

**MALE PARTNER INVOLVEMENT IN PREVENTION OF MOTHER
TO CHILD TRANSMISSION OF HIV/AIDS AT HOIMA REFFERAL
HOSPITAL IN HOIMA MUNICIPALITY**

BY

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DECLARATION

All the information presented in this study is my original work.

I therefore declare that this dissertation is a true copy of my study finding and has never been submitted in the same way or in any different form to any institution for any academic qualification.

NAME OF AUTHOR: SEBWAMI RICHARD

SIGNATURE

DATE

DEDICATION

I dedicate this research to my family my wife linda and daughter Clarke, my father Mr. Kyamanywa Joseph and my beloved mother Nakawala Desirrantakyamanywa, to my brothers and sisters my classmates, my supervisors, who guided both with knowledge and in terms of finance and lastly to my girlfriend.

APPROVAL

This research report by **SEBWAMI RICHARD** has been written under my close supervision and is being submitted for examination with my approval.

SUPERVISOR: MR.TUTAMWEBWA THOMAS

Signature.....

Date.....

ACKNOWLEDGEMENT

I give honor and thank the Lord Jesus Christ for His love, grace and care for taking me through the entire study period.

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May God bless you all abundantly?

TABLE OF CONTENT

DECLARATION	I
DEDICATION	II
APPROVAL	III
ACKNOWLEDGEMENT	IV
TABLE OF CONTENT	V
LIST OF TABLES	VII
LIST OF ACRONYMS	VIII
OPERATIONAL DEFINITIONS	IX
ABSTRACT	X
CHAPTER ONE:	1
1.0 INTRODUCTION.....	1
1.1 BACKGROUND.....	1
1.2 PROBLEM STATEMENT	2
1.3CONCEPTUAL FRAME WORK	4
1.4 OBJECTIVES OF THE STUDY.....	5
1.4 .1 BROAD OBJECTIVE.....	5
1.4.2 SPECIFIC OBJECTIVES.....	5
1.5 RESEARCH QUESTIONS.....	5
1.6 SCOPE OF THE STUDY	6
1.6.1 GEOGRAPHICAL SCOPE.....	6
1.6.2 CONTENT SCOPE	6
1.6.3 TIME SCOPE	6
1.7 JUSTIFICATION	6
CHAPTER TWO	7
LITERATURE REVIEW	7
2.0 INTRODUCTION.....	7
2.1.0KNOWLEDGE AND ATTITUDE OF MALE PARTNER INVOLVEMENT IN PMTCT	7
2.1.1 KNOWLEDGE ABOUT MTCT AND PMTCT	7
2.1.2 FACTOR THAT INFLUENCE ATTITUDE TOWARD PMTCT	9
2.2.0LEVEL OF MALE PARTNER INVOLVEMENT IN PMT CT THROUGH HCT.....	11
2.2.1 HEALTH SYSTEMSVERSUS MALE PARTNER INVOLVEMENT IN THE PMTCT	11
2.3FACTORS ASSOCIATED WITH MALE PARTNER INVOLVEMENT IN HCT DURING PMTCT.....	12
CHAPTER THREE.....	14

METHODOLOGY	14
3.0 INTRODUCTION.....	14
3.1 STUDY DESIGN	14
3.2 STUDY AREA.....	14
3.3 STUDY POPULATION	15
3.4 SAMPLING PROCEDURE	15
3.5 SAMPLING SIZE	15
3.6 DEFINITION OF VARIABLES.....	16
3.7 DATA COLLECTION	16
3.7.1 RESEARCH INSTRUMENT	16
3.7.2 DATA COLLECTION PROCEDURE	16
3.7.3 QUALITY DATA CONTROL	16
3.7.4 DATA MANAGEMENT	16
3.7.5 DATA ANALYSIS.....	17
3.8 ETHICAL CONSIDERATIONS	17
3.9 SELECTION CRITERIA	17
3.10 DISSEMINATION OF RESULTS	18
CHAPTER FOUR	20
4.1 INTRODUCTION.....	20
4.2 RESPONDENT’S SOCIAL DEMOGRAPHIC DATA	20
4.3 KNOWLEDGE AND ATTITUDE OF MALE PARTNER INVOLVEMENT IN PMTCT	23
4.4.LEVEL OF MALE INVOLVEMENT IN PMTCT THROUGH HCT	24
4.5 FACTORS ASSOCIATED WITH MALEPARTNER INVOLVEMENT IN HCT DURING PMTCT.....	26
CHAPTER FIVE	27
DISCUSSIONS, CONCLUSION AND RECOMENDATION.....	27
5.0 INTRODUCTION.....	27
5.1 DISCUSSION	28
5.2 CONCLUSIONS FOR THE PMTCT PROGRAM	31
5.3 RECOMMENDATIONS.....	31
APPEDIX ;II QUESTINARES.....	37
1.0 DEMOGRAPHIC INFORMATION	37
APPENDIX :III MAP SHOWING HOIMA REGION	41
APPENDIX: IV MAP OF UGANDA SHOWING HOIMA DISTRICT	42

LIST OF TABLES

Table 1 showing respondent's social demographic data.....	19
Table 2 showing respondents' knowledge and attitude of male partner involvement in PMTCT.....	22
Table 3 showing respondents level of male involvement in HCT during PMTCT.....	23
Table 4 showing participants response on factors associated with male partner involvement in HCT during PMTCT.....	26

FIGURES

Figure1. Chart showing participant's response on whether they had come for both counseling and testing.....	25
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LIST OF ACRONYMS

ANC	Ante-natal clinic
CCA	Community counseling aide
HCT	HIV counseling and testing
HIV	Human Immune Virus
MTCT	mother to child transmission of HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
STIS	Sexually Transmitted Infections
UNAIDS	The joint United Nations Program on HIV/AIDS
VCT	Voluntary Counseling and Testing
VHTs	Village Health Teams

OPERATIONAL DEFINITIONS

Attitude: The way male and female partners think feel or behave towards the involvement of males in PMTCT.

Behavior: A specific, observable, often measurable and usually customary action.

Belief: A commonly held understanding about male involvement in PMTCT and its consequences.

Environment: The social, political or economic conditions that influences behavior.

External policies: Funders, principles or regulations that might influence an intervention.

Internal policies: Organizational principles or regulations regarding staff members, participants, in the PMTCT program, specific procedures, methods, programs, collaboration, and professional ethics

Involvement: To take part in or to make somebody take part in the PMTCT program.

Knowledge: The information, understanding and skills that were gained through education or experience that supports or deters the involvement of males in PMTCT.**Lifestyle:** A collection of related behaviors that go together to form a pattern of living

ABSTRACT

Introduction: This study was carried out to document the male involvement in the prevention of mother to child transmission of HIV/AIDS at Hoima referral hospital in Hoima municipality.

Broad objective

The purpose of the study was to assess the knowledge and attitude, the level of male involvement and factors associated with male involvement in the prevention of mother-to-child transmission of HIV in Hoima municipality.

Methodology:

This study was a descriptive cross section in which quantitative method of data collection was employed in collection of data from respondents. Questionnaires were distributed to participants to assess the knowledge and attitude, the level of male involvement and factors associated with male involvement in PMTCT in Hoima municipality. Sample size of 200 participants was used, this included the Male partners who had escorted their pregnant partners to the antenatal clinic aged between 20-50 years. The predominant religion were Catholics 59% and Seventh Day Adventists. Regarding educational levels, majority of respondents had completed secondary level and above (61%) and the predominant ages were between 20-29 years.

Results: The study revealed that very few male partners were involved in the PMTCT programmes especially during HCT because of being at old age group above 30 years, couples, couples not living together, high number of wife's pregnancies four and above, having no knowledge on methods of MTCT, and husbands failure to discuss HCT with their wives.

Conclusions: From the findings I concluded that majority of the respondents have ever had about the male involvement in the PMTCT but there was still low male involvement in PMTCT programs at antenatal clinics.

Recommendation: There is a need to do an in-depth assessment of women's experiences when tested HIV-positive in the presence of their partners at the ANC, as well as to develop strategies to improve male involvement. The study again recommends a formative research on the use of incentives to promote male involvement in the PMTCT program and the government should train more of the Health promoters and the VHTs in order to reach even those that are deep in the village that are not having easy access to the health facility.

CHAPTER ONE:

1.0 Introduction

This chapter contains background of the study ,problem statement, broad objective of the study, objectives of the study, specific objectives, scope of the study ,research questions, justification

1.1 Background.

HIV pandemic created an enormous challenge to the survival of mankind worldwide (federal HIV/AIDS, 2007) .Worldwide there are an estimated 33.3 million people infected with HIV; Sub-Saharan Africa bears the greater burden with an estimated 22.5 million people infected with HIV (WHO, 2010). According to UNAIDS, women represent 52% of those infected with HIV worldwide and in Sub-Saharan Africa 60% of those infected with HIV are women [WHO,2010]. With a national adult HIV prevalence of 1.5% (1.9% in women and 1.0% in men), Ethiopia is one of the country's most severely hit by the epidemic (central statistical agency, 2011) . Mother-to-child transmission (MTCT) is an important source of HIV infection among Ethiopian children, which accounts for more than 90% of pediatric AIDS [1, 4].

Prevention of Mother-to-Child Transmission (PMTCT) programs have been proven to be effective in reducing the risk of HIV transmission from infected mothers to their children (G.N.Khuoh et al 2010). Without intervention, the risk of MTCT of HIV ranges from 20% to 45%. With specific interventions in non-breast feeding populations, the risk of MTCT can be reduced to less than 2% and to 5% or less in breastfeeding populations (WHO, 2010). Antenatal care (ANC) is a major entry point for PMTCT programs especially in countries with a high prevalence of HIV. It creates an opportunity to capture pregnant mothers and their male partners to reverse the transmission of HIV during pregnancy, labour, and breastfeeding (A.Adera et al 2015) Male involvement is necessary for improving women's uptake of core PMTCT services; it is a key contributor to community acceptance and support of PMTCT (F.Haile 2014)., actual involvement of male partners in PMTCT programs in several counties of Sub-Saharan Africa is low and programs report difficulties in attracting the involvement of male partners. Studies conducted in African countries showed that male involvement in PMTCT during pregnancy ranges from 11% to 58.3% (J.Homsy et al 2006)

In Uganda, UNAIDS, estimated that there were 130 000 children aged 0 to 14 years, and 810 7000 adults aged 15 and above living with HIV at the end of 2007; more than half of these adults were women (WHO, 2010). Regional and gender variation in the prevalence of HIV have been observed in Uganda with a higher prevalence of HIV in urban areas(12.8%) in comparison to rural areas (6.5%) and a higher prevalence HIV among women (8%) among men(5%). Higher prevalence rates were also seen with increasing wealth (WHO, 2011). Deterioration in behavioral indicator especially an increase in multiple concurrent partnerships while 35% were attributed to discordant monogamous couples.

The Uganda AIDS Commission report that, in spite of massive prevention effort, social, economic, cultural and behavioral factor continue to drive women, men and adolescents into high risk sexual behavioral-these factors include poverty and inequity. Poverty and inequity influence people to engage in commercial sex or transactional sex. Other factors that are mentioned are: gender and sex issues which increase the vulnerability of women to HIV are; low condom use, polygamy, extramarital relationships, little access to antiretroviral therapy, normalization of HIV/AIDS (D.Getu et al,2011)

1.2 Problem statement

In Hoima municipality there has been recording of fewer males on the Prevention of Mother- to-child transmission of HIV program since its initiation in the year 2000, although the PMTCT coverage has been reported to be approximately 95%, in the sense that all the pregnant women who have been coming to ANC in at Hoima referral hospital have agreed to be counselled and tested for HIV (script record, 2010 / 2011). From 2008 -2012, a total of 22,631 pregnant women were offered prevention of mother-to-child-transmission services (PMTCT). These women were encouraged to bring along their male partners during the next antenatal care visits and only 1060 male partners (4.7%) visited PMTCT sites. This represents a low HIV prevention opportunity as men can infect their wives with HIV or be infected especially in discordant relationships where

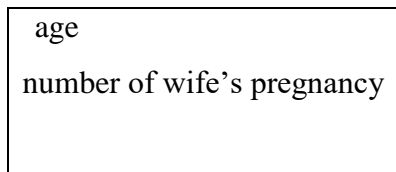
they are unaware of their status, hence unlikely to practice safer sex. This can be seen in a case where a mother tested HIV-negative during ANC while her husband was not tested. A few months after delivery, the baby, the mother and the father were tested HIV-positive, with the mother having a high CD4 count and her husband having a low CD4 count, which implies recent infection in the mother, possibly from her husband during pregnancy. There is also a potential for re-infection of HIV-positive women by yet another strain of HIV by a male partner. Without male involvement, women will also find it difficult to disclose their HIV status to their partners will find It challenging to choose safe infant feeding options or properly adhere to anti-retroviral treatment (Z.Pembara*et.al*, 2011).

This study, therefore, was intended to assess the knowledge and attitudes, to assess the level of male involvement and the factors contributing to low male involvement in HCT during the prevention of mother-to-child transmission of HIV / AIDS program in the Hoima municipality, with the aim of proposing interventions to ensure improved male involvement in the PMTCT program as better male involvement can positively change the PMTCT outcomes.

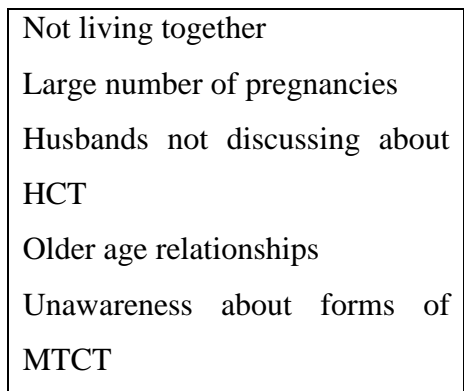
1.3 Conceptual frame work

Independent variable

Social demographic data



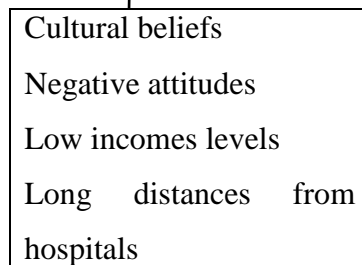
Family factors



dependent variable

Low male involvement in PMTCT programs

Intervening factors



Explanation of the conceptual frame work

Age being at old age and in a relationship there's low turn up for PMTCT activities due to increased responsibilities and work overload similarly to those partners whose wives have gotten more 4 pregnancies, partners not living to together have limited coordination and they are more less likely not to attend antenatal clinic for PMTCT programs, on another hand partners who do not discuss about HCT there's little knowledge about PMTCT and hence unaware of about the different forms of MTCT hence low male involvement in PMTCTprograms. However there are other intervening factors that deters male partner

involvement in PMTCT and they include cultural beliefs, negative attitudes towards PMTCT, low income levels, long distances from the hospital among others.

1.4 Objectives of the study

1.4.1 Broad objective

The purpose of the study was to assess the knowledge and attitude, the level of male involvement and factors associated with male involvement in the prevention of mother-to-child transmission of HIV in Hoima municipality.

1.4.2 Specific objectives

1. To assess the knowledge and attitude of male partner involvement in PMTCT.
2. To determine the level of male partner involvement in HCT during PMTCT
3. To assess the factors associated with male partner involvement in HCT during PMTCT.

1.5 Research Questions

1. Which knowledge and attitude do the community members have towards PMTCT and males involvement in PMTCT?
2. To what extent are male partners involved in PMTCT?
3. Which factors are associated with male partner involvement in the PMTCT program for HCT?

1.6 Scope of the study

1.6.1 Geographical scope

This study covered areas around Hoima municipality and the key target areas included Hoima referral hospital basically covering antenatal clinic of Hoima referral hospital. The study covered those individuals within Hoima municipality in Hoima district.

1.6.2 Content scope

This study covered the findings about community knowledge and attitude of male partner involvement in PMTCT program, level of male partner involvement in PMTCT and the factors associated with male partner involvement in HCT during PMTCT program

1.6.3 Time scope

The study processes lasted for 6 month from January up to July

1.7 Justification

The findings from the study might not only contribute to a body of knowledge, but will also be used to influence and inform policymakers and program managers in matters pertaining to improving male involvement in PMTCT interventions, which could help decrease HIV transmission to infants. This might be done by identifying the characteristics of the non-participating male population group and targeting them with suitable health interventions including behavior change communication, with the possibility of reducing the HIV infection rate among children born to HIV-positive mothers. Active male involvement is one of the efficient ways to control this vertical transmission by making sure that both parents act jointly to implement all the prescribed PMTCT interventions. It would also inform whether the PMTCT setting could be an acceptable opportunity to counsel and test males for HIV, thus paving way for their participation in subsequent PMTCT endeavors. The Ministry of Health and Social Services in general might be able to achieve the Millennium Development Goal number 6, that of combating HIV.

CHAPTER TWO

LITERATURE REVIEW

2.0 introduction

This chapter contains, knowledge and attitude of male partner involvement in PMTCT, level of male involvement in PMTCT and factors associated with male partner involvement in HCT during PMTCT.

2.1.0 knowledge and attitude of male partner involvement in PMTCT

2.1.1 knowledge about MTCT and PMTCT

Successful PMTCT intervention and achieving the goal of eliminating new HIV infection in children by 2015 laid out in the UNAIDS global plan is highly dependent on everyone, especially women of child bearing age having accurate and up to date knowledge about HIV transmission, risk of transmission to babies and interventions available to reduce and possibly eliminate the transmission of the virus to children. PMTCT have over the years been an area of interest to many with a good number of studies carried out to assess knowledge level of people especially among women with mixed outcome (WHO, 2010). Highlight from some of these studies are outlined below.

Gebreegziabher et al (2008) conducted a study of 461 pregnant women attending ante natal clinic in four health facility in Ethiopia. Findings from his study showed that most of them 457(99.1%) have heard about HIV/AIDS of which, 419 (92.7%) mentioned the major routes of transmission and 437(94.8%) knew that HIV can be transmitted from an infected mother to her baby. Majority of them 433(93.9%) also knew that MTCT of HIV is preventable.

Tatagan et al (2010) also conducted a hospital based study in Togo among women attending ante natal clinic, 210 pregnant women were surveyed. Findings from the study showed they have a high knowledge of sexual HIV transmission. The women identified unprotected sex (93.8%), sharing sharp objects soiled with blood (80.5%) as key route of transmission; only (27.1%) were

able to identify maternal to child transmission as a route of HIV transmission with (77.1%) agreeing that unprotected sexual relations raised the risk of HIV transmission to the child.

Petrie et al (2007) conducted a pilot study of 36 educated women enrolled in a PMTCT program at the Vanguard Community Health Centre in Western Cape. Finding from the study showed a high general knowledge of HIV with 88.9% of them scoring 80% more in the assessment of general HIV knowledge.

Artwinne et al (2012) conducted a community based study on Knowledge and practice of women in rural Uganda, findings from a sample of 100 women showed that 91% of the women surveyed were aware that MTCT can occur while only 72% were aware that it can be prevented.

Chirwa (2011) conducted a health facility based research of pregnant women offered HIV counseling and testing as part of PMTCT intervention. His findings showed that 86% of the women who accepted HIV counseling and testing and 85.5% of women who refused testing were aware that MTCT can occur, while just 41.4% were aware that MTCT can be prevented using antiretroviral drugs.

Moses et al (2009) conducted a study of 172 pregnant women attending ante natal care in a tertiary hospital in North Eastern Nigerian. Findings from there study showed there is a high level of knowledge of HIV transmission and sexual prevention but only 42% of them had accurate knowledge of preventive intervention to babies.

Olugbenga et al (2013) also did a study in south-western Nigeria that showed high level of awareness about HIV and AIDS among 420 women of reproductive age 15-49 years surveyed (99.8%). The knowledge about MTCT and PMTCT of HIV was also high with 92.1% and 91.4%, respectively.

In conclusion, studies reviewed showed relatively high level of knowledge of HIV and MTCT among women reviewed. It is important to note that most of the studies except two were conducted among pregnant women attending ante natal clinics who might likely have developed interest based on this. The two community based studies conducted in Uganda and Nigeria also showed high level of HIV awareness related knowledge.

2.1.2 Factor that Influence Attitude toward PMTCT

Attitudes of the women towards PMTCT are a key factor that can positively or negatively affect utilization of PMTCT services. This makes it important to review factors that influence attitude of the study population toward PMTCT. Outline below is a review of existing literature on related studies.

Muula et al (2004). Findings of a study conducted in Malawi indicated that of the 321 women surveyed, 99.7% were in favour of breastfeeding their babies and shared that a woman who do not breast feed will likely be considered to have intent of killing her baby or that she was already pregnant again or the baby was not given birth to by her, It might also be inferred that she is sexually promiscuous and so she does not want to “contaminate the milk,” or she has diseases of the breasts, tuberculosis or HIV and AIDS

Olugbenga et al (2013) their study findings from Nigeria showed despite high level of awareness about MTCT and PMTCT, a significant portion (71.27%) of the study population had poor attitudes towards PMTCT of HIV services. The study though was silent on why the women’s attitude towards PMTCT service was poor.

Moses et al (2009) conducted a study of 172 pregnant women attending ante natal care in a tertiary hospital in North Eastern Nigerian. Findings from there study showed the use of breast milk substitute by HIV positive mothers and condom use to prevent during sexual intercourse recorded poor responses from the women, with only 42 (24.4%) and 58 (33.7%) of the women

respectively having favorable attitude towards both. The women not in support of breast milk substitute indicated refusal by their spouses as reason for not being in favour of it, the importance placed on breast feeding at the community was also given as a reason for not endorsing it. Those who rejected the use of condoms said the

practice was against their religious beliefs while a few shared the beliefs that withdrawal before ejaculation and use of antibiotics after sex can equally prevent HIV infection. Majority of the women surveyed 106 (61.6%) said they will be willing to support their spouses who tested positive for HIV.

Chirwa (2011) in a study conducted in Malawi showed 75% of HIV positive pregnant women surveyed in the study tend to not discussing their status with their partners compared to 86% of HIV negative women who tend to discuss their status with their partners, 92% of the women surveyed irrespective of HIV status felt that a couple with HIV should not have children. All the women surveyed, irrespective of HIV status prefer to breastfeed their babies rather than resort to breast milk substitute. The study also noted that HIV positive women among the respondent were more likely to indicate acceptance of treatment intervention to prevent MTCT than HIV negative women. The study also reported that a large proportion of the women surveyed, that is above 90% of positive women and all of the HIV negative women felt it was acceptable for their partners to have sexual relation outside their marriage.

2.2.0 Level of male partner involvement in PMT CT through HCT..

2.2.1 Health systems versus male partner involvement in the PMTCT

In Uganda, men are reportedly forced to wait an entire day for care at antenatal clinics, and are excluded from the sessions where their wives are examined and have to wait outside without any information about what is happening to their pregnant wives. Lack of adequate space at the antenatal clinics coupled with a shortage of health workers and an increase in women attending antenatal care are said to demotivate men from attending ANC with their spouses since they have to wait for a long time before they are attended to (Kalemboet *al.*, 2011). These findings are supported by a study in the Machakos County of Kenya that reveal that men view health clinics as facilities for women, since they mainly offer services to females. Because of the unwelcome set-up of most health facilities for men, and the negative attitude of health providers, men get discouraged to actively participate in these critical services (Ongweny-Kidero, 2014). In the study conducted in Addis Ababa and Tanzania community there was very low male involvement in HIV counseling and testing which was 44% and 46.3%, respectively of the male partners who

hard escorted their wives and received both counseling and test (J.Homsy et al 2006, D.Getu et al,2011),and another finding in Cameroon that showed 58.3% of male involvement in PMTCT activities like HCT (G.N.Nkuoh et al,2010) and other pooled estimates of studies conducted in India, Cameroon, Georgia, and the Dominican Republic which was 36.1% and another study conducted in Cape Town, South Africa, which was 32% (B.K.F.Mohlala et al, 2011). Implying that there's a very low male partner involvement in PMTCT activities especially during HCT.

In the same study, ANC services are reportedly not supportive of men in the sense that, their presence at ANC is not recognised and respected by the health professionals and pregnant women attending the clinic. Most of the workers at ANC clinics are female nurses who do not openly share information about reproductive health with men. This is an issue that could have probably also contributed to the disparity of the knowledge among men as they are not well motivated to attend ANC where information on the PMTCT is easily accessed. Study findings in Mbeya City by Mbezi (2010) also suggest that a male health worker should attend to men.

A systematic review has identified barriers and facilitators of male participation in the PMTCT of HIV and ANC services as being male unfriendly, lacking in customer care and attention to male partners, and not trusting the health system confidentiality. These barriers result in men feeling left out of the programme and eventually choosing to stop going to health facilities with their partners (Morfaw et al., 2013). HIV testing policies that have previously focused on the individual, rather than couples, to know their status, are thought to play a role in deterring male involvement in the PMTCT. The presence of VCT centres, therefore, provided the opportunity for male partners to test on their own. The PMTCT programme also utilises women as messengers of the invitation to men and this is viewed as a deterrent to male involvement because men do not wish to receive instructions from women (Morfaw et al., 2013).

2.3 Factors associated with male partner involvement in HCT during PMTCT

Mother-to-child transmission (MTCT) of HIV remains a major public health problem and continues to account for a substantial proportion of new HIV infections among young children (WHO,2011). The delivery of HIV counseling and testing (HCT) services toward pregnant

women for prevention of mother-to-child transmission (PMTCT) is one of the most important HIV prevention strategies (WHO,2014). During the past decade, significant progress has been made in scaling up PMTCT services to pregnant women, particularly in resource constrained countries (J.Homsy et al, 2006). The risk of MTCT of HIV can be reversed through the detection of maternal infection during pregnancy and administration of antiretroviral (ARV) prophylaxis (G.N.Nkuoh et al, 2010)

In a study carried out at the same clinic it was found out that there was a higher level of younger male partners involvement in PMTCT during HCT than older partners. (I.T. Kamal et al 2001) and on another study conducted in South Africa, 23.5% of individuals 50 years of age and above did not know the route of transmission of HIV from mother to child (O.Shisana et al,2005). Moreover, an operational research conducted in Zimbabwe showed that as age increased majority of men fear going for HIV tests (Z.Pemberai et al, 2011). However, similar studies conducted in Cameroon and Western Uganda showed that the proportion of males accompanying their partner increased with age, for example, in rural western Uganda males older than 35 years were 2.89 times more likely to receive VCT than those of 35 years or younger (G.N.Nkuoh et al,2010 F.M.Bwambale et al,2008).

Furthermore, other studies conducted in India and Kenya showed that males who had fewer children were more likely to assist their partner in pregnancy and childbirth than males who had large number of children (department of reproductive health and research,2011) .

A study conducted in Zambia showed that knowledge and the total score on level of involvement were positively and significantly associated with male partner involvement in HCT (T.Dinzela et al 2006).As a result of increased level of knowledge and awareness about HCT during PMTCT.Male partners who discuss HCT with their wives get much more involved in process of HIV counseling and testing during PMTCT than those that do not discuss about HCT and PMTCT (T.Dinzela et al 2006).

CHAPTER THREE

METHODOLOGY

3.0 introduction

This chapter contains study design, study area ,study population, sampling size ,sampling procedure ,selection criteria ,data collection, research instruments ,data collection procedure ,data quality control, data management, data analysis, ethical consideration and dissemination of results.

3.1 Study design

A cross sectional descriptive study was used in which quantitative methods were employed, this was done by formulation and use of close ended questions on a pre-designed and a pre- tested questionnaire to collect data. This was appropriate so as to assess the male partner involvement in Prevention of mother to child transmission of HIV/AIDS.

3.2 Study area

This study was carried out at Hoima referral hospital, which is located in Hoima municipality about 200km west of Kampala the hospital caters for populations of the greater Bunyoro region ,encompassing the districts of Bunyoro that is Hoimakibaalemasindi,Bulisa,kiryandongo,kyankwanzi,kiboga and the eastern part of DR Cong ,overall grossing over 3 million people .The present bed capacity is 300 according records of the hospital.it is a busy hospital encompassing around 130 patients per day, approximately 3000 clients per month since it is the only big hospital in the region. Due to a number of factors very few men attend antenatal approximately 30 men per day. The hospital is one of the oldest hospitals in Uganda, as far back as 1935 initially, it was meant to serve a small area but it was promoted to referral in 1994 targeting the greater Bunyoro region.

3.3 Study population

The study was encompassing male partners presenting with female partners attending antenatal clinic at Hoima referral Hospital willing to provide required information

3.4 Sampling Procedure

Simple random sampling was done so as to obtain the representative population to participate in the study. Random numbers were designed and presented, the numbers were ranging from 1 to 100 whoever, picks 1, 3, 5, 7... 100 was allowed to participate in the study. This was done repetitively until a required sample size is obtained.

3.5 Sampling size

The sample size was determined using the (Kish and Leslie, 1965) formula.

$$S = z^2 * pq / d^2$$

Where;

S = the sample size

Z = a number relating to the degree of confidence you wish in the results. Where z is 1.96 if the degree of confidence is 95%

d = the error anticipated 5%

P = an estimate of the proportion of 50% of the people falling into the group in which there's the population of interest.

$$q = 1 - p$$

Therefore the sample size is;

If $z = 1.96$, $p = 50\%$ (0.5), $q = 0.5$ (0.5), and $d = 5(0.05)$

$$s = 1.96^2 * (0.5 * 0.5) / 0.05^2$$

$$s = 384$$

From the above formula the sample size is 384 respondents

3.6 Definition of Variables

Independent variable: Male partner involvement.

Dependent variable: Prevention of mother to child transmission of HIV/ Aids.

3.7 Data collection

The questionnaires were distributed to the respondents based on their convenience.

3.7.1 Research Instrument

Self-administered questionnaires were used as instruments for collecting data. Close ended questions were used, open questionnaires was mainly orally where clarity was needed, which did not require the respondents name or address; this was done to ensure confidentiality and instill confidence in the study.

3.7.2 Data collection procedure

The data collection tools were pre-tested at Hoima referral hospital for suitability. Data from clients was collected using a self-administered questionnaire in English and some translation was done for those who were unable to read English.

3.7.3 Quality data control

Quality was achieved through training research assistants for 1 day on collecting data using questionnaire, total involvement of the researcher in data collection and close supervision of research assistants.

3.7.4 Data management

The filled in questionnaires was checked for validity before leaving data collection site. Data was coded and entered correctly in the computer. The questionnaires kept properly in a locker to avoid losses and access to those not authorized.

3.7.5 Data analysis

Data was analyzed using Microsoft excel, the analyzed information was presented as frequency distribution tables, and pie charts.

3.8 Ethical considerations

Preliminary arrangement was made, permission was sought from the concerned authorities in the administration of allied health sciences Kampala international university western campus

The partner's of pregnant women were informed of their rights and risks of participating in the study. Written informed consent was sought from them and each given a copy of the consent form to sign if he consented. The signed informed consent sheet was detached from the questionnaire and kept separately so that they could not be linked. No names were recorded on the data collection questionnaires. Throughout the study, privacy, and confidentiality was emphasized. All data was collected in a private setting

3.9 Selection Criteria

3.9.1 Inclusion criteria

To be included in this study, a participant had to be:

A male, aged from 20 to 50 years of age, residing in the Hoima district for over one year, and in a sexual relationship with a pregnant woman attending ANC at Hoima referral hospital and have consented to participate.

3.9.2 Exclusion criteria

Male partners whose female partners were pregnant, but they were non-residents of the Hoima district.

Male partners whose female partners are pregnant but they were outside the Hoima district at the time of the study.

All males below 20 years and above and are not residents of Hoima district

3.10 Dissemination of results

The information after analysis was discussed; conclusions and recommendations was made and It was presented to Kampala International University, School of Allied health sciences (Western Campus) to present to the marking board of Kampala international university in charge of research and a copy is kept for reference and for publication and further reference

CHAPTER FOUR

4.1 INTRODUCTION

This chapter presents results of data analysis that was interpreted in terms of tables, pie charts, and simple statements.

4.2 RESPONDENT'S SOCIAL DEMOGRAPHIC DATA

The response of this study was generally good , the mean age of partners who participated was 34.38 years. The majority 50.5% of them reported the current pregnancy as second or third. Among the respondents 49.5 % reported that the average distance of the living area to the referral hospital is less than five km. and regarding of the amount of money for transport majority 46% paid less than10,000 ugsh

Table 1 showing respondent's social demographic data

Variation (v)	Frequency(f) Total =200	Percentage (%) Total =100
AGE		
20 – 29	38	19
30 -39	114	57
40+	48	24
Religion		
Catholic	118	59
Moslem	66	33
Others	16	8

Education status

No formal education	32	16
Primary education	46	23
Secondary and above	16	61

Occupation

Private business	70	35
Government worker	50	25
NGO	40	20
Daily labor	28	14
Farmer and others	12	6

Wife's number of pregnancies

1	80	40
2-3	101	50.5
4-5	17	8.5
6+	2	1

Time of leaving together		
Not living together	6	3
1 - 5 years	122	61
6 -10 years	52	26
11 – 15 years	16	8
16 years +	4	2
Distance to the referral		
Less than 5km	99	49.5
5 – 10 km	62	31
5 and above	39	19.5
Money paid for transport		
Do not pay	20	10
Below 10000 ugsh	92	46
Above 10000 ugsh	68	34

4.3 KNOWLEDGE AND ATTITUDE OF MALE PARTNER INVOLVEMENT IN PMTCT

All of the respondents 100%,knew about the prescence of HIV in Uganda and at least one route of MTCT and 60%, 30%and 10 % of them reported MTCT of HIV during pregnancy child birth and breast feeding, respectively.

The majority of the respondents knew atleastone method of PMTCT where by 70% of them knew that provision of ARTs for the mother could help to reduce MTCT of HIV.on the other hand 21% of them knew that avoiding breastfeeding is one the alternatives of preventing HIV transmission from mother to child but only 9% of the respondents were aware that risk of MTCT of HIV could be reduced by caesarean section. Among them 90% of the respondents knew the presence of HCT for pregnant women during their ANC visit, 95% of them agreed on the necessity of partner testing, 51% of the respondents reported they feel nothing when seen with their pregnant wives and 47% of the respondents reported that they feel happiness when seen with their pregnant wives whereas 2% reported that they feel ashamed.

Table 2 showingrespondents' knowledge and attitude of male partner involvement in PMTCT

Variables	Frequency (f)	Percentage %
	TOTAL:200	TOTAL:100
Awareness about the prescence of HIV		
YES	200	100
NO	0	0
forms of MTCT		
During pregnancy	120	60
During child birth	60	30
During breast feeding	20	10

PMTCT methods		
ART	140	70
Caesarean section	18	9
Avoiding of breast feeding	42	21
Presence of PMTCT during ANC		
visit	180	90
Yes	8	4
No	12	6
I don't know		
Necessity of partner testing		
Yes	190	95
No	10	5
Feeling when seen with pregnant women		
Feel nothing	102	51
Feel happiness	94	47
Feel ashamed	4	2

4.4.LEVEL OF MALE INVOLVEMENT IN PMTCT THROUGH HCT

Among partners, 67% discussed HCT with their pregnant wives. And more than two thirds 69% of them had willingness to accompany their pregnant wives to PMTCT clinic, 51%of them visited PMTCT clinic with their wife. About 42% of respondents were involved in the counseling part only and 40% of them participated in both counseling and testing, meaning the overall involvement in HCT (Table 3).Among those involved in HCT, 60% were involved because they felt responsibility. Work overload which was mentioned by 53% of the respondents, to them, was the main reason for noninvolvement of partners (Table 3)

Table 3 showing respondents level of male involvement in HCT during PMTCT.

Variable	Frequency (f)	Percentage%
	Total= 200	Total=100

Discussed about HCT with their wives		
Yes	134	67
No	66	33
Willingness to visit PMTCT clinic with his wife		
Yes	138	69
No	62	31
Visited PMTCT with his wife		
Yes	102	51
No	98	49
Involving in counseling only		
Yes	84	42
No	116	58
Involving for both counseling and testing		
Yes	80	40
No	120	60
Reasons for partners involvement		
Feel responsibility		
Yes	120	60
No	80	40
Initiated by provider		
Yes	78	39
No	122	61
Initiated by wife		
Yes	52	26
No	148	74
Reasons for partners non involvement		
Work over load		
Yes	106	53
No	94	47
Fear of acquiring of the virus		

Yes	92	46
No	108	54
Confidentiality issue		
Yes	38	19
No	162	81

4.5 FACTORS ASSOCIATED WITH MALEPARTNER INVOLVEMENT IN HCT DURING PMTCT

In multivariable analysis, being at younger age group, couples living together, wife's number of pregnancies, having knowledge about methods of MTCT, and husbands discussing HCT with their wives were positively and significantly associated with male involvement in HCT. The odds of male involvement in HCT was higher in 20–29-year 24% and 30–39 years' 57% age groups as compared to those who were 40 years of age and above according to the respondents. Those partners who are living together with their wives 82.5% were more likely to be involved in HCT according to respondents view. Wife's gravidity one and two to three who showed by 40% and 50.5% respectively reported that gravidity of one and two to three was more significantly associated with male involvement in HCT compared to those who had more than four and above pregnancies. The likelihood of male involvement in HCT was found to be high by 81% among those who knew at least one mode of mother-to-child transmission. Of respondents 78% reported that discussion about HCT with their wives had increased odds of involvement in HCT compared to their counterparts who would not discuss HCT with their partners (Table 4)

Table 4 showing participant's response on factors associated with male partner involvement in HCT during PMTCT

Variable	Frequency (f)	Percentage (%)
	Total =200	Total =100
Age		

20 – 29	48	24
30 -39	114	57
40+	38	19
Living together		
Yes	165	82.5
No	35	17.5
Wife's total pregnancy		
One	80	40
2 – 3	101	50.5
4 – 5	17	8.5
6+	2	1
knowing mode of MTCT		
Yes	162	81
No	38	19
Discussing HCT		
Yes	156	78
No	44	22

CHAPTER FIVE

DISCUSSIONS, CONCLUSION AND RECOMENDATION

5.0 Introduction

This chapter includes the discussion of results, conclusions and recommendation.

5.1 Discussion

KNOWLEDGE AND ATTITUDE OF THE COMMUNITY TOWARDS PMTCT

All of the respondents 100%, knew about the presence of HIV in Hoima municipality and at least one route of MTCT where by the majority reported HIV during pregnancy is the major route of MTC and the majority of the respondents knew at least one method of PMTCT these findings are in agreement with (Gebreegziabher et al 2008) who conducted a study of 461 pregnant women attending ante natal clinic in four health facility in Ethiopia. Findings from his study showed that most of them 457(99.1%) have heard about HIV/AIDS of which, 419 (92.7%) mentioned the major routes of transmission and 437(94.8%) knew that HIV can be transmitted from an infected mother to her baby. Majority of them 433(93.9%) also knew that MTCT of HIV is preventable. These findings could have been due to increased modernization and government emphasis through communications on radios, televisions and other social medias to create awareness within the communities

Among them 90% of the respondents knew the presence of HCT for pregnant women during their ANC visit, 95% of them agreed on the necessity of partner testing, and majority 51% of the respondents reported they feel nothing when seen going for testing with their pregnant wives and 47% who would feel happiness whereas 2% reported that they feel ashamed this concluded that majority of the respondents had appositve attitude towards PMTCT these findings were contradicting with (Olugbenga et al,2013) findings from Nigeria that showed despite high level of awareness about MTCT and PMTCT, a significant portion (71.27%) of the study population had poor attitudes towards PMTCT of HIV services. The study though was silent on why the women's attitude towards PMTCT service was poor, the difference in the findings could have been due to the difference in the level of education of the participants and the population under study.

Level of male involvement in PMTCT

In this study, about 40% of the partners escorted their wivesto ANC and received HIV counseling and testing together. This finding is relatively similar to study conducted inAddis Ababa and Tanzania community which was 44% and 46.3%, respectively (J.Homsy et al 2006, D.Getu et al,2011). However, the finding is lower than that reported in Cameroon which was

58.3% (G.N.Nkuoh et al,2010) while it was higher than pooled estimate of studies conducted in India, Cameroon, Georgia, and the Dominican Republic which was 36.1% and another study conducted in Cape Town, South Africa, which was 32% (B.K.F.Mohlala et al, 2011). Thus, the finding of this study implies that there is already an encouraging platform for male involvement in the study area, and this could serve as a springboard to achieve full scale male involvement in PMTCT in Hoima municipality and other similar urban areas.

Factors associated with male partner involvement in HCT during PMTCT

This study demonstrated that the level of male involvement in HCT was found to be higher among younger male partners. This finding is consistent with reviewed literatures which found that males involved in HCT were younger than those who received HCT alone in the same clinic (I.T. Kamal et al 2001). This might be due to increased communication between couples and level of knowledge expected to be reduced with age. This is supported by study conducted in South Africa, 23.5% of individuals 50 years of age and above did not know the route of transmission of HIV from mother to child (O.Shisana et al,2005). Moreover, an operational research conducted in Zimbabwe showed that as age increased majority of men fear going for HIV tests (Z.Pemberai et al, 2011). However, similar studies conducted in Cameroon and Western Uganda showed that the proportion of males accompanying their partner increased with age, for example, in rural western Uganda males older than 35 years were 2.89 times more likely to receive VCT than those of 35 years or younger (G.N.Nkuoh et al,2010 F.M.Bwambale et al,2008). The difference with these studies could be explained by the existence of social support and difference in health service utilization in the later studies.

A result showed that 82.5% of the male partners of pregnant women reported that living with their wives would make them significantly more likely to be tested than those partners of pregnant women living in separated place. Absence of the male partner for discussion at home and decreased likelihood of accompanying his pregnant wife during ANC follow-up could be the possible explanation for the above finding.

In this study, male involvement in HCT was significantly associated with wife's number of pregnancies. This could be explained by the fact that for each additional pregnancy say from one to 2-3, by 40 and 50.5% respectively there is increased frequency of contact of mothers with

health care workers which increases their awareness and their chance of discussion with their husbands and a dramatic fall by fourth and above pregnancy probably due to work over load and increased awareness about HCT and their sero status and men seeing it of no value of getting involved again . Furthermore, these findings line with studies conducted in India and Kenya and showed that males who had fewer children were more likely to assist their partner in pregnancy and childbirth than males who had large number of children(department of reproductive health and research,2011).

Among the respondents 81% reported that partners who know at least one mode of transmission of HIV from mother to child are more involved in HCT compared to their counterparts. This finding is similar to the study conducted in Zambia which showed that knowledge and the total score on level of involvement were positively and significantly associated (T.Dinzela et al 2006). This might be due to increased level of knowledge and awareness about HCT expected to have a positive influence on men's involvement in HCT.

Having history of discussion about HIV testing with pregnant wife remained significantly associated with male attendance at the antenatal clinic for HCT which was suggested by 78% of the respondents who reported that discussing HCT among partners would promote male partner involvement in PMTCT. This finding was similar to another study conducted in Zambia (T.Dinzela et al 2006) who stated that male partners who discuss HCT with their wives get much more involved in process of HIV counseling and testing during PMTCT than those that do not discuss about HCT and PMTCT at all. Having discussion with their wives might help them to get what they heard from the health care workers during their wives' ANC visit which could be the possible explanation for increased uptake of partners.

The possibility of social desirability bias due to sensitiveness of issues and cross-sectional nature of the study which fails to show causal relationship were among the limitations of this study. The Study was conducted at the referral hospital and with close supervision and organized valid records which is the strength of this study.

5.2 CONCLUSIONS FOR THE PMTCT PROGRAM

From the findings the majority of the respondents have ever had about the Male involvement in the PMTCT and despite the existence of several program promoting maleinvolvement in HIV counseling and testing during their wives' pregnancy as a part of PMTCT, still lower proportion of them accompany their wives for HCT. The prevalence of male involvement was found to be significantly higher among partners who are younger, living with their wives, are living with multigravida wives, are knowledgeable about mode of mother-to-child transmission of HIV, and discussed HCT with their wives. Therefore, there is a need of an intervention in the independent predictors.

5.3 RECOMMENDATIONS

There is a need to do a comprehensive research on male involvement, looking at different settings to compare disparities in the private and public health facilities. There is also need to do an in-depth assessment of women's experiences when tested HIV-positive at the ANC, as well as to develop strategies to improve male involvement. The study again recommends formative research on the use of incentives to promote male involvement in the PMTCT program. Another possible research area could be on the use of religious and social organizations to promote male involvement in the PMTCT program

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APPENDIX I. INFORMED CONSENT FORM

I am SEBWAMI RICHARD, a student of Kampala International University. I am conducting a study to determine male partner involvement in Prevention of Mother to Child Transmission of HIV in Hoima municipality.

You have been chosen to take part in the study because you are directly or indirectly involved in child bearing.

I would wish to request for your voluntary participation in this study. All the information gathered from this study will be treated with utmost confidentiality and the records obtained shall be used for research purposes only. During the course of this study, you will be free to withdraw at any point.

Please sign in the space provided below if you agree to take part in the study.

Thank you.

Signature of respondent.....date.....

APPEDIX ;II QUESTINARES

1.0 DEMOGRAPHIC INFORMATION

circle the appropriate or fill in

1. What is your religion?

a) catholic b) moslem c) others

2.AGE a) 20 – 29 b) 30 – 39 c) 40+

3.Level of education ; a) no normal education b) primary education c) secondary and above

4. occupation; a) private business b) government worker c) NGO d) daily labor e) farmer and others

5.wife's number of pregnancy ; a) 1 b) 2-3 c) 4-5 d) 6+

6.Distance to the hospital; a) less than 5km b) 5 -10km c) more than 10km

7.money for transport to the hospital; a) do not pay b) below 10,000Ugsh c) above 10,000Ugsh

1.1.KNOWLEDGE AND ATTITUDE OF THE COMMUNITY TOWARDS PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV/AIDS

Tick the appropriate

1.in which of the following forms does mother to child HIV/AIDS transmission occur

a) during pregnancy

b) during child birth

c) during breast feeding

2.which of the following is the best method of PMTCT

a) ART

b) caesarean section

c) avoiding of breast feeding

3. is there an activity known as HCT during antenatal visit?

a) yes

b) no

c) I don't know

4. Is it a necessity for both partners testing for HIV

a) yes

b) No

5. How do you feel when you go HIV counseling and testing and you are seen with your pregnant woman?

a) feel nothing

b) feel happiness

c) feel ashamed

2. LEVEL OF MALE PARTNER INVOLVEMEN IN PMTCT PROGRAMS

1. have you ever discussed about HCT with your wife

a) Yes b) no

2.do you feel willing to visit PMTCT clinic with your wife

a) yes b) No

3.Do you visit PMTCT clinics with your wife

a) Yes b) No

4.Did escort your wife to the hospital only for counseling

a)yesb) No

5. Did you escort your wife to the hospital for both HIV testing and counseling

a) yesb) No

6.why are you getting involved in PMTCT program?

a) Fulfill responsibility yes /no

b) Initiated by provider yes / no

c) Initiated by wife yes / no

7.what can make you not getting involved in PMTCT programsespecially HCT?

a) work load yes / no

b) fear of acquiring virus and stigma from positive results yes / no

c) Confidentiality issue yes / no

FACTORS ASSOCIATED WITH MALE PARTNER INVOLVEMENT IN PMTCT DURING HCT

1. By what age range is it appropriate to getting involved in PMTCT for HCT

a) 20 -29

b)30 – 39

c) 40+

2.Does living together encourage you to get involved in PMTCT and come for HCT than those living separate.

a) yes

b) No

3.by what number of pregnancy do most escort their wives for HCT?

a) 1

b) 2 – 3

c) 4 – 5

d) 6+

4.Does knowing the mode of MTCT most likely do promote male partner involvement in PMTCT.

a) Yes

b) No

5. do you discuss HCT the results of testing with your wife?

a) yes

b) No

APPENDIX :III MAP SHOWING HOIMA REGION



APPENDIX: IV MAP OF UGANDA SHOWING HOIMA DISTRICT

