC, long waiting times was cited as an obstacle to male involvement in antenatal care. Antenatal health services were perceived as being male unfriendly, and these consequently discouraged men from getting involved. Another barrier noted from the FGD with men who do not accompany their wives to the clinics, is mistrust in the confidentiality of the health care workers. Most men felt that they were not assured of confidentiality when dealing with the health workers who may not guard their engagements as confidential.

One informant mentioned that weaker relationships either because couples are not cohabiting together or do not share affection with each other, constituted a barrier to male involvement. This was probably linked to a lack of communication or a general demotivation of the men in the women's affairs including ANC. "Fidelity within a relationship was also identified as potential barrier in that men who were faithful to their spouses were less likely to be involved in VCT and ANC, probably based on the general belief that their own fidelity meant that their spouses were equally faithful and uninfected", said one doctor from Shalom Community hospital.

Majority of the participants in the FGDs felt it was important to know their HIV status. If the test is positive, they would take care of themselves to prolong their lives and protect their partners as well as their unborn children. One of the female participants in the FGDs for women who are accompanied by their husbands said:

"As much as there is fear of what the results will show, it is important for couples to go for HIV counseling and testing to be sure of their status and to take all the necessary precautions to ensure the good health of the couple and the baby". (33 year old mother of two).

Female participants indicated that since it was compulsory to take the HIV test during ANC, they did not have a choice. All the participants in the various categories of the FGDs described the treatment received by people living with HIV in the community as "rejection" and "abandonment". A few participants, however, said that those with strong spiritual beliefs would care for people living with HIV. Others felt that HIV awareness level had increased and most people who are educated are more caring towards those living with the virus.

"The only persons who can continue to associate with HIV positive people are those who fear God, who know that God decides the affairs of men." (33 year old mother of three).

One of the men from the FGD category of men who accompany their wives said:

"Well before, when someone was HIV positive, people avoided them, but now, because of sensitization and awareness on HIV and AIDS, they embrace them.....even if they are eating, you join hands and eat and make the person feel at home" (34 year old father of two).

From the KIIs, it was noted that male partner participation is an influential factor in their wives willingness to accept VCT, because a spouse' status is a joint status. Male participation acts a catalyst to boldness of women to go for the testing, because it assures them of moral support.

“Voluntary Counseling and Testing (VCT) services are effective, reliable and are an assurance of optimal health consideration. They influence societal approach and treatment of HIV patients and are a determinant to HIV statistics in a given area. Testing positive is not the end of your life. There are still other things to do in life”. (Doctor from Athi River Medical Services).

4.4 Factors encouraging male involvement in ANC and PMTCT

“ANC and PMTCT experts are enough to serve the whole sample area and there is no room to disclose one's status, owing to high ethical practice of the health providers. There is high support from the facilities to community members enrolled in PMTCT programs” said one doctor from Athi River Health Centre, during one of the KIIs.

From the KIIs, the importance of men understanding the benefits associated with male involvement in ANC and PMTCT was reiterated. These benefits include, increase in men who are sensitized on mechanisms that lead to the prevention of mother-to-child HIV transmission; improved knowledge and practice of risk reduction strategies, for example, reduced sexual partners and condom use; improved disclosure and consequently reduced stigma, resulting in ease of antiretroviral use; improved contribution of male partners towards material and financial needs of women; improved birth preparedness; improved financial and support towards safe infant feeding practices; and secured marriages.

“Men participating in this program learn how to help their spouses during pregnancy, and understand pregnancy challenges. If we do not participate in the program, we shall not be informed. Our wives get problems especially in the third trimester of their pregnancies and they cannot perform many tasks. We are now able to have HIV-free babies, even when their mothers are HIV positive”. (Nurse, Shalom Community Hospital).

During all the FGDs consisting of the various categories, it was noted that providing ANC services for couples such as couple voluntary counseling and testing during weekends or non-working hours, facilitated male partner involvement in ANC/PMTCT activities.

One nurse from Athi River Medical Services said that:

“The previous perception that the cultural beliefs and norms of this community towards engaging men and women in discussion of pregnancy issues is that PMTCT and ANC are women affairs. However, currently, these beliefs and norms have decreased, as more men are now participating too, because of the sensitization and awareness programs we continuously conduct”.

4.5 Strategies and Policies in ANC and PMTCT programs

It was noted from the KIIs, that the government’s efforts are effective since their target is projected towards the national population. However, the challenge is that the government’s focus is concentrated in some areas or counties more than others.

“In Athi River, we have had low government and health stakeholder’s involvement, consequently, making the awareness level reduce drastically and eventually tampering with the prevalence rate of HIV in this area”. (Doctor, Shalom Community Hospital).

Community health workers, Ministry of Health representatives, local NGOs and church leaders, are opinion leaders who should be comprehensively involved in MTCT and PMTCT awareness creation, to facilitate increased knowledge in these programs.

“Remember in the past when someone had to do family planning, both the partners had to endorse the decision. But nowadays, women make their own decisions and men feel they do not have to be involved. Unless you come for HIV testing as a couple, the testing is done individually and one must consent to their partners being informed”. (Nurse, Athi River Medical Services).

One of the doctors from Athi River Health Centre noted that the most effective strategies that could be embraced in order to create awareness and understanding by communities, particularly community leaders, in mobilizing members of their communities to access ANC and PMTCT services, include; consolidation of church and health facilities efforts geared

towards ANC and PMTCT services; quarterly house to house sensitization; each health facility should have a quarterly community awareness day and County Representatives should mobilize county support in terms of finances for the health facilities to effectively conduct outreach services.

“We have so many user-friendly VCT centers which are usually not crowded. They are more private and one can access them using one entrance and leave using another. Not many people see your face and most men are encouraged to attend. It takes a very short time to complete the session”. (Doctor, Shalom Community Hospital).

A nurse from Shalom Community hospital mentioned that husbands are precautious about their children’s well-being and hence would give all the support to their wives to ensure their children are not directly infected. Studies in Kenya found that women accompanied by their partners for HIV testing were three times more likely to return for antiretroviral prophylaxis. Couple post-test counseling was also associated with an eight-fold increase in post-partum follow up, as well as greater antiretroviral utilization and formula feeding (Betancourt *et al.*, 2010 and Farquhar *et al.*, 2004).

Encouraging the women to come along with a treatment supporter for the counseling sessions prior to initiation of antiretroviral therapy preferably the partners would help in educating the partners appropriately and improving adherence in the long run. Apart from reviewing the counseling techniques, the knowledge of the adherence counselors also needs to be evaluated as their beliefs and attitudes are central to effective counseling.

“With the disclosure of HIV status to partners, who in most cases is the husband, he will not only provide support but will act as treatment partner for the spouse. We, therefore, need to encourage these women, to disclose their status to get the maximal benefit of disclosure. It is important, however, to note that women should not be forced to disclose their status, as HIV status disclosure has been reported to be accompanied by partner violence. Instead women who decline to disclose should be counseled and encouraged until they feel safe to disclose.” (Doctor, Athi River Health Centre).

5.0 CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This section presents the key findings in respect to assessing the approaches to male partner involvement in ANC and PMTCT in Athi River, as well as conclusion and recommendations.

5.2 Summary of Findings

Objective 1: To assess male attitudes, perceptions and concerns towards male involvement and participation in ANC and PMTCT.

Men view health clinics as facilities for women which mainly offer female services. Because of the unwelcome set up of most health facilities for men, and the negative attitude of health providers, men get discouraged to actively participate in these critical services. The study confirmed that the number of women attending ANC and PMTCT programs without their spouses was higher than the number of couples enrolled in these programs. All the participants were in monogamous marriages. Since most service providers are women, men shy away from seeking services from the facilities. Another finding is that the male attitudes and perceptions towards these services are shaped by lack of information, sensitization and awareness.

Objective 2: To assess the factors that hinders or encourages the involvement of males in antenatal and PMTCT care programs.

The study found that the factors which hinder male participation in ANC and PMTCT are varied. Male participation affects income generating activities. Men feel that it would not be ideal use of their time to accompany their spouses to the health facilities because of the length of time taken to complete the required procedures. This would negatively impact their source of livelihood. Social and cultural beliefs that are mainly shaped by their traditional and cultural beliefs also hinder men from actively participating in these programs. Men also have a superiority complex which dictates that they would be lowering their dignity and self-esteem by accompanying their wives to health facilities. Lack of adequate awareness and sensitization on the importance of involving men in these programs also plays a negative role in ANC and PMTCT services not realizing their full impact. Men are also ignorant of the benefits of attending the services as a couple. For PMTCT to be effective, the couple should both be involved in the full program for the benefit of their health and the well-being of their

baby. Unfortunately, most reproductive health awareness programs target more women than men which subsequently create barriers and increase the number of ignorant men.

A couple of factors which encourage men to participate in ANC and PMTCT are that some men, with the aim of supporting their spouses and subsequently their whole family, take keen interest in these programs and participate fully. Men who support their spouses during PMTCT believe that the well-being of their spouse depend on them and the role they play in participating in ANC and PMTCT. Community leaders also play a huge role in creating awareness on such programs because they are opinion leaders and community members regard their advice highly.

It is important to note that income generating activities are an important aspect for men in this community. They feel that any activity that interferes with their income would not be welcome. Most men feel that they fulfill their role by meeting the cost of the services and no other expectation should be required from them when this need has been fulfilled. After all, their concentration in income generating activities plays a key role in the sustenance of the whole family.

5.3 Conclusion

This study identified various factors, both positive and negative, that influence male involvement in ANC/PMTCT. Some of the participants do not have good understanding of ANC/PMTCT and are still being influenced by traditional norms and beliefs. In as much as there are some men who accompany their wives to the health centers and believe it is their duty and responsibility, there are some who feel that providing financial support towards pregnancy and prenatal care and other financial needs in the home, is adequate. Some men feared the HIV test while others felt that they were busy providing a source of livelihood to their families, with no time to accompany their wives to clinic. High male superiority complex which endears men towards controlling, being authoritative and having a sense of supremacy towards their wives also plays a key role in male participation in ANC/PMTCT.

The study also found out that men participation in ANC/PMTCT was also being negatively affected by programmatic factors. Most ANC/PMTCT service providers are female and may not be receptive and pleasant towards men, in order for them to feel relaxed and comfortable

while seeking services at the health centers. These factors have influenced some men to respond positively to the call of accompanying their pregnant spouse to ANC/PMTCT.

5.4 Recommendations

Based on the findings of this study, the following recommendations are proposed for the improvement of men's participation in ANC/PMTCT in Athi River sub-location of Mavoko Constituency in Machakos County:

Men should be sensitized to understand that a good husband is the one who provides to his wife financially and supports her throughout her pregnancy, irrespective of their HIV status. The men should also be encouraged to know their HIV status and to participate fully in the spouses' pregnancies for better outcomes.

In as much as the time taken in clinics is generally long, men must be socialized to understand that their role in reproduction is as important as the women's roles and they must create time for the benefit of the family and their future offspring. The management of health centers should also implement time saving systems and procedures to save on time spent while there.

Effort can also be made to design and implement programs specifically for ANC/PMTCT service providers that aim at changing their negative attitudes towards their clients or patients. More male service providers should be engaged in these services to enable men feel comfortable. Health personnel should also be sensitized and trained on how to handle delicate medical issues like HIV to ensure patients do not feel uncomfortable or unwanted at any one time especially when in the health facilities. Counseling that is geared towards assisting the couples accept their status and adhere to the required recommendations for their well-being should also be highly specialized.

Communication skills of partners should be enhanced to ensure couples are able to air their views without any intimidation whatsoever from either partner. Interventions should also be sought to include community opinion leaders and elders who are respected in the society. These interventions should target patriarchy and other cultural inhibitions to ANC/PMTCT, such as use of traditional medicine as opposed to modern medicine, treating women as equal

partners in marriage rather than subordinates, ensuring children from an early age are sensitized on the values of respecting girls and women and treating them with love rather than hostility.

Government policies and strategies that relate to ANC, HIV and PMTCT should be equally and continuously distributed to benefit the whole nation and to ensure that the needs of every citizen is represented.

In as much as this study has explored male attitudes on involvement in ANC in the prevention of MTCT of HIV, in Athi River sub-location, there is still need to conduct further studies in other parts of the country. This would encourage comparison of the findings and draw up comprehensive conclusions that can inform policies and strategies that would address the varying needs of the male population in the country in as far as ANC and PMTCT involvement and participation is concerned.

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APPENDICES

Appendix 1: Consent Seeking Form

Hello Sir/ Madam,

My name is Eunice Kidero, a Masters student at the Nairobi University, studying MA in Gender and Development. I am conducting a research study in partial fulfillment of the requirement for the award of this degree, titled, *“An assessment of male attitudes on involvement and participation in antenatal care and prevention of mother-to-child transmission of HIV”*, in Athi River sub-location of Mavoko Constituency, Machakos County.

This study and its procedures have been approved by the University of Nairobi, College of Humanities and Social Sciences, Institute of Anthropology, Gender and African Studies. The overall purpose of the study is to assess the existing understanding and approaches to male partner involvement in respect to preventing HIV transmission from mothers to babies in Athi River. All what is required of you is to honestly respond to the questions that I will be asking you.

You have been selected on purpose and we wish, with your permission, to interview/discuss with you. The interview/discussion will be recorded to ensure the information captured is accurate. Some of the questions asked, may be of a sensitive nature, but please note that your name will not be recorded in the questionnaire, and any details related to your privacy will be kept confidential. No personal information about you (such as your name) will be used or disclosed to anyone. Instead, you will be assigned a number and this will be used in place of your name. Your participation in this survey is very important and we rely on you to provide us with accurate information.

There are no risks or direct benefits to you associated with your participation in this study. However, we feel that your participation will contribute greatly in knowing how best to address challenges related to improving program implementation in respect to preventing HIV transmission to babies. Please be assured that we want to learn from your experience and all the information we collect will be used to help us control HIV/AIDS in your community and the country at large. You may choose to stop your participation at any time or refrain from answering questions. It is expected that each session will not last more than one hour.

At this time, do you want to ask me any question about this study?

May I have your permission to include you in this interview/discussion?

Yes proceed with the discussions

No curtail the discussions

If you do not want to participate, why.....

Signature: _____

Date: _____

Appendix 2: Letter of Introduction

TO WHOM IT MAY CONCERN

My name is Eunice Kidero and I am an MA student at the University of Nairobi, College of Humanities and Social Sciences, Institute of Anthropology, Gender and African Studies.

I am conducting a research study in partial fulfillment of the requirement for the award of this degree, titled, *“Exploring male attitudes on involvement in antenatal care: the case of prevention of mother-to-child transmission of HIV in Athi River sub-location of Mavoko Constituency, Machakos County”*.

The overall purpose of the study is to assess the existing understanding and approaches to male partner involvement in respect to preventing HIV transmission from mothers to babies in Athi River.

Your participation in this study is very important and I will rely on you to provide us with accurate information. There are no risks or direct benefits to you associated with your participation in this study. However, we feel that your participation will contribute greatly in knowing how best to address challenges related to improving program implementation in respect to preventing HIV transmission to babies. Please be assured that we want to learn from your experience and all the information we collect will be used to help us control HIV/AIDS in your community and the country at large. You may choose to stop your participation at any time or refrain from answering questions.

Thank you in advance for your cooperation.

Eunice Kidero

Appendix 3: Interview Guidelines for Key Informants

1. Community's knowledge and attitudes regarding healthy pregnancy and prenatal care

1.1 How would you evaluate the knowledge and attitudes regarding healthy pregnancy and prenatal care?

2. Attitudes toward HIV testing and disclosing HIV status

2.1 What is your take in voluntary counseling and testing (VCT) and its influence in acceptance of HIV screening?

2.2 Do you think male partner participation is an influential factor in their wives willingness to accept VCT?

3. Men's role in Wife's pregnancy and antenatal care

3.1 In this community, what roles do men play in women's pregnancy and antenatal care?

3.2 What is your experience in counseling women or couples who have tested positive to HIV in as far as accepting to enroll in PMTCT program is concerned?

4. Barriers to involvement and motivation of men to accompany wives to ANC

4.1 Could you spell out what you think are the perceptions and attitudes towards ANC and PMTCT services of members of this community? What about opportunities and barriers?

4.2 If barriers to PMTCT were classified into "societal barriers" (or systemic barriers), social network and individual barriers, how would you classify this community's reaction?

5. Engaging men and women in discussion of pregnancy issues

5.1 What are the cultural beliefs and norms of this community towards engaging men and women in discussion of pregnancy issues?

5.2 What role does cultural beliefs, traditions and norms of this community play to either impede or promote ANC and PMTCT?

6. Awareness of prevention of mother-to-child transmission and services

6.1 Has awareness creation in ANC and PMTCT programs been successful? If not, why?

7. Strategies and Policies in ANC and PMTCT programs

- 7.1 What do you think about the government's efforts to formulate and implement strategies towards PMTCT programs and which stakeholders should be involved?
- 7.2 Who, in your view, are opinion leaders who should be comprehensively involved in MTCT and PMTCT awareness creation, to facilitate increased knowledge in these programs?
- 7.3 What are the best strategies that could be embraced towards creating awareness and understanding by communities, particularly community leaders, in mobilizing members of their communities to access ANC and PMTCT services?
- 7.4 What is your take towards integrating text book theories and community traditions, norms and beliefs towards ANC and PMTCT?

8. Taking anti-retroviral during pregnancy: Husband's support and adherence issues

- 8.1 Do you think husbands would give adequate support to their wives who are taking anti-retroviral during pregnancy to ensure they fully adhere to the requirements?

Appendix 4: Topic Guideline for Focus Group Discussions (FGDs)

- 1. Women attending ANC and PMTCT Programs without their spouses.**
- 2. Women attending ANC and PMTCT Programs with their spouses.**
- 3. Men whose wives have enrolled in PMTCT programs but are not accompanying their wives.**
- 4. Men who accompany their wives to ANC and PMTCT Programs.**

Topic 1: Pregnancy and prenatal care

- 1.1 How would you classify a “good husband”?
- 1.2 What are your expectations as the man’s role during his wife’s pregnancy?
- 1.3 What are men’s roles in ensuring that their wife has a healthy pregnancy and delivers a healthy baby?
- 1.4 Do men accompany wives when they visit the antenatal clinic (ANC)?
- 1.5 Point out factors that may hinder and/or encourage men from accompanying wives to the ANC.

Topic 2: Mother-to-Child Transmission of HIV Issues

- 1.1 Please describe what you think an HIV-positive pregnant woman can do so that she does not give the virus to her infant? (*Probe: Anything else?*)
- 1.2 What have you heard about services being offered in this community to help the HIV-positive pregnant mother so she doesn’t pass the virus to her new baby?
- 1.3 Where did you hear about these services? (*Probe: The radio, my wife, etc.*)
- 1.4 Why do you suppose that more people in this community don’t take advantage of these hospital services that help prevent HIV-positive pregnant women from passing the virus to the baby?
- 1.5 What have you heard about the use of some drugs to reduce the transmission of HIV from an infected mother to her child?
- 1.6 *For men:* If your pregnant wife was told by the doctor to take a particular drug to prevent transmitting HIV to her baby, how do you think you might react? Would you support her in taking this medication? Why/why not?
- 1.7 Who would you most trust to give you accurate information on your wife’s pregnancy and how to prevent giving the HIV virus to your baby? (*Probe: Health workers, media, religious leader, etc.*)

1.8 Is there anything else anyone would like to say about this topic (or the other topics we've discussed today)?