

**UNIVERSITY OF NAIROBI**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

**FACTORS THAT INFLUENCE MALE PARTNER INVOLVEMENT IN  
(PMTCT) PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV IN  
MURANG'A DISTRICT HOSPITAL: HEALTH CARE PROVIDERS FACTORS.**

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## **DECLARATION BY CANDIDATE**

I, the undersigned, hereby declare that this is my original work and has not been presented for any other academic award at the University of Nairobi or any other institution.

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## **DECLARATION BY SUPERVISOR**

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

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## **DEDICATION**

I dedicate this work to the Almighty God for His special guidance and protection of my loved ones and myself throughout the study period.

## **ACKNOWLEDGEMENTS**

Special thanks and appreciation to all my loved ones especially Benato and Gem for their enduring love and encouragement.

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## ACRONYMS AND ABBREVIATIONS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Anti natal Clinic
<b>ART</b>	Anti Retroviral Therapy
<b>ARVs</b>	Anti Retroviral drugs
<b>CBO</b>	Community Based Organization
<b>CCC</b>	Comprehensive Care Clinic
<b>CHW</b>	Community Health Worker
<b>DH</b>	District Hospital
<b>FP</b>	Family Planning
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HCP</b>	Health Care Provider
<b>HCW</b>	Health care worker
<b>HCWs</b>	Health Care Workers
<b>HIV</b>	Human Immunodeficiency Virus
<b>IATT</b>	Interagency- Task Team
<b>ICPD</b>	International Conference on Population and Development
<b>IEC</b>	Information, Education and Communication
<b>KAIS</b>	Kenya AIDS Information Survey
<b>KDHS</b>	Kenya Demographic Health Survey
<b>KNBS</b>	Kenya National Bureau of Statistics
<b>MCH</b>	Mother and Child Health
<b>MOH</b>	Ministry of Health
<b>MTCT</b>	Mother to child transmission

<b>NASCOP</b>	National AIDS/STI control Programme (NASCOP), Kenya.
<b>NGO</b>	Non Governmental Organizations
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PNC</b>	Post Natal Care
<b>PNC</b>	Pre - Natal Care
<b>QCA</b>	Qualitative Content Analysis
<b>SPSS</b>	Statistical Package for Social Science
<b>STI</b>	Sexually Transmitted Infections
<b>UNAIDS</b>	United Nations AIDS Program
<b>UNGASS</b>	United Nations General Assembly Special Sessions
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization

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## ABSTRACT

The purpose of the study was to establish the factors that influence male partners' involvement in Prevention of Mother to Child Transmission (PMTCT) of HIV and focused on health care provider factors in the context of Murang'a District hospital, Kenya. The study adopted a census method and aimed at contacting all 110 PMTCT clients as respondents and all 10 Health Care Workers (HCWs) as key informants. To complement each other, structured interviews, in-depth interview guides, secondary data collection guide and observation checklist were used as key data collection instruments. The raw data from the field was analyzed using Statistical Package for Social Sciences and MS excel. Descriptive statistics were used in interpretation of findings and mainly used frequencies and percentages to present the data.

The study revealed that the majority of the respondents (78%) had education up to secondary school and beyond and that majority (44%) was married. The study established that out of the 108 respondents, 53.7 percent of them had informed their male partners about their PMTCT clinic appointment while 46.3 percent indicated that they had not. Three quarters of the respondents (75%) stated that they would like to involve their partners in the PMTCT program and 25 percent indicated that they would not. Despite the majority of respondents (75%) indicating that they would like to involve their partners in the PMTCT program, only 53 percent had invited their male partners to accompany them to the PMTCT clinic and 47 percent had not.

On the other hand, the study found out that 19 percent of the respondents had ever been accompanied to the PMTCT clinic by their male partners while the majority, (81%) had never. The study findings indicated that 1.9 percent of the respondents had ever attended PMTCT support group with their male partners while the greater percentage (98.1%) of the respondents stated that they had never. The study results further revealed that 16 percent of the respondents and their male partners had ever been counseled on PMTCT and the majority (84%) had never. The study established that more than three quarters of the respondents (78.7%) indicated that the HCWs had discussed the importance of male involvement with them while 21.3 percent stated that HCWs had not discussed.

The study findings further revealed that majority of the respondents (97.2 %) had been asked by the HCWs to invite their male partners while 2.8 percent indicated that they had not been asked. As regards the provision of Information, Education and Communication (IEC) materials to the respondents by the HCW, 1 percent indicated that they had been provided and the majority, (99 %) stated that they had not. A small percentage (15%) of the respondents confirmed that HCWs paid attention and invited male partners to the PMTCT clinic while the larger percentage, (85%) said the HCWs did not. Results from cross tabulation of data revealed that economic activities of the respondents were only associated with the partner being aware of the respondents visit to the hospital and that economic activity was not associated with all the other aspects related to uptake of male involvement services in PMTCT clinic.

Further, cross tabulation showed that marital status of the respondents was associated with several aspects related to participation in male involvement services in PMTCT clinic. Marital status was associated with partner being aware of clinic visit, respondent having ever invited the partner to the clinic and respondent ever having had a joint counseling session with the partner. Marital status factor was not associated with any other aspects of male involvement. Cross tabulation results revealed that age and level of education were not significant factors associated with any of the aspects of male involvement.

In conclusion, major impediments to male involvement in PMTCT program were found to be that staff were not trained in PMTCT and male involvement; inadequate space for counseling; inadequate community mobilization and sensitization; lack of integration of health services and lack of proper male involvement guidelines in PMTCT program. The findings indicate that the level of male involvement is still minimal.

The study therefore recommends that the health facility should hire more HCWs, train them on male involvement in PMTCT program and provide them with guidelines and standard operating procedures for the PMTCT program. The facility should expand counseling rooms, integrate health services and conduct community outreach activities.

## **CHAPTER ONE: INTRODUCTION**

### **1.1 Background to the Study**

The HIV epidemic continues to grow despite several decades of advocacy, awareness raising and investment in programmes to control the spread of (HIV) Human Immunodeficiency Virus (UNAIDS, 2009). By 2008 an estimated 33.4 million people were infected, a threefold increase since 1990. Two thirds of the people living with HIV are in Sub-Saharan Africa, and thus the HIV epidemic in this region is outpacing the treatment and prevention response, which is partly explained by the lack of alignment between programmatic and financial HIV prevention needs and the prevailing prevention responses (UNAIDS 2009). Globally, prevention strategies have not addressed the key drivers of the epidemic and efforts aimed at addressing underlying social norms that hinder the capacity of individuals to prevent HIV infection remain weak. This calls for tailoring of HIV prevention responses to match the needs (UNAIDS, 2009; Colvin, Kasedde, 2009).

In Sub-Saharan Africa, HIV/AIDS pandemic remains a major public health challenge while in many African countries, widespread testing of women for HIV infection remains an elusive goal (WHO, 2008). This elusiveness also persists in women's primary access to HIV testing and education offered during Prenatal Care (PNC) visits and through Prevention of Mother-to-Child Transmission (PMTCT) programs. (WHO, 2008). Further, HIV testing of men also remains a challenge, with only an estimated 6.1 per cent of men in sub-Saharan Africa having ever been tested for HIV and receiving the results. It is however perceived that one strategy to increase HIV testing and counseling in men is to include male testing in PNC (WHO, 2008).

In Kenya, the first case of HIV was diagnosed in 1985 and since then, according to United Nations AIDS program UNAIDS (2010), an estimated 1.5 million people are living with HIV and around 1.2 million children have been orphaned by AIDS. In 2009, 80,000 people died from AIDS related illnesses (UNAIDS 2010). PMTCT program is a highly effective approach to the prevention of HIV transmission from a mother to her child, yet in many developing countries numerous barriers to PMTCT access and uptake persist. During the XVIII International AIDS Conference in

Vienna in July 2010, one skills building workshop looked at how gender relations influence PMTCT outcomes. (UNAIDS, 2010).The conference also, in particular advocated for male participation in prevention of vertical HIV transmission programmes in order to improve outcomes for women and children in prevention of mother to child transmission (UNAIDS, 2010).

As shown by several studies, use and uptake of interventions for HIV prevention are increased by male participation in antenatal care of their spouses together with couple counseling and HIV testing. For example, Berer (1999) indicates that male partners can influence women's uptake of HIV testing and prenatal services. Berer further noted that women may experience difficulty adhering to treatment due to concerns about disclosure to a partner. However, increasing evidence suggests that partner support results in greater antiretroviral therapy (ART) adherence and antenatal clinic attendance, as well as lower transmission rates of HIV to a child (Berer, 1999).

### **1.1.1 HIV Prevalence in Kenya**

Heterosexual sex is the primary form of transmission of HIV in the country, and the epidemic varies greatly across demographic groups. Kenya's HIV prevalence peaked during 2000 and, according to the latest figures, adult HIV prevalence has now stabilized to around 6.3 percent according to the most recent Kenya Demographic and Health Survey KDHS ( 2008—2009) which is a dramatic reduction (UNGASS, 2010). This decline is thought to be partially due to an increase in education and awareness and high death rates. Many people in Kenya are still not being reached with HIV prevention and treatment services as indicated by the fact that only 1 in 3 children needing treatment are receiving it (WHO, 2010). This demonstrates that Kenya still has a long way to go in providing universal access to HIV treatment, prevention and care.

As far as UNGASS (2010) is concerned, HIV infections are easily prevented in healthcare settings. Nevertheless, 2.5 percent of new HIV infections occurred in health facilities in Kenya where women are disproportionately affected by HIV. In 2008/09 HIV prevalence among women was twice as high as that of men at 8 percent and 4.3 percent respectively (UNGASS, 2010). This disparity is even greater in young

women aged 15-24 who are four times more likely to become infected with HIV than men of the same age (UNGASS, 2008).

Kenya's National AIDS/STD Control Programme (NASCO) 2002, estimates that there are 1.2 million babies born each year in Kenya and that as many as 10 per cent of pregnant women in Kenya are living with HIV/AIDS. At least 50,000 to 60,000 infants in Kenya are thought to become infected with HIV as a result of Mother to Child Transmission (MTCT) each year. According to the Kenya Demographic and Health Survey (KDHS) in 2003 by MOH, knowledge that HIV can be passed from mother to child is high in Kenya. The survey indicates that 72 per cent of women and 68 per cent of men reported that HIV can be transmitted through breast milk; 33 per cent of women and 38 per cent of men know that the risk of MTCT can be reduced when the mother takes certain drugs during pregnancy; about 50 per cent of women and 60 per cent of men have heard of Voluntary Counseling and Testing (VCT) while only about 15 per cent of them have actually gone for testing. These facts however indicate that more children are at risk of getting infected as most of the adult (85 per cent) have not gone for HIV testing (KDHS, 2003).

### **1.1.2 Murang'a District Hospital**

Murang'a District Hospital is located in Murang'a district within Murang'a Township, bordering Kirinyaga, Nyeri and Thika Districts. Murang'a district is located in central province of Kenya. According to Kenya Census data 2009, the district has a population of 942,581 (KNBS, 2009). Murang'a district hospital is located in County of Murang'a, Kiharu Constituency, Kiharu Division and Karuri Sub Location. This hospital is currently operational and its' capacity currently stands at 270 beds and 58 cots (KNBS, 2009). Among the services it offers are Curative Outpatient Services, Clinic for Prevention of Mother to Child Transmission of HIV, Comprehensive Care Center for HIV positive clients, Tuberculosis Lab and clinic.

Like in many other hospitals in sub Saharan Africa and Kenya in particular, PMTCT services in Murang'a District Hospital are mostly biased for women and children. PMTCT programmes here have done very little to involve men. Therefore, a lot needs to be done to improve male participation in this hospital. Probably, the PMTCT programs should be revised to conveniently increase male participation.

### **1.1.3 Male involvement in PMTCT**

With men's participation in PMTCT, the testing and counseling they receive in the PMTCT clinic promotes sexual and reproductive health of women and men as both of them will know their HIV status and therefore cut the risk of infections and or re-infections (Greene, 2002). Men and women of all ages, married or unmarried have their own sexual and reproductive health needs. However in spite of the call for men to take responsibility for their sexual and reproductive health, the sexual and reproductive health needs of men remains poorly understood (Lee, 1999). In South Asia for example, men have been found to be mainly concerned with psychosexual disorders (Collumbien et al., 2000). Hitchings et al. (2009) says that in the UK, men in a sexual health clinic expressed preference for confidential and quick services over medical expertise, rapid access or patient- centered services. According to Pearson (2003), young men sought sexual health services primarily to remedy crisis situations such as symptoms of Sexually Transmitted Infections, (STI) and to obtain condoms while Lee, (1999) portends that ideally, it is important that everyone receives lifelong education about reproductive health, STI and condom use.

Reproductive health programs have also not been targeting men and this has weakened the impact of the programs' interventions since men who can significantly influence their partner's reproductive health decisions to use of health resources are left out (KDHS, 2008-2009). This is especially so in African setup where men wield considerable power in decision making with regard to Family Planning options and utilization, PMTCT and support for mothers and infant feeding options. According to KDHS (2008-2009), there is increased prevalence of HIV among married couples with 78 percent couples not being aware of HIV status for their respective sexual partners.

In 2008, the number of people living with HIV worldwide reached an estimated 33.4 million and heterosexual transmission was the leading cause of HIV transmission in Sub-Saharan Africa (Higgins et al., 2010). Heterosexual men have been regarded as active transmitters of HIV and not active agents in prevention, conversely heterosexual women have been portrayed as especially vulnerable to HIV infection because of biological susceptibility and men's sexual power and privilege (Higgins et al., 2010).

## **1.2 Problem statement**

PMTCT programs are an important component of the whole HIV prevention strategy. The idea of involving men in matters related to women's reproductive health started to attract a lot of interest especially after the 1994 International Conference on Population and Development (ICPD) in Cairo and 1995 women's conference in Beijing (Drennan, 1998). In these two conferences, the stakeholders were able to recognize the many roles men can play in bringing the reproductive health services to success (Clark et al., 2001). Even though involving men in these programs has been associated with an increased uptake of PMTCT interventions by women, it remains one of the major challenges encountered by the program implementers (Rutenberg et al., 2003). Increasing evidence indicates that partner support enhances adherence to Antiretroviral Therapy (ART) and antenatal clinic attendance as well as lower transmission rates of HIV to a child (Berer, 1999). Qualitative studies point out the contradiction between male beneficial attitudes towards HIV testing in pregnancy and low uptake, a suggestion that indicates external barriers to successful implementation of male involvement (Theuring, 2009 and Auvvien et al., 2010). Studies indicate that HIV services are not reaching out fully to men. In Ethiopia, a study was carried out on 663,603 pregnant women for 2004 to 2009 where 13.5percent (986) were HIV positive and showed that male testing was low at only at 4.9 percent, with a worrying decline over time by 14% from 2004 and 2009. Men report that the antenatal environment is a women's' environment and not conducive to their attendance (Snow et al., 2010). According to Mirkuzie et al. (2010), the environment is not conducive, the way of operationalizing the request for invitation to test is often mediated through women and thus an indirect invitation may be perceived with lower validity or desirability by men. Furthermore using women as go between may add an unnecessary burden on their shoulders and according to Mirkuzie et al.(2010), there does not seem to be any global policy on male involvement in HIV testing in pregnancy or ongoing vertical transmission provision of HIV (MTCT). Thus in the absence of direct policy, male testing in HIV pregnancy may present serious missed opportunity in the reproductive health especially in PMTCT (Mirkuzie et al., 2010).

The benefits of male involvement in women's reproductive health and PMTCT in particular are well recognized and have been recommended by many (Ekouevi et al., 2004). However reports from various PMTCT facilities indicate generally low male participation and its negative impact on the level of uptake of interventions by women in these programs (Rutenberg et al., 2002). This low involvement by men deprives women of their partners' care and support in coping with HIV infection, in taking antiretroviral therapy and making appropriate infant feeding choices (UNICEF, 2001). On the other hand, Kraft et al. (2007) portends that identifying discordant couples is a specific HIV prevention opportunity that is missed if partner testing is overlooked during the PMTCT service provision. Cost-effectiveness analysis showed considerable benefits for male partner testing, which would identify HIV positive fathers and thereby intervene to prevent new transmission to pregnant women and obviate infants acquiring HIV which could be heightened if the mother had newly acquired HIV (Kraft et al., 2007).

Since men in Kenya principally make key decisions in the household, it is fundamental to involve them in promoting planning and reproductive health matters for the household. This calls for male partner contribution in whole cycle of pregnancy, delivery and care for the baby in order to have successful interventions that will enhance mother and baby pair survival (Rutenberg et al., 2002). Men can change the course of the HIV epidemic by taking action in prevention since the very actions that prevent HIV infection also promote the sexual and reproductive health of both women and men (Greene, 2002). Why this low involvement, and what could be the factors influencing it?

Male involvement in mode of childbirth, continuing to use treatment services and feeding decision- making needs to be understood as well as the factors associated with parenting a child in the presence of HIV (Mirkuzie et al., 2010). This study therefore, looked into the factors that influence male partners' involvement in PMTCT program and focused on health care provider factors in the context of Murang'a District hospital, Kenya. Specifically, the study contacted the PMTCT clients as respondents and HCWs as key informants.

Establishing these factors is important in order to identify appropriate recommendations.

### **1.3 Research Question**

Taken from the background description above, this study aimed at understanding the following questions:

- i. What is the extent of male involvement in PMTCT in Murang'a District hospital?
- ii. What are the service providers' factors that influence male involvement in Prevention of Mother to Child Transmission at Murang'a District Hospital's PMTCT clinic?
- iii. What strategies can the PMTCT service providers put in place at the PMTCT clinic to encourage men to participate in the program at Murang'a District Hospital?

### **1.4. Broad Objective**

The study aimed at establishing the service provider's factors that influence male partners' involvement in prevention of mother to child transmission (PMTCT) of HIV at Murang'a District Hospital.

#### **1.4.1 Study Objectives**

This study was based on the following objectives:

- i. To determine the extent of male partner involvement in PMTCT in Murang'a District Hospital.
- ii. To establish the health services provider related factors that influence the involvement of male partners in PMTCT program in Murang'a District Hospital.
- iii. To identify the best strategies that health care providers can put in place to encourage male partner involvement in the PMTCT program in Murang'a District Hospital.

### **1.5 Scope and Limitations of the Study**

The scope of this study was limited to looking into the service providers' related factors that influence male partners' involvement in Prevention of HIV transmission from mother to child and was conducted in Murang'a District Hospitals' PMTCT clinic. The subjects of this study were health care providers in PMTCT and PMTCT clients in Murang'a District Hospital.

- i In determining the extent of male partner involvement in PMTCT, the study was limited to the issue of male accompanying a female partner to the PMTCT clinic and receiving health services and information together in the PMTCT clinic.
- ii To establish the health care provider's factors that hinder or encourage male involvement in PMTCT in Murang'a District, the study was limited to the views of the PMTCT clients as well as the Health care providers in the PMTCT clinic. Focus was on factors related to health care providers in the PMTCT clinic.
- iii To identify the best strategies that could be put in place to encourage male partner involvement in the PMTCT program, the study limited itself to health care providers' practices in the PMTCT clinic and focused on the views of the clients and health care providers in the PMTCT clinic in Murang'a District Hospital.

## **CHAPTER TWO: LITERATURE REVIEW**

In this chapter, the literature review for this study is discussed. This literature review highlights the types, quantities and content of consulted sources and also the way in which they were acquired. The review covers theoretical or empirical sources related to the main concepts found in this study. They were reviewed with the aim of gathering enough insight into the topic to refine the problem being studied, to become familiar with the existing body of knowledge on the topic and to choose and define the methodology used for this study.

### **2.1 Concept of Prevention of Mother to Child Transmission of HIV (PMTCT)**

Mother to child transmission (MTCT) of HIV is when a HIV positive woman passes the HIV virus to the baby. Transmission of HIV from mother to child is also referred to as “Prenatal Transmission” or “Vertical Transmission”. According to WHO (2007), most of the children infected with HIV acquired it from their infected mothers.

Mother-to-Child Transmission can take place during pregnancy and or after birth. During pregnancy, the fetus can become infected by contact with the maternal blood through a placental hemorrhage or by swallowing infected amniotic fluid (Rutenberg et al., 2003). Some of the maternal factors which increase the chance of mother-fetus transmission of HIV are discussed by Rutenberg et al. (2003) as follows: malnutrition, high viral load, maternal sero-conversion during pregnancy and other sexually transmitted diseases and lack of or poor compliance with antiretroviral drug therapy.

There are other factors that increase the risk factors of mother –to- child transmission which include the rapture of the vaginal tissue, the contact of maternal blood and vaginal secretions and vaginal delivery (Horizon Programme, 2002). Presence of a high viral load in a pregnant woman is correlated with transmission of HIV to the baby. This higher risk is related to greater exposure to maternal secretions caused by the rapture of membranes. The most significant risk after birth is breastfeeding. According to the Horizon programme, (2002) it has been confirmed that there is presence of HIV in breast milk which poses a risk for the breastfeeding infants.

Breastfeeding causes 16-29 percent of HIV transmission to the breastfeeding babies while the risk of HIV transmission is also increased by mixed feeding of breast milk and other food sources. According to hypothesis by scientists, introduction of new foods to the baby triggers the infant's immune response thus attracting white blood cells to the gastrointestinal tract which increases targets for the HIV viruses to spread infection. Scientists hypothesize that an infant's immune response is triggered by the introduction of new foods, attracting white blood cells to the gastrointestinal tract thus increasing targets for the HIV viruses to spread infection (Horizon Programme, 2002).

Vertical Transmission is the cause of most incidents of HIV in children aged below fifteen years. A Further 5 percent-20 percent will become infected through breastfeeding (WHO, 2004). Therefore it is important to prevent the passing of HIV from mother to child. Without intervention or treatment, the possibility of HIV transmission from mother to child is 20 percent - 40 percent. However, with the appropriate intervention and treatment, transmission can be reduced from around 25 percent to less than 2 percent (WHO, 2004).

## **2.2 Male partner involvement in PMTCT**

Promotion of men's involvement or participation in women's health programmes has been a source of much interest in the recent years, even though its meaning continues to vary from source to source. According to Lee (1999), men's involvement can be viewed from programme perspectives and may mean men supporting choices and rights of their female partners, or men doing something about their own reproductive and sexual behavior as a way of protecting their partners. For Rutenberg et al. (2003), men's involvement may mean many things, depending on the couple and community. Some men may choose to go to the clinic with their female partners, get involved in counseling and be tested for HIV, while many choose not to visit the clinic, but instead support their partners in coping with HIV in other ways like paying for their partner's health care and/or provide transport for their partner to reach the clinic (Rutenberg et al., 2002).

According to Drennan (1998), the topic of men's involvement is further complicated by the wide range of terms used in the literature to qualify it. This terminology

includes: men's participation, men's responsibility, male motivation, male involvement, men as partners, and finally men and reproductive health. For Drennan (1998), the terminology used does not matter as long as the purpose is to describe the process of social and behavioral change that is needed for men to play more responsible roles in reproductive health services.

### **2.3 Reasons for male partner involvement in PMTCT**

In 2008 mother-to-child transmission of HIV accounted for 390,000 new infections among children below 15 years of age in Sub-Saharan Africa. According to the Inter-Agency Task Team (IATT, 2007) male involvement is a critical component of the PMTCT program. According to Maman, (2008) male involvement is necessary for improving women's uptake of core PMTCT services; it is a key contributor to community acceptance and support of PMTCT and it has been linked to greater uptake of testing, greater uptake of Antiretroviral Therapy, increased condom use, increased communication and support for infant feeding choices. Therefore, male involvement is critical for primary prevention of HIV and for avoiding unintended pregnancy (Maman et al., 2008).

Despite many challenges, the importance of involving men in the prevention and treatment of HIV/AIDS programmes for women has gained increased recognition in the literature, especially after the 1994 Cairo and 1995 Beijing consensus documents, which agree that men are crucial to bringing about changes in women's health status (Lee, 1999). The call for involving men in reproductive health issues has emphasized on the role of men in improving the health of their families and themselves (White et al., 2003). Involving men is important because men do influence women's access to health services through their control of finances, women's mobility, and means of transportation and health care decisions (Greene, 2002). Lee (1999) calls this role the "gate keeping" authority of men. For Kumar (1999), the need to involve men, as defined by the International Conference on Population and development (ICPD) and the Beijing Conferences, is even more crucial in the African context, because of the rapid spread of the HIV/AIDS pandemic and because of cultural norms and taboos which reinforce negative stereotypes about male involvement in reproductive life issues (Kumar, 1999). These factors call for responsible sexual and reproductive

behavior by both men and women if HIV/AIDS is to be controlled. Rutenberg et al. (2003) also recognize the importance of men's roles in PMTCT. According to these authors, it is difficult to consider optimal uptake of PMTCT interventions without the partner's understanding and consent. In the case of breastfeeding, for example, lack of partner support has been identified as a barrier to replacement feeding for HIV-infected women since women who choose to exclusively breastfeed need partner support (Baggaley et al., 2000).

While the benefits of male involvement seem to be indisputable, Kumar (1999) mentions opposing views in some circles that consider men's involvement as a way of increasing men's control over women's reproductive life (Kumar, 1999). The argument is that as men are already involved in all major human activities, why should they acquire more control over women's reproductive life as well? (Kumar, 1999).

Clark (2001) warns against some of the pitfalls to be considered in the process of involving men: firstly, the fact that involving men should be constructive, in the sense that it should always protect women's interest without being paternalistic. Secondly, involving men should not result in subtraction of resources from women's programmes for the sake of men's programmes (Clark, 2001).

Kumar (1999) portends that there are other many reasons why men should accompany their women to the PMTCT clinics and goes on to discuss some of the benefits as follows. Firstly, basic knowledge in HIV; when men accompany their female sexual partners to the PMTCT clinic, their knowledge of HIV increases, and their behavior becomes supportive and their receptiveness to HIV testing increases (Kumar, 1999). Accompanying their sexual partners to the PMTCT clinic increases access to information, knowledge and awareness that facilitates good choices. Men who have accessed information are able to help on planning for delivery and also support the women in adhering to HAART (Highly Active Antiretroviral Therapy) in order to protect the baby from HIV infection during pregnancy, labor and delivery (Kumar, 1999). Secondly, it also helps men access testing services that allow them to know their HIV status and thereafter plan their future together with their female partners. Pregnant women and their partners are usually given a HIV test as a routine

ANC service, thus enabling couples to protect their baby from being infected during pregnancy, labor and delivery. Thirdly, it ensures adherence to the PMTCT clinic appointments among men as those men who have not attended the PMTCT clinic are not able to support their sexual partners in adherence mainly because they do not understand the benefits or that they do not know their partners HIV status. Fourthly, when men accompany their wives to the PMTCT, they get support on HIV status disclosure. A pregnant HIV positive woman who has not disclosed her HIV status to her partner, family or friends is generally less likely to accept preventive drugs and may refuse to practice unconventional methods of infant feeding, for fear of revealing that she is infected, hence risking the well being of the infant. Such a woman will also miss out on family support during and after pregnancy (Kumar, 1999).

Couples need to go for HIV counseling and testing with their sexual partners to establish their status to protect their baby from possible HIV infection and other related STIs (Ntabona, 2002). Adherence to HAART for pregnant women dramatically reduces perinatal transmission: a woman who has not disclosed to her sexual partner may not be able to adhere well to HAART and will not be able to use condoms, get good nutritional support and will most likely have stress. Moreover she will not attend clinic in time and will not access health information (Russo et al., 2009).

If couples are counseled and tested then there is less potential for blame and accusation (Clark, 2001). 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 take-up rates. According to Clark, (2001) this will improve the well being of the family, thus increasing the chances of survival for the child. Those women who are uncomfortable disclosing to their male partners on their own, can chose an option of provider and/or counselor-mediated disclosure. HIV positive pregnant women who do not disclose their status to their partners usually do not return to the clinic, therefore putting the baby's life in jeopardy (Clark, 2001). Increased adherence to care and medication occurs as people disclose HIV status, and provides an opportunity to discuss safe sex and family planning choices with sexual partners. Pregnant women get support for safer infant feeding practices,

financial and emotional support as a result of disclosure of HIV status to their partners (Clark, 2001).

Counselors can emphasize on 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 up-take rates. Counseling the male partner also increases chances for female partner and children to seek HIV counseling, testing, care and treatment if needed (Russo et al., 2009).

According to Barker (2010), providing diagnosis and treatment of STIs to couples as a part of routine HIV care, with particular care to syndrome management, diagnosis, and treatment of genital herpes and other STIs in HIV-positive persons and their partner is crucial. For HIV-positive women and couples who desire children, it is important to discuss strategies to reduce the likelihood of transmission to sexual partners and infants. Couple screening and prompt treatment of STIs will reduce chances of HIV transmission to the baby and re-infection to each other (Barker et al., 2010). Programs such as Women Fighting AIDS in Kenya are successfully working towards increasing male involvement in PMTCT services (Ovaro and Kaduwa, 2008).

## **2.4 Theoretical Review of Literature**

This study will be guided by the Gender Schema Theory and the Social Construction Theory.

### **2.4.1 The Gender Schema Theory**

Gender schema theory suggests that children play a more active role in their own gender development from an earlier age. In 1981, Dr. Sandra Bem formally introduced the Gender schema theory to explain how individuals become gendered in society, and how sex-linked characteristics are maintained and transmitted to other members of a culture. According to Bem 1981, Gender schema theory mainly focuses on the role of cognitive organization in addition to socialization. The theory postulates that children learn how their cultures and or/societies describe the roles of men and women and they internalize this knowledge as a gender schema or unchallenged underpinning belief. According to Bem (1995) gender schema is then used to organize consequent experiences. The perceptions of children on men and women are thus an

interaction between their gender schemas and their experiences. Eventually, children will incorporate their own self – concepts into their gender schema and will assume the traits and behavior that they deem suitable for their gender (Bem, 1995).

According Bem, (1995) gender schema theory suggests that a child's gender development reflects the increasing complexity of the schemas it develops around maleness and femaleness and by about the age of two the child is able to label it and others as female or male. This reflects the development of a basic gender schema. The child then starts to seek out information from its environment in order to increase its understanding of maleness and femaleness and thereby to guide its own behavior (Bem, 1995). The child identifies activities and objects associated with its own gender and start to ignore or reject those that do not fit in with this. At this early stage a child's understanding of gender is simplistic and quite rigid and this is reflected in its' behavior (e.g. a three year old girl may reject any object that isn't pink). Bem portend as their gender schemas increase in complexity, however, the child becomes better at coping with ambiguity and their ideas about what is acceptable or appropriate start to relax. On the other hand, Eagly et al. (2000) portends that consequences of gender roles and stereotypes are sex-typed social behavior because roles and stereotypes are both socially shared descriptive norms and prescriptive norms.

According to Bem (1985), Gender schema theory holds that children learn conceptions of appropriate gender behavior and the network of gender related associations from their culture and then they learn to apply this network as they evaluate and incorporate new information. The child's pre existing views about gender will impact how new information is perceived. According to Bem (1985) initially, a child learns to assess attributes differently for different genders (For example, the child sees boys as stronger than girls). Eventually, the child sees dimensions as belonging entirely to one sex and not the other. The dimension is completely removed from the schema that they apply to one gender. (The concept of "strong" is no longer applied to girls in any degree. Instead girls are viewed as the opposite: "weak".). The outcome is that the sexes become different to the child, "not only in degree, but in kind." (Bem, 1985)

Fortunately, the process of developing a gender schema is not finite or immutable. Because gender schema theory sees gender schemas as learned and dynamically constructed, it provides for the Social learning theory and for this reason Dr. Bem (1985), says that children learn gender roles by being rewarded for some behaviors, punished for other behaviors, and by watching others perform gender (modeling). Although Dr. Bem agrees that gender roles are learned, she believes that children are not only passively receiving the information about gender roles, but are then actively using that information to organize and comprehend the larger world.

Traditionally, men have been viewed as financial providers, whereas women have been viewed as caretakers. Therefore this form of mindset, which could also be held by the Health Care Providers, may discourage male involvement in many duties which are coded as women's.

#### **2.4.2 The Social Construction Theory**

The Social Construction Theory as postulated by Gergen (1985) indicates that human beings' experiences are usually based on the way they interpret the world and themselves thus essentially building realities in which they live. Therefore human behavior is frequently influenced by circumstances, time and context which means that different meanings are assigned to different experiences. Consequently, people are required to understand the cultural/historical context that exists when the information is gathered in order to understand the different social relations (Khan, 2009).

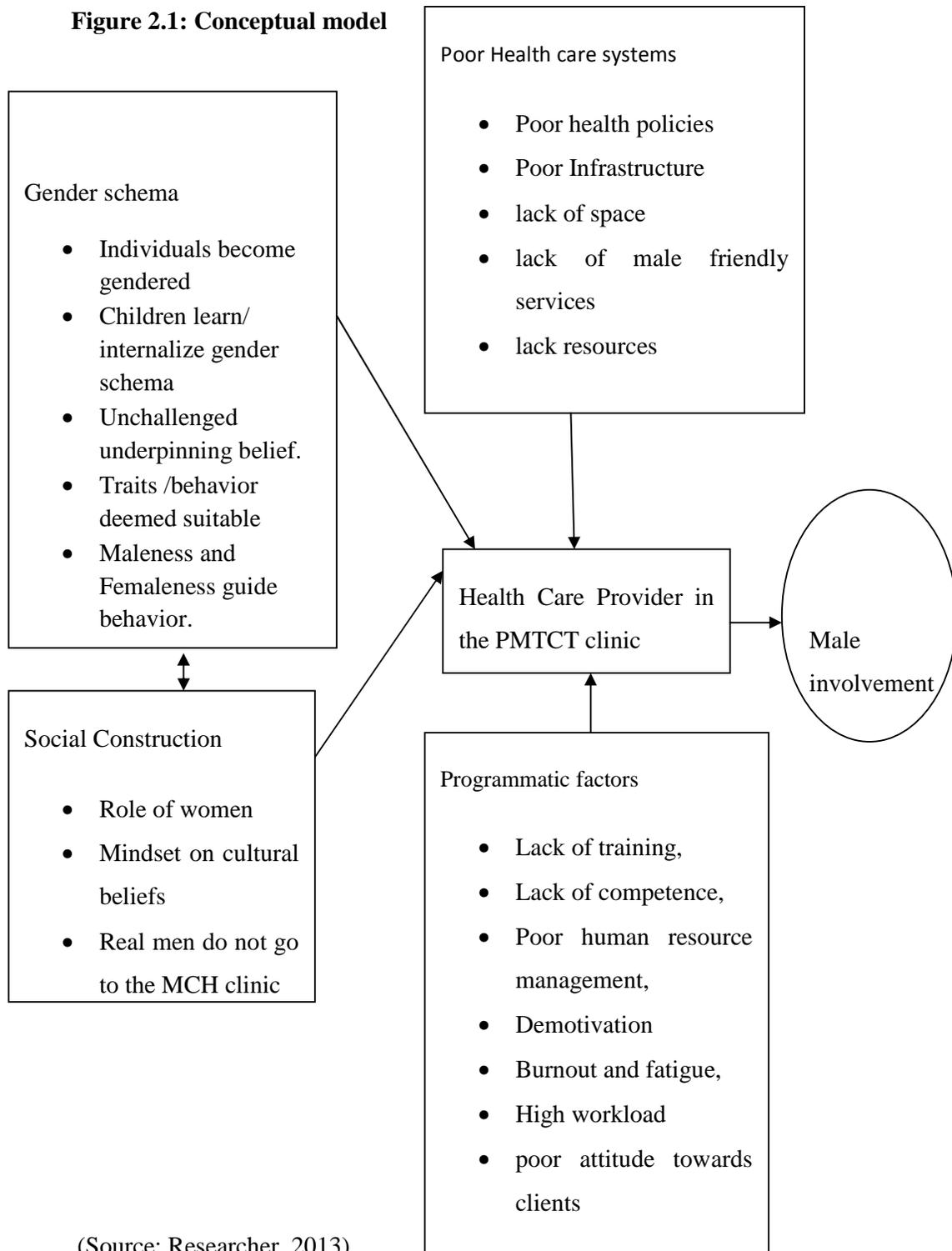
The Social Construction Theory is suitable for understanding the relevance of hegemonic masculinity in male involvement in PMTCT programs in Kenya. (Garson and Peiss, 1985). The concepts of masculinity (and femininity) are socially constructed and people adopt from their culture and reproduce through their own actions. This is responsible for the way men (and women) think and act and thus not their role identities or psychological traits (Garson and Peiss, 1985). Therefore from this perspective gender is viewed as a dynamic social construct, which is continuously being shaped by cultural concepts and notions of masculinity and femininity. The involvement of men in PMTCT has been socially constructed whereby matters around child bearing are seen as exclusively a women's responsibility (Khan, 2009). Social

constructionism may be defined as a perspective which believes that a great deal of human life exists as it does due to social and interpersonal influences (Gergen, 1985). The subjects that social constructionism is interested in are those to do with what anthropologists call culture, and sociologists call society: the shared social aspects of all that is psychological.

Social constructionism regards individuals as integral with cultural, political and historical evolution, in specific times and places, and so resituates psychological processes cross-culturally, in social and temporal contexts (Khan, 2009). Apart from the inherited and developmental aspects of humanity, social constructionism also hypothesizes that the very aspects of humanity are created, maintained and destroyed in our daily interactions with others through time. The social practices of all life begin and are recreated in the present and eventually end (Khan, 2009). For psychotherapy, this view emphasizes the importance of the acquisition, creation and change of emotional behavior, therapeutic ability and ways of interpreting things and people. (Khan, 2009). Because the genetic material of each race and region is different, as well as the cultural practice, then we say right from the start that there is no universal human nature. What social constructionism shows to be important are the ways in which socialization and enculturation, amongst the people we have known, plus the current influence of those whom we now know, are the most active in shaping our mutual existence with others (Khan, 2009).

## 2.5 Conceptual frame work

**Figure 2.1: Conceptual model**



(Source: Researcher, 2013)

In figure 2.1 of the conceptual model, various factors may affect health care workers which in turn affect male involvement in PMTCT program. HCW are also part of a culture/society that believes that child care is a woman's' role. According to the Gender schema theory, children learn and internalize traits that are deemed appropriate for male and females. Children learn femaleness and maleness and they become gendered whereby they are guided by unchallenged belief on what behavior is suitable for male and female. Cultural beliefs, norms and attitude affect the way HCW view male involvement in PMTCT. In cultural beliefs, both men and women believe that attending the PMTCT clinic is the role of women and that the PMTCT services are meant for women. The PMTCT program is also not well designed to suit men as most of the time men are referred to other departments for their medical care. The HCW is not able to offer male friendly services due to the design of the PMTCT clinic as it is targeting and focusing on women and children. The HCW are usually demotivated with high workload, burnout and fatigue and hence they are not ready to accommodate male clients as they see them as extra burden who can seek services in other general departments.

## **CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY**

Outlined in this chapter is the research methodology that was used to accomplish the objectives of the study. The chapter also presents the research design, target population, study site, sampling design, data collection methods and tools, data analysis, ethical considerations and data presentation.

### **3.1 Research Design**

The study used a descriptive survey design. A descriptive survey design involves description of characteristics of a group or individuals drawn from a given population. The design helps a researcher to obtain complete and accurate information to answer the research questions for the study. Khan (1993) recommends descriptive design for its ability to produce statistical information about aspects of education that interest policy makers. A research design outlines the aim, uses, purpose, intentions and plans within specified constraints that include: location, time, money and human resource availability.

### **3.2 Site Selection and Description**

The study was carried out in Murang'a District Hospital which is located in Kiharu Constituency, Kiharu Division and Karuri Sub Location and covers both urban and rural settlements of Murang'a region. The Hospital is located in Murang'a Town and is the largest health facility in the County.

Murang'a District Hospital is the largest health facility in the district and is located in Murang'a district in Murang'a County and mainly serves rural and urban population around Murang'a town. Murang'a County borders Nyeri, Kirinyaga and Kiambu Counties in Central Kenya. Murang'a is one of the districts of Kenya's Central Region. According to the Kenya Census report (2009) Murang'a District has a population of 942,581. Murang'a is located between Nyeri and Thika. To the South, 10 kilometers away is Maragua town while 15 kilometers Northwest lies Sagana town. (Kenya Census, 2009). Murang'a district has varying altitudes that make the county quite cold in the months of May to mid-August. There are kikuyu farmlands rolling to the west of Murang'a town and are visible as far as the eyes can see. Due to its fast

growth, Murang'a town has been able to attract a lot of business from traders and farmers from the bordering districts. Some of the fast upcoming businesses are banks, lodges and hotels, post office, petrol stations, restaurants serving local and exotic dishes, supermarkets, dry cleaners, lively supermarkets and night clubs playing latest local and Western music

There are 271 health facilities in Murang'a County and among them are 112 centers which are run by the government. Privately owned facilities are 125 in total while another 31 health facilities are run by faith based organizations. There are a few centers managed by community based organizations. These facilities range from District Hospitals to maternity/nursing homes and slightly over two thirds of them (2/5) are government supported. Out of these 271 facilities, 52 government sponsored health institutions offer PMTCT services (Softkenya.com).The governments' health sector has partnered with other organizations including Non-Governmental Organizations (NGOs), United Nations Children's Fund (UNICEF), community based organizations (CBOs), private institutions and faith based organizations to offer PMTCT services in these facilities (Softkenya.com).Murang'a District Hospital is the largest government sponsored health facility in Murang'a District and has a bed capacity of 270 beds and 58 cots (SoftKenya.com).

Among the services offered at the hospital include; Curative Outpatient Services, Clinic for Prevention of Mother to Child Transmission of HIV, Comprehensive Care Center for HIV positive clients, cervical cancer screening, Tuberculosis Lab and clinic.

### **3.2.1 Units of Analysis**

In this study the units of observation were PMTCT clients and HCWs who work in the PMTCT clinic while the units of analysis were Health Care Provider factors that influence male involvement in PMTCT program.

### **3.3 Sources of Data**

Primary data was sourced from PMTCT clients (women) and PMTCT Health Care Workers (HCWs) at Murang'a district hospital's PMTCT Clinic. Secondary data

relating to the number of PMTCT clients, male involvement and staff information under the study was sourced from hospital records.

### **3.4 Target population**

Target population for the study comprised of all the 110 active PMTCT clients and all the 10 Health Care Workers (HCWs) including the in-charge of the PMTCT clinic at Murang'a District Hospital. These figures were per the records of active PMTCT clients enrolled at the facility by 31 December 2013 and all the 10 staff that had been working at the facility.

### **3.5 Sampling Design and Procedure:**

Since the target population for the study was fairly small, the study used a census design with an intention to interview all the 110 active PMTCT clients and 10 Health Care Workers. The major consideration was the fact that the PMTCT clients and the PMTCT clinic HCWs were best placed to give their opinion and experiences in PMTCT since they were already in the program.

The researcher used purposive sampling to select one HCW for the in-depth interview. This was because the researcher had to identify the most appropriately placed person in terms of experience, knowledge, authority and expertise in PMTCT

#### **3.5.1 Selection of study site**

The site selected for this study was Murang'a District Hospital.

#### **3.5.2 Selection of respondents**

In this study, there were respondents who included the PMTCT clients and key informants who included the Health Care Workers at the PMTCT clinic. According to the head of the clinic, clients visited the facility in three groups per week (Mondays, Tuesdays and Fridays). Each group was assigned a specific day and therefore, clients were contacted on their respective clinic day during data collection period. Clients' honoring of clinic appointment was good and had been indicated to be over 98 percent in the appointment diary at the clinic. For those clients who did not honor their clinic

appointments, the researcher did home visits to the client using the Community Health Workers (CHWs) who were guided by the locator information that was documented in the clients' file.

### **3.6 Methods of data collection**

In this study, various methods of data collection were used. The researcher employed and trained two research assistants to collect data. Face to face interviews were conducted to obtain required information from the PMTCT clients and PMTCT clinic HCWs. Use of this method was appropriate given that there were some respondents who were illiterate and semi-illiterate. In addition, it helped to clarify questions in order to get the right responses.

In-depth interview was conducted with the PMTCT clinic in charge to enable the researcher gather rich information on key areas of the study. Observation method was used to record the number of female clients who were accompanied by their male partners to the PMTCT clinic and this was done during the time the respondents (PMTCT clients) attended their PMTCT clinic appointments. To collect secondary data, desktop review of registers and hospital documents was done to extract the relevant information.

### **3.7 Data collection tools**

Two structured interview schedules were developed for PMTCT clients and HCWs. Simply put, an interview schedule is a pre-coded tool that specifies the order and wording of questions and often filled by an enumerator. Structured interview schedules were administered to the respondents and answers were recorded alongside the questions and coded. Structured questions were suited for this study as they allowed collection of uniform information. While the information sought from clients and HCWs was the same, clarifications on the questions were made for each respondent to ensure they gave the intended information. Therefore, the researcher factored in the issue of reliability especially internal consistency in the questionnaires.

An interview guide was designed and used to gather in-depth information from the clinic in-charge. It was precise with brief open ended questions addressing the three

objectives of this study. An observation guide was used to guide the researcher in picking the number of female clients accompanied by their male partners. Specific issues that were captured included but not limited to the number of male partners attending PMTCT clinic, estimated age and behavior while at the clinic. A checklist was used to ensure that all the required registers and documents were obtained in order to extract the necessary secondary data.

A pilot test on the instruments to verify their reliability and validity was carried out one week before the study commenced. About 15 PMTCT clients and 3 HCWs were interviewed during the pilot testing. During the actual data collection exercise, the researcher immediately received and cross checked each filled questionnaire for completeness and consistency and rectified all anomalies that came up.

### **3.8 Data analysis**

Data analysis involves synthesizing and developing detailed insights and relationships among variables from raw data. Data analysis was carried out in line with the three objectives of the study.

Data collected in the field was cleaned, coded, entered and processed in the computer using Statistical Package for Social Sciences (SPSS). Quantitative data was detailed and was analyzed using SPSS. Tests of independence using Pearson chi square and Fishers exact test were done. Using Descriptive statistics, quantitative data was analyzed by generating measures of central tendency which were mainly frequencies and percentages. Main quantitative variables were analyzed using descriptive statistics including; age, education level, marital status, healthcare worker related factors, rating on male involvement among others.

Qualitative data was analyzed using qualitative content analysis (QCA). Schreier (2012) defines qualitative content analysis as a method of describing and interpreting qualitative information in a systematic way. QCA involves identifying themes or topics, then coding and collating various variables in order to provide detailed and predictable characteristics about a population. Therefore, themes and topics from interviews were collated and coded in line with the objectives of this study to allow objective interpretation and analysis of the relationship among variables as well as

making inferences. Views from different respondent categories were analyzed for consistency to determine to what extent generalization can be made. Some of the variables that were under this context include; perceptions, level of agreement or disagreement and observable behavior.

### **3.9 Data presentation**

Analyzed data was presented in frequency tables and cross tabulation.

### **3.10 Ethical Considerations**

Given the sensitivity of the study especially on the PMTCT clients (respondents), the researcher and the research assistants ensured that they remained humane and ethical during the data collection period. To assure the respondents that the study was to be used solely for academic purposes, the researcher obtained an introduction letter from the Head of Department at the University of Nairobi, which was used to seek approval for collecting data from the PMTCT clinic for the research project. In addition, the researcher gave assurance to the respondents that all information given would be treated with confidentiality and questionnaires would remain anonymous without name or identification number of the interviewee.

## CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION

The study sought to establish the factors that influence male partner's involvement in prevention of mother to child transmission (PMTCT) of HIV at Murang'a District Hospital.

The results presented in this study are pegged on the following research questions:

- i. What is the extent of male involvement in PMTCT in Murang'a District hospital?
- ii. What are the service providers' factors that influence male involvement in Prevention of Mother to Child Transmission at Murang'a District Hospital's PMTCT clinic?
- iii. What strategies can the PMTCT service providers put in place at the PMTCT clinic to encourage men to participate in the program at Murang'a District Hospital?

### 4.1 Response Rate

A total of one hundred and eight (108) out of the intended one hundred and ten (110) PMTCT clients were interviewed at the hospital. On the other hand, a total of nine (9) out of the intended ten (10) health workers were interviewed.

**Figure 4.1: The front gate of Murang'a District Hospital**



## 4.2 Demographic characteristics of the PMTCT clients

This section gives the demographic attributes of the respondents including age, marital status, level of education and economic activity.

### 4.2.1 Literacy level of the PMTCT clients

Past empirical studies show a near perfect correlation between the literacy level of women and the rate and extent at which they are willing to adopt new reproductive health methods (Hollen, 2011). It is in this background that this study sought to establish the level of education of the PMTCT female clients and the findings are presented in table 4.1 below.

**Table 4.1: Literacy level of PMTCT clients**

<b>Literacy Level</b>	<b>Frequency</b>	<b>Percentage</b>
Never attended school	3	2
Primary not completed	4	4
Primary completed	17	16
Secondary not completed	46	44
Secondary completed	33	31
College not completed	2	1
College completed	3	2
<b>Total</b>	<b>108</b>	<b>100</b>

According to table 4.1 above, 44 percent of the respondents had attended secondary school though they had not completed and 31 percent had completed secondary school. It is also evident that 16 percent completed primary school while 4 percent did not complete primary school. Those who completed college education were 2 percent while 1 percent did not complete college education and 2 percent had not attended school.

**Table 4.2: A cross tabulation of age versus education level**

Age	Education		Total
	Primary and Below	Secondary and Above	
24 and below (n=10)	30.0%	70.0%	100.0%
25-34 (n=73)	16.4%	83.6%	100.0%
35 and Above (n=24)	33.3%	66.7%	100.0%
Total (n=107)	21.5%	78.5%	100.0%

From the results in table 4.1 and 4.2 above, the results indicate that majority of the respondents had education as the total number of those who attended secondary school and beyond were 78.5 percent. Majority (83.6%) of those who had attained secondary school education and beyond were in the 25-34 years age category while 16.4 percent attained primary level education and below. The results show that among those respondents in 35 years and above age category, 66.7 percent of them had attained secondary school education while 33.3 percent of them had attained primary school education and below.

#### **4.2.2 Marital Status of PMTCT clients**

The marital status of women determines their economic prowess and consequently it has a bearing on their ability to manage HIV/AIDS (Desclaux, 2009). According to Tischler (2004), marriage is defined as an institution found in all societies; it is the socially recognized and supported union of individuals of opposite sexes. He also defines nuclear family form as being made up of a married couple and their biological or adopted children. This section sought to find out the respondents' marital status and the results are presented in table 4.3 below.

**Table 4.3 Marital status of PMTCT clients**

<b>Marital status</b>	<b>Frequency</b>	<b>Percentage</b>
Divorced	4	4
Married	47	44
Single mother	23	21
Separated	26	24
Widowed	8	7
<b>Total</b>	<b>108</b>	<b>100</b>

As can be seen in table 4.3 above, majority of the respondents (44 %) were married. Those who had separated from their partners were 24 percent while 21 percent were single mothers. The results indicate that 7 percent and 4 percent were widowed and divorced respectively. The fact that most of the respondents were married is in line with KAIS report that indicated a higher HIV prevalence among married couples (KAIS, 2012). In this study the findings indicated that though 56 percent of the respondents were either divorced, single, separated or widowed, they had male partners with whom they engaged in sexual relationships.

**Table 4.4: A cross tabulation of age versus marital status**

<b>Age</b>	<b>Marital Status</b>		<b>Total</b>
	<b>Currently Married</b>	<b>Currently Single*</b>	
24 and below (n=10)	60.0%	40.0%	100.0%
25-34 (n=73)	46.6%	53.4%	100.0%
35 and Above (n=24)	33.3%	66.7%	100.0%
<b>Total (n=107)</b>	<b>44.9%</b>	<b>55.1%</b>	<b>100.0%</b>

\*- Divorce, Separated, Widowed, Never married

It is interesting to notice that study results in Table 4.4 shows that 46.6 percent of the respondents within the 25-34 years age category (n=73) were currently married and in the same age group, 53.4 percent of them were currently single. In the 35 years and above age category, 33.3 percent of the respondents were married while the majority, (66.7%) were currently single. In a study on gender and marital status differences, Tschann (2013) found that married peoples' intimacy, disclosure and health seeking behavior was higher in comparison to the unmarried.

#### **4.2.3 Economic status of the PMTCT clients**

The economic status of an individual has a direct relationship with his or her propensity to seek medical service. According to Greener (2007) scholars attribute health seeking behavior to economic status of the involved individuals particularly women. (Greener et al., 2007) PMTCT services have some financial expenses like travelling expenses even in cases where it is offered 100 percent free of charge. This section focused on the distribution of PMTCT clients based on three social economic characteristics including: Literacy level; marital status; and economic activities. The respondents were asked questions on their economic activities with the aim of getting data on the relationship between the economic statuses of the clients and their propensity to seek PMTCT services. The findings are thus presented in Table 4.5 below;

**Table 4.5: Economic status of PMTCT clients**

<b>Economic Activity</b>	<b>Frequency</b>	<b>Percentage</b>
Farmers	38	35
Casual laborers	32	30
House wives	20	19
Unemployed	13	12
Permanent job	5	4
Other	0	0
<b>Total</b>	<b>108</b>	<b>100</b>

It is clear from table 4.5 above that in regard to economic activities, 35 percent of the respondents were engaged in farming activities while 30 percent were casual laborers. The study revealed that 12 percent were unemployed and 4 percent were permanently employed while 19 percent were housewives. The findings are in line with the employment pattern of Kenya and indeed other less developed countries where the bulk of the population is engaged in farming. The revelation low level of women with permanent jobs at 4 percent may indicate that few women have secure jobs with financial stability. The findings reveal that the largest percentage (90%) of the respondents categorized themselves as famers, casual laborers or housewives.

**Table 4.6: A cross tabulation of age versus economic activities**

Age	Occupation		Total
	Employed	Unemployed	
24 and below (n=10)	10.0%	90.0%	100.0%
25-34 (n=73)	34.2%	65.8%	100.0%
35 and Above (n=24)	45.8%	54.2%	100.0%
Total (n=107)	34.6%	65.4%	100.0%

The study results presented in the cross tab above indicated that the majority (65.8%) of the respondents within the age category of 25-34 years, (n=73) were unemployed while 34.2 percent of them were employed. In the 35 years and above age category, (n=35) 54.2 percent of the respondents were unemployed while 45.8 percent of them were employed. According to Msuya et al. (2008), women were more likely to bring their partner to the clinic if they had a high monthly income and had expressed the intention to share HIV results with their partner during enrolment. The results in the cross tab reveal that in all age categories, majority of the respondents were unemployed.

### **4.3 Main Findings**

The main findings were guided by the objectives of the study which included the following:

- i. To determine the extent of male partner involvement in PMTCT in Murang'a District Hospital.
- ii. To establish the health services provider related factors that influence the involvement of male partners in PMTCT program in Murang'a District Hospital.
- iii. To identify the best strategies that health care providers can put in place to encourage male partner involvement in the PMTCT program in Murang'a District Hospital.

#### **4.3.1 Extent of male involvement**

Establishing the extent of male involvement is important as men are the decision makers in most of the African settings. According to Greene (2002), male involvement is vital as men do influence women's access to health services through their upper hand in control of resources including finances, women's movement and mobility, means of transportation as well as decisions on health care.

The study thus sought to investigate the extent of male involvement in the PMTCT program in Murang'a District Hospital. The respondents were asked questions relating to their male partners awareness, accompaniment, involvement and invitation into PMTCT program yielding the results in table 4.7 below:

**Table 4.7 Extent of male involvement in the PMTCT program**

(A) Male accompanying a female partner to the PMTCT clinic	Yes		No		Total	
	F	%	F	%	Total F per row	Total % per row
Is your partner aware that you are in this clinic today?	58	53.7	50	46.3	108	100
Would you like to involve your partner in PMTCT program?	81	75	27	25	108	100
Have you ever invited your partner to accompany you to the PMTCT clinic	22	53	51	47	108	100
Has your partner ever accompanied you to the PMTCT clinic?	22	19	86	81	108	100

According to the study results presented in Table 4:7 above, 53.7 percent of the respondents stated that their male partners were aware that they were in the clinic on that day while 46.3 percent indicated that their partners were not aware. Three quarters of the respondents (75%) stated that they would like to involve their partners in the PMTCT program and 25 percent indicated that they would not. Despite the majority of respondents (75%) indicating that they would like to involve their partners in the PMTCT program, 53 percent had invited their male partners to accompany them to the PMTCT clinic and 47 percent had not. On the other hand, the study found out that 19 percent of the respondents had ever been accompanied to the PMTCT clinic by their male partners while the majority, (81%) had never.

It is clear from the study findings that slightly more than half (53.7%) of the respondents' male partners were aware of them being in the clinic that day, while 46.3

percent confirmed that their partners were not aware. This percentage is in line with findings by Kasseye (2005) who found a higher percentage (69%) of women who had informed their partners of PMTCT clinic. The findings also concur with those of Ladner (1996) who in his study in Rwanda found a higher percentage of male partners who had been informed by their female partners about PMTCT clinic. According to the results from cross tabulation (table 4.9) marital status of the respondents was associated with partner being aware of clinic visit. In a study on gender and marital status differences, Tschann (2013) found that married peoples' intimacy, disclosure and health seeking behavior was higher in comparison to the unmarried. On the other hand, the cross tabulation results (table 4.12) showed that education of the respondents was not a significant factor associated with any of the aspects regarding uptake of male involvement services in the PMTCT clinic.

The revelation that 46.3 percent of the respondent had not informed their male partners on their attendance to the PMTCT clinic that day is in line with a report by Theuring et al. (2009) who contend that despite the fact that men may be motivated to get involved in the PMTCT program, they lacked information that men were called upon to attend ANC/PMTCT services with their wives, an aspect that poses a major limiting factor for their involvement. Results from cross tabulation (table 4.10) indicate that economic activities of the respondents were actually associated with the partner being aware of the respondents visit to the hospital. A study done by Msuya et al. (2008) showed that women who had expressed the intention to share HIV results with their partner at enrolment and had a high monthly income were more likely to bring their partner to the clinic. In their study in Malawi, (Aarnio et al., 2009) reported that lack of male involvement in PMTCT consequently undermines the potential benefits of antenatal HIV prevention efforts thus representing a missed opportunity to effectively prevent vertical transmission of HIV. According to Mohlala (2011) male partners therefore seem to be the forgotten equation.

**Table 4.8: Cross tabulation of age versus participation in PMTCT services**

Age Category	Proportion of respondents in each category reporting their male partners as having been involved in PMTCT in each stated aspect											
	Partner aware of clinic visit		Willingness to invite partner		Ever invited partner to accompany to clinic		Ever been accompanied by partner to clinic		Ever participated in support group with partner		Ever participated in a joint counseling session with partner	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
24 and below (n=10)	60.0 %	40%	60.0 %	40%	50.0 %	50%	10.0 %	90%	0%	100 %	0%	100 %
25-34 (n=73)	58.9 %	41.1 %	76.6 %	23.4 %	54.8 %	45.2 %	26.0 %	74%	2.7 %	97.3 %	20.5 %	79.5 %
35 and above (n=24)	33.3 %	66.7 %	70.8 %	29.2 %	45.8 %	54.2 %	16.7 %	83.3 %	0%	100 %	8.3 %	91.7 %
Total (n=107)	53.3 %	46.7 %	73.8 %	26.2 %	52.3 %	47.7 %	22.4 %	77.6 %	1.9 %	98.1 %	15.9 %	84.1 %

The cross tabulation above presents study results revealing that most of the respondents were in the 25-34 years age category (n=73) and a large percentage of them (60%) were willing to invite their partners. In the same category, 58.9 of them indicated that their partners were aware of the clinic visit that day while majority of them in the same age category (97.3%) had never participated in a support group with their partners. It is also interesting to note that in the same age category, the larger majority (79.5%) had never participated in a joint counseling session with their partners while 76.6 percent of them were willing to invite their male partners to the clinic. The results also indicate that 45.2 percent of the respondents in the same category (25-34) had never (0%) invited their partners to the PMTCT clinic.

According to Ntabona (2002) it is important for both men and women to go for HIV counseling and testing with their sexual partners to establish their status to protect

their baby from possible HIV infection and other related STIs. In the 35 years and above age category, majority (66.7%) indicated that their partners were not aware of the clinic visit that day while none of them (0%) had ever participated in a support group with their partners even though the same age category majority, (70.8%) had expressed willingness to invite their partners. It is interesting to note that among the youngest age category, 24 year and below (n=10), none of them had ever participated in a counseling session with a partner. Further, results indicate that in this younger age category, none (0%) had ever participated in a support group with a partner.

According to the study findings, more than half (53 %) of the respondents had ever invited their male partners to accompany them to the clinic and this could also be attributed to the fact that the HCW were routinely discussing the importance of male involvement with the PMTCT clients as confirmed by a key informant. According to this study's cross tabulation results, (table 4.9) marital status of the respondents was associated with respondent having ever invited the male partner. According to Msuya et al. (2008) women who live with their partners are more likely to invite and bring their partners as well as share HIV results .On the other hand, cross tabulation results (table 4.6) reveals that age of the respondents was not a significant factor associated with any of the aspects of male involvement.

However this result reveals that the other 47 percent of the respondents had not invited their male partners. This begs the question why? According to Kiarie et al. (2006), women constitute a barrier to male involvement by not informing/involving their partners in PMTCT due to the fear of domestic violence .The key informant asserted that men were not fully involved, a fact that could be attributed to the cultural inclinations which include factors such as innate risk attitudes or cultural background which undermines the effects of the male involvement campaigns (Kimberly and Kessler, 2014). In her study in Uganda, Dukti (2010) asserted that male participation would have to start from attending health education talks and understanding pregnancy needs of their partners, to couple counseling, 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.

According to the Ministry of Planning and National Development in Kenya (2003), research has revealed that involvement of male partners in PMTCT can significantly improve the outcome of the program. According to WHO (2007) , specific interventions to prevent mother-to-child transmission of HIV include: Increasing access to HIV testing and Counseling, Antiretroviral (ARV) therapy, Safe delivery practices, counseling and support on infant-feeding methods, provision of care and support for HIV infected mothers, their infants, partners and families . According to Peltzer et al. (2010), increased male involvement has been identified as a critical strategy for the Presidents’ Emergency Plan for AIDS (PEPFAR) countries to enhance implementation of PMTCT interventions.

**Table 4.9: Cross tabulation of marital status versus participation in PMTCT services**

Marital Status	Proportion of respondents in each category reporting their male partners as having been involved in PMTCT in each stated aspect											
	Partner aware of clinic visit		Willingness to invite partner		Ever invited partner to accompany to clinic		Ever been accompanied by partner to clinic		Ever participated in support group with partner		Ever participated in a joint counseling session with partner	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Currently married (n=48)	72.9 %	27.1 %	81.3 %	18.7 %	64.6 %	35.4 %	29.2 %	70.8 %	2.1 %	97.9 %	25.0 %	75 %
Currently, single* (n=60)	38.3 %	61.7 %	68.3 %	31.7 %	43.3 %	56.7 %	18.3 %	81.7 %	1.7 %	98.3 %	8.3 %	91.7 %
Total (n=108)	53.7 %	46.3 %	74.1 %	25.9 %	52.8 %	47.2 %	23.1 %	76.9 %	1.9 %	98.1 %	15.7 %	84.3 %

*\*-Include never married, widowed, divorced and separated*

The cross tabulation results from the study show that marital status of the respondents was associated with several aspects related to respondent's participation in male involvement services in PMTCT clinic. Marital status was associated with partner being aware of clinic visit, respondent having ever invited the partner to the clinic and respondent ever having had a joint counseling session with the partner. Marital status factor was not associated with any other aspects of male involvement.

In the currently marries category (n=48), 72.9 percent of them said that their partners were aware of the clinic visit while in the currently single category that had the majority of the respondents, (n=60) 38.3 percent of them confirmed that their partners were aware of the clinic visit. It is interesting to note that in the currently single category, an overwhelming majority (91.7%) had never attended counseling sessions with their partner. The results further reveal that 98.3 percent of the respondents in the currently single category had never participated in a support group with their partners despite the fact that 68.3 per cent of the same category of respondents had indicated that they were willing to invite their partners to the PMTCT clinic. In all the age categories however, results indicate minimal participation of male partners in support groups as majority of the respondents had never attended support group with their partners. The results indicate that those who had attended support group with their partners were 2.1 percent and 1.7 percent for currently married and currently single respectively. The cross tabulation results on table 4.9 show that marital status was associated with respondent ever having had a joint counseling session with the partner. According to Haile and Brhan (2014), previous testing and counseling for HIV was also associated with increased husband accompaniment of pregnant mothers to the ANC/PMTCT clinic. Respondents who have been tested and counseled with their husband previously were 5 times higher to come with their husbands than their counter parts. Being informed about the availability of VCT service in the ANC was also associated with increased husband accompaniment i.e. mothers who tell their male partners about the availability of VCT service in the ANC clinic were 4 times higher to be accompanied by their male partner to the ANC than those who didn't. The same study done in Uganda showed that increased knowledge and awareness of male partners about the availability of VCT services in the ANC clinic and its

importance with the prevention of mother to child transmission of HIV was associated with increased husbands participation in ANC/PMTCT (Haile and Brhan, 2014)

On the other hand, the study findings (Table 4.7) indicate that three quarters (75%) of the respondents stated that they would like to involve their male partners in PMTCT clinic. These findings concur with Grady et al. (1996) who assert that women express great interest in wanting their partners to be involved in joint decision making in reproductive health. According to the key informants, all health care workers discussed the importance of male involvement with the clients which could have enhanced women's willingness to involve their partners. According to Kang'oma (2011), women reported that they would be very happy to see their men getting involved in PMTCT services because it is admirable to be accompanied by your spouse to the ANC and it shows that he is a loving and responsible man. This was echoed by Roy et al. (2002) who reported that 89 percent of women wanted their partners to accompany them on their next family planning visit and 94 percent would have liked their partners to be present during their family planning session.

The revelation by the study findings that 25 percent of the women would not want to involve their partners shows that a quarter (25%) of male partners had not been called upon by their female partners to participate in the PMTCT program. This is further confirmed by Theuring et al. (2009) who asserted that lack of information that men were called upon to attend ANC/PMTCT services with their wives was the major limiting factor for their involvement.

On the other hand, Kiarie et al. (2006) reported that women constitute a barrier to male involvement by not informing/involving their partners in PMTCT due to the fear of domestic violence. This notion is further confirmed by Msuya et al. (2008) who found out that the reluctance on the part of the woman to involve their male spouses was grounded in numerous fears. There was the fear of divorce, accusation of infidelity or of bringing the infection into the relationship as well as the fear of stigmatization of the woman who is HIV positive.

**Table 4.10 Cross tabulation of economic activities versus participation in PMTCT services**

Occupation(Economic activity)	Proportion of respondents in each category reporting their male partners as having been participated in PMTCT in each stated aspect											
	Partner aware of clinic visit		Willingness to invite partner		Ever invited partner to accompany to clinic		Ever been accompanied by partner to clinic		Ever participated in support group with partner		Ever participated in a joint counseling session with partner	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Employed*(n=37)	39%	61%	70.3%	29.7%	45.9%	54.1%	29.7%	70.3%	2.7%	97.3%	18.9%	81.1%
Unemployed (n=71)	62%	38%	76.1%	23.9%	56.3%	43.7%	19.7%	80.3%	1.4%	98.6%	14.1%	85.9%
Total (n=108)	53.7%	46.3%	74.1%	25.9%	52.8%	47.2%	23.1%	76.9%	1.9%	98.1%	15.7%	84.3%

\*-Include casual workers

In the cross tabulation above, the study results reveal that economic activities of the respondents were only associated with the partner being aware of the respondents visit to the hospital and that economic activity factor was not associated with all the other aspects related to uptake of male involvement services in PMTCT clinic.

In the unemployed category (n=71), 62 percent of the respondents said their partners were aware of the clinic visit while 85.9 percent of them said they had never participated in a joint counseling session with their partners. In the same age category, 80.3 percent of them said they had never been accompanied to the clinic by their partners while in the employed category (n=37), 70.3 percent of them said they had been accompanied by their partners to the clinic. As regards partner invitation, 56.3 percent of the respondents in the unemployed category said they had ever invited their partners while 45.9 percent in the employed category said they had never. It is interesting to note that among the unemployed category, (n=71) 19.7 percent said they had been accompanied to the clinic while among the employed category, (n=37) 29.7

indicated they had been accompanied. The cross tabulation results indicate that the respondents in both economic activity categories were hardly receiving joint PMTCT services with their partners.

As far as accompaniment is concerned, the study findings (table 4.7) show that 19 percent of the respondents had ever been accompanied to the PMTCT clinic and this was echoed by the key informant who asserted that PMTCT clients were normally requested to bring their male partners, though the women were unable to convince their male partners to accompany them to the clinic. The study findings show that a larger percentage, (81%) had never been accompanied to the clinic by their male partners. These findings concur with those of Semrau et al. (2005) who in their study in Zambia, found out that only 10 percent of women were able to encourage their male partners to participate in PMTCT program. The study findings further concur with those of the Horizon program (2002) in Uganda which indicated a low percentage of clients coming to the clinic as a couple. The revelation that a larger percentage (81%) of respondents had not been accompanied to the PMTCT clinic indicates low male involvement.

According to PATH report (2007) reproductive health services are designed to meet women's and children's needs and this results to men not considering the programs as a source of information and help for them. In her study, Dukti (2010) found out that the fact that PMTCT program is delivered in Health centers where women and not men are more likely to go hinders male involvement in PMTCT program. Further Dukti asserts that "most programs are found in the health centers where men rarely go. The women are common there because they take children for treatment, vaccination and attend antenatal clinic". According to the secondary data at Murang'a PMTCT clinic, 2 couples had ever been tested and counseled in the last nine months. During the study, the researcher observed a few men escort their female partners to the PMTCT clinic, though hardly were men seen entering the PMTCT consultation room. The researcher noticed that most men were walking away after their female partners sat at the waiting bay or entered into the PMTCT consultation room. This indicates that not all couples who make their way to the clinic together benefit from the PMTCT services.

According to Baggaley, (2000) male involvement in PMTCT also includes male partners accompanying their female partners to the PMTCT clinic, a notion that is supported by Kalembo et al. (2011) who argue that; with male partner involvement in PMTCT, a couple has a chance to make informed decisions on living positively with HIV and share responsibility for preventing HIV transmission to their baby. This study revealed low male involvement as far as accompaniment was concerned and this was echoed by the key informant who stated that women were not able to convince men to accompany them to the PMTCT clinic, as indicated below;

“Yes, but they are unable to convince men to accompany them”

#### 4.3.2 Extent of joint PMTCT services

The study sought to find out to what extent PMTCT clients received services together with their male partners. To meet this objective, the respondents were asked questions regarding health services they received in the company of their male partners. The results are shown in table 4.11 below:

**Table 4:11: Extent of male and female clients receiving health services and information together (Joint services)**

(B) Male and female clients receiving Health services and Information together	Yes		No		Total	
	F	%	F	%	Total F per row	Total % Per row
Have you and your partner ever attended PMTCT support group together?	2	1.9	106	98.1	108	100
Have you and your partner been counseled on PMTCT together?	17	16	91	84	108	100

The study findings in Table 4:11 above indicate that 1.9 percent of the respondents had ever attended PMTCT support group together with their male partners while the greater percentage (98.1%) of the respondents stated that they had never. The study results further reveal that 16 percent of the respondents had been counseled on PMTCT together with their partners and the majority (84%) had never.

Generally, it can be deduced from these findings that the facility was experiencing low male involvement in PMTCT program. This was echoed by key informants who said that male involvement in PMTCT was not optimal. Though the facility has a support group for PMTCT clients and their partners, there was minimal (1.9%) participation from men as found out by the study and as indicated in the support group list of participants.

**Table 4.12: Cross tabulation of education level versus participation in PMTCT services.**

Education Level	Proportion of respondents in each category reporting their male partners as having been involved in PMTCT in each stated aspect											
	Partner aware of clinic visit		Willingness to invite partner		Ever invited partner to accompany to clinic		Ever been accompanied by partner to clinic		Ever participated in support group with partner		Ever participated in a joint counseling session with partner	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Primary and below (n=23)	60.9%	39.1%	82.6%	17.4%	52.2%	48.8%	21.7%	78.3%	4.3%	95.7%	17.4%	82.6%
Secondary and above (n=85)	51.8%	48.2%	71.8%	28.2%	52.9%	47.1%	23.5%	76.5%	1.2%	98.8%	15.3%	84.7%
Total (n=108)	53.7%	46.3%	74.1%	25.9%	47.2%	52.8%	23.1%	76.9%	1.9%	98.1%	15.7%	84.3%

The cross tabulation results in the Table 4.12 above indicate that education was not a factor associated with any of the aspects of male involvement. In the Primary level education category (n=23), 60.9 percent of the respondents said that their partners were aware of the clinic visit while in the secondary school education category, 51.8 percent of them indicated that their partners were aware of the clinic visit. As regards participation in a counseling session as a couple, 82.6 percent in the primary education level category said they had never attended while 84.7 percent secondary education level category said they had never attended. In the Primary school education category, 95.7 percent of the respondents said they had never participated in a support group with their partners while in the secondary school category, 98.8 percent said they had never. As regards attending a counseling session with partners, the results reveal minimal participation for both categories. Those who had received couple counseling in the primary school education category were 17.4 percent and 15.3 percent from the secondary school education category.

On the other hand, the key informant cited support group and health talks as some of the key services that men are involved in at the clinic. However, from the researchers observation and as indicated by the key informants, there was minimal male involvement in these activities and as the study found out, majority of the respondents (98.1%) had never attended the PMTCT support group with their male partners. In their study in DRC (Congo), Ditekemena et al. (2009) found out that cultural barriers represent the most pertinent barriers to male involvement in PMTCT. They found out that this is a multifaceted barrier, the strongest elements being the recognition of antenatal care as the women's place, and associated discomfort for all men found within the setting. According to a report by Frederick (2013) the most frequently reported barrier of male involvement in the ANC/PMTCT care is the perception that antenatal care was a woman's' activity, it is also 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 is further confirmed by the key informant who asserted that men associate the MCH/FP (Mother and Child Health/Family Planning) room to women and children as indicated below;

“Men associate the MCH/FP room to women and children”

As far as counseling is concerned, the study results showed that 16 percent of the respondents had been counseled together with their male partners. The rest who are the majority (84%) had not received counseling in the company of their male partners. This indicates low male involvement in counseling and also concurs with similar findings reported by Semrau (2005), in Zambia where only a small percentage (10%) of women were able to encourage their husband's participation in PMTCT program.

The revelation from the findings is further confirmed by the key informant who stated that the HCW had not received training on male involvement and couple counseling. This lack of skill could contribute to HCW paucity of confidence in counseling and discussing male involvement hence the low percentage. According to the key informants, the facility did not have guidelines on male involvement in PMTCT which could further compound the problem. The fact that 84 percent of the clients had not been counseled together with their male clients indicated that most respondents went through the PMTCT program without having their partners involved in counseling.

According to Bymugisha (2010), greater involvement of men in long-term prevention, care and support services for mothers and their children can increase child development and survival, particularly by supporting mothers to adhere to child feeding advice. Harvey (2013) reported that male involvement in PMTCT and other family planning activities can reduce the risks of vertical transmission and infant mortality by more than 40 percent. From the study findings, it is clear that the biggest percentage (84%) of the respondents' male partners were not involved in counseling at the PMTCT clinic. As confirmed by one of the key informants, the women were not able to convince their male partners to accompany them to the clinic and men were reluctant to enter the PMTCT consultation room as indicated below;

‘They are reluctant to enter the PMTCT room but those who come are offered counseling and testing and are willing to protect their families’

Though family planning and counseling were mentioned by the key informant as some of the key activities in which men were involved, secondary data indicates that 2 couples had been tested and counseled at the clinic in the last 9 months. Going by the researcher's observation during the study, the clinic is too small and congested leaving very little space for comfort and confidentiality during counseling. According to Aarnio (2009) distrust in the confidentiality of the health care system was identified as an obstacle to male involvement. This is further supported by Hilber (2010) who contend that counseling requires a high degree of confidentiality which if compromised, makes the couples uncomfortable.

**Figure 4.2: The only table in the PMTCT consultation room at Murang'a District Hospital**



The key informant further cited condom use education and provision of Septrin and ARV drugs as some of the key activities in which men are involved. On the contrary, the researcher did not see any man participating in condom use demonstration and none was issued with Septrin and ARV drugs during the period of the study. This could be attributed to the fact that men have been reluctant to participate in reproductive health initiatives, but also due to the fact that most HIV related and reproductive health policies have not been focusing on the male side over the last two

decades (Burke et al., 2004). In Kenya particularly, there has been selection bias towards females in most of the recent studies on HIV and AIDS which has accumulatively created a literature gap on the critical role of men in HIV/AIDS programs including PMTCT (Hahn et al., 2011). The researcher observed that, men who escorted their partners to the clinic later proceeded to the CCC for HIV care and follow-up. This observation was further confirmed by the key informant as below.

“Some men who escort women just proceed to the CCC department”

The findings imply a daring situation of either inadequate investment in the engagement of men in the PMTCT program or lack of sufficient knowledge among the male populace on the significance of the services in the management of HIV/AIDS (Souza, 2012).

#### **4.3.3 HCW factors that hinder or encourage male involvement**

To unravel the influence of health care workers on male involvement, the study sought to collect data from the respondents on HCW factors that may hinder or encourage male involvement in PMTCT. Successful implementation of health care programs requires both human and infrastructural capacity if the project goals are to be achieved (Brystad and Moland, 2009). In this light, the study focused on the activities of the health care workers to ascertain their potential and infrastructure in regards to their performance particularly on their ability to bolster male involvement in the PMTCT program. The results are as presented in table 4.13 below.

**Table 4.13: Health Care Workers factors that influence male involvement**

<b>HCW factors that influence male involvement PMTCT program</b>	Yes		No		Total	
	<b>F</b>	<b>%</b>	<b>F</b>	<b>%</b>	<b>Total F per row</b>	<b>Total % per row</b>
<b>Question</b>						
Has your HCW discussed with you on importance of involving your partner in PMTCT clinic?	85	78.7	23	21.3	108	100
Has the HCW ever asked you to invite your partner?	105	97.2	3	2.8	108	100
Does the HCW provide you with IEC materials to share with your partner?	1	1	107	99	108	100
Do you think that the HCW pay attention and welcome the male partners into the PMTCT clinic?	16	15	92	85	108	100

From the study findings in table 4.13 above, it is clear that more than three quarters of the respondents (78.7%) confirmed that the HCW had discussed male involvement with them while 21.3 percent stated that HCW had not. The study findings revealed that majority of the respondents (97.2 %) had been asked by the HCW to invite their male partners while on the other hand 2.8 percent indicated that they had not. As regards the provision of IEC materials to the respondents by the HCW, 1 percent indicated that they had been provided and the majority, (99 %) stated that they had not. Respondents were asked whether they thought the HCW paid attention and welcome male partners to the PMTCT clinic and the findings revealed that 15 percent gave an affirmative answer while the majority (85%) said no.

As can be seen in table 4.13 above, majority of the respondents (78.7%) affirmed that the HCW had discussed the importance of involving their male partners in PMTCT clinic while the rest, 21.3 percent said they had not. The study findings reveal that the

HCW were discussing the importance of male involvement with majority of the PMTCT clients. This is in agreement with a study report by Kang'oma (2011) who affirmed that women discussants acknowledged that PMTCT service providers were encouraging men to accompany their wives to the ANC to get counseled and tested for HIV together and that the HCW demanded women to be accompanied by their spouses when going to the ANC more especially during the first visit.

According to the findings in table 4.13 above, 97 percent of the respondents admitted that they had been asked by the HCW to invite their male partners. It can therefore be deduced from the study findings that the health care workers were making efforts to have the PMTCT clients invite their male partners. These findings confirm the key informant's assertion that the health care workers discussed male involvement with the PMTCT clients, a discussion in which male invitation is a component.

From table 4.13 above, 1 percent of the respondents had ever been given IEC materials and 99 percent had never been given IEC material to share with their male partners. The study therefore revealed that majority of the respondents was not accessing IEC materials from the PMTCT clinic. This is a missed opportunity by the clinic considering that at clinic level, it is the role of the HCW to ensure that they facilitate access to information on PMTCT to clients and their partners in order for the program to meet its objectives. However the key informant confirmed that the clinic had a shortage of IEC materials and therefore only a few of the HCW had ever given out IEC materials to the PMTCT clients. Further observation by the researcher revealed lack of IEC materials including the male invitation cards. This observation on lack of IEC materials and access to information on PMTCT is further confirmed by Burke (2004) who portend that men feel marginalized by the inadequacy of access to information as they receive second-hand information through their wives. This lack of knowledge about HIV and importance of male involvement in PMTCT has direct implication for information, education and communication initiatives hence highlights the need to increase male education on HIV/PMTCT and target information for men by various means. (Theuring et al., 2009).

From the findings in table 4.13 above, majority of the respondents (85%) felt that the HCW did not pay attention to men and did not welcome them to the PMTCT clinic. These findings were confirmed by the key informant who stated that the health care workers get burnout, they forget to invite men inside the clinic and lacked training and guidelines on male involvement. This lack of training of the HCW could impact negatively on the way they discussed male involvement as they did not understand the components and the guidelines, particularly for partner invitation and service provision. This observation is supported by Benkele (2007) who reported that lack of capacity and motivation among HCPs were some of the systemic factors that hinder male involvement. In Uganda, men reported having been forced to wait an entire day for care at the antenatal clinics, a heavy sacrifice for someone who needs to work for their family. They were also excluded for the session in which their wives were being examined and had to wait outside without any information about what was happening to their pregnant wives (Kalembo et al., 2011) According to Shankar (2003) long waiting time at the antenatal clinic was cited as an obstacle to male involvement in antenatal care while antenatal health services were perceived to be male unfriendly, and this consequently discourages men from getting involved. This is further supported by Kamal (2002) and Hilber (2010) who reported that men want to make use of the existing public health care facilities, but the way these facilities function is not very conducive to their utilization because of constraints related to the time schedule, the attitude of the health care providers and the expenses involved.

The researcher observed that when men arrive at the clinic, they barely get attention from the HCWs. This observation is further supported by Dukti (2010) in her findings in a study in Uganda by revealing that lack of customer care and attention for the male partners deterred male involvement in the facilities. Although men accompanied their partners to facilities, attention was given to the women, the men were left waiting without any responsibilities or service to keep them busy, so they felt left out of the program and chose to stop going to health facilities with their partners. According to Kalembo et al., (2011) HCW mistreated the male spouses, and embarrassed them. In his study in Malawi, Kang'oma (2011) reported that some men mentioned that some nurses ill-treat patients and they do not want to see their pregnant wives being mistreated at the hospital.

The researcher observed that the clinic room is too small such that if men were invited in, it would be difficult to do proper counseling due to lack of privacy. This observation is supported by Kalembo et al. (2011) who found out that, lack of adequate space in the antenatal clinic coupled with shortage of health care workers and increased number of women attending antenatal care demotivated men from attending antenatal care clinics with their spouses since they had to wait for a long time before they were attended to.

Evidence from observation further shows the degree of congestion given that; the consultation room has one desk as a work station for all staff that includes at least one clinical officer, one nurse and two volunteer mentor mothers (peer educators). This inadequacy of ample space could be a reason that discourages the HCW to invite men inside the consultation room.

**Figure 4.3: PMTCT consultation room at Murang'a District Hospital**



#### **4.4 Strategies that could be put in place to encourage male to participate in the PMTCT program**

To ameliorate the level of male involvement in the program, holistic strategies that can act as impetus for men to participate in the activities are required (Scott et al., 2005). In this context, the study sought to identify various strategies aimed at

boosting male participation. This part of the study required the respondents and the key informants to suggest various strategies that can improve male participation. Effective utilization of such strategies is dependent on uncovering the pertinent issues that augment male participation in maternal health care (Kululanga et al., 2012). According to Berer (1999), male involvement in the antenatal care, couple counseling and testing for HIV enhances uptake of activities for the prevention of HIV. For example, he indicates that male partners can influence women's uptake of HIV testing and prenatal services as partner support results in greater adherence to antiretroviral therapy (ART) and antenatal clinic attendance leading to lower transmission rates of HIV to a child. Lack of adherence may occur when women experience difficulty keeping up with treatment due to concerns about disclosure to a partner. According to Medley et al. (2004), optimal uptake and adherence to PMTCT recommendations is difficult for women whose partners are not supportive of their involvement.

The respondents suggested the strategies discussed below.

#### **4.4.1 Educate men through community outreaches and media**

The respondents suggested that public and community health care workers need to work at community level and engage in stigma reduction campaigns that sensitize men on PMTCT. Adherence to PMTCT services is vital in HIV prevention and hence the respondents suggested that the community health workers should participate in education and sensitizing men on PMTCT and work with the health facility in encouraging men to participate. This is supported by WHO (2010) report which indicated that a lot of people in Kenya are still not being reached with HIV prevention and treatment services. Male participation facilitates adherence to the PMTCT clinic appointments among couples. Men who have not received information on PMTCT services are incapable of supporting their female partners in adherence for failure to understand the benefits or the fact that they are unaware of their HIV status (Russo et al., 2009).

A successful case of this approach is in Zimbabwe, where Rutenberg et al. (2002) undertook a study on male involvement projects and reported that cultural beliefs augmented the community belief of men who openly supported their female partners by accompanying them to the clinic as “bewitched” or “weak”. This is in line with the

respondents who felt that community education and sensitization on male participation in PMTCT would mitigate such social misconstruction and perception. This suggestion is supported by Mlay et al. (2008) who affirmed that a possible way to encourage male involvement would be to initiate diverse community – based initiative to address gender norms and societal attitudes towards male involvement in PMTCT activities. They assert that men should be brought to realize that it is unacceptable to preserve outdated cultural norms at the risk of endangering their infants (Mlay et al., 2008). It is therefore important to work with community leaders such that additional support is provided to women, and men are encouraged to participate in PMTCT activities. In addition, studies have shown that men who are well-informed about reproductive health matters are more likely to support their partners in contraceptive use, use contraception themselves, and exhibit higher conscientiousness for their children (Grady et al., 1996). Further, Baggaley (2000) reported that the level of ignorance amongst men in most PMTCT settings is so significant that very few are aware that their female partners have been tested during their antenatal care and are enrolled in PMTCT program. Therefore the community based programs that would normalize male PMTCT participation and minimize associated stigma should be initiated (Mlay et al., 2008). On being asked what can be done to encourage men to participate in reproductive health concerns, the key informants had this to say:

“Keep encouraging women, public education , sensitize men and train more HCW to be involved in the clinic”

“community education through the public health social mobilizations’

#### **4.4.2 Use of invitation cards**

The respondents suggested that the clinic should be giving out invitation cards for men through the female clients and that the invitation to partners could be written on the antenatal cards. In support of this suggestion, similar reports on partners’ invitation cards have been made in Tanzania by Theuring et al. (2009) who established the effectiveness of using such an approach, where there was a 30 percent

increase in male partner counseling when men were sent a letter of invitation to take part in PMTCT programs. In a similar study, Koo et al. (2013) found out that the use of such invitation cards received affirmative rejoinder among a group of men and women in a health facility in Pretoria, South Africa. In this study, the respondents suggested that the invitation can be in form of direct invitation phone calls to the male partners as well as sending community health workers for home visits to invite the men face-to-face (Koo et al.,2013). Sending out of invitation letters from the health care workers inviting men to participate in PMTCT through their spouse was identified as a facilitator of male involvement by Wall (2012) in his study in Rwanda where it was found out that the use of invitation letter was perceived as a medical prescription which obliged the spouse to attend.

The key informant had this to say;

“Replenish invitation cards to give to the women”

#### **4.4.3 Invite men into the counselling room and offer prompt services**

The key informants asserted that men should be invited into the counseling room immediately they avail themselves to avoid long waiting hours at the clinic. They also suggested that when men arrive at the clinic, they should be given more attention by providing sitting space, privacy and prompt services. This strategy is supported by Dutki (2010) who, in her study revealed that men were perceived as neglectful and occasionally inflexible, bearing in mind that they claimed to be constantly busy, yet would rather be involved in leisure time activities than participate in seeking health services with their partners. The researcher observed that most men who accompanied their partners to the PMTCT clinic hardly got invited into the consultation room by the HCW. The Key informant confirmed that some health care workers forgot to invite men in to the clinic and as indicated by the secondary data, 2 couples had been tested and counseled at the clinic in the last 9 months. The assertion by the key informant that some HCW forgot to invite men into the consultation room is further confirmed by Burke (2004) in his study in Tanzania who found out that men considered they to be marginalized by PMTCT programs. According to Betancourt et al. (2010) the reality is that traditional PMTCT programs focus mostly on women,

ignoring the important role of men and hence the moderate levels of successful male involvement in PMTCT can be partially explained by this narrow focus on women alone.

The affirmation was made by a key informant as indicated below;

“Some health care workers forget to invite the men into the clinic”

This strategy as suggested by the study respondents is further supported by Hearings’ finding in his study in Meyer, Tanzania in 2009, where he reported that barriers to PMTCT attendance for men included lack of information and knowledge, no time and neglected importance (Theuring, 2009).

The key informant had this to say;

“Invite men inside the room”

“Prompt service delivery upon arrival of the client and husband”

#### **4.4.4 Addition of Healthcare workers**

The key informants confirmed that the facility has inadequate number of staff to deal with the ever increasing new enrolment in PMTCT and therefore more health care workers should be engaged. This strategy is further supported by Bystander and Moland (2009) who assert that both human and infrastructural capacity have to be met if the project goals are to be achieved. As indicated by the key informant, the staff members that are available on a daily basis are stressed and keep rotating to work in other departments. This high workload causes burnout which could lead to HCW poor attention to clients which could lead to low participation in PMTCT among men. This is evidenced by the key informant’s response below;

“We need more staff in PMTCT to handle all cases including offering services in the PMTCT room”.

“Add more regular staff specifically for PMTCT so that they can have time for private sessions with couples .We have many clients”

“Some of the HCW who are supposed to support this clinic have been deployed in other departments so the workload here is high. This causes burnout and the staff do not have enough time for each client”

#### **4.4.5 Expand counseling rooms**

According to the key informant, there was not enough room for privacy during couple counseling, hence they suggested that room for privacy should be created. Lack of privacy in many antenatal settings should be put into consideration as this infringes on personal space making it hard to maintain confidentiality due to small or lack of space which discourages both men and women from attending the clinic (Berer, 1999). The suggestion is further supported by Aarnio, (2009) who asserted that more male friendly changes within health facilities rendering ANC and PMTCT services are necessary. These should include the implementation of couple counseling and testing as a routine within the health service, strengthening couple counseling and creating male friendly spaces within the ANC premises. This means that the approach engaged in provision of PMTCT services, particularly the way they are structured can be a restraining factor to male participation in PMTCT program (Aarnio, 2009). The key informants had this to say;

“The PMTCT room is very small, we need more room”

“Expand the PMTCT clinic to give more room , right now we have no space for chairs”

“Provide room for couples counseling”

#### **4.4.6 Avail IEC Materials**

According to the key informants, there should be IEC materials available to enable the clients to read and take home to their male partners. The key informants reported that the facility did not have IEC materials for PMTCT and none for male involvement in particular. The facility relied on IEC material supply from a partner NGO and the public health departments but they had not received any supply for a long time. This suggestion is further supported by Mohlala et al. (2011) who portend that these sensitization activities include the pasting of flyers and posters in areas frequented by

men, and use of the media to discuss and encourage men to participate in HIV/PMTCT.

The above observation is evident from the key informants' assertion below;

“Have IEC materials to take home”

#### **4.4.7 Integration of services into the PMTCT clinic**

PMTCT clinic should provide integrated services so that men do not have to go to other departments. This suggestion is in line with PATH (2007), who reported that reproductive health services are designed to meet women's and children's needs and this results in men not considering these programs as a source of information and help for them. According to Benkele, poor communication between couples and misconception that reproductive issues are a reserve of women affect PMTCT program (Benkele, 2007). This is further supported by Kiarie (2009) in his study conducted in Nairobi which concluded that offering VCT services to men at antenatal clinic with options for couple and individual counseling is an important opportunity and acceptable strategy for increasing male involvement in PMTCT.

The PMTCT clinic should incorporate all services in order to serve as one stop shop for couples seeking PMTCT services. Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs and therefore everyone should receive lifelong education about reproductive health, STIs and condoms use (Lee, 1999). According to the key informants, the HCW had not been trained in male involvement and therefore encountered competence challenges as far as integrating health services was concerned. The secondary data indicated that no HCW was trained in couple counseling, a service that is a key component in boosting male involvement. The key informant confirmed that the clinic did not have integrated services and men had to go for treatment in other departments like the CCC.

“Provide integrated services for CCC and PMTCT, offer ART in PMTCT room for men”

“ Comprehensive screening and health education to the couple”

Offer screening services to men like in STI screening, TB screening

#### **4.4.8 All staff should be trained in male involvement**

The respondents suggested that all the HCW should be trained in male involvement. According to the key informant, the HCWs were inadequately trained considering that they had not received training especially in PMTCT, couple counseling and male involvement. It is in light of this that the respondents suggested training as a strategy to be applied in order to equip the HCW with the necessary skill required in offering comprehensive health package. This strategy is further supported by PEPFAR report (2011), which indicated that it is important to support effective strategies for hiring and training the health care providers in order to be able to allow essential integrated PMTCT services. PMTCT campaigns disseminate information by means of large and small community organized meetings, one-to-one discussions from health workers to individuals, which call for greater interpersonal skills (Kamali et al., 2003)

According to the key informants, the training should be accompanied by availing guideline on male involvement. Providing services without training and guidelines could contribute to lack of competence which consequently could lead to poor male involvement. The key informant had this to say;

Train all staff in “PMTCT PLUS” and sensitize them on male involvement

#### **4.4.9 Engage male peer educators and HCW**

According to the respondents, the clinic should consider engaging male peer educators and male HCW so that men who prefer to be attended to by men can feel comfortable. The Horizon program, (2002) in Zimbabwe, supports this strategy through its report in which it states that men felt that female counselors were a barrier to their involvement in the PMTCT programs. This suggestion also concurs with Burke et al. (2004), who in their study in Tanzania revealed that men preferred to receive information from fellow men and that they were uncomfortable with having to receive health information in mixed gender sessions. From the researcher’s

observation, the PMTCT clinic is mainly dominated by female health care workers. According to the secondary data on PMTCT clinic staffing, the female health workers constitute 87.5 percent which indicates female dominance among the staff in reproductive health services.

According to PATH report, antenatal and mother and child health clinics are women's ground that cannot be easily modified to accommodate men. Given the fact that service providers are mostly females, they may be biased towards female related services (PATH, 2007). This indicates gender imbalance in the PMTCT health care workforce which augments the fallacy that the clinic is biased towards female services. The key informant had this to comment;

“Engage male peer educators and male HCW”

**Figure 4.4: A female peer educator (Mentor Mother) gives peer counseling to a client outside the PMTCT consultation room**



## **CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

### **5.0 Introduction**

This chapter presents the summary and conclusion of the study. It gives recommendations drawn from the findings of the study as presented in chapter four. Recommendations for future research related to the topic of the study are also given.

### **5.1 Summary of findings**

The following were major findings that emerged from the data analysis. Their themes were guided by the following research questions.

- i What is the extent of male involvement in PMTCT in Murang'a District hospital?
- ii What are the service providers' factors that influence male involvement in Prevention of Mother to Child Transmission at Murang'a District Hospital's PMTCT clinic?
- iii What strategies can the PMTCT service providers put in place at the PMTCT clinic to encourage men to participate in the program at Murang'a District Hospital?

#### **5.1.1 Extent of male involvement in PMTCT program**

The study found out that most of the respondents, (53.7) had informed their partners that they had a PMTCT clinic appointment at the time they had the appointment. The rest, (46.3%) indicated that they had not. On the other hand, the majority of the respondents (75%) stated that they would like to involve their partners in the PMTCT program while 25 percent indicated that they would not. These findings revealed that a big percentage, (75%) of the respondents were willing to involve their partners though only 53 percent of the respondents had ever invited their male partners to clinic. Further, the study revealed that a notable percentage of the respondents, (47%) had not invited their male partners, a fact that could be the reason why only 19 percent had ever been accompanied by their male partners to the PMTCT clinic. This clearly means that the majority of the respondents (81%) had never attended the clinic

in the company of their male partners. The findings therefore indicated that, whereas most of the respondents (75%) were willing to have their partners involved, only a small number of them (19%) had ever been accompanied to the clinic by their male partners.

The study found out that the PMTCT clinic had hardly offered joint services to couples. This is evidenced by the fact that only (1.9%) of the respondents had ever attended PMTCT support group with their male partners, meaning that the overwhelming majority (98.1%) had never. Lack of attendance to the PMTCT support group means that men were missing out on treatment literacy and psychosocial support services which could lead to low awareness on availability and benefits of PMTCT program. There was also an indication of low couple counseling activity at the PMTCT clinic as only 16 percent of the respondents had ever been counseled as a couple in the clinic, meaning that the rest, 84 percent had received no couple counseling. From the study findings, it can be deduced that the clinic was experiencing low male involvement and PMTCT female clients were hardly receiving joint services with their male partners. The fact that 84 percent had never received couple counseling is an indication that women were largely participating in PMTCT program without the support of the male partners.

From the study findings and observations made, it is clear that very few men accompany their female partners to the clinic. The findings showed that while most of the respondents (75%) were willing to have their male partners participate in the program, some of them (47%) were not inviting their male partners to the clinic. On the other hand, even after 53 percent of the respondents indicating that they had ever invited their male partners, not all of the men invited ever accompanied their female partners to the clinic as only a small percentage (19%) of the respondents had ever been accompanied.

#### **5.1.2 Health services provider factors that influence male involvement**

The majority of the respondents (78.7%) confirmed that the HCWs had discussed the importance of male involvement with them while 21.3 percent indicated they had not. It is evident that the HCWs were making effort in ensuring that they discussed the importance of male involvement with the PMTCT clients. The same effort was

revealed in this study since the largest percentage of the respondents (97.2 %) had been asked by the HCWs to invite their male partners while a small percentage (2.8 %) indicated they had not. The results showed that HCWs were supporting the PMTCT clients in terms of discussing the importance of male involvement as well as asking them to invite their male partners. Surprisingly however, the study found out that only 1.9 percent had ever attended PMTCT support group as a couple and only 16 percent had received couple counseling at the clinic. This indicated that despite the apparent health care workers efforts, male involvement was still minimal. What could be causing this contradiction?

The findings revealed that there was lack of provision of IEC materials to the respondents as only 1 percent indicated that they had ever received and the largest percentage (99 %) stated that they had not. This could cause scantiness of knowledge regarding services on PMTCT at community level and especially among the male community who rarely attend reproductive health clinics. On the other hand, the study findings showed that only a small percentage (15%) of the respondents indicated that the HCWs paid attention and invited men into the PMTCT consultation room. The largest percentage (85%) indicated that the HCWs were not paying attention and were not welcoming the male clients into the consultation room.

The study revealed that the HCWs were actively involved in discussing the importance of male involvement as well as asking the PMTCT clients to invite their male partners. Observations by the researcher indicated that some men came to the clinic but ended up not receiving any health services. This presents lost opportunities and could be detrimental to male involvement. This is because, if a man had been given an invitation to accompany their partners to the clinic and end up not getting any services or even understanding why they were invited, it may reflect negatively on the clinic and such men could contemptuously influence their peers at community level. The findings of the study indicated a clear capacity gap as the health care workers were not well trained and were not executing some of their key roles in enhancing male involvement.

### **5.1.3 Strategies that could be put in place to improve male involvement in the PMTCT clinic.**

According to the respondents, educating men through media and community outreach programs is imperative as it would ensure that reproductive health information and importance of male involvement in health matters would reach more people. In order for male involvement activity to succeed in the PMTCT program, the HCWs need to work closely with the community public health workers who can do advocacy work as far as the benefits of male participation in reproductive health and PMTCT are concerned.

The HCWs need to ensure that they invite men into the counseling rooms and offer prompt services. The study findings showed that men who avail themselves at the PMTCT clinic hardly get attention and invitation into the consultation room. This could send a message to the male clients that they are actually not welcome and that the clinic is a women and children's place. However this lack of invitation could be due to lack of training of the health workers, some of whom may not know what services they need to offer to male clients once they get into the consultation room. According to the researchers' observation and confirmation from the key informants, the clinic does not have a defined health care package for men.

The study revealed that though the PMTCT clinic had an adequate number of staff, it experienced staff shortage due to the fact that the same staff were deployed elsewhere to relieve other staff in various departments, leaving a lean number of staff in the PMTCT clinic. The key informant confirmed that the health care workers in the clinic had a high workload leading to fatigue and burnout.

The health facility needed to consider expanding the counseling rooms to ensure that there was adequate space for PMTCT clients and their male partners. Space was identified as a crucial impediment to male involvement due to privacy and confidentiality. Even when health care workers are well equipped, the issue of infrastructure may be a hindrance to male involvement and therefore the PMTCT program needed address it.

The facility lacked IEC materials and male invitation cards as confirmed by the key informant as well as the researchers' observation. Reading materials on male involvement in PMTCT, guidelines on PMTCT program and a brochure on men's health care package should be provided to all clients who visit the clinic.

Integration of services in the PMTCT department is essential in ensuring that both men and women get health care services once they arrive at the clinic without going to seek basic HIV, reproductive and PMTCT services in other departments. The clinic needed to accommodate the men who accompany their female partners to the PMTCT clinic.

As suggested by the respondents and the key informants, it was vital that all health facility staff be trained in male involvement program. Understanding of what male involvement entails by all those working in the PMTCT clinic is critical in ensuring the success of the same. The study findings indicated that while a number of health care workers in the PMTCT clinic have long experience in health provision, not all of them are at the same level of awareness of PMTCT program. The key informant confirmed that the health care workers did not have adequate awareness and training to help them fully implement male involvement in PMTCT program.

It is also clear from the findings that the health facility and development partners on the ground had not done much to institutionalize male involvement into the PMTCT program. Partners play a key role in providing the necessary support including trainings, provision of materials and even infrastructure. One key observation is that despite male involvement in PMTCT being a very important component of prevention of mother to child transmission of HIV, male involvement training and orientation had not been provided to the HCWs, an oversight that could highly affect the success of the program.

According to the respondents, it is important for the clinic to consider engaging male HCWs and maintain a gender balance in the workforce. The PMTCT clinic is mainly dominated by female HCWs who constitute 87.5 percent of the staff and this could send a wrong signal to the community by confirming that the reproductive health clinic is a place for women and children. Men who want to be attended to by male

HCWs might consequently opt not to accompany their female partners to the clinic if they discover that they are not likely to find a male HCW at the clinic.

## **5.2 Conclusions**

Male behavior is fundamental in reproductive health, especially in preventing the transmission of HIV and other STDs. Therefore programs should encourage men to adopt positive behavior such as participation in reproductive health matters, consistent condom use and remaining faithful to a single partner. The study revealed that major hindrances to the successful implementation of male involvement in the PMTCT program include lack of staff training in PMTCT and male involvement. The findings revealed that there was inadequate community mobilization and sensitization on PMTCT as well as lack of guidelines on male involvement in the PMTCT program. The findings further indicated that there was unremarkable success despite the apparent efforts made by the HCWs to promote male involvement in PMTCT programs.

## **5.3 Recommendations**

On the basis of the above findings of the study, the following recommendations were made:

- (1) Male involvement strategy in PMTCT program needs to be well packaged, documented and shared with all health care workers. The guidelines and standard operating procedures should be provided and well understood by all the health care providers in the facility.
- (2) The facility should train HCWs in PMTCT and male involvement in PMTCT program.
- (3) The facility needs to engage more health care workers especially male, in order to reduce the workload and allow more time for the HCWs and clients. Engagement of male HCWs will ensure gender balance and address the myth that reproductive health clinic is a women's domain.
- (4) The facility should organize community outreach activities in which community opinion leaders are involved as advocates for male involvement in reproductive health.

#### 5.4 Areas for further research

- Marital status and economic activities were found to be significant factors associated with uptake of male involvement services in PMTCT program. Further investigations would give more insights.
- The study was done in a high volume facility which could have influenced HCWs factors due to high workload. Therefore there is need for a similar study to be done in a low volume health facility.
- This study focused on PMTCT clients and Health Care Providers within the health facility. A study can be done focusing on male partners and community health care workers at community level.
- The study was undertaken in a public health facility that is supported by the Murang'a County Government. Therefore there is need to conduct a similar study in private health facility to bring up comparative findings.

**Figure 5.1: the main road leading to Murang'a Town**



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## **APPENDICES**

### **APPENDIX I**

#### **PMTCT Client Structured Interview Schedule**

**Interview No:.....**

Dear Respondent,

I am Cecilia Muchemi,

I am a student pursuing a Master of Arts Degree at the University of Nairobi. I am carrying out a research on Factors that influence male involvement in PMTCT in Murang'a District Hospital, focusing on Health Care Workers factors. The questions asked under this questionnaire are solely for academic purpose and information sought will only be used in writing academic research paper in partial fulfillment of the requirements for the award of Masters Degree in Medical Sociology at The University of Nairobi. You are kindly requested to participate in this study by responding to this questionnaire. Your responses will be treated with the highest confidentiality. The questionnaire will remain anonymous without respondent's name.

## SECTION A: PERSONAL DETAILS

Please tick where appropriate

1. Please indicate the state you are in

i. Am Pregnant [ ] How many months pregnant? \_\_\_\_\_

ii. A Mother to < 24 months old child [ ] Age of child  
\_\_\_\_\_ Months

2. Place of residence

Location \_\_\_\_\_

Sub-location: \_\_\_\_\_

Village/ Estate: \_\_\_\_\_

3. Age bracket of the respondent

i. Below 20 years [ ]

ii. 21 – 24 years [ ]

iii. 25 – 29 years [ ]

iv. 30 – 34 years [ ]

v. 35 – 39 years [ ]

vi. 40 – 44 years [ ]

vii. 45 – 49 years [ ]

viii. 50 + years [ ]

4. What is the highest level of your academic qualification?

i. Never attended school [ ]

- ii. Did not complete Primary school [ ]
- iii. Completed Primary school [ ]
- iv. Did not complete Secondary school [ ]
- v. Completed secondary school [ ]
- vi. Did not complete College/University [ ]
- vii. Completed College/University [ ]

5. What is your marital status?

- i. Married [ ]
- ii. Separated [ ]
- iii. Divorced [ ]
- iv. Widowed [ ]
- v. Single mother (never married) [ ]

6. What economic activity do you engage in for a living?

- i. Farming [ ]
- ii. Casual laborer [ ]
- iii. Permanent employment [ ]
- iv. House wife [ ]
- v. Unemployed [ ]
- vi. Other (Specify.....) [ ]

**SECTION B: EXTENT OF MALE INVOLVEMENT IN PMTCT PROGRAM**

7. For how long (months) have you been attending the PMTCT clinic?

\_\_\_\_\_months

8. What is the frequency of your visit to PMTCT clinic

- i. Once a week [  ]
- ii. Every two weeks [  ]
- iii. Once a month [  ]
- iv. Irregularly (I skip some appointments) [  ]

**Table 1: Extent of male involvement in PMTCT**

	Kindly tick YES or NO		
		✓ Yes	✓ No
A	<i>Male accompanying a female partner to the PMTCT clinic</i>		
1	Is your partner aware that you are in this clinic today?		
2	Would you like to involve your partner in PMTCT program?		
3	Have you ever invited your partner to accompany you to the PMTCT clinic?		
4	Has your partner ever accompanied you to the PMTCT clinic?		

B	<i>Male and female clients receiving Health services and Information together</i>		
1	Have you and your partner ever attended PMTCT support group together?		
2	Have you and your partner been counseled on PMTCT together?		

**SECTION C: HEALTH CARE WORKERS FACTORS THAT HINDER OR ENCOURAGE MALE INVOLVEMENT**

**Table 2 Health Care Workers Factors that influence male involvement**

	<b>Kindly tick YES or NO</b>		
		<b>✓ Yes</b>	<b>✓ No</b>
1	Has your HCW discussed with you on importance of involving your partner in PMTCT clinic?		
2	Has the HCW ever asked you to invite your partner?		
	Does the HCW provide you with IEC materials to share with your partner?		
3	Do you think that the HCW pay attention and welcome the male partners into the PMTCT clinic?		

**SECTION D: STRATEGIES THE CLINIC SHOULD PUT IN PLACE TO INCREASE MALE INVOLVEMENT IN THE PMTCT PROGRAM.**

1. What are some of the strategies that could be put in place to encourage male partners to be more involved in PMTCT program? **Give at most three strategies that focus on HCW practices.**

- (i) .....  
.....  
.....
- (ii) .....  
.....  
.....
- (iii) .....  
.....  
.....

## APPENDIX II

### PMTCT HCWs Structured Interview Schedule

Interview No:.....

Dear Respondent,

I am Cecilia Muchemi, a student of Master of Arts Degree in Medical Sociology at the University of Nairobi. I am carrying out a research on Factors that influence male involvement in PMTCT in Murang'a District Hospital, focusing on Health Care Workers factors. The questions asked under this questionnaire are solely for academic purpose and information sought will only be used in writing academic research paper in partial fulfillment of the requirements for the award of Masters Degree in Medical Sociology at The University of Nairobi. You are kindly requested to participate in this study by responding to this questionnaire. Your responses will be treated with the highest confidentiality. The questionnaire will remain anonymous without respondent's name.

#### SECTION A: PERSONAL DETAILS

**Please tick where appropriate**

1 Gender of the respondent

- i. Male       ii. Female

2. What is your job designation?

- i. Medical Doctor
- ii. Clinical Officer
- iii. CCC in charge (Cadre)
- iv. Pharmacist
- v. Lab. Technologist
- vi. Nurse
- vii. Peer Mentor
- viii. Other  Please Specify.....

3. In which age bracket do you fall?

- i. 25 years and below [ ]
- ii. 26 to 35 years [ ]
- iii. 36 to 45 years [ ]
- iv. 46 to 55 years [ ]
- v. 56 years and above [ ]

4. What is the highest level of your academic qualification?

- i. Primary School (KCPE/ CPE) [ ]
- ii. Secondary School (KCSE) [ ]
- iii. College (Certificate) [ ]
- iv. College (Diploma) [ ]
- v. University [ ]

5. For how long have you been working as a healthcare practitioner?

- i. < 2 years [ ]
- ii. 2 – 3 years [ ]
- iii. 3 – 5 years [ ]
- iv. 5 - 10 years [ ]
- v. Over 10 years [ ]

6. For how long have you worked in this clinic?

- i. Less than 1 year [ ]

ii. 1 – 2 years [ ]

iii. 3 – 5 years [ ]

iv. Over 5 years [ ]

7. Have you received any special training in PMTCT services?

i. Yes [ ]

ii. No [ ]

8. If YES, please indicate what type of training you received duration of training?

.....

---

**SECTION B: EXTENT OF MALE INVOLVEMENT IN PMTCT PROGRAM**

**Kindly tick as appropriate**

1: How would you rate the extent of male involvement in prevention of MTCT in this clinic?

i. Fully Involved [ ]

ii. Involved [ ]

iii. Moderately involved [ ]

iv. Sparingly involved [ ]

v. Not Involved [ ]

**Table 1: Extent of male involvement in PMTCT**

	Kindly tick YES or NO		
		✓ Yes	✓ No
i.	Do you discuss male involvement in PMTCT with the clients?		
ii.	Have you ever tested and counseled a couple in this clinic?		
iii.	Do you have a support group for clients and their partners?		

13 Please mention 4 **KEY** Health services in which men are involved in this PMTCT clinic

(i).....

(ii).....

(iii).....

(iv).....

**SECTION C+: HEALTH CARE WORKERS FACTORS THAT HINDER OR ENCOURAGE MALE INVOLVEMENT**

**Table 2: Health Care Worker factors that influence male involvement in PMTCT**

	<b>Kindly tick YES or NO</b>		
	<b>Training</b>	<b>✓ Yes</b>	<b>✓ No</b>
1	Have you been trained in PMTCT?		
2	Have you been trained in partner testing and counseling?		
3	Do you have guidelines on male involvement in PMTCT?		
	<b>Partner Invitation cards</b>		
4	Do you have partner invitation cards?		
5	Do you give partner invitation cards to female clients to deliver to their partners?		
	<b>Male health services</b>		
6	Do you have a health services package for men in PMTCT clinic?		
7	Do you offer health services to male partners who accompany their women to PMTCT clinic?		

	<b>IEC material</b>		
8	Do you have IEC material on male involvement in PMTCT?		
9	Do you give your clients IEC materials on male involvement to take to their male partners?		
	<b>Privacy</b>		
10	Do you offer couple counseling services?		
11	Is there a room that provides privacy during couple counseling?		

**SECTION D: STRATEGIES THAT COULD BE PUT IN PLACE TO IMPROVE MALE INVOLVEMENT IN PMTCT CLINICS**

1: What are some of the strategies that could be put in place to encourage male partners to be more involved in PMTCT program? **Give at most three strategies that focus on HCW practices.**

- i).....
- .....
- .....
- (ii).....
- .....
- .....
- (iii).....
- .....
- .....

**APPENDIX III**

**IN DEPTH INTERVIEW GUIDE**

(1). What is your role in this Clinic?

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

(2) For how long have you been working in this clinic?

(i) Less than 2yrs ( )

(ii) 3-4 ( )

(iii) More than 4 years ( )

(3) What is your understanding of PMTCT?

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

(4) What is your understanding of male involvement in PMTCT?

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

(5) Do you have male partner invitation cards in this clinic?

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

(6) Are men reluctant to go for couples counseling and testing for HIV?

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

(7) Are there factors at the facility that deters men from participating in reproductive health/PMTCT issues? Discuss

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

(8) What strategies do you have in place to involve male partners?

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

(9) What can be done to encourage men to participate in reproductive health issues such PMTCT?

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

(10) are there any Health care provider factors/practices in this clinic that deter men from participating in reproductive health/PMTCT issues? Discuss

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

(11) Do you feel your PMTCT clients are well informed about male involvement in PMTCT?

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

(12) Do you think the Health Care Worker is well empowered to encourage male involvement in PMTCT?

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

**APPENDIX 1V**

**OBSERVATION GUIDE**

(1) Are PMTCT clients accompanied by their male partner to the PMTCT clinics' waiting bay?

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

(2) Does the PMTCT client enter into the clinician's room together with the male partner?

.....  
.....

(3) Does a PMTCT client and her male partner enter into the counselor's room?

.....  
.....

(4) Are there IEC materials with male involvement information accessible to clients?

.....  
.....

(5) Most clients are accompanied by their male partners/not accompanied

.....  
.....

(6) Are there male services offered in the PMTCT CLINIC?

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

**APPENDIX V**

**SECONDARY DATA COLLECTION CHECKLIST**

**This information will be picked from hospital records**

- (1) Number of HCW trained and sensitized on new PMTCT guidelines  
.....
- (2) Number of HCW trained in Male involvement in PMTCT  
.....
- (3) Number of HCW trained in couple counseling  
.....
- (4) Number of couples tested and counseled in the PMTCT clinic in the last 9 months  
.....
- (5) Number of female clients whose partners attend PMTCT support group  
.....
- (6) No. of male partners who received treatment in the PMTCT clinic in the last 9 months  
.....

**APPENDIX VI**

**RESEARCH RESPONDENT’S INFORMED CONSENT FORM**

**Read this consent form and you may ask as many questions as you like before you decide whether you want to participate in this research study. Any concerns can be raised before, during or after your participation**

**Research title:** Factors that influence male involvement in Prevention of Mother to Child Transmission of HIV in Murang’a district hospital: Health Care Worker factors

**Researcher:** Cecilia Muchemi

**Introduction:** I am MA student in Medical Sociology at the University of Nairobi.

**Purpose of this research study:** You are asked to participate in this research study designed to describe Factors that influence male involvement in Prevention of Mother to Child Transmission of HIV in Murang’a District Hospital, focusing on health care provider factors.

**Procedures:** You will be asked to answer questions led by a research assistant; this will take about twenty minutes of your time.

**Possible Benefits:** Your participation in this study may not have any immediate benefits for you personally but in the long term findings from the study may be used to improve the PMTCT program for the benefit of the community as a whole.

**Risks:** There are no known risks associated with participation in this type of study.

**Confidentiality:** Your identity in this study will not be disclosed. Results of the study may be published for learning purposes but will not give any identifiable reference to you.

**Compensation:** There is no financial compensation for your participation in this research.

**Study approval:** This study has been approved by the ministry of education through the University of Nairobi institutional research and ethics committee.

**Consent:**

**I have read and understood this consent form and I volunteer to participate in this research study**

Respondents’ signature.....Date.....

Researcher’ signature.....Date.....

Witness’s signature.....Date.....

**APPENDIX VII**

**TIME PLAN**

<b>Activity</b>	<b>No</b>	<b>De</b>	<b>Ja</b>	<b>Fe</b>	<b>M</b>	<b>Ap</b>	<b>M</b>	<b>Ju</b>	<b>Jul</b>	<b>Au</b>	<b>Se</b>	<b>O</b>	<b>No</b>
	<b>v</b>	<b>c</b>	<b>n</b>	<b>b</b>	<b>ar</b>	<b>r</b>	<b>ay</b>	<b>ne</b>	<b>y</b>	<b>g</b>	<b>pt</b>	<b>ct</b>	<b>v</b>
Proposal development													
Approval													
Data collection													
Data analysis/ Project write up													
Project submission													

## APPENDIX VIII

### BUDGET

Proposal development	20,500.00
Stationery	15,700.00
Typing and printing proposal	34,000.00
Photocopy (proposal questions )	27,000.00
Transport	25,000.00
Accommodation	14000
Research Assistants	15000
Miscellaneous expenses (15%)	22,680.00
<b>Total Cost</b>	<b>173,880</b>

## APPENDIX IX

### RESEARCH PERMIT



UNIVERSITY OF NAIROBI  
DEPARTMENT OF SOCIOLOGY & SOCIAL WORK

Fax 254-2-245566  
Telex 22095 Varsity Nairobi Kenya  
Tel. 318262/5 Ext. 28167

P.O. Box 30197  
Nairobi  
Kenya

18<sup>th</sup> February, 2014

TO WHOM IT MAY CONCERN

RE: CECILIA W. MUCHEMI-C50/76703/2009

Through this letter, I wish to confirm that the above named is a bonafide postgraduate student at the Department of Sociology & Social Work, University of Nairobi. She has presented her project proposal entitled; **"Factors that influence male partner involvement in (PMTCT) prevention of mother to child transmission in Muranga District Hospital: Health Care Providers factors?"**

Cecilia is required to collect data pertaining to the research problem from the selected organization to enable her complete her project paper which is a requirement of the Masters degree.

Kindly give her any assistance she may need

Thank you.

  
Dr. Robinson Ocharo  
Chair, Dpt. of Sociology & Social Work

Cc: Dr. Robinson Ocharo - Supervisor



**APPENDIX X**

**AUTHORIZATION LETTER FROM MURANG'A DISTRICT HOSPITAL**

**MINISTRY OF HEALTH**

Telephone: (060) 30244,  
Fax: (060) 30244,  
When replying please quote,  
Ref: MRG/VOL 1/68/12



COUNTY DIRECTOR OF HEALTH,  
MURANG'A COUNTY,  
P. O. BOX 69,  
MURANG'A

Date: 20<sup>TH</sup> JUNE 2014

**TO WHOM IT MAY CONCERN**

**RE: PERMISSION TO CONDUCT RESEARCH FOR  
CECILIA W. MUCHEMI IN PMTCT CLINIC MURANG'A COUNTY  
REFERRAL HOSPITAL- MURANG'A COUNTY**

The above mentioned who is a student at University of Nairobi has been permitted to undertake a research on 'Factors that influence male partner involvement in (PMTCT) prevention of mother to child transmission in Murang'a District Hospital: Health Care Providers factors'.

Any assistance accorded to her will be highly appreciated.

  
**DR. KANYI W.W.  
COUNTY DIRECTOR OF HEALTH  
MURANG'A COUNTY**

