KNOWLEDGE OF MOTHER TO CHILD TRASMISSION OF HIV AND PERCEIVED BARRIERS FOR PARTICIPATING IN MATERNAL AND CHILD HEALTH CARE AMONG MEN IN MTWARA RURAL DISTRICT.

By

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH (MPH) OF THE UNIVERSITY OF DAR ES SALAAM.

SEPTEMBER, 2005.

CERTIFICATION.

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation entitled: *"Knowledge of Mother to Child transmission and perceived barriers for participating in Maternal and Child Health care among Men in Mtwara Rural District"* in partial fulfillment of the requirement for degree of Master of Public Health.

Prof. E.P.Y Muhondwa.

(SUPERVISOR).

Date.....13th November 2015.....

STATEMENT OF COPYRIGHT

DECLARATION.

I, Vincent Rodney Mtweve, declare that this dissertation is my original work, and that it has not been presented and will not be presented to any other University for similar or any other degree awards.

CANDIDATE 'S SIGNATURE: .....

Date: 15.11.05

DEDICATION

I dedicate this work to the memory of my late father Rodney Mtweve, my mother Mary Mtweve, my son Luke and my beloved wife Flaviana.

ABSTRACT.

A cross sectional survey study was undertaken in Mtwara rural district during June 2005, to determine the Knowledge of MTCT of HIV and perceived barriers of participating in MCH care among Men.

Studies have shown that there is lack of men's participation in MCH and PMTCT services, limiting women's uptake of PMTCT services. As PMTCT has just been introduced in Mtwara rural district, this study therefore aimed to find out what men know about MTCT and the barriers that prevents them to participate in MCH services. The findings provide baseline information that will help to design ways to increase men's participation during scaling up of PMTCT.

Multistage cluster sampling was used to select Wards, Villages, and Streets. A total of 396 men were interviewed, interviewer administered questionnaire was used to collect data, and then analysis was done using Epi Info 6.04 version computer program.

The study results indicated that 38.4 % have high level of MTCT knowledge, 45.5% moderate level and 16.2% poor knowledge. Men with some education scored higher level of MTCT knowledge than men with no education ($p = 0.002$). Most of the respondents (90.2%) are willing to support PMTCT strategies if pregnant partner is found to be HIV positive. Willingness to support was found to be high in men with some education than in men with no education ($p = 0.001$).

Men's participation in MCH care was found to be high, particularly in accompanying a partner to ANC, maternity for delivery and doing household chores. However only 10.4% of men participated in antenatal clinic sessions and 51.9% discussed family planning with their partners. High proportion of young men less than 25years accompanied their partners to ANC ($p = 0.004$) and men with some education ($p = 0.002$).

Tendency to discuss family planning was found to be high in men who have fathered less than 5 children ($p = 0.0002$), men with some education ($p = 0.01$) and those who accompany their partners to ANC ($p = 0.000$).

Participants who did not participate in some of the MCH care activities were asked for reasons that prevented them in doing so. Reasons given as barriers to their participation in MCH care are that they view themselves as passive players and their participation is not needed for their partners to get proper care. There was significant difference in reason for not attending ANC sessions given between men who have fathered less than 5 children and those with more than 4 children ($p = 0.002$).

This study concludes that men of Mtwara rural district are potential partners in PMTCT and MCH care.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care.
DMO	District Medical Officer.
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
MCH	Mother and Child Health
MPH	Master of Public Health
MTCT	Mother to child transmission
MOH	Ministry of Health
NACP	National AIDS Control program
PMTCT	Prevention of Mother to Child Transmission
RCH	Reproductive and Child Health
RH	Reproductive Health
STD/STI	Sexually Transmitted Disease/Infections
TACAIDS	Tanzania Commission for AIDS
TRCHS	Tanzania Reproductive and Child Health Survey
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
UNAIDS	United Nations program for AIDS
USAID	United States Agency for International Development.
VCT	Voluntary Counseling and Testing

WHO	World Health Organization
WEO	Ward Executive Officer
VEO	Village Executive Officer

CHAPTER ONE.

1.0 INTRODUCTION.

1.1 Magnitude of Mother to Child Transmission of HIV (MTCT).

Tanzania has one of the highest prevalence of HIV in the Sub-Saharan Africa. The 2003/4 HIV Indicator survey showed an overall prevalence of HVI among adults of 7%. The prevalence among women was higher (8%) than among men (6%). The prevalence among couples was 2.6% and 8.8% among discordant couples (TACAIDS, 2004)

The prevalence among women who deliver in health facilities was 13.3%, and those attending ANC was 9.6%. Without any intervention the cumulative risk of Mother to Child (MTCT) Transmission of HIV is close to 40%. Each year approximately 180,000 HIV positive women deliver 72,000 HIV positive babies, which greatly contributes to rising infant morbidity and mortality. Mother to Child Transmission is responsible for 90% of HIV infection in children below 15 years of age (Massawe, 2003) and at the end of 2003 there were estimated 1.1 million AIDS orphans (USAID, 2004).

1.2 Prevention of Mother to Child Transmission (PMTCT)

In Tanzania PMTCT was started in 2000 on a pilot basis at Bukoba regional hospital and four consultant hospitals. It was integrated into Maternal and Child Health services. In 2002 PMTCT services were expanded to seven regional hospitals and the surrounding municipal and health centers. The second phase of expansion (2005/6) will cover nine regional hospitals and two district hospitals in each region (MOH, 2004). Through

private public partnership by the end of 2004 there were 4438 PMTCT sites (Hospitals, Health centers and Clinics) providing PMTCT services through out the country (Beson, 2004).

The PMTCT package involves Counseling and Voluntary testing for HIV (CVT), Modified Obstetric care, Antiretroviral provision, Infant feeding options and Care for the HIV infected mothers and children.

Evaluation of the PMTCT pilot sites identified fear of stigma, discrimination and abandonment due to lack of male involvement, to be the prominent barriers to women's uptake of PMTCT services in all five sites. The team noted very low community awareness of PMTCT and lack of IEC strategic material to target men and other community members. The majority of women did not disclose their HIV status to their partners for fear of violence and abandonment. This lack of disclosure prevented women from attending counseling and limited their infant feeding choices (Swartzendruker et al, 2002).

It appears that some of these factors which mediate men's involvement might have a bearing on PMTCT whose success depends on the support the mother receives from her partner. Only 44% of the mothers deliver at health facilities (TRCHS, 1999) and even though more than 80% go for antenatal care most of them make only one visit, which is not enough for antenatal care to have an impact.

1.3 Men's Participation in MCH/RCH services.

Maternal and child health (MCH) presents many opportunities for involving men in reproductive health. Men hold the decision making power in matters including use of family income, access to health care, and reproductive and contraceptive choices, involvement of male partners in RH services may have a crucial impact on women's and families' reproductive health (Kunene, 2004).

Men's decisions and actions make a difference during pregnancy, delivery and postpartum period. Their roles include the following: -

Planning their families. The first step that men can take to promote safe motherhood is to plan their families, limiting births and spacing them at least two years apart are good for maternal and child health.

Supporting contraceptive use. Men can accompany their partners to meet with a family planning counselor or health worker. Together, they can learn about the available contraceptive methods and choose the one that best meets their needs. A man can help his partner use modern methods correctly, and he can use a male method himself. Men can encourage their partners to seek help from a health care provider if side effects occur. They also can endorse trying another method if one method proves unsatisfactory.

Helping pregnant women stay healthy. When his partner becomes pregnant, a man can make sure that she gets proper antenatal care, which may entail providing

transportation or funds to pay for her visits. He can also accompany her on the antenatal visits, where he can learn about the symptoms of pregnancy complications.

Men can help women have safe pregnancies and healthy babies by ensuring that they receive nutritious food.

Arranging for skilled care during delivery.

Majority of women delivers their babies without skilled assistance, helped only by untrained traditional birth attendants or family members. Men can help by arranging for a trained attendant to be available for the delivery and by paying for the services. They also can arrange ahead of time for transportation and can buy supplies, if necessary.

Avoiding delays in seeking care. Men are often the ones who decide when a woman's condition is serious enough to seek medical care. They also decide how a woman will be transported to the clinic. Men can avoid delays by learning the symptoms of imminent delivery and of delivery complications.

Helping after the baby is born. Men can learn about potential postpartum complications and be ready to seek help if they occur. Men also can make sure that women get good nutrition while they are breastfeeding. During the postpartum period men can help with heavy housework, and taking care of other children. They can encourage breastfeeding, which helps the uterus contract. Finally, they can begin using contraception to space the next birth.

Being responsible fathers. The roles that men play as fathers and the ways in which they affect their children's health have been gaining attention. Men can become more involved in helping their children's healthy development—for example, ensuring that their children receive all of the needed immunization (UNFPA 2002; Prince 2003).

1.4 Barriers to male involvement in maternal and child health care.

Men face both Socio-cultural and institutional barriers to their involvement in MCH care.

It is widely recognized that men are often marginalized by maternal and child health services and are provided with limited access to basic information and knowledge to help them make informed choices and decisions in order to protect and promote their own health as well as that of their families. (Kindyomunda, 2003.)

Male participation in MCH services is constrained by externalities, such as widespread poverty, multiplicity of physical barriers to access antenatal and maternity care, inadequate health infrastructure and low morale of health personnel.

Because PMTCT has been integrated in MCH care which has predominantly been a women's affair with minimal involvement of men, it is feared that men will not participate actively in PMTCT and are likely to present barriers to effective use of PMTCT by HIV infected women.

1.5 STATEMENT OF THE PROBLEM.

Lack of male participation in Mother and Child health services is likely to affect the uptake of the services for Prevention of Mother to child transmission by women. This is likely to compromise the efforts to reduce the magnitude of Mother to Child Transmission of HIV.

Men are the key contributors to community acceptance and support of MCH and PMTCT services. Because they continue to be leaders and decision-makers in their households and communities, they control most of the societies and their institutions (Burke, 2004).

It has been shown that without male participation women fail to disclose their status for fear of male reaction, limiting their uptake of PMTCT services (USAID, 2003; Swartzendrunker et al 2002; Kisanga, 2004; Risasi, 2004)

Some studies have shown that Men are willing to participate but have no necessary skills. Lack of MTCT knowledge, social cultural and institutional barriers are the factors affecting their involvement in MCH services (Kisanga, 2004; Burke M, 2004).

This study was done in Mtwara rural district where the level of knowledge of MTCT among men is not known. PMTCT has just been introduced in the district. The services are currently available in one health center. Because each society defines its gender roles and responsibilities differently, perceived barriers of men's participation in MCH services and hence in PMTCT services might differ from those found in other areas. This study sought to find out what men in Mtwara know about Mother to child transmission of HIV and whether understanding of the importance of PMTCT might

impel them to overcome perceived barriers to participation .in MCH care in which PMTCT is integrated.

1.6 RATIONALE OF THE STUDY.

As MTCT of HIV rate is increasing, raising Infant morbidity and mortality rate, men are important partners in antenatal care and prevention of MTCT of HIV. The barriers preventing men participation in MCH/RCH services and their knowledge on MTCT of HIV need to be known in order to inform community sensitization efforts for the promotion of PMTCT uptake.

This study sought to provide baseline information, which will help to design ways to increase male participation during scaling up of PMTCT services. Because PMTCT is part of RCH services, addressing the barriers of men's participation in MCH services will improve uptake of PMTCT.

1.6 LITERATURE REVIEW

Current strategies on HIV/AIDS in Tanzania are geared towards improving the health of HIV infected mothers and reducing the transmission of the virus to their children during pregnancy, labour, delivery, and post-delivery through breastfeeding. Towards these efforts, increasing the level of general knowledge of transmission of the virus from mother to child and reducing the risk of transmission by use of anti-retroviral drugs are critical to achieving this goal (TACAIDS, 2004).

Lack of MTCT knowledge among men is a barrier to their participation in PMTCT and hence MCH care, as shown in a study done to identify factors that influence male participation among community members in Dodoma, Tanga and Kilimanjaro (Burke, 2004). Men assume that if one partner is positive, the other partner is also positive and the community uses the child's health as a proxy HIV test, i.e. if the baby is well then the parents are HIV negative. Similar findings were found in a study done in Majengo Health center. The study sought to assess male participation on the ongoing PMTCT and to describe reasons for failure to participate as perceived by men (Kisanga., 2004).

It has been shown that cultural definition of maleness is a barrier for men participating in MCH services. Male heads of households would wish to do more when their partners fall ill but are curtailed by cultural definitions of maleness and the roles defined which determine masculinity. Men frequently describe the fear of being ostracized and ridiculed by other men in the community as a major factor for their reluctance to be more actively involved in domestic activities. In an interview conducted in late 2001, educators working in urban and rural areas of South Africa described the impact of community norms that deter men from becoming involved in activities regarded as women's work (Dean, 2003).

Institutional barriers prevent men's access to reproductive health information and services due to existing structures that does not meet their needs. A study conducted in KwaZulu Natal, South Africa involving over a thousand men on attitudes towards providing care and support to their partners during pregnancy, showed that men were

could bring their partners for counseling and testing. Four reasons were frequently mentioned as barriers to men's participation. Fixed clinic hours interfering with their jobs, perception that pregnancy and child issues are women's arena, belief that they will have similar HIV results with the woman if they were to test. And that some women are "casual partners" or "mistresses" and men were not willing to be seen with them.

Studies done on barriers of male participation in MCH care have not linked it with PMTCT, which is now a component of MCH services. Studies done in Tanzania have examined barriers to men's participation in MCH services largely by asking women attending PMTCT services. This study sought to break with this tendency. It was a community based study involving men and linked PMTCT services to MCH services of which they are a part.

1.8 THE RESEARCH OBJECTIVES

1.8.1 Broad objective:

To determine men's Knowledge of MTCT of HIV and their Perceived barriers of participating in Maternal and Child Health services.

1.8.2 Specific objectives:

1. To assess men's knowledge on Mother to child transmission of HIV
2. To assess the different ways that men participate in Mother and Child health services
3. To determine the perceived barriers of men's participation in Mother and Child health services.

2.4. Inclusion criteria for selection of study sample.

The following criteria were used to select respondents for the study: -

1. Fathers of underfive children in the study area.

2. Must be residents of the selected villages and streets.

3. Only those who gave consent were to be interviewed.

2.5. Sample size estimation:

The sample size was estimated using the formula, $n= z^2pq/ \varepsilon^2$

Where n =Expected minimum sample size.

z = is a standard value which corresponds to 1.96 (at 95% Confidence Interval).

p = proportion males of men who have knowledge of MTCT and participate in ANC in Tanzania. In this case it is unknown, therefore **p** was taken as 50 %(0.5).

ε =Is the Margin of error on **p** was taken at 0.05.

q = 1-p, thus 1-0.5 =0.5

Therefore $n = \frac{1.96 \times 1.96 (0.5(1-0.5)}{0.05 \times 0.05} = 384.16$

It was however decided to exceed the minimum sample size and interviewed 396 men.

2.5.1. Determining the number of men to be interviewed in each village.

Proportional allocation of sample size to selected villages was done considering the population of eligible study subjects in each village. Referring to 2002 National census the three villages had a total of 1985 eligible study subjects, Nambeleketela (670),

Msijute (455) and Mpapura (860). Proportional allocation of the sample population (396) to each village was done as follows; -

Nambeleketela. 670/1985 x 396 = 134

Msijute. 455/1985 x 396 = 91

Mpapura. 860/1985 x 396 = 171

Total = 396.

2.5.2. Sampling methods.

The participants for the study were selected using a multistage random sampling technique. A list of all 18 wards in Mtwara rural district was obtained from the District Medical Officer. In the first stage, all 18 wards were written on separate pieces of paper and three wards were randomly selected for the study using the lottery method. Ziwani, Mayanga and Ndumbwe were selected. Letters were sent to the Ward Executive Officers (WEOs) of the three selected wards. The second stage involved selecting one village per ward. All villages of a ward were written on separate pieces of papers and one village from each ward was randomly selected by lottery method. The three selected villages were Nambeleketela, Msijute and Mpapura. Third stage was selecting two streets/hamlets in each village. A list of hamlets of a village was written in a separate piece of paper and two hamlets chosen by lottery method. The village executive officers (VEOs) informed the Street Leaders of the identified streets of the study. On the day of the interviews, the Street Leaders and researchers passed through the households and introduced the Researchers to eligible men found in their households.

2.6. Recruiting and Training of Research Assistant.

One-research assistants who is a form six graduate was recruited and trained on how to administer the questionnaires and assist the principal researcher during data collection. Training was done for two days prior to the actual date of the study.

2.7. Permission to conduct the study.

The permission to conduct the study was obtained from relevant authorities that included the MUCHS Research and Publications Committee, Mtwara regional medical officer, Mtwara rural District executive director and district medical officer, and finally ward executive officers. Informed consent was obtained from all respondents for their willingness to participate in the study. Explanation was given on study objectives, and how the information obtained will improve the MCH care and hence PMTCT. They were told that their participation in the research is voluntary and information obtained will be kept confidential and shall be used for research purpose only.

2.8. Data collection instrument.

Structured interviews were conducted with respondents who met the inclusion criteria. The principal researcher and research assistant administered the questionnaire. The questionnaire included both closed and open-ended questions. The Swahili version questionnaire translated from the English version was used after it has been pretested.

2.9. DEFINITION OF TERMS.

2.9.1 Mother to child transmission of HIV.

HIV infected woman passing infection to child, which takes place in the womb, during labor and through breast milk.

2.9.2 Knowledge of mother to child transmission of HIV.

Knowledge of MTCT was assessed by 8 questions, 1 score was awarded for each correct response and 0 score for incorrect response. Scale for MTCT knowledge is as follows:

Poor knowledge = Scores 0 - 2.

Moderate knowledge = Scores 3 - 5.

High knowledge = Scores 6 - 8

2.9.3 Antenatal care (ANC).

- Care of pregnant woman and her unborn baby. It includes the following activities:
- Fetal growth monitoring
- Preparation for birth and potential complications
- Immunization
- The selecting of co-existing diseases and treatment
- PMTCT
- Screening and treatment of Syphilis and other STIs.
- Family planning services
- Screening those who are at risk of complication

2.9.4 Men's participation in MCH care.

Male participation is used as an umbrella term to encompass the various ways in which men relate to reproductive health problems and programs, reproductive rights and reproductive behavior. The way men accept and indicate support to their partners' needs choices and rights in reproductive health and Men's own reproductive and sexual behavior (UNFPA, 1995). Men's roles in MCH include the following;

During pregnancy men ensure: -

- Good nutrition to prevent anemia in pregnancy
- Plenty of rest for pregnant woman by helping domestic work
- Ensure proper antenatal care, provides funds and transport for antenatal visits
- Accompany their partners for HIV/STD counseling and testing and other ANC services
- Provide transportation to hospital for delivery and avoids delays
- Learn about pregnancy symptoms and complications

During delivery

- Men arranges delivery to be conducted by skilled attendant
- Arrange ahead of time for transportation and by paying for delivery and services

During postpartum

- Men can help heavy housework

- Can encourage breast-feeding and begin using contraception
- Learn about post partum complications and be ready to seek help if they occur
- Ensure post partum woman gets good nutrition

During non pregnancy interval period

- Limiting birth by supporting contraceptive use, spacing child birth by at least two years and communicate each other to meet needs.
- Ensuring that their children receive all the needed immunizations and helping children's day to day care.

(UNFPA 2002; Prince 2000).

CHAPTER THREE.

3.0 RESULTS

The socio-demographic characteristics summarized below are presented in Table 1. Due to non-response on some questions, total number of response (**n**) on some variables appears less than 396 (Tables 11, 12, and 13).

3.1 Socio-demographic characteristics.

A total of 396 men participated in a study, of whom 134(33.8%) were from Nambeleketela, 91(23%) were from Msijute and 171(43.2%) from Mpapura. The mean age of study participants was 37 years, and the age ranged from 16 to 74 years.

Most of the respondents (79.7%) were engaged in subsistence farming. Moslem constitutes (90.2%) of the sample and the rest were Christians. Most of the study respondents (82.8%) were married, and 5.1% were single.

About three quarters (74.5%) of study respondents have fathered less than 5 children, the mean number of children fathered was 4 children. Some 68.7% of men had fathered a child within past three years, the rest last fathered a child within last 4 to 5 years.

Of 396 study respondents, 56.6% have attended primary education and 31.3% have never attended any education.

Table 1. Socio-demographic characteristics of the respondents.

Age. (n=396)	**n**	**%**
16 - 25 yrs.	58	14.6%
26 - 35yrs.	161	40.7%
36 - 45yrs.	95	24.0%
46 -55yrs.	5 1	12.9%
56 - 65yrs.	25	6.3%
66+yrs.	6	1.5%
Education (n=396)		
No education.	24	31.3%
Adult education.	18	4.5%
Primary education.	223	56.3%
Secondary education.	11	2.8%
College education.	6	1.5%
Quran/madrasat.	14	.3.5%
Religion (n = 396)		
Muslims.	357	90.2%
Christians.	39	9.8%
Marital status (n = 396)		
Single.	20	5.1%
Married.	328	82.8%
Others.	48	12.1%

Table 1 ctd.

Number of children fathered (n =396)		
1-2. children.	194	48.9%
3-4. children.	101	25.5%
5+. children .	101	25.5.%
Duration since fathered last child (n = 396)		
0-11mths.	76	19.2%
1-3 yrs.	197	49.7%
4-6yrs.	123	31.1%
Occupation (n = 396)		
Fisherman.	21	5.3%
Peasants.	315	79.5%
Business.	16	4.0%
Small scale business.	38	9.6%
Employed.	6	1.6%

3.2 Assessment of men's knowledge of MTCT

Knowledge on MTCT of HIV was assessed. Respondents were asked if they know that HIV can be transmitted from mother to child, if the answer was yes they were further asked questions whether the Virus could be transmitted during pregnancy, during delivery and during breastfeeding. The results show that 87.1% of men knew that HIV

can be transmitted from mother to child. About 56.6% know that transmission can happen during pregnancy, 39.9% during delivery and 67.9% during breastfeeding.

Respondents were further asked about the possibility of HIV positive mother to deliver an HIV negative baby and healthy looking baby to have been born with HIV virus.

Only 37.9% of respondents know that there is a possibility of HIV infected mother to deliver an HIV negative baby. Some 64.1% know that baby born with HIV can look healthy. Then they were asked about discordant results and possibility of uneventful delivery for HIV positive pregnant woman. Of the 396 respondents, 33.6% of them know that there is a possibility of only one partner to be HIV positive (discordant couples) and 77.5% know that HIV pregnant woman can deliver uneventful. There were 8 questions to assess MTCT knowledge. The distribution of scores is shown in Table 2.

Table 2. Frequency distribution of MTCT Knowledge scores.

Level of knowledge.	Score.	Freq.	Percent
	0	17	4.3%
Low knowledge.	1	22	5.6%
	2	25	6.3%
	3	26	6.6%
Moderate	4	70	17.7%
	5	84	21.2%
	6	89	22.5%
High.	7	48	12.1%
	8	15	3.8%
Total		396	100.0%

The scores above were subdivided into three levels of MTCT knowledge. Most of the respondents (83.9%) scored between moderate and high level of knowledge on MTCT, the mean score was 4.6, the highest score of 8 was attained by 3.8% of respondents and score 0 was attained by 4.3% of respondents.

The exploration of the association between the levels of knowledge and education status was done (Table 4).

Table 4. Education by level of MTCT knowledge.

	No education.	**Some education.**	**Total**
High.	56(35.9%).	96(40.0%).	152
Moderate.	62(39.7%).	118(49.2%).	180
Poor .	38(24.4%).	26(10.8%).	64
Total.	156(100%)	240(100%).	396

(χ^2 =12.96. df = 2. p = 0.002)

The result show that the difference in level of MTCT knowledge between those with some education and uneducated was statistically significant (p = 0.002). Of the 152 (40%) respondents who scored high level of MTCT knowledge, 40% of them have attained some education compared to 35.9% of those without education. About half of respondents (49.2%) with some education scored moderate level of knowledge compared to 39.7% of men without education, and poor score was higher in men with no education than those with some education.

Exploration was done on variation between knowledge of MTCT and other socio-demographic characteristics and revealed differences that were not statistically significant. In particular there was no significant differences of MTCT knowledge between age groups, marital status, duration since fathered last child, number of children fathered and occupation.

3.2.2 Willingness to support HIV infected pregnant partner

Respondents were asked if they were willing to support their pregnant partners if they were tested and found to be infected with HIV. Variation of willingness by different socio-demographic factors was done and only education showed difference that was statistically significant, the results are shown in Table 5.

Table 5. Education by willingness to support pregnant partner/wife if tested HIV positive.

	No education.	**Some education.**	**Total.**
Can offer support.	133(85.3%).	224(93.3%).	357(90.2%).
Can't offer support.	23(14.7%).	16(6.7%).	11(9.8%).
Total.	156(100%).	240(100%).	396.

($\chi^2 = 6.93$. $p = 0.009$).

The results (Table 5) show willingness to support was high, 90.2% of respondents said they can offer support to pregnant partner/wife if tested HIV positive to implement measures for prevention of mother to child transmission of HIV. Of the 240 respondents with some education, 93.3% of them showed willingness to support HIV positive partner compared to 85.3% of those without education. The difference was statistically significant ($\chi^2 = 6.93$. $p = 0.009$).

3.3 Different ways men participate in MCH care.

Men's participation in MCH care was determined, based in their experience when wife/partner was pregnant, participation was focused during antenatal care, Maternity and postpartum care. The results are shown in table 6.

Table 6. The result below shows various ways men participated in antenatal care.

Type of participation.	n (%)
Accompanied partner to ANC during pregnancy at least once. (n=396)	269(68%)
Attended ANC session when accompanied their partner. (n=269).	28(10.4%)
Helped to do domestic work during pregnancy. (n=396)	368(92.9%)
Participated in deciding the delivery place for wife/partner. (n=396).	285(70.0%)
Accompanied the partner to health facility for delivery. (n=396).	208(88.9%)
Helped domestic work after delivery. (n=396)	370(93.4%)
Discussed about family planning after delivery.(n=396)	205(51.9%)

Majority (68%) of men at least once accompanied their partners to attend antenatal clinic, but most of them did not attend antenatal sessions when their partners were receiving services inside the clinic. Only 10.4% of them attended ANC sessions.

Most of men helped their pregnant partners to do domestic work during pregnancy and after delivery (92.9% and 93.4% respectively). About two thirds of respondents (70%) participated in deciding for the place to go for delivery when their partners were in labour. Half of respondents (50.1%) discussed family planning with their partners after delivery (Table 6). Variation of this helping/supportive behavior was examined by Socio-demographic characteristics, and results are shown in tables 7, 8, 9, 10, 11, 12, and 13.

Table 7. Age of respondents by accompanying a wife/partner to antenatal clinic.

	16-24yrs.	**25-55yrs.**	**>55yrs.**	**Total**
Accompanied partner. at least once	30(76.9%).	229(70.2%).	10(32.3%).	269.
Did not accompany.	9(23.1%).	97(29.8%).	21(67.7%).	127.
Total.	39(100%).	326(100%).	31(100%).	396.

($\chi^2 = 20.30$. df = 2. p = 0.000).

The results (Table 7) show that accompanying the partner to ANC decreased with age. Of the 269 respondents who accompanied their partners to ANC, 76.9% were aged less

than 25years, 70.2% of were aged 25 - 55yrs and 32.2% of respondents were aged >55years. The differences between age groups were statistically significant (p = 0.000).

Table 8. Education level by accompanying partner/wife to antenatal clinic

	No education.	**Some education.**	**Total.**
Accompanied partner at least once.	93(59.6%).	175(73.3%).	269.
Did not accompany.	63(40.4%).	64(26.7%).	127.
Total.	156(100%).	240(100%).	396.

(χ^2= 8.15. p = 0.004)

Of the 269 (68%) respondents who accompanied their partners to ANC, majority of them (73.3%) have attained some education, compared to 59.6% of men without education. The difference was statistically significant (p-value = 0.004).

Table 9. Number of children fathered by accompanying a partner to antenatal clinic.

	1 - 4 children.	> 4children.	Total.
Accompanied partner. at least once.	213(72.2%).	56(55.4%).	269
Did not accompany.	82(27.8%).	45(44.6%).	127
Total.	295(100%).	101(100%).	396

($\chi^2 = 9.67$, $p = 0.002$)

The results above show that high proportion (72.2%) of respondents who fathered less than 5 children accompanied their partners to ANC, compared to 55.4% of respondents who have fathered more than 4 children. The difference was statistically significant ($p = 0.002$). Variation of accompanying a partner to ANC with other socio-demographic factors like, village, occupation, and duration since last child fathered revealed differences that were not statistically significant.

Table 10. Village by role played to help partner/wife attend antenatal clinic (for those who did not accompany their partners/wife to ANC).

n=127.	Nambeleketela.	Msijute.	Mpapura.	Total.
Provided fare/ transport.	23(48.9%).	22(88.0%).	40(72.7%)	85(66.9%).
Paid for treatment.	6(12.8%).	2(8.0%).	6(10.9%).	14(11.0%)
Helped domestic work.	18(38.8%)	1(4.0%).	9(16.4%).	28(22.0%)
Total.	47(100%)	25(100%)	55(100%).	127(100%)

(χ^2 =14.67. df = 4. p = 0.005)

Only 127(32.1%) of respondents never accompanied their partners to ANC during pregnancy care. But they participated in another way to help their partners attend ANC. More men from Msijute facilitated transport to ANC than men from other two villages. Facilitating transport was the common role played than paying for treatment and helping domestic work, the observed difference between villages and roles played was statistically significant (p = 0.004). Variation of role played to help partner by other Socio-demographic characteristics revealed differences that were not statistically significant.

Table 11. Number of children vs. discussing family planning after delivery.

n=395	1 - 4 children.	>4 children.	Total.
Discussed family planning.	169(57.3%)	36(36.0%).	205.
Did not discuss family planning	126((42.7%)	64(64.0%).	190.
Total	295(100%)	100(100%)	395.

($\chi^2 = 13.52$. $p = 0.0002$)

More respondents (57.3%) who have fathered less than 5 children discussed family planning with their partners compared to 36% of respondents fathered more than 4 children. The difference is statistically significant ($p = 0.0002$). Other Socio-demographic characteristics when varied with discussing family planning revealed differences that were not statistically significant.

Table 12. Discussing family planning Vs accompanying a partner to antenatal clinic.

	Accompanied partner to ANC.	**Did not accompany partner to ANC.**	**Total.**
Discussed family Planning.	161(59.9%).	108(40.1%).	269(68.1%)
Did not discuss family Planning.	44(34.9%).	82(65.1%).	126(31.9%).
Total.	205	190	395

($\chi^2 = 21.31$. $p = 0.000$).

High proportion of respondents (59.9%) who accompanied their partners to ANC discussed family planning, compared to 40.1% of men who did not accompany their partner to ANC. The difference noted was statistically significant ($p = 0.000$).

Table 13. Discussing family planning Vs Education

	No education.	**Some education.**	**Total.**
Dscuss family Planning.	68(43.9%).	137(57.1%).	205(51.9%)
Did not discuss Family planning.	87(56.1%).	103(42.9%).	190(48.1%)
Total	155	240	395

($\chi^2 = 21.31$. $p = 0.01$).

The results above show that there was difference in discussing family planning by education. About 57% of respondents with some education discussed family planning

compared to 43.9% of men with no education. The difference observed was statistically significant (p = 0.01).

3.4 Perceived barriers of participation in MCH care.

The results below show the reasons respondents gave in explaining why they did not participate in antenatal, maternity and post partum care. The results are presented in Tables 14, 16, 18, 19, 20 and 21.

Table 14. Reasons for not accompanying partner to ANC

n =127	**n(%)**
Clinic hours interfere with my work.	58(45.7%)
Antenatal services are not for men.	14(11.0%)
Clinic is not far from home.	14(11.0%)
She managed to go alone.	10(7.9%)
She had no problems.	8(6.3%).
Other reasons.	23(18.1%)

Respondents gave various reasons explaining why they did not accompany their partners to antenatal clinic as shown in table 14 above. Most common reason (45.7%) given was, *clinic hours interfere with their activities/duties.*

Table 15.Shows the results of an exploration of the association between perceived barriers to respondent's participation in ANC by Village.

Table 15. Village by reasons for not accompanying partner/wife to ANC

n=128	Nambeleketela.	Msijute.	Mpapura.	Total.
Clinic hrs interfere with my duties.	13(27.0%).	19(76.0%).	27(49%).	59
This is women's issue.	9(18.8%).	2(8.0%).	2(3.6%).	13
Other reasons.	26(54.2%).	4(16.0%).	26(47.3%).	56
Total.	48.(100%).	25(100%).	55(100%).	128

(χ^2 =20.38, df = 4, p = 0.0004)

Majority (76%) of respondents from Msijute compared to 27% from Nambeleketela and 49.1% from Mpapura failed to accompany their partners to ANC clinic because clinic hours interfere with their activities. The difference between villages was statistically significant. (p = 0.0003). Variation of reasons with occupation and other socio-demographic factors revealed differences that were not statistically significant.

Of the 268 respondents who accompanied their partners to ANC, 241(89.9%) of them did not attend ANC sessions with their partners. Table 16 below shows reasons given by respondents that hindered them to attend the sessions.

Table 16. Reasons for not attending ANC sessions among those who accompany their partners/wives to ANC during pregnancy.

n=241.	**n(%)**
I didn't know that I could get services from antenatal clinic.	59(24.5%)
Men can not be allowed to enter antenatal clinic.	92(38.2%)
Antenatal services are not for men.	45(18.7%)
I was not requested to attend.	36(14.9%)
Other reasons.	9(3.7%)

The commonest reason cited was *" Men can not be allowed to enter the ANC*" followed by "*I didn't know that I could get services from antenatal clinic*" The result of variations of these reasons by last child fathered is given in table 17.

Table 17. Number of children fathered by reasons for not attending ANC sessions.

n=241	1-4 children.	>4children.	Total.
I didn't know I could get services from ANC.	52(27.7%).	7(13.2%).	59.
Men are not allowed to enter ANC.	74(39.4%).	18(34.0%).	92.
ANC services are not for men.	36(19.1%).	9(17.0%).	45.
Other reasons.	26(13.8%).	19(35.8%).	45.
Total.	188(100%).	53(100%).	241.

(χ^2 =14.93. df =3.p = 0.002)

Reasons mentioned above were more given by respondents who have fathered less than 4 children compared to respondents with more than 4 children. The difference shown was statistically significant (p = 0.002). Variation of these reasons by other socio-demographic factors revealed differences that were not statistically significant.

Among 396 respondents interviewed, only 28(7.1%) of them did not help their partners with household chores during pregnancy. Reasons that prevented them in helping their partners are shown in table 18 below.

Table 18. Reasons for not helping domestic work during pregnancy.

n=28.	**n(%)**
We didn't stay together/she went to her parents.	8(28.6%)
Pregnancy is not an illness.	6(21.4%)
I had other things to attend.	4(14.3%)
It is shame for a man to do domestic work.	2(7.1%)
Other reasons.	8(28.6%)

The commonest reasons that prevented them in helping domestic work was "*We didn't stay together/she went to her parents*" and "*Pregnancy is not an illness*". Variations of these reasons by socio-demographic characteristics revealed difference that was not statistically significant.

Among 396 respondents interviewed, 111(28%) did not participate in deciding for their partner's place of delivery. Results in table 19 below show reasons given which hindered them to take part in decision making.

Table 19. Reasons for not taking part in deciding where the partner should go for delivery.

n=111	**n(%)**
It is women's issues.	30(27.0%)
I was away/traveled.	27(24.3%)
We did not stay together/she went to her parents.	20(18.0%)
Traditional birth attendant decided.	18(16.2%)
Other reasons.	16(14.4%)

Most of respondents said, "*It is women's issues*" (27%) and "*I was away/traveled*" (24.3%). Exploration on the variation between these reasons and background variables revealed differences that were not statistically significant.

Only 26(6.6%) of respondents did not accompany their partners to health facility for delivery, when asked why they didn't accompany their partners to health facility, they gave reasons which are shown in table 20 below.

Table 20. Reasons for not accompanying partner to health facility for delivery.

n=26.	**n(%)**
I am disabled.	2(7.7%)
I took care of children.	2(7.7%)
I trust health workers.	1(3.8%)
I was busy.	3(11.5%)
I had no experience.	1(3.8%)
I was not staying with her/she went to her parents	7(26.9%)
I was away/traveled.	10(38.5%)

The reason of not accompanying a partner to health facility for delivery mentioned most frequently was "*I was not staying with her/she went to her parents*". Explorations done for variation of these reasons by socio-demographic characteristics of respondents and revealed differences that were not statistically significant.

Some 190 (48%) of respondents did not discuss family planning and gave different reasons as shown in table 21 below.

Table 21. Reasons for not discussing family planning with his partner.

n=190.	**n(%)**
No need to discuss, we abstain until the baby is old enough.	101(59.2%)
She conceives with difficult.	27(14.2%)
Family planning is women's affair.	16(8.4%)
No need to discuss.	8(4.2%)
We have not yet decided.	5(2.6%)
Other reasons.	33(17.4%)

Majority of men (59.2%) said, "*there is no need to discuss family planning because it a custom to abstain until the baby stops breastfeeding*". Exploration on variations between reasons given and different socio-demographic factors revealed differences that were not statistically significant.

CHAPTER FOUR.

DISCUSSION.

4.1 Knowledge of Mother to child Transmission of HIV.

The results of this study indicated that majority of men have knowledge of Mother to child transmission of HIV. Only few respondents showed poor knowledge of MTCT, amounting to sixteen percent (Table 2).

Knowledge of MTCT among respondents is higher than what was found during HIV/AIDS indicator survey in 2003, in which it was found that MTCT knowledge among men of Mtwara was 68.9% (TACAIDS - THIS 2003).

In this study some 68% of respondents know that HIV can be transmitted during pregnancy, this is slightly higher than what was found in HIV/AIDS Indicator survey in which 63% of men of Mtwara knew that HIV can be transmitted during pregnancy.

This study found that transmission during delivery was least known, only 39.9% of men know that HIV can be transmitted during pregnancy (Pg. 22, sec.4.2). The majority of respondents think HIV transmission can not happen during delivery. This has negative implications for PMTCT, as the risk of HIV transmission during delivery is 20%, twice the risk during pregnancy and breastfeeding. At this stage modified obstetric care and ART is corner stone of PMTCT, and men's knowledge is important in order to make sure that their partners deliver in health facilities so that such intervention are taken.

Respondents with some education were found to have high level of knowledge of MTCT than those without education (Table 4). Similar findings were also noted in 2003 HIV/AIDS Indicator survey (TACAIDS-THIS, 2003). This difference can be explained by the fact that education is important in accessing and understanding health information, those with education have access to health information through IEC and other means compared to those who have no education.

pregnant partner is HIV infected (Table 5). Similar findings were noted in a study done in Botswana and South Africa (Busi, 2004), in which 97% of respondents said they would offer support an HIV infected partner to feed their babies with formula. Education was also found to be associated with willingness to offer support, men with some education were more willing than men with no education.

Misconception about MTCT was also tested as part of MTCT knowledge. Only 33.6% of respondents know that among couples there is a possibility of only one partner to be HIV positive (discordant couples). Of all respondents, 150(37.9%) know that there is a possibility of HIV pregnant woman to deliver HIV negative baby (pg.22.4.2) This shows that majority of men believe that there is no possibility of discordant couple and once they are HIV infected the baby will also be infected. This has a negative implication on PMTCT as was found in studies done in Moshi, Dodoma and Tanga, in which Men assume that if one partner is HIV positive the other partner is definitely positive so there

is no need to be tested. And child is used as a proxy HIV test, i.e. if baby is well then parents are HIV negative (Burke 2004, Kisanga 2004).

4.2 Different ways men participate in MCH care.

Majority of men helps their partners in doing household chores during pregnancy and after delivery (Table 6). Type of house hold chores done include cooking, house cleaning, laundry, taking care of children, collecting firewood, fetching water and pounding cereals. These findings are in contrast to those found in a study done in South Africa in which men frequently described fear of being ostracized and ridiculed by other men in the community which explained their reluctance to actively involve themselves in domestic activities (Dean, 2003).

Majority of men who accompanied their partners to ANC were not invited to attend the clinic sessions (Table 6). Similar situation was found in a study done in India (Population council, 2002). It was found that 60% of women were accompanied by husbands but were usually allowed into ANC rooms only when a referral to a hospital is considered very necessary or when husband acts as a translator for a woman who can not understand the provider's language. This is because ANC activities are traditionally viewed as for women only, lack of men's participation into clinic sessions has negative implications on reproductive health of both men and their partners. ANC session is also an opportunity to address men's reproductive health needs like detection and treatment of STDs, sexual problems like impotence, prostate cancer, infertility etc.

Higher proportion of men accompanied their partners to health facility for delivery compared to those who accompanied their partners to ANC (Table 6). This difference may possibly be explained by the common belief that labour is a critical period compared to the antenatal period.

Tendency of men to accompany their partners to ANC was found to be high in young age, men with some education and men who have fathered less than 5 children (Table 7, 8, and 9). This pattern can be explained by the fact that educated men have more access to health information and are more likely to understand the importance of supporting their partners. Young men are more flexible and can easily get away from traditional life which discourages to engage in arenas which are viewed as for women only. Men who have fathered more than 5 children are less involved in going to ANC, possibly because they think their partners are more experienced in pregnancy and child birth, hence they can manage without their male partners.

After delivery only half of respondents discussed family planning with their partners, and it was found to be high in men with some education, having fathered less than 5 children and men who accompany their partners to ANC (Table 11,12 and 13). Education exposes one to health information and is likely to understand family planning methods hence can discuss family planning with his partner. It is also possible that men who accompany their partners to ANC are more informed about family panning methods than those who do not go to ANC.

4.3. Perceived barriers of participating in antenatal clinic

Of all respondents, 127(32%) never accompanied their partners to antenatal visit. The reasons given were, clinics interfere with their duties, it is a woman's issue, she managed to go alone, she had no problems and the clinic is not far from home (table 14). Some of these findings has also been found in other studies done in South Africa and Moshi-Tanzania. Frequent reasons given as a barrier to men's participation in attending counseling were fixed clinic hours interfering with their jobs and perception that pregnancy and child issues are women's arena (Kisanga, 2004; Kunene, 2003).

These results indicate that men perceive that their only responsibility when necessary is to make sure a woman goes to the clinic and not for them to attend the clinic. That is why even those who accompanied their partners to antenatal clinics, only 10% managed to attend clinic sessions, most of them just waited outside the clinic. Reasons given reflect the cultural norms according to which maternal and childcare are women's arena. Consequently men lack the necessary skills to participate even though they might want to participate. Similar situation was found in study done in South Africa (Dean, 2003). The ways ANC services are organized also prevent men's participation in ANC sessions. Though men go to ANC with their partners health workers do not invite men to attend this is evidenced by frequent reasons given like "I was not requested to attend the sessions" and " I didn't know that I can get services from ANC" (Table 14). High proportion of men from Msijute compared with men from other villages did not accompany their partners to antenatal clinic, frequent reason given was "clinic hours

interfere with their duties" and most of them facilitated transport of their partners to ANC (Tables10 and 15). Women of Msijute attend ANC much far from their village, this can be a reason for men to say they have no time to go to ANC and there fore they facilitate transport for their partners to attend the clinic. Majority of respondents in three villages are peasants, and occupation was not found to be associated with failure to accompany their partners to ANC.

Reasons given for not discussing family planning indicate that respondents are not well informed about family planning practice. The most frequent reason given was "There is no need to discuss because they abstain until the baby is old enough" (Table 21). This, suggest that men lack the knowledge and skills of family planning. Pregnancy, they believe that it is not proper to practice sex and use family planning methods while the mother is breastfeeding.

CHAPTER FIVE.

5.0 CONCLUSIONS AND RECOMMENDATIONS.

5.1 CONLUSIONS.

The majority of respondents in Mtwara rural district were found to be aware that HIV can be transmitted from mother to child, even though their knowledge on ways of MTCT transmission of HIV and the possibility of HIV transmission during delivery was least known by respondents. Some misconceptions about MTCT of HIV were found. The majority (66.4%) of respondents did not know about the possibility of discordant results and over two thirds believed that HIV infected mother could not deliver HIV negative baby. The study noted that men with some education were more knowledgeable than those with no education. Majority of men were willing to support PMTCT strategies if the pregnant partner was found to be HIV positive. Education level was found to be a factor in willingness to support HIV infected partner, where men with some education were more willing than men with no education. These results indicate that Men of Mtwara rural district are potential partners in PMTCT.

This study has shown that men do participate in antenatal, maternity and postpartum. However the level of attendance at antenatal clinic sessions was found to be very low and that of discussing family planning with the partner was also low. Accompanying a partner to antenatal clinic was highly associated with age, education and family size. In

particular young men aged less than 25 years, men with some education, and those who had fathered less than 5 children reported of accompanying their partners to the clinic. Discussing Family planning was associated with men with some education and those who accompany partner to antenatal clinic. Higher proportion of men with some education and those who accompany their partners to antenatal clinic discussed family planning with their partners after delivery.

Reasons given as barriers to their participation in antenatal, Maternity and Postpartum care, were largely cultural resulting in men perceiving themselves as having a passive role in maternal and child health care.

5.2 RECOMMENDATIONS

Health education programs should intensify MTCT education to men, as they dominate decision making in families, communities and institutions. They often control women's use of reproductive health services in which PMTCT is integrated.

Introduce couple participation/counseling in all four antenatal visits of focused antenatal care also during postpartum care. And for this to happen there is a need to sensitize health workers about the importance of inviting men in ANC sessions as a routine practice.

Men should be sensitized about the importance of participating in MCH care and that they are equally important as women in all activities pertaining to mother and child health care.

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