

**AN EXPLORATION OF MALE PARTICIPATION IN A PMTCT PROGRAMME IN
WEST ITAM, AKWA IBOM STATE, NIGERIA**

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KEY WORDS

- Prevention of Mother-to-Child Transmission of HIV (PMTCT)
- HIV-positive women
- Male partners
- Participation
- Barriers
- Benefits
- Antenatal Care (ANC)
- Primary Health Care (PHC)



ABSTRACT

Since the introduction in 2005 of prevention of mother-to-child transmission of HIV (PMTCT) services in Akwa Ibom State in Nigeria the PMTCT programme has faced several challenges including that of poor male participation in the PMTCT programme. To date no research has focused on the issue of male participation in PMTCT programmes in Akwa Ibom State, and there is thus a limited understanding of why so few male partners of HIV-positive pregnant women participate in the State's PMTCT programme. It is therefore important to explore the factors affecting male involvement in PMTCT programmes in Akwa Ibom State, so that strategies can be put in place to help improve the overall health of their families and themselves. The overall aim of the study was thus to explore the factors affecting male participation in the PMTCT programme at a primary health care center in West Itam, Akwa Ibom State, in Nigeria.

This explorative study was conducted using a descriptive qualitative research approach. The research study approach helped to understand the perspectives of the male partners of HIV-positive pregnant women who received the PMTCT intervention, as well as key informants in the Primary Health Care (PHC) facility where these PMTCT services are offered. The study population consisted of all males living within the catchment area of the West Itam PHC, Akwa Ibom State, Nigeria. In the research study, 11 men were purposively sampled: five of whom were the partners of HIV-positive women who had attended, or were currently attending the PMTCT services at the West Itam PHC with their partner. The other six interviewees were local male community members – who would be eligible to potentially accompany their partner to PMTCT services at the facility.

The data was collected through individual, in-depth interviews with the male partners and community members using a semi-structured interview guide. One focus group discussion (FGD) was conducted with key personnel working in the West Itam PHC using a semi-structured interview guide. All interviews and the FGD were tape-recorded and transcribed. Thematic analysis was used to analyse the data.

Ethical approval was first obtained from the UWC Research Ethics Committee and the Ethics Committee of the Akwa Ibom State Ministry of Health before proceeding with the study.

From this study, it is suggested that most of the respondents knew that PMTCT services are offered at the PHC West Itam. They knew their partner's next antenatal appointment, but only

very few accompany their pregnant partners to the antenatal clinic. The striking reason being a lack of time/being busy. The key means of support of the partners' antenatal visits was giving their pregnant partners money for transport, and money for food/snacks (at the clinic).

Inter-spousal communication was found to be good, and there appeared to be a perception by the men that antenatal clinic (ANC)/PMTCT is not only for women, with most of the men agreeing that it is useful for men to participate in PMTCT.

The barriers to male participation in the PMTCT programme that were elicited in this study include lack of belief about HIV/AIDS and lack of awareness about PMTCT and the perception of PMTCT as a "women's affair". Another barrier to male participation in the PMTCT programme was the men being busy with their jobs/lack of time, and fear.

Facility-based barriers include delays/time wasting at the clinic, and the nurses, who were identified as having an unaccommodating attitude towards the clients.

Finally, the fact that the nurses and counsellors at the PHC West Itam were all female was a problem for men.

It is recommended that there is need for advocacy and education to raise awareness about HIV/AIDS, and encourage male participation in PMTCT. It is also important to encourage the disclosure of HIV status by the women to their male partners. Furthermore, a separate male counselling unit needs to be created, as well as ensuring the employment of male nurses and counsellors. Additionally, the female nurses at the facility need to be trained/re-trained on proper attitude and confidentiality, and efforts must be made to avoid delays at the clinic.

DECLARATION

I declare that '*An Exploration of Male Participation in a PMTCT Programme in West Itam, Akwa Ibom State, Nigeria*' is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Echey Ijezie

March 2017

Signed:



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I acknowledge this mini-thesis as a true test of participation, and sincerely thank those who have helped make it come true with their support.

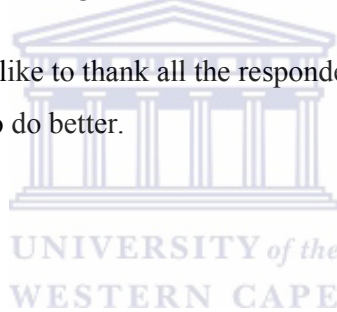
I wish to thank Almighty God for His love and mercy towards my family and me.

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LIST OF ACRONYMS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
PMTCT	Prevention of Mother-to-Child Transmission of HIV
HCT	HIV Counselling and Testing
PHC	Primary Health Centre
ANC	Antenatal Clinic
NGO	Non-Governmental Organization
CNO	Chief Nursing Officer
CHO	Community Health Officer
CHEW	Community Health Extension Worker
STI	Sexually Transmitted Infection
UNGA	United Nations General Assembly
PEPFAR	President's Emergency Plan for AIDS Relief
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
NACA	National Agency for the Control of AIDS, Nigeria
NASCP	National AIDS and STI Control Programme, Nigeria,
IATT	Inter-Agency Task Team for Prevention and Treatment of HIV infection in Pregnant women, Mothers and their Children.

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Chapter 1: INTRODUCTION

1.1 Background

HIV and AIDS are significant causes of maternal and childhood morbidity and mortality all over the world (Morfaw, Thabane, Mbuagbaw & Nana, 2012). In 2008, over 430,000 children were newly infected with HIV, and over 90% of these occurred via mother-to-child transmission (MTCT) of HIV (Morfaw *et al.*, 2012). MTCT of HIV can occur transplacentally in the uterus during pregnancy, perinatally during the process of labour and delivery, and postnatally during breastfeeding (Nkwo, 2012). Without intervention, the rate of transmission from mother to child is 20% to 45%, though this risk can reduce to 2% in non-breastfeeding settings, and 5% in breastfeeding settings with specific interventions (Morfaw *et al.*, 2012).

The male partner has a pivotal role to play which can contribute to favourable outcomes in the reproductive health of women and the prevention of MTCT (PMTCT) (Morfaw *et al.*, 2012; Brusamento *et al.*, 2012). In addition to having a positive impact on women's access to PMTCT services, male involvement in PMTCT can also enable men to test for HIV and access appropriate prevention and care services themselves.

The benefit of involving men in reproductive health services and PMTCT in particular is well-recognised and has been advocated by many authors (Katz *et al.*, 2009, Brusamento *et al.*, 2012). It has also been established that male partners play an important role in women's uptake of antenatal HIV counselling and testing (HCT) and PMTCT programmes (Katz *et al.*, 2009). However, reports from various PMTCT sites in sub-Saharan Africa still show low participation of men in the programme, which has a negative impact on the level of uptake by women of the available interventions in these programmes (Peltzer, Jones, Weiss, & Shikwane, 2011).

According to the 2010 Nigeria national HIV sero-sentinel survey, Akwa Ibom State has the second highest HIV prevalence rate amongst the 36 states in Nigeria, namely 10.9% (Federal Ministry of Health of Nigeria, 2010; Bashorun *et al.*, 2014). Since the introduction of PMTCT services in Akwa Ibom State in 2005, the programme has expanded in scope from seven health facilities in 2005, to 24 sites in 2009 (Akwa Ibom State Ministry of Health, Nigeria, 2009), and increasing to 34 sites in 2012 (Akwa Ibom State Ministry of Health,

Nigeria, FHI360 & UNAIDS, 2013). These PMTCT sites are situated in health facilities in all the 31 Local Government Areas in the State.

However, the PMTCT programme in Akwa Ibom State has faced several challenges, which have continued to limit its success, according to local health workers and health managers. One of these challenges, which policy-makers specifically noted as early as 2009, was the poor level of male involvement in PMTCT programmes within the State (Akwa Ibom State Ministry of Health, Nigeria, 2009). Unfortunately, the issues remain today.

1.2 The Research Problem

To date, no research has focused on the issue of male participation in PMTCT programmes in Akwa Ibom State, Nigeria, and there is thus a limited understanding of why some male partners of HIV-positive pregnant women do not participate in PMTCT programmes in Akwa Ibom State. It is therefore important to explore the factors affecting male involvement in PMTCT programmes in Akwa Ibom State, so that strategies can be put in place to help improve the overall health of their families and themselves.

1.3 The Study Context and Setting

Akwa Ibom State is one of the 36 states in Nigeria and is located in the south-south geopolitical zone. It shares boundaries with Rivers State on the west, Cross River State on the east, Abia and Imo States on the north, and the Atlantic Ocean on the south (Akwa Ibom State Ministry of Health, Nigeria, 2009).

There are 590 health facilities in the state, of which (as of 2012) 409 had ANC services and only 34 were providing anti-retrovirals (ARVs) for PMTCT (Akwa Ibom State Ministry of Health, Nigeria, FHI360 & UNAIDS, 2013).

The Primary Health Centre (PHC) in West Itam is one of the busiest PHCs in Akwa Ibom State. It is located in Ward 8, in Itu Local Government Area of Akwa Ibom State. The ward is made up of ten local areas, is semi-urban in nature and is inhabited mainly by civil servants, businessmen and subsistence farmers. As at 2010, the ward had a total population of 19,722 (Akwa Ibom State Ministry of Health, Nigeria, 2009) which is the drainage population that the PHC in West Itam is expected to serve.

The activities that take place at the West Itam PHC include HIV Counselling and testing (HCT), antenatal clinic and deliveries, PMTCT services, Directly Observed Treatment Short-

course (DOTS) services, immunization services, child welfare counselling and support, family planning, the provision of medical care through the general out-patient clinic, antenatal care and deliveries, health education (including, for example, nutrition demonstrations and health outreach campaigns into the community). The HIV Counselling and Testing/ PMTCT/DOTS unit is headed by a registered nurse/midwife and supported by the Centre for Integrated Health Programmes (an indigenous non-governmental organization [NGO]) and the Akwa Ibom State Ministry of Health. It carries out HCT as well as provides ARVs to pregnant women who attend ANC in the facility. It also dispenses anti-tuberculosis drugs to tuberculosis patients as part of the DOTS programme.

Between January and December 2010, 903 pregnant women were counselled for HIV testing at the PHC in West Itam, of which 539 opted-in for testing at the first visit. Out of these 539 tested, 53 were HIV-positive, representing a 9.83% sero-prevalence rate among those attendees tested (Akwa Ibom State Ministry of Health, Nigeria, 2010).

At the time of the study (i.e. between February - July 2015), the Primary Health Care Centre in West Itam had 14 staff comprising six Chief Nursing Officers (CNOs), two Community Health Officers (CHOs), three Community Health Extension Workers (CHEWs), two Health Assistants and one security guard. A doctor came for consultations once a week from the Department of Community Health, University of Uyo Teaching Hospital, Uyo, Akwa Ibom State. None of these 15 staff members were male.

Each of the health worker cadres mentioned above play a specific role in the delivery of health services, and in particular the PMTCT programme from the PHC:

- The overarching role of the CNOs is to maintain a warm, friendly and supportive environment to encourage ANC visits and to gain clients' confidence and respect. They also ensure that the clients know of the benefits of the PMTCT services, and establish linkages and work positively with traditional birth attendants (TBAs).
- The CHOs work principally *in* the facility and treat minor illnesses, provide HIV counselling and testing services, provide ARV prophylaxis, counsel mothers on safer infant feeding practices, healthy living, safer obstetric procedures, and provide early infant diagnosis services.

- Similarly, the Health Assistants work principally in the health facilities, and run errands as directed by the CNOs, such as the retrieval of a client's records card, or escorting a client to the laboratory.
- The doctor (usually the postgraduate resident doctors on clinic rotation from the Community Health Department of the University of Uyo Teaching Hospital, Uyo, Akwa Ibom State, Nigeria) is responsible for daily consultation of clients, early detection and treatment of sexually transmitted infections (STIs), regular follow-up of infants, and facilitating referrals for prompt management of illnesses.
- The CHEWS work in the communities and refer clients and patients to the PHC. They serve as liaison personnel between the PHC and the surrounding communities with whose members they make time to discuss their health concerns such as cultural preferences for home births, births in religious houses and deliveries by TBAs.

In terms of its physical layout, the health centre has a labour room, five in-patient beds, an examining/palpation room, injection room, an immunization hall and staff quarters (Akwa Ibom State Ministry of Health, Nigeria, 2010). The immunization hall also serves as the consulting room for the nurses, CHOs, CHEWs, and the Health Assistants. The clients wait their turn to be seen by one of the health workers on the benches in the immunization hall. The office of the head of the facility serves as the consulting room for the doctor and the CNO and, for privacy that is also where the HIV clients are seen.

This team in the PHC West Itam reports to the Director of Primary Health Care in the Akwa Ibom State Local Government Service Commission, who in turn reports to the Director of Public Health in the Akwa Ibom State Ministry of Health.

1.4 Contextualizing PMTCT within the Nigerian Health System

The health system in Nigeria can be divided into the formal and informal sectors. The formal sector is further sub-divided into public and private sectors, which is further stratified into primary, secondary and tertiary levels, according to the sophistication of services provided (NASCP, 2014).

The primary level is the most basic and is provided at the primary health care (PHC) facilities, which include health posts, health centres and maternity homes (NASCP, 2014).

The PHC system is the main channel of providing health services, including Maternal, Newborn and Child Health (MNCH) services, to the grassroots population. The National Health Policy stipulates that local government areas (LGAs) are in charge of the PHC system (NASCP, 2014). According to the national minimum health care package, a population of not more than 20,000 is expected to be served by at least one primary health care centre (NASCP, 2014). Equipping and staffing one PHC clinic in each of the 9,522 wards to provide comprehensive MNCH, including PMTCT services, would go a long way in getting health care closer to the people (NASCP, 2014).

Within the health system in Nigeria, the secretariat of the PMTCT programme in Nigeria is based in the PMTCT unit of the HIV/AIDS Division in the Public Health Department of the Federal Ministry of Health (Agboghoroma, Sagay & Ikechebelu, 2013). The PMTCT National Task Team (PMTCT NTT) is the technical working committee on PMTCT that reviews the PMTCT activities in the country and provides directions for the PMTCT programme (Agboghoroma, Sagay & Ikechebelu, 2013). The members include Obstetricians and Gynaecologists who are also site coordinators, Paediatricians, Public Health Physicians, representatives from relevant departments/units in the FMOH – (HIV/AIDS, Reproductive Health, Nutrition, Food and Drugs), National Primary Health Care Development Agency, PLHIV and Development partners active in PMTCT in the country (Agboghoroma, Sagay & Ikechebelu, 2013).

The Core Partners Forum is a medium created for core partners, donor organizations and major stakeholders to streamline their contributions and plans in line with the national strategic plan (Agboghoroma, Sagay & Ikechebelu, 2013).

Site PMTCT committee also exist in health facilities rendering PMTCT services. The members of the site committee include medical doctors and midwives and nurses working in maternity and child health units, pharmacists, laboratory staff, medical record staff, counsellors and social workers (Agboghoroma, Sagay & Ikechebelu, 2013). The site committee meet regularly to ensure the PMTCT services are rendered as provided for in the guidelines (Agboghoroma, Sagay & Ikechebelu, 2013).

The overall coordinator for PMTCT in Akwa Ibom State is the State HIV/AIDS Programme Coordinator (SAPC).

The researcher is a Consultant Paediatrician and, a former State Programme Manager who worked with a well-known NGO in Akwa Ibom State, which supports HIV/AIDS services in health facilities across the State. PHC West Itam is one of those facilities, and the researcher along with his former team members at that time, used to pay regular supervisory visits to it. The study is important to the researcher because during the course of his time working with the NGO, he observed that very few men were involved in the PMTCT programme at West Itam PHC. He then decided to explore the reasons behind this observation.

1.5 An Outline of the Report

The report of the study comprises of six chapters as follows:

Chapter 1 introduces the study. Chapter 2 reviews the literature for information that is likely to be relevant to the aims and objectives of the study. Chapter 3 describes the research design and methodology used for data collection as well as data analysis procedures, rigour, ethical considerations and limitations of the study. Chapter 4 presents and analyses the results of the study in terms of the extent of the participation of men in PMTCT as well as the barriers they encounter. Chapter 5 discusses these findings in the context of existing information from previous studies as well as from the point of view of existing theory. Lastly, Chapter 6 summarises the key findings of the thesis and suggests recommendations based on these findings.

Chapter 2:

LITERATURE REVIEW

2.1 PMTCT as a key HIV-related intervention

The international HIV/AIDS response has had the prevention of mother-to-child transmission of HIV (PMTCT) as an urgently important issue, and this has been demonstrated by the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly Special Session on HIV/AIDS in 2001 (United Nations 2001), the Abuja Call to Action Towards an HIV-free and AIDS-free Generation in 2005 (High Level Global Partners, 2005), the Political Declaration of the United Nations General Assembly High-Level Meeting on AIDS to work towards universal access to HIV prevention, treatment, care and support in 2006 (United Nations General Assembly, UNGA, 2006), and numerous other high-level statements by multilateral organizations (President's Emergency Plan for AIDS Relief, PEPFAR, 2010).

Over the last three decades, the HIV/AIDS epidemic has snowballed to become a significant challenge for the world, with 186 countries reporting HIV cases or deaths in 2012 (Ortblad, Lozano & Murray, 2013).

In 2014, there were 36.9 million (34.3 million – 41.4 million) people living with HIV (UNAIDS, 2014). Since 2000, about 38.1 million people have become infected with HIV and 25.3 million people have died of AIDS-related illnesses (Joint United Nations Programme on HIV/AIDS, UNAIDS, 2014). In 2014, 1.2 (1.0–1.5) million people died from HIV-related causes globally (UNAIDS, 2014).

Most of these infections and deaths are in sub-Saharan Africa (SSA). In 2014, there were 25.8 million (24.0 million–28.7 million) people living with HIV in sub-Saharan Africa, with women accounting for more than half the total number of people living with HIV in sub-Saharan Africa (UNAIDS, 2014).

The transmission of HIV infection from an HIV-infected mother to her child during pregnancy, labour, delivery or breastfeeding is known as mother-to-child transmission (MTCT) (World Health Organization, WHO, 2010). Worldwide, 220 000 (190 000–260 000) children became newly infected with HIV in 2014 (UNAIDS, 2014). As of 2014, about 2.6 million children under 15 years of age were living with HIV, with 88 per cent of them residing in sub-Saharan Africa (Elizabeth Glaser Pediatric AIDS Foundation, EGPAF, 2015; UNAIDS, 2015).

In Nigeria, there are about 60,000 children newly infected with HIV every year, and this is the highest of the annual new cases globally (Sagay, 2013).

Over 90% of these paediatric infections occur through mother-to-child transmission (MTCT), and over 90% of MTCT occurs in SSA (UNAIDS 2010; Tudor Car *et al.*, 2012; Iloh *et al.*, 2015).

Furthermore, without effective intervention, one third of infants living with HIV die before their first birthday, and more than half die before the age of two years (United Nations International Children's Emergency Fund, UNICEF, 2013). Indeed, the 2010 Expert Panel Report and Recommendations to the U.S. Congress and U.S. Global AIDS Coordinator (on Prevention of Mother-to-Child Transmission of HIV) indicate that without intervention, 25–40% of infants born to HIV-positive mothers will become infected. Approximately 5–10% of infants would be infected during pregnancy, 10–15% of infants would be infected during labour and delivery, and 5–20% of infants would be infected during breastfeeding (PMTCT Tanzania National Resource Centre for Prevention of Mother-to-Child HIV Transmission, 2015).

With current interventions, there can be a reduction in this risk to less than 5%. It therefore shows that the transmission of HIV from a pregnant woman to her infant is preventable (PEPFAR, 2010).

The provision of Prevention of Mother-to-Child Transmission of HIV (PMTCT) interventions in an effective manner improves maternal health and infant HIV-free survival (PEPFAR, 2010).

PMTCT is an important part of the over-arching HIV prevention efforts, and it provides a significant opportunity for stopping the increase of the HIV epidemic (PEPFAR, 2010). It involves a 4-pronged approach for the provision of a comprehensive PMTCT package:

Prong 1: Prevention of HIV infection among women of childbearing age.

Prong 2: Prevention of unintended pregnancies among women living with HIV.

Prong 3: Prevention of transmission of HIV from mothers living with HIV to their infants.

Prong 4: Treatment, care and support for mothers living with HIV and their children and families (PEPFAR, 2010).

Significant achievements in increasing the implementation of PMTCT programmes have been recorded in many countries in the world. For example, the 2009 Universal Access Report (UNAIDS, WHO, UNICEF, 2009; PEPFAR, 2010) indicated that 70 of 123 low- and middle- income countries featured have established a national PMTCT scale-up plan that includes population-based targets - representing an increase from 34 countries in 2005. Related to the increasing access to PMTCT services and its incorporation into the 'mix' of HIV preventative strategies, UNICEF (2012), noted that according to UNAIDS estimates, in 2011, 57% of pregnant women living with HIV in low and middle-income countries received effective antiretroviral drugs for prevention of mother to child transmission (PMTCT), a significant increase from 48% in 2010.

Worldwide, in 2012, there were more than 900,000 pregnant women living with HIV that accessed PMTCT services, resulting in a coverage rate of 62%, with four priority countries (Botswana, Ghana, Namibia and Zambia) achieving PMTCT coverage of 90% (AVERT, 2015; UNAIDS,2013).

Between 2001 and 2012, there was a 52% reduction in new HIV infections among children globally (AVERT, 2015; UNAIDS, 2013). Similarly, UNAIDS (2015) reported that between 2000 and 2014 the number of children acquiring HIV infection globally was reduced by 58% 520,000 in 2000, to 220,000 in 2014.

However, many challenges still exist in the implementation of PMTCT programmes, with the main challenge being ensuring that a high proportion of women and children in need of antiretroviral therapy (ART) can access it (UNICEF, 2012). In addition, there is still a need to significantly expand PMTCT programmes in order to achieve the target of zero new infections among children and mothers by 2030 (UNAIDS, 2015).

2.2 PMTCT programmes in the context of the HIV epidemic in Nigeria

Nigeria is the most populous African country with an estimated population of 177,071,561 as at July 2013, a Total Fertility Rate (TFR) of 5.5, and an annual growth rate of about 2.54% as at 2013. Nigeria has over 250 ethnic groups (National Agency for the Control of AIDS, Nigeria, NACA, 2014). The languages include English (Official), Hausa, Yoruba, Igbo and over 500 other indigenous languages (NACA, 2014). Approximately 50% of the population lives in urban areas with an annual rate of urbanization estimated to be at 3.75% (NACA, 2014).

The country has 36 states and the Federal Capital Territory (FCT) with the states further divided into 774 Local Government Areas (LGAs). The states are grouped into six geopolitical zones based on geopolitical considerations: North East (NE), North West (NW), North Central (NC), South West (SW), South East (SE) and South-South (SS). The geopolitical zones have different characteristics, with each zone having its own unique size, composition of population, ecology, language, norms, settlement patterns, economic opportunities and historical background (NACA, 2014).

With an estimated population of 177,071,561 and a national sero-prevalence rate of 4.1%, Nigeria has the second highest HIV burden world-wide after South Africa (Nkwo,2012; NACA 2014). Nigeria contributes 30% of the global burden of MTCT (Anoje *et al.*, 2012), and unfortunately, significant challenges in PMTCT exist, with only about 11% of HIV-infected pregnant women being reached with PMTCT services (Nkwo, 2012).

Based on projected HIV estimates of 2013, approximately 3,229,757 people now live with HIV in Nigeria, while it is estimated that 220,394 new HIV infections occurred in 2013. A total of 210,031 died from AIDS related cases. It is also estimated that a total of 1,476,741 required anti-retroviral drugs (ARV) in 2013 (NACA, 2014).

Between 2009 and 2011, Nigeria's rate of HIV incidence among children declined by just two per cent, compared with declines of 30 to 60 per cent among other sub-Saharan countries (UNAIDS, 2013 as cited by Adesina & Alkenbrack, 2014).

To achieve the UNAIDS target of zero new infections, Nigeria has renewed efforts to expand the coverage of PMTCT services (NACA, 2011 as cited by Oladokun, Ige & Osinusi, 2013).

The PMTCT programme in Nigeria commenced in July 2002 in six tertiary facilities in the six geopolitical zones of the country. With the support of key development donors and partners such as UNICEF and the Center for Diseases Control (CDC) this was then scaled up to 11 by the end of 2003. With massive support from PEPFAR and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) the number of sites has so far increased to 5,767 as at December 2013 (NACA, 2014).

In November, 2014, Nigeria committed itself to the goal of eliminating MTCT by 2015 with the Presidential launch of the National Operational Plan for the Elimination of Mother To Child Transmission of HIV in Nigeria (2015-2016) (NACA, 2015). In line with this goal, the Health Sector Plan and the 2010 National PMTCT guidelines outline clear strategies to

accelerate the expansion and strengthening of PMTCT services through decentralization and integrated service delivery at the Primary Health Centres (PHCs) (NACA, 2014). To support such commitments a PMTCT scale-up plan was developed in 2012 to accelerate PMTCT programming at the state level – starting with the 12 priority states: Abia, Akwa Ibom (where this study was conducted), Anambra, Bayelsa, Benue, Cross-Rivers, Kaduna, Kano, Lagos, Nassarawa, Plateau, Rivers and the federal capital territory (Abuja). These states bear 70% of the burden of the epidemic and have consistently shown a high HIV prevalence (NACA, 2014).

The PMTCT scale-up programme has had a positive impact on the provision of HIV-related services for women. Data in 2013 from PMTCT services in the country showed that the number of pregnant women counselled, tested and receiving results increased from 1,120,178 in 2011 to 1,706,524 in 2013. This represents an improvement from 2010 when only 907,387 pregnant women were counselled, tested and received their HIV test result (NACA, 2014).

Similarly, the number of HIV-positive pregnant women who received ARVs to reduce the risk of MTCT also increased from 13,000 (in 2006) to 58,000 (in 2013). However, this was still only 27% of the 244,000 HIV-infected women who were estimated to have been pregnant in 2013 and required the medication (National AIDS and STI Control Programme, Nigeria, NASCP, 2014).

However, despite these positive changes, estimates in 2014 show that the coverage for PMTCT in Nigeria still remains low (30.1%) with a small increase from the estimated coverage of 25.9% in 2012. In contrast, the PMTCT coverage in South Africa and Botswana is approximately 80% and 100% respectively (Adesina & Alkenbach, 2014; UNAIDS, 2014).

2.3 The challenges in implementing PMTCT programmes in Nigeria

Challenges being experienced with the PMTCT programme in Nigeria include the following: funding gaps, over-dependence on donor support, inadequate uptake of PMTCT services by pregnant women; minimal male involvement and poor community participation in PMTCT (NACA, 2014). In much of Nigeria, antenatal care is perceived as the business of women, and men are hardly seen in the clinics where such health services are rendered (NACA, 2014). As a result, the Federal Ministry of Health of Nigeria has recommended a set of strategies to strengthen the PMTCT programme in Nigeria (NACA, 2014), which include the following:

- improved coordination of all relevant partners (e.g. avoiding providing services in locations where other partners with similar interests may have begun working) (Burlew *et al.*, 2014);
- accelerating the implementation of the PMTCT scale up plan (for example, by increasing the PMTCT coverage to 90%, with the refurbishment and strengthening of 200 new primary health facilities to provide PMTCT services) (Federal Ministry of Health of Nigeria, 2010);
- creating greater demand for PMTCT through community mobilisation strategies, including encouraging male involvement in the programme) (Federal Ministry of Health of Nigeria, 2010);
- promoting greater community involvement by targeted advocacy to community gatekeepers and policy makers to increase their support for SRH and HIV prevention programmes (Federal Ministry of Health of Nigeria, 2010);
- promoting male involvement by the establishment of male-only roundtables in communities to discuss family health and well being (NACA, 2014); and,
- integrating Traditional Birth Attendants (TBAs) care of pregnant women as part of the national effort to address PMTCT (NACA, 2014).

2.4 Male Participation as a key strategy within PMTCT programmes

In this section, male participation as a key strategy within PMTCT programmes will be reviewed along with the benefits, barriers and facilitating factors of male participation in PMTCT.

Male participation in PMTCT has been recognized in international PMTCT policy to improve the overall health of women, children and the family in general (WHO, 2012). Male partners who are supportive of and willing to be tested for HIV and communicate with their partner about sexual and reproductive health matters provide much needed support and potentially strengthen their pregnant partner's commitment and involvement in PMTCT programmes (Auvinen, Suominen, & Valimaki, 2010; AVERT, 2015).

In many African environments where PMTCT is offered, men are the key decision makers (Akarro, Deonisia & Sichona, 2011). It will thus be difficult or impossible to bring about

change in relation to PMTCT without working with men (Sternberg & Hubley, 2004; Kalembo, Yukai, Zgambo & Jun, 2012).

The concept of male participation in PMTCT has been conceptualized by some authors as falling into a continuum ranging from a man attending antenatal care with his partner (Byamugishawine, Tumwine, Semiyaga & Tylleskar, 2010; Brusamento *et al.*, 2012) to knowing the partner's antenatal appointment; discussing antenatal interventions with his partner; financially supporting his partner's antenatal visits; finding out what goes on at the antenatal clinic, to the man agreeing with his partner to use a condom during the current pregnancy (Byamugisha *et al.*, 2010) and providing his support for safe infant feeding (Brusamento *et al.*, 2012).

In the Nigerian national PMTCT guidelines (Federal Ministry of Health, 2010) the roles of the male partner are highlighted as vital, and include things such as:

- financial provision and final decision-making on ANC utilization, delivery location and services and infant feeding practices;
- acceptance and support to facilitate access to ANC and PMTCT services and support for infant feeding that promote HIV-free survival of infant and good health outcomes for the mother;
- making himself available to participate in HIV counselling and testing;
- acceptance and consistent practice of safer sex practices and appropriate family planning methods.

The idea of encouraging males to participate in a health programme such as PMTCT is not unusual or new (Toure, 1996; Greene *et al.*, n.d.) Indeed it has been put to use in various family planning programmes and child health programmes, with men as clients, men as partners, and men as agents of positive change (Greene *et al.*, n.d.). The intended result is to have men involved in reproductive health efforts as advocates for needed services, supporters of their partner's needs, and as beneficiaries of services for their health and wellbeing (Bernstein & Hansen, 2006).

2.4.1 The Benefits of Male Participation in PMTCT interventions

The male partner's role is a significant factor in the success of the implementation of PMTCT programs in Sub-Saharan Africa (Ditekemena *et al.*, 2012). The benefits of involving men in women reproductive health services, and PMTCT, in particular are well recognized and have

been advocated for by many authors (Katz *et al.*, 2009). It has been established that male partners play a role in women's uptake of antenatal HCT and PMTCT programmes (Katz *et al.*, 2009). This is recognized by the Inter-Agency Task Team (IATT) for Prevention and Treatment of HIV infection in Pregnant women, Mothers and their Children, which in its review stated that male participation in PMTCT is vital in the implementation of the PMTCT programmes particularly prongs 1 and 2 (IATT, 2012). The IATT also suggests that men have a strong influence of women's access to and utilization of PMTCT services and have recommended that country-level action with regards to PMTCT should include strategies that promote greater involvement of men in PMTCT (IATT, 2012).

2.4.2 The Barriers to Male Participation in PMTCT programmes

Despite the positive potential of male involvement in PMTCT, various reports still show low participation of men in PMTCT programmes, which potentially has a negative impact on the level of uptake of interventions in these programmes by women (Peltzer *et al.*, 2011). For example, in Sub-Saharan Africa, male partner involvement has been recorded to be as low as 12.5% to 18.7% in hospital settings (Kalembo, Yukai, Zgambo & Jun, 2012).

It has been observed from research in 3 geopolitical zones of Nigeria by Journalists Against AIDS (JAAIDS) supported by the International Treatment Preparedness Coalition (ITPC), that male support for women accessing PMTCT in Lagos state, Nigeria, is poor (Adeeyo *et al.*, 2014). Other findings of poor male participation in PMTCT programmes in Nigeria have been obtained by Adelekan, Edoni & Olaleye, (2014), whose study was aimed at determining men's level of awareness and barriers to their participation in PMTCT programmes in Osogbo, Nigeria. In their study, they found that only a few participants reported that they had ever accompanied their wife to ANC (Adelekan *et al.*, 2014).

A systemic review of the barriers and facilitators of male involvement in prevention programmes of mother-to-child transmission of HIV by Morfaw *et al.* (2013) identified the barriers to male involvement mainly as societal barriers, health system-related barriers, and individual barriers.

The societal barriers identified by Morfaw *et al.* (2013) include the perception by the society of the unacceptability of men being involved in antenatal care and PMTCT because it is purely a woman's affair that does not involve men, and it is a thing of shame for a man to be found in such settings (Morfaw *et al.*, 2013). In most parts of Nigeria, antenatal care is

viewed as women's affair, and it is rare to find men in clinics where such care is provided (NACA, 2014), and this is due to the fact that most of the men wrongfully believe that antenatal/PMTCT is a woman's affair (Adeeyo *et al.*, 2014). This perception by some men that issues about pregnancy concerns only women was also observed in the study by Nkuoh, Meyer, Tih & Nkfusai (2010) in Cameroon, and in the study by Falnes *et al.*, (2011) in northern Tanzania, where the respondents indicated that the antenatal clinic is an area for women only, where men are deemed to be out of place. This gender hierarchy is an unappreciated challenge in the PMTCT programme (Falnes *et al.*, 2011).

Furthermore, the society ridicules men who accompany their wives to the ANC, as such men are deemed as jealous, over-protective and lacking in self-confidence (Nkuoh *et al.* 2010, Morfaw *et al.*, 2013). In Nigeria, few men usually accompany their wives on visits to antenatal clinics for fear of being ridiculed by peers (they may be called “woman wrapper” by their peers) (Isichei *et al.*, 2015). Other societal factors identified by Morfaw *et al.* (2013) include the patriarchal nature of the African society where power is concentrated on the men, and women are not allowed to lead. As a result, the women are not in a position to take domestic decisions concerning antenatal care and HIV counselling and testing (Morfaw *et al.*, 2013). This becomes a major impediment to the efforts of women in involving their spouses in PMTCT. Additionally, a cultural communication pattern of "silence" by men, and "non-complaint" by the women gives an impression that all is well (Morfaw *et al.*, 2013). This cultural communication pattern impairs dialogue between the partners, and prevents male involvement in PMTCT (Morfaw *et al.*, 2013).

The health system-related barriers identified by Morfaw *et al.* (2013) include long waiting times at the antenatal clinic. Some men feel that attending the antenatal clinics with their pregnant partners is a waste of time, which could have been spent earning a living. This finding was obtained by Kululanga, Sundby, Malata, & Chirwa (2011) in Malawi and Kalembo *et al.*, (2012) working in Uganda and Malawi. This issue of time being taken away from their jobs, was also identified as a barrier to male participation by Koo, Markin & Forsyth (2013), in their cross-sectional study from one health care centre in Mamelodi township, Tshwane (Pretoria), South Africa. The male respondents in their study cited the time required for testing, counselling and obtaining results, as time taken away from their jobs (Koo, Markin & Forsyth, 2013).

Other health system-related barriers identified by Morfaw *et al.* (2013) include male unfriendliness of the PMTCT services, and lack of trust in confidentiality of the health care system. Nyondo, Chimwaza & Muula (2014) identified insufficient number of health care workers, and the unfriendly attitude of the health care workers as barriers to male involvement in PMTCT. The antagonistic attitude of the health workers at the facilities towards men has also been identified as a barrier (Byamugisha *et al.*, 2010; WHO, 2012).

The identified individual barriers Morfaw *et al.* (2013) include lack of communication within the couple, unwillingness of men to find out their HIV status as a result of fear of/shame of being HIV-positive or the fear of community stigmatization, as well as the "stubborn" nature of men. Other individual barriers include the notion by men that the HIV status of their spouse was a proxy of theirs, and the reluctance of women to involve their partners because of fear of domestic violence, and stigmatization of divorce (Morfaw *et al.*, 2013).

A lack of knowledge about MTCT has been identified by Boniphase *et al.* (2009) as a barrier to male participation in PMTCT. This issue of lack of knowledge about MTCT being a barrier has been corroborated by studies by Adelekan, Edoni & Olaleye (2014) working in Osogbo, Osun State, Nigeria, and by Nyondo, Chimwaza & Muula (2014) in Blantyre, Malawi. In the study by Adelekan *et al.* (2014), the majority of the 160 participants in the study had no knowledge about what the PMTCT programme was composed of, and assumed that giving drugs to HIV infected pregnant women was all that the programme offered. Similarly, in the study by Nyondo *et al.* (2014), they observed that some of the respondents had inadequate knowledge about PMTCT services and what roles they (the men) were supposed to play.

Furthermore, the predominance of the international focus of PMTCT programmes on women and children has appeared to preclude men (WHO, 2012). The design of these PMTCT programmes, are principally for and served to women, without significant conventional or unconventional means of involving the men (Auvinen, Suominen, & Valimaki, 2010).

2.4.3 Factors that Facilitate Male Participation in PMTCT programmes

Given the identified benefits of having male partners more involved in PMTCT it is important to reach out to, motivate and support men to participate in PMTCT programmes.

The actions that facilitate men's involvement in PMTCT are related to the health system or the individual. These include the invitations given to the men for HTC, as well as offering the

PMTCT services to them at sites other than the antenatal clinics. Issuing invitation letters through the pregnant spouse (Auvinen, Kylma, Valimaki, Bweupe & Suominen, 2014), development of messages specially designed for men, male-specific health education sessions and creating areas within facilities that are male-friendly (Ditekemena *et al.*, 2012) having been employed as measures to improve male participation in PMTCT. Utilizing sites other than the antenatal clinics, such as bars, churches and job sites, for HTC services has resulted in increased male participation in PMTCT (Morfaw *et al.*, 2013).

Extending the couple HTC services to weekends has also been shown to improve male involvement in PMTCT (Morfaw *et al.*, 2013).

Other facilitating factors for male involvement in PMTCT include prior knowledge of their HIV status, prior male HIV testing, as well as the financial dependence of women (Morfaw *et al.*, 2013). In Nigeria, some of the ways of improving male involvement in PMTCT that have been employed include encouraging women to attend ANC with their male partners very early on in their pregnancy, promoting couple HIV counselling and testing, encouraging the sharing of results by couples or partners, and discussing infant feeding choices with partners and spouses (Federal Ministry of Health of Nigeria, 2010).

Incentives such as moving up the waiting line at antenatal clinics, for women who are accompanied by their male partners, have been successful in encouraging and increasing male participation in PMTCT programmes (NACA, 2014). This has resulted in a good outcome in Benue state, Nigeria (NACA, 2014). In Benue State, Nigeria, the PMTCT Site Coordinators – in an attempt to increase male participation in PMTCT clinics – established a rule that women who came to the Family Support Clinic (FSC) (a PMTCT site) for antenatal care and were accompanied by their husbands, would be moved up in line and attended to earlier. This serves as an incentive for women to bring their men to the clinic. It also gives the clinicians an opportunity for couples counselling and testing. Thus far, the outcome has been encouraging, with men involved in the programme being cooperative, and all children born in the clinic under the programme have been HIV negative (NACA, 2014).

There are programmatic plans at the level of NACA, to engage men at the community level in men-only dialogues. This will serve to address norms affecting effective involvement of men in ANC/PMTCT (NACA, 2014).

Additional measures include advocacy among policy-makers and health providers to pay more attention to the sexual and reproductive health (SRH) and HIV needs of men, and also addressing socio-cultural factors and financial barriers to male participation in PMTCT (IATT, 2012).

Betancourt, Abrams, McBain & Smith Fawzi (2010) have indicated that family-centred prevention measures can be effectively integrated within programmes. This family-centred approach to HIV prevention is a useful direction for the prevention of paediatric HIV infections while improving the overall health of the family (Betancourt *et al.*, 2010). One of the lessons learnt from this approach is that father involvement is a crucial component in helping to improve family health outcomes (Betancourt *et al.*, 2010).

2.5 Summary of the literature

The international HIV/AIDS response has had PMTCT as an urgently important issue, with Declaration of Commitment on HIV/AIDS, and numerous other high-level statements by multilateral organizations. The literature shows that most of the HIV infections and HIV/AIDS-deaths are in sub-Saharan Africa. In Nigeria, there are about 60,000 children newly infected with HIV every year, and this is the highest of the annual new cases globally. However, estimates in 2014 show that the coverage for PMTCT in Nigeria still remains low (30.1%). Male participation is a key strategy within PMTCT programmes, and has been recognized in international PMTCT policy to improve the overall health of women, children and the family in general. In the Nigeria National PMTCT Guidelines, the roles of the male partner are highlighted as vital. Despite the positive potential of male involvement in PMTCT, various reports still show low participation of men in PMTCT programmes, which potentially has a negative impact on the level of uptake of interventions in these programmes by women. The barriers of male involvement in prevention programmes of mother-to-child transmission of HIV have been identified mainly as societal barriers, health system-related barriers, and individual barriers, while the actions that facilitate men's involvement in PMTCT are related to the health system or the individual.

However, with all the available literature, there appears to be a gap in information on male participation in PMTCT in West Itam, Akwa Ibom State, Nigeria. It is therefore important to identify and describe the experiences of male partners of PMTCT clients and male community members, so that strategies can be put in place to encourage the men to be more

involved in the PMTCT programme at the health facility, and help improve the overall health of their families and themselves.



Chapter 3: METHODOLOGY

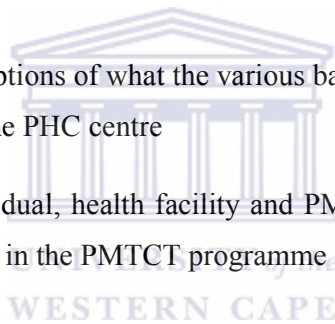
This chapter describes the methodological approaches to the study and describes the research design and strategies in detail.

3.1 The Aim and Objectives of the Study

The overall aim of this study was to explore the factors affecting male participation in the PMTCT programme at a primary health care (PHC) centre in West Itam, Akwa Ibom State, Nigeria.

The objectives of the study were:

1. to describe the experiences, perceptions and opinions of male partners of HIV-positive pregnant women who have (or are) participating in the PMTCT program at a primary health centre in West Itam
2. to explore local men's perceptions of what the various barriers are to male participation in the PMTCT programme at the PHC centre
3. to identify contextual, individual, health facility and PMTCT programme-related factors that affect male participation in the PMTCT programme at the PHC centre.



3.2 The Study Design

This explorative study was conducted using a descriptive qualitative research approach. Qualitative research aims at elucidating lived experiences and the questions of “why”, “what”, and “how” (Green & Thorogood, 2004). This approach helps to understand the perspectives of actual and prospective male partners of HIV-positive pregnant women who participate in the PMTCT intervention, as well as key informants in the PHC facility where these PMTCT services are offered. This provides insight into the extent of male participation because the information is derived from the lived experience of the respondents (Cooper & Endacott, 2007). Using a qualitative approach also helps capture the respondents' expressed views and opinions, and enables the researcher to ask open-ended questions to the respondents so as to get rich information within their own context (Carter & Little, 2007).

3.3 The Study Population

The study population consisted of all males living within the catchment area of the West Itam PHC, and staff working at this public health facility. West Itam is in Itu Local Government Area (LGA) of Akwa Ibom State, Nigeria. Itu LGA has a population of approximately 127,856 with 65,410 males, and 62,446 females (Nigeria National Population Commission, 2006). The population are mostly Ibibio speaking groups, with pockets of Efik and Ijaws, and they predominantly farm, fish and trade (Edet *et al.*, 2014; Akwa Ibom State Government Online, 2016). In terms of the staff working at the West Itam PHC, at the time of the study, the facility had a total of 14 staff members, with five staff members working on the PMTCT programme (these five were the population for the staff component of the study sample).

3.4 Study Sample and Sampling Procedures

In the study, 11 men were purposively sampled: five of whom were the partners of HIV-positive women who had, or are still, attending the PMTCT programme at the West Itam PHC and had accompanied their partner to this facility. To be eligible as a study participant the men had to have accompanied their HIV-positive, pregnant partner on *at least* one occasion to receive her PMTCT services at the facility.

The other six males making up the sample were local community members, of a similar age and living in the same geographical location to the first five respondents. They were all men who could, theoretically, have been in the same position as the others (i.e. having an HIV-positive, pregnant partner who was attending PMTCT services at the local facility) and thus, ideally, would also have been encouraged and eligible to accompany their female partner to PMTCT services at the facility.

The six male respondents from the community (i.e. potentially eligible to accompany their partner to the local facility for PMTCT services) were recruited within the community through the representative of a local community-based organization (CBO). This CBO focuses on providing information and training on the health care and support for people living with HIV/AIDS. The Project Director of this local CBO is very familiar with the West Itam community having lived and worked there for many years. She identified potential respondents and contacted them by phone to inform them about the research project and the researcher. Then, and with their consent, sent their phone numbers to the researcher. The

researcher then contacted them by phone, and if they were still in agreement, set up a meeting at a mutually agreed time and place.

In constituting the sample of men that were currently or had previously accompanied their HIV-positive partners to the PMTCT programme at the West Itam PHC, the researcher sought the guidance of the Matron-In-Charge of the West Itam PHC who provided him with the antenatal register of antenatal attendees who were receiving PMTCT services. She reviewed the register with the researcher, and then helped to identify the women whose male partners had come forward for HIV testing and who had participated in the PMTCT programme, i.e. these were women who had disclosed their HIV status to their male partners. The Matron-In-Charge then called those she had identified from the register and contacted them by phone, described the purpose for her call and explained the study to them. With their consent, she then provided the researcher with their phone numbers, and he in turn contacted them to set up a suitable time and date and venue for an interview.

Both sets of respondents were thus sampled using the purposive sampling technique, which may be defined as selecting individuals, or groups of individuals based on specific purposes associated with answering the questions of a research study (Teddlie & Fu, 2007). It is used primarily used in qualitative studies, with typically small sample sizes, and the focus is on the depth of information generated by the cases, with the sample being selected before the study begins, during the study, or both (Teddlie & Fu, 2007).

Purposive sampling method was therefore used to search out cases that could shed some light on the phenomenon of male participation in the PMTCT programme at the West Itam PHC.

Prior to interviewing the male partners and community members, a focus group discussion (FDG) was arranged with key personnel working in the West Itam PHC. It was thought that doing a FGD with members of staff working at the PHC West Itam would prepare the researcher for the individual interviews with the male partners of actual and prospective clients of the PMTCT programme.

In preparation for the focus group discussion and the recruitment of male partners, the researcher met with the Matron-In-Charge of the Antenatal Clinic (ANC) of the PHC West Itam, and shared with her the purpose and nature of the study – and the motivation for

holding a FGD with clinic staff. She was asked to introduce the study to all of the facility staff in a staff meeting and identify the staff that were willing to take part in the FGD.

Those who eventually participated in the FGD were the Matron-In-Charge of the ANC unit, a female nurse that works in the ANC unit, and a female Community Health Officer. There were 5 staff members specifically working on the PMTCT programme at the time of the study, but only three participated in the FGD. This small number of participants at the FGD was as a result of doctor's strike at the time, and so the doctor who comes for consultations at the PHC West Itam was not available at the time. In addition, there was also lack of interest expressed by some of the health care workers at the facility to participate in the FGD.

3.5 The Data Collection Instruments and Procedures

3.5.1 The Focus Group Discussion with Health Workers

Focus Group Discussions (FGDs) are discussions facilitated by a moderator (the researcher) and a group of respondents, usually about six to ten in number, who are fairly homogenous with similar socio-cultural backgrounds and experiences or concerns (Duggleby, 2005). Focus Group Discussion is also a very efficient tool with regards to its timesaving feature (Byers & Wilcox, 1991). Additionally, other benefits of the FGDs are that they are useful when there is little prior knowledge of the particular problem, the fact that FGDs can generate a very wide range of responses (Byers & Wilcox, 1991) and that the interaction between respondents in a FGD can generate new thinking about a concept of interest.

Prior to interviewing the male partners and community members, the focus group discussion with personnel working in the West Itam PHC was facilitated using a semi-structured interview guide (see Appendix A). The FGD took place in the office of the Matron-In-Charge, and lasted for about 1 hour and 50 minutes. At the start of the FGD the purpose of the study was introduced to the participants by the researcher (see Appendix B), who also outlined what could be expected during the course of the interview and the fact that he would like to record the proceedings. The participants were provided with information about the process of informed consent, and each one voluntarily consented to participate in the FGD (see Appendix C) and to have it recorded.

Light refreshments were provided at the end of the interview where the participants asked the researcher a number of questions, namely, whether there was external funding for the research, and whether they (the participants in the FGD) had any specific roles in the research study (they assumed that it was a new programme that was being introduced to the facility). The researcher responded to their questions, and the participants also stated that it was their hope that the outcome of the research study will assist to improve male participation in the PMTCT programme at West Itam PHC.

The FGD was beneficial to the researcher as it provided valuable insight into the extent of male participation in the PMTCT programme in the facility, the factors affecting the men's involvement, and ways to improve upon it.

3.5.2 In-Depth Interviews with Male Partners and Community Members

The data with the male respondents was collected through individual, in-depth interviews with both the male partners of the facility's PMTCT clients, and local community members using a semi-structured interview guide (see Appendixes D & E). In-depth interviews seek to explore the concepts of interest in great depth. They afford the researcher the opportunity to intensively and individually interview the respondents so as to find out their perspectives on a particular subject matter (Boyce & Neale, 2006). They are particularly useful in obtaining very detailed information about an individual's thoughts and behaviours (Boyce & Neale, 2006). They are also valuable in circumstances when people are not comfortable discussing issues in the presence of others, and also when a researcher needs to obtain individual opinions instead of group opinion (Boyce & Neale, 2006).

The interviews with male partners of the PMTCT clients were held at mutually agreed venues, dates and times. With the exception of one interview (that was held at a quiet parking lot on a Sunday evening - as requested by the respondent who said his home will not grant him privacy), all the other four interviews took place at the homes of the respondents.

As with the FGD, the purpose of the study was introduced to the study participants using the information sheet (Appendix B), and the process of the interview was shared – including the possibility of it being audio-recorded. The participants were given information about the process of voluntarily consenting to be interviewed (Appendix F) and once they had signed the consent form, the interview began. Light refreshment was provided at the end of each

interview, with provision made for other members of the family. The interviews took place in a quiet and private room at their homes, with just the researcher and the male partner alone. All the five respondents politely declined a small financial token for their time.

The interviews and the FGD were conducted in English as respondents all felt comfortable speaking English. All interviews and FGDs were tape-recorded and later transcribed.

Though the researcher wanted to interview more partners and community members – and identified a few more men to do individual interviews –he struggled to get hold of them/get them to commit.

Following the interviews with the five partners and six community members theoretical saturation occurred – i.e. no new information emerged from the interviews. Theoretical saturation is defined as a situation where:

"the researcher asserted that he had saturation 'grounded in the empirical confidence attained from repeatedly comparing data to additional data'"
(Cutcliffe &McKenna 2002:614 as cited by Tuckett, 2004:8).

3.6 Data Analysis

Thematic analysis was used to analyse the data. Thematic analysis is an approach in qualitative analysis that relies on the identification and reporting of patterns (themes) in the data (Braun & Clarke, 2006). It is typically a comparative process whereby the various respondents' accounts are compared with each other to classify commonly recurring 'themes' (Green & Thorogood, 2004). The analysis process involves assigning codes to each sentence to denote the meaning unit. After that the codes were grouped together and named them to form themes, using the "scissors-and-paste method". In this method, coded extracts (themes) were collected under the same headings (Green & Thorogood, 2004). As the extracts were collected under each heading, they were compared with each other, and more themes started emerging. This process was repeated for all the transcripts. It helped to identify patterns that were emerging under each theme, and to help compare, contrast and build up categories and meanings.

3.7 Rigour

Rigour was achieved in the proposed research study by utilizing three criteria for rigour. These were:

- Auditability, which refers to the documentation, or paper trail, of the researcher's thinking, decisions, and methods related to the study (Jeanfreau & Jack, 2010). A detailed account of all the steps and processes involved in conceptualizing and implementing this research study has been described in this chapter. For example, the purpose of the study, data collection processes, the settings, the data analysis method and the categories used to contain the data (Sandelowski, 1986) have been elaborated on here and elsewhere in this document.
- Member checking, which assisted in achieving trustworthiness, another aspect of rigour (Creswell & Miller, 2000). At a later date after the interviews were conducted, and the transcription done, the researcher contacted all the respondents, and met with them individually. He then read back the transcripts to them, and as part of conversation with the researcher they confirmed that this is what they had said previously during the interview. This helped ensure the accuracy of the data, i.e. that the transcripts (or the data obtained) was indeed an accurate recording of what the respondents had discussed with the researcher.
- Finally, the data obtained during the study were reviewed by a local colleague who is a researcher and is conversant with the concept of male participation in PMTCT. He is a Consultant Community Physician, and he reviewed all the transcripts, and helped add new insights into some of the emerging themes that had been drawn together by the researcher from the in-depth interviews. He also discussed the preliminary analysis with the researcher. This peer review mechanism also helped ensure trustworthiness (Creswell & Miller, 2000).

3.8 Ethical Considerations

The ethical considerations are paramount in this qualitative research study and the researcher ensured that he observed a sense of responsibility and respect for the dignity of the respondents (Artz, nd). Ethical approval was first obtained from the UWC Research Ethics Committee (10 April 2014) before proceeding with the study (see Appendix G).

Approval to conduct the study was then obtained from the Ethics Committee of the Akwa Ibom State Ministry of Health (see Appendix H). Participation in the study was voluntary for all the respondents and key informants. They were all provided with an information sheet (Appendix A) stating the details of the research study, requesting their voluntary participation and assuring them of confidentiality. Their informed consent was sought – one for the FGD and one for the interviews (Appendix C and F) – and those willing to participate in the research signed the relevant informed consent form. No names appeared in any of the transcripts or the reports of the study.

There was no expected harm in this study given its nature. However, a professional counsellor at the PHC West Itam was on hand in case any of the study participants required emotional support or counselling as a result of the study activities. If such a situation were to have arisen, the researcher would have referred and/or accompanied the respondent to meet with the counsellor.



Chapter 4:

RESULTS

This chapter presents the results from the discussion with three health care workers at the West Itam PHC, as well as the in-depth interviews with 11 men who were purposively sampled. The results describe the experiences, perceptions and opinions of the respondents concerning male participation in PMTCT. The results reveal the local men's perceptions of what the various barriers are to male participation in the PMTCT programme at the PHC centre. They also reveal the contextual, individual, health facility- and PMTCT programme-related factors that affect male participation in the PMTCT programme at the PHC centre. The chapter concludes with a description of the respondents' recommendations for ways to improve male participation in PMTCT.

4.1 Description of the respondents

The background information of the three health workers who participated in the group discussion and the 11 male respondents is illustrated in the two tables below:

	Age	Sex
Health Worker	55 years	F
Health Worker	49 years	F
Health Worker	46 years	F

In order to protect their anonymity, the three health workers who took part in this study have not been numbered in the above table as is the case in the remainder of this and subsequent chapters (e.g. Health Worker no 1, Health Worker no 2).

Table 2: The 11 male respondents who participated in individual interviews					
Male partners of PMTCT clients					
	Age	Marital Status	Number of children	Level of Education	Occupation
Partner 1	39 years	Married	2	Secondary	Farmer
Partner 2	37 years	Married	4	Primary	Farmer
Partner 3	42 years	Married	1	Secondary	Trader (food stuff)
Partner 4	34 years	Married	1	Ordinary National Diploma (OND)	Primary School Teacher
Partner 5	32 years	Married	3	Secondary	Trader (food stuff)
Local community members					
	Age	Marital Status	Number of children	Level of Education	Occupation
Community Member 1	43 years	Married	3	Secondary	Farmer
Community Member 2	38 years	Married	2	Secondary	Farmer
Community Member 3	44 years	Married	2	Primary	Fisherman
Community Member 4	32 years	Married	2	Ordinary National Diploma (OND)	Civil Servant
Community Member 5	33 years	Married	2	Secondary	Trader (food stuff)
Community Member 6	36 years	Married	2	Secondary	Trader (motorcycle spare parts)

4.2 The opinions, perceptions and experiences of the health workers

4.2.1 Opening talking points

In order to establish the context, the health workers were asked what proportion of men attends antenatal care with their pregnant partners. They shared the following impressions:

When we talk about the involvement, some of them will just do the escort and leave immediately. Only on very few occasions would we see a man. I think only once that I saw a man inside, and I rewarded him. So I will say it is less than 0.5 %.

(Health Worker no.1)

It will be more than that 0.5%... it should be around 2%.

(Health Worker no.2)

Yes, just 9 to 10 men, out of 900 women, just to escort the women (into the facility).

(Health Worker no.3)

The health workers were also asked why it is useful to involve men in PMTCT and they suggested the following:

It is important to involve men because when they are involved, it will be easy to treat both the man and the woman, then it will bring about reduction in this percentage of HIV in our state and country at large.

(Health Worker no.2)

If the men are involved, the man will know the extent of protection to himself, the wife, to the children...there is no man that will not want to raise a family. If they know, they will be able to bring up these other ones, the children, to be void of HIV. Yes, because if I am a man, and that is my wife, and we know that we are reactive parents, we will know when to meet, how to meet, how to reduce the load in us to be able to cater for this other group coming. But where the man and the woman are working separately, it is a problem.

(Health Worker no.3)

The health workers were requested to mention the ultimate goal they are trying to reach at their facility in terms of male involvement in PMTCT. They shared the visions as follows:

Increased access to testing and drugs uptake, increased adherence...

(Health Worker no.1)

Yes, because there is going to be enlightenment, and there is going to be increased acceptance, and increased disclosure, and increased acceptance of each other, even when there is a discordant result, there is going to be increased awareness and acceptance of the results because they are going to be educated or counselled at the same level. And so, the man will be aware that this thing is not bought, it is not a stolen something, and from there they can also look after themselves, and so there is going to be improved health. And (a) reduction in child (HIV) transmission.

(Health Worker no.1)

Can we also add increased uptake in terms of delivery... hospital delivery.

(Health Worker no.3)

When the health workers were asked whether they thought that men are doing enough to assist their HIV-positive female partners in accessing PMTCT services, they all said 'No!' in unison.

4.2.2 Possible reasons for poor involvement of men in PMTCT

The health workers provided a number of possible reasons for the poor involvement of men in PMTCT which included: general cultural norms around gender, specific dynamics around control (for example, the access a woman will get /not get to money for the purposes of a visiting a health facility), and practical issues and constraints around service delivery, such as the non-accommodating attitude of some nurses, the lack of male health workers, the low levels of staffing and the perceived time constraints of men.

With regards to the general cultural norms around gender, it was mentioned by the health workers that there is a perception that ANC/PMTCT is a woman's affair:

Me I want to start it this way...in our society, men were not coming for antenatal initially with their wives, it is purely a women affair to go to antenatal. So awareness has to be created.

(Health Worker no.3)

The cultural disapproval of a man "carrying the wife's handbag" was also stated by the health workers in the FGD as a factor affecting male involvement in PMTCT:

I think the culture is just the same as looking down on a man that carries his wife's handbag and follows the wife. They look at him as a mediocre, that he is being controlled by the wife.

(Health Worker no.1)

The health workers mentioned that there is a perception that a man that accompanies his female partner for ANC/PMTCT is under her control:

Some will even feel that the society they will look at them as those their wives are putting them in their pockets. So they will look at them as mediocre.

(Health Worker no.2)

Specific dynamics around control (such as women's access to money for these purposes) were also identified by the health workers as reasons affecting male participation in PMTCT. They suggested that there is a perception that a man that accompanies his female partner for ANC/PMTCT is perceived to be 'lazy' or 'tight-fisted', and that he wants to scrutinize the way the woman spends money:

I think the society will also look at it and say that when you follow your woman to the health centre and maybe stay there until you come back together, people that look at you will think you are lazy...instead of going to find money you are (just) following a woman about.

(Health Worker no.1)

That you want to know every Kobo [Nigerian coin] the woman spent.

(Health Worker no.1)

You can comment....you tight fist too much, is it why you are following her around so that you won't let her spend money, so that you will be checking money.

(Health Worker no.1)

The health workers also stated that the ANC visits were opportunities for the women to collect money from their male partners, and so they (the women) might also discourage the men from coming along so they will not find out *how* they spent the money:

Another thing is that the women themselves don't want the husbands to come because what they collect from their husbands, they will collect enough to take care of their feeding, (the) baby's clothing and the ... this thing... (the) medications, so there are some cases they don't want him to come.

(Health Worker no.2)

Yeah, they say that's the only time they can get money from the husband!

(Health Worker no.2)

Other reasons given by the health workers for poor male participation in PMTCT include: a lack of awareness, and fear (on the part of the woman) of losing her marriage:

When you don't even know what is wrong, you cannot do anything about it. Assuming I'm the wife, and I have been tested positive, as I went back, I will not tell my husband, how can he help me... and I will be afraid because he will send me packing, at the knowledge that I am reactive (HIV positive).

(Health Worker no.3)

4.2.3 Identifying health facility-related, PMTCT programme factors and community factors affecting male involvement in PMTCT

Practical issues and constraints around service delivery – such as the non-accommodating attitude of some nurses, the lack of male health workers, staffing levels and perceived

time constraints on men – were also identified by the health workers as factors that hinder men from participating in PMTCT.

The non-accommodating attitude of some nurses towards the male partners of HIV-positive pregnant women was highlighted as a particular challenge by the health workers in their discussion:

So... such things will also be a challenge because the man will think that if I go there the nurses will use a sharp mouth to finish me.

(Health Worker no.1)

They also identified that the fact that there were no male workers at the health facility as a significant factor affecting male involvement in PMTCT:

You know... we are mostly females in the profession... health workers in facilities like this. A man will come and look for the doctor, anybody that wears trousers automatically becomes a doctor! That is what the men will come and look for.... Even a female doctor at this table is a nurse... even when you have to tell the man that she is a medical doctor, he'll say no I'm seeing a nurse. But bring a health worker, even a junior CHEW in trousers and the man will feel very free to be attended to.

(Health Worker no.3)

Inadequate number of staff at the health facility was also identified by the health workers as a factor affecting male involvement in PMTCT – given it leads to the staff members being often over-worked, and losing focus on their responsibilities. The idea being that the quality of care might then be perceived in a negative light and further discourage men from attending:

We have less hands to work here, and at times somebody can work to the extent that she becomes confused and doesn't know what to do again, and people are expecting you to work like (a) jackal.

(Health Worker no.2)

Lack of time was another reason given by the health care workers for the poor involvement of men in PMTCT:

Another thing is that... this is a civil servants' state, business and civil service. So, I do not think that there is a man that will want to leave his job or business to come and stay (at the facility with is partner).

(Health Worker no.2)

4.3 The opinions, perceptions and experiences of the partners of PMTCT clients and male community members

4.3.1 Knowledge about HIV/AIDS

The respondents' narratives demonstrate that they do not know how to expand the acronyms, with only 2 respondents (partner no. 4, and community member no. 2) able to correctly state the meanings of both HIV and AIDS. Some knew what HIV stands for, but did not know what AIDS stands for, and vice versa:

AIDS is just, I don't even I don't know the meaning of AID fully but that 'I' stand for immune, then the A though I don't know either say... density or whatever, so I don't even remember the meaning of AID again, but in school time, we taught all those things. They give us handout for AID and HIV. So the thing is far I don't remember again.

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(Community member no.4: a young civil servant)

Whilst not being familiar with the actual acronym, most of the respondents had a good knowledge of the main modes of transmission of HIV. However, somewhat surprisingly, a significant theme emerging from the interviews was that many of the respondents mentioned getting a haircut at a saloon (hairdresser) as a potential risk or route of HIV transmission. So whilst the respondents mentioned that coming into direct contact with blood, semen and vaginal fluids was, correctly, a potential route of HIV transmission, it appeared that they were incorrectly extrapolating their understanding of the exchange of HIV infected blood (via sharing needles or from a blood transfusion) to being equivalent to sharing hair or nail cutting instruments like barbers clippers or nail clippers. For example:

The mode of transmission principally is... through sexual intercourse, if the infected person has sexual contact with the person that does not have (HIV)... Then... blood transfusion, when you transfuse blood, infected blood there is

likelihood or you use needles, used needle or blade, even barber's shop, the clipper if not sterilised, there is tendency that one may likely acquire HIV, the virus. Those are the principal modes of contracting HIV/AIDS.

(Partner no.1: a young farmer)

There is... those in the saloon it can be transmitted through that, either (from the barber to (someone going to the) barber.

(Partner no.3: a middle-aged trader)

Unprotected sex, (and) it could be through using sharp objects, for barbing, barbing saloon this and that or cutting of nails, it could be through kissing this and that, it could be through blood transfusion...

(Community member no.1: a middle-aged farmer)

A number of the respondents noted that a mother can transmit the HIV to her child in her womb, during labour and by breastfeeding. Overall, the responses highlighted that they were generally well informed on how a mother can transmit the HIV to her child:

She can give it to her child in the womb or by breastfeeding.

(Partner no.4: a young primary school teacher)

Well maybe during childbirth... well from the little much that I know, they say it could be, it could be through breastfeeding.

(Community member no.2: a young farmer)

... when one or they cut those things that coming out from the womb, those... placenta, when they cut the placenta from the mother, during that time, the child may be infected during parturition. Secondly through breastfeeding.

(Community member no.4: a young civil servant)

When asked about how the risks of transmission of HIV from mother to the child can be eliminated, one respondent (Community member no. 2) had some fairly detailed knowledge:

Yes, maybe not allowing the mother to go through child delivery, that is (by rather having (a) caesarean section and (by her) being conscious (about) taking drugs, drugs as prescribed so that the mother can breastfeed the child if necessary.

(Community member no.2: a young farmer)

The other respondent's responses suggested that they were familiar with some – but not all of the PMTCT interventions:

Education, that's number one... number two, ... we encourage women to attend (the) health centre, not traditional attendants. (A) good government health centre that has facilities ok and all that.

(Partner no.1: a young farmer)

You go (to) hospital...

(Partner no.2: a young farmer)

Community member number 4 appears to know that mixed feeding is harmful to the baby, but did not mention any other strategy:

If you breastfeed your child with, along the line you give water, you (meaning the child) will be affected, so is essentially you breastfeed your child for 6 months without water, that is how I use to do my own.

(Community member no.4: a young civil servant)

When asked about the meaning of PMTCT, three of the eleven respondents knew what the acronym "PMTCT" stood for and a further four had heard of it before. The rest (four) had never heard of the term before:

It means prevention of mother-to-child transmission.

(Partner no.4: a young primary school teacher)

Ok, the term, it means prevention of mother-to-child transmission.

(Community member no.1: a middle-aged farmer)

... I heard it but I don't know the meaning... I heard it... pertaining to woman, under pregnancy.

(Partner no.5: a young trader)

4.3.2 Knowledge about and involvement in the local ANC & PMTCT services

When asked, 5 of the 6 community members knew about the existence of PMTCT services at the PHC West Itam:

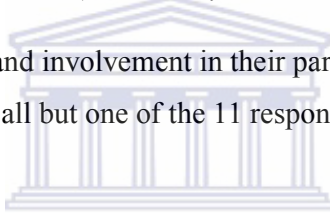
Yes they have a programme there.

(Community member no.1: a middle-aged farmer)

During pregnancy they do it now...it's compulsory they are doing now already.

(Community member no.4: a young civil servant)

In terms of their knowledge and involvement in their partner's visits to the facility for their antenatal consultations, all but one of the 11 respondents knew their partner's next antenatal appointment:



... any time that she come back from hospital, she will tell me, then I will keep that day in my head, when that day reach I will remind her.

(Community member no.4: a young civil servant)

I do ask her... what date is your own appointment day. She will show me and I will just time it, tomorrow is your appointment day, get ready to go.

(Partner no.5: a young trader)

When asked whether they accompanied their partner to her antenatal appointments, only one respondent (Partner no. 2) said that he went every time. The other respondents seem to accompany their partners on an ad-hoc basis and mostly, it appears, just to drop them off at the facility:

Yes, sometimes I go, sometimes if I am engaged with other things, sometimes I drop her, (and say) please take care, let me go back to what I have been doing.

(Partner no.5: a young trader)

It depends... sometimes... if I am free, I will go and drop her there... but if I am busy I will just give her the money for transport.

(Community member no.3: a middle-aged fisherman)

Apart from accompanying their wives to the facility so that they can make their antenatal appointments, the partners suggested they also provide other types of support to their wives as they participate in the antenatal programme. For example, they provide financial support for transport or food/snacks (at the clinic) as well as providing advice on their general healthcare:

(I) help (by providing) transport money... I can even convey her down there myself.

(Partner no.3: a middle-aged trader)

(I provide) advice - by advising her... advising her that she should take care of the child even if in my absence, she should not give her water and if it has, if she has any bleeding, she should not go close to the child, she should make sure that she cleans everything, all the apparatus that we use for the child during bed, it should be clean before, even the feeding time, everything should be clean so that the child will not be infected.

(Community member no.4: a young civil servant)

(In his 'advice', community member no.4 further suggests that if a HIV-infected mother is bleeding (from any body part), she should take precautions concerning the bleeding, and minimise contact with the child).

In exploring with the respondents whether they discuss the details of their partner's visit to the facility and the antenatal treatment they receive, all but one of the respondents (Community member no. 1) affirmed that they do discuss these matters with their partner. Discussion seems to relate to tests conducted, the test results, the medications that are prescribed by the attending health workers, any improvements in the partner's clinical condition, as well as preparations towards delivery and infant feeding options:

That is one of the problems... I think I made a mistake.... I never did that, am very wrong.

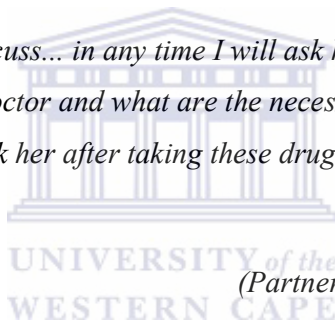
(Community member no.1: a middle-aged farmer)

(Community member no. 1 had lost his first wife to an AIDS-related illness. He did not usually discuss the details of her visits to the facility with her, nor the antenatal treatment she received at the time. He is quite distraught and remorseful that he was not involved in her antenatal visits. He is now re-married).

Yes... well ... I discuss with her, I ask her questions about what went on at the clinic, she will tell me. If there is any test, she will tell me. If there is any results, she will give it to me, sometimes I will go myself and see the results.

(Partner no.1: a young farmer)

Yes, we normally discuss... in any time I will ask her, whether she took the drugs given to her by the doctor and what are the necessary treatment that she took and then the others... I ask her after taking these drugs, is there any improvement or not.



(Partner no.3: a middle-aged trader)

I do discuss with her... did they give you injection? She say no, did they give sometimes I ask she say yes, did they give you tablets? She say yes, what type of tablet? She will show me. I say have you taken it? She say yes, what of this one? She said... they said she will not take that one.

(Partner no.5: a young trader)

Yes. She should take her drugs... during delivery, she should not make, even (if I) am not at home, if it happens, she should find somebody that will take her to the nearest facility... well we talk about feeding options... yes.

(Partner no.4: a young primary school teacher)

The respondents had different impressions of what the health workers do at the antenatal visits and what the purpose of the antenatal visits are. The activities that the men understood to be undertaken at these visits ranged from retrieving the women's antenatal

cards, to conducting a physical examination, tests or investigations, prescribing and administering medications, giving advice to praying with the women and supporting some income-generating activities:

Well, by my experience, what they do is they do test them (HIV test) for at least the first timers. They have, they do cards, in fact they do devotion and ... I see them, I think they pray and they will sing and all that to encourage the women and like... the meeting of these PMTCT (participants)... they share experiences... yes and in fact I was marvelled because I just happened to attend one of their meetings, they were sharing their experiences. Some of them shared how they told their husbands, some didn't express fear why they are not telling their husbands and all that. And these nurses, they were wonderful, telling them all the things. But the PHC here, I know they have even a farm they gave to them to plant something to support themselves, so I see them do all that. I see the women, some of them go there and plant... what do you call it, waterleaf.

(Partner no.1: a young farmer)

Yes, the nurses they play the important role, many a times they will sit them down and advise them on what to do, they give them drugs, even when the husband comes, they will tell the husband to take care of the wife. Don't run away from her because of one thing or the other. So they are very... in fact they did a lot of job (activities) here.

(Partner no.3: a middle-aged trader)

They educate them... check their weight... their BPs... and they conduct some tests.

(Partner no.4: a young primary school teacher)

The respondents viewed the purpose of the antenatal visits in different lights. Overall, they appear to have a good idea of what happens at the visits. Some know quite a bit of detail, whilst others know very little.

In terms of the respondent's understanding of the purpose of the antenatal visits, a significant theme emerging from the interviews was that most of the respondents stated that the main purpose was to provide for the well-being of the mother and her unborn child, and to ensure a safe delivery:

(The purpose of these visits) over all?... number one, (it) is the women to take care of themselves. Number two, the women to take care of their children when (they are) born. Number three, they tell them how to relate even at home (with) your husband, your neighbour, even other children. Those are the things that really were the purpose and they will check the position of the baby and all that, but they take their blood sugar and all that. These women that are infected, they will run routine check, say go for your CD4 and go for this one. I think that is the purpose and to find out whether their drugs is finished and give them (more).

(Partner no.1: a young farmer)

To make sure the baby and the child, the baby and the mother is ok, you know fit, so that the mother most especially was to be well ok taken care of before the delivery date.

(Community member no.2: a young farmer)

I think the purpose of the antenatal visits is to keep the mother and baby in good health, and to see to it that the delivery is smooth.

(Community member no.6: a young trader)

The prevention of the transmission of HIV from the mother to child also emerged as one of the other purposes of the antenatal visits:

The main reason is to prevent the disease not to transmit to the child.

(Partner no.3: a middle-aged trader)

... and even the foetus, the babies they carry in their stomach, how they can, see how they can prevent them from passing one disease to the foetus that they are carrying, and to keep them healthy.

(Community member no.1: a middle-aged farmer)

I think to reduce all these PMTCT child deaths.

(Community member no.5: a young trader)

4.3.3 *Opinions about male involvement in ANC & PMTCT services*

The opinions of all of the male partners and community members was sought on the particular issue of male involvement in ANC & PMTCT. The first of these issues was whether a pregnant woman should obtain her male partner's permission before getting herself tested for HIV. Most of the respondents (seven of the eleven) stated that a pregnant woman should obtain her male partner's permission before getting an HIV test, frequently citing the role of the male as the head of the house as the rationale behind this view:

She should take permission from the husband because... the husband is the head of the house.

(Partner no.3: a middle-aged trader)

Yes, she should (ask her husband). If she goes on her own and he finds out, he will be very angry. So she ask him first before going for the test... yes, she should.

(Community member no.6: a young trader)

The other three respondents (Partner no. 4 and Community member nos. 1, 4 & 5) felt differently, saying that it was not necessary for a pregnant woman to obtain her male partner's permission before going for an HIV test. One of these respondents (Community member no. 1) even suggested that she should secretly do the test. A critical issue here is the extent to which the respondents recognized (or not) the right of women to control their own health. Another of these respondents (Community member no. 4) highlighted the importance of this right and noted that his position was not universally accepted in this society:

Well, to me I think ... a woman should not wait until she obtains permission from a man. In fact I would even advise a woman to go secretly first, secretly because there are some men, that they must have gone on the test and they are aware that they are not, they are not positive, so (if... it is discovered that you are infected, that may even spell doom for the marriage, you may have delinquency, you may even break up. So to me I want advise every woman, you can go on your own if you have your ways, go on your own secretly, go and ascertain your own status secretly.

(Community member no.1: a middle-aged farmer)

If your husband say (wait) until his approval, it means that, the husband did not love her wife.

(Community member no.4: a young civil servant)

No she can do it when visiting hospital or when she is advised to undergo HIV test.

(Community member no.5: a young trader)

With regards to whether a pregnant woman should disclose her HIV test result to the male partner, all the respondents affirmed that she should, with one of the community members suggesting that this be done with some careful consideration about how this be done in a way that would not 'break' the marriage:

It's good to tell the husband, yes she should tell the husband about it.

(Partner no.1: a young farmer)

Ok it's good to tell but... she (should) will tell him indirect way, indirect, so that something will not happen accidentally for you or to break the marriage because it may happen, you tell her or him, the marriage break at that point.

(Community member no.4: a young civil servant)

When the respondents were asked whether attending ANC to access PMTCT services should be done by a woman alone, most of them (nine of the eleven) disagreed, stating that the it should not be done by the women alone, with a significant theme emerging that there are important roles for the male partner to play at the facility:

No, I do not think it is the women alone.

(Partner no.3: a middle-aged trader)

No... the husband supposed to follow... yes, and to note, there are some women when they are under pregnancy, they cannot move from here to there, sometime they say (to the husband) take this... this thing, go to pharmacy, go buy drugs. The husband would rush and buy the drugs, then tell the woman, sit down relax, let me come (help you).

(Partner no.5: a young trader)

It should not be done with, by women alone, because sometimes there are situations if you man don't learn, if you don't join your woman to learn on how to take your daughter or your children to hospital, there will come a time that she will be sick, and then the other child is also sick... (or) sometime they may be separated, not in the same hospital because I remember when my daughter was separated from the mother I was the one running up and down. So I think... a man should share in the responsibility.

(Community member no.1: a middle-aged farmer)

Some of these respondents, whilst being supportive of male involvement in PMTCT, did raise concerns about the pressure this would place on their (working) time:

No, I don't think so... it should not be done by the women only. Ideally well... you know that men actually should support it, but... but we men are busy, you know... to just there and sit down, doing what?

(Community member no.3: a middle-aged fisherman)

Anyway, is not the only women, but because of time factor... for a man.

(Community member no.4: a young civil servant)

The two respondents (Partner no. 1 and Community member no. 6) who suggested that a woman should attend ANC services alone – without her male partner, noted how isolated and possibly overwhelmed a man would feel in a room full of pregnant women:

(I)n a developed culture, I think... it is the husband and wife that should go, but here, when you go to the health centre you see a hundred women and you are the only man, in fact when you turn... you will run away. So the environment is not accommodating for a man to be there... you see all their tummy is protruding and you alone (it) may be you will (but) even the women (themselves) will be asking you questions: what do you want here? ... No, he does not need to be involved... I think the role is just advisory.

(Partner no.1: a young farmer)

I believe that (it) is a women matter... they should be allowed to handle it themselves... yes, I believe so.... No, it is for women. That is what I believe...

because even the whole place in the hospital is full of women that came, so what am I going there to do?

(Community member no.6: a young trader)

However, apart from the above two respondents, the rest of the respondents provided some strong motivation for why a man should be involved in accessing PMTCT services with their partner. This included the need for the men to get tested to know their HIV status and to then take preventive measures and/or medications and to gain information to then be able to support their partner, and to create awareness among the men:

Yes... you know since this disease is... a transmitting disease, it also involves men to go for test... so that they know their status... well it's only when they know their status if they (are) involved in the same this thing (HIV), they can also take drugs to prevent it.

(Partner no.3: a middle-aged trader)

He has to be involved... because... the partner if truly he loves the wife, he should encourage the wife when the wife is going, he should go there and hear what the nurses and the doctors, the advice they are going to give... in terms of, there are certain things the wife might come back home to tell the husband, this is what the doctor, the nurses says, the husband might not really believe, so it is good for the both of them to attend.

(Partner no.4: a young primary school teacher)

Yes, very necessary... so that he can get tested and he will know his status, and then take prevention measures. He need to... stay alive. It will also help him support his wife.

(Community member no.3: a middle-aged fisherman)

4.3.4 The possible reasons for the lack of male involvement in PMTCT services

In reflecting on the reasons why they think men do not involve themselves in PMTCT, the respondents suggested that this was due to a lack of awareness and a disbelief and possible fear about HIV/AIDS and the commonly held belief that PMTCT was a woman's affair – which was, in turn, reinforced by the fact that the clinic was filled with women.

In addition, the lack of time that working men had to accompany their partners to a facility was also noted – something which could either be a genuine barrier to their involvement or a convenient excuse to evade some of their responsibility. The ‘voice’ of respondents on the possible reasons for a lack of male involvement in PMTCT include the following:

Firstly, there is a lack of awareness about the issue:

They are not, there is no awareness... yes, there is no awareness.

(Partner no.4: a young primary school teacher)

I think it is because they are not fully aware of what this... (what) PMTCT is about.

(Community member no.3: a middle-aged fisherman)

Secondly, some shy away from testing for HIV and entertaining the thought that they are themselves HIV positive:

Sometimes because they didn't do the test, so they don't believe (they are HIV positive).

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(Community member no.4: a young civil servant)

Thirdly, PMTCT is seen as a women's issue:

The man will believe, look its women affairs, why should I be there.

(Partner no.1: a young farmer)

It's because they feel it's just a woman affair.

(Community member no.2: a young farmer)

Fourthly, only women populate the clinic:

The environment – because take for instance on Tuesday is immunization, I think the first Friday of every month, the PMTCT women meet, you will see more than fifty, you will not see a single man. So the environment does not allow the man.

(Partner no.1: a young farmer)

Fifthly, men are perceived as not having sufficient time to attend the facility because they are busy working and thus have limited spare time:

Work, busy.

(Partner no.4: a young primary school teacher)

Our men are busy... their work... chasing money! That one is important.

(Community member no.3: a middle-aged fisherman)

(It is the) time factor... for me to come with my wife, sometime I have work to do, so I will, rather I will send her to come (to the clinic) while I am going to my job.

(Community member no.4: a young civil servant)

Sixthly, some thought that there was little valid justification for men not being involved and that their lack of involvement was in fact a result of them evading their familial responsibilities:

It is not because of PM (TC) alone, generally, some men are known to be always shying away from responsibilities. One, it may be because of the lean financial background. Two, they don't want to be exposed, to be known, to be associated with that (HIV) story... because people feel that when you are an HIV patient or when you are infected, you are a condemned person, people should not come nearer or closer to you. In the past people were afraid, so they may shy away because they don't want to be associated with such thing, they don't want to bear any brunt of... responsibility, ... and they don't want to support the programme... they don't want to bear financial responsibility.

(Community member no.1: a middle-aged farmer)

And lastly, it is as a result of their fear of HIV and their own sense of vulnerability:

(It is the) fear of the unknown...

(Partner no.4: a young primary school teacher)

Maybe some people are... cowards. They may... even look at the programme as if it is not going to work, they may even wait to see let other people try let me see,

they will want to see (what) everybody does it in their community before they (join)...

(Community member no.1: a middle-aged farmer)

4.3.5 The perceived level of involvement of men

When asked, the majority of respondents (8 of the 11) were of the opinion that men were not doing enough to assist their HIV-positive female partners in accessing PMTCT services and that men should be encouraging and supporting the women, be involved in accompanying their female partners to the clinic, as well as showing an interest in the activities at the antenatal clinics – along with educating their fellow community members about the PMTCT issue:

(The lack of involvement)... is (because of a) fear of stigmatisation... people are still non-believers – that HIV/AIDS is real. ... (also because of) custom and tradition, you know our people still believe that HIV/AIDS... is from the witchcraft and so they prefer to go to church and pray than to go to the hospital and do the test. So men are not doing enough.... They should be involved in educating people that this thing is not witchcraft. This is very important in our community.

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(Partner no.1: a young farmer)

(B)ut some are careless, they don't even care what is happening. They say go, go to your clinic, leave me alone... they suppose to follow their women to antenatal... encourage them, (ask them) have you taken your drugs? gone to the clinic on the appointment day?

(Partner no.5: a young trader)

They are not getting, they are not getting enough support... some men are not interested.... They should come forward and show more interest in the programme.

(Community member no.1: a middle-aged farmer)

No way. They are not... the men generally do not show any interest at all. They just allow the woman to carry the load. Majority of the men don't even go to the

clinics... at least they should accompany the women to the clinic for antenatal... they should also show some interest in what they are doing in the clinic.

(Community member no.3: a middle-aged fisherman)

The remaining 3 respondents that did feel men had tried to, or were sufficiently involved in the programme noted that they felt men were encouraging their female partners to attend the facility, standing by them and providing financial and moral support:

Yes, they have tried... you know some men, not all, some men no matter what is happening, they will stand by their wife... that is they will give her support, financially, moral and otherwise, prayerfully.

(Partner no.3: a middle-aged trader)

Well, they have tried.

(Community member no.4: a young civil servant)

4.3.6 Experiences and/or perceptions of the barriers to male involvement in the PMTCT clinic

The respondents identified barriers in the clinic that make it difficult for men to be involved in PMTCT. These included the fact that the clinic is *only* ever filled with women:

(T)he presence of too many women. So men... they wouldn't want to go there.

(Partner no.1: a young farmer)

I think what discourages men the most is that the place is full of women... both the pregnant women and the nurses that are there, you will feel that you do not belong there, honestly you will feel out of place.

(Community member no.3: a middle-aged fisherman)

In addition, an array of potential ways in which the clinic made men feel uncomfortable in themselves was suggested:

Firstly, the fear of being identified by someone they know:

Yes..., it may be fear of being known, they don't want to be known, maybe they have (another) relationship, people that will know them when they go there with their women, they don't want those people to see them...

(Community member no.1: a middle-aged farmer)

Secondly, the sense of male pride also appeared to be at stake if a man was thought to be attending the PMTCT programme:

Well you know some men, some men feel you know, pride (is important) in some men generally.... So pride really plays a lot, they don't want to come in (to the programme), they don't want to access it.

(Community member no.2: a young farmer)

I think some men may be ashamed.

(Community member no.5: a young trader)

Thirdly, there was a perception that the quality of care and lack of resources at the local facility was not as desired:

They are delaying to care for the patients... (and) there is no money... to buy drugs, because we use to buy drugs here... no, the main drugs for HIV is free, but the immune booster they sell for you, something like... the other one that I used to take they are selling, ...what do they call it, they call it... septrin an immune booster.

(Community member no.4: a young civil servant)

... but I know they should equip the hospital to the standard...

(Partner no.3: a middle-aged trader)

The nurses' negative attitudes towards their clients – and their reinforcement of the notion that the PMTCT programme was for the involvement of women alone – was also noted as a potential barrier:

(The) attitude of nurses... the way the nurses address the women, the man might not want to tolerate it.

(Partner no.4: a young primary school teacher)

Some of the nurses don't know how to talk to patients... they just talk anyhow. At times it can be insulting (and) you may even feel bad. No man wants (to witness) that kind of thing.

(Community member no.6: a young trader)

In addition:

The nurses felt it (PMTCT) is just a woman affair... yes... yeah, no awareness in their side.

(Partner no.4: a young primary school teacher)

(T)hat is why some men did not like to follow their wives go (in to the facility) because the nurses they say... mister, this is... a woman's matter, sit down there (and) wait.

(Partner no.5: a young trader)

When specifically asked whether the nurses are accommodating or not towards the male partners of HIV-positive pregnant women, the majority of the respondents (8 of the 11) stated that the nurses *were* accommodating:

They are not rude... they are friendly with everybody that comes here – they are not rude at all.

(Partner no.3: a middle-aged trader)

Ok... when they come, they treat them fine, because some of them are also a patient so they treat them as is their own. They will treat them fine.

(Community member no.4: a young civil servant)

The rest of the respondents (3 out of 11), either thought that the nurses were *sometimes* accommodating or not at all accommodating – as illustrated below:

Nurses, some of them, a very few percentage... the way they will scold your wife, the way they will descend on them, talk to them carelessly, you may be embarrassed, so that by the time you get out of that place for one day that day,

you may not be even happy to be invited there again, to avoid further embarrassment... they are very saucy, eh, they are rude... (The) majority are good, 80% are good... (but) if you are unlucky to fall within their armpit, the armpit of the rude ones, you see how they treat your wife, they talk to your wife...

(Community member no.1: a middle-aged farmer)

Importantly, it needs to be highlighted that all of the nurses and counsellors at the PHC West Itam are female, and the respondents were asked if this was a problem for the male partners of the HIV-positive women that are attending the PMTCT programme. The majority of the respondents (9 of the 11) affirmed that it was a problem for men, with a significant theme emerging that the men will be more comfortable talking to and confiding in a male nurse or male counsellor particularly on sensitive issues:

Yes.... why (I) am saying this is because, man to man, this is man talk now, ... this is man talk, so it encourage a man to... if there is a man, man to man, ... man to man will tell you, even ask for help, but man to woman, man may not want to open up.

(Partner no.1: a young farmer)

Yes, I think men, yea, we should have nurses, male nurses and counsellors who are males also.... in order to encourage the men... at least when they come to the clinic, they will see a man they can confide with a male nurse or a male counsellor.

(Partner no.4: a young primary school teacher)

It's a problem to other men because there are some men who cannot disclose their privacy to women, there are some. If there are certain things that affect them in their private part, they won't be able to naked themselves and show, but if a man doctor, they will open, they remove their cloth and they say doctor this is what is going on, this is what is going on, can you help me? They say yes but if the woman, they will fear.

(Partner no.5: a young trader)

Well... I think most men will prefer to talk to a fellow man instead of a woman, especially with something private like HIV. It is not easy to talk to a woman concerning personal things.

(Community member no.3: a middle-aged fisherman)

Well... actually... it will be easier to talk man-to-man on things like this..., so many men may be discouraged from coming when they see that it is only women that are there. You know our men, they can be funny.

(Community member no.6: a young trader)

The remaining respondents stated that having an all-female nurses and counsellors at PHC West Itam was not a problem:

No... I don't think... I am very free with them, they are very free with me.

(Partner no.3: a middle-aged trader)

It's not a problem, to me.

(Community member no.5: a young trader)

4.3.7 Recommendations

In terms of recommendations for the future – specifically in how to make the ANC and/or PMTCT programmes more male-friendly, the respondents from the health team, the clients and the community members provided the following suggestions:

Firstly, in terms of an organizational type change and considering priorities within the health facility itself, it was suggested that male nurses and counsellors be employed as a priority:

I believe, the ANC should not be (just) women, we should not have only women nurses, we should have both male and female (and) male counsellors also.

(Partner no.4: a young primary school teacher)

I will tell them to go and recruit male nurses that will talk privately to the men.

(Community member no.3: a middle-aged fisherman)

Secondly, the idea of creating a separate male counselling unit was also put forward:

The first thing is creating a different department for receiving and counselling the men.

(Health Worker no.1)

They should have a separate room for men. The women gossip a lot... I mean the nurses, they gossip.

(Community member no.3: a middle-aged fisherman)

Thirdly, another suggestion made by one of the health workers, and linked to arrangements within the facility, was that women who come along with their male partners be attended to first – in other words, they be given a ‘fast tracked’ consultation as an incentive to bring their partners with them:

Attending to them first, those that come with their husbands, we used to attend to them first to encourage others.

(Health Worker no.2)

Associated with this idea of finding creative ways of reducing the waiting times, it was suggested by respondents that waiting times in general require some form of ameliorated action. A number of the respondents felt that the delays experienced in accessing care/a consultation, required some direct attention and/or investigation – as is illustrated in the quotes below:

(D)on't waste time.

(Partner no.2: a young farmer)

I believe the ANC should not be just once booking or once dating, I think they should split, ... you don't expect 500 or 300 women to come in a particular clinic day.

(Partner no.4: a young primary school teacher)

(D)elaying... I want them to refrain from that act.

(Community member no.4: a young civil servant)

Another suggestion in relation to the improvement of service delivery, was that the services to HIV-positive women ought to be at no cost:

We may begin to give free delivery services, for the HIV-positive mothers.

(Health Worker no.1)

Fourthly, and again related to the staff, it was suggested that all the existing and new staff should be trained or retrained on being able to provide patient-centred care (which includes and respects the client's right to confidentiality):

Attitudinal change training for all staff (should be provided)... so that those ones that have been here will be able to supervise the younger ones and pick (up) any negative attitude and try to educate them.

(Health Worker no.1)

Most of these nurses we have in this facility... I believe their capacity needs to be rebuilt again... because some of them they have served government for 35 years, may be before, during that time they were not aware that a man should accompany the wife.

(Partner no.4: a young primary school teacher)

I equally would want them not to disclose whatever secret information that a man gives out to them. They should confide it, even when the man is giving the information that has to do with his wife, they should know how they package it.

(Community member no.1: a middle-aged farmer)

Lastly, the raising awareness amongst the general population about issues related to PMTCT was also suggested:

Advocacy to the people ... in the community, the Ward Development Committee (WDC), on men coming out.

(Health Worker no.3)

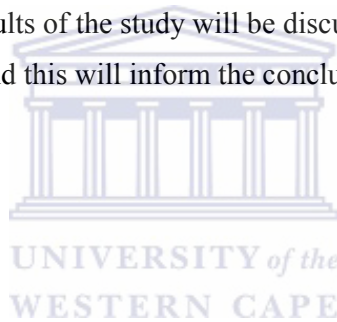
(There should be a) campaign against (HIV) stigmatisation... should be community-based in the rural areas because if you go to the rural areas now, you will even be crying for the people. They are not even aware of what is going on.

(Partner no.1: a young farmer)

They should air over the radio, I mean communication matters in everything, if the verbal discussion cannot solve the problem, they can go on air, they can publicize it in the paper... maybe they will send a letter to the nearby village, that is to their chief, then they give the bell to ring, telling the people that there is a need for men to go to the hospital.... The chief will give the either the town crier the bell to ring around.

(Partner no.3: a middle-aged trader)

In the following chapter, the results of the study will be discussed and compared with other findings in relevant literature, and this will inform the conclusions and recommendations thereafter.



Chapter 5:

DISCUSSION

5.1 Introduction

This study set out to identify and describe the experiences of male partners of PMTCT clients and male community members, specifically in relation to understanding why some male partners of HIV-positive pregnant women do not participate in the PMTCT programme at the primary health centre in West Itam, Akwa Ibom State in southern Nigeria. The insights that were gathered will hopefully inform the development of strategies that can be put in place in order to help improve the involvement of men in the PMTCT services offered in this local area. Hopefully, these insights can also be considered by others stakeholders working in the PMTCT field that might share similar programmatic challenges and be implementing their PMTCT programmes in a similar contextual milieu.

This study has added to the understanding of the extent of affect male participation in the PMTCT programme at the West Itam PHC, and the factors affecting their participation. Most of the respondents knew their partner's next antenatal appointment, but only very few accompany their pregnant partners to the antenatal clinic. The barriers to male involvement in the PMTCT programme that were elicited in this study include lack of belief about HIV/AIDS, perception of PMTCT as a "women's affair", delay/time wasting at the facility, and the fact that nurses and counsellors at the PHC West Itam were all female.

5.2 Knowledge about HIV/AIDS

From the in-depth interviews with the five male partners of PMTCT clients of the West Itam PHC and the six male community members who are currently not partners of PMTCT clients (but could potentially be in the future), it was apparent that there was poor knowledge of the actual meaning of the HIV/AIDS acronyms among the respondents. This is in keeping with the study by Usman et al., (2015), in Ondo State, Nigeria, where only 41.9% correctly defined HIV as human immunodeficiency virus, and 35.9% correctly defined the acronym AIDS. The population in West Itam, Itu LGA, Akwa Ibom State, Nigeria, are predominantly farmers, fishermen and traders (Edet *et al.*, 2014) (similar to the people recruited into the study sample), and might not have had access to formal education beyond high school, which might account for their inability to state the full meanings of HIV/AIDS. However, more important was their general understanding of the main modes of transmission and their

understanding of HIV-risk behaviours. Most of the respondents had a good knowledge of the main modes of transmission of HIV.

A striking theme that emerged in the study was that all of the respondents mentioned getting a haircut at a saloon as a mode of transmission. This is consistent with the study by Biadagelegn *et al.*, (2012) in Ethiopia, where 97.5% of the respondents affirmed that unsterile (barbing) blades/equipment could transmit HIV. Similarly, it is thus worrisome that so many of the male partners and community members in this study seemed to have *incorrectly* extrapolated the basic mechanism of transmission i.e. coming into direct contact with blood/semen/vaginal fluids and extended that to include sharp cutting instruments – barbers clippers, nail clippers. It appears that the previous and/or current HIV/AIDS awareness raising and educational events have not been able to communicate a sufficiently clear message in this regard – and thus not been able to re-orientate or deconstruct the community's perception or belief regarding the risk of contracting HIV through hair and nail cutting in a public hairdressing saloon (or salon).

The respondents in this study were generally well-informed that a mother can transmit the HIV to her child in the womb, during labour and by breastfeeding. Similar findings were obtained by Nsagha *et al.*, (2014) in Buea in the South West region of Cameroon, where 77.1% of the men had correct knowledge on prenatal transmission of HIV to babies, and 74.2% of the men had correct knowledge on HIV transmission during breastfeeding.

Furthermore, the respondents in the study correctly noted a variety of means by which the risks of transmission of HIV to the child can be eliminated, such as going to the health centre to receive medications, and also having a caesarean section. This finding is consistent with that of Nsagha *et al.*, (2014), where 60% – 68.9% of men had correct knowledge of PMTCT, and that of Makoni *et al.*, 2016, in the Midlands province in Zimbabwe, where the majority of cases had fair knowledge on PMTCT.

The - level of knowledge about HIV and PMTCT demonstrated by the respondents in this study, can be explained by the fact that over the past years, community based interventions (CBIs) have resulted in the promotion of, and increase in HIV awareness (Salam *et al.*, 2014). In the study by Salam *et al.*, (2014), 39 studies were reviewed. These studies focused mainly on community-based HIV prevention educations, counselling sessions, women's groups and peer leadership, amongst others. Their review findings suggest that CBIs to increase HIV

awareness and risk reduction are effective in improving knowledge, attitude and practice outcomes (Salam *et al.*, 2014).

5.3 Knowledge about and involvement in the local ANC & PMTCT services

In exploring the knowledge about and involvement in the local ANC & PMTCT services, five of the six community members knew that PMTCT services were offered at the PHC West Itam.

In relation to the partners of the PMTCT clients, all but one of the five respondents knew their partner's next antenatal appointment. In a study conducted in Mbale district, Eastern Uganda, by Byamughisha *et al.*, (2010), it was found that only 55% of the 387 respondents knew their partner's ANC appointments. Similarly, Tilahun & Mohamed, (2015), in a study in Arba Minch Town and Arba Minch Zuria district, Southern Ethiopia, found that 59.3% of the 698 respondents knew their partner's next antenatal appointment date.

However, despite all (but one) of the respondents in this study knowing their partner's next antenatal appointment, when it came to accompanying their pregnant partners to the antenatal clinic, only one of the respondents in this study stated that he does so. This is similar to what Byamughisha *et al.*, (2010) found in their Ugandan study where only 4.7% of the 387 men had attended ANC with their partners. Similarly, Aarnio *et al.*, (2009) in a study in Malawi found that only 8.5% of the 351 of men interviewed had ever accompanied their wives to ANC, and Van Rensburg & Nyandat (2016) in a study in Kenya, observed that only 18.3% of the women were accompanied by their male partners to the antenatal clinic. Nkuoh *et al.*, (2010), in Cameroon, found that though most men consider accompanying their wives to ANC/PMTCT as good practice, fewer men actually do this, with only 43.3% having accompanied their wives at least once. This finding has been corroborated by Kwambai *et al.*, (2013) who – in a study in rural western Kenya – found that, despite the perceived benefits of accompanying their wives, the men rarely do so in practice. Therefore, it is a common thread that most men do not accompany their female partners to the ANC.

An emerging theme from the in-depth interviews was a lack of time and or being too busy to accompany their pregnant partners to the antenatal clinic. Rogers-Bloch (2012), in a study conducted in six focal states in Nigeria (Bauchi, Benue, Cross River, Federal Capital Territory, Lagos and Sokoto), found that one of the most common reasons for men not

accompanying their wives to their antenatal visits was a lack of time as a result of work demands. Similar findings of a lack of time as a reason for not accompanying their pregnant partners to the antenatal clinic have been made by Theuring *et al.*, (2009) in a study conducted in the Mbeya Region, Tanzania; Nkuoh *et al.*, (2010) in their study in Cameroon, and Adelekan *et al.*, (2014) in Osogbo, Nigeria. It was generally found that even though the majority of the participants agreed that it is good to accompany their wives to ANC, only a few of the partners interviewed in these studies reported that they had ever done so, due to lack of time as a result of work.

Despite these and other men being noticeably absent when it came to physically accompanying their partner to the clinic/facility most of the male partners in this study mentioned giving their pregnant partner money for transport, and money for food/snacks (at the clinic) as a key means of support. Similarly, in the study by Byamugisha *et al.*, (2010), 97% of the men provided financial support to their spouses to attend ANC. A very similar proportion of men (97.9%) was reported by Tilahun & Mohamed (2015) in a study in Arba Minch Town and Arba Minch Zuria district, Southern Ethiopia, as having provided financial support to their spouses to attend their antenatal visits. This observed pattern may be due to the fact that the men perceive that once they have given the women money for transport, then they (the men) have provided the necessary and sufficient support – especially considering that many of them would not feel ‘at home’ in a facility populated almost entirely with women. Indeed, men typically report their role in pregnancy is that of being a provider (Kwambai *et al.*, 2013), and to make money available for childbirth and postnatal care (Nkuoh *et al.*, 2010; Singh, Lample & Earnest, 2014).

Inter-spousal communication which, when good, engenders male support of PMTCT uptake (Busza *et al.*, 2012), was also explored in this study, and it revealed that all (except one) of the respondents discuss their partner's antenatal treatment with them. This is important because Nkuoh *et al.*, (2010), and Morfaw *et al.*, (2013), identified cultural communication patterns in which men and women do not fully express themselves, as an impediment to male involvement in PMTCT. When couples discuss issues together, decision-making is easier, and there is an association with an improvement in the knowledge of maternal and reproductive health services (Mutombo, 2014 as cited by August, 2016).

Another significant theme emerging from the interviews was that most of the respondents (both partners and community members) stated that the main purpose of the antenatal visits

was to provide for the well-being of the mother and her unborn child, ensure a safe delivery, and also to prevent the transmission of HIV from the mother to child. It is therefore apparent that the respondents understand and appreciated the value of antenatal care. This has been alluded to by Nkuoh *et al.*, (2010) and Adelekan *et al.*, (2014) in their studies in Cameroon and Nigeria, respectively, where the men stated that during antenatal visits, the women are physically examined, laboratory tests are carried out, and services are rendered to HIV-positive pregnant women to prevent HIV transmission from mother to child.

5.4 Opinions about male involvement in ANC & PMTCT services

The opinions of the respondents were sought on various aspects of male involvement in ANC & PMTCT services. Most of the male respondents interviewed stated that a pregnant woman should obtain her male partner's permission before doing her HIV test. This finding is in keeping to that of Aarnio *et al.*, (2009) study in Malawi, where the men emphasized the importance of prior spousal agreement of antenatal HIV testing, and even considered HIV testing without their consent a justifiable reason for divorce. Male dominance in spousal decision-making, especially in the patriarchal African setting, has been documented (Caldwell, Caldwell, & Orubuloye, 1992 as cited by Conroy, 2014; Aarnio *et al.*, 2009), and it has negative impacts on all the four components of a comprehensive PMTCT programme (Ghanotakis, Peacock & Wilcher, 2012).

In this study, all the respondents affirmed that a pregnant woman should disclose her HIV test result to the male partner. This is very important in the light of the fact that HIV-positive status disclosure appears to be a complex but critical factor for the utilization of PMTCT and maternal health services (Spangler *et al.*, 2014; Medley *et al.*, 2004 as cited by Batte *et al.*, 2015). Spangler *et al.*, (2014), in their study in Nyanza Province, Kenya, found that HIV-positive pregnant women who had not disclosed to anyone had the lowest levels utilization of maternity and PMTCT services. Furthermore, Medley *et al.*, 2004 as cited by Batte *et al.*, 2015, stated that the disclosure of HIV status by pregnant women to their sexual partners is the cornerstone of PMTCT and prevention of HIV prevention among couples.

Interestingly, despite the low level of direct involvement of the male partners and community members, there was a strongly held belief by the respondents that ANC and PMTCT services are not *only* for women, because the majority of the respondents (i.e. 8 of the 11 interviewees) disagreed that attending ANC to access PMTCT services should be done by

women alone. In fact, most of them (9 of the 11), agreed that it is useful to involve men in PMTCT. It thus appears that most of the respondents accept that men ought to be a part of the PMTCT programme. This is in contrast to the study by Amsalu, Tiruneh, & Abajobir (2013) in Ethiopia, where about half of the 139 respondents (50.7%) agreed that PMTCT clinics were only for women and children, and other studies (Nkuoh *et al.*, 2010; Cuco *et al.*, 2015; Nesane, Maputle & Shilubane, 2016), where most of the men were of the opinion that attending ANC or and/or PMTCT should be done by women only. This begs the question: if the male partners of HIV-positive pregnant women (both existing and prospective) living in the West Itam district areas understand the importance of the ANC and PMTCT interventions, are theoretically committed to support more direct male involvement in these services, and are already providing material support to their partners to participate in these services, *why* do the most of them end up *not* accompanying their partners to the facility?

5.5 Barriers to male involvement in the PMTCT programme

The barriers to male involvement in the PMTCT programme were thus explored in some depth in this study. A lack of knowledge about HIV/AIDS and maternal health issues contribute to the non-involvement of the male partners in maternal healthcare services (Nesane *et al.*, 2016). This is a disturbing issue, and has been identified as an important barrier to male involvement in PMTCT (Morfaw *et al.*, 2013). This barrier therefore indicates that a lot of work still needs to be done in the local communities to improve the knowledge and awareness about HIV/AIDS. Improving the understanding and awareness of male partners facilitates good choices, and leads to their being involved in PMTCT (Byamugisha *et al.*, 2010; Alemayehu *et al.*, 2014).

The perception of PMTCT as a "women's affair" with the clinics being filled with women, was another barrier reported by the male respondents to getting more involved in PMTCT in this study. This has also been observed by many authors (Nkuoh *et al.*, 2010; Morfaw *et al.*, 2013; Vehvilainen-Julkunen & Emelonye, 2014; Okoli & Lansdown, 2014; van den Berg *et al.*, 2015; Cuco *et al.*, 2015). It may be as a result of a traditionally embedded perception in African societies that issues relating to pregnancy, delivery and infant feeding are purely for women to handle, with men having no place in these matters (Kululanga *et al.*, 2012; Shiyagaya, Shikongo & Justus, 2016). Indeed, male involvement may even be viewed as a foreign concept (Kululanga *et al.*, 2012). This scenario has been compounded by the inadvertent exclusion of men from maternal health services (Kululanga *et al.*, 2012;

Olugbenga-Bello *et al.*, 2013; Ampt *et al.*, 2015; van den Berg *et al.*, 2015). This exclusion of men stems from factors such as socio-cultural/traditional gender norms where pregnancy and child birth are considered "women's affairs/women's business", a lack of agenda for men and, programmatic policies that tend to focus exclusively on women in maternal health programmes (Kululanga *et al.*, 2012; Olugbenga-Bello *et al.*, 2013; Ampt *et al.*, 2015; van den Berg *et al.*, 2015). This is buttressed by the fact that in some instances, even *health workers* shoo the men away from the antenatal clinic, stating that it was "women's affairs", as was revealed in the in-depth interviews in this study.

The shirking of responsibility by the men with regards to ANC/PMTCT was another barrier identified in this study. This avoidance of the burden of care has been observed by Morfaw *et al.*, (2013) in their study of male involvement in PMTCT, based on a review of 24 studies from peer-reviewed journals. There tends to be a common perception amongst men that the ANC activities are outside or beyond their responsibilities, and that PMTCT is similarly perceived to be a woman's responsibility (Falnes *et al.*, 2011). This may be related to and reinforced by the reference in this study by some of the respondents that PMTCT is a "women's affair".

Another barrier to male involvement in the PMTCT programme that was raised in this study was the men were invariably busy with their jobs and thus there were limitations on their time to attend health services with their pregnant partners. This phenomenon of the men being busy or not having time has been reported by several authors as a significant impediment to male involvement in PMTCT (Theuring *et al.*, 2009; Byamugisha *et al.*, 2010; Ditekemena *et al.*, 2012; Morfaw *et al.*, 2013; Makoni *et al.*, 2016; Nesane *et al.*, 2016). The prioritization of work and/or related economic activities by the men – and specifically placing work above attending ANC with their partners, has been reported by Mohlala, Gregson & Boily (2012), in a study they conducted in Cape Town, South Africa. The prioritization of work above ANC/PMTCT was of particular relevance in the case of casual workers who are not entitled to paternity leave/family responsibility leave, and therefore, the natural tendency is for them to "choose" to go to work rather than attend ANC with their pregnant partners (Mohlala *et al.*, 2012). The respondents in this study were mostly traders, fishermen and farmers. It is indeed the reality that for these categories of workers, every day where one is *not* working involves a loss of daily income, and this carries significant (negative) economic consequences.

Unfortunately, the fear of the possible result of an HIV test being positive, the fear of being identified by someone whilst attending the PMTCT or ANC programme, the fear of being perceived to be under the woman's control, of being 'tight-fisted', a coward and of experiencing a sense of shame and/or embarrassment for being associated with a women's health programme were some of the other barriers to involvement that were identified in this study. These fears and emotions have been well documented and form part of the societal/cultural barriers to male involvement in PMTCT (WHO, 2012; Morfaw *et al.*, 2013; Makoni *et al.*, 2016). Normalizing the involvement of men in PMTCT – although difficult and something that will take time – will address many of men's concerns because it will then be considered 'normal' or 'regular' or anticipated and expected that all men would participate in such interventions (WHO, 2012).

Important facility-based barriers to men's involvement in PMTCT were also elicited in this study, one of which was the delay in receiving assistance and the perceived time wasting at the clinic. Men who perceive delays in service provision in a health facility are significantly less likely to be involved in PMTCT (Makoni *et al.*, 2016). This may be linked to the fact that many of these men are breadwinners (Mohlala *et al.*, 2012), therefore may not like the idea of being kept waiting at the ANC for the whole day.

The nurses were also identified a number of facility-based barriers to men's involvement in PMTCT in this study: the first was the unaccommodating attitude of some of the nurses towards their clients, where some of the nurses are said to have "sharp mouths". This was shared in the discussion with health workers – and although it did not appear to be corroborated by the partners and potential clients interviewed in this study, it is important that instances of the lack of patient-centred care has been observed by the health workers themselves.

The one facility-based barrier area that the majority of the male respondents affirmed was the fact that all of the nurses and counsellors at the PHC West Itam being female *was* a problem for men, and that the men will be more comfortable talking to/confiding in a male nurse or male counsellor particularly on sensitive issues.

This staffing of a facility by predominantly female staff has been identified by Mohlala *et al.*, (2012) as a barrier to male involvement in PMTCT. Nursing is a female-dominant profession, which often fails to attract many male recruits (Ozdemir, Akansel & Tunk, 2008). This is as

result of matters such as status and the pay, as well as the gender role stereotyping of the profession (Ozdemir, *et. al.*, 2008). It is therefore imperative for policy measures to be put in place to address this gender-imbalance, by employing male nurses and counsellors, because it is an important factor for those men who express a preference for a nurse's or counsellor's gender (Koo *et al.*, 2013).

5.6 Limitations of study

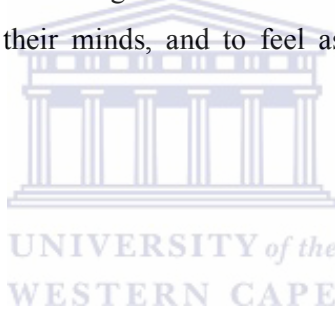
Due to the fact that this study was only conducted in one semi-urban site (in the PHC in West Itam) and used qualitative research methods, the findings of this study are limited to the particular experiences and opinions of those 5 male partners of PMTCT clients, and the 6 male community members who did not participate or are potentially eligible to participate in the PMTCT programme at the primary health centre in West Itam. The same principle applies to the 3 health workers working at the PHC West Itam and who participated in a FGD. The PMTCT-related experiences described in this study cannot therefore be generalized to *all* the male partners of PMTCT clients, nor to *all* male community members, nor to *all* the health workers working at the PHC West Itam facility. They also cannot be generalised to male partners of PMTCT clients in other settings, for example, an urban area of Nigeria, or to male partners of PMTCT clients in other African countries.

Another limitation of this study was that a significant proportion of the pregnant women who attend PMTCT do not inform their male partners of their HIV status. This came to light at the start of the research study. While the researcher was going through the facility register with the Matron, he observed that there were hardly any women that had brought their male partners in. Additionally, the Matron stated that less than 2% of male partners were coming in with their pregnant partners. As a result, it was difficult to even identify male partners who were aware of the HIV status of their female partners – and had accompanied their partner to the facility – and ask them if they would be willing to participate in the research study.

Furthermore, there were only three participating health workers in the planned focus group discussion. As a result, it may have affected the possible spectrum of responses that could have been obtained. This low number of participants at the FGD was as a result of a doctor's strike at the time, and so the doctor who comes for consultations at the PHC West Itam was not available at the time. There was also lack of interest expressed by some of the remaining health care workers at the facility.

Another limitation of the study is that as a former State Programme Manager working with a well-known NGO in Akwa Ibom State, which supports HIV/AIDS services in health facilities across the State (PHC West Itam is one of those facilities, and the researcher along with his former team members at that time, used to pay regular supervisory visits to it), the researcher might have been perceived by the health workers in the FGD, as one who already knows the reasons why men are not involved in the PMTCT programme and so they may have given all the "text-book" reasons, and not necessarily their honest experiences.

Finally, some of the male respondents may not have been as forthright as they might have been in sharing all of their ideas and opinions given that they might have perceived the researcher (who was also the interviewer) as a health worker with whom they felt they ought not be too critical of the health service or the health facility in his presence. The possibility of this social desirability bias – despite the researcher introducing himself as a someone who is working on his Masters dissertation – might have reduced the possibility of the respondents being absolutely free to speak their minds, and to feel assured of confidentiality and no consequences.



Chapter 6: CONCLUSION AND RECOMMENDATIONS

From this study, it is suggested that most of the respondents knew that PMTCT services are offered at the PHC West Itam. They knew their partner's next antenatal appointment, but only very few accompany their pregnant partners to the antenatal clinic. The most significant reason for this was a lack of time/being busy. The key means of support of the partners' antenatal visits was giving their pregnant partners money for transport, and money for food/snacks (at the clinic).

Inter-spousal communication was found to be good, and there appeared to be a perception by the men that ANC/PMTCT is not only for women, with most of the men agreeing that it is useful to involve men in PMTCT.

However, the barriers to male involvement in the PMTCT programme that were elicited in this study include lack of belief about HIV/AIDS and lack of awareness and the perception of PMTCT as a "women's affair" with the clinics being filled with women. Another barrier to male involvement in the PMTCT programme was the men being busy with their jobs/lack of time.

Fear was also a key barrier identified in this study, and includes fear of the possible result of the HIV test, the fear of being identified by someone they know, the fear of being perceived to be under the woman's control, the fear of being perceived as being tight-fisted, as well as cowardice, and shame/embarrassment.

Facility-based barriers to men's involvement in PMTCT include delay/time wasting by being at the clinic, and the nurses' themselves, who were described as having an unaccommodating attitude towards the clients.

Finally, male partners of PMTCT clients, and the male community members who did not participate or are potentially eligible to participate in the PMTCT programme at the primary health centre in West Itam, affirmed that the fact that nurses and counsellors at the PHC West Itam were all female was a problem for men, and that the men would be more comfortable talking to/confiding in a male nurse or male counsellor, particularly on sensitive issues.

Recommendations

The recommendations that are outlined below are based on the results of the study, which has provided several valuable insights into the extent of male involvement in the PMTCT

programme in PHC West Itam, and the barriers that the men encounter. It is hoped that the recommendations will assist in addressing some of these barriers, so as to encourage the men to be more involved in the PMTCT programme at the health facility:

1. Advocacy and education to raise awareness

There is need to conduct advocacy visits, local discussion groups and enlightenment campaigns to the communities around the facility to create and raise awareness about HIV/AIDS, and to encourage male involvement in PMTCT. These efforts should be directed at couples and not only the women in the communities. It should involve *regular* meetings with the community gatekeepers, town hall meetings and the use electronic and print media. There should also be efforts at facilitating and supporting the familial and social environment.

2. Encourage the disclosure of HIV status by the women to their male partners

Couple HIV counselling and testing should be encouraged as much as possible, and the women should be counselled on disclosure of their HIV status to their male partners.

3. Create a separate male counselling unit

It is important to create a separate counselling unit or programme for men. It will help assure the men that there is a comfortable location for them at the facility, and that the facility is not for women alone.

4. Employment of male nurses and counsellors

Active effort should be made to employ male nurses and counsellors. This will allay some of the concerns that the men have about discussing sensitive issues with female nurses and counsellors, particularly for those men who express a preference for a male nurse or counsellor.

5. Train/re-train the female nurses on proper attitude, and confidentiality

Regular attitudinal training should be conducted for the nurses at the PHC West Itam, to engender professionalism, courtesy and confidentiality in their work.

6. Minimise and avoid delays at the clinic

There is need to reduce the waiting time at the facility. This will encourage the men to participate in the PMTCT programme, in the knowledge that any time they visit the clinic, they will be attended to quickly.



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Appendix A: Interview guide for FGD with health workers

Domain 1: Opening talking points

- What proportion of men attend antenatal care [PMTCT programme specifically] with their pregnant partners at the West Itam PHC? [Prompt: check if the figure they agree on is based on data/stats for a specific period or is based on their impression/perception]
- In your opinion and based on your experience: why is it useful to involve men in PMTCT? [Prompts: if they respond in terms of 'theory' you might want to then ask them if they have seen any such reported benefits in reality/their practice in the PHC]
- What is the ultimate goal you are trying to reach at your facility in terms of male involvement in PMTCT?
- Do you think men are doing enough to assist their HIV-positive female partners in accessing PMTCT services?

Domain 2: Possible reasons for poor male involvement in PMTCT

- Can you tell me some of the reasons why you believe only a small percentage of men are accompanying their partners to their ANC/PMTCT appointments?

Domain 3: Identifying health facility-related, PMTCT programme factors and community factors affecting male involvement in PMTCT

- Are there practical or physical barriers in the clinic or community that make it difficult for men to be involved in PMTCT programme? For example, are the men not able to take time off work to attend the clinic with their partner? Or do they have to wait for a long time for an appointment as they have to return to work quickly?
- Can you think of other examples of such barriers that might be limiting their involvement? [Prompts: Are the nurses accommodating towards the male partners of HIV-positive pregnant women? Are there male counsellors active at the facility? Are there some cultural taboos that make it difficult for men to attend the ANC appointments?]

Domain 4: Recommendations

- What do you think needs to be done differently in the clinic to encourage more male partners to come with their partners? Or that would be more supportive of male partners attending the clinic?
- What do you think needs to be done differently in the way we provide PMTCT services to make it easier and more comfortable for men to attend with their partners?



Appendix B: Information sheet

(Note: the following will be placed on a Faculty of Community Health Sciences SOPH letterhead).

INFORMATION SHEET

Project Title: An exploration of male participation in a PMTCT programme in West Itam, Akwa Ibom State, Nigeria.

What is this study about?

This is a research project being conducted by Dr. Echey Ijezie at the University of the Western Cape. We are inviting you to participate in this research project because your perspective on male involvement in PMTCT is important. The purpose of this research project is to understand why some male partners of HIV-positive pregnant women do not participate in PMTCT programmes in Akwa Ibom State. It is important to explore the factors affecting male involvement in PMTCT programmes in Akwa Ibom State, so that strategies can be put in place to help improve the overall health of their families and themselves.

What will I be asked to do if I agree to participate?

You will be asked to participate in an interview at a mutually agreed location in West Itam. The interview questions will assess the knowledge, awareness and attitude of male partners of HIV-positive pregnant women about their participation in the PMTCT programme at a primary health centre in West Itam. It will also explore men's perceptions of what the various barriers are to male participation in the PMTCT programme at the PHC centre. Additionally, the interview will identify contextual individual, health facility- and PMTCT programme-related factors that affect male participation in the PMTCT programme at the PHC centre. The interview will last about one-and-a-half hours.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, all information from the interviews will be kept in a locked cabinet. The computer files will be password-protected. Your name will not be included on the surveys and other collected data. A code will be placed on the survey and other collected data.

Through the use of an identification key, the researcher will be able to link your survey to your identity; and only the researcher will have access to the identification key.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There may be some risks from participating in this research study. There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about why some male partners of HIV-positive pregnant women do not participate in PMTCT programmes in Akwa Ibom State. We hope that, in the future, other people might benefit from this study through improved understanding of male involvement in PMTCT programmes in Akwa Ibom State, so that strategies can be put in place to help improve the overall health of their families and themselves.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits for which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

There is no expected harm in this study given its nature. However, a professional counsellor at the PHC West Itam will be on hand in case you require emotional support or counselling as a result of the study activities. If such a situation arises, the researcher will refer and/or accompany you to meet with the counsellor.

What if I have questions?

Dr. Echey Ijezie at the University of the Western Cape is conducting this research. If you have any questions about the research study itself, please contact Dr. Echey Ijezie at: 0803 525 2064, and echey4@gmail.com.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Director:

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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

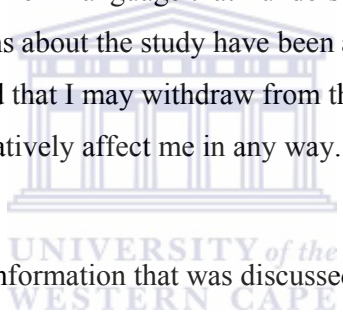
Appendix C: Informed consent for FGDs

(Note: the following will be placed on a Faculty of Community Health Sciences SOPH letterhead).

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: An exploration of male participation in a PMTCT programme in West Itam, Akwa Ibom State, Nigeria.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study.



I also agree not to disclose any information that was discussed during the group discussion.

Participant's name.....

Participant's signature.....

Witness's name.....

Witness's signature.....

Date.....

Appendix D: Interview Guide for male partners of PMTCT clients

Knowledge about HIV/AIDS:

1. What is HIV?
2. What is AIDS?
3. What are the modes of transmission of HIV?
4. How can a mother transmit the HIV to her child?
5. How can the risks of transmission to the child be reduced/eliminated?
6. Have you heard of the term/name PMTCT? (And if so) What do you understand is meant by this term/name?

Knowledge about and involvement in the local ANC & PMTCT services:

7. Do you know if PMTCT services are offered at PHC West Itam?
8. Do you know your partner's next antenatal appointment? Your partner has been attending PMTCT services at West Itam. Do you always go with her to the antenatal? Or just sometimes? With the current pregnancy, how many times have you accompanied your partner to her antenatal/PMTCT appointment?
9. Do you support your partner's antenatal visits in other ways – for example, do you pay for transport to the PHC? And in any other ways?
10. Do you discuss your partner's antenatal treatment with her? What kinds of things do you discuss about it?
11. Can you give me some examples of what the nurses do at the antenatal care visits. What is the purpose of the antenatal visits?

Opinions about male involvement in ANC & PMTCT services:

12. What do you think of the following statements:
 - A pregnant woman should obtain her male partner's permission before doing the HIV test.
 - A pregnant woman does not need to tell her partner the results of her HIV test. (Prompt: would the interviewee's response be the same for both a positive HIV test result and a negative HIV test result?)
 - Attending the ANC to access PMTCT services should be by women alone.
 - A male partner of a HIV-positive woman does not need to be involved in PMTCT.

13. Do you think it is useful to involve men in PMTCT? Why do you think that? Can you explain a little why you believe that?
14. Should a pregnant woman tell her male partner the result of the HIV test?
15. Can you tell me some reasons or beliefs why you think men may not involve themselves in PMTCT?
16. Are men doing enough to assist their HIV-positive female partners in accessing PMTCT services? If yes – why do you think that? If no – why do you think that? What else do you think men should be doing?

Experiences and/or perceptions of the barriers to male involvement in the PMTCT clinic:

17. Are there barriers in the clinics or facilities that make it difficult for men to be involved in PMTCT programme? If yes: Can you give some examples of such barriers? If no: 'It is interesting you say that, because only about 4 % of women attending the PMTCT programme at the West Itam PHC are accompanied by their partner'. I am wondering why the rest of the partners (96%) don't come along: there must be something stopping those men going to the PHC with their partners. What do you think is stopping them?
18. Do you think the nurses are accommodating or not towards the male partners of HIV-positive pregnant women? [Prompts: Are the nurses rude? Are they judgmental? Do the nurses pass discourteous remarks about men?]
19. All of the nurses and the counsellors at the PHC West Itam are female – do you think this is a problem for the male partners of the HIV-positive women that are attending the PMTCT programme? Why/why not?

Recommendations:

20. What advice or recommendations would you like to give to the staff and manager of the West Itam PHC as to how they could increase the number of males that come with their HIV-positive, pregnant partners for their PMTCT services?

Appendix E: Interview Guide for male community members [*male community members are the men in the community who did not participate or are potentially eligible to participate in the PMTCT programme at the primary health centre in West Itam*]

Knowledge about HIV/AIDS:

1. What is HIV?
2. What is AIDS?
3. What are the modes of transmission of HIV?
4. How can a mother transmit the HIV to her child?
5. How can the risks of transmission to the child be reduced/eliminated?
6. Have you heard of the term/name PMTCT? (And if so) What do you understand is meant by this term/name?

Knowledge about and involvement in the local ANC & PMTCT services:

7. Do you know if PMTCT services are offered at PHC West Itam?
8. Do you know your partner's next antenatal appointment? Your partner has been attending PMTCT services at West Itam. Do you always go with her to the antenatal? Or just sometimes? With the current pregnancy, how many times have you accompanied your partner to her antenatal/PMTCT appointment?
9. Do you support your partner's antenatal visits in other ways – for example, do you pay for transport to the PHC? And in any other ways?
10. Do you discuss your partner's antenatal treatment with her? What kinds of things do you discuss about it?
11. Can you give me some examples of what the nurses do at the antenatal care visits. What is the purpose of the antenatal visits?

Opinions about male involvement in ANC & PMTCT services:

12. What do you think of the following statements:
 - Attending the ANC to access PMTCT services should be by women alone.
 - A woman should obtain her male partner's permission before doing the HIV test.
 - A male partner of a HIV-positive woman does not need to be involved in PMTCT.
13. Do you think it is useful to involve men in PMTCT? Why do you think that? Can you explain a little why you believe that?
14. Should a woman tell her male partner the result of the HIV test?

15. Can you tell me some reasons or beliefs why you think men may not involve themselves in PMTCT?
16. Are men doing enough to assist their HIV-positive female partners in accessing PMTCT services? If yes – why do you think that? If no – why do you think that? what else do you think men should be doing?

Experiences and/or perceptions of the barriers to male involvement in the PMTCT clinic:

17. Are there barriers in the clinics or facilities that make it difficult for men to be involved in PMTCT programme? If yes: Can you give some examples of such barriers? If no: 'It is interesting you say that, because only about 4 % of women attending the PMTCT programme at the West Itam PHC are accompanied by their partner'. I am wondering why this 4% is so low...there must be something stopping men going there. What do you think is stopping them?

18. Do you think the nurses are accommodating or not towards the male partners of HIV-positive pregnant women? [Prompts: Are the nurses rude? Are they judgmental? Do the nurses pass discourteous remarks about men?]

19. All of the nurses and the counsellors at the PHC West Itam are female – do you think this is a problem for the male partners of the HIV-positive women that are attending the PMTCT programme? Why/why not?

Recommendations:

20. What advice or recommendations would you like to give to the staff and manager of the West Itam PHC as to how they could increase the number of males that come with their HIV-positive, pregnant partners for their PMTCT services?

Appendix F: Informed consent for individual interviews

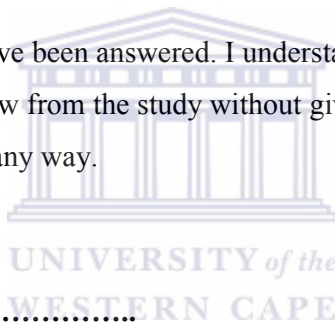
(Note: the following will be placed on a Faculty of Community Health Sciences SOPH letterhead).

CONSENT FORM

Title of Research Project: An exploration of male participation in a PMTCT programme in West Itam, Akwa Ibom State, Nigeria.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate.

My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.



Participant's name.....

Participant's signature.....

Witness.....

Date.....

Appendix G: Ethical Approval (University of the Western Cape)



**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT**

UNIVERSITY of the
WESTERN CAPE

10 April 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Dr E Ijezie (School of Public Health)

Research Project: An exploration of male participation in a PMCT programme in West Iam, Akwa Ibom State, Nigeria

Registration no: 14/3/22

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.



Patricia Josias

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

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

Appendix H: Ethical Approval (Akwa Ibom State Ministry of Health)

GOVERNMENT OF AKWA IBOM STATE OF NIGERIA

Telephone: 085-204091
Telegram: HEALTH

Our Ref:
Your Ref: MH/PRS/99/VOL.V1/163



OFFICE OF THE HON. COMMISSIONER
MINISTRY OF HEALTH
IDONGESIT NKANGA SECRETARIAT
BLOCK 8, P.M.B. 1030
UYO

15th April, 2014

Dr. Echey Ijezie
Center for Integrated Health Programs (CIHP)
7, Mbuoty Close, Mutual Alliance Estate
Aka Itiam Road
Uyo
Akwa Ibom State.

RE: APPLICATION FOR ETHICAL CLEARANCE FOR MPH RESEARCH STUDY

I am directed to convey the approval of the Honourable Commissioner for Health to you to carry out a research work on the topic:


AN EXPLORATION OF MALE PARTICIPATION IN A PMTCT PROGRAMME OF HIV/AIDS IN WEST ITAM, AKWA IBOM STATE, NIGERIA

This approval is conditional on you seeking and obtaining the informed consent of your participants, and ensuring their strict confidentiality.

While conducting your research, no invasive procedure is allowed on your participants.

Make a copy of your work available to the Office of the Honourable Commissioner for Health on completion!

Best wishes!



Dr. Boniface Ukpong, MBBCh (Cal), MPH (Leeds, England)
For: Honourable Commissioner.