


Reply to “Male Involvement’ in Women and Children’s HIV Prevention: Challenges in Definition and Interpretation”

To the Editors:

We appreciate the letter by Montgomery et al in response to our study that showed an association between male partner involvement and improved infant outcomes (HIV-free survival) in Kenya.1 As was highlighted by the authors, male involvement in prevention of mother-to-child transmission of HIV (PMTCT) is recommended by multiple public health advisory bodies,2 including the World Health Organization, which states that there is a need to “increase the involvement of male partners in PMTCT services (eg, couples counseling, partner testing).”3 Most national guidelines in sub-Saharan Africa are similar,4,5 yet what comprises involvement is not well defined. As was recommended in this letter, there is a need for research to define clear objectives for male involvement in PMTCT. To date there is a paucity of studies on partner participation in prevention of vertical transmission programs. Rates of male HIV testing in the antenatal setting have been historically low. With few exceptions, partner testing rates are consistently less than 30% in research settings.6 There are also minimal data from men themselves on their perceived barriers to antenatal clinic attendance and HIV testing in that setting. One of the few studies that provides information obtained directly from men on barriers to involvement found that the most frequently reported reason for failure of participation in PMTCT was a lack of knowledge regarding the existence of services or the necessity for men to take part in them.7 Therefore, in addition to clarifying definitions of male involvement in PMTCT, further research is needed to determine the self-perceived roles of, and barriers to, involvement of male partners.

As was discussed by Montgomery et al, confounding and bias may have existed in our observational study, similar to other studies on male involvement that have investigated surrogate end-points such as antiretroviral prophylaxis and feeding choice.8–12 We agree with the authors that randomized controlled trials are needed to rigorously evaluate if varying forms of male involvement improve outcomes. Appropriate trial design will be crucial to ensure equipoise13 and it may be beneficial to randomized participants to comparative forms of male involvement rather than a control that excludes men from participating in their family’s healthcare.

In conclusion, we concur with the recommendations by Montgomery et al regarding the need for more robust study designs aimed at delineating beneficial forms of male involvement. In addition, we stress the need for such work to focus on men themselves with the immediate aims of understanding perceptions of their roles in prevention programs and barriers to their involvement in PMTCT settings.

Adam Aluusio, MS*
Barbra A. Richardson, PhD, MS†
Rose Bosire, MChB, MPH‡
Grace John-Stewart, MD, PhD§
Dorothy Mbori-Ngacha, MChB, MMed, MPH∥
Carey Farquhar, MD, MPH‡
*Stony Brook University Medical Center
∥Departments of Biostatistics and Global Health,
REFERENCES


ERRATUM


In the article by Tariq et al, appearing in the Journal of Acquired Immune Deficiency Syndromes, Vol 57, No. 4, pp. 326–333 entitled “Use of Zidovudine-Sparing HAART in Pregnant HIV-Infected Women in Europe: 2000–2009,” there was one incorrect item printed in Table 2. In the 5th column, ‘n (%)’, under multivariable model: for ZDV-containing HAART it should read 3453 (28.6).

REFERENCE