MALE UPTAKE OF PREVENTION OF PARENT-TO-CHILD TRANSMISSION OF HIV/AIDS PROGRAMME IN ZIMBABWE: A CASE OF PRIMARY HEALTH CARE POLICY IMPACT IN MAKONI DISTRICT

BY

TAWANDA MUNYANYI

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ABSTRACT

Although the significant impact that male partners have on the health decisions and well-being of women have been well documented, prevention of mother-to-child transmission (PMTCT) programmes in many countries, including Zimbabwe, has largely been targeted exclusively at women. This study focused on male uptake of prevention-of-mother-to-child-transmission of HIV program in Zimbabwe. A qualitative and quantitative study was conducted among lactating and pregnant women ,village and church leaders, MoHCC,ZNFPC,ZAN,ZNNP+ who are directly involved in PMTCT program at clinics,hospitals,management and administration of sexual and reproductive health issues in Makoni District. Male participation in PMTCT was examined under Pre-delivery; delivery and Post-delivery phases of women pregnancy. Structured interviews focus group discussions and self administered questionnaires were conducted among 110 participants, quantitative data was analysed using SPSS software package, emerging themes and sub-themes were then developed into concepts for correlation and triangulation purposes. The main findings show that respondents recognized the benefits associated with as well as showed positive attitudes towards male participation in the PMTCT programme; participants expressed the view that although most of their partners provided financial support during pregnancy, they were not involved in the PMTCT program; and they believed that partner involvement would be in the interest of their unborn children. Perceived obstacles to male partners' involvement included socio-cultural factors, fear of knowing their HIV status and factors relating to health care systems, and among the demographic characteristics, age and level of education were positively associated with an increase in the level of involvement, while the duration of the relationship with the female partner was negatively associated with the level of men involvement. Suggested ways of encouraging male participation from respondents included sychronisation of government health policies with existing structures such as peer education, Village health workers and Home Based Care Givers, adjusting current labour practices (so that men could be permitted to attend clinics with their partners) and the use of peer educators for mobilizing male participation. The study concluded that the positive attitudes of women on male participation and the benefits it may hold, point towards the possible re-designing of the PMTCT program in Zimbabwe, where more male involvement would be encouraged as an integral part of this prevention strategy.

DECLARATION

I declare that Male uptake of Prevention of Parent-To-Child Transmission of HIV/AIDS Programme in Zimbabwe: A case of Primary Health Care Policy Impact in Makoni District is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Student…… Date……

Supervisor…… Date……

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DEDICATION

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ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal clinic
ART	Anti-retroviral therapy
ARVs	Anti-retroviral drugs
AZT	Zidovudine
CHWs	Community health workers
CSO	Central Statistics Office
DOI	Diffusion of innovation theory
FHI	Family Health International
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goals
MoHCW	Ministry of Health and Child Welfare
MoHCC	Ministry of Health and Child Care
MTCT	Mother–to-child transmission
N	Frequency
NVP	Nevirapine
PATH	Programmes for appropriate technology in health

PHC	Primary Health Care
PMTCT	Prevention of mother-to-child transmission
STDs	Sexual transmitted diseases
UNAIDS	United Nations AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary testing and counselling
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

The World Health Organization spearheads health programmes across nations through technical and financial support. These co-ordinations culminated in the Alma-Ata Declaration (1978) that set minimum standards and guidance for management of Primary Health Care (PHC) programmes at the global front. Millennium Development Goals (MDGs) then came as efforts towards the elimination of HIV/AIDS, reduction of child mortality and morbidity. Mother to child transmission of HIV (PTCT) can occur during pregnancy, labour, delivery and breastfeeding. Without treatment, up to 30% of babies born to HIV-positive women become infected with HIV during pregnancy and around 20% become infected through breastfeed (WHO, 2013) Report.

As efforts to make the best from the effectiveness of PMTCT, WHO promotes a four-pronged comprehensive approach, aimed at upgrading maternal and child health in the context of an HIV epidemic (MDGs 3 and 4) . The approach advocates for HIV testing and counselling for pregnant women, where a pregnant woman is found HIV positive and wants to continue her pregnancy, she should receive health education on management for herself, and antiretroviral (ARV) prophylaxis during labour. Pregnant women also undergo routine counselling on safe infant feeding options, and clinical reference for continued care for themselves and their children after delivery.

At introduction of PMTCT programmes, clients had the options to undergo counselling and testing until policies were revised and HIV/AIDS screening became mandatory for all pregnant women. However, room was still left for those who may insist not to be tested to choose their way. According to WHO Report (2011) PMTCT accounted for up to 11 % coverage in Africa South of the Sahara with 54% showing implementation disparities at country levels. According to the WHO Report (2011) then, the number of children still infected by HIV in the region of Africa continued to rise, although at different levels. These continued increases were attributed to challenges faced during the implementation of the PMTCT programmes such as large proportions of home deliveries, shortages of personnel, inadequate supplies of test kits, varying distribution and availability of PMTCT service delivery points, lack of supplementary feeds for women who may opt for non-breast feeding for their infants, and logistical and social implications after testing HIV positive, such as lack of spousal support. HIV/AIDS was reported as the leading cause of death among people aged between 21 and 55 years in the WHO Report,(2011),while HIV prevalence in pregnant women was estimated around 17%.In Zimbabwe PMTCT was introduced in 2003, and by 2006, WHO estimated Zimbabwe's PMTCT coverage to be 27% (WHO,2013).

The implementation of PMTCT services in Zimbabwe began in a few pilot projects where individual projects used different models, which became difficult to monitor and evaluate in terms of effectiveness of interventions(UNAIDS 2013).Subsequently

national and local PMTCT guidelines and policies were developed for planning, implementation and management strategies. These guidelines were informed by HIV/AIDS Policy of (1998) and subsequent amended editions advocate for comprehensive collaboration of all stakeholders to design holistic HIV/AIDS policies and programmes. These efforts set the benchmarks and tone for the current PMTCT, ANC and VCT policies that promote couple involvement in reproductive health matters. This research investigates the uptake of PMTCT programme by males in rural Zimbabwe and explores how male participation in PMTCT programmes can enhance Antenatal (ANC), HIV testing and hospital delivery.

1.2 Background of the Study

HIV and AIDS continue to have a major negative impact on the lives of humankind in the world, Zimbabwe included. According to The National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Mothers and families Alive 2011-2015, 90% of children infected with HIV acquire it through transmission from mother to child (MTCT). The plan estimates that in 2012 about 98 490 children less than 15 years were in need of ART, and HIV contributed to 26 % of maternal mortality and 21 % of under –five deaths(MoHCW,2013) Report. The Ministry of Health and Child Care has as a result taken a commitment to curb the transmission by rolling out the Prevention of Mother to Child Transmission (PMTCT) of HIV programme nationally starting in 2003 in line with the World Health Organisation guidelines. Zimbabwe has

committed herself to the goal of elimination of new HIV infections among children by 2015,and keeping their mothers alive, in line with the Global Plan launched in June 2011,(WHO 2011).In order to improve maternal and child health outcomes, the country is rolling out the provision of more efficacious regimens for PMTCT according to (WHO 2013) guidelines, scaling up Paediatric HIV care and treatment, including provision of ART to children under the age of two years regardless of CD4 count .

Alongside the provision of HIV transmission combat regimens by the government of Zimbabwe, perennially, national fiscal budgets, donor supported funding and programmes targeted at the MoHCC for scaling up of child mortality, martenal and paedtriatic issues, MoHCC, UNAIDS and WHO Reports (WHO, 2013) do not depict a positive progression by the nation towards the elimination of the new infections of HIV/AIDS. It has also been observed that many more pregnant mothers deliver at home, or register their pregnancy late at the local clinic or hospitals. These practices negate the smooth implementation of the PMTCT programme in that many more pregnant mothers deliver without having gone through the HIV tests, and in the event of one being HIV positive, transmits the HIV virus to the foetus. The end result is that children are born infected and their life health and span is put in uncertainities.The levels of maternal morbidity and mortality eventually rise. These developments triggered the research to locate the role being played by men in efforts to reduce and eliminate the paediatric HIV/AIDs towards the goal of no new HIV/AIDS infections among new born babies.

This study set to assess male participation in PMTCT programmes in Makoni District and ways of improving male participation in ANC, VCT and PMTCT, among several health life saving programmes.

1.3 Purpose of Study

The study seeks to investigate whether men in Makoni District are participating in PMTCT programmes. The study will investigate and analyse male participation in PMTCT in general and Makoni district in particular, noting implied and explicit indicators of participation or non participation. The research findings will guide recommendations on possible strategies to engage men into meaningful PMTCT programme uptake.

1.4 Statement of the problem

Male participation in VCT, PMTCT and ANC programmes is the way to go for sustainable strategies towards zero new HIV/AIDS infections in new born babies, yet gaps lie in the policies: Do men and women perceive VCT, PMTCT and ANC interventions with the same lenses as that of the government? Is the government as policy maker aware of gaps within the implementation landscape? Does setting structures and making policy pronouncements amount to guarantee of uptake, efficiency, effectiveness and quality output? Some schools of thought (Ntabona,2013) question the

monitoring and evaluation of the PMTCT programme agencies' sincerity, effectiveness and efficiency, forthwith the compatibility of measurement tools with social, economic and religious sectors.CDC (2007) report on PMTCT programme implementation challenges recognise men as key actors in marital and family health matters, but are structurally and latently excluded in the PMTCT programme implementation as the guidelines and policy do not attach any legal obligation on the parties. While the Zimbabwean PMTCT policy for maternal health is comprehensive and holistic, it is silent on men's entry point and roles, and redress where non participation by men is noted.VCT remains optional in Zimbabwe, and as a result male participation in one's spousal health matters remain not only optional, but relegates the matter to bedroom emotional matters, the majority of which have resulted in pregnant women shouldering the social, psychological and physical challenges that go with pregnancy, Antenatal Care (ANC),Pre-test and post-test counselling and ultimate outcome.

1.5 Hypothesis

Male involvement in PMTCT programmes in Zimbabwe, Makoni District will lead to more pregnant mothers registering at local health centres early and receive clinical support through HIV testing, counselling and PMTCT provisions well in time .This will reduce maternal and morbidity rates in the community and the country. Men are not participating enough in PMTCT programmes, they are bound by structural and

institutional processes and situations that eventually put the lives, health and well being of their women, children and the entire national communities into risk the transmission of HIV/AIDS ,especially to children during delivery.

1.6 Research Questions

1.6.1To what extent are men participating in PMTCT programmes in Zimbabwe?

1.6.2 What influence male participation in PMTCT programme in Zimbabwe?

1.6.3 In what ways do men support pregnant spouses for ANC and VCT services at health centres in Zimbabwe?

1.7 Objectives of the Study

The study seeks to:

1.7.1 Investigate male uptake of PMTCT programmes in Zimbabwe.

1.7.2 Analyse factors linked to PMTCT programmes in Zimbabwe.

1.7.3 Examine the extent to which men support pregnant women in Ante-natal care (ANC) and VCT.

1.7.4 Explore ways in which male uptake of PMTCT programmes may be enhanced.

1.8 Importance of the study

Government and all stakeholders to HIV/AIDS programming have declared zero new infections of HIV/AIDS .These efforts need to be complimented with responsible

behaviour by all. However information on the ground point to new born baby infections at delivery. It is believed that the uptake of PPTCT interventions by women will improve with involvement of male partners. Therefore, male PMTCT uptake and involvement need to be explored, and findings fed into PMTCT programming. The study will also make a contribution to the already existing board of knowledge on the involvement of men in women's reproductive health services.

1.9 Study Assumptions

The study assumes that:

PMTCT policies are for both men and women.

19.2Male participation in PMTCT programmes increases adherence

1.10 Delimitation

The study was carried in Makoni District, which comprises rural and urban wards. Makoni district is comprised of 55 political wards .The study was undertaken in communal, old and new resettlements (A 1 and A2), namely; wards 5 and 35.These wards represent a sample of the population of Zimbabwe which are found in communal, resettlements and urban settings. The terms male uptake in this study is restricted to men's involvement in PMTCT programmes under the study, and any other generic

interpretations may not have similar connotations as implied in the study. These groups are then representative of the people of Zimbabwe in terms of settlement areas.

1.10 Limitations of the study

The study was carried out in ward 5 and 35 of Makoni District. The study was constrained by lack of time to involve all the men and women in the two areas on PMTCT programmes, therefore, not all pregnant, lactating women and their spouses participated in the study. The study involved working directly with local health staff who overwhelmed malaria patients as these areas are semi-arid, region 4A and B where rainfalls come with malaria infections in the first four months of the year .These developments coincided with hospital understaffing challenges, hence, the researcher had to wait until the nurses trained for the study had finished serving all the patients on the day, and in some cases had to postpone the data collection exercise to a new date in liaison with the sister-in-charge. The period of data collection also coincided with the tobacco picking, curing and selling activities, making it difficult for participants to turn up in adequate numbers, and the researcher joined mobile outreach health teams so that participants could then be reached at the outreach point. The researcher also faced challenges of low male participants at both health centres and outreach points, and had to make individual family appointments and collected data from either tobacco fields, curing barn sides or in their homes as per their choices In some situations the researcher

had to reschedule the data collection exercise to Fridays when some of the study participants would be off-field as per area traditional and customary regulations.

1.12 Definition of terms

Perception – A process of human transactions with environment which gives meaning in one's experience, represents one's image of reality and influences one's behaviour, Dabies, (2000).

Male Participation – Male enrolment into the PMTCT programme, MOHCW (2003).

PMTCT – Prevention of mother to child transmission of HIV.

Likelihood of action – activities initiated or performed by the individuals to achieve, maintain or promote maximum health.

Men-In this study, men are individuals of male gender who are either married to or sexual partners of women who have at least been counselled and tested for HIV in PMTCT settings, in Makoni district, Zimbabwe.

Men's uptake-men's readiness to be counselled and tested or actually having been counselled and tested for HIV together with the female partner in a PMTCT setting.

1.13 Conclusion

This chapter introduced the entire study. The chapter highlighted the importance of men's involvement in the uptake of PMTCT interventions by women. The background information to the research problem, which is men's low involvement in the PMTCT programme, is covered at international, national and local level. The study's aim and objectives are also covered. The study aims to assess the extent of men's uptake of PMTCT services and to make recommendations for improvement. The uptake indicators are acknowledged as awareness, socio-cultural and programmatic factors and demographic characteristics. Definitions of key concepts are also given in this section.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

In this chapter, the literature reviewed for this study is presented. This literature review show the types, quantities and content of consulted sources and also the ways they were acquired. The review covers theoretical and empirical sources related to concepts found in this study. These were consulted with the aim of gathering information and knowledge about the topic; refine the problem being studied; be acquainted and make relevant choices of research methodology. The literature review was conducted prior to study data collection. Various sources were accessed to find the literature and these included the Internet and Zimbabwe Open University library and Ministry of Health and Child Care (MoHCC)/WHO publications on Reproductive Health, Health Research, Primary Health Care and PMTCT, and Policies from the health departments.

2.1 Theoretical Framework

Polit and Hungler (2005) state that having a problem linked to a theoretical context enhances the meaningfulness of a research study. The design, data collection strategies, data analysis and interpretation of findings flow from that conceptualisation. Concepts from the Health Belief Model (Burker 2004) informed this study. The Health Belief Model was adopted and used to guide the study. This model assist participants shape their behaviour that is risk for specific diseases and practices. The model was preferred

because of its key concepts; namely, perceived susceptibility, perceived severity, perceived benefits and cues to action (Auvinen et.al , 2010), implications (UNAIDS, 2010).In this research Health Belief Model was used to elicit men's perceptions on PMTCT programme. Theories of male participation and involvement in PMTCT programmes in Zimbabwe, Africa and the world were interrogated and informed the study, drawing lessons and best practices.

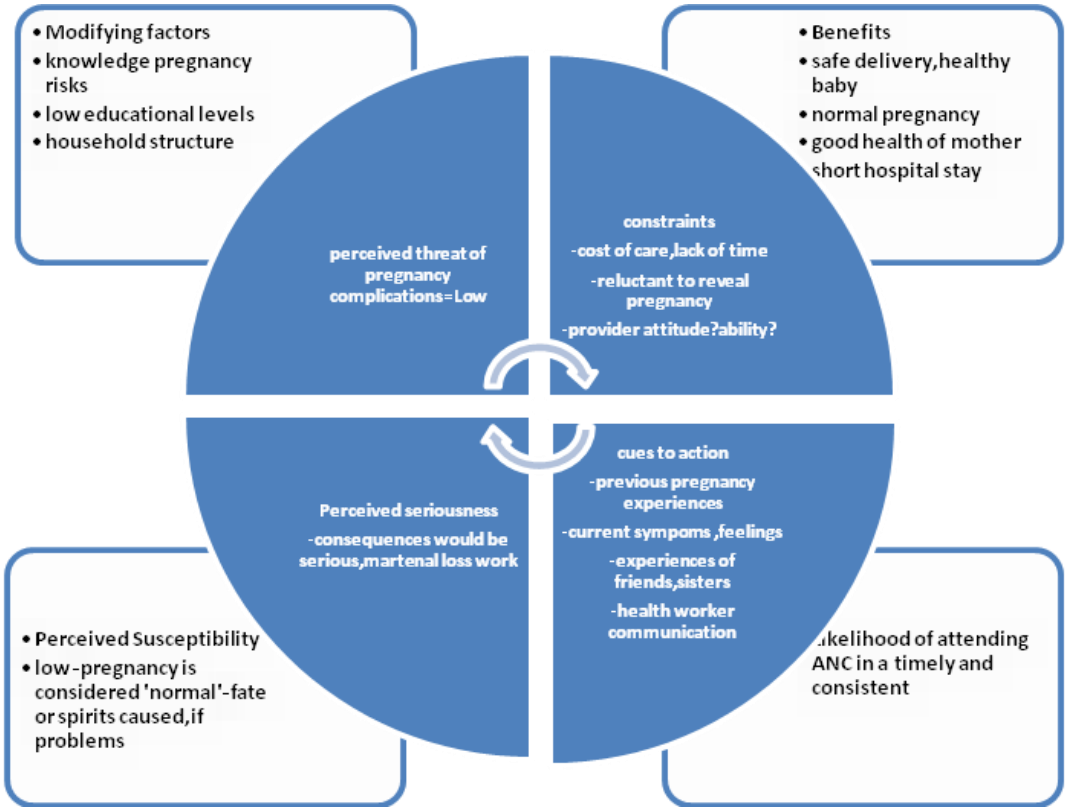

Figure 1: Health Belief Model (Burker 2004)

According to Brieger (2006) the Health Belief Model draws on Lewin's force field theory wherein human behaviour anchor on perceptions, meaning that the way one acts is in response to how and what one perceives the values, benefits and rationality of a phenomena. These guide the decision making processes, and ultimately, the results in view of the perceived consequences. Furthermore, Brieger (2006) alleges that the key word in the model is perception. In view of HIV/AIDS as a disease, the threat central to the perception is addition of disease perception against cultural aspects regarding definitions of words such as disease and illness. In the investigation of male uptake of PMTCT programmes, the study took cognizance of human behaviour as influenced by their perceptions of the relevance of PMTCT with regards to HIV/AIDS, vertical transmission effects, gravity, and implications to all humankind. Knowledge and understanding of these issues generate perceptions, which in turn drive men to respond in a particular way, judging the seriousness, susceptibility of all family parties, benefits, cues to action in light of perceived and real constraints and threats. The Social Learning and Cognitive Theory (Brieger 2006) uphold the Health Belief Model (Burker 2004) on the basis that a person's behaviour is influenced and shaped by the environment. Male uptake of PMTCT programmes or not would more or less be determined by the social, economic, religious and physical surroundings of their settings. The study therefore investigated male involvement in PMTCT programmes in the context of these factors.

2.2 Conceptual Framework

The main theory used to construct the conceptual framework for this study is the social cognitive theory. In the social cognitive theory, the concepts of environment and situation were adopted and adapted as given in Glanz et al (2002). The concepts of environment and situation in this context refer to the subjective and objective factors that can affect a person's behaviour but are physically external to that person and are external to the cognitive representation of the environment by that person (Glanz et al 2002). In this study, these concepts were used in the conceptualisation of socio-cultural factors like gender norms which may influence men in their own community or environment.

2.3 Research Conceptual Model

The following model served as a guide to this study. The model was inspired by Selvan et.al, (2001) in their study of perceived norms, beliefs and intended sexual behaviour among higher school students in India. The model presupposes that individual characteristics such as age and educational standards, structural features like cultural dimensions and institutional dynamics like settings of the infrastructure, entry or exit points among others as influential to human behaviours, levels of response or reactions of the programme participants. These concepts were then considered critical to this study with regard to male uptake of PMTCT programmes.

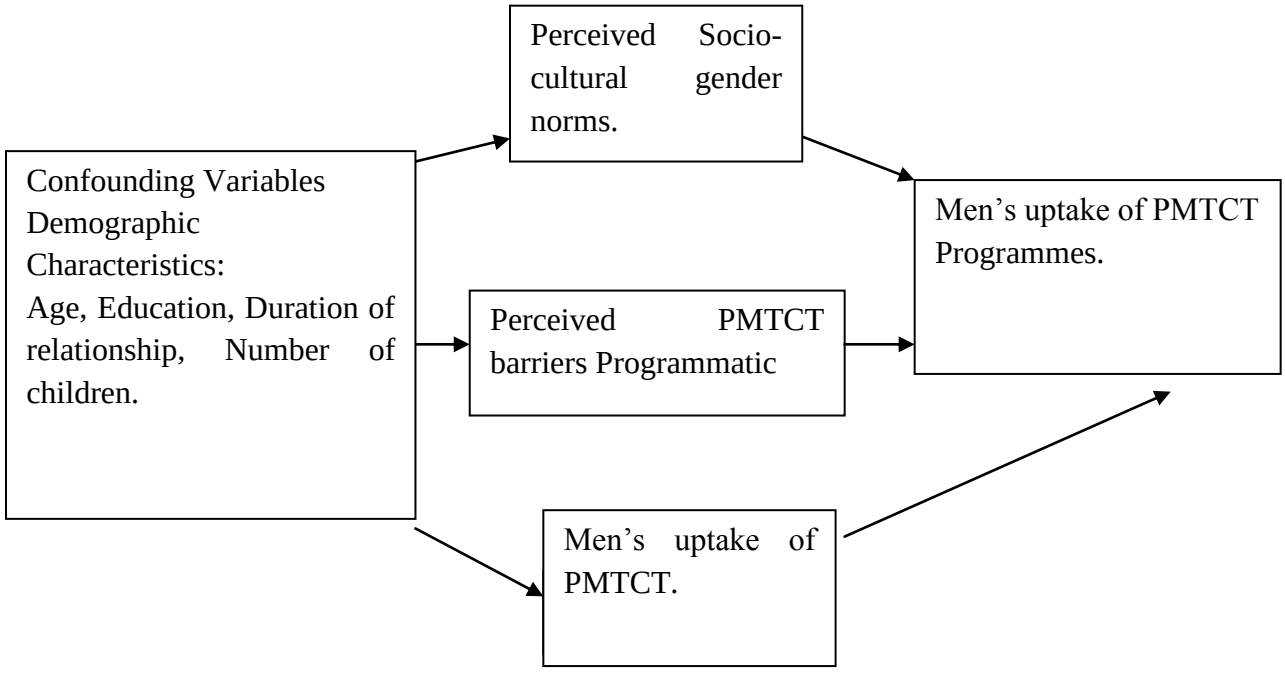

Figure 2:Research Conceptual Model(adopted from Selvan at.ai.2001)

The study was further informed by Koo's (2013) theory of participation and development which acknowledges that male involvement in women's reproductive health programmes is pivotal. The theory claims that men are decision makers, and this role is bestowed upon them by cultural and socialization institutions.Byamugisha et.al (2011) concur with Koo (2013) that culture, traditional practices and beliefs influence one's perceptions, analysis of perceived susceptibility, severity, benefits and behaviours within cultural ,economic and religious settings..The study informed by theories of participation in health development programmes investigated male participation in

PMTCT programmes within the frameworks of human thinking and behaviour as espoused by the Social Learning Theories of Breiger (2006).

The Social Learning Theory describes perception as a process of human transactions with the environment which gives meaning to one's experiences, represents one's image of reality and influences one's behaviour(Dabies,2000).This study's investigations were guided by this view, and male perceptions and behaviours accorded a status that was used to interrogate the influences of the environment and the male views on PMTCT.Ministry of Health and Child Welfare(MoHCW,2003) describes male participation as male enrolment into the PMTCT programme. This was also used to relate to male uptake of the PMTCT programme throughout this study, and interchanged with male involvement as well.

2.4 Men's Involvement in PMTCT

The understanding of the concept men's involvement varies with the context in which it is used and its definition differs from source to source in the literature. According to Maman (2012), men's involvement is dependent on the socio-cultural context though there are as yet no clear-cut guidelines on how far the partner participation can go. According to Lee (1999)men's participation include attending women's health education sessions and attending counselling sessions.However,for Rutenberg et al (2002), men's involvement entails choosing to come to the clinic with their partners, be counselled and

get tested for HIV, support their partners in coping with HIV infection and support them financially or other welfare contingencies that they encounter. In this study the focus of involvement of men in PTCT will be on their readiness to provide support or their support to their female partners in core PMTCT interventions, including counselling and testing; use of prophylactic antiretroviral drugs, among others. (Farquhar et al, 2004). Involvement will then be assessed by:

• Men's readiness to be counselled and tested or actually having been counselled and tested for HIV together with the female partner in a PMTCT setting

• Men's readiness to support or their actual support of female partner in managing VCT, PMTCT or ANC transactions.

• Men's readiness to support or actual support of female partner in the choice of Infant feeding option

2.5 Empirical Review

2.5.1 Male Participation in PMTCT Programmes

Participation in PMTCT programmes across the global landscape has been met with scepticism by men, for varied reasons and diverse backgrounds. According to Koo (2013), male partners play a role not only in women's risk of acquiring HIV but also in uptake of antenatal regimens. This assertion is based on a research undertaken in Nairobi, Kenya from September 2001 to December 2002.The study followed up with multiple hospitals and clinics to gather data on the participation of men in antenatal

activities, from the day a woman registers her pregnancy for the first time with the clinic up to the delivery stage. The main objective being to assess the extent of male involvement in the PMTCT programme.PLos One (Koo,2013)reported that the involvement of male partners in antenatal VCT was associated with vertical and sexual HIV transmission, while couple VCT was shown to have greater benefits, but few men accompany their partners to antenatal clinics. The study further laments the limited research about men's involvement in VCT and antenatal settings.

Reece et,al.(2010) in the article 'AIDS CARE' cited by Cole (2013) alleges that when transmitted from mother to child, the human immunodeficiency virus(HIV) is typically passed during pregnancy, labour and delivery, or through breastfeeding, Centre for Disease Control and Prevention (CDC 2007) and World Health Organisation(WHO 2008).The authors acknowledge that in Kenya(where the research was undertaken),PMTCT programmes have focused primarily on women, leading some to call for the need to examine men's ,and particularly male spouse's engagement in PPTCT in order to fulfil the objective of these programmes to not only decrease incidence among female spouses but also among infants, and to generally ensure familial level support for the HIV prevention and care needs of the family unit as a whole.

The discussion acknowledges male involvement in PMTCT and antenatal activities as limited in the country of study, and analysts have called for new discussions to centre on ensuring that men play an active role in the PMTCT programmes. Reece et. al. (2010)

came up with seven reasons why male involvement in PMTCT programmes is low in Kenya, which are: work related; spousal and familial relationships; child and parent well-being; HIV –related stigma; cultural and gender norms; education, support, and awareness of program; and structural issues related to prevention of mother-to-child transmission (PMTCT) clinics. Another study on the PMTCT programme and extent of male involvement was carried in Kenya from 1999 to 2005 by Aluisio. The authors concur that vertical transmission accounts for the largest proportion of HIV infections among women and infants.

HIV programmes in Zimbabwe are regulated by MoHCC policies on HIV/AIDS .This policy came into life in compliance with World Health Organisation WHO (2012) guidelines which required all member states to have a policy towards the management of the disease. The policy is made up of 43 guiding principles, and of interest for this study are principles 5, 11 and 17.Principle 5 states that reducing HIV transmission should be central to combating the HIV/AIDS epidemic. Principle 11 also emphasizes that breastfeeding should continue to be encouraged unless there are viable options to ensure appropriate infant and child feeding for women who know they are HIV positive. The last principle for the purposes of this writing is number 17 which says that voluntary HIV counselling and testing services should be made available to all members of the public.

These principles, for a start state that HIV transmission should be controlled, or stopped completely for a healthy nation. While HIV can be transmitted vertically, transmission of the virus to children is said to occur mainly at delivery, giving the reasons why WHO and UNICEF(WHO 2013 Report), collaborating with donor stakeholders came up with resolutions on PPTCT as the most effective means and stage by which child HIV infection can be controlled. (Levack, 2007). The adoption and implementation of the PMTCT programme is not restricted to Zimbabwe, therefore, references to how international states are managing male involvement in PMTCT programmes is noted herein. Infection with the HIV and AIDS continue to be leading causes of morbidity and mortality among women and children worldwide (UNAIDS 2013). According to 2008 estimates, over 430,000 children were newly infected with HIV, and over 90% of these were through parent-to-child transmission (PTCT) of HIV, (WHO: 2012) Report.

Ford (2012) recognises prevention of HIV infection of babies as a priority. At present the World Health Organization (WHO: 2012) promotes a comprehensive four-pronged approach for PMTCT. This includes: prevention of HIV infection among childbearing women, preventing unintended pregnancies among women living with HIV; preventing HIV transmission from a woman living with HIV to her infant; and providing appropriate treatment, care, and support to mothers living with HIV, their children, and their families. These programs are said to be more focused on women and generally omit men and pertinent questions around the effect of male participation in preventing PTCT

of HIV among pregnant women, and how has this participation can be rolled out emerge.

The male partner plays an important role in women's reproductive health and improvement of PMTCT outcomes. According to Bonphace (2009), this role of the male partner in women's HIV acquiring risk, uptake of voluntary counselling and testing (VCT) of HIV and PMTCT programs has been described in many studies. Studies from Kenya and Tanzania indicate that educating men on family healthcare improves health-seeking behaviour for antenatal care and immunisation, enriches communication for female support. The significance of male partner participation is also recognized by the WHO in their 2010 PMTCT Strategic Vision document where it is stated that male partners play an equally important role in the scale-up of PMTCT services.

Peltzer at.al (2007) notes that in this era of the HIV/AIDS epidemic, more attention is directed towards incorporating men into reproductive health education interventions. This is presumed to increase the uptake of couple counselling and disclosure of HIV status, open doors for the provision of services to HIV-negative couples and discordant couples, and preventive care and treatment for HIV-positive couples and their families. Furhermore,male involvement enhances partner support for follow-up care for HIV-positive pregnant women,HIV-exposed infants, ARV adherence, adherence to infant feeding methods, and early management of HIV-exposed infants

(Dabies:2000).According to Amsalu (2013),male participation eliminates harmful consequences faced by women who seek PMTCT services such as stigmatization and gender-based violence,actually,it addresses the healthcare needs and responsibilities of men, providing them with positive male norms, and linking them to other healthcare services.

WHO (2013) Report observes that Sub-Saharan Africa has the highest number of mother to child transmissions of HIV.The report states that PMTCT programme plays a big role in reducing the PTCT, although its effectiveness in Sub-Saharan Africa hinges on involvement of male partners considering the fact that man are decision makers in African family settings. They make important decisions that have big impact on women's health. According to Burke (2011) many sub-Saharan countries adopted male partner involvement in PMTCT programme with an aim of increasing the uptake of PMTCT services and the programme has made progress in improving the effectiveness of PMTCT services.However,the strategy is faced challenges, the biggest being low male partner involvement.

2.6 Strategies of Preventing MTCT of HIV/AIDS

2.6.1 Transmission of HIV

HIV may be transmitted to the infant during pregnancy, at the time of delivery, and through breastfeeding (Bajunirwe and Muzoora, 2005)). For a known HIV-infected mother who becomes infected in the antenatal period, the additional risk of transmission of HIV to her infant through breastfeeding has been estimated at 19% and up to 27%in cases where mothers acquire HIV in the postnatal period (EGPAF,2009). Factors assumed to increase perinatal transmission include: high maternal viral load; recurrent sexual transmitted diseases (STDs); malaria; Vitamin A deficiency; preterm delivery; vaginal delivery; duration of rupture of membranes longer than four hours; placental disruption; invasive procedures during delivery, breastfeeding and mixed feeding The majority of children who are infected with HIV were infected through PTCT or vertical transmission (EGPAF, 2009). According to Preble and Piwoz (2001), children who acquire HIV through this way face severe morbidity and mortality, especially in settings where specialised care is not available. In countries where PMTCT interventions have been fully implemented, rates of transmission from mother to child have been estimated to be as low as 2% (Prebble and Piwoz 2001). In developing countries such as those in sub-Saharan Africa, according to Piot and Coll-Seck (2012), where PMTCT programmes are not always easily accessible and prolonged breastfeeding is a norm, the rates are still estimated to be as high as 23-34%.

2.6.2 Strategy to reduce MTCT of HIV

United Nations agencies recommend a four-pronged strategy to prevent PTCT of HIV, which includes (WHO, 2013):

1. The primary prevention of HIV infection among parents-to-be.

2. The prevention of unwanted pregnancies in HIV-infected women.

3. The prevention of HIV transmission from infected women to their infants.

4. Treatment, care and support of infected and affected women, their children, partners and families.

Leichty (2010) consider three of these as core to PMTCT interventions, and these are VCT, ART and counselling for infant feeding options. VCT is considered by some as the most important intervention for PMTCT, arguing that importance of VCT in PMTCT lies in the fact that it has the potential to reach large numbers of women who may already be infected with HIV or at high risk of becoming infected. Experiences from a number of PMTCT centres demonstrated that VCT in PMTCT is a key to successful men's involvement when it takes the form of couple counselling who perceive VCT programmes which work with couples to be more successful than those working with women alone(Merilly,2012).

2.7 Male involvement

The treatment of men's involvement in the literature is examined in terms of its meaning and importance, as follow:

2.7.1 Interpretation of Male Involvement in PMTCT

Men's involvement or participation in women's health programmes vary from one context or situation to the other, it is not cast in iron anywhere. According to Chikonde (2009), men's involvement can be viewed from directions, may mean men supporting choices and rights of their female partners or men doing something about their sexual and reproductive health as means to protecting their partners. However, Rutenberg et al (2002), define using examples of events like men going to the clinic with their female partners, getting involved in counselling and being tested for HIV, while others' choices may not include visiting the clinic, but supporting partners in coping with HIV in other ways, pay partner's health care and transport costs for the to reach the clinic.. According to the Horizon Programme (2013), involvement of men is rather difficult to measure its degree is very difficult because as it is complicated by the terms used to qualify it. These include: men's participation, men's responsibility, male motivation, male involvement, men as partners, and, men and reproductive health.Drennan (1998) dismisses the debates around terms and posits that terminology used does not matter as long as the purpose is

to describe the process of social and behavioural change that is needed for men to play more responsible roles in reproductive health services.

2.7.2 Justification for Male Involvement in PMTCT Programmes

The importance of involving men in the prevention and treatment of HIV/AIDS programmes for women continues to gather momentum especially after the 1994 Cairo and 1995 Beijing conference which acknowledge men as crucial to bringing about changes in women's health status. (SAFAIDS, 2010). This shout to involve men in reproductive health issues notes the role of men scaling up the health of families at (UNAIDS, 2003).Men influence women's access to health services through their control of finances, women's mobility, and means of transportation and health care decisions (Klepp, 2010). (Lee,1999), the need to involve men, as defined by the Beijing Conferences, is critical for African settings because of the rapid spread of the HIV/AIDS pandemic and cultural norms, values and taboos which reinforce negative stereotypes about male involvement in reproductive life issues.

Giddens (2001) postulates that all cultures have values that give meanings and provide guidance to humans as they interact with their social world, and these influence men and women living in the same society about what are considered appropriate roles and responsibilities for each gender. It is these values and perceptions that tend to reinforce social institutions such as traditional and religious groups in the society. PATH (1997)

notes unfavourable social and religious climate in some societies where sexual matters are not discussed openly and men may feel uncomfortable talking about reproductive health needs with their partners and health workers. These similar observations are espoused by Kumah (2012) and Drennan (1998) who admit that some cultural norms and taboos in Africa reinforce negative stereotypes about male involvement in reproduction matters and some even condone abuses of women's reproductive rights by men. According to Gupta (2011), while gender is culture-specific, there is consistency across cultures in the disparities among women's and men's roles, access to resources, and decision-making powers. The set up of a programme can be a barrier to men's participation in reproductive health service PATH (1997) highlights that reproductive health services are designed to meet women's and children's needs and this shuts out men, and service providers are mostly females; they may be biased towards female related services. While PMTCT programmes accept the role of men, little have been done very little to involve men. According to this author, antenatal and mother and child health clinics are women's spaces that cannot be easily adapted to accommodate men. Green (2002) believes that men want to make use of the existing public health care infrastructures which not conducive to them due to constraints like time schedule and the attitude of nurses

According to Bajunirwe and Muzoora (2005) in a study on barriers to the implementation of PMTCT programmes in Rwanda, 77% of rural women felt that their

husbands must be consulted to them undergoing VCT for PMTCT.According to the study, women who thought they should consult their husbands before being tested were less likely to accept the test compared with those who thought they did not need to consult their husbands. Women who thought their husbands would allow them to test were more likely to accept the test than those who thought their husbands would not approve. Greene et.al (2004) reported similar perceptions among men who believe women should consult men before VCT to avoid conflicts.

2.8 Summary

The literature reviewed was meant to gain more understanding on men's uptake of PMTCT programmes, and place this study against the general picture of men and PMTCT and to identify literature gaps which might support the choice of this topic .The studies referred to in the previous sections confirm the involvement of men in PMTCT services. Women's uptake of these services is considerably influenced by the attitudes of their male partners. These studies also show that it is not very easy to convince men to be involved in programmes which are designed for and provided by women. Some of the factors influencing the attitudes which are found in these studies are related to gender norms and roles, to the flow of information about the programmes, and programmatic factors related to the unfriendliness of PMTCT clinics towards men. The literature has also demonstrated that PMTCT programming, institutional and structural barriers are not peculiar to Zimbabwe only, but common across all nations, especially Africa. The

prevalence and, morbidity and mortality rates of HIV/AIDS were noted as reportedly higher in Africa South of the Sahara in the literature, while studies depict unclear destiny of the countries in view of the HIV/AIDS disease, despite global collaborations to eliminate new HIV/AIDS infections.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

The methodology used to conduct the research on men's uptake of PMTCT is discussed in this chapter. The chapter covers the study design, the study population and sample, data collection method and instruments, ethical considerations, validity and reliability, and data analysis plans.

3.1 Research methods

The study investigated male participation in PMTCT programmes in Makoni District. This study is a mixed one, using both quantitative and qualitative approaches. While some of the research instruments measured quantitative data, the research additionally gathered qualitative data as this will enabled a one to one interface with respondents, an approach deemed critical for collection of data that requires individual feelings, expression of emotions, probing and clarifications on salient phenomena during the data capturing process, with concurrent triangulation, qualitative in-depth interviews and Focus Group Discussions (FDGs). The respondents gathered at designated points, such as at clinics or schools that are within their easy reach, and days. Structured interviews and questionnaires were extended and conducted on a door-to-door basis to participants who for some reason failed to attend group sessions. These methods were chosen on the basis of their abilities and appropriateness to people and areas of Makoni who are

mainly tobacco farmers, and the period of this research was at the peak season of tobacco farming business. Hence, the options to visit respondents at their door-steps as they were busy curing, grading, picking and packaging tobacco for onward ferriage to tobacco auction floors.

3.2 Research Approach

Quantitative and qualitative approaches were used to investigate men's uptake of PMTCT programmes in Makoni District. The research approach was informed by Burns and Grove (2005)who propound that quantitative methodology revolves around reductionism, logical deductive reasoning, some degree of control by the researcher, use of a structured data collection instrument, statistical analysis and generalisation. In this study, reductionism involved breaking down the PMTCT programme into components which were studied, such as perceived benefits from PMTCT programme, duration of relationship, perceived PMTCT programmatic and men's awareness and knowledge of PMTCT issues. Logical, deductive reasoning involves generating conclusions from a sample of participants and generalising them to a larger population. The data pertaining to men's involvement in PMTCT programmes in Makoni from this research was then reduced to facts and concepts that were generalized to all Zimbabwean men's attitudes and participation in PMTCT programmes. The research probed and analysed men's perceived significance of PMTCT programmes against other factors within their social,

economic and cultural environments. The researcher controlled the choice of the research problem, research methodology, variables to be studied and control on the effect of extraneous factors. Data collection and analysis involved the use of a structured data collection instrument (interviews, FGDs and questionnaires) and statistical analysis using SPSS 16.0 version.

3.3 Research Design

A descriptive design was used to understand men's uptake of PMTCT programmes in Makoni District .This decision is approved by Polit and Beck (2004) who reiterates that descriptive designs as meant for observations, descriptions and documentation of aspects of a scenario as it unfolds for a defined population. This study investigated and analysed men's behavioural tendencies and perceptions towards PPTCT and HIV/AIDS at large. In order to extract issues from these observations, the study probed men and women (lactating and pregnant) and their spouses on PMTCT issues and examined their interpretations, perceptions and practices. Cross-sectional designs are conducted in the present time to examine what currently exists and they are fundamentally characterised by the fact that all data are collected at one time (Brink and Wood 1998).

In the views of Brink and Wood (1998), descriptive designs help to identify embedded relationships among variables of a population under investigation, and may be

scientifically backed through mechanical correlations.Furhtermore,previous studies information may also feed into the unveiling evidence, and relationships or suspicions of that nature may then be documented and conclusions drawn. The suspicions of a relationship between men's uptake of PMTCT programmes and the different potential factors influencing it were defined and analysed within the framework and context of the reviewed literature (chapter 2) and participants' responses.

3.4 Research Population

3.4.1Selection of research population

The study population included women who got pregnant and registered with Weya Rural Hospital of ward 5 and Mayo 1 Clinic of ward 35,all in Makoni District, between March 2013 and March 2014, and at least counselled and tested (VCT),PMTCT and ANC, without any consideration of the HIV sero-status of the women, their husbands or sexual partners.87 village heads from the two study areas(ward5 and 35), two councillors,8 nurses,2 being sisters-in-charge,1 District Nursing Officer(DNO), 1 Zimbabwe Aids Network (ZAN),1 District Medical Officer (DMO),1 District Aids Coordinator(DAC),2 Zimbabwe National Family Planning Council officials (ZNFPC),2 Zimbabwe National Network for People Living With HIV/AIDS (ZNNP+) officials and 8 church leaders.

The study elicited the views of key informants because they are the gate keepers to development programmes that come to the community.Furhermore, their views give an

overall insight into the multiple extraneous factors that abound the society at large, such as the social environment, economic and cultural phenomena whose existence may promote or discourage programme support. The district officials are involved in the management and co-ordination of the programme implementation processes, and PMTCT falls directly under HIV/AIDS programmes, resulting in DAC, ZAN, ZNNP+ and ZNFPC being key stakeholders to the programme, hence, the decision to include them in the study.

3.5 Inclusion and exclusion criteria

The inclusion criteria for the study population included the following:

1. Male and female gender

2. Marriage or relationship with a woman counselled and tested for PMTCT during the period March 2013 to March 2014

3. Pregnancy registration with Weya or Mayo 1 clinic

4. Residence in Makoni District, ward 5 or 35, Manicaland Province, Zimbabwe.

religious affiliation

5. Employment and directly working with pregnant women, HIV/AIDS and PMTCT issues

6. Leadership roles over a village, ward or religious group

The following were not considered for the inclusion criteria:

1. The HIV sero-status of the potential respondent or his female partner

2. The man's age, race, political or religious affiliation

3.6 Type of Sample and Sampling Technique

Makoni Rural District Council is made up of 39 political wards, resettlements and communal areas. The population densities vary, with the communal areas' populations being higher than those from the resettlement areas. The study ward sample were chosen purposively after having noted the high HIV/AIDS prevalence among women and children during government co-ordinated registrations for Corn Soya Blend (CSB) provision intervention in the areas compared to other wards in the district in 2012.

Table 1: Populations by gender disaggregation for ward 5 and 35

Year	Ward	Population	Male	Female	Women of child bearing ages	Men of child bearing ages	Girls	Boys
2012	5	18963	7667	11296	5012	2846	6284	4821
			(40.4%)	(59.6)	(47%)	(37.1%)	(53%)	(62,9)
	35	17367	7394	9973	4001	3981	5972	3413
			(42.6%)	(57, 4%)	(40, 1%)	(53, 8%)	(59, 9%)	(46,1)

A systematic random sampling technique was used to select the sample units. According to Polit and Beck (2004), systematic sampling technique involves the selection of every *k*th case from a list or group (sampling frame) and, this *k* (the sampling interval), is established by dividing the total study population by the desired sample size. This study's population size is 1235 men and women, as per the clinical ANC registers for the period under review, and 34 key informants. The sampling frame was established using the two hospitals' PMTCT, VCT and ANC, 635 pregnant women registered pregnancies between March 2013 and March 2014.Personal records of these women were used to identify addresses of their male partners. The study population was then

divided by the sample size, which is 10% of the total population (127) to establish a sampling interval of about 3. Every third person on the list was selected as sample unit and the starting point was the 6th person, selected randomly by dropping a pencil on the register. In this instance, 30 women and 30 men made the sample for the study questionnaires similar exercise was carried out for the remaining names on the registers for the Focus Group Discussion sample, which gave 14 participants: 7 men and 7 women. Add to 34 key informants, bringing the total study sample to 110.

3.7 Method of Data Collection

3.7.1 Data Collection Approach

The data collection method for this study was face-to-face interview using structured interviews for key informants, self administered individual questionnaires for men and women, as well as Focus Group Discussions (FDGs) for men and women. Two FDGs were conducted, one in each ward, one for men only (ward 35), and one for women only (ward 5). The first FDGs for men and women only were meant to create an environment that encourages maximum participation by women or men who may not open up in the discussions if mixed with other sex. The themes and sub-themes from these FDGs were then used for triangulation of views and opinions of participants from the two study areas. The questionnaires were distributed to participants: 30 questionnaires for men and another 30 for women. Each FDG comprised of seven participants. This was to ensure maximum participation, enough time check and triangulate issues emerging from the

discussions. Questionnaires and FDGs were administered in two languages, shona and English to enable all participants to express themselves best in a language they felt comfortable with. This also enhanced the response rate, quantity and quality of information gathered.

3.7.2 Research Instruments

The instruments used to collect and measure data on men's uptake of PMTCT programmes in Makoni District were structured interviews, self administered questionnaires and Focus Group Discussions. The development, structure, and contents of these instruments are discussed below.

3.7.3 Development of the instrument

The research instruments under discussion were developed specifically for this study. Different approaches were simultaneously used to develop the items included in this instrument, as advised by Brink and Wood (1998) and Boynton and Greenhalgh (2005).Central issues on the extent of men's participation such as couple pregnancy registration at the clinic, VCT processes and ANC visits assisted the designing of the instruments to measure them in the local study area context. From the review of the literature, statements and findings from previous studies were identified and adapted into questionnaire items. The sources include studies such as those by Burke et al (2004a)

and Maman (2004) that noted culture, programmatic and institutional issues as factors that play a part in men's decisions to participate in PMTCT programmes. The review of literature also identified statements from monographs and conferences reports on men's involvement in reproductive health, such as those by Kamal (2002), Ntabona (2002), Rutenberg et al (2002) and Sharma and Singh (2004).From the literature, some items from instruments used in previous studies were also adapted, such as those from the behavioural surveillance questionnaire by Family Health International (2000).The researcher's ground experience of Makoni PMTCT programme also played a role in the development of some of the questionnaire items.

3.7.4 The Variable "Level of Men's Involvement"

Taking into consideration the conceptual definition given in chapter 1, the level of men's involvement in this study was measured by collecting information on men's intentions to be involved, or their active involvement, in the following PMTCT activities:

1. Being aware of the partner's counselling and testing for PMTCT.
2. Accompanying pregnant spouse for pregnancy registration with the clinic
3. being ready to discuss HIV testing for PMTCT with their female partner.
4. Attending MCH/PMTCT sessions together with the female partner for HIV counselling and testing.
5. Supporting their female partner in taking ARVs and adhering to them.
6. Visiting the pregnant spouse while awaiting delivery at the clinic.

7. Going to collect the spouse and the new baby from the clinic home on the day of discharge

3.8 Pre-testing of the Instrument

The questionnaire was tested with 10 pregnant women and their spouses (10) at St.Josephs Hospital in Mutare.This help the study to estimate the amount of time taken by each participant and planned ahead of time for the data collection process, identified and corrected ambiguous questions and questions which might not have been easy for both men women from the community to answer. The issues raised by this group helped in the improvement of the instrument. The revised instrument was later tested on ten nurses who were also seconded for in-house short training for the study data collection interviewers in April 2014.The improved research instruments were then submitted for final guidance to the research supervisor.

3.9 Reliability and Validity

3.9.1 Validity

Validity refers to the question whether there is evidence to support the assertion that the methods are really measuring the abstract concepts that they purport to measure. Another aspect of validity concerns the quality of the researcher's evidence regarding the effect of the independent variable on the dependent variable (Polit and Beck 2004).

3.9.2 Internal Validity

Internal validity refers to the margin to which the outcomes of a study give a true picture of the actual status of a situation, excluding all other extraneous influence (Brink et.al 2006). The researcher used the focus group discussions and interviews as primary data for the study considering that participants would open up and express issues right from the sub-coconscious, and the triangulation processes of issues and data from the various sources and processes gave some magnitude and strength to the research findings and conclusions. The use of systematic random sampling techniques; selection of respondents with similar characteristics were attempts to achieve higher degrees of internal validity in the study. The use of the pilot study and training of the nurses for the data collection from the administration of questionnaires at clinic levels were strategies to ensure that the data collection process would be within the desired direction and limits, and minimise contamination.

3.9.3 External Validity

Brink et.al (2006) perceives external validity the extent to which the results of a study can be generalised to other settings or groups. Polit and Beck (2004) postulate that external validity applies to the extent to which a sample is representative of the broader population. This therefore means that even the study setting and processes of data collection is representative of other environments. In view of these contentions, the

study adopted systematic random selection of a large sample in attempts to enhance external validity, and making the sample more representative, as well as comparison of the findings with other studies from the literature. Over 70% of the population of Zimbabwe is said to be indigenous people(ZIMSTAT,2012), with the advent of the Land Reform Policy, many people have moved into more communal styled life from the traditional farming compound systems, hence, practices and generic factors most likely similar, making the study findings easy to generalize to the larger male population.

3.9.4 Reliability

Reliability involves the correctness and consistency of information output of a study and This is normally linked to approaches used to measure research components. According to Brink et.al.(2006) in instances where research participants do not clearly and fully understand questions, processes or objectives of the study, reliability problems arise The use of face-to-face interviews and questionnaires wherein questions and discussions were translated to vernacular languages were strategies employed by the researcher to enhance research results reliability as the participants were able to express themselves in a language they understood best, sought clarifications directly and obtained instance clarifications are some of the methods used to improve reliability in this study. All the three research instruments were translated to vernacular language. The decision to use structured interviews for key informants was driven by the deliberate desire to authenticate some of the clinical and technical issues in the health sector from the

experts such as DMO, DNO and Matron. Furthermore, the use of the SPSS 16.0 package was designed to ensure that the analysis data output would be in a form that can be read, interpreted and communicated in scientifically accepted form and mode for further readers and investigators or consumers.

3.10 Data Analysis

3.10.1 Quantitative Data

Quantitative data was collected using self administered questionnaires. Questionnaires were divided into two sets: one set for men and another for women. All the questionnaires were made up of 20 questions each. The collected quantitative data was cleaned and coded and entered in the computer for analysis with the computer using SPSS 16.0 computer software. Frequency distribution tables and descriptive statistics were used to present the analysis of each variable. Correlation analysis was conducted to assess the relationship between men's involvement and the different factors, and to measure the level and extent of men's uptake of the PMTCT programme. Tables, a pie-chart and bar chart were used to illustrate the results of the analysis process.

3.10.2 Qualitative Data

Qualitative data was collected using structured interviews and FGDs.The interview scheduled was made up of 21 questions, divided into 5 sections. Section A collected

demographic data of the respondents, section B collected data on pregnancy registration processes, section C collected data on pregnancy delivery phase, section D collected data on post-delivery phase while section E collected data on PMTCT,VCT and ANC policy matters. Data collected through FGDs and structured interviews was classified into themes and sub-themes that emerged from the discussions. This led to thematic analysis of data to generate the ideas and issues that were presented by the participants in the discussions and deliberations.

3.11 Ethical Considerations

The study considered voluntary participation, confidentiality and anonymity, informed consent, risk reduction, scientific honesty and permission to carry out the research from the responsible authorities as critical. Participants have personal rights and the study made every effort to honour these rights to the end of the study by observing the following ethical virtues:

3.12 Voluntary Participation

The researcher educated and explained the purpose of the research and its form and approach to all the participants prior to the date for the data collection at the clinics, villages and homestead. Village heads for the respective participants were first informed before visiting the homestead of the participants. The rights of respondents to participate

in the research or not, as they chose, was respected. All respondents participated freely after receiving information on the study and their rights to answer questions or not, right to avoid being made uncomfortable and right to withdraw at any time during the process of questioning were explained to them.

3.13 Minimising risk to participants

The research was carried out with minimum risk for respondents. The only possible risk could arise from questions related to HIV/AIDS testing which participants could have found embarrassing. This was circumvented by the presence of the nurses and the VCT clinic resident officer for each clinic who ensured this was reduced by talking to the participants on HIV/AIDS first, and these participants are well acquainted to him as they always meet him when they visit the clinics for VCT, PMTCT and ANC routines.

3.14 Informed Consent

Participants were provided with adequate information on the research before the
Data collection exercises, and consent forms were issued to each participant before. The consent forms were written in both English and vernacular languages for the participants to understand the written information best. (Appendice1).

3.15 Confidentiality and Anonymity

The right of participants to anonymity and confidentiality was ensured by making the questionnaire anonymous, by keeping secret the information revealed by participants and participants were informed that any research findings publications will not reveal their identity in a way that would relate to the respondent.

3.16 Scientific Honesty

Scientific honesty was observed as much as possible in this report by ensuring proper cross -referencing, triangulation of emerging themes and listing all scientific sources at the end of this report.

3.17 Permission to Conduct Research

Authority to conduct research was obtained from district health authorities in Makoni District. The research proposal was also submitted to the Ethics Committee of Africa University. Traditional authorities of each village where participants are resident and interviews and /or questionnaires would be distributed door-to-door were informed in advance.

3.18 Summary

It is against each of these research questions that the analysis and interpretations are made for this study. Data was collected through three methods: questionnaires for lactating and pregnant woman and their spouses (60), Focus group discussions for both men and lactating and pregnant women as well as interviews for key informants (34) from Ministry of Health and Child Care (MoHCC), District Aids Coordinator (DAC), Zimbabwe National Network for People Living with HIV/AIDS (ZNNP+), Zimbabwe National Family Planning Council (ZNFPC), local traditional leadership (8) and church leaders (8). Data presentation is done in this order in this chapter, and analysis made forthwith. Male participation in PMTCT programmes was investigated at three levels: Pre –Delivery, Delivery and Post-Delivery, and data presentation and analysis is made within these contexts. A demographical characteristic of the study participants is presented, followed by the main themes that arose in the course of the research. Data collection took place from 17-31 March 2014. The returned completed questionnaires were numbered, and the data cleaned and then transferred to an electronic Statistical Package for Social Scientists (SPSS) 16.0 computer software spreadsheet for analysis with the same computer software.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents the findings from the study per research question and objective, and discusses the analysis and interpretation of data. Conclusions and recommendations are all made on the basis of the findings from each research question and objective. The data was collected with the aim of answering the research questions, which were:

1. To what extent are men participating in PMTCT programmes in Zimbabwe?
2. Which factors may discourage male participation in PMTCT programme in Zimbabwe?
3. In what ways do men support pregnant spouses for ANC and VCT services at health centres in Zimbabwe?

4.1 Response Rate and Sample Size

Data was collected from 110 respondents in the community through face-to-face Interviews (34 respondents), structured questionnaires (60 respondents) and Focus Group Discussions (14 respondents). This response rate was 100% of the expected 110 respondents (the sample size).

4.2 Analysis and Interpretation of the Data

The results of the analysis of data are presented below, according to each section of the questionnaire and item, using tables, graphs and summary statistics. Data analysis and interpretation was done in the context of pre-delivery, delivery and post-delivery phases of pregnancy of women. A total of 60 questionnaires: 30 for men and 30 for pregnant lactating women were used to collect data. Each questionnaire was made up of 20 questions.34 interviews were conducted on an individual basis, and each interview schedule comprised of 21 questions and lasted for an average of 25 minutes. Two FGDs were also held, one in each ward, and one for men and the other for women, and lasted for 2 hours each on average.

4.3 Demographic Characteristics

The demographic characteristics of the research participants are illustrated in the diagrams below.

4.3.1 Age

Lactating and pregnant female participants' ages were gathered both from the local clinic MoHCC HIV Testing and Counseling, PMTCT and OI/ART monthly return registers for the study period. Participants ranged in age from 15 to 40 years. The most

common age group was between 25 to 29 years, constituting while 38.3 % followed by the 20-24 age range that made up for 18% of the study participants.

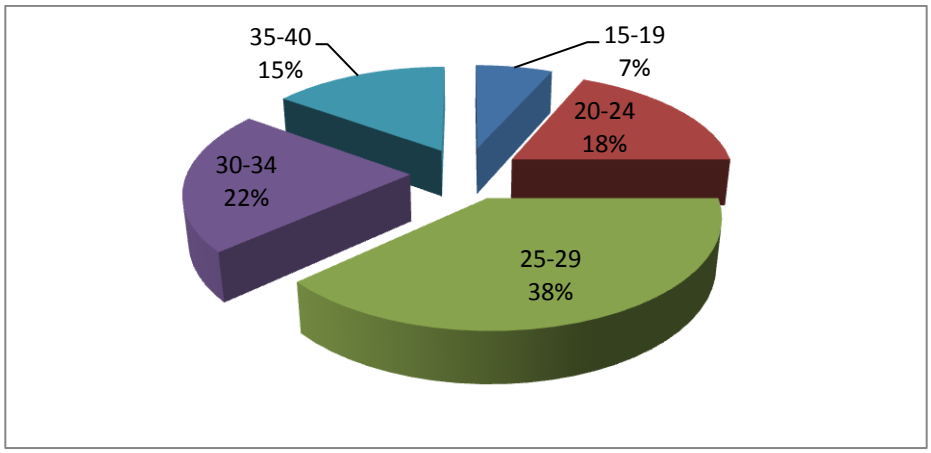

Figure 3: Age of Respondents

4.3.2 Marital Status

Majority of the participants (92%) were married. 2 (3.3%) of the 60 of participants individually interviewed were single. All the focus group participants and key informants were married women and men. There were exceptions in marital status for some of the participants who were divorced or widowed in the sample of study.

4.3.3 Educational Level

Seven (11.6%) of the sixty participants had tertiary education, while for the majority of the participants; the highest education level was secondary (53.3%) education level.

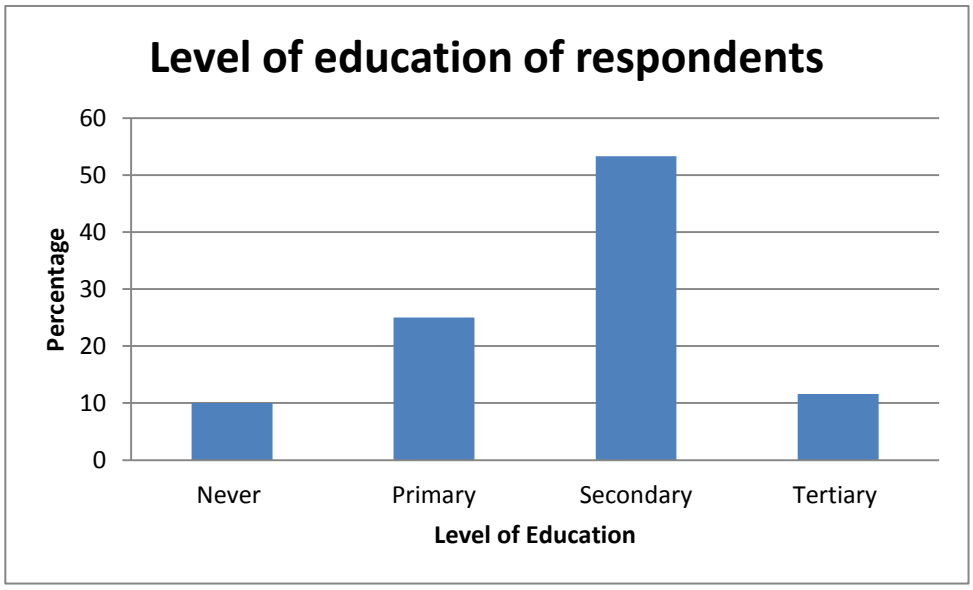

Figure 4 Level of Education of Respondents

Figure 5: Level of education of respondents

4.3.4 Employment

Thirty (50%) of the sixty participants were employed in non formal sectors, while 9 (15%) of them were working in professional capacities, and 15 (25%) were in no form of employment outside communal farming activities which were mainly subsistence.

4.3.5 Number of children

For 35% of the participants, this was their first pregnancy, while 36% were multigravid.

4.3.6 Duration of Relationship

The gestational age of the index pregnancy was below five months for two of the 20 participants (33.3%), while 60.1% had a gestational age between 6 and 7 months. 2 of the participants,6.6% (one in the focus group, and one individually interviewed) gave the age of their current pregnancy as 9 months.

Table 2: Duration of Relationship

Duration	%
1-3 years	28.3
4-6 years	10.0
7-10 years	36.7
+11years	25.0

Pregnancy Phase 1-Pre-delivery Phase: Research Question 1: To what extent are men participating in PMTCT programmes in Zimbabwe?

Table 3:Pregnancy Registration Information

Registration of last Pregnancy			Registration of last/current pregnancy with spouse	
	Frequency	Percentage	Frequency	Percentage
Yes	47	78.3	30	50.0
No	13	21.7	20	33.3

The table illustrates that a large number of pregnancy (78.3%) registered with local health centres from the study areas,however,as the same table demonstrates, few pregnant women are accompanied for these registrations by their spouses (20%).Of great interest also from the study on the basis of the preceding table is the discordant figure of 10 (16.7%) pregnancies that are unaccounted for in the study, may be because they were never registered or the participants were not in a position to state their opinions. On the basis of this position from the table analysis, it can be doubted whether men are supporting their pregnant female spouses as 33.3% of the pregnancies were reportedly registered by females who were not in the company of their male spouses.

This was also noted in FGDs when 5 male participants (35.7%) cited that for them it is not really necessary to go with their female spouses for pregnancy registration, saying

details needed and relevant at the time and across the pregnancy life time mainly centre upon the wife, not man. When the participants were asked how they have been supported by their partners during the present pregnancy, the responses were a mixed one. While the majority of them 12(40% said their partners have been supportive, 2(6.3%) reported having been rejected by their partners since they became pregnant, especially when their HIV status were known.

One of the participants in the FGDs, a divorced mother of one talked about the strained relationship she had with her former partner, and the lack of support from him:

Ever since I fell pregnant we have been fighting. Sometimes he sleeps out for as long as a month or more without communicating his whereabouts to me.l got no support from him each time l got pregnant, asking him to come with me to the clinic was inviting trouble, or else he would then find reason to sleep out, away from me, arguing that the new baby will suckle milk from the mother, not from the father, hence, there was no reason him visiting the clinic with me. (FGDs participant 6: age 34 years)

He does not stay here… but communicates very often; he wants to know my state of health and the children, when l visit him we discuss family health issues at length.

(Interview participant 10: 32 year-old).

I live with my husband. We have two other children besides the one I'm pregnant with. He is caring and supportive; he actually took me for a scan and paid all the hospital bills.

(Focus group Participant 4: 34-year old).

Of the twenty-six structured interview participants (76.5%) who are married, 27 (79.4%) reported that pregnant women do not get enough support from the husbands, citing numerous challenges ranging from men influenced by their socializations and general misunderstandings of neo-natal issues. They spoke about how men support pregnant women financially, but never ask questions about activities at the clinic. Most of the participants, MoHCC personnel who are into day to day pregnancy and health management and administration at various levels stated that they were surprised by the attitude of most men when their spouses are admitted or detained at hospitals for health reasons, or come to deliver as the husband does not show up, sometimes does not even pay the hospital maternity service fees, worse still, coming to assist the wife get home after delivery.

According to MoHCC and DAC structured interview participants, it is government policy that every pregnancy should be registered with the clinic or health centre as soon as the woman conceives. They said,

Pregnancy registration with clinics should be done as early as you feel you are pregnant. This will help early identification of ailments and detection of risk factors for early interventions, baseline observation and investigations for issues like blood pressure to exclude albumen urea (protein urea).

The same view points were shared by the ZNNP+ and ZNFPC participants who said their departments were campaigning for "ZERO NEW HIV/AIDS INFECTIONS", and reiterated that PMTCT was the critical breaking point for the success of this campaign as it means a new generation without HIV/AIDS infections. Hence, they are engaging both government and stakeholders to mobilize resources meant for educating and awareness building on PMTCT among men in the entire country. They bemoaned the past and current approaches to HIV/AIDS awareness, education programmes and mitigating strategies which they acknowledged tented to put focus on the pregnant mother, and practically excluding husbands of the women.

Interviews and focus group discussions noted that men have general understanding of PMTCT, though the majority of them have little appreciation of its significance in reducing the transmission of HIV/AIDS during pregnance.9 FGDs participants (64%) ,7 of them male concurred that men's attendance at the antenatal clinic was a rare experience and expectation in their communities. PMTCT services are accessed by pregnant women at the antenatal clinic (ANC), and there was a general consensus

among the participants that men are rarely ever seen at the ANC. Most of these participants have never seen a man attend the ANC:

In my area l have seen very few of them bringing sick relatives like children, mothers or fathers, not accompanying pregnant women for ANC,no! On televisions or hearing of it in radios only, and if the ones from my community can do the same, then the world will have turned upside down as the cultures and socialization systems consider such behaviours by men a taboo and unAfrican actually.

(Interview participant 11: age 42 years Village head).

Three (10%) participants reported previously seeing men at the antenatal clinic:

Last year l saw a man at the clinic, but people gazed at him. He moved from one consulting room to the other with his wife, and seemed not caring about the people around the place.

(Interview participant 13: 26 years). According to another interview participant and RGN:

People from European states do that (attend ANC), and these live in urban areas mostly. African man are not comfortable doing so.

(Interview participant 17: age 39 years Church leader).

Some of the women have witnessed partners who came as far as the gate of the clinic before turning back:

He turns around at the gate, and only returns to fetch me in the afternoon.

(FGD participant 4: age 23 years).

Pregnancy Phase 1-Pre-delivery /Delivery Phase: Research Question 2: Which factors may discourage male participation in PMTCT programme in Zimbabwe?

4.4 Perceived Barriers to Male Involvement in PMTCT

The research participants mentioned confounding structural, cultural, institutional and programmatic factors which they perceive to militate against meaningful male involvement in PMTCT programmes. These obstacles can be broadly categorized into four: socio-cultural factors; fear of knowing their HIV status; time factors; and health system factors. Each of these barriers to male uptake of PMTCT programmes is discussed below as per the views and perceptions of the research participants, analysis and interpretations made thereof.

4.4.1. Fear of Knowing Their HIV Status

Eleven of the participants from the FGDs (78.6%) believed that the fear of knowing their HIV status is one of the reasons men do not want to come with their partners for PMTCT. Some of the participants said some men will never go for an HIV test themselves, using their partner's status during ANC as a proxy indication of theirs.

The issue of testing for men was of particular worry to a participant who said:

If a woman is tested and knows her status, the husband considers it as if he has known his too. Using the results from the women, they take it will be the same for them, so they see no need for them to visit the clinic.

(FGD participant 14: age 26 years).

This is similar to the opinion of another participant when asked about what she perceived as obstacles to male participation:

If you undergo the testing yourself as the wife, men consider that as their test as well without physically being tested, arguing their status and mine are the same, why getting tested twice.

(FGD participant 8: age 38 years).

According to one of the Focus group participants:

Men do not want to be tested and know their results; they seem to habour lots of fear.

(FGD participant 5: age 31 years).

Table 4: Couple testing and feeling

	Feeling of Having an HIV/AIDS Test	
	Frequency	Percentage
Yes	29	43.3
No	22	36.6
Happy	20	33.3
Afraid	4	6.7(19)
Frightened	5	8.3(24)
No feeling	1	1.7

Table 3 statistics sums the study participants' views as couple testing and feelings following the tests are examined. Out of the 29 (43.35) participants who underwent couple testing at pregnancy registration, 4 (6.7%), amounting to 19 participants reported feeling afraid, while 5(8.3%), amounting to 24 participants felt afraid of having been HIV/AIDS tested. The fear of being tested and /or coming to know of one's sero-status by men has been noted as a factor discouraging men from the study area from fully and actively supporting the PMTCT programmes. This then raises more pertinent questions as to the extent of the damage in terms of the health of the babies born to these men, the

extent to which MoHCC, ZNNP+ and ZNFPC programmes would make an impact in view of this perception.

4.4.2. Socio-cultural Factors

Most of the male participants believed that the socio-cultural norm in which ANC and PMTCT are perceived primarily as a woman's affair is one of the obstacles to men's involvement in the program. According to them, a man attending antenatal clinic with his partner could be perceived by the society too "weak", and men do not attend the clinic to avoid being ridiculed.

Clinics are for women only, even if you check the set up and the number of female health workers, you will be convinced that men do not belong to those places.

(Interview participants 13 and 21: age 32 and 36 years old respectively: one traditional and the other a church leader).

They take it as if this is something for women only, so they are shy to participate.

(FGD participant 5: age 39 years).

They do not want to come to the clinic saying that they are not pregnant.

(Interview participant 4: age 13 years).

One of the interview participants (participant 27: age 41: Female village head) puts this more succinctly when she said;

If one of them is visiting the clinic with the wife, to others it is like he is being controlled. So they do not want to give that type of impression to their friends. He can accompany you and turn around at the gate, what he does not want to do is to enter the clinic with you, because he is going to be laughed at by his friends.

However, three of the FGD participants stated that their partners have come to the clinic with them previously, though they have since stopped due to pressure from their elders and other relatives who condemn them alleging that they behave like bewitched people ,and two of whom are also using Antiretroviral:

Since I've been visiting the clinic, I use to invite him as per health staff recommendations when he is off…he is taking ARVS too. (FGD participant 13: 26 years).

We did come together and attended the class; especially by the time we started taking the pills.

(FGD participant 9: age 37 years).

An analysis of the figures of those men who went with their pregnant spouses toregister the pregnancy at the clinic and underwent Voluntary Counseling and Testing (VCT),and the trends after the tests showed that for those men whose sero-status turned out to be negative, they tended to continue supporting their pregnant spouses in ANC and VCT/PMTCT programmes at the health centres (25%).However, for those whose results

were positive or discordant, they tended to stop the support for PMTCT for their spouses,frequence of visits tended to decline (75%). One FGD and key informant comments upheld this observation saying positive VCT results posed serious social, psychological and health challenges as violences, discriminations and divorces have been experienced by many pregnant women after these results. Two traditional leaders interview participants and five church leaders castigated government PMTCT policy arguing that it has destroyed families as there are no legal frameworks to enforce the programmes at grassroots level, other than having the legal issues written on paper. While they acknowledged the benefits they accrue from knowledge of the pregnant mother's sero-status early, their worry lie on the programmes lacking sustainability and hard economic situations in the country which they said eventually leave the pregnant women, foetus and family at large exposed when drugs are in short supply at times at the local clinics.

4.4.3. Time Factors

Going to the antenatal clinic to access PMTCT services involves spending long hours at the health facility. Participants were of the view that men are unwilling to wait for such a long period of time, and that this could be one of the reasons they were not participating in PMTCT.

Interview participant 4 described his own experience, stating that although he would have loved to attend the clinic with his spouse, he was too busy to wait. Another female FGD participant said:

My husband is self employed and very busy; he may take me halfway the journey here and rushes back for work.

(FGD participant 4: age 23 years).

A participant remarked during the Focus group discussion about the fact that men are simply unable to wait for hours at the clinic:

They feel uncomfortable, and do not wait; you will hear complain that you delayed coming back, what were you still doing with the nurses.

(FGD participant 11: age 34 years).

Another participant who said her husband has been attending the clinic with her because he is also on antiretroviral therapy also commented about the time constraints faced by her husband. When asked if her partner was still interested in attending the clinic with her, she responded:

He is caring and loving, but working, he doesn't have time.

(FGD participant 10: age 37 years).

Correlations drawn from the statistics for male visits to clinics for pregnancy registration, ANC, VCT and checking on pregnant spouse awaiting delivery at the clinic demonstrate that man's trends of visits decline gradually, even for those men who used to frequent the institutions. Interview participant number 33,a primary care nurse with one of the local clinic in the area of study concurred that men are sometimes very impatient .She said they are restless waiting for normal routine checks being carried out for their spouses whom they would have accompanied, and in some instances they would leave the spouse and only pitches up after she is through with the business for the day, while others would even leave to go and read the newspaper or sleep in the shade outside or the car. Key informants from the MoHCC acknowledged that most of the ANC, VCT and PMTCT programmes take time, and the DNO stressed that this process and time taken is necessary as they have observations and investigations to make on the pregnant women before they release her. He said that's their business and regulated role to ensure maximum reduction and prevention of any potential harm to both the fetus and the pregnant women.

4.4.4. Health System Factors

Antenatal care and PMTCT services as currently being implemented are designed mainly for women, in the opinion of some of the research participant. In fact one of the

women described her surprise when she learnt men are allowed to attend the clinic with their partners:

We thought men are not allowed to come here, we have no idea that men are allowed. (Interview participant 13:41 years old).

One of the participants spoke about her partner's refusal to attend the clinic with her because he does not like being attended to by female nurses who conduct the ANC and PMTCT services:

He shies away being attended to by female nurses. So would rather lose more money visiting private male surgeries. (FGD participant 2: age 30 years).

4.4.4.1 Perceptions about Health Care Workers' attitude to male involvement in PMTCT

Most of the female participants perceived that health care workers (mainly nurses) will be glad to have men accompany their partners to the clinic. According to them, the general attitudes of the nurses towards them have been good and they believe this will be extended to any male partner that attends the clinic. This positive perception was exemplified by one of the interviewed participants (Primary Care Nurse) believed nurses' response to men attending the clinic with spouse:

I personally will feel very happy because we want men to come, and that shows us that the husband is caring Besides being policy that couples should visit the clinic together, and despite male involvement in PMTCT and ANC being shrouded in mysteries and stereotypes, educating a couple on health matters facilitates, encourages and increases adherence, which is good for the fetus, father and mother. (Interview participant 13: age 36 years).

Another participant expressed the same view;

They will be happy, because they will be able to tell if l have been listening to what they have been telling me. They said that when you come to the clinic, the person who has impregnated you must accompany you, so that he can also listen to what is being advised at the clinic.(Interview participant 4: age 23 years).

One respondent was of the view that the nurses will be happy to see men at the clinic as this will actually make their job a lot easier:

Health personnel encourage women to come in the company of their male spouses as this will help teach and explain family health issues to both parties, so I think it will be a bit easy if they could attend the PMTCT,ANC and even be

present in the labour ward as the wife delivers. That way man will be able to appreciate their partners' health better.

(Interview participant 2 years: age 3).

One of the participants however had a different opinion. According to interview participant 5, nurses do not encourage men to attend the clinic with their partners. She said:

At our clinics men are asked to leave the ANC unit if they are with their wives. They are not permitted entering the ANC room where the nurses check on our health. One of the reasons is that there will be other women from other men who will be having health pains, so men are not allowed to see these naked women as they are not their spouses. (Interview participant 25: age 32 years).

The preceding information, though mixed, demonstrate that in some instances men are discouraged from taking an active role in PMTCT programmes by the knowledge or experiences of health staff or institutions where they are not accommodated as partners to the programme. The PMTCT Policy Document is very explicit with regards to inclusivity matters for spouses, but perhaps there is lack of coordination of policy matters in the ministry, or capacity on the part of the hospital management levels to identify gaps and provide in-house capacity development on policy issues. Alternatively,

inadequate resources, both human and material could be impeding factors that lead to inconsistency in policy interpretation and application in the MoHCC institutions.

4.5 Pregnancy Phase: Pre-Delivery/Delivery/Post Delivery Phase: Research Question 3:

In what ways do men support pregnant spouses for ANC and VCT services at health centres in Zimbabwe?

A 32-year old participant spoke about how this has improved her relationship with her partner:

> *Honestly, involving men in the program help because they are able to see the processes of ANC. They know what exactly is going on when you say you are going for ANC visits. Since the time he accompanied me to the clinic, he became informed about the processes of pregnancy.* (FGD participant 10: age 32 years).

4.5.1 Current level of Male Involvement in PMTCT

Research participants expressed their views about the current level of male partners' involvement in the PMTCT program. This came from their personal experiences of their relationship from their partners, as well as from what they have observed in the clinic and their neighbours or community. Three sub-themes were identified: men's attendance

at the antenatal clinic, disclosure of HIV status to the partner, and partner's support during this pregnancy.

4.5.2 Disclosure of HIV status to Partners

Four of the structured interviewees from the MoHCC explained that male involvement in PMTCT helps the pregnant women manage their health properly and efficiently as they have somebody to fall on when they face challenges. They said to date they have observed this especially when VCT results are positive, some male spouses go extra miles in ensuring that their female spouses are supported through regular counseling visits, supplies of drugs and medical examinations to check on the safety of both the pregnant woman and the foetus. Couple testing (56, 9%) Discordant results (39,2%),68,8% were happy with results, Approximately 75%, were women, Participants who received HIV and PMTCT education (76%),Men who had HIV education (63,2%),Feelings of having an HIV test (65,5% were happy),Only 10,3% of these were men who were happy

> *I have tested and the nurses asked me if there is someone I'm going to tell and I said I will tell my husband, when I got home it was not easy but l had to tell him when he asked how it went . On the next Thursday, we were supposed to come together here at the clinic, although he was busy at work he took time off and came with me. He was also tested and he tested positive. He then sought*

knowledge and information on how best we would move on without risks to the baby and me. Now we visit the clinic together for replenishments and counseling, and this move has given me mental peace. (FGD participant 13: age 29 years).

One of the MoHCC official participants, while stating the different ways in which men can support pregnant women said:

Early pregnancy registration helps early detection of any possible pregnancy related challenges; hence, early observations and investigations are done. The presence of the male partner then makes communication of results of the observations and investigations easier for the women. We expect men to accompany their spouses so that in the event of results that need decision making, it becomes easier for the two to discuss and take appropriate options in time. This also reduces conflicts and domestic violence as the parties are counseled. (FGD participant 5: age 28 years)

Participants who have disclosed their HIV status to their partners reported positive responses and support from them. According to one of these women:

He said its fine and said I should always inform him when I'm coming to the clinic. I always do that, and after I have finished from the clinic, he phones and asks how it went. (FGD participant 6: age34 years).

I personally will feel very happy because we want men to come, and that shows us that the husband is caring Besides being policy that couples should visit the clinic together, and despite male involvement in PMTCT and ANC being shrouded in stereotypes, educating a couple on health matters facilitates, encourages and increases adherence, which is good for the fetus, father and mother. (MoHCC –PCN interview participant 13: age 36 years).

According to MoHCC interview participants, men support pregnant women by making baseline observations and investigations possible when they encourage their spouses to visit the hospital for booking the pregnancy as soon as the woman feels pregnant. This is reported to allow early identification of adherences and risk factors for early interventions, and the support of the male partner may also be manifested through the financial support for the referral visits to specialists were necessary, procurement of drugs and moral support by just being with the pregnant spouse when she needs him. The officials concurred that today in Zimbabwe PMTCT has moved a step further by the introduction of the Option "B"plus intervention wherein a pregnant woman undergoes routine observations and investigations and VCT.Wherein the results are positive, the

pregnant woman is immediately referred to ART/OI department where she is switched to ART for life, unlike in the past when the pregnant woman would be given options to opt in or opt out. The current situation is mandatory; hence, the presence of the male partner would help both parties to be educated on the intervention and management issues of the situation. Men are said to support PMTCT by constantly and regularly visit their pregnant spouses when they are at the hospital waiting for delivery, collecting their spouses' home after delivery as well as being physically present when the wife is delivering in the labour ward.

An analysis of the responses from the study on issues regarding age of pregnancies at registration, frequency of male visits to clinics while spouses was waiting for delivery as well as encounters of pregnancy delivery health problems demonstrated that those pregnant women who register with the clinics late have a higher chance of experiencing delivery health problems, while most male respondents do not visit their spouses at the hospital, nor even go to collect them after delivery(75%) of the participants acknowledged not visiting or collecting their spouses. This then denotes low levels of male uptake of PMTCT programmes and support of the spouses through PMTCT, VCT and ANC (Table 5).

Table 5:Frequency of Husbands" Visits Before delivery cross tabulation

Are the results the same * Frequency of husband`s visits before delivery Cross tabulation

		Frequency of husband`s visits before delivery				
		Once	Two times	More than three times	None	Total
No	Count	0	0	3	9	12
	% within Are the results the same	.0%	.0%	25.0%	75.0%	100.0%
	% within Frequency of husband`s visits before delivery	.0%	.0%	23.1%	90.0%	40.0%
	% of Total	.0%	.0%	10.0%	30.0%	40.0%

All the participants, except one, said it will be good for men to attend the ANC with their partners, and all of them will be glad for their partners to come with them to the clinic. Some of the benefits of male partners involvement and attendance at the ANC/PMTCT clinic mentioned by the participants include helping to get the men counseled and tested, improves the relationship between the couple, as well as making

the women feel happy and appreciated. This will also help the men feel more responsible and "bond" more with the child, improves and protect the health of the child, convince them to use condoms, and also enables them to provide support for their partners by reminding them of what is said at the clinic.

One interview participant spoke about the benefits to the child:

It is the right thing to include them so that we can come with them and listen to ways of protecting the child together.

(Interview participant 9: age 37 years).A similar opinion was expressed by another woman:

Maybe that's where things can be improved, because we will be educated on how to protect the child and so on and I will be very glad if that can happen.

(Interview participant 5: age 26 years).

4.6 Theoretical, Conceptual Frameworks and Research Findings

Demographic characteristics of the study participants such as age of males, age of the marriage and number of children in the marriage partnership seem to contribute to male support of the pregnant spouse as those in older marriages and with more than two children tended to be more supportive to their spouses than those with one or two

children or first pregnancies. Visits to clinic in waiting (41, 9% 3 times). There is a positive correlation between frequencies of visits with age of marital status. This concurs with Selvan et.al (2001)'s research model wherein the authorities acknowledge that level of education, duration of marriage relationship, age of the parties to the issue under research and other characteristics like number of children can have inherent direct and indirect influence to the perceptions and behaviours(Chapter 2:Section2.5 Figure 2.2).The Health Belief Model which informed the study,Burker(2006) anchors on perceived susceptibility, perceived severity, perceived benefits and implications.

The study findings established that for those men who tended to support their pregnant spouses in PMTCT interventions, respondents who registered their pregnancies (95, 5%), 60% of these were males who supported their wives had high appreciation of the benefits that accrue from the programmes to their families and relationships. They in turn also do so to avoid costs and severities that may come with pregnancy complications(Key Interview Informant 7: age 43 years).Lewin's force field theory, Briger (2006) postulates that human behaviour anchors on perceptions .Knowledge and understanding of these issues will generate perceptions (Chapter 2 :Section 2.4 Conceptual Framework).The Social Learning and Cognitive theories heavily informed the study, and the research outcomes were in great resonance with the perceptions of the respondents who cited social,economic,religious and physical settings as barriers to male uptake of PMTCT programmes.

4.7 Summary

The chapter presented the study findings on male uptake of PMTCT programmes in ward 5 and 35 of Makoni District.110 respondents participated in the study. Data was collected in March-April 2014 and analysed using SPSS version 16.Descriptive statistics were used to describe demographic information, while qualitative data gathered through FGDs and structured interviews generated themes which projected perceptions of men and their participation in PMTCT. Inferential statistics were also used to check relationships between variables. Responses from questionnaires demonstrated that male uptake of PMTCT programmes is not uniform in the areas and across the groups, FGDs and Structured interviews pointed to structural, programmatic, institutional and cultural barriers to meaningful male participation in PMTCT programmes. Key informants who happened to be mainly from government health related departments and organizations reiterated government commitments to the fight against HIV/AIDS through various policies,PMTCT programmes being just an offshoot, ZNNP+ and ZNFPC collaborating to eliminate new infections of HIV/AIDS.ZAN and NAC in their annual HIV/AIDS Global Commemorations have thus adopted the motto: *ZERO NEW HIV/AIDS INFECTIONS* as a signal of their convictions towards the desire to see the PMTCT programmes gain ground and positive impact in the country. The interpretations of the data point to weak PMTCT policy impact on ground as there is low male participation in PMTCT programmes, lack of adequate community leadership buy-in of the PMTCT programmes, as well as disintegrated programme coordination that is projected in

different health institutions implementing PMTCT policy programmes differently in the same district.

CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter provides a summary of the study, making conclusions related to the research questions. Recommendations are made based on the findings of this research for future studies and improvements of the PMTCT interventions.

5.1 Summary

Discussion on the result and findings of this thought provoking research piece will be stratified according to the following:

Findings from this study show that the level of male participation in PMTCT, as measured by attendance at the ANC, is very low. Most of the participants understood the antenatal and intrapartum interventions to reduce MTCT of HIV, which are mainly antiretroviral prophylaxis for the mother and infant. Some of the participants however had no clear understanding about PMTCT programmes objectives, leading to weak support towards their pregnant spouses, specifically participating in the pregnancy registration, VCT and ANC, which is the main thrust of post-natal PMTCT as this creates awareness and appreciation of the medical mechanisms towards ensuring HIV/AIDS free births and generations. According to WHO (2007) involving men in PMTCT services could increase the uptake of couple counseling and disclosure of HIV

status. This would open doors for the provision of services to HIV-negative couples and discordant couples, as well as preventive care and treatment for HIV-positive couples and their families. The study findings posed a scenario in which male uptake of PMTCT programmes is shrouded in mixed interpretations, with some supporting their female spouses while those who do not are perceive male participation in PMTCT activities as non events, influenced by socialization from both religious and cultural settings. The Health Belief Model of Burker (2006) states that human behavior anchors on perceptions, meaning that the way one acts is in response to how and what one perceives the values, benefits and rationality of a phenomena. The evidence gathered in this study from church (mainly apostolic) and traditional leadership illustrate that some of the low male uptake of PMTCT are a result of the nature of perceptions and values inculcated in them by their cultural and/or religious backgrounds.

The study established that there is minimum support nor participation in PMTCT by males in the area of study noting the high percentages of males who fail to accompany their spouses for ANC to health centres, visit their female spouses at health centres while they are waiting delivery at the hospitals nor go to collect their spouses after they have delivered. While the data from the key informants cited numerous PMTCT campaign programmes and government driven initiatives through stakeholders like NGOs,ZNFPC and ZNNP+ to bring men at the forefront of PMTCT programmes, there seems to be little impact, or low appreciation from the communities and community gatekeepers

considering the fact that village heads perceive the programmes negatively. The ultimate result is that a policy that has no buy-in from the stakeholders it purports to serve is doomed as it has no social platform for its application, hence, low impact of the PMTCT programmes basing on this study's findings. Results of studies from other countries in Africa, such as Uganda, Tanzania and Kenya reveal similar pattern of poor male partner's involvement in PMTCT.

All these authors are of the view that to be effective in Sub-Saharan Africa, PMTCT interventions need to be designed to encourage more male participation and engagement. Some of the participants in this study have never seen a man attend the clinic before. Although only three out of the 20 participants (15%) in the study stated that their partner have been to the clinic with them, the majority said their partners provided other type of support, mainly in the form of money to them to facilitate their attendance at the clinic. A similar pattern was reported by Byamugisha *et al.* (2010) among male partners of HIV-positive women. Study further established the existence of other structural, institutional and programmatic factors that militate against male meaningful and active participation in PMTCT programmes. These factors, in addition to cultural and religious socializations, include fear by men of knowing their HIV/AIDS status, time and Health institutions related barriers. In a scenario of these factors impeding active male participation, critical questions regarding extents of HIV disclosures to these men by their pregnant spouses after VCT interventions alone at the health centres come into

play, and remain in suspense. The long term impact of these factors on the general health of the new born generations is a cause for concern. A major factor mentioned by the participants is the societal perception that ANC is exclusively for women and that only weak men, controlled by their partners visit such clinics. This is similar to the finding in Kenya by Reece *et al.* (2010), where research participants felt that traditional cultural norms and gender roles prevalent in the region made it particularly difficult for men to attend the programs with their wives. Nkuoh *et al*. (2010) reported that most of the men respondents in a study conducted about PMTCT in Cameroon regarded the PMTCT and antenatal care services as a woman's affair. Likewise, according to Falnes *et al.* (2011), antenatal clinics are regarded as 'female arena' in northern Tanzania. Findings from this study reveal that the level of male partners' involvement in PMTCT remains low although most of the women would like their partners to be more actively involved in it. The study suggests a positive attitude among pregnant women towards male participation. There is a perception of inadequate male support among the study participants, who would like to see men do more than just providing financial support to facilitate women attendance at the antenatal/PMTCT clinics. Considering the various benefits attributed to male participation by the research participants, continuing low involvement of men in PMTCT perhaps indicate the deep-seated gender role within the community, where pregnancy and child-bearing is a woman's responsibility. The current reality in South Africa of a low perinatal HIV transmission rate of 3%, attributable to antiretroviral use during pregnancy and immediate childbirth period, is contrasted with a

late post-natal transmission rate of up to 18%, indicating possible lack of support for the nursing mothers, shows the urgent need to engage men in the PMTCT strategies.

5.2 Conclusions

These conclusions are hereby made on the basis of the research findings and answers obtained from the research questions.As the efforts to stem the tide of the HIV epidemic continues, prevention of vertical transmission presents a veritable opportunity to prevent unborn children from the pain and misery that HIV infection signifies. The global community has rightly committed itself to the elimination of new infections among infants in high-burden countries, mostly in Sub-Saharan Africa, where more than 90% of HIV-positive pregnant women live. The focus of the prevention of mother-to-child transmission (PMTCT) program, in many countries has traditionally been on pregnant women. As recent evidence has shown, male partners are as equally important in the successful implementation of such a program. This study provides some insights about the involvement of men in PMTCT program from the perspectives of men, women, traditional and religious leaders who believe more is not being done to take men on board. The eventual outcome is poor programme impact, and in this case more harm than good to the health of new born babies, future generations and the women in general.

5.3 Recommendations

The following recommendations are made on the basis of the findings from this study:

1. Health workers (preferably, male health care workers) should do home visits to teach men about HIV, VCT, ANC, PMTCT and to explain to them the importance of being involved in the program.

2. Government legislation on PMTCT should be enforced, decentralized and comprehensive village based outreach programmes undertaken through all stakeholders (churches and traditional institutions) engaged, and make it compulsory for husbands to accompany their wives to the clinic.

3. Information about men engagement in PMTCT should be publicised on the radio, television, magazines as well as on social networks.

4. Government existing structures: Peer education, Village Health workers (VHW), Home Based Care Givers (HBC) and Case Care Workers (CCW) should be strengthened for localized education and awareness campaigns.

References

Aluisio,A.,Richardson,B.,Bosire,R., John-Stewart,G.,Mbori-Ngacha,D and Farquhar.(2011).*Male Antenatal Attendance and HIV Testing Are Associated With Decreased Infant HIV Infection and Increased HIV-Free Survival, Journal of Acquired Immune Deficiency Syndrome*,56,76-82

Auvinen,J.,Souminen,T. and Valimaki,M.(2010).*Male Participation and Prevention of Human Immunodeficiency Virus(HIV)Mother-to-Child Transmission in Africa*,Psychology,Health and Medicine, *East African Medical Journal*.

Babbie, E.R. and Mounton, J (2001). *The Practice of Social Research*, Cape Town, Oxford University Press.

Bajunirwe, F and Muzoora, M. (2006). *Barriers to the implementation of programs for the prevention of mother to child transmission of HIV:* A cross-sectional survey in rural and urban Uganda, AIDS Research and Therapy 2(10):1-7

Boynton, P.M.and Greenhalgh, T. (2005).*Hands on Guide to questionnaire research: Selecting Designing and Developing your Questionnaire*. British Medical Journal: 328:1312-1315

Brink,H.,Van der Walt,C. and Van Rensburg,G.(2006).*Fundamentals of Research Methodology for Health Care Professionals*(2nd edition),Cape Town,Juta and Company (Pvt) Ltd.

Brink, P.J., and Wood, M.J. (1998).*Advanced Design in Nursing research*, Thousand Oaks, Sage.

Burker, M., Rajabu, M. and Burke, J (2009). *Male Participation in PMTCT Programmes in Tanzania*, Geneva.

Byamugisha, R., Tumwine, J., Semiyaga, N. and Tylleskar, T. (2010). *Determinants of Male Involvement in the Prevention of Mother –to –Child Transmission of HIV Programme in Eastern Uganda Reproductive Health Journal*

Centre for Disease Control-CDC (2000). *Family Planning Methods and Practice*, Africa Atlanta, USA.

Chikonde, S., Saudby, M. and Martison, T (2009). *Acceptability of PMTCT, Journal of AIDS* 34(3)572-574

Cole, H.M. and Fontanarosa, P.B. (2005*). Improving Men's Health*, Lippincott, New York.

Dabbies, N. (2010). *Patients and Careers Perceptions of Factors Influencing Participation, Journal of Advanced Nursing*, 32(2)318-326.

Drennan,M.(1998).*Reproductive Health: New Perspectives On Men's Participation,* Population Reports, Series 1,Number 46,Baltmore.

Elizabeth Glasser Paediatric Aids Foundation (2009). *Increasing Male Involvement in PMTCT Services:* A Success Story of Virginia Rural Health Centre in Zimbabwe, Harare, Zimbabwe.

Giddens, A. (2001). *Sociology, 4th* Edition, Cambridge, Polity Press.

Glanz,K.,Rimmer,B.K. and Lewis,F.M.(2002).*Health Behaviour and Health Education:*Theory,Research and Practice,3rd Edition,San Franscisco,John Wiley and Sons.

Greene, M.E. (2000).*Changing Women and Avoiding* Men, Stereotypes and Reproductive Health Programmes, IDS Bulletin 31(2)49-59

Horizon Programme (2003). *PMTCT: From Research to Practice*, New York, Population Council.

Kamal, I.T. (2002). *Field Experiences in Involving Men in Safe Motherhood*: Programming for Male Involvement in Reproductive Health, WHO Report, Washington DC, USA.

Klepp, K.I., Manongi, R, and De Paoli (2004*). Factors Influencing Acceptability of Voluntary Counseling and HIV-testing Among Pregnant Women in Northern Tanzania*, AIDS CARE 16(4)411-425

Koo, K., Makin, J. and Forsyth, B. (2013). *Where are the men? Targeting Male Partners in Mother-to-Child HIV Transmission,* AIDS CARE, Psychological and Socio-medical Aspects of AIDS/HIV, 25(1)43-48

Kumah, O.M. (1999). *Fostering Male Involvement and Partnership*: A Stepwise Process, Kigali. Rwanda

Lee, R.B. (1999). *Men's Involvement in Women's Reproductive Health Projects and Programmes in the Philippines*, Reproductive Health Matters, Oxford University Press.

Levach,A.,Mahony.E.,Bernal,V.L.,Burger,M. and LaRosa (1999).*Male Participation and Sexual and Reproductive Health: New Paradigms:* Three Case Studies: Involving Men to Address Gender Inequalities,Mexico,Washington.

Liechty, C.A. (2005). *The Revolving Role of HIV Counseling and Testing in Resource-Limited Settings: HIV Prevention and Linkage to Expanding HIV Care Access: Journal of AIDS,* 17(2)154-158

Maman,S.,Moodley,D. and Groves, A.(2011).*Defining Male Support During and After Pregnancy from the Perspective of HIV-Positive and HIV-Negative Women in Durban, South Africa, Journal of Midwifery and Women's Health* 53(4),325-331

Merrily, O and Johnson, J.O. (2001). *Meeting Health Needs of a Vulnerable Population: Perceived Barriers, Journal of Community Health Nursing*, 18(1)35-52

MoHCW (2000). *National AIDS Control Programme*, Harare, Zimbabwe.

Ministry of Health and Child Welfare (2001). *Reproductive Health Services Delivery Guidelines*, Harare, Zimbabwe.

Ministry of Health and Child Welfare (2005).*AIDS Epidemic*, Geneva, Switzerland.

Ministry of Health and Child Welfare (2006). *Manual for PMTCT in Zimbabwe*, Government Printers, Harare.

Ministry of Health and Child Welfare (2006). *Prevention of Mother to Child Transmission of HIV:* Participant Manual, Harare, Zimbabwe.

MoHCW (2013). *Annual Report*, Government Printers, Harare, Zimbabwe.

Ministry of Health and Child Welfare (2012). *Zimbabwe National HIV Strategy*, Harare, Zimbabwe.

Newell, M.L. (2001).*Prevention of Mother to Child Transmission of HIV: Challenges for the current decade*, Bulletin of the World Health Organisation 79(12):1138-1144

Nkuoh ,G.,Meyer,D. and Nkufusai,J(2010).*Barriers to Men's Participation in Antenatal and Prevention of Mother to Child HIV Transmission Care in Cameroon,Africa,Journal of Midwifery and Women's Health*,22,363-369.

Ntabona, A.B. (2002) *Involving Men in Safe Motherhood*: The Issues, WHO.

Peltzer,K.,Mosala,T.,Shisana,O.,Nqueko,A. and Mngqundaniso,N.(2007).*Barrier to Prevention of HIV Transmission from Mother-to-Child(PMTCT)in a Resources Poor*

Setting in the Eastern Cape, South Africa. African Journal of Reproductive Health 11(1)57-6

Piot, P. and Coll-Seck, A. (1999). *Preventing Mother to Child Transmission of HIV in Africa,* Bulletin of the World Health Organisation 77(11), 869-870

Polit, F. and Hungler, P. (2005). *Nursing Research Principles and Methods*, J.B.Lippincott Company, Philadelphia.

Prebble, E.A. and Piwoz, E.G. (2001). *Prevention of Mother –to-Child Transmission of HIV in Africa:* Practical Guidelines for Programs, Washington DC

Rutenberg,N.,Kabibala,S.,Mwai,C. and Rosen,J.(2002).*Integrating HIV Prevention and Care into Maternal and Health Care Settings*,Nairobi,Kenya.

Reece,M.,Hollub,A.,Nangami,M. and Lane,K.(2010).*Assessing Male Spousal Engagement with Prevention of Mother-to-Child Transmission(PMTCT) Programs in Kenya,* AIDS CARE 6(22),743-750

SAFAIDS (2003). *HIV and AIDS Management* 2(1)12-14

Selvan,M.S.,Ross,M.W.,Kapadia,A.S.,Mathai,R. and Hira,S.(2001).*Study of Perceived Norms, Beliefs and Intended Sexual Behaviour Among High School Students in India,* AIDS CARE 13(6)779-78

UNAIDS (2000).*HIV/AIDS Country Profile*, Zimbabwe, Geneva.

UNAIDS (2004). *Report on the global AIDS epidemic*, Geneva, Switzerland.

UNAIDS (2005). *Strategies to support the HIV related needs*, Geneva, Switzerland.

UNAIDS (2003). *HIV and AIDS Management*, 2(1)12-14 Lowenson, R. and Kerkhoven, R.

UNAIDS, *Joint United Nations Programme on HIV/AIDS (2011).* AIDS at 30: Nations at the crossroads.

WHO (2000*).The World Health Report, Reducing Risks, Promoting Healthy Life,* Geneva, WHO.

WHO (2006). *National Psycho-social Support Guidelines for the prevention of mother to child HIV transmission in Zimbabwe, Harare, Zimbabwe*

WHO (2007). *HIV and Infant Feeding, PMTCT WHO Library, Geneva*

WHO (2012*). Programming for Male Involvement in Reproductive Health: Report for the Meeting of WHO Regional Advisors in Reproductive Health*, Washington DC, USA.

Zimbabwe Central Statistics (2012*). ZDHS A Report*, Harare.

List of Appendices

Appendix 1: Consent form

Consent Form

Dear participants

My name is Tawanda Munyanyi,l am a student at Africa University, undertaking a master of Public Policy and Governance Degree.l am carrying out a study to investigate male uptake of Prevention -of-Mother-to Child Transmission of HIV/AIDS.

l am kindly requesting you to participate in the study. The information obtained will be treated in confidence and the study findings will be used to assist the process of perfecting the PMTCT programme. Your identity will not be disclosed and code numbers will be used for identification, so feel free to participate.

Your decision to participate or not will not affect the care given to you or your family or your relationship with the health care providers. Your participation is voluntary and you are free to withdraw anytime without any penalties. If you agree to participate may you sign in the space provided below. If you have to communicate with me or if you need any clarification my contact address is:

Farm Community Trust of Zimbabwe

Stand Number 3, Mayo Growth point

Headlands

Rusape

Cell: 0777 081 850/0735 606 740

If you agree to participate please show by signing

Investigator:…….

Signature……..

Date:……..
Participant Signature:……
Date:…….
Thank you for your participation.
Witness:……
Date:……..

Appendix 2: Questionnaire for men

Section A: Personal Information

1. Sex:

Male		Female	

2. How old are you?

15 -19yrs		20 -24yrs		25-30yrs		30-40yrs	

3. How old is your marriage with your spouse?

>3 yrs		4-7yrs		8-10yrs		<10yrs	

4 What level of education did you attain?

never		primary		secondary		Tertiary-	

5. What is your religion?

catholic		protestant		Pentacostal		Other	

6. How many children do you have?

one		two		three		Four +	

Section B: Men's Participation in PMTCT: Pregnancy Phase

7. Is your wife lactating or pregnant at the moment?

Lactating		Pregnant	

8. At what age (months) did she register the pregnancy?

2 months		3 months		6 months		<7 months	

9. Did you go with her for the registration of the pregnancy with the clinic?

Yes		No	

10. Were you educated about HIV/AIDS and PMTCT at the clinic on this day?

Yes		No	

11. Were you and your wife tested for HIV/AIDS at the clinic on this day?

Yes		No	

12. How did you feel after being tested for HIV on this day?

Happy		Angry		Afraid	Nothing	

13. Were your results and those of your wife the same?

Yes		No	

Section C: Men's Participation in PMTCT: Delivery Phase

14. How many days did your wife stay at the clinic awaiting delivery of the new baby?

>1 week		2weeks		<3 weeks	<4 weeks

15. How many times did you visit her while at the clinic awaiting delivery?

once		two times		<3 times		none	

16. How many days did your wife and the new baby stay at the clinic/hospital before discharge?

1 day		2 days		<3days		Don't know	

17. Did you come to collect your wife home on the day of discharge from the clinic/hospital?

Yes		No	

Section D: Men's Participation in PMTCT: Post Delivery Phase

18. Did your wife experience any health challenges within 1week-3 months after delivery?

Yes		No	

19. Do you think it is good for men to be educated on VCT, PMTCT and ANC?

Yes		No	

20 Are you willing to be trained as a peer educator for VCT, PMTCT and ANC?

Yes	

No	

Appendix 3: Interview Schedule

1. Sex:

Male		Female	

2. How old are you?

20 years		>30years		>40years		45-70years	

4. How many children do you have?

Nil		1		>2		<3	

5. What is your job title?

Nurse(CN)		Sister(RGN		DNO/DMO		DAC	

5. How many years have you been in this employment?

>1 year		>5years		<6 years		<10years	

6. What level of education did you attain?

None		Sec+NC		Sec+RGN		Degree	

7. What is your religion?

Catholic		Pentacostal		Protestant		Other	

Section B: Men's Participation in PMTCT: Pregnancy Phase

8. What is the ministry's policy on pregnancy registration?

9. At what stage/age of pregnancy are pregnant women registering at your clinic/hospital?

10. Why does the ministry require pregnancy registration at this stage?

11. Do you require family members of the pregnant women to be present? Why?

12. Are these family members coming with the pregnant women then? If yes, what are the statistics like per month? If not, what are the reasons for not, in your view?

13. When they come together, what processes are taken prior to, and after pregnancy registration? Why?

14. After registration, after what intervals do pregnant mothers visit the clinic? What for this time? Who else would prefer to be in the company of the pregnant woman?

Section C: Men's Participation in PMTCT: Delivery Phase

15 .At what age of the pregnancy are pregnant women expected to visit the clinic for delivery

16. On delivery what are the roles of the men with regards to PMTCT issues?

17. Is there any other information that is relevant specifically related to PMTCT that you think we can share at this stage?

Section D: Men's Participation in PMTCT: Post Delivery Phase

18. After delivery, where do men come in, and for what?

19. What is the trend of men in your view and experience regarding coming to the clinic at this stage?

20 In cases where men fail to avail themselves, how do you handle the PMTCT issues with the women only, especially where the women tests positive.

Section E: Policy and PMTCT for Zimbabwe

21. What is the way forward in your view towards engaging men and women in VCT, PMTCT and ANC programmes in future?

Appendix 4: Focus group discussions

1. What are the reasons for the Government funded PMTCT programme in Makoni? Is it working for the pregnant women and their spouses in your view?

2. How do you want men and women to participate in the PMTCT programmes in your areas?

3. Men play a very important role in the PMTCT programme in Makoni at Pregnancy, Delivery and After Delivery stages. Do you agree or disagree? Explain your views.

4. If all men to pregnant women participate in the PMTCT programme in Makoni, there would be zero new infections in newly born babies. Is this true? Explain.

5. Education on PMTCT to both men and pregnant women should start when the pregnant women visits the clinic to register the pregnancy.

6. PMTCT programmes work better when men are involved as they will support pregnant women through to the birth of the child. Is this true?

7. What programmes and PMTCT activities do you think the government of Zimbabwe should bring to Makoni in order to scale up men"s participation in PMTCT, VCT and ANC?

Appendix 5: Questionnaire for women

Section A: Personal Information

1. Sex:

Male		Female	

2. How old are you?

15 -19yrs		20 -24yrs		25-30yrs		30-40yrs	

3. How old is your marriage with your husband?

>3 yrs		4-7yrs		8-10yrs		<10yrs	

4. What level of education did you attain?

never		primary		secondary		Tertiary-	

5. What is your religion?

catholic		protestant		Pentacostal/Ap		Other	

6. How many children do you have?

one		two		three		Four +	

Section B: Men's Participation in PMTCT: Pregnancy Phase

7. Are you pregnant or lactating?

Lactating		Pregnant	

8At what age of pregnancy did you register your pregnancy at the clinic?

➢ 3month		3 months +	

9 Did your husband accompany for the pregnancy registration?

Yes		No	

10. Were you educated about HIV/AIDS and PMTCT at the clinic on this day?

Yes		No	

11. Were you and your husband tested for HIV/AIDS at the clinic on this day?

Yes		No	

12. How did you feel after being tested for HIV on this day?

Happy		Angry		Afraid		Nothing	

13. Were your results and those of your wife the same?

Yes		No	

Section C: Men's Participation in PMTCT: Delivery Phase

14. How many days did you wife stay at the clinic awaiting delivery of the new baby?

>1 week		2weeks		<3 weeks		<4 weeks	

15. How many times did your husband visit you while at the clinic awaiting delivery?

once		two times		<3 times		none	

16. How many days did you and the new baby stay at the clinic/hospital before discharge?

1 day		2 days		<3days		Don't know	

17. Did your husband come to collect you home on the day of discharge from the clinic/hospital?

Yes		No	

Section D: Men's Participation in PMTCT: Post Delivery Phase

18. Did you experience any health challenges within 1week-3 months after delivery?

Yes		No	

19. Do you think it is good for men to be educated on VCT, PMTCT and ANC?

Yes		No	

20 Are you willing to be trained as a peer educator for VCT, PMTCT and ANC?

Yes		No	

Appendix 6: List of key informants

District	Name	Location	Designation
Makoni	Benza,L.	MoHCC-Rusape	DNO
	Chitumba,A.	MRDC-Makoni	DAC
	Manuhwa,G.	Chiendambya	ZNNP+
	T.Mukovamombe	Ward 5	Village Head
	Majero,P.	Chiendambuya	ZNFPC
	Muzembe,T.	Ward 5	Councillor
	Masaka,T	Ward 35	Councilor
	Zivave,F.	Weya Hospital	Sister-in-charge
	Useni,P.	Mayo 1	Sister-in-charge
	Mrs J.Johwa	Ward 5	Village head
	Doctor P.M. Mungate	Rusape Gen.Hospital	DMO
	Mrs N.Ngano	Ward 35	Village head
	T.M.Machingauta	Marange Apost	Church leader
	N.V.Paganga	Mayo clinic	Sister-RGN
	S.P. Garikai	Mayo clinic	Sister-PCN
	R.Chiuta	Weya hospital	Sister-PCN
	P.Nyarota	Weya hospital	Sister-RGN
	A.S.Mashava	Marange	Church leader
	P.Saunyama	Mugodhi	Village head
	J.Z.Mapingire	Ward 5	Village head
	T.Hofisi	Weya hospital	Sister-PCN
	G.Bhunu	Rusape hospital	Hospital Matron
	P.Mukwakwasha	ZNFPC	IEC Officer
	WA Mawarire	A.FM	Church leader
	E.Mukonho	Ward 5	Village head
	A.Chinotimba	Zviratidzo	Church leader
	R.T.Makovere	Mashanga AFM	Church leader
	C.C.Chiripanyanga	Mugodhi	Church leader
	W.P. Mugore	Jerusarema	Church leader
	C.Chatiza	Ward 35	Village head
	M.Marange	Zuva Rabuda	Church leader
	K.Kamutanho	Ward	Village head
	Z.Nemarire	Ward	Village head
	L.P. Makoni	Ward	Village Head

Appendix 7: Research authority letter

AFRICA UNIVERSITY
(A United Methodist-Related Institution)

INSTITUTE OF PEACE LEADERSHIP AND GOVERNANCE

Investing in Africa's Future

P.O. BOX 1320, MUTARE, ZIMBABWE - OFF NYANGA ROAD, OLD MUTARE - TEL:(263-20) 66758/60075/60626/61611 - FAX:(263-20) 66758/61785 - EMAIL:ipigdirector@africau.ac.zw - Website www.africau.edu

15 April 2014

TO WHOM IT MAY CONCERN

Re: Permission to Undertake Research for Dissertation at Africa University

Tawanda Munyanyi student registration number **129321** is a student at Africa University. He is enrolled in a degree program in Peace, Leadership and Governance and is currently conducting research for his project, which is required for completion of the program in June 2014. The research topic is **"Male uptake of the Prevention of Mother to Child Transmission Programme in Zimbabwe: A Case of the Impact of the Primary Health Care Policy Impact in Makoni District ".** Tawanda is expected to undertake this research during the period January- April 2014 before the dissertation can be submitted to the Faculty in May 2014.

The student will share with you the results of this research after its approval by the Institute.

We thank you for your support and cooperation regarding this research.

Yours sincerely

Prof. P. Machakanja
Director

"Living our Vision in Faith, Embracing Diversity, Developing Leaders for Africa"

Appendix 8: Shona translation of questionnaire

1. Sex:

Murume		Mukadzi	

2. Munemakore mangani ekuberekwa?

15 -19yrs		20 -24yrs		25-30yrs		30-40yrs	

3. Mava nemakore mangani maroorana?

>3 yrs		4-7yrs		8-10yrs		<10yrs	

4. Makadzidza kusvika parugwaro rwupi?

never		primary		secondary		Tertiary-	

5. Munonamta kuchitendorano chinonzi chii?

catholic		protestant		Pentacostal/Ap		Other	

6. Mava nevana vangani?

one		two		three		Four +	

Section B: Men's Participation in PMTCT: Pregnancy Phase

7. Mune mwana mucheche here kana kuti makazvitakura?

Mucheche		Pamuviri	

8. Makanyoresa pamuviri penyu kuchipatara pava nemwedzi mingani?

➢ 3month		3 months +	

9 Pakunonyoresa pamuviri kuchipatara makaenda mese nemurume wenyu here?

Hongu		Kwete	

10. Makadzidziswa pamusoro pe HIV/AIDS here pamakanyoresa?

Hongu		Kwete	

11. Imi pamwe nemurume wenyu makaongororwa ropa here musi uyu?

Hongu		Kwete	

12. Maongororwa ropa musi uyu makanzwa sei mupfungwa menyu?

Kufara		Kusuwa		Kutya		Hapana	

13. Zvakabuda paongororo yeropa renyu zvainge zvakafanana here?

Hongu		Kwete	

Section C: Men's Participation in PMTCT: Delivery Phase

14. Mai vakagara nguva yakareba zvakadii kuchipatara vakamirira kusununguka?

>1 week		2weeks		<3 weeks		<4 weeks	

15. Baba vakashanya kakawanda zvakadii kuchipatara uku panguva iyi?

once		two times		<3 times		none	

16. Vasununguka mai vakagara kuchipatara kwenguva yakareba zvakadii?

1 day		2 days		<3days		Don't know	

17. Baba vakanotora mudzimai wavo nemwana here kubva kuchipatara musi wavakabuda?

Hongu		Kwete	

Section D: Men's Participation in PMTCT: Post Delivery Phase

18. Mudzimai asununguka pana urwere here kana matambudziko avakazosangana nawo?

Hongu		Kwete	

19. Zvakanaka here kuti varume vadzidziswe nezve VCT, PMTCT and ANC?

Hongu		Kwete	

20 Imi mungada here kuzoita basa rekufamba muchizodzidzisa vamwe pamusoro pe VCT, PMTCT and ANC?

Yes		No	