DETERMINANTS OF MALE PARTICIPATION IN PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT)

A CASE STUDY OF MZUMBE WARD, MOROGORO

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A CASE STUDY OF MZUMBE WARD, MOROGORO

By

NEEMA AYOUB MTEGA

A Dissertation Submitted to the School of Public Administration and Management in Partial Fulfilment of the requirements for the Award of the Degree of Master of Public Administration (MPA) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation **entitled "Determinants of male participation in Prevention of Mother to Child Transmission of HIV (PMTCT). A case study of Mzumbe Ward, Morogoro".** A dissertation submitted in partial/fulfillment of the requirements for award of the degree of Master of Public Administration of Mzumbe University.

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DECLARATION AND COPYRIGHT

I, **Neema Ayoub Mtega**, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature ……

Date……..

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DEDICATION

This work is dedicated to my late father Mr. Ayoub Mtega and my late mother Miss. Editha H. Ngatunga who played a big part to my well-being through their endless love, encouragement and inspiration which enabled me to be who am today and accomplish this level of education. I will always love and appreciate you, no matter how far you are from me, may God rest your souls in peace.

LIST OF ABBREVIATION

AIDS	:	Acquired Immune –deficiency Syndrome
ANC	:	Antenatal Care
ARV	:	Antiretroviral Therapy
CDC	:	Centre for Disease and control
EMTCT	:	Elimination of Mother to Child Transmission
FGD	:	Focus Group Discussion
HCT	:	HIV Counseling and Testing
HIV	:	Human Immune-deficiency Virus
MOHSW	:	Ministry of Health and Social Welfare
MTCT	:	Mother To Child Transmission
NACP	:	National AIDS control program
PMTCT	:	Prevention of Mother to Child Transmission
TACAIDS	:	Tanzania Commission for AIDS
TMHS	:	Tanzania Malaria and HIV survey
UNAIDS	:	United Nations Global Program on HIV/AIDS
UNGASS	:	United Nation General Assembly Special Session
UNICEF	:	United Nation Children's Fund
URT	:	United Republic of Tanzania
VCT	:	Voluntary Counseling and testing
WHO	:	World Health Organization

ABSTRACT

This study explored determinants of male participation Prevention of Mother to Child Transmission of HIV (PMTCT) a case study of Mzumbe ward Morogoro. Specific objectives of the study were to examine male participation in PMTCT service, to identify factors that impinges or facilitates male participation in PMTCT service in Mzumbe ward and identify effects of male participation in PMTCT service in Mzumbe ward.

The study adopted a case study design. Data for this study were collected through interview, focus group discussions, observation and documentary review. A sample size of fifty (50) respondents comprising of twenty eight (28) male and twenty two (22) female were used in this study. Purposive and Accidental sampling techniques were used to establish sample size of fifty respondents. The analysis was done using content analysis approach. The analysis was guided by variables generated in conceptual framework and organized by logic flow of research objectives and research questions.

The findings indicate that, majority of men in the community think that providing financial support to their sexual partners was involvement enough and no further involvement should be expected from them. Although there are men who participate in PMTCT service but majority of male in the community do not participate in the program main reasons include, lack knowledge about PMTCT service, fear of getting Tested, presentation of male in the reproduction health policy, communication between couples, time and schedule of PMTCT clinic, privacy and confidentiality, income status of individual and occupation status. The study indicates that low male participation in PMTCT service lead to low utilization by pregnant women and their infants in PMTCT services and this lead to high maternal and infant morbidity/mortality rate. Therefore, there is necessary need for the government to formulate policies and strategies that will encourage male participation in PMTCT services.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.0 Introduction

This chapter presents background to the study, statement of the problem, objectives of the study (general objectives and specific objectives), research questions and significance of the study. Furthermore, this chapter presents the main limitations of the study as well as the organization of the study.

1.1 Background of the Study

Acquired Immuno-deficiency Syndrome (AIDS) it is a harmful disease that is caused by virus known as Human immunodeficiency virus (HIV). Normally HIV transmit from one human being to another through exchange of body fluids which include, semen, blood, vaginal secretions and breast milk (Jackson 2002). This disease is one among leading health problem that affect many countries in the world until today (UNAIDS/WHO, 2000). The United Nations' Joint program on HIV/AIDS (UNAIDS) lately released statistics show that, at the end of 2014, the number of people tested HIV positive worldwide were nearly 36.9 million and newly HIV infected worldwide by the end of 2014 were almost 2 million people (UNAIDS, 2015). Despite necessary strategies applied and significant progress on scaling up HIV prevention programs the number of children who become newly affected with HIV worldwide every year remains high (Children fact sheet, 2014). The number of children who became newly infected by the end of 2014 was around 220,000 (UNAIDS, 2015). The report estimated that more than 90% of those children living with HIV were infected during pregnancy, birth or breastfeeding, (UNAIDS, 2015).

The spread of HIV/AIDS in the world has caused so many negative impacts and one among those negative impacts is death of higher number of people due to AIDS related illness. As reported by UNAIDS (2015), number people who died due to ADS-related illness by the end of 2014 was almost (980,000 – 1.6 million), that's makes 23.5 million

AIDS related deaths from 2000 to 2014 and the number of orphans due to AIDS by the end of 2014 was almost 78,000.

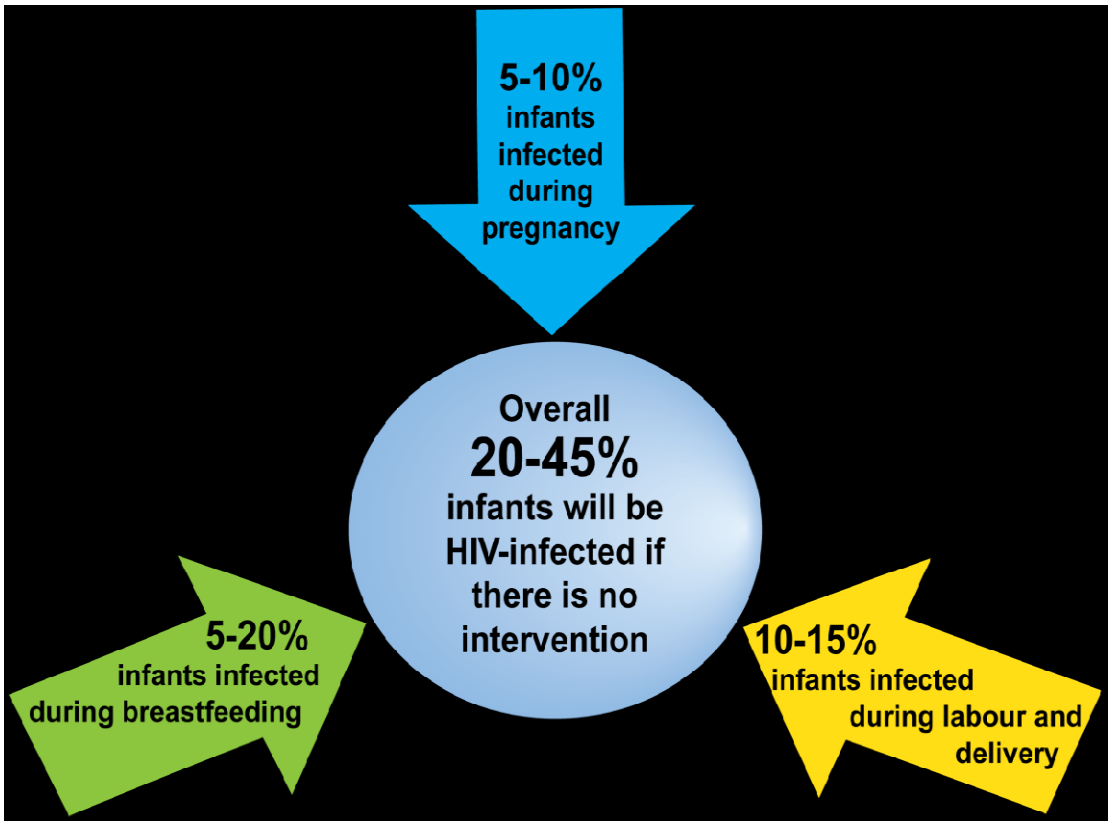
One among the regions which are most affected by HIV/AIDS is Africa (WHO, 2015). According to Jackson, (2002) African countries have become a seat for HIV/AIDS. WHO, (2015) reported that Africa have 25.8 million of people living with HIV and also the report estimated that 66 % of the global AIDS-related deaths by the end of 2014 occurred in Africa and almost 70% of the global total new infections occurred in Africa.

Tanzania has around 43.6 million people and it is estimated that, in 2011, the number of people living with HIV were 1.6 million and among them 1.3 million were aged 15 years and older (TACAIDS et al, 2013). In order to reduce the number of people who test HIV positive which was increasing every year since its discovery in 1983 in the country, national commitments were established to fight against the epidemic. The national commitments include presidential announcement of HIV/AIDS as a national disaster (1999), establishment of TACAIDS (2000) and Development of Multi-Sectoral Strategic Framework (2003-2007). The outcome of those national commitments was improvement of Health sector strategy on HIV/AIDS which involve four thematic areas including Prevention, Care, treatment and impact mitigation which resulted in establishment of PMTCT program (URT, 2013).

Mother to child Transmission (MTCT) of HIV/AIDS is the major primary source of HIV infection in children or infants. It was reported that at the end of 2012, total number of people living with HIV were around 1.6 million whereby sexual transmission accounted for 80% of the infection, 1.8% was due to blood transfusion and 18% was due to mother to child transmission (URT, 2013). MTCT may occur during pregnancy, labour, delivery and during breastfeeding. In Tanzania mother to child transmission account for 90% of all infections in children and infants, and is also responsible for 5-10% of new infection in every year in the country (TACAIDS et al, 2013). With more than 1.5 million births annually and 6.9 per cent HIV prevalence at antenatal clinics, approximately 103,500 HIV positive women deliver HIV-exposed infants annually in Tanzania.

Assuming a 35% transmission rate without PMTCT interventions, an estimated 36,225 children will be infected with HIV each year. Therefore it is crucial and necessary to design and implement prevention of mother-to child transmission (PMTCT) services in all regions in Tanzania. The figure below explains the risk of MTCT without any PMTCT intervention.

Figure **1.1: Estimated risk of MTCT without PMTCT intervention**



Source: MOHSW, 2013

The first developing country in the world to launch a nationwide plan for prevention of MTCT was Brazil, followed up by other developing countries like Nigeria and Tanzania (Veloso Vg, et al 2010). As a public health approach Tanzania initiated Prevention of Mother to Child Transmission of HIV (PMTCT) programs or interventions which projected to reduce the risk of mother to child transmission of HIV/AIDS through Ministry of Health and Social Welfare. Tanzania‘s national PMTCT intervention targets

on prevention of HIV in women of reproductive age, pregnant women, their partners, families, children and communities.

According to MOHSW (2013), PMTCT pocket guidelines, the comprehensive approach to PMTCT recommended in Tanzania consists of the following elements:

i. Primary prevention of HIV infection
ii. Prevention of unintended pregnancies among women living with HIV
iii. Prevention of HIV transmission from mothers to their infants during delivery
iv. Provision of treatment, care, and support to women living with HIV, their partners, infants and families
v. Antiretroviral (ARV) prophylaxis for HIV-exposed infants,
vi. Early infant HIV diagnosis and treatment
vii. Counseling and support for safer infant feeding practices

Major PMTCT interventions according to MOHSW (2013), take place during;

A. ANC which include HIV counseling and testing, Antiretroviral treatment (ART).
B. Labour & delivery includes HIV testing and counseling during labour and delivery, ART for the mother and ARV prophylaxis for the infant, Obstetric interventions during labour and delivery.
C. On-going RCH care which include Infant feeding counseling and Follow-up visits.

The objective of the nationwide scale up plan (2009 – 2013) was to advance the health system of mother, father and their children by scaling up comprehensive PMTCT and pediatric HIV care and treatment. However, during its execution, there has been a shift from treatment to eradication of HIV infections among infants or children (EMTCT) by 2015, and keeping infants or children and their parents well and alive (MOHSW 2013).

In Tanzania provision of PMTCT services started in 2003. At the end of 2012 the number of PMTCT implementing centers had increased from 3,029 in 2008, 4,301 in 2010 to 4,832 in 2012. Pregnant women arrive at at ANC by PMTCT services by 2012 added up to 1,625,811 and among them 54,978 tested HIV positive, total number of

infants tested for HIV infection were 26,608 and among them 2,328 were positive (MOHSW, 2013).

Table 1.1: PMTCT summary data (2012)

Pregnant women reached ANC by PMTCT service	1,625,811
Pregnant women tested for HIV	1,036,948
Pregnant women tested positive	54,978
Previously known HIV positive	27,833
Total pregnant women who are HIV positive	82,811
Total women received ARV	73,955
Infant tested for HIV before 2 month of age	26,608
Infant tested positive	2,328
Total number o infant receive ARV	71,571
Partners tested for HIV	219,895
Partners tested positive	34,278
Total number of PMTCT implementing sites	4,832

Source: *Ministry of health and social welfare, National AIDS Control Program, 2013*

Regardless of its insertion in the PMTCT guidelines male partners' participation in PMTCT is still a new notion in the country that has not been wholly implemented within PMTCT program. Men are key stakeholders in sexual and reproductive health and play an essential role in reproductive health care services. Male In facts play a significant part in women's utilization of health services. Sadly in spite of, the progress registered in the implementation of the PMTCT program in the country male involvement in PMTCT of HIV services remains low.

1.2 Statement of the Problem

In 2011, an international health strategy was launched to decrease 90 percent of number of HIV new infection through MTCT by the end of 2015 and this strategy was known as PMTCT (UNICEF, 2014). Studies have shown that in different countries PMTCT still faces a lot of problems in its implementation process mostly in utilization of PMTCT services those problems include accessibility of VCT services, lack of professional health servants, fear of disclosure of HIV results, stigmatization and lack of male partner involvement in the program (Kiarie JN et al, 2003). According to TACAIDS et al,(2013), in Tanzania 85% of women and 79% of men know that HIV can be transmitted through MTCT but only 55% of men and 64% of women know that transmission can be reduced through PMTCT intervention. Data show that 98% of pregnant women attend Antenatal clinic during their pregnancy and 26% of pregnant women male partners participate in PMTCT services. In Mzumbe Health Centre, at the end of 2015, there were 209 pregnant women who tested for HIV and only 73 male partners were aware of their HIV status (Mzumbe health centre, 2016), and in Mikongeni dispensary pregnant women who knew their HIV status were 138 and 50 male partners were aware of their HIV status (Mikongeni dispensary, 2016).

Male partners play a role not only in women's risk of acquiring HIV but also in terms of her utilization of the PMTCT program. Male partners support mothers to test for HIV, to return for the results, and to receive medication (Msuya et al 2006 and Farquhar et al 2004). Also male partners support mothers to follow the infant feeding advice given and make decision on use of condom if they are supposed to (WHO, 2012). Despite the growth of PMTCT service in Tanzania still PMTCT implementers face different challenges and one of the major challenge, is poor participation of male in the program (URT, 2013). Male participation in PMTCT is still low despite different interventions or strategies created to ensure male participation in PMTCT (THMS, 2011-2012). This study aims to explore determinants of male participation in PMTCT and identify effects of male participation in PMTCT.

1.3 Objectives of the Study

1.3.1 General Objective

The main objective of the study is to explore determinants of male participation in PMTCT in Mzumbe ward.

1.3.2 Specific Objectives

1.3.2.1 To Examine participation of male in PMTCT services in Mzumbe ward

1.3.2.2 To identify factors that impinges or facilitates male participation in PMTCT in Mzumbe ward.

1.3.2.3 To identify effects of male participation in PMTCT in Mzumbe ward.

1.4 Research Questions

1.4.1 How do male participate in PMTCT program?

1.4.2 What are the factors that impinge or facilitate male participation in PMTCT in Mzumbe ward?

1.4.3 What are the effects of male participation in PMTCT?

1.5 Significance of the Study

This study will give out or provide a general understanding on the effectiveness of PMTCT program and rational of involving male in the program to pregnant women and their male partners. Therefore, male will be familiar with their roles in the PMTCT program which will stimulate male participation in the program.

The findings will provide useful information and general knowledge about determinants of male participation in PMTCT services to different stakeholders like health service planners who may use it in designing strategies or formulating policies which will target both male women and whole community so as to increase PMTCT uptake among male in all regions in Tanzania.

In addition, the study will also provide some assistance to other researchers who due to this study will get valuable information through study findings which could be a source of new research topics.

1.6 Limitation of the Study

The goal of the study was to come up with determinants of male participation in PMTCT. This would require a bigger sample covering a wide range of people with different cultural backgrounds than the available resources could allow. Moreover, some of the responses from the interviewees were ambiguous due to either ignorance on the subject matter or participants were reluctant to provide information fearing that some information could be used against them.

Another limitation is from the purposive sampling that was used. The researcher targeted individuals who were available during data collection process rather than selecting from the entire population of Mzumbe ward. The limitation of this approach is that the sample size may not be representative of the entire population. Also due to time and funding limitation, the study did not cover a sample that is big enough or time that is long enough to capture all the information regarding male participation in PMTCT.

1.7 Delimitation of the Study

This study focused on assessment of male participation in PMTCT and establish factors that influence male to be or not to be involved in the prevention of Mother to child HIV /AIDS Tanzania a case study took place in Mzumbe ward.

1.8 Organization of the Report

This research report is organized into five chapters. Chapter one presents the background to the study, statement of the problem, research objectives, research questions, and significance of the study, scope, limitations of the study, delimitation of the study and definition of key terms.

Chapter two deals with literature review which include theoretical framework and empirical data review, followed by chapter three which covers the research methodology. Chapter four presents the findings and discussion, and finally Chapter five provides the summary, conclusion and recommendations.

1.9 Definitions of key terms

1.9.1 HIV/AIDS

Human immunodeficiency virus (HIV) is the virus that causes Acquired Immuno-deficiency Syndrome (AIDS). This virus attack the immune system and condition referred to as AIDS is caused by HIV damaging the immune system cells until the immune system can no longer fight other infection that would usually be able to prevent. According to Jackson (2002) AIDS is the end of HIV infection and is a serious often fatal disease of the immune system. Common there is two kind of HIV namely HIV 1 and HIV 2.

1.9.2 MTCT

Mother to child transmission (MTCT) of HIV can be refer to type of HIV transmission where by HIV pass from mother or woman who is HIV- positive to her child or infant and it might occur either during pregnancy period, birth or during breastfeeding. MTCT is most common way for children to become HIV- positive (AIDS info, 2014)

1.9.3 PMTCT

According to MOHSW (2013), prevention of mother-to-child transmission of HIV (PMTCT), is the generally used term for programmes and interventions planned to trim down the threat of mother-to-child transmission of HIV. The major targets of PMTCT programme or service include, women of reproductive age, pregnant women and their sexual partners, children, families and communities

1.9.4 Male participation

In PMTCT service male participation refers to the involvement of pregnant women male partners in the program.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers the review of literature on male participation in PMTCT, experiences and contributing factors. It provides both theoretical and empirical literature study.

2.2 Theoretical Review

This is described by scholars as the a literature review which based on the secondary source of information which may comprise any publication written by the writer who did not observe direct or participate in the event portrayed (Msabila T, and Nalaila S, 2013).

2.2.1 Overview of HIV/AIDS and MTCT

AIDS is the last stage of HIV infection and is a severe fatal disease which mostly affects immune system (Jackson, 2002). There are two common kinds of HIV which are HIV-1 and HIV-2. HIV-1 was identified in early 1980s and another type of HIV, is known as HIV-2 and it was identified in 1986. On the other hand, the transmission speed of HIV-1 is said to be higher than trasmission speed of HIV-2, and people who are victim of HIV-1 develop AIDS prior to victims of HIV-2 (American Red Cross, 2003).

HIV is said to be related to Simian (monkey) Immunodefiency Virus (SIV) but regardless of extensive research, the origin of HIV and exactly when, where and how human beings became affected by Simian Immunodeficiency Virus is still unclear. But what is clear up to now is that HIV/AIDS has no known cure and it has 100% mortality rate (Jackson, 2002). HIV/AIDS is considered as virulent disease epidemic which spreads over a large area, affects almost all countries in the world; it is actively spreading and is responsible for death of millions of people (Jackson, 2002).

HIV transmits from one infected individual to another individual through straight contact with some of the body's fluids. HIV mainly pass from one person to another through unprotected sexual intercourse, infected blood transfusions and hypodermic needles and from mother to child transmission, however not all body's fluids can transmit HIV other body's fluids, like tears, do not transmit HIV (CDCP 2003).

Mother to child transmission (MTCT) of HIV is one of common ways of HIV transmission which involves transmission of HIV infection from a pregnant woman to her infant or child. According to UNICEF (2011), MTCT is also known as vertical transmission or parental transmission of HIV which takes place during:

a. Pregnancy: As the fetus develops, HIV may cross the placenta.
b. Labour and delivery: During delivery, the infant is exposed to high volumes of maternal fluids.
c. Breastfeeding: Breast milk contains virus that may be transmitted through the infant‘s digestive tract.

In 2009, more than any other region worldwide an estimated of 860,000 pregnant women were found HIV positive in Eastern and Southern Africa, on top of that the region was also a centre of 47% of the global total HIV positive children, of which over 90% were infected through MTCT (UNICEF, 2011). In underdevelopment countries, mostly in Eastern and Southern of Africa, all deaths among infants or children under five years of age 10 to 28 percent are caused by HIV/AIDS, more than half of all infant who are born HIV positive will die before their second birthday if there is lack of effective treatment (UNICEF, 2011).

2.2.2 Concept of PMTCT

A global strategy called PMTCT was launched to minimize or reduce the number of HIV new infection through MTCT by 90% by 2015 (UNICEF, 2014). According to Tadesse and Muula (2004), the common elements in PMTCT are the desire to know the HIV status of pregnant women, to prevent HIV transmission from women infected with

HIV to their children or infants and to change sexual behaviours, from having more than one sexual partners to sticking with one sexual partner or adopting safer sex practices, encouraging partner testing and adopting suitable family-planning methods.

Tanzania adopted the PMTCT program, whose target has been set in compliance with UNGASS and Abuja Declaration of December 2000 targets which were set in June 2001. The UNGASS Declaration aimed at reducing the rate of children affected with HIV in different countries by 50% at the end of 2010, by ensuring that 80% of expectant mothers have access to PMTCT services, including ARVs (United Nations, 2007). This was supported by the Call to Action for the eradication of HIV infection to children and Infants, issued by the Inter-Agency Task Team (IATT) on PMTCT and pediatric HIV High Level Partners Forum in Abuja, Nigeria in 2005 (United Nations, 2007).

In Tanzania the major goal of the national PMTCT Program is to achieve a HIV/AIDS free generation in the whole country by reducing the number of children born with HIV from HIV positive mothers, providing an opportunity for identification of HIV-infected women and delivery of other interventions to prevent HIV transmission to infants as well as care and support to HIV-infected women, children and their families (MoHSW, 2007).

2.2.3 Overview of male participation in PMTCT

The campaign for men's participation in women's reproductive health programs was initiated by the International Conference on Women in Beijing in the mid 1990s and the International Conference on Population and Development in Cairo in 1994. According to ICPD-POA chapter four, section 4.27 state that;

> " special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted

and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children". (UNFPA,1994).

In 2002, WHO formulated recommendations advising couple's HIV testing in settings with high HIV prevalence (WHO, 2002). WHO (2010-2015), PMTCT Strategic Vision, focus on the need to involve male partners in utilization of PMTCT services in African countries. WHO initiated the policy guidelines which focused on the assumption that couple testing would help boost men support for women to use PMTCT services, create opportunities for secondary prevention by counseling both women and their male partners about HIV/AIDS, and enhance the uptake of testing and discovery of HIV infected persons (WHO, 2010).

Rutenberg et al (2002) argued that men's participation in PMTCT may mean a lot of things, depending on the couple status and nature of community, some men in the community may voluntary decide to go to the clinic with their sexual partners, get involved in all process including counseling and get tested for HIV, while other men may decide to never visit the clinic, but instead support their female partners in coping with HIV in one way or the other in case they are positive, pay for their partner's health care bills, or pay for transport for their partner to attend clinic. According to UNAIDS (2011), the international plan indicate that efforts must be taken to secure the involvement and support of men in all aspects of these programs and to address HIV and gender related bias that impedes service access and uptake as well as client retention.

2.2.4 Rationale or importance of involving males in PMTCT.

i. When men decide to take action to prevent HIV infection, they can change the course of epidemic and every action that prevents HIV infection also promote the sexual and reproductive health of both women and men (UNPF, 2008).

ii. When male partners are involved and get to know their HIV status, this will enhance the chances of infant's healthy survival and a HIV free generation (UNAIDS, 2012).

iii. Men participation improves communication between men and his sexual partners, and allow both women and men to decide on different issues regarding their reproductive health matters. The process of involving men in reproductive health matters will help them to be more sensitive to women's needs and therefore enhancing women's status.

iv. Almost all settings in Africa where PMTCT is provided men trend to be the main decision makers (Akarro *et al.*, 2011).

v. Without working with men, change would be very difficult or impossible (Sternberg and Hubley, 2004)

vi. According to Kumah (1999) due to the rapid spread of HIV/AIDS epidemic and due to culture and taboos in African context which contribute to negative stereotypes about male participation in reproductive health issues it necessary and crucial to form all strategies possible to ensure involvement of men

vii. Furthermore, if both women and men attend counseling sessions together and get tested together then there is less chance for blame and accusations (Semrau et al., 2005). Counselors can emphasize the man's role for protecting the health of his partner and the whole family, and can promote the use of PMTCT service and other related service will enhance higher rates of treatment and care uptake (Semrau et al., 2005).

2.2.5 Effect of male participation in utilization of PMTCT service

One among effects of male participation in utilization of PMTCT is the rate of HIV positive born infected infants. Reports on Tanzania national response on HIV shows that as level of male involvement increases and the rate of HIV positive infants decreases. Table 2.1 below show the relationship of male participation and infants status, as reported in national response reports, in 2009 male who attend PMTCT and test for HIV were 181,185 and in this year infants who tested HIV positive were 3,274, in 2010 male were 298,990 and number of infants tested positive was 2,151 and in 2012 number of male who attended PMTCT and tested were 219,895 and infants who tested HIV positive were 2,328 (MHSW 2010-2013) .

This shows that in 2009 level of male involvement was low and number of positive infants was high while in 2010 number of male involvement was high and number of positive born infants was lower compare to 2009 and 2012. So if the level of male participation in PMTCT and ANC will increase then the rate of HIV positive born infants will decrease.

Table 2:1 Male attendance in PMTCT and test for HIV Vs number of women received ARV and infants tested positive

	2009	**2010**	**2012**
Male attendance in PMTCT and test for HIV	181,185	298,990	219,895
Women received ARV	58,833	79,579	73,955
Infants tested positive	3,274	2,151	2,328

Source; Documentary review on National response reports

2.2.6 Overview of the national PMTCT policy/guidelines in Tanzania.

The Ministry of Health and Social Welfare (MoHSW) has been implementing PMTCT services in the country since 2000 and by 2004 services were scaled up to cover all regions in Tanzania. Implementation of these services was guided by the National PMTCT Guidelines that were developed in 2004 and revised for the first time in 2007. The guidance was made to accelerate the achievement of elimination of new HIV infections in children and keep both children and their mothers alive and healthy. PMTCT services provided in Tanzania include routine HIV testing and counseling; provision of lifelong antiretroviral treatment for all HIV positive pregnant and lactating women; antiretroviral (ARV) prophylaxis for HIV-exposed infants; safer delivery practices; early infant HIV diagnosis and treatment; counseling and support for safer infant feeding practices; long-term follow-up care for mother and child; and services for family planning (MOHSW, 2004).

National PMTCT guidelines issued in 2004 state as follows "It is important to consider the influence of gender on vulnerability to HIV infection when working to prevent MTCT of HIV, this can only be addressed if both sexes appreciate their interrelated roles and practices that increase the risk of MTCT can be modified once communities understand the relationship between these practices and the transmission of HIV". The national PMTCT guidelines issued in 2004 by MOHSW, state that "all mother and child health facilities should initiate strategies to encourage pregnant women to attend the PMTCT program together with their male partners". This guideline is very relevant for this study because it brings out clearly the need for male involvement in the program especially in antenatal VCT which is the starting point for PMTCT service. According to the national guidelines male participation play a big role in the success of PMTCT. The male participating in PMTCT service are involved in core activities such as to participate in health education sessions, HIV Counseling and testing in antenatal clinics with their partners, support their wives or sexual partner during pregnancy and after delivery as well in infant feeding and care.

2.3. Empirical review

Burns and Grove (2005), state that a review of relevant literature is conducted to generate a picture of what is known about a particular situation, and the knowledge gaps that exist in a situation.

2.3.1 Review of studies from North, West, Central and South Africa

Haile and Brhan (2014), on their study on Male involvement in ANC/PMTCT, conducted a cross-sectional study among 473 pregnant women attending ANC/PMTCT in Mekelle in Northern Ethiopia. The study found out that 20% of pregnant women had been accompanied by their partners to the ANC/PMTCT service. According to the study Male partner involvement in ANC/PMTCT was low and the factors that affected male involvement in ANC/PMTCT in Makelle were maternal knowledge of HIV sero status, willingness of female to inform their husband or sexual partners about the availability of VCT services at ANC. Previous history of couple counseling were identified as independent determinants of male participation in ANC/PMTCT. The study recommended that a comprehensive strategy should be put in place to sensitize and advocate the importance of male partner involvement in ANC/PMTCT in order to reach out male partners.

In Mwanza District in Malawi a retrospective cohort study done by Kalembo FW et al (2013), with the title “Association between male partner involvement and the uptake of Prevention of Mother-to-Child Transmission of HIV (PMTCT) Interventions”, found that around 476 HIV positive pregnant women were registered in a PMTCT program. Among those who were followed-up in the study, 65 (13.7%) had a male partner involvement while 411 (86.3%) had no male partner involvement. This shows that male participation was low in Mwanza district during the study. The study also found out that there was significant difference in the uptake of PMTCT interventions. Positive women who were supported by their partners were more likely to use protective measures like condom, deliver at the hospital instead home and complete follow-up in the program

compared to those positive women without male partner involvement. Also, the findings showed that women with a male partner involvement were ten times likely to have infants who are not born with HIV than those pregnant women without male partner participation. The study concluded that male partner involvement increase utilization of PMTCT services by pregnant women tested HIV positive and recommended that modified public health care models are required to increase the rate of male involvement in the program.

Another report from Malawi showed that male partners who did not often go forward to test for HIV with their partners, contributed to female partners dropping out and or non-cooperation at many level of PMTCT services (Malawi, Ministry of Health, 2008). Kang'oma (2011) in a study with the title "Exploring factors affecting men's involvement in Prevention of Mother to Child Transmission of HIV programme" showed that men had a better understanding of what PMTCT is all about than expected. Almost all men had positive attitudes towards the program; they also approved fellow men's involvement in PMTCT programmes and considered such men who participate in the program as loving, caring and responsible husbands. However, translating this knowledge and supportive attitude into practice was still a big problem for a majority of men. According to the study, fear of being tested for HIV was the main reason men shied away from participating in the program.

In South Africa, Ladur AN, et al (2015), conducted a research with the main objective of exploring community members' (men and women) and health workers perceptions of male involvement in PMTCT in order to create possible ways of increasing male partner participation in ANC and improve outcomes and follow up of pregnant women accessing PMTCT service. The findings suggests three kinds of men; men who are or would be actively involved in PMTCT, men who are not involved but could be motivated, and men who are resistant to getting involved in any kind of support for their partners (except maybe for financial support).

The study also found that men were unwilling to participate in PMTCT service due to stigma and negative attitudes from nurses. It also revealed that HIV testing, disclosure and direct health worker engagement with men increased male involvement in PMTCT. Using men in the media and community to reach out to fellow men with prevention messages tailored to suit specific audience was found to reduce negative perception that ANC is woman's domain.

Another study was conducted in Lusaka – Zambia by Auvinen et al (2013), with a title "Midwives' perspectives on male participation in PMTCT of HIV and how they can support it in Lusaka". The study describes midwives' perception on male involvement in PMTCT and the methods that could be used to influence male participation in Lusaka District. The study shows that male partner involvement can prevent women and their infant from being exposed to HIV by adopting preventive behavior in their relationship and by utilizing health care services. According to this study, methods that midwives can use to improve male participation include, intervening risk behavior, influencing individuals, the community and health personal and also providing disease intervention service. The study showed that cultivating a male-friendly approach in antenatal care is urgent to protecting infants.

The other research that was conducted at Blantyre – Malawi by Nyondo et al (2014) on stakeholders' perception on factors influencing male involvement in PMTCT service identified different barriers on male involvement in PMTCT. The barriers include lack of knowledge on male involvement in PMTCT, social-economic factors, relationship issues, unplanned or extramarital pregnancies, timidity to be seen in a woman's domain, fear of knowing one's HIV status, unwillingness to be associated with the services, health facility based factors, peer influence and culture. According to the study the factors that potentially promote male involvement were categorized into community, health facility and family level or personal factors. Clearly therefore, the success of male involvement lies on recognizing sources of barriers and forestalling them.

2.3.2 Review of Studies from East Africa

A study conducted in Athi River sub-location of Mavoko Constituency, Machakos County in Kenya reported that some of the men accompanied their wives or partners to the clinic and believe it was their responsibility. Others felt that providing financial support towards pregnancy and parental care and other financial needs at home was enough, while others felt that they were busy providing a source of livelihood to their families with no time to accompany their wives or partners to clinic (Ongweny-Kidero,2014).

Byamugisha et al, (2010), conducted a cross-sectional survey with main purpose of exploring determinants of male participation PMTCT of HIV program in Mbale district in Eastern Uganda. The survey involved 388 men aged 18 and above, whose spouses were attending ANC. The study found out that the level of male involvement in PMTCT program was low. The factors that contributed to low male involvement included health factors such as health workers behavior, unfriendly environment and clinics designed for women, social-economic factors such as costs of transport, education level, occupation and culture. The study though warned that recruitment of respondents through their spouses in the ANC in the hospital setting could introduce selection bias.

2.3.3 Review studies from Tanzania

A study conducted by Bonifance (2009), in Kilimanjaro region to determine willingness and participation of males in PMTCT program found out that of the 138 respondents, 103 (74.6%) were not willing to participate in PMTCT programs by accompanying their couples to the Antenatal clinics. The majority of them (61.4%) had not participated in PMTCT programs in Antenatal Clinics. The main reasons for non-participation were listed to include: being busy (25.2%), cultural reasons (21.4%), lack of knowledge on the importance of the programs (21.4%). It was reported that most males did not participate in PMTCT programs because they did not see the importance of such

programs, or they were hindered by cultural settings in the community which posed negative perceptions toward the programs.

Akarro et al, (2011), in their report titled ‘evaluation on male participation on the programme for PMTCT of HIV/AIDS conducted in Ilala Municipality in Dar-Es-Salaam Tanzania’ revealed that communication barriers between pregnant women and their male partners were the main limiting factors of follow up and utilization of PMTCT services. The findings showed that other limiting factors of knowledge, attitude and communication behaviors among partners had a greater chance of influencing a follow up to uptake of PMTCT services. Also, HIV/AIDS education and PMTCT knowledge among spouse within the community was still low. The findings suggested that PMTCT utilization acceptance required a change of cultural attitude in the community. The study only evaluated the male involvement in the PMTCT Service of HIV/AIDS and the area of study was Ilala Municipal in Dar es Salaam. The main difference of the Akarro study to our study is in the area of study and the study populations. Akarro et al, conducted their study in an urban setting but our study is in a rural setting. So, it is possible to get new information on male participation in PMTCT services.

Another research in Tanzania was done by B. Michel, (2010) who conducted a study in Rural Tanzania on the difficulties of male Engagement in PMTCT: Masculinity and Fear. The objective of the study was to examine how men respond to the challenges of HIV and Prevention of Mother to Child Transmission (PMTCT) of HIV with reference to their various discourses of masculinity and disease, and their responses to modernity. The results show that nearly all men expected their partner to seek for their permission before participating in VCT and PMTCT programs. Participating in VCT and PMTCT programs were more similar with modern discourses of disease, an equitable masculinity and an engagement with modernity. In this study Media were demonstrated to be powerful mediators of influence on male participation. Fear of knowing one’s HIV status was identified in the study as a major barrier to men’s involvement in PMTCT.

In addition, men whose partner had participated in PMTCT programs expressed a less masculinity and were more supportive of traditional approaches. The study concluded that men's response to the implications of PMTCT needed a careful consideration in planning and strategizing PMTCT programs.

Msuya et al., (2008), reported that women with higher education often discussed HIV and reproductive health issues with their male partners compared to those with low level of education. Women with income were more likely to participate in HIV testing and counseling, and well-informed couples were more likely to increase mutual support and adopt a low risk behavior, regardless of the test results.

2.4. Literature review gap

Review of related literature is critical and places the study within the conceptual framework. Both, the theoretical and empirical literature review shows that male participation in PMTCT has big impact on the PMTCT uptake. Most of the valuable information or data concerning men and PMTCT relates to HIV testing or VCT, more research is needed regarding other ways of male participation or other roles that male play in PMTCT like financial support, approval to use HIV prevention measures. This study explores determinants of male participation in PMTCT program and factors contributing to low male participation in PMTCT, particularly those relevant to Tanzanian context. It is evident from the literature review that few such studies have been conducted in Tanzania. The results may generate valuable information to guide planning programs to improve male participation in PMTCT.

2.5 Theoretical framework

In this study the researcher will use two theories or models which are relevant to the study. Theories which will be used are hegemonic masculinity theory and social construction which will guide the study.

2.5.1 Social Construction Theory

Social Construction Theory tries to explain how society construct different phenomena and analyze the world. According to the theory, social idea and categories are mainly socially constructed and then are accepted in society as reality like the concept on manhood and womanhood, example decisions in the family is men responsibility and not women responsibility. According to Khan (2009), human beings' experiences are usually based on the way they interpret the world and themselves thus essentially building realities in which they live. According to Garson and Peiss (1985), the concepts of masculinity which are socially constructed and people adopt them from their culture and reproduce through their own actions play a major role for the way men (and women) think and act and thus not their role identities.

This theory is relevant to the study because it shows how men participation in PMTCT and other reproductive health issues are affected by different phenomena which are being constructed by the society. The concept of Manhood and Womanhood which are social contracted are contributing factors to male participation in PMTCT services.

2.5.2 Hegemonic masculinity

Hegemonic masculinity theory was also used to understand male participation in PMTCT programs. Hegemonic masculinity is one among social contracted phenomena which tries to explain practices that promote the dominant social position of men and the subordinate social position of women. Connell sees hegemonic masculinity has a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experiences, personality and culture (Connell 1999)".

This theory is useful for understanding gender relation and its applicable aspect of social life, and how men act and interact in the community. Connell (1999), argued that, hegemonic masculinity consist of behaviors, languages and practice existing in

particular organization locations and culture, which are commonly related with males and which are not defined as feminine. Hegemonic masculinity is associated with idea of manhood (being “real man”) or man world. “Many men are not involved in the ANC/PMTCT process because years of gender power imbalance have created a culture which fences out men from female reproductive health, considered a woman’s issue which should be handled by women alone (Gupta 2002)”.

According to Mbonye et al, (2010), men do have a lot of power in the family and society, and those powers account as one of the factors that affect uptake of PMTCT. Due to the concept of manhood men feel that they are responsible in making decision concerning everything in the house or in the relationship that include to grant permission to their partners and whether to support or not to support them to undertake PMTCT service. In all these men believe to have a last say. Hegemonic masculinity and social construction theory both are related because they bring up the concept of manhood and womanhood in the community/society and both influence male to or to not participate in PMTCT program.

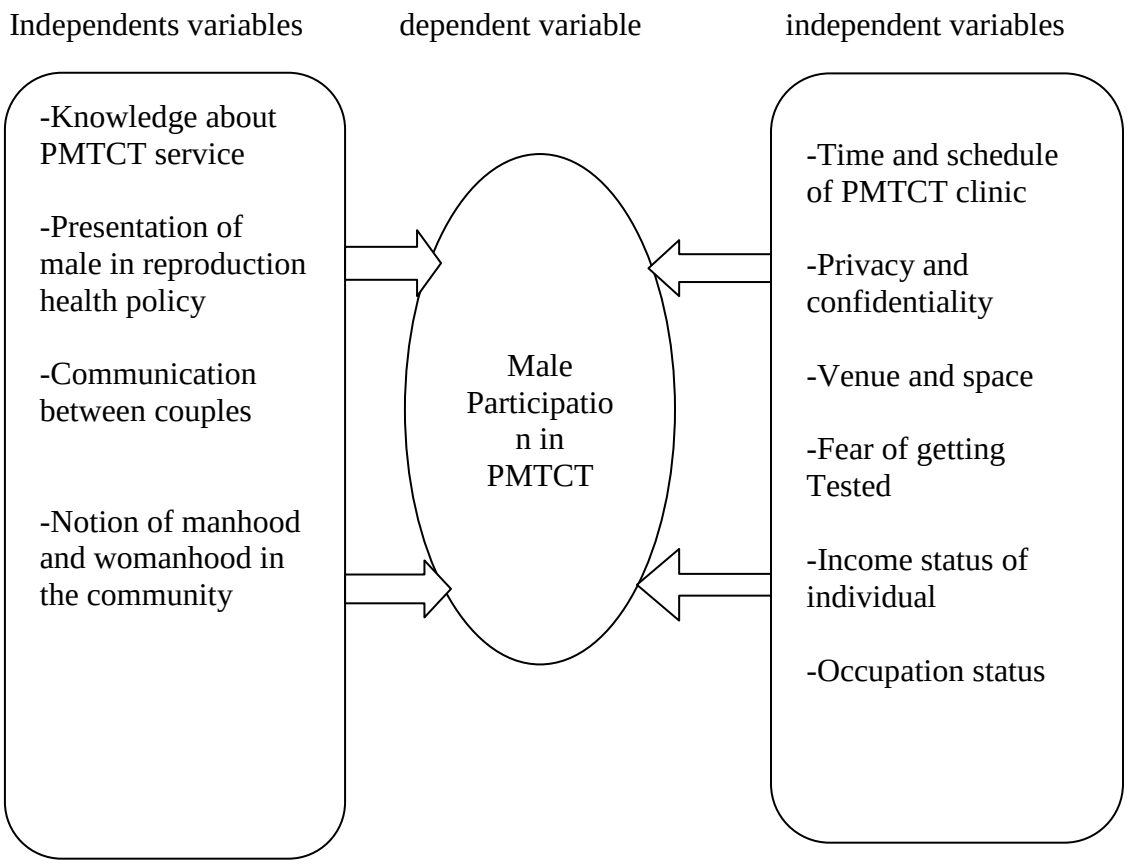
2.6. Conceptual Frame Work

This part will present conceptual framework on determinants of male participation in PMTCT at Mzumbe ward in Morogoro in which the analysis of the study will be made. We develop a framework that presents relationship of variables based on the assumption resulting from the reviewed literature.

Figure 2.1 demonstrate the hypothesize model for this study. The study assume that factors that determine male participation in PMTCT service include, Knowledge about PMTCT service and knowledge about rational of male involvement in PMTCT services may facilitate or stand as obstacle to male participation in the program, also presentation of male in the reproduction health policy, communication between couples, the notion of manhood and womanhood in the community, time and schedule of PMTCT clinic, privacy and confidentiality of PMTCT clinics, venue and space where PMTCT clinic

take place, fear of getting tested, income status of individual and occupation status all of this factors determine male participation in the program. Theoretical framework is as presented in Fig. 2.1 below.

Figure 2.1: Conceptual framework



Source: Designed by Researcher 2016

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter cover detailed information about research design, area where study will be conducted, sample size, sampling techniques, data collection methods that will be used by the researcher to collect data, and data analysis methods. The methodology typically, encompasses concepts such as paradigm, theoretical models, phrases and quantitative or qualitative techniques (Msabila D, and Nalaila S, 2013).

3.2 Research Design

For the purpose of this study, the Case Study design was adopted since it is a fairly exhaustive method that enables the researcher to study deeply and thoroughly different aspects of the phenomena; it's flexible to data collection methods such as interviews, focus group discussion and observations. It is the one that saves both time and costs (Adam J and Kamuzora F, 2008).

3.3 Area of the study

The study was conducted in Mzumbe ward, the area was purposively selected due to its relevancy to the study. Mzumbe ward is relevant to the study because it is one among the places in the country where PMTCT activities take place and also Mzumbe ward was selected due to researcher's ability to reach the particular area during data collection, and therefore the research to be conducted in reachable environments and this minimized costs and time respectively. The area was also chosen for the study because HIV prevalence in Morogoro is 3.8% which is high compare to other regions like Tanga 2.4%, Dodoma 2.9% and Lindi 2.9% (THMIS 2011/2012).

Mzumbe ward is located in Mlali division, which is among four divisions forming Mvomero District which is among 7 Districts of Morogoro region. Mzumbe ward is located 6^0-33^0- S 37^0-6^0 E and its distance from Morogoto town along Morogoro- Iringa high way is about 30km. Mzumbe ward covers an area of 718.94 km^2. According to the Tanzania National census of 2012, Mzumbe ward had a total population of 19,056. Appendix 3 is a map which shows the area of study.

3.4 Sampling frame, and sampling procedures

Purposively sampling was used to sample two PMTCT clinics among three clinics located in Mzumbe ward. Accidental sampling technique was used to sample pregnant women, men in the community and health workers, respondents who were present at the time during data collection. All members had an equal chance of being selected to form the sample. Also purposive sampling was used so as to obtain respondents from medical officers in charge at PMTCT clinic. We purposively chose to get information from respective officers and not otherwise.

3.4.1 Unit of Analysis

The units of analysis in this study include the following

i) Key stuff in PMTCT
ii) Pregnant women reaching PMTCT clinics without their partners
iii) Couples attending PMTCT clinic
iv) Men in the community both married and men with sexual partners irrespective of their HIV Sero status.
v) Health staff at Mzumbe ward.

3.4.2 Study population

From the perspective of study design, study population involved pregnant women male partners regardless of their age, occupation and education background, pregnant women under PMTCT or ANC service and health workers in Mzumbe ward. Also the study

population included key staff working in the PMTCT clinic from both Mzumbe Health Centre and Mikongeni dispensary. A summary of study population is shown in table below.

Table 3.1: Target population

Respondents	**Data collection method**	**No. of respondents**
Pregnant women attending PMTCT clinic without their partners	(2)FGD	10- women 8-women
Couples attending PMTCT clinic	(1) FGD	2-women and 2-men
Men in community	(3)FGD	26-men
Health workers	Interview	1-man and 1 – woman
PMTCT key stuff	Interview	1-man and 1-woman

3.4.3 Sample size

The study involved a total of 50 respondents comprising 28 men and 22 women; including key stuff working under PMTCT program in Mzumbe ward. The small population size makes even the proposed sample for the study to be smaller. This size of the sample was ideal in accordance to the limited financial resources and time on the side of researcher

3.5 Data collection methods

Data collection methods included documentary review, interviews, photographs, focus group discussion and observations. Most of the type of data collected was qualitative.

3.5.1 Observation

Non-participatory observation was used to collect data that supplement the data collected through other methods like interview and documentary review. The supplementary aspects that were observed include pregnant women who attend clinic, male who accompany their partners in the clinic, and male who participate in VCT, how health staff treat males who accompany their partners in clinic and availability of friendly environment for male in clinic. The rationale for using non-participatory observation is its ability to provide accurate data as the researcher witnesses what actually happened in its natural setting.

3.5.2 Interview

This method was used for the key health staff working in PMTCT clinics in Mzumbe ward and other health study at Mzumbe ward. The interview was conducted face to face in order to get information from the respondents. The information was required to be clear and unbiased**.** The rationale of using the interview method is that it allowed flexibility in data collection since the researcher was able to clarify ambiguous questions and even ask follow up questions depending on the context.

3.5.3 Focus group discussion (FGD)

A total of six (6) FGD meetings were conducted, two (2) FGDs involved pregnant women (10 women) in the first group and (8 women) second group who came for antenatal services without their male partners for HIV testing and counseling irrespective of whether they were positive or negative, three (3) FGDs involved men in the community both married and men with sexual partners irrespective of their HIV status. Two such groups consisted of eight (8) men and the third group consisted of (10) men. The last FGD involved couples who had attended clinic together (2-couples).

3.5.4 Documentary review

The researcher made use of documentary review, which included reading published and unpublished materials such as files, various daily, monthly, quarterly and annual PMTCT and HIV/AIDS reports which helped to provide valuable information of the study. Also various documents prepared by different researchers, articles and books were used to obtain information and this constituted secondary type of data collection.

3.6 Data analysis

This study was a qualitative research, whereby the information obtained from respondents was not express in numerical form. Data collected was analyzed using content analysis and presented so as to enable the researcher to answer the research questions and meet the objectives of the study from which conclusions and recommendations were drawn. The researcher used audio-recordings from interviews and FGDs which were conducted in the participant's preferred language, mostly in Kiswahili and late translated to English. The recorded data were then transcribed in text form, according to the research objectives, research questions and variables which supported the explanations.

3.7 Ethical considerations

The researcher sought permission to conduct the research from health canter and dispensary through the letter from Mzumbe University. All the protocol that may be demanded by the health centers was observed. Consent was sought and obtained from all the participants before commencing the interviews and discussions. The researcher also assured the participants that all information collected will be confidential and there will be no reference to the person giving the information. The researcher also informed the participant about their rights including the right of withdrawal from the interview or discussion.

CHAPTER FOUR

FINDINGS AND DISCUSSION

4.0 Introduction

This chapter presents demographic information and findings of a specific objective. The data presentation is organized and guided by three specific research objectives such as male in PMTCT, Factors that impinge or facilitate male participation in PMTC and the effects of male participation in PMTCT as well as appropriate mechanisms that can improve male participation in PMTCT.

4.1 Characteristics of the Respondents

This part describes the characteristics of the respondents from Mzumbe health centre in the selected departments. The description includes sex, age, marital status, and educational level as the respondents.

Given the nature of the study, it was deemed necessary to obtain gender specific information about the participants who were involved in the provision of this data. The information had to be collected from both males and females on determinants of male participation in prevention of mother to child transmission (PMTCT) in Tanzania. The findings from the Table 4.1 revealed that 66% of participants were male while 44% of respondents were female. The findings from table 4.1 below indicates the majority of participants, 34% are aged between 36-45 years, followed by participants aged between 46-55 years (26%), those aged between 26-35 made up 18% of all participants, 14% participants were 56 years and above and four percent were aged between 18 and 25years. The majority of participants (92%) are mature people aged above 25 years.

Data about the education qualifications of participants is presented in Table 4.1. The table shows that 62% of the participants had primary or secondary level education. The remaining 48% had either a diploma or higher level education qualification. Basing on the level of education, the composition of participants is assuring of being able to

provide reliable and valid information on this study. The group is capable of having knowledge about PMTCT in Mzumbe ward. Table 4.1 below, shows that 64% of participants were married, 30% of participants were single, 4% of respondents were divorced, and 2% of the participants were widowed. This means that the majority of respondents lived as couples that could be participating in the PMTCT program.

Table 4.1 Characteristics of the Respondents

Variables	Categories	Frequencies	Percentage (%)
Gender	Male	28	66
	Female	22	44
Age of respondents	18-28	4	8
	26-35	9	18
	36-45	17	34
	46-55	13	26
	56+	7	14
Education qualification	Primary Education	6	12
	Secondary Education	14	50
	Diploma	9	28
	Degree	9	18
	Master	2	4
Marital status	Single	15	30
	Married	32	64
	Divorced	2	4
	widowed	1	2

Source Field Data, 2016

4.2. Male Participation in PMTCT

The need for male participation in PMTCT was emphasized by the nurses working in the programme. According to the nurses, male involvement in PMTCT has a positive impact in every stage of the PMTCT program. Male partners are expected to take leading roles in the implementation of the PMTCT just as they take a leading role as head of family.

They should lead in making decisions on the implementation of PMTCT programme and supporting their female partners on successfully implementing those decisions.

Participants' opinions on participation of males in PMTCT were varied. In one of the FGDs one male participant made the following interesting comment:

> *"One of my roles as a father is to escort my wife to clinic and if they need me to test for HIV, I get tested and sometimes I take my child to clinic alone. I let my wife rest because I believe raising a child is also my duty" (a father in a 26-35 years group).*

Fewer men in the community do accompany their wives or sexual partiners to PMTCT and VCT centers as it shown in Figure 4.1 below, male accompany his wife to PMTCT centre.

Figure 4.1: Couples receiving PMTCT service at one of PMTCT clinic in Mzumbe ward.

Source: field picture 2016

In a FGD consisting of women who were not accompanied by their male partners one participant argued that expecting men to participate in PMTCT service, especially expecting men to accompany their sexual partners to attend ANC/PMTCT appointments is almost an illusion. The woman presented this view in the following words:

> *"Our Tanzanian men, the only role they know of or are familiar with is providing financial aid. They think providing financial support is enough for us to deliver a healthy baby, when you tell them about VCT and ANC they will just say it's not their responsibility. That is a woman's thing; going to clinic is absolutely not their duty" (36-45 years old pregnant woman).*

But the other participant in the same group argued that it was important for male partners to support them during the whole period of pregnancy and after the birth of the child, saying;

> *"It is necessary for him to accompany me to the clinic and to provide all the necessary support because it's not my duty alone to raise the baby. It is also his duty. We did have fun together creating this pregnancy, why should he now leave me to raise the baby on my own, and pretending to be busy with I don't know what…" (36-45 years old mother of 2).*

This is view was supported by one of the nurses who stated that it is important for men to participate fully not only in PMTCT or ANC but during the whole period from pregnancy through delivery to child rearing. According this nurse, men should provide the necessary support including getting involved in testing for HIV together with their partners so as to protect their children.

Regarding the idea of male partners accompanying their female partners to ANC/PMTCT, only a few male partners agreed that this is a good practice and that it is one of their roles of men as fathers. The majority felt that the provision of finance for ANC registration and delivery fees is their most important role in supporting their wife's

pregnancy. This view was lucidly presented by one respondent from FGDs consisting of men who did not accompany their wives, who said:

> *"my duty as a head of the house is to put food on the table and provide financial support but to go to clinic it's her duty as a mother not my duty, I have millions of things to do, to go to clinic and get tested will just waste my time. This is even contrary to Hon. Magufuli's clarion call "hapa kazi tu" that we need to do work, going to clinic? To do what?" (56+years old a father of four).*

With regard to the use of HIV preventive measures like condom during pregnancy so as to prevent new infection and prevent HIV transmission to the child, two male respondents offered the following interesting comments:

> "*I will do anything to protect my baby, even if I should use condom for the whole year I will use it, because I believe that nobody in his right mind will wish to harm his own child"(18-25year old father of one)*
>
> *"We, men are ready to use condom but the problem is with our wives. Women do not like to use condoms at all; they say they do not feel anything using a condom. And even if they have been advised by doctors or nurses to use the condom they do not tell us*" (26-35 year old)

This later view was even supported by one woman who said:

> *"It is true most of us women hate using a condom. In fact, we feel awkward using a condom with your husband and this is because most of us we trust our men so much so that we see using a condom is not necessary ……"(18-25 pregnant woman)*

The tendency for married women or those who are in long-term relationship to desist from using a condom as an HIV prevention measure was amplified in the discussion with women who went to clinic without their male partners. Two women presented the following comments:

> *"If you go to your husband and tell him that we should use a condom he will just conclude that you have another man in your life and probably the baby is not his.*

Otherwise, why should you use a condom while you're his wife and you are faithful?" (a pregnant woman and a mother of two.

"When men have an affair with women outside their marriage most of time they use condoms or other protective measures, but when they are with their wives they do not want to even hear the word condom; only men with HIV knowledge can agree to use preventive measure… " (a pregnant woman in FDG)

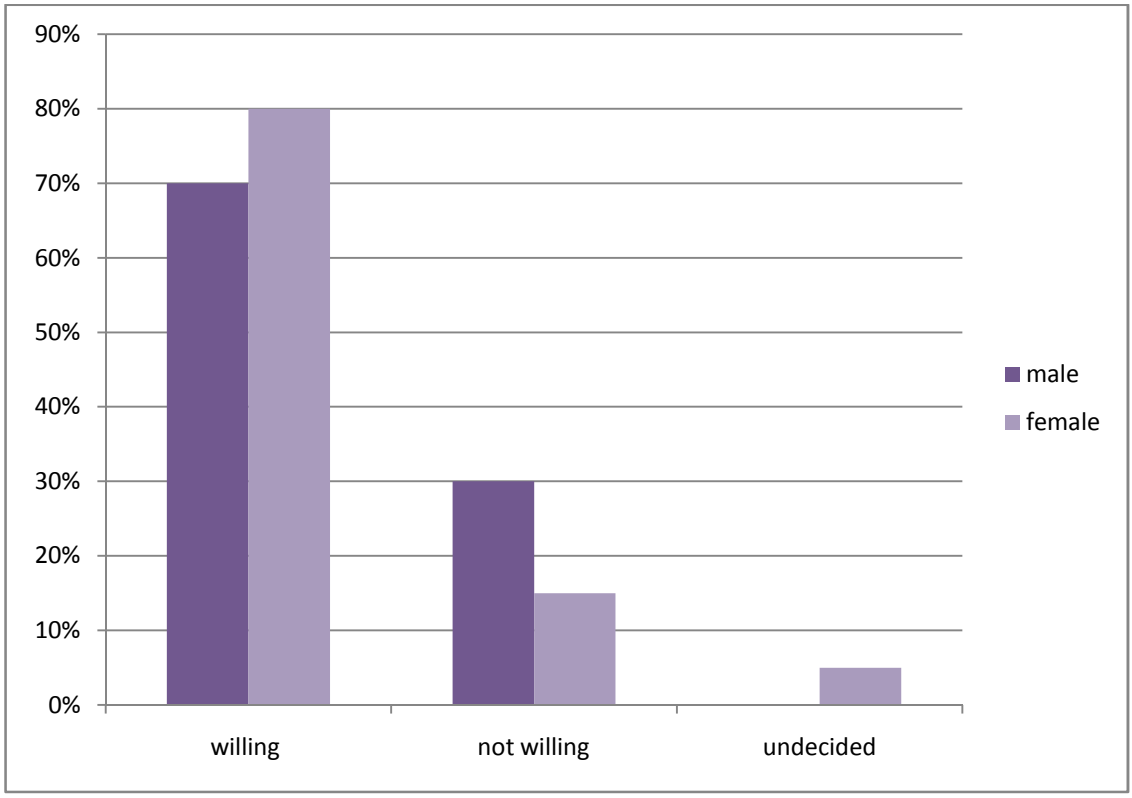
Distaste of using a condom is not only confined to women, as some of men said that using a condom affected their ability to enjoy and perform well during sex intercourse. In the discussion one man remarked:

"Can you eat a banana without pealing it and actually enjoy it really? …..if you can't enjoy it then how can you enjoy having sex using a condom? Because using a condom is just the same as eating a banana with its cover" (18-25 year old)

The comments above indicate that most of the men consider direct skin contact during sexual intercourse as prove of intimacy and that it represents men's level of control over their sexual partners. Direct skin contact is akin to asserting men's masculinity or manhood. This view is consistent with Kimmel arguments as quoted by Ouzgane and Morrell (2005) "sexual performance is one of the important areas in which masculinity is socially constructed and enacted and failure in sexual performance by man can challenge the essence of masculinity and make some men doubt if they are 'real men'.."

Overall however, 80% of the women that were interviewed were willing to use condoms, 15% were not willing and the remaining 5% were undecided. On the other hand, 70% of male participants were willing to use HIV preventive measures and 30% were not willing to use preventive measures as shown in figure 4.2 below.

Figure 4.2: Participants willingness of using preventive measure such as condom



Source: Field Data (2016)

From an interview with health workers in Mzumbe ward, it became apparent that men participate in PMTCT in different ways. These include providing financial support, helping women decide on different issues concerning their pregnancy including abortion if it need be, attending VCT together with their partner, and helping women cope with the new situation and use drugs when diagnosed being HIV positive. This is also supported by Kalembo et al, (2012) who argued that men are also encouraged to be supportive to their wives if found HIV positive and that such finding would persuade them to adhere to all PMTCT protocols.

4.3 Factors that impinge or facilitate male participation in PMTCT

4.3.1 Knowledge about PMTCT

According to the study, knowledge about PMTCT is one among factors that facilitate male participation of PMTCT. This is corroborated with the following response from an interview with health workers:

> *"In order for male members to participate in PMTCT they need to know the benefits and their role in the program, to have full knowledge of how PMTCT is conducted. Male participation is sometimes dependent on one's education background. Most of time people who have high level of education seem to have better knowledge on reproductive health than those who have low level of education or are not educated at all. If all male had full knowledge on PMTCT then their participation would likely be higher than the current situation" (health worker at Mzumbe health centre)*

This view was strongly subscribed in the discussion with 10 men who are resident at Mzumbe ward, who insisted that knowledge about PMTCT will enable male members participate in every stage of PMTCT service. Lack of knowledge will lead to poor male participation. In other words, if people have full knowledge about the benefits of male involvement in the programme it will lead to higher male involvement in the service. This is line with Ditekemena et al (2012) and Koo et al, (2012) observations that women who adhere to PMTCT programmes are more likely to be accompanied by their husbands to ANC/PMTCT clinic compare to those who do not adhere to the programme. Also, couples with good level of education are likely to freely discuss issues related to their HIV status and family health care management than those with lower level of education.

Discussions with women who were not accompanied by their male partners, confirmed that knowledge about PMTCT is an important factor even in making decisions concerning PMTCT service. Two women posited as follows:

"If our husbands will have a bit of knowledge concerning PMTCT services and its rational to our health it will be easier for us as couples to make different decisions on PMTCT including using HIV preventive measures like condom"(26-35 years old pregnant woman)

"Without the men knowing the benefits of HIV preventive measures and getting such knowledge straight from the doctors or nurses in counseling and education talks it will be very difficult for them to agree to use such measures. Clearly, education and awareness raising about PMTCT to both women and male is important".

These views are consistent with the findings made by Duff et al, (2011) and Msuya et al (2006) who reported that well-informed men were more likely to participate positively in the decision making for the well-being of the couples and well-informed couples were more likely to adopt a low risk behavior and increase mutual support, regardless of the test result. Along these lines the participants in this study observed that lack of knowledge about PMTCT was one of the major barriers towards male participation in PMTCT. For example, in our interview with PMTCT key stuff at Mikongeni dispensary it was reported that lack of knowledge was the main factor that inhibits male members from even making decisions on the use of PMTCT services or even allowing their female partners to reach ANC for PMTCT service.

This opinion was share by participants from different categories in our FGDs. The FGDs emphasized that lack of adequate information and knowledge on the benefit of male involvement is what limit male in the community to not participate fully in the program. The same kind of findings were reported by Brusamento et al. (2012), who found that lack of awareness of what PMTCT is and its importance to the well-being of families was one of the reasons for low male involvement in PMTCT uptake in Africa countries.

To amplify the importance of this finding, in one of the FGDs couples at ANC clinic, one man was quoted saying:

"*There is no education to both women and men in the community about HIV or VCT and PMTCT in general, that's why men do not see the benefits for them to support their women or to test for HIV. In view of this, sometimes women have to lie that they do not know the father of their pregnancy just to protect their men from coming to clinic. And that is because of they do not know the benefit of male involvement..." (26-35 father of one).*

But the women who were not accompanied by their male partners in clinic, complained that their men were stubborn and did not want even to spend a second to discuss about going to clinics The men claimed that they were always too busy with ensuring there was food on the table to find time for such matters as participating in PMTCT. But this is all due to lack of awareness on their role in PMTCT. Because of the insistent plea by the PMTCT providers of bringing their partners to the service, women were sometimes forced to go for ANC/PMTCT visits with fake partners just to allow them get access to the service regardless of the risks involved. One woman quoted saying;

" Because of the stubbornness of her husband to refuse to go to clinic with her and get tested as it was strictly ordered by PMTCT service providers, my friend decided to take her brother to VCT and pretend that was her husband. The two were tested because the nurse did not discover that was a brother and not a husband" (26-35 years old pregnant woman).

4.3.2 Occupation status

Responses from discussions on how occupation status affects male participation in PMTCT programme indicate that the level of income either facilitates or hinders men's participation in the program. In our discussion with couples reaching ANC for PMTCT service, it was agreed that one of the barriers to male participation in PMTCT was the kind of work one is involved in. In some of the jobs it not easy to be allowed absence from the work place so to accompany your partner or be involved in PMTCT activities. This view is implicit from the following three remarks. The first is from a woman who said:

"If clinics were conducted on Saturdays and Sundays my husband would often times accompany me to attend to PMTCT services but because these clinics take place on weekdays, particularly for Mzumbe health centre, clinic for pregnant women are held on Wednesdays, it is hard for my husband to accompany me because he is always on working schedules"(26-35 year pregnant woman)

The second is from a man who said:

"No one is too busy when it comes to his own child, but in reality men who are self-employed are more likely to participate in PMTCT compared to majority of us who are just employees. Although, we are willing to participate but our jobs sometimes makes it hard for us to participate in the program…" (36-45 years old, father of two)

The other is from a group of women who were not accompanied by their partners which said:

"if the both of us agree to be busy with PMTCT program and came together to clinic who will work and make sure there is enough money to support us"(pregnant woman)

The view of being constrained by work circumstances was also reported in a study conducted in Rwanda by Kowalczyk et al (2002). The study reported that men with well-paid jobs were more likely to participate in PMTCT programs than those with low salaries.

4.3.3 Financial status

Some of the men complained that it was expensive to enroll in PMTCT service, mentioning specifically the element of transport fare. They argued that high transport cost to PMTCT clinics made them to leave the woman to go by herself so as to reduce unnecessary cost.

This finding is consistent with Nkuoh et al., (2010) who reported that men complained of ANC and obstetric care bills as an obstacle that prevented men from participating in ANC/PMTCT. The report found out that although ANC and PMTCT services were

officially provided for free in almost all Sub-Saharan African countries, in reality, unofficial charges and indirect and opportunity costs summed up to a significant expenditures which deterred many couples from accessing the services.

4.3.4 Fear of getting tested

The fear factor is having its toll in men's participation in PMTCT. According to the discussion fear of testing for HIV and particularly fear of having a positive HIV test repels most men from attending VCT or ANC. The three quotations below are telling quite a lot about the impact of the fear factor on participating in PMTCT.

> *"My husband has refused to come to VCT with the excuse of being too busy or tired but in the real reason he is just afraid of testing for HIV. To get tested is not an easy thing, but we women do it because we have no option other than to do it. Fear is what prevent many men from attending VCT or PMTCT clinics"(36-45 pregnant woman with two children.*

> *"Other men are just afraid of testing for HIV and particularly they are afraid about how the result will come out. This is mainly because many men have "michepuko". They are having sexual intercourse with more than one partner, even married couples are unfaithful to their marriages, and this is why they are afraid of getting tested (a nurse at Mikongeni dispensary)*

> *"Some of the men are afraid of testing for HIV aids. They always claim that there is no need for them, men, to attend ANC and VCT because when their wives attend and test for HIV, and the results come out negative then automatically they are also HIV negative (a pregnant woman).*

The fear factor is dominant in most African countries. This has been documented by Getu (2011), in a study where some the men reported being mentally tormented by HIV testing. Getu quoted one men saying;

"*It will be too much for me to bear, so I will never go for an HIV test…..*".

Likewise Akarro, et al. (2011) and Koo, et al. (2013) reported that sometimes fear is such a big problem that it stops pregnant women that tested HIV positive from revealing their HIV status to their partners or avoiding to involve them in their care; and hence the low male participation in PMTCT activities.

4.3.5 Privacy and confidentiality

A FGD with men revealed that men are willing to participate in the PMTCT program provided VCT centers are conducted in private and user-friendly settings. That is if there is high level of confidentiality and privacy. But, most of the group members though that most of the VCT centers are either lacking the privacy and the staff do not treat the information with confidentiality it deserves. Clients have to feel safe and free for them to participate in VCT with their partners without fearing of their HIV status being exposed to the community.

It was argued that men mainly mistrust the PMTCT service providers because the way the service provision is arranged does not assure confidentiality. This fear is aggravated by the fact most of the PMTCT service providers are female nurses. Generally, men felt uncomfortable to talk to female nurses about their sexual problems since they do not trust women that much and it is hard for them to explain their sexual issues to women.

The setting at provision was also putting off some of the men as the following remark portrays:

> *"It is hard for us to accompany our partners to clinics because we men do not feel comfortable at these clinics. You may go to the clinic and find you are the only man in the whole clinic and the rest are all women looking at you..."(Married man).*

The issue of suitable setting for male participation in PMTCT is quite relevant for the PMTCT services in Mzumbe Ward. The VCT or PMTCT clinics have only one door for entering to test for HIV and you exit through the same door after getting your HIV test results. When exist the HIV testing rooms you face people who are waiting for their turn and everyone is looking at your face. Sometimes it is not easy to contain your feelings about your HIV status report. So, some of the people may read or predict your results by looking at your facial expression. It is clear therefore, a setting such as the one shown in Figure 4.3 below has significant impact in male participation in PMTCT activities.

Figure 4.3: Women at clinic waiting for service

Source: Field Pictures (2016)

4.3.6 Time and schedule

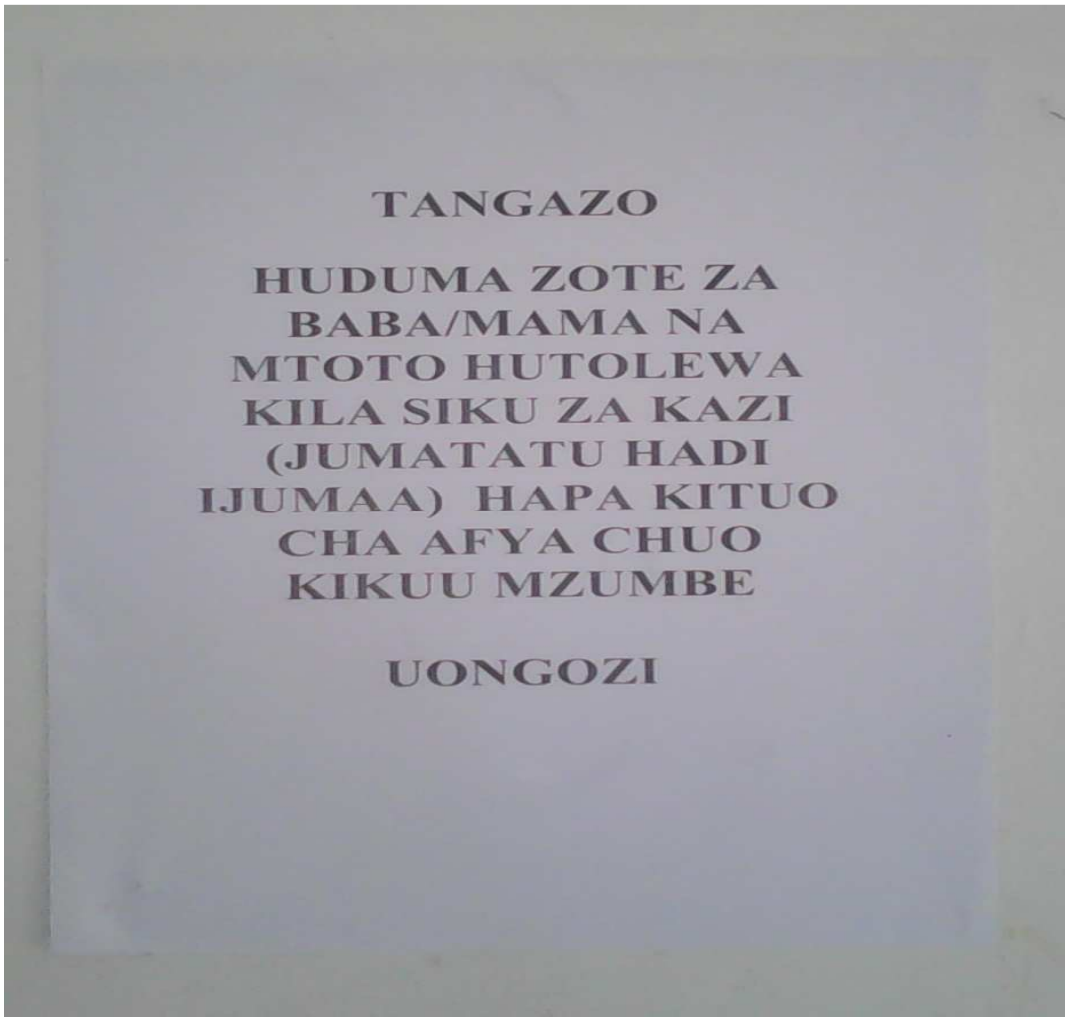
Time and schedule of PMTCT clinics is also a factor which influence male participation in the program. In interview with health workers at Mzumbe ward, it was argued that schedules of PMTCT clinics affect male participate in the program. Health workers claimed that, men sometimes are willing to participate in every stage of PMTCT including escorting their partners to PMTCT clinic but the problem is time and schedule of PMTCT appointments. Most often the clinics take place in weekdays and in the mornings which makes it hard for men to participate.

One woman in a group interview reported as follows:

> *"My husband is not afraid of getting tested and is shy to accompany me to ANC clinic. The problem is time and days the services are provided. These are usually provided from morning to afternoons in weekdays. How do you expect my husband to come with me when he is busy working so we can get food and other necessity at home"(18-25 years old, pregnant woman)*

This complaint is vindicated in a poster at Mzumbe Health Centre which indicates days for which reproductive health services are provided. According to the advertisement shown in figure 4.4 below, all PMTCT services are schedule on weekdays only.

Figure 4.4, one among posters at Mzumbe health centre indicate when PMTCT/ANC clinic services are provided



Source: Field Pictures (2016)

4.3.7 Communication between couples

Good communication between men and their female partners is associated with high male involvement, high HIV status disclosure and support between husband and wife. This was revealed by one of the men in a group discussion as quoted below:

> *"Good communication is what matters. If couples have good communication, and wives explain to their husbands all the procedures*

and PMTCT timetable, it would be easy for the husbands to take part in PMTCT program"(participant in FGD)

This view was also emphasized by one of the health workers at Mzumbe ward. According to the health worker, good communication will bring male to participate in the program and would make it easy for couples to discuss about sexual and PMTCT matters without hindrances. Such discussion would enable couples to make decisions about what to do to bring-up a healthy child. But some cases women are the ones inhibiting male participation in PMTCT activities. This brought up by one of the participants who claimed that many women do not ask their partners to accompany them to the clinic. The women concerned would only inform their partners that they were going to the clinic on a particular day and that they need money for that purpose. Such woman would not say that, "you can accompany me to the clinic!". So, in such circumstances poor communication from the women affect male participating in the PMTCT activities.

It was also argued that sometimes it is hard for the male partner to discuss issues concerning ANC or PMTCT with their female partners when pregnant because a lot of women distaste from such discussions during pregnancy. Pregnant women are generally very demanding, their moods and attitudes swing, thereby making it hard for them to hold serious discussions with their male partners on such matters. This is poignantly presented by one man who was quoted saying:

"The behavior of most women change when they become pregnant; pregnant women are nagging too much, they curse you for no reason, so how can you discuss anything with her when all that she can do is get mad at you."(36-45 years old)

In the case of Mzumbe Ward, one unique reason for why male participate in PMTCT program could not work is that some of the girls were impregnated by University students. Such male partners, that is the students involved, had either left the University

without knowing that they had fathered the children or even when they were still at the University they could not get involved because of lack of communication.

> *"One of the challenges we face here at Mzumbe ward is when you tell a pregnant women to come to ANC with their partners others claim that, the father to their pregnancy was a university students and that they cannot reach them anymore since they already finish their studies and left the University and hence they do not know where they are (a nurse at Mikongeni dispensary)"*

4.3.8 Venue and space

PMTCT clinics are often unable to concurrently accommodate both pregnant women and their partners because of a lack of space. In an interview with health providers in Mzumbe ward, it was acknowledged that PMTCT centers do not have enough space for both women and their partners to sit comfortably and wait for service. This was seen as one of the barriers for men to participate in the program. This situation is similar to the one reported about Uganda by Byamugisha et al., (2010). In their report Byamugisha et al found out that lack of space to accommodate both pregnant women and their male partners in ANC clinics was a major obstacle to male involvement in Uganda.

During the field study the researcher observed a serious lack of venue and space to accommodate both women and their sexual partners at both Mikongeni dispensary and Mzumbe health centre. At Mikongeni there was only one bench for both women and their male partners waiting for PMTCT service as shown in Figure 4.5 below.

Figure 4.5: Facility and Space for PMTCT Customers queuing for service

Source: field picture 2016

At Mzumbe Health Centre venue and space for PMTCT service is also a problem. There isn't enough space to accommodate both women and their partners at same time. Most of the time the whole space and chairs are occupied by women as shown in figure 4.6 below.

Figure 4.6, Crowded waiting area at Mzumbe Health Centre

Source: Field picture 2016

4.3.9 Presentation of men in reproductive hhealth policy

According to health workers in Mzumbe ward, the way policies on reproductive health are formulated and promoted has significant effect on male participation in PMTCT programmes. In one of the interview one of health worker at Mzumbe ward, remarked as follows:

> *"…. policy is a major factor which influence male involvement in reproductive health and PMTCT in general, because people are always influenced to act according to the system of the particular place"(nurse at Mzumbe health centre).*

This view was supported by men in one of the group discussion. The group posited that most men are aware of the reproductive health policy which has existed for a long time in the country. In the eyes of the group the policy portrays reproductive health as

essentially a women's issue. The basis of this notion comes from the following words presented by one of the group members in the FGD:

> *"One of the barriers to male participation in PMTCT in our community is the belief that pregnancy is a ''woman's affair''. This belief is contributed by reproductive health policy. Most of us are familiar with reproductive health policy which literary is known as mother and child health (afya ya mama na mtoto). The wording in the policy connotes the main focus is on the mother and child, and there is no role for the men. Although the policy has now been reworded to reads health of father, mother and child, but this later version is not known by the majority especially in rural areas"(26-35 years old man)*

The notion that reproductive health is a preserve of women is reinforced by hospital policy or rules that do not allow men to enter in labour rooms when their female partners go to deliver babies. The society has now taken as a general practice that expecting mothers are escorted and assisted by female attendants such as sisters and mother-in-laws, and not the male partners. This reinforces the view that male presence in labour or reproductive health facilities is irrelevant and is not appreciated. Such a view affects the level of male involvement in reproductive health. This behavior is consistent with Theuring's argument that the existing cultural or traditional barrier to male involvement in reproductive health services has been exacerbated by the tendency of health systems to structurally segregate men from reproductive issues" (Theuring et al. 2009).

4.3.10 Notion of manhood and womanhood in the community

The notion of manhood and womanhood as socially constructed in the community may facilitate or impinge male involvement in PMTCT. In group discussions one woman argued that the norms and traditions obtaining in the ward present men as superior to women. As such it almost impossible for a woman to tell her husband what to do and how to do it. This notion of manhood and womanhood forbids women from making decisions on matters regarding health care and includes preventing women from involving their partners to PMTCT/ANC.

The notion of male domination in many countries is well documented, Akarro et al, (2011) reported that men are the decision makers in many of the African settings where PMTCT is offered. Without working with men, change would be very difficult or impossible (Sternberg and Hubley, 2004). This notion of manhood is well guarded. This was observed during this study when the researcher visited PMTCT clinics for expecting mothers at Mzumbe Health Centre. One young man in his mid-twenties came with his partner to the clinic. A group of men were passing near the clinic and saw him outside the clinic waiting for his pregnant partner to be attended. The group started laughing at him, calling names and hulling obscene words to him until a benevolent nurse escorted him and his partner into the clinic.

On the other extreme, years of gender power imbalance have created a culture which fence out men from reproductive health which is again wrongly considered as women's issues. And therefore these should be handled by women and not otherwise (Gupta 2002). This wrong notion is also reported by Kumah (1999) and Drennan (1998) who maintain that some cultural norms and taboos in Africa reinforce negative stereotypes about male involvement in PMTCT services, and some even condone abuses of women's reproductive rights by men. The impact of such misconceptions on PMTCT is well documented by Skovdal. According to Skovdal et al (2011), the mere thought of being tested and found to be HIV positive and later developing AIDS is a big threat to a man's sense of masculinity. The fact of being ill is seen as criticism to a man's sense of manhood as this is perceived to be jeopardizing his role as head of the household and is a sign of a man being weak or unable to control his sexuality and his family in general. This notion was vindicated by one man in a group discussion who said:

> *"I grew up not seeing my father or grandfather going to clinic together with his partner. So, in my mind I know that it is our tradition that men do not go to clinic and I fear if I start going to clinic now how will my father and community in general treat me" (18-25 years old single man).*

4.4 Effects of male participation in uutilization of PMTCT sservices

Theoretically, one of the outcomes of male participation in PMTCT program is that there will be increased voluntary testing, follow up of HIV test results and uptake of HIV prevention measures. These will in turn lead into reduction in new infection from pregnant women to infants. It was argued that men should participate equally in PMTCT programmes because there are also vehicles for transmitting HIV to infants. This was brought up by one health worker who said:

> *"Just like women, men also play a big part in the risk of transmission of HIV to newborns or infants. So, they have the same natural duty as women in making sure that their partners and their newborns are safe from HIV transmission. In fact, when they get tested for HIV they are reducing the chances of HIV transmission not only to their newborns but also to their partners"*

Study from Nairobi, Kenya which was a sixteen-year prospective cohort study found that mothers who received care together with their partners reduced the mutual risk of HIV infection and infant mortality rate by 44% compared to the birth outcomes were male involvement is low (Alusio et al, 2011). Others studies reported that women with supportive partners during their pregnancy are more motivated to undergo HIV testing and they normally collect their HIV results and disclose the HIV results to their partners (Baiden.F. 2005).

Studies in Kenya found that pregnant women who were being accompanied by their male partners for couple HIV testing were more likely to return for antiretroviral prophylaxis (Farquhar *et al.*, 2004). This is has also been supported in the discussions with pregnant women as observed in the following comments:

> *"Sometimes when we (women) go back home and tell our husbands that the doctor advised that we do this or that, or that we were forbidden by nurses to do this and that because of our conditions, they would just*

assume it is all lies. And that we just have our own agenda. But if they came with us to couple counseling and hear what the doctor's advice us, we would be able to decide on different issues peacefully without arguments"(26-35 years old pregnant woman)

"It would be important for my husband to accompany me for ANC and PMTCT, first it will give me comfort because I have someone with me and he will also get a chance to hear the advises direct from the doctors and nurses so that I can be able deliver a healthy baby"(26-35 years old pregnant woman).

Similar findings were also reported from Zambia and Kenya where couples that were accompanied to HIV counseling improved the uptake of HIV testing, antiretroviral prophylaxis, alternatives to prolonged and mixed breastfeeding, and reduced risk of undesirable social events compared with those who attended counseling individually (Farquhar et al., 2004 and Semrau et al., 2005).

4.5 Mechanism for improving male participation in PMTCT

4.5.1 Provision of education about HIV/MTCT and awareness raising about PMTCT

Participants in group discussions and interviews considered awareness rising as the best mechanism to improve male participation in PMCT. The following comments are telling a lot about the role awareness raising in facilitating male involvement in PMTCT programmes.

"The major cause of low involvement is lack of education about HIV/AIDS and PMTCT services. So, the best way to make both males and females participate in PMTCT services, as it should be, is to provide education to all members in the community, not just men themselves but all adults in the community. This will at least improve male participation in PMTCT.."(26-35 years old, father of one)

"if you ask me what to do to improve male participation, the answer is simple. Create awareness on the rationale for male participation in PMTCT through education, and not just to adults but from the grassroots level, meaning from primary school, up to higher education so that everyone in the society will understand…" (18-25 year old single)

Alternative mechanisms for involving men in PMTCT is to make this service as part of the health education that takes place in the outpatient department instead of limiting it to ANC. Through outpatient services it could be possible to reach more people. This approach will involve more men because most of the men are found in general medical outpatient department than in ANC. This idea was proposed by one nurse during in-depth interviews. The nurse remarked as follows;

"*Health talks within outpatient department about male involvement are what will improve male participation in PMTCT because if we only discuss it on ANC, the only people who will be informed will be women. And as such the message will not get to men..." (Nurse at mikongeni dispensary)*

The two alternatives mechanisms could be augmented by taking advantage of community events such as open-day functions like international AIDS day to promote male involvement in PMTCT programs because such occasions attract almost all the community members. By promoting the programme in such events it will be easy for men in the community to get the right message and become aware of their roles in the program.

4.5.2 Strengthen laws and regulations in PMTCT centers

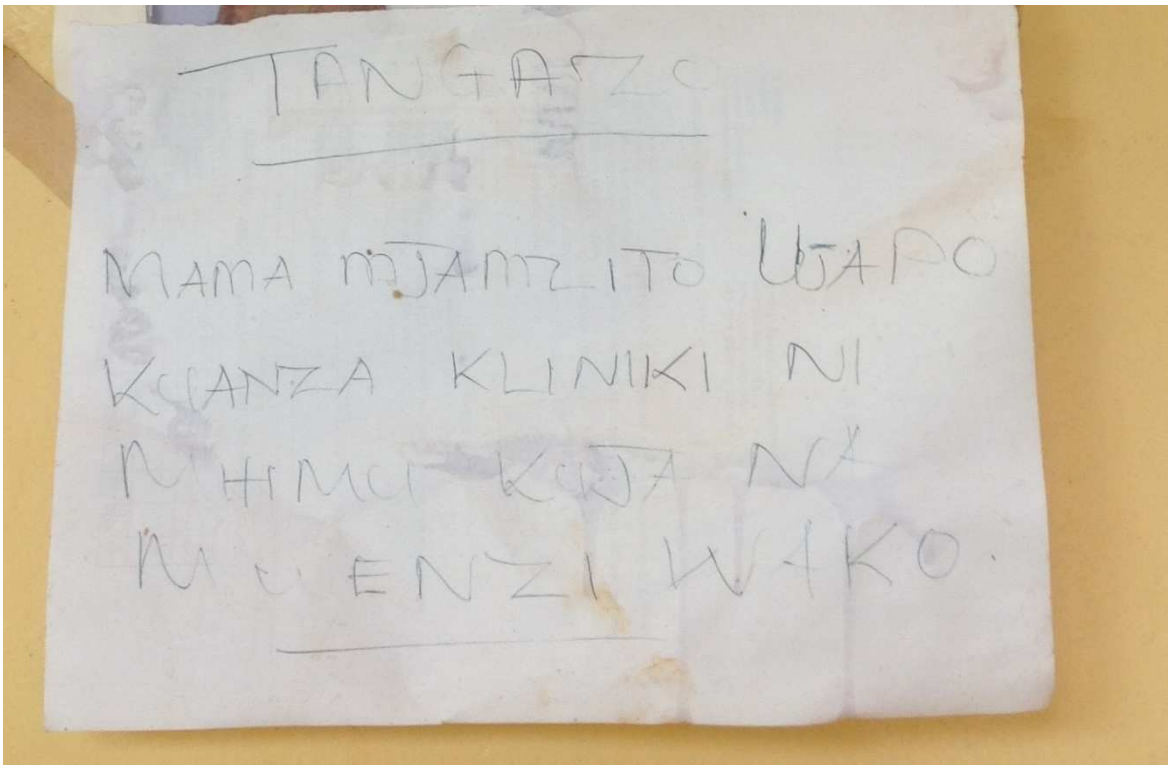
The participants in both interviews and focus group discussions felt that all PMTCT centres in Mzumbe ward requires every pregnant woman when attending clinic for the first time should come with the male partner there are no mechanisms for enforcing this requirement. At worst the requirement constitutes another burden on women rather than on men. Justifiably, health providers should insist men to attend couple counseling and

testing and the necessity for men to facilitate their female partners to access PMTCT services. The requirement that a woman should be accompanied by her sexual partner when attending the first visit to a clinic ought to have a legal force that binds also the men. The measure in place so far only bind the women; as explicit in the following remark from the nurse:

> *"If a woman come alone, without her sexual partner, for her first visit, no one will attend to her because it will encourage other women to do so and men will not feel the need to attend" (a nurse at Mzumbe health centre)*

Figure 4.7 below is a poster at one of PMTCT clinic in Mzumbe ward which insists that women should go with their sexual partners when they enroll in PMTCT/ANC services so as to improve male involvement in PMTCT service.

Figure 4.7: One of the poster at PMTCT clinic at Mikongeni dispensary



Source: Field picture 2016

4.5.3 Create male – friendly environment in PMTCT clinic

Participants in FGDs with men in the community suggested that the systems and facilities in clinics should be male friendly. The processes and treatment by service provides should encourage male partners to access reach PMTCT services without making them feel unwanted or uncomfortable. Service providers should treat their clients with courtesy and preserve confidentiality. Such treatment will encourage men to participate in the program.

This goes hand in hand with the need for gender balance amongst PMTCT attendants in all the clinics and ensuring flexibility on operating time. Currently, most clinics have acute shortage of male attendants. The participants also complained about long waiting time for service at the clinics. Long waiting time discourages men from participating in the programme. Shorter waiting time will encourage men to attend clinics because they will know they will not waste much time before going back to their private errands. Concern for flexibility on operating time was echoed in discussions with couples who were not accompanied by male partners. One of the women remarked:

> *"For our partners to participate in PMTCT service like VCT, health providers should be flexible with operating times. I would at least wish they opened the clinics during weekends instead of sticking to weekdays. If they stick to weekdays then they should open up to evenings so as be fair to everyone" (36-45 years old pregnant woman)*

4.5.4 Doing away with repugnant culture and traditional believes

PMTCT programmes need to work hard on influence the society so that it abandons some of its culture and traditions norms that are repugnant with male participation in PMTCT program. This was advocated by one participant from women who were not accompanied to the clinic by their husband when she said:

> *"As society we need to let go some of the culture and traditions which have no importance at all, like the traditions which hinder men from accompanying their partners to clinic because the world is changing and we need to change as well". 18-25 years old pregnant woman)*

This argument was also supported by Datta (2011) who reported that the advent of HIV epidemic has created a situation where fatherhood in African settings needs to be reconstructed so that men can adopt new gender parenting roles of caring for the sick and the dying as well as children. These roles are traditionally associated with women and mothers but not fathers, brothers or sons. The later are not expected to take up these care roles for their family members, wives, children or siblings.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

5.1 Introduction

This chapter presents the summary, conclusion and Policy implications of the study. The summary shows key study findings. The conclusion shows what the study findings suggest and recommendations show what needs to be done to address the problem.

5.2 Summary

The aim of the study was to explore determinants of male participation in PMTCT services at Mzumbe ward in Mvomero district in Morogoro region. Specifically, the study aimed to determine male participation in PMTCT program as perceived by PMTCT service provider, pregnant women and male in Mzumbe ward, also to examine factors that impinge or facilitate male participation in PMTCT services in Mzumbe ward and effect of male participation in utilization of PMTCT services.

Literature review and empirical studies reveal how male participate in PMTCT to enhance effectiveness of PMTCT service provision. The typical responsibilities of male partners that have been emphasized in the literature review and corroborated by responses from interviews and group discussions include accompanying their female partners to PMTCT/ANC clinics during pregnancy and after delivery. Male partners should also attend counseling sessions together with their female partners, voluntarily test for HIV and discuss the results of the test with their partners. In addition, they should provide financial support to their female partners so as they can be able to be enroll in the service. Financial support is required to cover PMTCT fees if there is any, transport fare and food when the clinic sessions last for more than half a day.

As heads of families, male partners have big influence on decisions affecting adoption and use of PMTCT services. Male partners are expect to be in the forefront to encourage their female partners to enroll in the service, and if need arises, agree to use protective measures like condoms. In Mzumbe ward, the study has found out overall willingness by both women and male on the use of protective gear, specifically the use of condom. Based on the interviews 80% of women and 70% of men were willing to use condoms as an HIV prevention measure. The study has also found out that where either one of the member, or the couple, is tested HIV positive, it is the role of the male partner to help them cope with their new HIV status including supporting and encouraging the respective member to receive proper treatment and care.

The main factors which facilitate or inhibiting male participation in PMTCT service include employment status and type of economic activities one is engaged in, fear of getting tested HIV positive and its associated stigma, timing of service provision, convenience of health provision infrastructure, and gender of PMTCT service providers. The majority of the health workers involved in PMTCT programme in Mzumbe ward are women and this makes men shy away from attending the clinics. This is made worse by lack of adequate space and convenient rooms for service provision in the clinics.

Furthermore, manhood and womanhood notion dissuade men from going for female dominated PMTCT services. This attitude is reinforced by reproductive health policy and practices which mainly focus on women and children, and compounded by lack of adequate knowledge about the role of male in PMTCT. The study also found out effect of male participation in utilization of PMTCT service, result show that low male participation in PMTCT service lead to low utilization by pregnant women and their infants in PMTCT services and this lead to high maternal and infant morbidity/mortality rate. In the study participants also suggest different ways to improve male participation in PMTCT which are provision of education and awareness rising on PMTCT issues including importance of male participation in the program to whole community and proper implementation of laws and regulation in PMTCT centers which may lead to

male involvement, create male – friendly in PMTCT clinic and elimination of culture and traditions which hinder male participation in PMTCT.

5.3 Conclusion

Male participation plays an important role in the success of PMTCT programs. Without positive involvement of men PMTCT programs can hardly achieve the desired outcomes. To succeed, appropriate mechanisms designed to improve male participation in PMTCT services should constitute a core components of the programme. The study found how male participate in PMTCT and identifies various factors which impinge male participation in the PMTCT program. This study found that lack of adequate knowledge about PMTCT and some still being influenced by notion of manhood and womanhood which is high driven by hegemonic masculinity notions which are social contracted. In as much as there some men who accompany their sexual partners to clinic and believe it their duty but there some who feel provide providing financial support towards pregnancy and parental care and other financial needs in home is enough.

Some men fear the HIV test and others feel their economic activities give them no time to accompany their sexual partners. Also communication between couples may lead to male participation or hinder male participation. The study also found out male participation in PMTCT was hindered by factors such lack of privacy and confidentiality in PMTCT clinic, lack of enough space and occupation status of individual.

Furthermore, there is need to review the policy and practices on provision of sexual and reproductive health services. Currently, the reproductive health policy and practices on provision of PMTCT services are too focused on women at the expense of excluding men in key pronouncements. Men often play a critical role in determining the reproductive health of women. Therefore, excluding men in reproductive health would end up increasing the number of HIV positive women and consequently increasing the number of infants born HIV positive.

However, the findings of this study reflect the situation in public health facilities at rural setting and may not be generalized to other settings.

5.4 Policy Implication

This section give recommendations based on study findings on how PMTCT policy and program could be improved so as to improve the level of male participation in PMTCT program in Mzumbe ward and Tanzania in general.

- According to the findings most of men think that their participation in PMTCT service and other related reproductive health service end by providing financial support and not otherwise but in reality men do have many roles to play in the program and not only provision of financial support. PMTCT policy should state clearly how men should participate in the program by state out their role in the program and advantage of their participation in the program.

- The study findings also show that there is a problem in reproductive health policy which fence men in reproductive health due to the fact that, the policy focuses much on women and children. Therefore sex and reproductive health policy include PMTCT should emphasis equal involvement of both female and male in reproductive health

- Lack of adequate knowledge about PMTCT and benefit of male involvemen in PMTCT was found as one of the factor that hinder male participation in PMTCT program male do not know their roles and benefit of their involvement so what should be done is MHSW should provide education and training concerning PMTCT service and the benefit of male involvement to the whole community so everyone get to understand PMTCT program.

- Effort should be made to ensure privacy and confidentiality in VCT centers and PMTCT centers, VCT centers there should be two doors, for entrance and another door to exist so patient can not face the crowd when they come out of testing room and also service providers should be trained on how to handle delicate medical issues like HIV so as patient could not feel uncomfortable or unwanted when they are at health centers.

- In order to create male – friendly environment more male service providers should engage in the services so as to make men feel comfortable and willing to participate and also health centers should allow men to inter in labor room when their sexual partners are delivering so men can be encourage to participate in every stage during the pregnancy of his partner.

- Improve couples communication skills through health education talks and counseling so as to enable couples to decide together on different matters concerning PMTCT and family matters in general.

- In as much as this study explored determinants of male participation in PMTCT in Mzumbe ward there is still need to conduct further studies in other parts of the country so as to encourage comparison of findings and draw up comprehensive conclusions that can help in formulation of policies and strategies which will improve male participation in the PMTCT program.

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APPENDENCES

Appendix I:

Interview Guides

1) How long have you worked in the PMTCT program?
2) What are your task in the PMTCT Program (explain)?
3) How do men participate in PMTCT program?
4) To what extent do men participate in PMTCT program?
5) What do you think could be the reasons why few men participate in the program especially in antenatal/PMTCT clinic attendance?
6) What will be the outcome of male participation in PMTCT program?
7) What do you do to encourage male involvement in PMTCT programs in Mzumbe health centre?
8) From your assessment, do you think they are helping in improving male involvement?

Appendix 2:

Topic Guideline for Focus Group Discussion (FGDs)

i) Pregnant women reach PMTCT clinics without their partners

ii) Couples attend PMTCT clinic

iii) Men in the community both married and men with sexual partners whose partners have ever been pregnant and visited antenatal and PMTCT clinics irrespective of their HIV Sero status.

iv) Health stuff at Mzumbe health centre

Topic 1; Pregnancy and parental care

1.1. What are your expectations as the man's responsibilities during his wife's pregnancy?
1.2. Do you think men and women should discuss about HIV during pregnancy?
1.3. In your opinion, do you think a woman can test for HIV during pregnancy without her husband's permission?
1.4. Do men accompany their wives when they visit the antenatal clinic (ANC)?
1.5. Point out factors that may hinder and/or encourage men from accompanying their sexual partners to the ANC.

Topic 2; Mother to child Transmission issues

2.1 Do you think HIV transmission from an infected mother to her baby can be prevented?
2.2 Please describe what you think an HIV-positive pregnant woman can do so that she does not give the virus to her infant?
2.3 Have you heard about the use of some drugs to reduce the transmission of HIV from an infected mother to her child?

2.4 In your opinion, do you think married couples should use condoms to reduce chances of mother to child transmission during pregnancy?

2.5 How do men react when a woman who is HIV positive does not breast feed her baby so as to avoid MTCT?

Topic 3. Male participation in PMTCT

3.1 Do you think it's important for men to attend ANC/PMTCT clinics get HIV counseling and testing together with their partners/wives?

3.2 How do men feel about attending ANC/PMTCT clinics with their partners for HIV counseling and testing?

3.3 How are men who accompany their partners to the ANC clinic regarded in your community?

3.4 How are men who do not accompany their partners to the ANC clinic regarded in your community?

3.5 Is it necessary for men to provide financial support to their wives when they enroll in PMTCT service? If it necessary why? If it not why?

3.6 What do you think could be the benefits of male participation in PMTCT programs?

3.7 What do you think could be the outcome of men participation in PMTCT program?

3.8 What do you think men should do in the PMTCT programs?

3.9 What do you think are the reasons for low men's attendance of ANC/PMTCT clinics and general participation in PMTCT programs?

3.10 How do men feel about women being sent from the hospital to invite them for couples counseling and testing in ANC/PMTCT clinic?

3.11 In what ways do you think men could be encouraged to attend PMTCT/ANC clinics and become actively involved in PMTCT programs?

Appendix 3

Map showing location of Mzumbe ward