EXPLORING MALE PARTNERS EXPERIENCES ARISING FROM SUPPORTING THEIR SPOUSES' LIFELONG ART

CASE STUDY: HEALTH FACILITIES IN SOROTI DISTRICT

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2015-M272-20017

UGANDA MARTYRS UNIVERSITY

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A POSTGRADUATE DESERTATION PRESENTED TO FACULTY OF HEALTH SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN PUBLIC HEALTH IN POPULATION AND REPRODUCTIVE HEALTH

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DEDICATION

This study is dedicated to all women living with HIV and all the men out there who have challenged gender norms and stood by their partners in contribution to the Elimination of Mother to Child Transmission of HIV; in sincere hope that this study will make other men learn from the their experiences and hence increased male involvement in reproductive health services.

ACKNOWLEDGEMENTS

As I complete this report, I give Glory and Praise to the Almighty God for His Grace upon my life during the entire period of my Master programme.

I would like to express my sincere gratitude to all the people who made it possible to complete my dissertation. I am very grateful to my academic supervisor, Ms. Vivienne Laing for her invaluable and technical support during the process of writing this dissertation.

I wish to acknowledge all the people who have contributed a great deal to the success of this work. They include my parents, friends, relatives and colleagues who have supported, encouraged and inspired me throughout this project. Management and staff of the different health facilities in Soroti for having allowed me to conduct my research; this fulfilled my research interests and I hope the work contained herein will contribute to increased male involvement in reproductive health services and hence Elimination of Mother to Child Transmission of HIV

Special thanks go to the participants who offered their time and provided valuable information; it is upon your perceptions and experiences that I have based my results for this dissertation and that is what makes the work original.

'God richly bless you all!!!'

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic/Care
ART	Anti-retroviral therapy
ARVs	Anti-retroviral drugs
AZT	Zidovudine
CD4	Cluster of Differentiation 4 cell
CHWs	Community Health workers
EMTCT	Elimination of Mother to Child Transmission of HIV
HIV	Human Immunodeficiency Virus
ICAP	International Center for AIDs care & treatment Programme
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
IRIN	Integrated Regional Information Network
KMCC	Knowledge Management and Communication Capacity Initiative
MOH	Ministry of Health
MPI	Male Partner Involvement
MTCT	Mother to Child Transmission
NHPS	National HIV Prevention and Strategies
NVP	Nevirapine
PLHIV	Person Living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
SdNVP	Single dose Nevirapine
SRRH	Soroti Regional Referral Hospital
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
UAC	Uganda Aids Commission
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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DEFINITION OF KEY TERMS

Male partner involvement	Activity of attending antenatal care as being indicative of MPI, but also included activities such as partners discussing antenatal eMTCT interventions and men providing financial support for antenatal visits in order to assess MPI (Byamugisha, et al., 2010).
PMTCT/eMTCT	Refers to preventive interventions aimed at reducing the chances of transmission of HIV from an infected mother to her baby
PMTCT Cascade	Refers to steps taken to access antenatal care, HIV testing and enrolment into care, initiating ART, follow up, access to postnatal care, testing the child and their enrolment into care, initiating the child on ART and follow up.
Option B	Women with CD4 > 350 cells/mm^3 beginning ART at 14 weeks into gestation, throughout pregnancy, and after birth until breastfeeding ceases.
Option B+/Lifelong ART	Women receive lifetime ART, even if CD4 count is >350 cells/mm^3. Under both options, infants born to HIV+ women receive daily zidovudine (AZT) for the first 4–6 weeks of life, PCR-based HIV screening at 6 weeks, additional rapid testing at 12 months and 24 months and ART if HIV-positive. (UNICEF, 2012).
Adherence	Means taking at least 95% of medications the right way, at the right time. Over time, this definition has been broadened to include more factors related to continuous care, such as following a care plan, attending scheduled clinic appointments, picking up medicines on time, and attaining regular CD4 tests (ICAP, 2010)
ANC	Refers to the routine health control of presumed healthy pregnant women, in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery; minimum of 4 antenatal visits, comprising interventions such as tetanus toxoid vaccination, screening and treatment for infections, and identification of warning signs during pregnancy.

ABSTRACT

Background: Men's involvement during ANC/eMTCT plays a vital role in the safety of their female partners' pregnancy and childbirth, by ensuring access to care, prevention of HIV transmission to the unborn child and provision of emotional and financial support to the spouse; but remains unacceptably low. Male involvement is influenced by the interaction between individual, families, peer, community and health system related factors. Therefore understanding the experiences of the supportive partners is important, so that existing eMTCT programs can identify and engage these men as allies in the care of women and their infants.

Objective: The main objective of the study was to explore the experiences of male partners involved in their spouses' lifelong ART at health facilities in Soroti district.

Methodology: A qualitative cross sectional study design that adopted In-depth Interview was used to collect data among male partners involved in their spouses' lifelong ART/Option B+ irrespective of their sero-status or backgrounds. Sample size of 13 participants used and it was determined using evidences from Guest, Bunce and Arwen (2006) that saturation often occurred around 12 participants in homogenous groups. Purposive sampling technique was used and consent was sought prior to data collection.

Results: The experiences of male partners regarding their involvement were generally good because of supportive peers, family members and community members; healthcare provider initiatives i.e. counseling, health education and family support groups motivated them. The attitudes and the welcoming nature of the health facilities also encouraged their involvement. Generally, when men value the aspect of having a negative child and have a supportive environment, culture and traditional norms can be ignored or changed so that one can achieve the perceived benefit.

Conclusion: Constructions of masculinity in patriarchal societies often limit the ways in which men engage in ANC/eMTCT, however such gendered division can be changed if men's roles were looked at as beyond just being passive recipients of new knowledge, skills and awareness, but as clients and partners who have a responsibility to their own health and the health of the others.

CHAPTER ONE: GENERAL INTRODUCTION

1.0 Introduction

Human immunodeficiency virus (HIV) remains a major challenge globally despite decades of advocacy and investment in programs to control the spread of the virus. In high-income countries, MTCT of HIV has decreased to about 1% through preventive measures, including effective voluntary counselling and testing for HIV and antiretroviral therapy (ART) (Car et al., 2011). Despite this significant progress, the number of children becoming newly infected with HIV remains unacceptably high in countries like Uganda; around 160,000 children in 2016 became infected with HIV; this equated to 438 children a day (USAID, 2017).

In 2012, the Uganda Ministry of Health embarked on a treatment strategy to eliminate mother-to-child transmission (eMTCT) of HIV known as "Option B Plus" (Option B+). Option B+ offers all HIV-infected pregnant and breastfeeding women lifelong antiretroviral therapy (ART), regardless of CD4 count or clinical stage (Eholié et al., 2016). The overall goal of the program was to improve ART uptake and retention, and thus the outcomes of HIV-infected pregnant women, their uninfected partners, and their infants within the continuum of HIV testing and treatment services (Kim et al., 2015; Schouten et al., 2011). Option B+ treatment strategy has the potential to profoundly impact maternal and infant outcomes, operational challenges throughout the cascade of PMTCT services may affect uptake and adherence to ART by pregnant women, the follow-up of HIV-exposed infants, and the long-term retention of this population (Cataldo et al., 2017).

Male involvement is recognized as a priority area for the elimination of mother to child transmission of HIV programmes (WHO, 2007). The male partner plays a role in terms of a

woman's risk of acquiring HIV (Msuya et al., 2006), utilization of the PMTCT programme: for the mother to test for HIV, for the mother to return for the result, for the couple to use condoms, for the mother to receive medication and for her to follow the infant feeding advice given (Falnes et al., 2011). Yet, very few partners participate in antenatal HIV counselling and testing (Msuya et al., 2008; Katz et al., 2009). Males are discouraged to attend ANC because of the way clinics are structured to receiving males; most times they are idle at the clinics and therefore do not feel the need to be at the ANC clinics even when they want to be supportive of their partners participating in the eMTCT programme ((Falnes et al., 2011). Most studies have focused on the fact that males are not involved (Sarker et al., 2007; King et al., 2008; Byamugisha et al., 2010; Mbonye et al., 2010; Mohlala et al., 2011) and have not explored their experiences especially for those that have been involved, to understand their challenges and how their community has impacted on their involvement in order to ensure sustained involvement. In addition, the information available about eMTCT comes from women and less so from males who attend ANC/eMTCT clinics (WHO, 2012). This leaves a substantial gap on how to ensure sustainable involvement by male partners; given the importance of male involvement in eMTCT and lack of studies on the experiences and perception of males who have been involved in ANC/eMTCT. There is an urgent need to gather information from the males about eMTCT programs to improve uptake of sexual and reproductive health services.

1.1 Background of the Study

Male involvement in pregnancy and childbirth influences pregnancy outcomes (Auvinen et al., 2010; Aluisio et al., 2011; Kalembo et al., 2013). There is epidemiological and physiological evidence (Katz et al., 2009; Wall et al., 2012) that male involvement reduces maternal stress i.e. emotional, logistical and financial support (Msuya et al., 2008; Falnes et al., 2011). In Uganda,

male involvement in eMTCT has been limited and many pregnant women attend maternal health services unaccompanied and unsupported by their partners (UNICEF, 2016). Although, Uganda has made significant progress towards the goal of eliminating mother-to-child transmission of HIV, the final push towards zero paediatric transmission will require intensified efforts of proven strategies, such as increasing male involvement (UNICEF, 2016) because women's decision making about their pregnancies and health are deeply influenced by their partners, communities and social norms and beliefs regarding HIV and AIDS (UNAIDS, 2011). Yet, most awareness and implementation efforts related to family planning and HIV prevention and care have been directed primarily at women, disregarding the cultural and gender norms that may impact women's decision making regarding these issues (Peacock et al., 2009).

One major factor that prevents some women from accepting HIV testing is the need to seek their partners' consent (Kalembo et al., 2013). A large number of studies (Moodley et al., 2009; Nkuoh et al., 2010; Akarro et al., 2011; Falnes et al., 2011; Kalembo et al., 2013; Ditekemena et al., 2014) have highlighted the difficulties that women have in getting their male partner to attend ANC and to be tested for HIV as well accessing on-going care if they have not disclosed their status with their partner. With male partner involvement in eMTCT, a couple has a chance to make informed decisions to living positively with HIV, to share responsibility for preventing HIV transmission to the unborn child and to discuss safer sex practices, as well as to make informed decisions to access care and treatment (Msuya et al., 2008; Peltzer et al., 2008; Malawi MoH, 2011; Kalembo et al., 2013).

Effective strategies to involve males in maternal and new born health in most studies varied and included male attendance at maternal health services, men's knowledge and attitudes, couple communication and relations, and service utilization of men and women such as treatment for sexually transmitted infections and HIV testing (Msuya et al., 2008; Kululanga et al., 2011; Adelekam et al., 2014). Programmes addressing couple communication, health education and gender norms which incorporate males into intervention strategies from the beginning, sometimes placing men in leadership roles, have been reported to be successful (Msuya et al., 2008; Kululanga et al., 2011; Adelekam et al., 2014). In contrast to traditional sexual and reproductive health education programmes which only distribute health information to women by women, these male inclusive programmes encourage men and women to view each other as equal partners in health and relationships.

Therefore if males are given the opportunity to participate in SRH programmes, such as family planning and the eMTCT programmes, they positively involve in promoting the health of their families and communities (Peacock et al., 2009; Theuring et al., 2009). It is against this background that this study aims to explore the experiences and perceptions of the male partners that are involved in eMTCT/ANC to inform other males and as a way of yielding positive results for the health of women, children and families.

1.2 Statement of the Problem

There is still low male involvement in their partner's lifelong ART in this patriarchal Uganda (WHO, 2012), in which Soroti forms part; where women have limited autonomy in decision-making, male involvement has the potential to bring about change because of the social power men hold. Due to deep rooted gender norms and health system factors which limit male

involvement, few interventions appear to be sustainable (Davis et al., 2013; Kululanga et al., 2011).

Although, men's role in providing emotional and material support to partners including financial support, permission to access health care, monitoring drug compliance and helping out on household chores have been identified in several studies as ways to improve women's uptake of eMTCT services (Peacock et al., 2009; Peltzer et al., 2008; Tweheyo et al., 2010), the cultural beliefs, gender roles and social stigma create barriers against men fully involving in their partner's adherence to lifelong ART. Though men might want to be more involved and help their wives with household activities, they feel they can not publicly present themselves in such a way; with increasing evidence that men can make a difference in maternal health, little is known about under what conditions men choose to become involved from either clients', or services' perspectives (Ladur et al., 2015). Men's perceptions about the benefits of eMTCT are positive and, in general, men are supportive of their partners' participation in eMTCT programmes (Theuring et al., 2009). However, even for those who participate, little is known about their experiences that arise from their individual, family and peer, community and institutional perspectives.

Therefore, this study aims at exploring the experiences of male partners arising from supporting their spouses' in lifelong ART at health facilities in Soroti district. This will specifically look at the male partners' experiences arising from their roles and responsibilities, family and peer, and community perceptions, roles and responsibilities and institutional approaches.

1.3 Research Questions

i. What experiences do male partners have regarding their role in their spouses' lifelong ART at health facilities in Soroti district?

ii. What experiences do male partners have on their spouses' lifelong ART arising from family and peer perceptions, roles and responsibilities?

iii. What experiences do male partners have on their spouses' lifelong ART resulting from community roles and responsibilities in Soroti district?

iv. What experiences do male partners have on their spouses' lifelong ART due to absence and presence of institutional approaches at health facilities in Soroti district?

1.4 Objectives of the Study

1.4.1 Major Objective

To explore the experiences of male partners who have been involved in their spouses' lifelong ART at health facilities in Soroti district.

1.4.2 Specific Objectives

i. To understand the experiences of male partner regarding their role and involvement in their partner's lifelong ART in at health facilities in Soroti district.

ii. To explore the experiences of male partners on their spouses' lifelong ART arising due to family and peer perceptions, role and responsibilities in Soroti District.

iii. To explore the experiences of male partners on their spouses' lifelong ART resulting from community perceptions, roles and responsibilities in Soroti District.

iv. To explore the experiences that arise due to absence and presence of institutional support approaches on male involvement in their spouses' lifelong ART

1.5 Scope of the Study

This study will aim to explore the experiences of male partners who are already involved in their partner's lifelong ART at health facilities in Soroti district; understand their perceived cultural opportunities and barriers for involvement; community and service support to ensure partner adherence to lifelong ART. A qualitative cross-sectional study design of a constructed list of male partners with pregnant women enrolled on lifelong ART (Option B+) ANC/eMTCT. Data will be collected using semi-structured questionnaires, in-depth interviews and document analysis techniques.

1.6 Significance of the Study

Male involvement in eMTCT is essential in a patriarchal society like Uganda where men are key decision makers. The data and information yielded from the study will give insights on the relevance of involving male partners and strategies of ensuring sustained male involvement in matters concerning the health of their women in the process of eliminating mother to child transmission in the country.

The findings and recommendations of the study should also be useful to the health providers, communities, policy makers and health planners when formulating policies that aim to further address the implications of not involving or involving both partners and strategies that reduce

stigma for the male partners that have been involved, in the struggle towards elimination of mother-to-child transmission of HIV, henceforth they will rely not only on the little that has been put forward for the relevance of male involvement but facts supported in this study will be of great importance. The researcher hopes that the study will form a basis for further research on the family-centred approaches and community support interventions for male involvement in health matters concerning their partners and its implications in general.

This should lead in the generation of new ideas for better and more efficient means of addressing transmission of HIV not only to unborn babies or infants but also strive towards the achievement of the WHO goal of eradicating the AIDS epidemic by 2030 (UNAIDS, 2014).

1.7 Justification of the Study

The purpose of this study is to explore the experiences of male partners involved in their spouses' lifelong ART at health facilities in Soroti district; understand their perceived cultural opportunities and barriers for involvement and explore if there is support for male involvement in their communities to ensure sustained male involvement.

According to the 2014 Uganda HIV and AIDS Country Progress report male involvement in PMTCT services is at 23.5 %. Although male involvement as indicated by the number of ANCs tested as a couple increased from 19.7% in 2013 to 23.5% in 2014, there is still low male involvement in eMTCT. The low involvement is due to poor sensitisation and cultural perception coupled by patriarchal based traditions which are dominant in Uganda this indicates low support for mothers during eMTCT/ANC since men are the decision makers in Ugandan societies (UAC, 2014; WHO, 2010).

Male participation in VCT impacts post-test counselling, improves communication, increases adherence to antiretroviral treatment and child-bearing decisions for HIV positive couples (Msuya et al., 2008; Aluisio et al., 2011); couples are more likely to adopt a low risk behaviour and increase mutual support, regardless of the test result (Katz et al., 2009; USAID, 2010; Koo et al., 2010; Mohlala et al., 2011; Falnes et al., 2011) as well as make informed decisions regarding the choice of a family planning method and the new-born feeding method (Msuya et al., 2008). Well-informed men are more likely to participate positively in the decision making for the well-being of the couple (Duff et al., 2011; Mlay et al., 2008); women with supportive partners are more motivated to undergo HIV testing, to return for the HIV test result and to disclose the HIV result to their partner (Delvaux et al., 2009).

As implementation moves towards lifelong ART for pregnant and lactating women, engagement of male partners in the eMTCT program is crucial and the primary reasons men are not involved is majorly constructed around the social world i.e. culture and the traditional role of men and women in childbirth and women's health (Aarnio et al., 2009; Tonwe-Gold et al., 2009; Peltzer et al., 2011). It is overcoming these barriers that will ensure men attend health services.

1.8 Theoretical framework

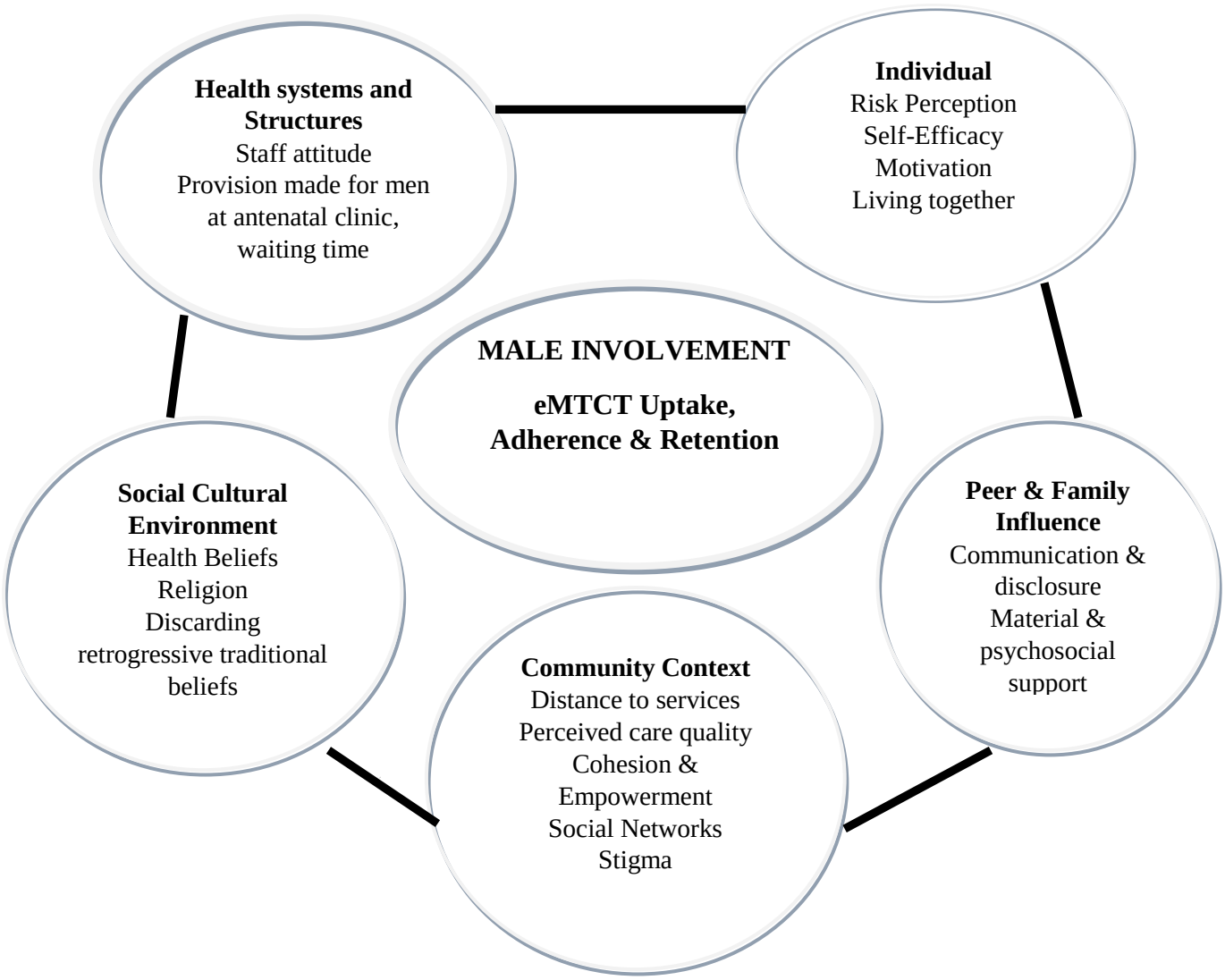
The study will use social ecological model that considers behaviour as being a result of dynamic and complex interactions of factors at the various social ecological levels in which the individual is situated. An individual's behaviour is shaped on the information, influence and interactions obtained within one's social networks, social environment and institutions. Health outcomes are increasingly recognized as being shaped less by individual behaviour and more by the wider environment in which people live and make choices, influenced by family and peers, local beliefs and values, cultural norms and practices and political and economic circumstances. Male

involvement has been greatly influenced by cultural and gender norms (WHO, 2008). The use of social ecological frameworks is found useful in understanding HIV treatment adherence and programme retention. It demonstrates the way in which an individual's behaviour and health outcomes are nested within different levels of social organization, which influence male involvement in their partner's uptake, retention and adherence into HIV treatment and therefore facilitates in identifying community-based approaches implemented to address barriers along the eMTCT care continuum (Busza et al., 2012). The social ecological framework can be divided into individual level factors, peer and family influences, the community context and the social cultural environment. Individual level factors include a person's risk perception, self-efficacy/motivation and knowledge (Mupenda et al., 2014; Shroufi et al., 2013; Busza et al., 2012). Peer and family influences have been shown to particularly facilitate eMTCT involvement; with lack of partner involvement there is a likelihood of reducing a woman's chances of engaging in eMTCT services, non-disclosure and access to resources like money impede utilization of eMTCT services (Mupenda et al., 2014; Tchendjou et al., 2011; Shroufi et al., 2013).

Community context refer to the prevailing attitudes and practices that men perceive to exist among those living in their immediate vicinity for example stigma, perceived quality of care, distance to health facilities and social networks (Merten et al., 2010; Mupenda et al., 2014). The socio-cultural environment, factors such as health and religious beliefs, gender norms and traditional practices in areas such as infant feeding can run contrary to the recommendations of eMTCT programmes (Roura et al., 2010; Shroufi et al., 2013; Byamugisha et al., 2010). Gender norms and social expectations of the roles that men play in reproductive health affects their attitudes and behaviours about HIV and pregnancy prevention, gender based violence, and their

participation in pregnancy, childbirth, newborn and child care. Programmes that address the social construction of gender roles through group or peer education, community outreach, mobilization, and mass media campaigns, and promote policy-level changes that support positive social norms have been seen to be effective in addressing social and behaviour change communication (Mupenda et al., 2014; Shroufi et al., 2013) such as male involvement in eMTCT. Figure 1 below explains the interaction between the factors that come into play to influence male involvement in eMTCT

Figure 1: Conceptual Framework



CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

In this chapter, the researcher reviews literature related to the barriers, facilitators, experiences and perceptions of male partner involvement in eMTCT/ANC lifelong ART. The review is conceptualized under the objectives of the study and focuses mainly on the importance of improving men's participation in elimination of mother to child transmission of HIV and also ensuring sustained male involvement in reproductive health.

2.1 Option B/B+/Lifelong ART and adherence

Option B and Option B+ are the two most comprehensive options recommended for the prevention of MTCT by the WHO (WHO, 2010). In both, an HIV+ pregnant woman with CD4 count <350 cells/mm^3 is immediately treated with triple-ART that continues through life. Option B provides that women with CD4 > 350 cells/mm^3 receive ART beginning at 14 weeks into gestation, throughout pregnancy, and after birth until breastfeeding ceases. Under Option B+, all women receive lifetime ART, even if CD4 count is >350 cells/mm^3. Under both options, infants born to HIV+ women receive daily zidovudine (AZT) for the first 4–6 weeks of life additional rapid testing at 12 months and 24 months and ART if HIV-positive (UNICEF, 2012). It is very important to adhere to the treatment standards as recommended by the healthcare provider.

The standard clinical definition of adherence has been taking at least 95% of medications the right way, at the right time. Over time, this definition has been broadened to include more factors related to continuous care, such as following a care plan, attending scheduled clinic appointments, picking up medicines on time, and regular CD4 tests (ICAP, 2010).

In this study, adherence to Option B+ regimen will include the following; Entering into and continuing on a care and treatment plan (retention in care), Taking medicines to prevent and treat opportunistic infections, Planning for/having a safe delivery in a health facility , Practicing safer infant feeding practices, Bringing the baby back often for check-ups and picking up medications for self and the child as scheduled, Participating in on-going education and counselling, Attending appointments and tests (such as antenatal and postnatal appointments and regular CD4 tests), Adopting a healthy lifestyle and understanding and minimizing risk behaviours, as much as is possible, recognizing when there is a problem or a change in health and coming to the clinic for care and support.

2.2 Male partner involvement and eMTCT uptake

The term MPI can be defined in different ways depending on the context. For example, a study conducted in Uganda similarly included the activity of attending antenatal care as being indicative of MPI, but also included activities such as partners discussing antenatal eMTCT interventions and men providing financial support for antenatal visits in order to assess MPI (Byamugisha et al., 2010). In addition, a study conducted in Kenya included couple counselling and testing as a form of MPI. It is therefore clear that MPI can refer to a range of activities within the context of pregnancy, and has not been clearly defined. In this study MPI in eMTCT will the focus on the support to their female partners in core eMTCT interventions which include the following activities; couple counselling and testing, practicing safe sex (use of condoms), reminding the wife about ANC appointments as well as attending, visits eMTCT clinics with his wife to bring ARVs, provides financial support for the wife, in terms of transport, feeding (balanced diet), reminding his partner to take ARVs and taking his as well and support for the female partner in the choice of infant feeding options.

Male partner involvement increases the uptake of eMTCT interventions by HIV positive pregnant women (Kalembo et al., 2013). From the eMTCT programme perspective, male involvement may mean men supporting choices and rights of the female partners (Aarnio et al., 2009; Montgomery et al., 2009; Mohlala et al., 2011; Kalembo et al., 2013) or men doing something about their own reproductive and sexual behaviours as a way of protecting their partners and their babies against HIV(Montgomery et al., 2006; Mohlala et al., 2011; WHO, 2012; Kalembo et al., 2013; Koo et al, 2013a; Kwambai et al., 2013). Male involvement increases adherence to and improves outcomes of programmes towards elimination of mother to child transmission of HIV (Peltzer et al., 2010; Maman et al., 2011; Kalembo et al., 2013; Koo et al., 2013). It means providing financial i.e. paying for health services, (Peltzer et al., 2007; Maman et al., 2011) or psycho-social support; loving and caring attitude toward an HIV positive spouse (Peltzer et al., 2007; Mlay et al., 2008; Nassali et al., 2009; Nkuoh et al., 2010; Maman et al., 2011; Musheke et al., 2013), supporting and promoting contraception to avoid unwanted pregnancies within HIV-positive couples and practising safer sex to avoid re-infection and other sexually transmitted infections during pregnancy (Aarnio et al., 2009; Montgomery et al., 2009; Mohlala et al., 2011; Kalembo et al., 2013). As well as, participating jointly in antenatal clinic visits and undergoing counselling and HIV testing for better understanding and promotion of the female partner's adherence to lifelong ART; supporting and promoting safe infant feeding options (Peltzer et al., 2007; Mlay et al., 2008; Aarnio et al., 2009; Byakika-Tusiime et al., 2009; Delvaux et al., 2009; Desgrées-du-Loû et al., 2009; Montgomery et a.l, 2009; Kasenga et al., 2010; Mbonye et al., 2010; Oladokun et al., 2010; Peltzer et al., 2010; Maman et al., 2011; Kalembo et al., 2013; Koo et al., 2013a; Kwambai et al., 2013; Villar-Loubet et al., 2013). The male partner's attendance at the antenatal clinic with his pregnant spouse has been considered as

providing a mean for male participation in eMTCT (Katz et al., 2009a; Aluisio et al., 2010; Nkuoh et al., 2010; Tweheyo et al., 2010; Mohlala et al., 2011; Koo et al., 2013a). Men's involvement plays a role in HIV prevention of new born infection by facilitating couple communication related to sexuality, which helps to reduce risk of transmission of HIV/AIDS and provide a conducive environment for supportive attitude to a pregnant spouse's disclosure of their HIV positive status (Desgrées-du-Loû et al., 2009; Aarnio et al., 2009; Musheke et al., 2013) which is a facilitator to promoting uptake of eMTCT/ANC services.

2.2.1 Why male involvement?

The beneficial impact of male involvement in programmes towards eMTCT of HIV among infants has been highlighted in most of the research concerning male involvement (Chinkonde et al., 2009; Bentancourt et al., 2010; Aluisio et al., 2011; Kalembo et al., 2013). A study conducted in 15 countries found that supportive male partners who were willing to test for HIV and communicate with their partner about sexual and reproductive health issues, increased the commitment of pregnant women to eMTCT/ANC (Auvinen et al., 2010). Male involvement in maternal health services is perceived as a means for couple HIV counselling and testing, an incremental process to achieving gender equity (Keehn et al., 2014; Davis et al., 2016), increased uptake of ARVs for eMTCT and practice of safe feeding measures (WHO, 2010; Kalembo et al., 2012; Car et al., 2012), as well as uptake of an HIV test (Kalembo et al., 2012; Gunn et al., 2016) and other eMTCT interventions in women (WHO, 2010; UNAIDS, 2011; Weiss et al., 2013) and reducing the risk of mother to child HIV transmission (Aluisio et al., 2011; Nyondo et al., 2014). By comparison, women in relationships with unsupportive males have reported violence, abandonment or fear of abandonment (Auvinen et al., 2010), shock, disbelief and discrimination among male partners of pregnant women who disclose their HIV status to their partners (Visser

et al., 2008; Makin et al., 2008). Cultural and gender norms in sub-Saharan Africa give men more power than women in sexual decision-making, including in regards to abstaining, having concurrent sexual partners, and using condoms (Van den Berg et al., 2015; Kacanek et al., 2012). Such norms prevent women from accessing family planning and sexual health services if male partners are not involved. The dominant cultures and values also affect men's experiences and behaviours towards eMTCT/ANC (Van den Berg et al., 2015; Clouse et al., 2014), which has been highlighted as a barrier in most studies targeting male involvement (Mlay et al., 2008; Aarnio et al., 2009; Byamugisha et al., 2010; Nkuoh et al., 2010; Falnes et al., 2011; Mohlala et al., 2012; Kwambai et al., 2013). The views on gender roles and infant feeding consider ANC as a women's responsibility (Mlay et al., 2008; Aarnio et al., 2009; Auvinen 2014). Men as supportive partners influence the family's social environment making it conducive to seeking treatment, improving uptake and being adherent to medication (WHO 2010; Kalembo et al., 2012; Van den Berg et al., 2015). There is an association between partner disclosure and HIV prevention; in a retrospective cohort study in Malawi; a total of 476 HIV positive women were enrolled in a PMTCT program and were followed-up. Of those followed-up in the study, 65 (13.7%) had a male partner involvement while 411 (86.3%) had no male partner involvement. Male partner involvement was significantly associated with condom use, hospital delivery and completion of follow-up in the program (Kalembo et al., 2013).

In addition, a sixteen-year prospective cohort study in Nairobi, Kenya found that male involvement reduced the combined risk of HIV infection and infant mortality by 44% compared to the birth outcomes of those born from mothers who received care alone (Alusio et al., 2011). Male involvement has been seen to promote HIV-infected mothers disclosure of their HIV status to their partners and receiving support in their infant-feeding choices that promotes successful

exclusive breastfeeding (Van den Berg et al., 2015). Interventions to promote MPI in eMTCT have often involved providing antenatal HIV testing and counselling for couples (Katz et al., 2009; Tweheyo et al., 2010). Counselling can improve couple communication about HIV, fertility-related decision-making, and gender equality as well as reducing the risk of transmission within sero-discordant couples (Tweheyo et al., 2010; Nyondo et al., 2014). Different studies from Sub-Saharan Africa pertaining male involvement have been conducted and documented in the following areas; male participation in the PMTCT of HIV, their views regarding participation in antenatal HIV testing and on the barriers faced by pregnant woman and themselves in taking part in different ANC activities (Katz et al., 2009; Nkuoh et al., 2010; Aarnio et al., 2010; Duff et al., 2012; Koo et al., 2013), determinants of male involvement in the PMTCT of HIV program and Couples Voluntary Counseling and Testing (CVCT) for HIV (Kizito et al., 2008; Mlay et al., 2008; Becker et al., 2010; Conkling et al., 2010; Byamugisha et al., 2010; Larsson et al., 2010; Tweheyo et al., 2010; Falnes et al., 2011; Mohlala et al., 2011; Wall et al., 2012; Jones et al., 2013; Musheke et al., 2013; Kwambai et a., 2013; Mohlala et al., 2013). Data has also been collected from women, when studying the definition of male involvement (Maman et al., 2011), women's attitudes toward male participation in PMTCT of HIV, (Nkuoh et al., 2013), disclosure of their HIV status to their partners, safer sex practices, infant feeding (Traoré et al., 2009; Engebretsen et al., 2010; Njunga et al., 2010; Jasseron et al., 2013) and have not focused on understanding the experiences of men in regards to male partner involvement in eMTCT.

The views of health care personnel and community members have been sought on male participation in PMTCT of HIV (Msuya et al., 2008; Theuring et al., 2010; Aluisio et al., 2011; Byamugisha et al., 2011; Osoti et al., 2013; Ladur et al., 2015) and not directly focused on the males themselves therefore using such populations as a proxy of measuring male involvement. In

some settings, emerging literature suggests that male transitioning to parenthood has psychological challenges (Genesoni et al., 2009). Some of these studies suggest that men are willing to engage, yet often feel marginalized. Indeed, almost all of the interventions do not directly approach men, but use women as a proxy to invite or take messages to their partners for attendance and inclusion. However, the male views of involved in ANC/eMTCT have not been well investigated as a measure of drawing more males to learn from their peers and direct approaches that may help to engage men towards sustained male involvement using a gender transformative approach.

2.2.2 Facilitators to male partner involvement

Participation by men in antenatal HIV testing and counselling is very low despite the many benefits of male involvement, studies from eastern and southern Africa have found testing rates ranging from 8% to 15% (Chandisarewa et al., 2007; Msuya et al., 2008; Katz et al., 2009; Falnes et al., 2011). Byamugisha, et al (2010) reported peer support groups, counselling, supportive health care workers, short waiting time, provision of food and transport as facilitators to male involvement.

An intervention in Tanzania that randomized pregnant women to individual voluntary counselling and testing (IVCT) for HIV or couple voluntary counselling and testing (CVCT) is a cautionary tale about the potentially negative impacts of certain ways of promoting male involvement on women's uptake of services. Half of the women randomized to CVCT did not return to the clinic, only 16% completed CVCT, and only 43% of the women randomized to CVCT completed HIV testing during pregnancy (either alone or with their male partners) as compared to 78% of the women in the IVCT group (Becker, et al., 2010). We should therefore engage partners as those who have a responsibility to share the burden of pregnancy and child

bearing and interest in advancing gender equality. Rather, that the basis of engaging them aims at fostering recognition of, and discussion around men as decision makers and gate keepers to women health; it should not be instrumental or a male privilege. Building on this, we should be aware on how interventions to involve men interact with this context.

A survey conducted in 2010 of over 10,000 women in rural Uganda found male decision making as one of the most widely cited reasons for not attending PMTCT appointments (Alusio et al., 2011). Couples counselling and testing has better retention in services throughout the PMTCT cascade (Theuring et al., 2009); couples counselling and status disclosure increases women's adherence to ART and regimens for elimination of mother-to-child transmission (Aluisio et al., 2011).

Studies show that men who regularly attend some sort of support group have been reported to more likely attend antenatal clinics with partners. Peers within a support group often encourage and motivate each other to support their partners during pregnancy and child birth (Lassorn et al., 2010; Kululanga et al., 2011; Koo et al., 2013a; Van den Berg et al., 2015).

Clearly, women's disclosure of HIV status to male partners engenders their male partner's supportive attitudes towards antenatal care (Bajunirwe et al., 2005; Koo et al., 2013).

Several studies have shed light on the facilitators to male participation that affect adherence to ART and utilization of eMTCT services, highlighting socio demographic, cultural, economic, health-systems and treatment related factors (Msuya et al., 2006; Aarnio et al., 2009; Falnes et al., 2011; Byamugisha et al., 2012). In Zimbabwe a study to explore obstacles and barriers to men's use of HIV services was conducted, the conclusion of the study was that men's use of HIV services was dependant on the social constructions of masculinity that characterise a context, the

openness and ability of the context and men living within it to discuss and deconstruct hegemonic masculinities (Skovdal et al., 2011) therefore eMTCT programs should integrate beliefs, values and practices of different cultural settings so that it can attract more male partners (Njunga et al., 2010; Kalembo et al., 2012). Men's participation in PMTCT is associated with being in a committed relationship which facilitates communication with their partners about HIV evidenced by a study from Nairobi where men who presented to the antenatal clinic for HCT were more likely to be in monogamous marriages and live with their partners. They were also more likely to have previously discussed HIV testing with their partner (27% versus 19%, P = 0.001) and willing to confide in their partner if they tested HIV seropositive (68% versus 59%, P = 0.004) than men who did not present to the clinic (Theuring et al., 2009). In another multivariate analysis, living with and reporting having previously discussed HIV testing with female partners remained significantly associated with male attendance at the antenatal clinic (OR (95% CI) = 4.34 (1.05 to 18.0) and 1.49 (1.12 to 1.97), respectively (Katz et al., 2009).

Other factors associated with men's participation in eMTCT include education level, knowing their sero-status and having heard about eMTCT; if they had heard about eMTCT, men were two times more likely to become involved than those who had not (Byamugisha et al., 2010).

Men have expressed the fear of learning one's HIV status following attendance of eMTCT/ANC services which impedes their participation (Aarnio et al., 2009; Theuring et al., 2009; Nkuoh et al., 2010; Kang'oma, et al., 2011; Nyondo et al., 2014) while men in Zimbabwe perceived HIV as a threat to their manhood and discouraged their partners in accessing ART services to avoid learning their HIV status indirectly (Skovdal et al., 2011). Equally, women have also expressed

the fear of learning their HIV status as a barrier to their participation in eMTCT programme (Nyondo et al., 2014).

Education level of men facilitates or impedes male participation in eMTCT programmes; low levels education in men limits their understanding of issues on HIV/AIDS and due to inadequate information, men have used their wives HIV test results as a proxy for their own HIV status (Desgrées-du-Loû et al., 2008; Nkuoh et al., 2010; Falnes et al., 2011; Auvinen et al., 2013) contrary to their educated counterparts (Mullany et al., 2007). In Zimbabwe it was found out that men who had never heard about PMTCT did not appreciate it as an important service, hence did not participate (Makoni et al., 2016). Similarly women's education level may positively or negatively affect male involvement and their adherence to ART; higher education levels contribute to better health literacy, which in turn promotes communication with health care providers and their male partners (Delvaux et al., 2009; Johnson et al., 2010; Kohler et al., 2012; Ayuo et al.,2013). In another study in New Guinea, men's literacy even when loosely defined as self-reported ability to read and write was strongly associated with their knowledge of SRH issues, discussion with their wives, and with their wives' utilisation of SRH services.

The wives of the respondents who were knowledgeable about ANC and supervised births were more likely to access these services than were those of many of the men who were unaware of their importance (Kura et al., 2013) therefore a significant association between education and utilization of eMTCT/ANC services.

A systematic review by Morfaw et al. (2013) showed that lack of time and the non-invitations to the health facility were the main reasons for low male participation. It is interesting to note that in this study being employed was associated with the likelihood of male partners being involved

in eMTCT (Morfaw et al., 2013) contrary with other studies where the association was found not to be significant (Kalembo et al., 2013; Dyogo et al., 2011).

Facilitators of male involvement in eMTCT are equally numerous and recurrent amongst studies in different settings but for the purposes of this discussion, factors affecting male involvement in maternal health services will be considered under the following categories.

2.2.3 Health system facilitators

Most of the activities which facilitate male involvement in ANC/eMTCT are linked to health systems interventions; for example sending out of invitation letters from the health centers inviting men to participate in ANC/eMTCT through their spouses is identified as a facilitator. In Rwanda invitation letters were given to spouses by influential agents within the community (Wall et al., 2012). The use of invitation letters was popular as it was perceived as a medical prescription which obliged the spouses to attend. Inviting male partners therefore appeared to be the most important facilitator (Wall et al., 2012). An interventional trial among pregnant women in Kenya showed increased uptake of voluntary counseling and testing (VCT) and promotion of safe sex during pregnancy if men were invited to PMTCT (Mohlala et al., 2011).

A recent randomized control trial, in Kenya, compared the effectiveness of inviting male partners to participate in VCT at the ANC using letters of invitation versus an in-person invitation by a health worker during a home visit. The results indicated an upsurge, when compared to previous investigations, with an 85% contact rate with male partners (Osoti et al., 2014). Tweheyo et al. (2010) suggested that obtaining health information from a facility health worker was positively associated with male partner attendance of ANC with their spouses. The finding suggests that males regard health workers as a credible source of health information, and this is influential on

their health behavior. The friendliness and welcoming of male partners by health workers is significantly associated with male involvement in PMTCT. Men need to feel that they are important and are part of the pregnancy when they accompany their wives for ANC (Makoni et al., 2016). In a descriptive qualitative study conducted by in Nigeria, married men agreed that it was important to accompany their wives for ANC. However, they highlighted that before accompanying their wives, they must feel needed (Adelekam et al., 2014).

In other studies, offering routine couple voluntary counseling and testing for HIV as the entry point into eMTCT services was a facilitator to MPI (Becker et al., 2010; Msuya et al., 2008; Katz et al., 2009). Couple VCT serving as a standard of care may have eliminated stigma faced by men attending ANC. This relatively high proportion depicts the importance of this facilitator. Providing ANC services for couples such as couple voluntary counseling and testing during weekends or non-working hours facilitated male partner involvement in ANC/eMTCT activities (Becker et al., 2010; Ditekemena et al., 2011). One study reported that change from voluntary counseling and testing to routine counseling and testing in accordance with WHO opt-out approach led to an increase in male partner HIV testing (Byamugisha et al., 2010).

Other studies in the Democratic Republic of Congo and Kenya found that use of indirect approaches, such as using peer counselors and approaching men in community-based settings such as bars and churches improved male participation and female adherence to the eMTCT cascade (Sherr et al., 2012; Saul et al., 2012).

Another facilitator reported in several studies is the site where voluntary counseling and testing (VCT) for HIV was offered. There is a general agreement that a conducive site is needed other than the overcrowded health centers, sites such as bars, churches or even their jobsites, was a

major facilitator to male partner involvement. This facilitator avoided the discomfort felt by men when attending the 'female oriented' ANC settings, and was a major boost to their involvement (Falnes et al., 2011; Ditekemena et al., 2011). Even though probably almost in direct contrast with the facilitator of conducive sites, the main facilitator for the men's eMTCT involvement reported by Katz et al. (2009) was the offering and testing for HIV for men within the antenatal care settings. VCT in these settings was shown to increase the likelihood sharing of results and subsequent male eMTCT participation because of the greater investment in the partnership and interest in the child's health (Katz et al., 2009).

The assurance of the presence of health personnel within the health facility is yet another facilitator that motivates men to attend and participate in eMTCT. Among the less prevalent facilitators, the presence of health personnel within the clinic whose role was to facilitate disclosure of HIV status amongst partners is a facilitator (Aarnio et al., 2009).

A further facilitator of male involvement is the differential targeting and offering of VCT for HIV to the men who accompanied their wives to the delivery ward. These men were usually more motivated in the health of their wives and future babies. Differential counseling of women is also identified as a facilitator of male involvement. In these settings, HIV positive women were specifically required to bring along their spouses for counseling and testing. This measure facilitated the adherence to eMTCT recommendations by selectively targeting the concerned male population (Kizito et al., 2008).

Open discussions on free prenatal HIV testing for partners such discussions by health personnel can help disintegrate cultural myths and provide men with the knowledge of possible benefits of their involvement and where to seek services (Jasseron et al., 2011). Therefore, successful

programs should shift the burden of requesting engagement of male partners from the pregnant women to the health system (through letter delivery) or a team of community health workers and addressed gender inequality through couples counseling or community-based interventions.

The attitude of health workers also facilitates male involvement; Theuring et al. (2010) found that in Tanzania the health workers attitude towards male involvement was twofold. On one hand, the providers accepted male partners' overall involvement in the services. But on the other hand, the providers had restrictive attitudes towards male participation in the services especially if the services were related to perinatal examinations or childbirth. Therefore providing motivational information, ensuring positive healthcare provider attitudes, and providing educational support and a male friendly environment to men are potential interventions to increase male involvement in eMTCT/ANC.

2.2.4 Male individual facilitators

Most men consider accompanying their wives to ANC/eMTCT a good practice. Yet fewer men actually do this, because they feel that the provision of finance for ANC registration and delivery fees is their most important role in supporting their wife's pregnancy (Nkuoh et al., 2010). As suggested by Nkouh et al. (2010) there is need to build upon the traditional value of financial responsibility, expanding a man's involvement to include supportive social roles in eMTCT/ANC. Men need time to consider eMTCT recommendations and to be ready with their partners before becoming involved (Katz et al., 2009). Men's understanding of HIV infection and their attitudes towards prevention are key factors in containing the disease and eliminating vertical transmission as well as the risk of infection to their wives (Kura et al., 2013). The knowledge of the male concerning HIV and eMTCT facilitates their involvement (Aarnio et al.,

2009). Dyogo et al. (2011) in Uganda found that lack of knowledge on the benefits and need of male involvement in maternal health care services was reported to contribute to low male involvement. In Zambia, knowledge of eMTCT was the strongest factor which was positively associated with male partner involvement in PMTCT (Tshibumbu, 2006). Where men are knowledgeable that HIV testing is beneficial for the baby, and that necessary treatment could be obtained, male involvement is increased. Moreover, men's knowledge on the perceived benefit of eMTCT, the perceived benefit from support and knowledge sharing among male peers as well as guidance from adults not to rush into violence or divorce because of HIV, are individual factors facilitates male involvement in eMTCT (Aarnio et al., 2009). The association between men's literacy and their wives' sexual and reproductive health practices was striking and yet much of the focus is put on the importance of female education in improving health outcomes forgetting the education of males is equally important (Kura et al., 2013).

Most men whether formally employed, informally employed or unemployed run around working for the family during the week; men work at least five days a week and may not have off days from work and find that the clinic's operating time is inconvenient for them. This implies that if clinics would open during weekends, more men would be available to accompany their wives for eMTCT (Makoni et al., 2016).

History of testing makes men more knowledgeable about HIV, and more implicated in their families health and enables them to better support their spouses to prevent child HIV infection (Aluisio et al., 2011). In Kenya men who reported prior HIV testing were more likely to attend ANC with their spouses (Aluisio et al., 2011; Katz et al., 2009). This report is not surprising; as such men are likely to have less stigmatizing attitudes, while also possessing greater HIV-related

knowledge. Men with fewer children and less knowledge about eMTCT were also more likely to successfully complete voluntary eMTCT counseling, possibly indicating a wish to better prepare for fatherhood (Katz et al., 2009). Behavioral change messages directed at women have a low potential for preventing STIs and HIV/AIDS while programmes directed at men are more likely to impact their attitude and sexual behavior (Kura et al., 2013). it is clear that there is an information gap in relation to study of men with regard to their feelings, concerns and attitudes of their involvement in eMTCT/ANC (kidero 2011) especially in regards to adherence that would create behavior change communication.

2.2.5 Female individual factors

A systematic review to identify barriers and facilitators to male involvement in elimination of pediatric HIV, the lack of financial independence on the part of women is a recognized facilitator of male involvement (Morfaw et al., 2013).

Akarro et al. (2011) and Koo et al. (2013) reported that fear is a big factor that stops pregnant women that tested HIV positive from revealing their status to their husbands and thus involve them in their care. They fear losing their marriages or relationships and be abandoned with their babies. In community based approach study on male involvement, pregnant women's disclosure to partners was positively associated with service use, women who kept their status secret found it challenging to store and take medications (Busza et al., 2012). However, there is surprisingly little recent literature on the preventive effects of HIV disclosure by heterosexual men to their female partners, beyond the associated positive outcomes relating to personal stress and social adjustment compared to more literature on female disclosure there is great association exists between partner disclosure and HIV prevention (Ramirez-Ferrero et al., 2012; Mfecane 2012).

At the 2010 International AIDS Society conference in Vienna, Austria, Sonke Gender Justice Network an NGO, reported that women's experiences upon disclosing their status to their male partners were often "complex and positive" posit violence levels of up to fourteen per cent, while others stated that about half of HIV-positive women said their partners reacted supportively to the disclosure (Visser et al., 2006; Desgrees-du-Lou et al., 2008; Rujumba et al., 2012) hence efforts to encourage disclosure in women should be emphasized.

2.2.6 Relationship dynamics facilitators

Most HIV infections in sub-Saharan Africa occur in stable relationships, either due to one of the partners being infected previously or because of infidelity (Malamba et al., 2005; Chomba et al., 2008). However, the factor of stability within a relationship is a facilitator to better quality relationships, dialogue and possibly mutual respect (Msuya et al., 2008; Aluisio et al., 2011).

In Kinshasa, it was found out that men with one sexual partner were twice more likely to be involved in PMTCT (Ditekemena et al., 2011), men who had more than one sexual partner were less likely to be involved in PMTCT. In Uganda, Condom use is higher among couples who engage in a dialogue on sexual risks (Larsson et al., 2010). The practice of ‘‘testing by proxy’’ (Morrill et al., 2006) by male partners of women who tested HIV-negative is worrying, given that in Uganda, an incidence modeling study conducted by UAC indicated that 43% of the new HIV infections among adults in the reproductive age group in 2008 occurred in discordant, supposedly monogamous, relationships (UAC, 2009).

Good and open communication support for both men and women in seeking routine HIV testing, discussing the challenges of living with HIV and being more supportive of their HIV-infected partners is an effective strategies to uptake of eMTCT/ANC services (Reece et al., 2010).

However, little is known about couples and their relationships in the context of eMTCT/ANC (Ramirez-Ferrero et al., 2012).

Rujumba et al. (2012) suggested that women in polygamous relationships feared that their partners would abandon them and shift to co-wives, which would lead to loss of support for the women and their children. Similarly, in Malawi the fear of HIV testing among men who engaged in extra marital affairs was the main reason why men did not participate in eMTCT services (Kang'oma et al., 2011). Health workers should consider the varying social positions in preparing and supporting women for disclosure moreover, non-disclosure can prevent HIV positive women from adhering to eMTCT interventions, thus increasing the risk of HIV transmission to the infants (Rujumba et al., 2012).

The nature and quality of relationships between men and women, especially between sexual behavior and affective relations needs to be investigated to improve couple communication on sexual risk; the evolution of preventive behaviors over time; and gender issues including negotiation and violence (Desgrees-du-Lo 2009). The impact of these nuanced relationships on a constellation of reproductive health outcomes must be considered. Researchers have begun to note the paucity of literature on relationships and the need for more

2.3 Barriers to male partner involvement

Literature points out to the contradiction between male beneficial attitudes towards HIV testing in pregnancy and the low uptake, suggesting that this implies external barriers to access (Theuring et al., 2009; Auvinen et al., 2010).

There is a variety of conceptual, policy, facility-based and socio-cultural factors that serve as barriers to the meaningful participation of men in eMTCT services. Conceptual and policy

barriers have encouraged the inadvertent exclusion of men from eMTCT and other reproductive health services (WHO, 2012).

2.3.1 Policy dimension

In the context of sub-Saharan Africa, despite overwhelmingly positive attitudes toward the elimination of mother-to-child transmission of HIV among men, their engagement in eMTCT efforts remains very low (Ramirez-Ferrero et al., 2012). Even with the promise shown in local and international studies, rates of male partner attendance at antenatal care (ANC) visits and participation in couples HIV testing remain low worldwide (WHO, 2012). There does not seem to be any global policy on male involvement in HIV testing in pregnancy or on-going vertical transmission provision (Sherr et al., 2012).

Generally, it appears that current HIV testing initiatives are less successful at reaching men than women (Sherr et al., 2012). In Ethiopia 663,603 pregnant women were studied from 2004 to 2009 where 13.5% (986) were HIV positive and showed that male testing was low at only 4.9%, with a worrying decline over time by 14% from 2004 to 2009 (Mirkuzie et al., 2010). Thus, in the absence of any direct policy, male testing in HIV pregnancy may represent a seriously missed opportunity to effectively prevent vertical HIV transmission. Increased international focus and resources have led many countries to concentrate their efforts on the proximate determinants of paediatric infection. Since vertical transmission of HIV to an infant can only occur from an HIV-infected mother, eMTCT programmes focus on women (WHO, 2012). Women have been made the centrepiece of efforts that are directed towards reduction of population growth, maternal and infant mortality and no equivalent urgent health issue has been identified with men to the same degree (Gutmann, 2007). The singular focus on women ignores the context of women's lives as members of a partnership, family and community and precludes a broader focus on overall

family health, including men (Betancourt et al., 2010; Njeru et al., 2011) which are a barrier to male involvement. Male partners therefore seem to be the forgotten half of the equation (Mohlala et al., 2011), when men are engaged they are far more likely to support women at critical points such as contraception to avoid unplanned pregnancies, deciding whether to take an HIV test, returning for test results, taking antiretroviral drugs, and practising safer infant feeding methods (Becomeu, 2011).

The historic institutionalization of women's health has led to particular antenatal and maternity structures that have yielded health services that are not welcoming of men or couples, contributing to men's perception of ANC clinic as a women's responsibility thus excluding men from participating in important health arenas (Ramirez-Ferrero et al., 2012).

Interventions to protect the rights of women are important in contributing to reproductive health equity but interventions that involve men can further strengthen reproductive health equity (WHO, 2012). The ever existent cultural barrier to male involvement in reproductive health services has been exacerbated by the tendency of health systems to structurally segregate men from reproductive issues (Theuring et al., 2009). Men must be viewed as a constituent part of reproductive health policy and practice in promoting the health of women, children and their own (Ramirez-Ferrero et al., 2012). The burden of family health is currently borne disproportionately by women but if emphasizes are put in efforts to involve men in the promotion of their own, women's and their family's health it will enable men and women to share responsibility for family health and also help to lay the groundwork for sustainable change(Ramirez-Ferrero et al., 2012).

2.3.2 Societal or cultural barriers

The most frequently reported barrier for male involvement in antenatal care identified across the different studies (38% of the studies) was the perception that antenatal care was a woman's activity, and it was thus shameful for a man to be found in such settings which cast a male partner as a provider (Mlay et al, 2008; Aarnio et al., 2009; Byamugisha et al., 2010a Nkuoh et al., 2010; Falnes et al., 2011; Mohlala et al., 2012; Kwambai et al., 2013; Adelekan et al., 2014; Van den Berg, 2015). It is culturally a taboo and shameful for a man to be found where "women go to give birth" (Homsy et al., 2006; Msuya et al., 2008). In eMTCT programmes, access to men is gained through women clients, but many men feel that women should not be telling men what to do even if the request comes through a health provider (Falnes et al., 2011; Larsson et al., 2012) because a man is supposedly not to follow his wife; he is supposed to take the lead.

Thus their participation in eMTCT would signal weakness and lack of masculinity and power to other men (WHO 2012) and contradict with traditional norms in communities which do not support the change of roles (Njunga et al., 2010; Nkuoh et al., 2010; Nkuoh et al., 2013). This dilemma is explained in a study in Zimbabwe where men who were verbally invited by their wives for the couple HTC in ANC had a low turn up (Makoni et al., 2016) compared to a randomized control trial where male partners participation in eMTCT was high because they were invited by a formal letter (Madzima et al., 2010). This implies that male partner involvement may improve if the clinics write formal invitation letters to male partners explaining the importance of their involvement (Makoni et al., 2016) other than using verbal invitation through their wives. Gender based stigma has been identified as a barrier to reproductive health services for women in the literature (Byamugisha, 2010; Davis et al., 2011; Falnes et al., 2011; Gross et al, 2013) as decision making and the generation of funds for treatment of women is still

left to men (Mullany, 2006; Falnes et al., 2011; Kwambai et al., 2013). According to Reece et al. (2010), the perception of male gender inequality is a barrier to male involvement in eMTCT; when a man accompanies his wife and he is seen by other men they may stigmatize him. The men who accompany their wives for ANC are ridiculed by society as being jealous, over protective of their wives and lacking self-confidence (Katz et al., 2009; Nkuoh et al., 2010). This dissuaded men from becoming involved. In addition, Nyondo et al. (2014) posit that partners deterred from participating in eMTCT services when invites come through his partner. Similar studies in Uganda, Malawi and Tanzania found that women could not ask their partners to take an HIV test because they had no authority over them (Larsson et al., 2010; Kululanga et al., 2011; Falnes et al., 2011) limiting MI in maternal health services.

Superiority norms held by men led to men shunning of any HIV related clinics for fear of being regarded as weak (Nyamhanga et al., 2013) or less masculine (Falnes et al., 2011). Furthermore some studies have showed that men who follow their partners to ANC clinics have been given names (Mullany et al., 2006; Kang'oma et al., 2011) for example in Malawi, a man who follows what his wife tells him is said to have unknowingly taken a local herb called "Khuzumule" which renderes him a "puppet" or makes him a fool (Kang'oma et al., 2010; Nyondo et al., 2014).

In Tanzania the potential conflict between certain eMTCT recommendations and cultural norms was also found to be a barrier. This was especially so with breastfeeding (Falnes et al., 2011). In a context where mixed infant feeding is the norm, the eMTCT recommendation of non-breastfeeding would go against that norm (Falnes et al., 2011). Following this eMTCT recommendation was frowned upon by male partners and this created a barrier to respecting the recommendation.

However, with the new WHO guidelines, Option B+ regimen gives a benefit of the possibility of breastfeeding for long and associated improved health of the child therefore curbing the barrier to non-breastfeeding in eMTCT (WHO, 2010).

The identified cultural communication patterns in which men and women do not fully express themselves, as a barrier to male involvement. This was perpetrated by 'silence' on the part of men or 'non-complaint' on the part of women to give a general impression of all being well. These communication patterns blocked dialogue within couples, thus limiting the chances of male eMTCT involvement (Nkuoh et al., 2010). Issues of power must be addressed if we are to end the silence regarding men's reproductive lives and the resulting non- involvement of men and couples through policy.

2.3.3 Health system barriers

The possible negative attitude of health care providers (Theuring et al., 2009; Reece et al., 2010), health care provider lack of common courtesy, poor handling of pregnant women, and health-care workers not allowing men to enter the antenatal clinic with their partners (Theuring et al., 2009; Byamugisha et al., 2010b; Larsson et al., 2010), and long waiting times at the antenatal clinic (Ditekemena, et al., 2011) have been identified as a potential reason for limited male participation in eMTCT/ANC. Many men feel unwelcomed and disrespected (Larsson et al., 2010), and therefore shun away from attending eMTCT programmes.

Distance, the cost of transport and the charging of unofficial user fees is another barrier cited in some studies (Byamugisha et al., 2010b; Larsson et al., 2010; Larsson et al., 2010; Reece et al, 2010). Poverty in this context manifests itself as poor health systems (Byamugisha et al., 2010a; Maman et a.l, 2011) and in poor families (Byamugisha et al., 2010; Lubega et al., 2013), both of

which are barriers to male participation. Already stretched health systems are struggling with multiple issues, at same time as families struggle with everyday living. Governments and also health facility management need to make sure that maternity services are delivered free of charge and that access to them is equitable (Osman et al., 2014).

The lack of integration of services is a discouraging factor for men from becoming tested, since men feel they will be seen in the clinics by other people. (Larsson et al. 2010) In addition, the opening hours are not favourable. Time spent at clinics and away from work or other income-generating activities is clearly perceived as a barrier to their participation in eMTCT programmes (Byamugisha et al., 2010b; Larsson et al., 2010; Orne-Gliemann et al., 2010; Reece et al., 2010; Falnes et al., 2011).

Two studies explored the feasibility of weekend testing to try and accommodate conflicting work demands for men. This was found to be feasible and attracted couples to test (Msuya et al., 2008; Conkling et al., 2010). it was complex to ask an employer for time off, not only because eMTCT or testing was related to HIV, which might bring up issues of sero-status, but also because these issues were deemed to be primarily women's concerns (Reece et al., 2010).

Several studies on MPI have found that men who accompany their partners to antenatal clinics are forced to wait outside (Byamugisha et al., 2010; Larsson et al., 2010; Koo et al., 2013; Kwambai et al., 2013). In fact many health workers are uncomfortable working with male clients in SRH programmes due to lack of knowledge and skills (Shemsanga, 2011; Kura et al., 2013). In Tanzania health care providers attitudes towards male involvement were twofold. On one hand, the providers accepted male partners' overall involvement in the services.

On the other hand, the providers had restrictive attitudes towards male participation in the services especially if the services were related to perinatal examinations or childbirth (Theuring et al., 2010). Indeed, a similar study conducted in the same region found that many men had been turned away by staff when attempting to attend these services with their partners (Theuring et al., 2010). In Zambia, midwives are trained to encourage MPI, but this does not necessarily lead to service environments which are conducive to male participation and health care providers' attitudes and services which are not male-friendly have also been identified as barriers to MPI (Auvinen et al., 2014).

It is argued that HIV testing and the involvement of men at antenatal services is structurally inaccessible, as antenatal care programs have been designed to include the routine counselling and testing of women, at the expense of their male partners (Koo et al., 2013).
One obvious implication of this system of logic is that HIV testing is usually proposed to men and women separately, and on very different occasions. This does not facilitate communication between couples regarding HIV, their status, or the adoption of preventive behaviours (Desgrees-du-Lou et al., 2008).

Other studies found that antenatal health services were perceived as being male unfriendly, and these consequently discouraged men from becoming involved (Katz et al., 2009; Theuring et al., 2010; Kapata et al., 2010).

Distrust in the confidentiality of the health care system was identified as an obstacle in one study (Aarnio et al., 2009). In addition, infrastructural challenges like low pay and morale, burnout, and personnel shortages seem to leave providers with little motivation to take on the additional demand of providing services to men and couples (Aluisio et al., 2011; Shemsanga, 2011).

2.3.4 Male individual factor barriers

The male partner related barriers included their lack of awareness of eMTCT issues (Duff et al., 2010; Larsson et al., 2010; Duff et al., 2012; Jasseron et al., 2013; Lubega et al., 2013). Most eMTCT awareness efforts have been directed almost exclusively at women, oblivious to the cultural role men play in women's decision making. The male partners are normally reluctant to learn their HIV status and have negative attitude towards eMTCT/ANC which is a major limiting factor to male involvement as well as the belief that one's partner's HIV status is a proxy for one's own (Msuya et al., 2006; Kizito et al., 2008; Aarnio et al.,2009; Morfaw et al., 2013).

In Kenya only 16% of male partners antenatal services and the findings showed that the major reason put forward by respondents for other men not attending the clinic was the fear of testing positive (Katz et al., 2009). For others, this reluctance was associated with the shame of learning one's HIV status especially if it turned out to be positive, community stigmatization, demonstration of men's 'stubborn nature' (Kizito et al., 2008; Aarnio et al., 2009; Mbonye et al., 2010), while in some cases it was stated that men did not just want to participate in ANC/eMTCT activities (Katz et al., 2009)

Lack of time to attend the antenatal clinic with his spouse (Theuring et al., 2009; Maman et al., 2011; Koo et al., 2013a; Nkuoh et al., 2013), the timing of ANC/eMTCT activities is in conflict with men's normal daily activities. Men simply do not have the time to participate in ANC and receive the knowledge necessary to implement eMTCT strategies (Falnes et al., 2011). A cross-sectional survey done in Uganda by Byamugisha et al. (2010) with 388 men aged 18 years and above, whose spouses attended antenatal care at Mbale Regional Referral Hospital, identified

factors that hindered men from attending eMTCT programmes; men claimed they could not divide time between looking for food to feeding the family and going to antenatal clinics with their wives. Some mentioned not having enough money to use for transport for two people.

The male partner's risky sex practices which add to the risk of HIV transmission and threaten the health of the mother and baby is a barrier to male involvement (Chinkonde et al., 2009; Moses et al., 2009). . Men who engage in multiple unprotected sexual relationships are at a higher risk of acquiring HIV (Makoni et al., 2016). In Zimbabwe men who had more than one sexual partner were less likely to be involved in eMTCT (Makoni et al., 2016).

Similarly Kinshasa, men with one sexual partner were twice more likely to be involved in eMTCT (Ditekemena et al., 2011). Kang'oma et al. (2011) in Malawi posit that men who engaged in extra marital affairs were less likely to participate in eMTCT services.

The man's perception of his own health and benefits of and participating in eMTCT was a limiting factor for ANC/eMTCT involvement (Theuring et al., 2009; Nkuoh et al., 2010) because they deemed themselves to be in good health, the self-perception of good health was a limitation to this portal of entry. Hence the whole exercise was deemed to be futile.

The lack of finances and consequently the avoidance of the burden of health care hindered men from attending antenatal care and upholding eMTCT recommendations. In some cases the men stated that they lacked the money to accompany their partners and pay for health care (Nkuoh et al., 2010).

In the study conducted by Nkuoh et al. (2010) sighted the problem of childcare, in the cases where both parents were to go for antenatal care, there would be no one left at home to look after

the other children this was seen as a barrier and this would hinder the male participation because then the partners would not be able accompany them to antenatal visits.

2.3.5 Female individual factors

Women constitute a barrier to male eMTCT involvement by not informing/involving their partners in ANC/eMTCT (Jasseron et al., 2011). The reluctance on the part of women to involve their male spouses is grounded in numerous fears. The fear of divorce, loss of economic security, accusations of infidelity or of bringing the infection into the relationship, stigma, as well as the desire to retain moral integrity and status (Msuya et al., 2008; Bond et al., 2010; Ujiji et al., 2010; Oladokun et al., 2010; Turan et al., 2011; Duff et al., 2012; Larsson et al 2012; Lubega et al., 2013). In Uganda, HIV-related stigma remains a challenge for women in accessing HIV prevention and care services including eMTCT (Duff et al., 2012). Non-disclosure by HIV positive pregnant women for fear of being accused by their partners for bringing HIV infection into the family underpins HIV prevalence as a sexually transmitted disease, which in this case would be interpreted to mean HIV positive women have been promiscuous or had other sexual partners (Rujumba et al., 2012). Having other sexual partners among women goes against the expected gender norms; whereas it is acceptable for a man to have more than one partner it is a taboo for women to do so (Rujumba et al., 2012). However, there is a discrepancy between anticipated and actual consequences of HIV status disclosure reported in a study conducted in Tanzania (Falnes et al., 2011) where men expressed a generally supportive attitude to a hypothetical HIV-infected spouse, contradicting the pessimistic view that was held among some of the women about disclosure. Nevertheless, the views expressed by the fathers could reflect a socially desirable reaction to the hypothetical question. Although men, who said that they would

not have trusted their spouses in this hypothetical situation, admitted that they would have been likely to blame and even divorce their partners (Falnes et al., 2011).

Therefore, negative outcomes of HIV status disclosure are likely to exist and need to be acknowledged. In addition, health care providers should consider the varying social positions in preparing and supporting women for disclosure (Rujumba et al., 2012).

2.3.6 Information/knowledge barriers

Awareness and knowledge about eMTCT programmes is important for men's involvement; it is clear that much remains to be done to increase knowledge among men about HIV testing and counselling because they depend on second hand information from their wives which tends to be inadequate most of the time (WHO, 2012). In general, men were unaware of antenatal voluntary counselling and testing services, a fact highlighted by 13% of the studies (Aarnio et al., 2009; Nkuoh et al., 2010). This barrier was quite pertinent as in the settings where it was described; these men were willing and motivated to participate in ANC /eMTCT but did not just know where to go for testing. In Tanzania, men had limited knowledge on eMTCT/ANC (Theuring et al., 2009). They neither understood what it meant nor of what importance it was. Peacock et al. (2009) suggested that men want to be supportive to their pregnant partners, but often did not know how or seemed to have vague concepts of paternal responsibility. There seems to be a gap in knowledge related to discordance. Some men question the need for testing if their partners had already been tested, believing that they would have the same test results as their partners (Falnes et al., 2011). Recent data from a large-scale survey done in Burkina Faso, Cameroon, Ghana, Kenya and the United Republic of Tanzania reveal that sero-discordancy is a serious reality indicating at least two thirds of couples in each country with at least one HIV-positive partner

who are HIV sero-discordant (Desgrees-du-Lou et al., 2008; Orne-Gliemann et al., 2008). Discordance is associated with anger and bitterness in the relationship, which challenges men's desire to support their wives and even to participate in services (Reece et al., 2010). In Eastern Uganda, men were well aware of media efforts to promote their involvement in testing, but they said that these media campaigns did a less effective job of explaining why men should be tested and what benefits they would derive from testing (Larsson et al., 2010). Despite the fact that men are motivated to participate in eMTCT, the lack of the particular information and benefit for their involvement is major limiting factor (Theuring et al., 2009). The male partner's low level of formal education may prevent men from understanding about HIV/AIDS.

Lack of motivation may cause the male partner to think that it is enough if the wife is taught about eMTCT issues, and it also results in reluctance to attend to the wife's demands to visit the antenatal clinic. Denial of HIV and indifference towards HIV issues are aspects indicating lack of motivation.

2.3.7 Relationship dynamics

The nature of relationships and their effect on MPI; Weaker relationships either because couples are not cohabiting together or do not share affection with each other, constitutes a barrier to male involvement (Aarnio et al., 2009). The nature and complexity of relationships between men and women has been identified as a barrier to MPI, as many couples may find themselves in less stable relationships where they are not married or cohabiting, and which may make MPI even less likely (Morfaw et al., 2013). Ugandan men who described their marriages as unstable and distrustful, were reluctant to attend couple counselling and testing by alluding to the conflict that

it may lead to in their marriages. These men were thus reluctant to attend antenatal services, as they were fearful of being tested (Larsson et al., 2010).

Cohabiting and marriage have been found to be associated with disclosure, indicating the importance of the nature of relationships as women who are in stable relationships appear to be more likely to disclose their HIV status and to receive support from their partners (Makin et al., 2008).

In a review of the determinants of MPI, it was found that factors associated with increased MPI included cohabiting with one's partner, while barriers to MPI included poor communication within couples (Ditekemena et al., 2012).

The importance of communication in improving MPI (Kalembo et al., 2012) has been highlighted in a study in Mpumalanga, where female participants discussed their feelings of helplessness to communicate with their partners (Villar-Loubet et al., 2013). These women perceived their partners as being uninvolved and uninterested in their antenatal care, while the men discussed their feelings of sadness and neglect after their partners had failed to involve those (Villar-Loubet et al., 2013). This again highlights the impact that the nature of relationships between men and women can have on MPI, as well as the need to increase communication within couples.

An unstable relationship with the 'typical' child being raised by their mother in a single-parent household is a barrier to MPI. Another concerning trend is that the proportion of children who have absent, living fathers is increasing (Holborn et al., 2011). While unstable relationships may lead to a lack of MPI, however, this may be perpetuated by women, who often do not inform their partners of antenatal care or eMTCT, or choose to not involve their partners in these activities, often from fear of their partner's reaction (Morfaw et al., 2013).

The majority of female participants believe that financial support is sufficient in terms of male support during pregnancy, and that most had never asked their partners to accompany them to antenatal visits, assuming that they would not want to do so (Nkuoh et al., 2010).

Fidelity within a relationship was also identified as potential barrier in that men who were faithful to their spouses were less likely to be involved in VCT and ANC (Theuring et al., 2009; Nkuoh et al., 2010), probably based on the general belief their own fidelity meant that their spouses were equally faithful and uninfected. Having many sex partners is a barrier among male partners in three ways; having extra marital partners, being polygamous and working as a prostitute: Taking into account the nature of relationships between men and women means acknowledging this reality, and then tailoring health services to fit these circumstances (Morfaw et al., 2013). There are many benefits to health of families when men critically examine norms of power, acquire new knowledge therefore, we must rally men to the cause, in policy circles and communities, and demonstrate the benefits of gender equality, shared decision-making, partnership and non-violence.

2.3.8 Perceptions and experiences Men in eMTCT/ANC

Perception is concerned with people's beliefs that they can exert control over their own motivation, thought processes, emotional states and patterns of behaviour. However, negative perceptions whether the efficacy of ART and its effects could act as barriers to adherence (Wasti et al., 2012). In Tanzania there was an overall positive perception of men regarding the attendance of their partners at ANC, but passive attitude towards their own involvement, attributed mostly to external factors (Vermeulen et al., 2016); similar to other studies there is a contradiction between men's positive attitudes and their low participation (Theuring et al., 2009;

Kwambai et al., 2013; Vermeulen et al., 2016). In Malawi and Nigeria male participants expressed an opinion that it was important for couples to become tested for HIV together with the intention of protecting their unborn child from HIV infection (Kang'oma et al., 2011). Adelekan et al. (2014) in a study that investigated married men perception and barriers to male involvement, men were asked if they think it is good to accompany their wife to ANC. The majority of the participants agreed that it is good and believed they needed to accompany their wives to ANC because she is carrying their pregnancy contrary to their perception only a few participants reported that they had ever accompanied their wife to ANC.

As suggested in literature, there seems to be a distinction between the male perception about their involvement and their actual involvement (Nkuoh et al., 2013; Adelekan et al., 2014). Perhaps the low participation of male in eMTCT/ANC is that most men describe pregnancy as something very common and not a particularly special moment in life. From their perspective the result of pregnancy was most important, with focus on delivery-related issues and less on the antenatal period (Vermeulen et al., 2016). The idea that ANC is a space for women has also been perpetrated by health care providers, a study in Ghana reported men often being sent from the delivery room by health care providers (Dumbaugh et al., 2014). There is a perception that men are less able than women to assume a caretaking role and women know more about birth and childrearing by nature of their gender which impedes male involvement in reproductive health issues (Dumbaugh et al., 2014). Generally men attitude towards their involvement is positive; men embrace the importance of their involvement (Montgomery et al., 2006). Some already go against the deeply entrenched cultural norms to carry out healthy practices such as exclusive breastfeeding, institutional delivery and joint decision making with their partners; nonetheless they do not always translate to behaviour change (Dumbaugh et al., 2014).

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

This chapter focused on the research process and presents an overview of the methods used in the study. The purpose of this chapter was to provide information on how the study would be carried out. According to Van der Walt et al. (2012), the research methodology section informs the reader of what the researcher did to solve the research problem or to answer the principal research question. Therefore, this chapter categorically presented the study design, study area, study population, selection criteria, sample size determination, sampling technique and procedure, data collection methods and tools, study variables, quality control measures, data management and data analysis, ethical consideration, study limitations and dissemination of results.

3.1 Research Design

The research applied a qualitative study method cross sectional in nature. A qualitative research method was employed because of its inductive nature which allowed more flexibility in investigating the study phenomenon. It provided grounds to understand the diversity of the issue being studied, generated in-depth information and assessed how the issue related to the broader social context with the aim of describing and understanding the phenomena from the informants' perspectives. It allowed for the investigation of males' involvement in their spouses' lifelong ART and sought to explore the experiences and, perceptions of male partners involved in their partner's uptake, adherence and retention into eMTCT services (enrolled in lifelong ART).

3.2 Area of study

The study was conducted at health facilities providing lifelong ART in Soroti district. The health facilities were purposively selected. Soroti is one of the districts in the Eastern region of Uganda, bordered by Katakwi in the Northeast, Amuria in the North, Kaberamaido in the West, Serere in the South, and Kumi District in the South East. It is predominantly occupied by the Iteso and Kumam (Soroti statistical abstract 2015). It has an estimated population of 296,833 of which 144,976 are male and 151,857 female (UBOS 2014). The HIV prevalence in the district is 5.3% with twenty HIV/AIDS Counselling and Testing (HCT) Sites (Soroti District Statistical Abstract, 2015; Health Management Information System (HMIS) and DDHS Office, 2015

Secondly, Soroti just like many societies, is a patriarchal society that holds on to the values and norms of women being submissive to their partners i.e., being respectable by not arguing with men and kneeling down when speaking to her husband, less knowledgeable and passive especially on sexual issues; a good woman should be respectful and this can be manifested in her being sexually available to her partner, allowing him sexual decision making authority giving men power over women (Datta et al., 2012) which impedes male involvement in reproductive health services therefore, with such grounded culturally norms the sample population will give me the desired outcome.

3.3 Study Population

In this study, the primary sample population of interest was males in an intimate relationship with an HIV positive pregnant or lactating spouse and actively involved in ANC/eMTCT, regardless of their HIV sero-status with respect to their social background and the factors which affect the nature of their involvement in their pregnant partners' lives who are enrolled on lifelong ART/Option B+.

3.4 Selection criteria

3.4.1 Inclusion criteria

- Male partners aged 18 years and older in an intimate relationship with pregnant and lactating woman enrolled in ANC/eMTCT.
- Males aged 18 years residing in the Soroti District with pregnant and lactating woman enrolled on eMTCT (lifelong ART).
- Males aged 18 years and older in an intimate relationship with pregnant and lactating woman enrolled on eMTCT (lifelong ART) residing in the Soroti District and has consented to participate in the study.

3.4.2 Exclusion criteria

- Male partners whose female partners were pregnant/lactating enrolled in ANC/eMTCT, but are non-residents of the Soroti District
- Male partners whose female partners are pregnant but are outside Soroti District in a period of one month.
- Male partners whose spouses' not enrolled on eMTCT/ANC.

3.5 Sample size determination

In this qualitative study, participants were purposively selected. Therefore, purposive samples are form of non-probability sampling hence the sample size relied on the concept of saturation or the point at which no new themes or information was observed in the data.

Based on the evidences, Guest, Bunce and Arwen (2006) propose that saturation often occur around 12 participants in homogenous groups. This nearly agreed with study by Latham (2013)

that had saturation at 11 participants. While Bertaux (1981, P.64) proposed fifteen (15) being the smallest acceptable sample size for all qualitative research. In addition, Crouch & MCkenzie (2006) propose less than 20 participants in a qualitative study.

Therefore based on the above proposed samples as a result of knowledge or information saturation during interviews, this study used a sample size of 13 participants for the semi-structured In-depth Interview among the male partners involved in their spouses' lifelong ART in health facilities in Soroti district.

3.6 Sampling technique and procedure

The researcher used purposive sampling for the sample population (male partners). The researcher also worked closely with TASO Office and health facilities in Soroti that offer eMTCT to ensure their support of the study and access to the study populations. The male partners were accessed by proxy through their spouses attending antenatal and maternal clinics and they were double checked in the register. Male partners who are actively involved as per register records, but did not turn up at the facility were contacted for their consent to participate. The researcher proposed to conduct in-depth interviews with male partners of positive HIV pregnant women who turned up at the eMTCT/antenatal clinic using In-depth Interview Guide.

Each participant was asked to read/read to and sign an informed consent form prior to the interview.

3.7 Data collection methods and tools

3.7.1 Data collection methods

The data in the study was collected using In-depth Interview (IDI) methods. Pre-prepared interview guides were used to gather the data and were structured in a flexible fashion to allow the participants to take the discussion in any direction but at the same time not losing track of the original topic of discussion. The in-depth interview was executed in an informal and conversational style at the health facility during ANC/eMTCT or a convenient place of choice by the participant. The data collection took about 45 minutes to 1 hour for each participant.

3.7.2 Data collection tools

The study used a researcher administered semi-structured In-depth Interview guide that were both closed for the demographic information and open ended to capture the qualitative aspects in regards to the experiences that roots from individual, family, community and institutional levels during engagement in spouses' lifelong ART.

At the beginning of the data collection, the research assistants ensured that very good rapport was built with the male participants in order to allow free flow of information. The purpose of the study was explained to each participant in order to confirm their acceptance and gain their informed consent. After obtaining consent from participants, interviews were audio recorded and field notes taken during each interview to supplement the transcripts.

The length of interview was also depending on the individual's comprehension of the questions as well as the direction of the participants responses. For the IDI, some questions were

considered adequately answered if saturation of information was reached on particular questions based on the earlier gathered information.

3.8 Quality Control Methods

In order to guarantee the quality of data collection, the study recruited two experienced research assistants knowledgeable about HIV/AIDS issues. The two underwent thorough training by the researcher for two days, day one was mainly to understand the purpose of the study as well as key parts of the methodology, and then the second day was focused on all the contents in the data collection tools. During the administration of the semi-structured interview, the research assistants were ensured to adhere to the standard data collection protocols. This involved consistent checking of the already collected data for completeness and regularity.

The tool was translated from English to Ateso and Kuman. The translated version of the tools was then given to another person to translate back to English to ascertain whether the meanings of the questions were maintained.

The audio recordings was transcribed verbatim and translated from vernacular language to English.

In each data collection stage, the data collected through In-depth Interview guide was checked for completeness before proceeding to the next participant and coded to prevent any errors during data entry.

3.9 Data Management and Processing

The data collected by audio recording and written notes was compared for completeness and relevance before merging them.

The verbatim from the participants was transcribed and compared with the written notes in order to incorporate whatever was missed by either method. The data recorded in the local language was translated into English.

The transcriptions were securely stored, and access to both will be based on the need of those involved in the research in order to ensure confidentiality.

3.10 Data Analysis

The numerical data from the demographic characteristics of the study participants is presented into charts, tables with their frequency counts and their percentages.

The transcripts were read repeatedly and thereafter exported to ATLAS Ti trial version for thematic coding and then content analysis was performed according to the respective study objectives. Similar categories were grouped into themes and subthemes which are presented as results. The results contain direct quotes from participants and the narrations are reported as were spoken by participants without editing the grammar to avoid losing meaning.

3.11 Ethical considerations

Approval letter of the study was obtained from Uganda Martyrs University's Ethical Review Board through the supervisor.

Ethical clearance thereafter was obtained from the Ethical Review Committee of The Aids Support Organisation (TASO).

A copy of university approval letter and ethical clearance forms were submitted to the District Health Office for permission and TASO Soroti Service Centre respectively to allow the researcher proceed with seeking consent and data collection. In addition, for all the purposively selected health facilities permission was sought from the health facility in-charges to give access

to the participants. The study participants were also briefed on their freedom to discontinue at any point they wished. The researcher ensured that the sampled participants are provided with information regarding the study background and objectives as well as benefits of participation such as to contribute to successful completion of the degree and for learning purposes. Thereafter, consent was obtained from each male partner selected before administration of the interview guide. For male partners who consented to participate in the study, further assurance was ensued of their confidentiality and privacy since their names would not be recorded anywhere but in case they felt uncomfortable an explanation on why they were selected for their views, opinions and experiences was given.

The consent forms of the study participants were filed and will be kept for about six months at the respective health facilities before disposal.

3.12 Limitations of the study

This study had limitations in relation to its scope. The participants were male partners and lived in rural areas in Soroti. Therefore, the results may not be generalizable to the urban parts of the population.

The researcher encountered the challenge in tracing the male partners that were reported involved in their spouses' lifelong ART since the ANC/eMTCT were spread apart and the researcher had to follow them up to their homes. The distances to the participant's homes from the health facility were quiet a long and the researcher had to meet all the transportation costs to reach to the respondent's home.

3.13 Dissemination of Results

The study report was submitted to faculty of Health Sciences of Uganda Martyrs University. It is envisaged that the book will be availed for other students to use. The final copy of the book will be submitted to the Office of District Health Officer of Soroti district and a copy submitted to TASO as well.

CHAPTER FOUR: RESULTS

4.0. Introduction

This chapter presents results of in-depth interview among 13 male partners involved in their partners' lifelong ART in Soroti district. The data was collected in May 2018 on the experiences of male partners regarding their role and involvement in their partner's lifelong ART, family and peer perceptions, roles and responsibilities, experiences resulting from community perceptions, roles and responsibilities and presence of institutional support approaches on male involvement. The results are presented according to the main themes and sub-themes.

4.1. Socio-demographic Characteristics of Participants

Table 1: Socio-demographic characteristics

Partic-ipant	Age	Marital Status	Education	Religion	Occupation	Date of data collection	Location
1.	41	Married	P.7	Catholic	Peasant	18.05.'18	Pamba
2.	36	Married	P.7	Catholic	Builder & peasant	19.05.'18	Oyomai
3.	32	Married	P.6	Anglican	Peasant	19.05.'18	Osudo
4.	40	Married	P.2	Catholic	Bicycle repairer/peasant	19.05.'18	Owolo
5.	32	Married	P.7	Catholic	Peasant/ Business (Shop keeper)	21.05.'18	Oregia
6.	26	Married	P.1	Anglican	Peasant	22.05.'18	Onyerai
7.	35	Married	P.3	Catholic	Peasant	23.05.'18	Mugana
8.	29	Married	S.6	Catholic	Peasant	23.05.'18	Aloet Akum B
9.	39	Married	P.7	Anglican	Carpenter	23.05.'18	Ogoloi
10.	36	Married	S.1	Anglican	Painter	24.05.'18	Onyorai
11.	25	Married	Tertiary	Pentecost	Mechanic	24.05.'18	Amen B
12.	43	Married	P.7	Anglican	Peasant	25.05.'18	Ogoloi
13.	48	Married	S.2	Anglican	Soldier	25.05.'18	Abia

Table 2: Distribution of Socio-demographics by Percentage

Variables	Frequency (n)	Percentage
Age of participants		
25-29	3	23%
30-34	2	15%
35-39	4	31%
40-44	3	23%
45-49	1	8%
Marital Status	13	100%
Education level		
Primary	9	69%
Secondary	3	23%
Tertiary	1	8%
Occupation		
Peasant	6	46%
Self-employed (Mechanic, painter, business)	6	46%
Civil servant (Soldier)	1	8%
Religion of participants		
Catholic	8	61.5%
Anglican	4	30.8%
Pentecostal	1	7.7%
Tribe of participants		
Itesots	10	77%
Kumam	3	23%

The researcher sought the socio-demographic information from the participants as a way of understanding the characteristics of the study participants and to affirm if they met the study criteria for generalization purposes. Therefore all the demographic information had no significance to the study outcome.

4.2. Experiences of male partner regarding their role and involvement in their partner's lifelong ART

4.2.1 Healthcare provider initiatives

Healthcare provider initiative can change the perception of male partners about their involvement and motivate them to continue i.e fast services for women with their male partners, counselling, friendliness and the welcoming attitude of the health workers, sharing of testimonies and family support groups have motivated men to participate. Therefore, most of the participants felt good about becoming involved in their wives' lifelong ART, the first time they visited the health facility. Availability of IEC materials about male involvement materials posted on information charts in several areas of the health facilities that supported their involvement in reproductive health. Generally, men reported positive experiences once they attended the clinic. This is however, was influenced by the information received during the visits at the ANC/eMTCT clinics.

> "It was exciting escorting my partner to the clinic amidst all the criticism……good enough we were both aware of our status and at the hospital where we were received. it was a good experience ……were given first priority, [a participant from Pamba village", Western Division, Soroti, 18th .05.2018].

Another participant stated;

> "".....Whenever we would come to the facility we would also be given special attention and served first as a couple so that encouraged me to continue coming", [Amen B, Soroti, 24th .05.2018]

Some men however, reported having worries in the beginning, but developed confidence

> "I had to accept the situation as I knew I had already acquired the virus and there was nothing much I could change. At first it was hurting to learn that I was positive but after I took heart and accepted. The very first time it was hard for me but after I accepted, we continued going together", [Ogoloi, Arapai, Soroti, 25th .05.2018].

They were able to overcome such fears through the counselling offered at the facility;

This means couple counselling in ANC/eMTCT has the potential to provide assurance to the male partners that their participation in ANC/eMTCT is important especially, when the importance of their involvement is explained to them during service delivery. When the health facilities are welcoming and non-discriminatory male partners will feel welcome. The attitude of the health workers and other initiatives as stated by the participants greatly facilitates and attracts male partners to become involved in maternal and child health.

4.2.2. Experience of having a negative child and providing protection for his unborn child

Good experience in this study was associated with having an HIV negative baby and a healthy and happy partner. Most of the participants mentioned that they were motivated by the negative outcome of HIV status of the unborn baby when their spouses keep attending ANC/eMTCT clinics as well as taking ARVs. Therefore, their concern was to prevent mother to child transmission of HIV. Some of the participants said;

> ".....we could give birth to a negative child if I continuously ensured that my wife took her medication and attended ANC/eMTCT clinics both at the main hospital and TASO. After one year the child was tested negative and this motivated me to continuously bring her to the facility", [Pamba village, Western Division, Soroti, 18th .05.2018].

Another participant said;

> "I was encouraged by the health workers to keep bringing her to the health facility so we could have a negative baby. When the baby was born it was negative. I was then motivated to come with my wife to the health facility to monitor our child's health", [Owolo, Kamuda S/C, Soroti, 19th .05.2018]

The outcome of an HIV negative baby is one of the main reasons that encourage couples to have subsequent attendance of ANC/eMTCT. Male partners tend to become more involved if they understand the importance of their involvement in eMTCT/ANC, their responsibility in their spouses' long life adherence and what it means to the unborn baby.

Some participants stated the desire to learn more about their health status. Health workers should ensure that male partners actively participate during eMTCT/ANC, inform them about major decisions taken regarding their partners health and their own. Positive attitude towards seeking health services in male partners can transform into healthy living in the family since men are the main decision makers and gate keepers to women's health hence their willingfull participation can be translated into good health.

> .....desire to learn more and understand the counselling or health education from the hospital. You know when you go to the hospital with your spouse you are able to learn things that you should not have known if she went alone. The other motivating factor is I wanted to make sure she is safe anything can happen if she is alone and again from the first visit the health workers encouraged us to go to the health facility together; test together and continue with the counselling to live positive lives [Aloet, Arapai, Soroti, 23rd .05.2018]

4.2.3. An act of love and taking responsibility

The general consensus was that a man should become involved in his partner's lifelong ART, and not only consider his social life because supporting their partners is their duty and responsibility as husbands;. They were also able to balance their time between accompanying their spouses for ANC/eMTCT and their usual work or businesses.

> "It has not interfered with my social life in any way. It is my duty and responsibility to take care of my family and therefore family comes first and then later in the day I join friends if there is need" [Mugana, Arapai, Soroti, 23rd .05.2018]

The fact that a male partner is the head of the household, he is expected to take up the role of taking care of the family and ensuring that his partner is happy as a sign of love. Participants stated that accompanying their wives would help them to show love and keep the woman happy, encourage and support the woman during the stress and discomfort of pregnancy.

The participants said;

> "It has not interfered with my social life in any way. It is my duty and responsibility to take care of my wife. I love my wife", [Aloet, Arapai, Soroti, 23rd .05.2018].

Another participant said;

> "It has not interfered with my social life in any way; I want to ensure that she continues taking medication/ARVs so that she remains a live to take care of our children. Health is very paramount to me so anything that promotes health I would associate with it freely", [Onyorai, Arapai, Soroti, 24th .05.2018]

Another participant said;

> "It has not greatly interfered with my life since the appointment days are spread. I normally reserve a few hours to go with my wife to the health facility and later come back after I have dropped her home to continue with my assignments/businesses", [Owolo, Kamuda S/C, Soroti, 19th .05.2018]

Another participant said;

> "It has not interfered with my social life. I have tried to make a balance between my social life and family time. I make sure I divide my time equally. But my wife is priority and my main motive is to ensure we have a negative child/baby" Oyomai village, Kamuda S/C, Soroti, 19th .05.2018]

Despite most of the participants' involvement, not having a negative influence in their social life, two participants said it somehow interfered with their social life. The first participant said on some occasions he lacked money for transport hence had to borrow to ensure they travel to attend the ANC/eMTCT and the other said he had to always ask for permission during appointment dates.

> "I can say there was some kind of interference because when there was no money it would challenge me to escort her for ANC/eMTCT and yet at the same time I was the bread winner…….sometimes I would have to borrow money so I could be able to attend the ANC/eMTCT", [Pamba village, Western Division, Soroti, 18th .05.2018]

Another participant said;

> "It has interfered with mainly my work especially in way because I have to ask for permission on the appointment dates", [Abia, Gweri, Soroti, 25th .05.2018]

4.2.4. Clear roles for male partners during ANC/eMTCT sessions

When participants were asked to state their roles during antenatal visits and in ensuring their partner continue to attend ANC/eMTCT, most of the participants said their main roles were accompanying their spouses on the appointment dates and participating in the counselling sessions on medication, feeding, breast feeding, condom use and being faithful to each other and sharing of experiences. If male partners do not have a role at the eMTCT/ANC clinics then they will not be involved. The health workers therefore have to ensure that the men are engaged too in the activities during ANCs and not left idle to sit outside as they wait for their partners.

Some of the participants interviewed said;

> "During antenatal clinics we enter together I am not left to sit out. We are counselled together on how to take medication, feeding especially during the time she was pregnant. We have attended all the antenatal sessions together" 1 [Amen B, Soroti, 24th.05.2018]

> "I support in reminding her of the appointment dates, we also normally have counselling together and participate in the family support activities", [Ogoloi, Arabaka, Soroti, 23rd .05.2018]

> "We normally enter together with my partner and counselling is done as a couple and then also there is health education. We are put together as people who have appointments that day and we share experiences and testimonies", [Aloet, Arapai, Soroti, 23rd .05.2018]

Several studies on male partner involvement have found that men who accompany their partners to antenatal clinics are forced to wait outside (Byamugisha et al., 2010; Larsson et al., 2010; Koo et al., 2013; Kwambai et al., 2013). If males are actively engaged during the ANC sessions and not left outside to wait for their partners then they will be involved this is evident in this study where male partners felt welcome because they were engaged and invited in the ANC clinics as a couple. It is through this session that the couple can learn from each other. Some of the participants also remind their spouses about the appointment dates for ANC/eMTCT and others help in carrying the baby during the visits. As stated by some of the participants;

"I keep reminding her of the appointments at the health facility. We normally have health education sessions at the facility. The health workers come up with the topic; and ask us (men and women) to share our ideas and experiences/testimonies....." [Mugana, Arapai, Soroti, 23rd.05.2018]

"My experience has mainly been to support with transport, reminding her to take the medication and also reminding her of the appointment dates. If I am not available I give her money for transportation", [Oyomai village, Kamuda S/C, Soroti, 19th .05.2018]

".....I also support in carrying the baby during immunization or any illness or even the usual checkup", [Onyerai, Asuret, Soroti, 22nd .05.2018]

4.2.5. Partner shared responsibility in ensuring adherence

Sharing of responsibilities goes beyond only accompanying their partner to antenatal clinics, but also includes gender roles. The constructive involvement and support in the elimination of paediatric HIV and the promotion of women's and family health is a shared responsibility. It is important to note that health providers offer ANC/eMTCT services on specific appointment dates and there is likelihood of one forgetting the date for the next visit especially where pregnancy comes with other complications. Therefore, reminding a partner about the time for taking medication and about the appointment is very significant in ensuring uptake, adherence and retention in ART as a responsibility of both partners. Most of the males interviewed reported reminding their spouses about the time for medication and ensuring food is available for taking the medication. In addition, some of them ensure they go and pick the drugs together; one participant supported in picking the drugs and water for the spouse to take.

".....my wife is very forgetful and I always keep reminding her of the time to take medication. As the man of the home I always request her for the appointment book and I check the book for the appointment dates so I can remind her on time", [Oyomai village, Kamuda S/C, Soroti, 19th.05.2018]

Male involvement is an important aspect in ensuring adherence to ART while at home so that the intended outcome of the therapy is achieved. It is therefore vital to ensure men acquire adequate

knowledge on health issues including ANC/eMTCT. Men as supportive partners influence the family's social environment making it conducive to seeking treatment, improving uptake and being adherent to medication (WHO, 2010; Kalembo et al., 2012; Van den Berg et al., 2015).

The male participants did not stop at supporting their partners at the health facilities, but also in farm work, fetching water, and at times in cooking food. Some participants said they support in taking care of the children and others reported sharing responsibilities on various domestic activities. This reduces the burden of carrying a pregnancy and at the same time actively participating in the house chores.

> "I support her in fetching water, cooking, washing dishes, and farming. I support her in all activities. Sometimes I even tell her not go to the farm even if she is not sick. I do not want my wife to grow weary because of farming" [Aloet, Arapai, Soroti, 23rd .05.2018]

It is important for the male partners to support their spouses in adherence to lifelong ART and show them affection. This creates mutual support and understanding among the couples which promotes positive living as well as adherence to ANC/eMTCT.

A participant said;

> "I do all home activities, cooking, farming, and fetching water, name it. We have division of labour here at home if she is busy doing something and I am free I support in other activities", [Ogoloi, Arapai, Soroti, 25th .05.2018]

Another participant said;

> "I support my wife mainly with the farming but if my heart feels like and I see that she is weak; I support her to go to the borehole to fetch water and at times cooking if she is really weak" [Owolo, Kamuda S/C, Soroti, 19th .05.2018].

It is necessary for couples to mutually support each other so that they do not leave the burden of carrying a pregnancy or taking care of a child to one partner however as a shared responsibility. Male partners involved in their spouses' lifelong ART appear to be significantly supporting their

spouses in home chores and this has translated into positive living. Male participants reported that their perspective on gender roles as treating their female partners as household equals and sharing chores such as cooking, cleaning, and childcare.

4.2.6. Perceived barriers to male involvement

Participants were asked to mention the challenges they have experienced in supporting their partners to attend and consistently take their medication.

More than half of the participants reported that they did not have challenges that hindered them from supporting their partners in ensuring the drugs are available, have food, and reminded them to take medications on time. This finding was supported by the following excerpts:

> "I have no challenges supporting my partner in ensuring she consistently takes her medication"[Ogoloi, Arabaka, Soroti, 23rd .05.2018]

> "I have not experienced any challenge yet. It has been a good experience because the most important aspect is ensuring that she eats well to be able to take medication well", [Oregia, Asuret, Soroti, 21st.05.2018]

Majority of the participants in this study were unemployed or self-employed and therefore did not experience any challenge in supporting their spouse because they could easily allocate their time and had no fear of losing their jobs as compared to men who are employed as one participant stated how he had to ask for permission from work to be able to attend to his health. This is a challenge to involvement in case permission is not granted and also if the appointment dates are not on the same day.

> “I have to ask for permission on the appointment dates", [Abia, Gweri, Soroti, 25th .05.2018].

However, some participants cited long distances to health facility and transport means as a challenge to their involvement and drug stock outs. The distance to the health facility and long waiting time at the facility are barriers to male involvement

> "The time spent at the facility. We spend a lot of time at the health facility on a clinic day or if we go for health services that is the only challenge. If you go in the morning you comeback like in the evening", [Oregia, Asuret, Soroti, 21.05.2018]

The findings in the study do not contradict with most of the studies that found distance and the cost of transport as a barrier to male involvement (Byamugisha et al., 2010b; Larsson et al, 2010; Larsson et al., 2010; Reece et al., 2010). According to Ditekemena et al. (2011), long waiting times at the antenatal clinic are identified as a potential reason for limited male participation in eMTCT/ANC. For male partner involvement to take place short distances to the health facility are necessary; because men are the bread winners in their families this also impedes their involvement; time spent at the facility would be used productively.This finding was supported by the following quotes:

> "Lack of finances could be the only challenge because as I accompany my wife, I have to provide for the family as well because I am the bread winner. The other challenge is having the balanced diet when swallowing her medication", [Pamba village, Western Division, Soroti, 18th.05.2018]

Another participant said;

> "The main challenge I would say is transport to the facility. The distance to the facility is a bit longer from this village and we have to borrow money at times to be able to come to the facility", [Ogoloi, Arapai, Soroti, 25th.05.2018].

Accessibility to the health facility is one of the facilitators in seeking health services by the couples on ART. The couples who live far from the health facility maybe discouraged to attend as a couple. As a way of saving money that would be used for transport, the man may decide to send only the wife to the facility so they could save that money for food.

The other challenge was related to discordancy and blame for being responsible for infecting the other partner hence temporary refusal to take medication due to anger. Anger and blaming one another for the infection may translate into domestic violence and hence broken families.

> "Sometimes when we have disagreements the issues of being discordant come up and we go back to zero and we have to come for counselling to be able to be happy. Also reminding her to take medication becomes a problem if you are not in talking terms", [Onyorai, Arapai, Soroti, 24th.05.2018].

Another participant states

> "We have had set backs; times when she blames me and does not wish to take her medication but I keep encouraging her for the sake of our baby and she listens"[Amen B, Soroti, 24th.05.2018]

4.3. Experiences of male partners on their spouses' lifelong ART arising due to family, peers and community perceptions roles and responsibilities

4.3.1 Family, peers and community perception, roles and responsibilities

Nearly half of the participants mentioned that their families and peers are supportive, encouraging and positive about the support they provide to their spouses. World Health Organisation (2008) recognises that individual behaviour is modelled by wider environment in which they live, meaning some of the decisions and choices especially on health are influenced by family and peers, local beliefs and values, cultural norms and practices and political and economic circumstances. In the case of male involvement, it has been greatly influenced by cultural and gender norms. Therefore, the by-in support of the family, peers is paramount to male involvement and couple adherence to treatment regimens some of the excerpts from the participants.

> "My family members do not have any issues with me supporting or accompanying my partner to the health facility to take ANC or escorting her to take the child for immunization. The family members are positive about it", [Osudo, Kamuda S/C, Soroti, 19th.05.2018]

Another participant said;

> "Some of my peers have encouraged me to support my wife because she is pregnant but others have been negative however I try to avoid such people who negatively impact me because I want my child to be negative.....The time I was away I called my friend to give my wife

> transport to go to the facility because her appointment was due. He was supportive, gave her the money and she was able to come to the facility", [Oyomai village, Kamuda S/C, Soroti, 19th.05.2018]

Family support is very vital in ensuring couple uptake, adherence and retention on lifelong ART. The majority of participants had support from their families and this encouraged their involvement. However, not all families can be supportive; one of the participants was alleged to have been bewitched by the wife because of the support he offered the partner including home chores meant to be performed by women. Another participant's family accused the partner for having infected their son.

> "I have been labelled as stupid by my family members, peers. I have also been told that I was bewitched by my wives how do I support them with house chores and yet that is a woman's area", [Pamba village, Western Division, Soroti, 18th.05.2018]

Another participant said;

> "Their perception was negative for some time because they were pointing accusing figures at my wife. They kept saying that she has killed their son she brought the virus and why would I stick with her but I assured her them that I love my wife and somehow they came to terms with it", [Ogoloi, Arapai, Soroti, 25th.05.2018]

Gendered divisions of labour place both genders in particular physical spaces: men at work, women at home. Although, some women farm or trade they are still responsible for completing household duties and the household is perceived as their main domain. The majority of the participants reported that they have ignored such gendered divisions for the sake of their spouses' welfare, since they were the ones who married them and not the community. They are able to overcome some of the community members' perception through counselling, church teachings, encouragement from friends and desire for HIV negative child. Participants' the excerpts below;

> "I ignore most of those cultural beliefs and practices. I have manoeuvred because of the interest I have in my partners' welfare and also because I love her. So I find no problem with accompanying her, supporting her with the home chores. The other thing how I have

> manoeuvred is because I have support from friends who also support their partners in the same way", [Mugana, Arapai, Soroti, 23rd.05.2018]

Another participant said

> "These cultural or negative perceptions can be addressed through understanding one another. I love my wife and understanding of her situation as a breast feeding mother and cannot move to the health facility alone. If you understand your wife's situation you can be able to ignore such perceptions", [Aloet, Arapai, Soroti, 23rd.05.2018]

Some of the participants did not disclose their HIV status to their families and peers and this hampered their involvement. Couples that disclose their status to family members and peers normally do not express discrimination and stigma from family members compared to those that have not. Disclosure relieves couples from emotional stress and enables them to receive psychological and material support from peers and immediate family as opposed to those who do not. Obtaining support and encouragement from family members may require disclosure as stated by one participant;

> "I have not disclosed to my family members yet and they live a bit far from here", [Oregia, Asuret, Soroti, 21st.05.2018].

Another participant said;

> "I have not disclosed to my family members so I do not know what their perceptions would be", [Aloet, Arapai, Soroti, 23rd.05.2018].

4.3.2. Psychological and material support as a facilitator

The participants whose HIV status was known to their immediate family members mentioned varied contributions that ranged from giving money, provision of food. Some of the immediate family members contributed by encouraging the partners to continue attending the clinics together and taking their medications. Other family members helped by providing bicycles to transport the couples to the health facility and one participant said his immediate family

members helped his partner in cooking. However, very few of the participants reported they had no contribution from their immediate family members.

Some of the participants said;

> "My family has been supportive especially my father he at times gives me money in times of lack or when my wife is sick. My brother, sister-in law and my mother normally accompany me and my wife to the facility especially in time of labour", [Oyomai village, Kamuda S/C, Soroti, 19th.05.2018]

Disclosure of HIV status by a couple to their family is important because they are likely to be supported by most of the family members. The support received has the potential to motivate the male partners or couples to attend ANC/eMTCT and have a positive life.

> "My family members keep encouraging us to take ART and also accompany my wife to the health facility because they see a great improvement in our lives as compared to before", [Onyerai, Asuret, Soroti, 22nd.05.2018]

The observable outcome as a result of adherence to ART is very important to couples and family members and this further builds confidence among the male partners and the families. This in turn enables the family members to continue providing support to the couples as stated by one respondent.

> "My immediate family members normally check in the appointment book and they keep reminding us to go to the health facility on the appointment date. Most times we use a bicycle to come to the health facility so if they have some little money and we lack they provide", [Onyorai, Arapai, Soroti, 24th.05.2018]

Another participant said;

> "My immediate family members mainly support us with food. If the harvest is good they send us some food and that has ensured that we feed well even as we take medication", [Mugana, Arapai, Soroti, 23rd.05.2018]

In order to foster adherence access to a balanced diet/ food impacts greatly on the HIV positive pregnant mother therefore one of the ways a family can support a positive couple is through providing food in time of lack. Most participants recognised provision of food by immediate

family members as contributions and support from the immediate family. Only participants who had not disclosed to the immediate family had challenges with receiving support from the family.

> "Most of my peers are very negative. They tell me I am doing something that a real man should not be doing.....Some friends help me with the bicycle also if I have failed to get from the family members but it is on rare occasions. Even supporting me with their bicycle they give but with a hardened heart", [Osudo, Kamuda S/C, Soroti, 19th.05.2018]

Prevailing attitudes and practices in the communities that men live in may hinder their involvement if men are not resistant to such negative practices then they may fail to be involved. In addition, some of them are still driven by their cultural beliefs and practices hence perceive one's support to his spouse a negative practice. One participant was negatively influenced by the community, but persistently become involved in supporting his spouse;

> "HIV did not come to affect animals but human beings so I do not care even if I am told that I am HIV positive". My peers have not supported me with anything even in terms of thoughts, money instead they are negative.....I have stood my grounds and continued to support my wife"[Owolo, Kamuda S/C, Soroti, 19th.05.2018]

4.3.3. Addressing negative perceptions and gender norms to involve more men

The participants were asked how they think negative perceptions and gender norms can be addressed to involve more men involved.

The majority of the males reported that in order to involve more males in their spouses' lifelong ART, there is need to conduct male targeted community based sensitization on the importance of their involvement and risks of not being involved. Some also mentioned having male mentors and have shared testimonies at the health facility and community levels as well as through radios. In addition, few of them also mentioned peer to peer education between male partners involved and those who are not so as to change their perceptions and have community health workers

provide encouragement, advice and health education to men during health campaigns from the participants excerpts below;

> "Continuous sensitization on the importance of male involvement at the health facility or community because when a man goes with the wife they can both share knowledge got from counselling", [Aloet, Arapai, Soroti, 23rd.05.2018]

Another participant said;

> "If men could have mentors; when they emulate it would change their perception and also men continuously giving their testimonies and the good experiences they have had in supporting their spouses this can be in the health facilities, community gatherings or even radio", [Ogoloi, Arapai, Soroti, 25th.05.2018]

Continuous sensitisation has the effect of imparting adequate information for couples hence they can use it meaningfully in their life. It is therefore valuable when partners share the benefits of their involvement in their spouses' lifelong ART. It is important that negative perceptions that about male involvement in their partner's lifelong ART support should be rejected through such interventions. Interventions such as assigning male mentors to male partners can have a significant impact on male involvement especially if these mentors have experienced positive outcomes from their involvement and if they are influential persons in the society. The practice of sharing experiences can encourage other male partners to also disclose to peers and health worker and hence improve their involvement.

4.4. Experiences due to presence of eMTCT approach in the health facility/hospital and at time of need but were not available

4.4.1. Inclusion and friendliness of health workers

The participants were asked to share their experience on presence of eMTCT approach in the health facility/hospital and experience during that time. The attitude of health care workers and welcoming environment at the health facility promoted their involvement.

The Health facilities where male partners are received well and recognised for their involvement in their spouses' lifelong ART enable them develop positive attitude towards healthcare services utilisation. Health facility barriers have been reported to impede involvement due the negative attitudes of health workers and the undefined roles of men during antenatal visits.

> "The experience has been really great I did not ever think I could have a healthy child and we are also healthy especially my wife. Yes, there is a time I wanted septrine but it was not available so I was advised to buy from out" [Amen B, Soroti, 24th .05.2018]

4.4.1.1 Health education and counselling

The participants were asked to mention the activities the health facility that ensured their in their spouses' lifelong ART.

The majority of the participants reported that the health education and counselling sessions, sharing of experiences and testimonies. In addition they also mentioned the availability of free ARVs, having HIV negative baby, good reception and attitude of the healthcare providers, availability of family support groups, mentor mothers and special service for couples in some health facilities made them to become involved in supporting their spouses. Actively involving male partners at the ANC/eMTCT clinics is a motivating factor because then the men will not feel useless when they accompany their women for ANC/EMTCT. From this study it is as one of the facilitators to male involvement as reported by some of the participants;

> "The health education sessions and sharing of testimonies and experiences have enabled me to continue involving myself....." [Mugana, Arapai, Soroti, 23rd .05.2018]

Another participant said

> "The health education sessions and sharing of testimonies and experiences have enabled me to continue involving myself and the fact that my spouse is not cautious about important health

communications I have to accompany her so that I obtain the information on my own" [Ogoloi, Arabaka, Soroti, 23rd .05.2018]

Another participant said;

"The counselling services, availability of the ARVs and services that prevent the virus from being transmitted to the baby. Also the good reception of health workers has attracted me", [Onyorai, Arapai, Soroti, 24th .05.2018].

Another participant said;

"There is special service for women who come with their spouses or couples. The health education sessions and sharing of testimonies and experiences have enabled me to continue involving myself.....the counsellors/mentor mothers share their testimonies of how long they have lived with the virus and that is encouraging because the first time we were tested positive we wanted the world to swallow us but we were counselled", [Amen B, Soroti, 24th .05.2018]

Serving couples first at the health facility as a way of promoting male involvement has been reported to be effectively similarly to this study participants also stated the same as a facilitator for their involvement. Sharing of experiences, testimonies and participation in group activities can positively shape the behaviour of other male partners become involved;

A participant said;

"Serving the women who come with their spouses exceptionally; maybe first to be served/ so that the men can be counselled, counselling of the couples, Drama/meetings, Expert client opportunities", [Pamba village, Western Division, Soroti, 18th .05.2018]

4.4.1.2 Giving couples first priority

The participants were asked whether they receive support or counselling from the health workers on drug use, feeding for both mother and baby. Most of the participants reported that the health workers have counselled them on positive living, nutrition/feeding, drug use and being faithful to

their partners. Counselling of the couples during ANC/eMTCT attendance is paramount to the health of the couple and the baby. Below are excerpts from respondents;

> "Yes we receive counselling on positive living, drug use, being faithful and not spreading the disease (HIV) to others, feeding and supporting one another among others", [Ogoloi, Arabaka, Soroti, 23rd .05.2018

> "Yes we receive counselling on positive living, drug use, feeding for both the baby and mother", [Amen B, Soroti, 24th .05.2018]

> "Yes we receive counselling on feeding for both the mother and the baby especially to ensure a balanced diet and to always be faithful to your partner", [Onyerai, Asuret, Soroti, 22nd .05.2018]

> "Yes we receive counselling on how to ensure we have a negative child, nutrition for my wife especially that she swallows ARVs and she is pregnant", [Oyomai village, Kamuda S/C, Soroti, 19th .05.2018].

> "The experience has been good but the only challenge is not finding ARV drugs at the health facility", Onyerai, Asuret, Soroti, 22nd.05.2018]

Long waiting time at the facility was also reported by some of the participants; however this was linked to particular participants that attended ANC/eMTCT at that health facility. However, the majority of the participants reported having good experience in supporting their spouses and had no challenge.

> "The experience has been good and we have not had any challenge. They keep calling us for follow up and we are happy", [Amen B, Soroti, 24th.05.2018]

4.5. Factors that promote male involvement in ANC/eMTCT

In response to a question on the ways that may promote male involvement, the respondents suggested several ways in which MPI in ANC/eMTCT may be promoted or enhanced. Promotions could be at different levels for instance a) Community, b) Health Facility and c) Personal.

4.5.1. Community level factors

4.5.1.1 Community sensitization

Taking advantage of community events as they occur in the community and preaching or teaching in church that emphasis love for one another may promote male involvement in ANC/eMTCT. Participants proposed that during community events or open day functions, messages on male partner could be shared. Other messages could be in form of posters (IEC) and on local radio stations, which can spark the interest in male partners eventually leading to their involvement. Currently, posters are available at the health centre but not in the communities; these posters could be placed in places where males frequent for example bars, video halls, churches etc.

> "…..Announcements on radios, male testimonies on radios and community gatherings or functions especially regarding male involvement integrating the importance of male involvement and love in church preaching", [Aloet, Arapai, Soroti, 23rd.05.2018]

Communication strategies like radio programmes and encouraging voluntary sharing of male testimonies in churches or preaching on carrying one another's burden and love could foster behaviour change among men, use of counsellors as stated by some of the participants

> "……...Drama on male involvement in churches and community gatherings; we normally have drama twice a month for sensitization", [Pamba village, Western Division, Soroti, 18th.05.2018]

Community Health Workers or Health workers should proactively reach out to the community and sensitize the males, on the relevance of male involvement in ANC/eMTCT and how they can be involved. One of the participants suggested that if community health workers would be facilitated so they are able to reach men and women that live far away from the health facilities

this would foster male involvement. Interventions that have involved follow up by community health workers have registered some little success;

> "....If the VHTs could be facilitated more like buy for them bicycles or even some little money so that they could reach most of the men who are positive in their area and educate them about male involvement", [Oregia, Asuret, Soroti, 21.05.2018]

4.5.1.2 Involvement of local leaders and other influential people

The local leaders and other influential people like chiefs play significant role in the communities they serve because live in the same community and understand the needs of the people; they can easily trust them therefore using them as a communication vessel for health interventions can create meaningful utilization of the services. Chiefs are custodians of culture and enforcers of customs and activities in communities where formal health services are situated. In light of their position and influence, they would ensure that their community adheres to what has been recommended by the health care workers. Men would easily listen to them

> "...LC1 and LC111 should become involved in sensitizing men and living as examples", Oyomai village, Kamuda S/C, Soroti, 19th.05.2018]

4.5.2 Personal/family level promotions

4.5.2.1 Using peer males

Peer male promotions in order to encourage men that are not patronizing the service, key use of male partners who are involved to reach other male partners, on an individual basis or through male only groups, and educate them on the relevance of their involvement in ANC/eMTCT services. Nearly half of the participants suggested peer males as a strategy.

> "Peer to peer education on male involvement; by the men who have already been involved e.g .using testimonies", [Aloet, Arapai, Soroti, 23rd.05.2018]

A participant suggested;

> "Peer to peer health education; health workers should reach them and fellow men who are also involved should reach those other men who are not involved. Peer to peer education; testimonies from men who have been involved", [Ogoloi, Arabaka, Soroti, 23rd.05.2018]

Conducting male only meetings/ gatherings or support groups. In these meetings the emphasis could be on male involvement; peer males that are involved would share their testimonies and experiences so that the others could also be encouraged to participate. The advantage of such meeting is that it allows for free participation among fellow males as opposed to when men are combined with women.

> "Community gatherings and meetings…...if men could be set aside from the women at the health facility and sensitized on male involvement", [Onyerai, Asuret, Soroti, 22nd.05.2018]

Recruiting leaders from the men's support groups to serve as peer discussion leaders to deliver educational sessions to other men in their communities about the importance of men's support and engagement with programmes like eMTCT /ANC is vital for male involvement.

4.5.2.2 Family support groups

The establishment of family support groups is an important initiative that allows transparent and transformative interaction that translate to behaviour change and sustaining the behaviour. It is therefore necessary to encourage couples join the family support group because it can increase male involvement due to the experiences encountered.

> "Other hospitals could also emulate from Princess Diana like Family Support Groups; mentor mothers, Mother baby care points and encouraging men to become involved in discussion at the health facilities.....", [Aloet, Arapai, Soroti, 23rd.05.2018]

Another participant

> ".…….Family support group, invitation letters to the male partners from the health worker and serve women who come with their men first", [Ogoloi, Arabaka, Soroti, 23rd.05.2018].

4.5.3. Health facility level factors

4.5.3.1 Drug distribution centres

The participants mentioned a number of interventions the health facilities could use to encourage males. These mainly included; community outreach or establishment of community drug distribution centres to reduce distance travelled, giving couples first priority, use of family support groups and inviting the males to the health facility through their spouses. Below are some of the excerpts from some of the participants;

> "Community outreach programmes/community drug distribution centre to reduce the distance from to the health facility", [Ogoloi, Arapai, Soroti, 25th.05.2018]

The distance to the health facilities impedes access to health services; in general the most male partners will prefer to stay at home, does some farming as their partners pick drugs or go to the health facilities without them. A participant therefore suggested to have more regular out programmes or an established community drug distribution centre this could foster involvement;

> "Community outreaches programmes/ community drug distribution points so that the services are nearer to the people. Women who do not come with their husbands can be denied services", [Onyorai, Arapai, Soroti, 24th.05.2018].

However, establishing a drug distribution centre would also have financial implications of employing a health worker and constantly stocking of drugs to avoid stock outs.

4.5.3.2 Using women of the male partners/invitation letters

One participant suggested use of women whose partners have not been involved to access them. Use of formal invitation letters and have the women deliver them to their partners. Those that respond to the invitation are appreciated, given first priority and actively engaged in the ANC/eMTCT clinics.

> "Health facilities should also use the wives of men who are not coming to the health facility. Use the wives to invite their men; maybe using invitation letters or denying their wives services if they do not come with their husbands and giving first priority to couples at the health facility especially on ART clinic or at the mother baby care point", [Mugana, Arapai, Soroti, 23rd.05.2018].

The results of this study show that once males attended the clinic and are informed about the reasons why they need to accompany their wives, they appreciate and recognise the value of participating in reproductive health, not just for themselves, but that of their spouses as well. Also, for most of the male partners that are involved, they have expected outcome of a negative baby or have had an experience of a negative baby and therefore have benefited from their involvement as well as support from the health facility, community and family members.

However, two participants suggested a controversial intervention of denying services or warning of women whose spouses are not involved in ANC/eMTCT. It is important to have such measures in place, but with caution that it does not hinder women from seeking health services especially for those that are not in a committed relationship.

> "Women who have not come with their spouses at the health facility should not be offered services/ or if they are given on that appointment day they should be warned that if they come without their spouses the next time they will be denied services", [Osudo, Kamuda S/C, Soroti, 19th.05.2018]

Another participant

> "Use women to invite their partners to the facility; If not you deny them services", [Amen B, Soroti, 24th.05.2018]

CHAPTER FIVE: DISCUSSIONS, RECOMMENDATIONS AND CONCLUSION

5.0. DISCUSSION

This study sought to investigate the experiences of male partners arising from supporting their spouses' lifelong ART at health facilities in Soroti. Male partners' experiences of their roles as perceived by the community, within the cultural context, and the health care setting, highlighted important focal points to consider in the planning of interventions aimed at improving male partner involvement in ANC/eMTCT in Uganda. The study was aimed at understanding the experiences of the supportive partners, so that existing eMTCT programs can identify and engage these male partners as allies in the care of women and their infants.

As clearly demonstrated when male partners value the aspect of having a negative child, culture and traditional norms can be ignored or changed so that one can achieve the perceived benefit. This illustrates that men especially can change societal norms and values when they realise the benefits to changing their behaviour. The health belief model has shown that when people in this case male partners see the perceived benefits then their behaviour can change and they can also be the agents of further change. The change in attitude of health workers towards male partners at ANC clinics has had a very beneficial effect. To promote positive health-seeking behaviour and male partners' participation in eMTCT programmes, it is critical both that services are welcoming to male clientele and that health workers are competent to meet their needs. Similarly a study in the United Kingdom indicated that when there are specific antenatal groups focussing on men's needs there are benefits in terms of reduced distress, increased ability to cope and improved relationship with their partner ((Redshaw, 2013). Thus, this needs to be spread to

other areas of the health service delivery to ensure that the men receive the services available and those that appropriate for their health needs.

From the study, offering couple HIV counselling facilitated communication between couples and increased the level of knowledge about ANC/eMTCT services. This is similar to the first Australian study to evaluate engagement by fathers in antenatal care indicated that males were positively influenced by adequate consultation with antenatal care staff (Jeffery et al, 2015). This means that when male partners understand the importance of their involvement they play an active role in applying the advice they receive, men will challenge traditional practices that might endanger their partner's health. According to the health belief model behaviour is determined by threat perceptions and beliefs about the benefits of the recommended action and potential barriers for its implementation. Therefore male partners become involved and support their HIV positive pregnant partners against all negative cultural and traditional norms because of the counselling and continuous health education from the health workers about the benefit of their involvement in ANC/eMTCT. Thus, such interventions need to be promoted and health workers skills enhanced to ensure that the health workers are able to offer messaging during counselling so that it can effect change in their perceptions about the some of the negative cultures and norms.

Joining or being part of a family support program facilitated the male involvement, clearly male partners were able to overcome the negative perceptions and traditional norms that hinder their involvement in ANC/eMTCT programs through joining family support groups. Support groups are like family; they help strengthen social ties among members of the support group which members also constitute part of the community. This means that the male partners are able to

change their perceptions about societal and cultural norms towards accompanying their partners to ANC/eMTCT and participating in household chores through encouragement and motivation from the peers and the community. Thus interventions to involve men should be focused around how men can interact with the cultural norms and be able to change their behaviour. Such interventions should be spread across health facilities.

The findings show that, the health facility initiatives such as offering first priority to women who attend ANC/eMTCT with male partners has changed the perception of men about their involvement. This illustrates that when health facilities become receptive to men, they can change societal norms and values when they realise the benefits to changing their behaviour. Indeed male partner involvement interventions that have been successful are those that have shifted the burden of requesting male participation from women to the health system itself (Dumbaugh et al., 2014; Theuring et al., 2009). Interventions that involve health education, counselling, and generally making the ANC clinics receptive to men are effective in causing men and women to question and contest rigid inequitable gender norms, or disregard them. However, such interventions should not infringe on the rights of women especially those with non-supportive partner or no partner and the responsibility to influence the men to attend ANC or seek care is not placed on the women. While attending ANC/eMTCT with a male partner is indeed honorable and promises well for the family, it unfairly puts pressure on the woman to convince their partner to accompany them for the ANC/eMTCT services in a culture where antenatal clinics are known as a woman's domain. Therefore the policies should take into consideration the power and culturally entrenched gender roles and monitor into the unintended effects of policy change to achieve desirable male involvement but at the same time not impeding service utilization for the women.

As clearly seen, when men factor in the reasoning of taking responsibility for the pregnancy and ensuring good health for their partners societal norms can be changed. The primary benefits of having a male partner involved during pregnancy is the reduction of maternal stress and the encouragement of positive maternal behaviours which have implications for the health of the baby; if men understand this gender norms can be challenged. Understanding how men negotiate through cultural norms and take responsibility for the pregnancy and the child can be explained through the lamb's theory that posits three processes; engagement, accessibility and responsibility. Constructions of masculinity in patriarchal societies often limit the ways in which men engage in ANC/eMTCT, however men are able to manoeuvre through such gendered division and engage as fathers; and as partners of positive women enrolled on lifelong ART through the health workers reminding them of their roles and responsibilities of not just being passive recipients of new knowledge, skills and awareness, but as clients and partners who have a responsibility to their own health and the health of the people who depend on them. Therefore, interventions should directly approach men but not use women as a proxy to invite or take messages to their men for attendance and inclusion.

From the findings, time constraints, such as balancing the need to provide for the family versus attendance to antenatal clinic and negotiating time off can be achieved when men value the aspect of having a negative child. A study in Australia that sought to evaluate engagement of fathers in antenatal care also suggested long working hours as a negative influence on male engagement in antenatal care services (Jeffery et al, 2015). This means men can change the societal and cultural norms that discourage men from participating in antenatal clinics. Thus if interventions for male involvement could extend to employers so that they become supportive towards male partners attending antenatal visits then this may give a sign about a changed

cultural atmosphere that allows and expects males to be involved in antenatal care/eMTCT hence improving work place norms.

Based on the study findings, we suggest that not only are there benefits to involving men, but men are already getting involved in ANC/eMTCT. Therefore, policy-makers need to be aware of men's involvement in ANC/eMTCT and promote an environment that is conducive for and facilitates men's involvement.

5.2 CONCLUSION

There is more to male involvement than HIV testing, and if virtual elimination of infants acquiring HIV is to be achieved, wider involvement of partners at all stages of care, treatment and provision must be explored. It is not unusual for men to be hesitant to shift gender responsibilities. However, there was an openness to move beyond current traditional roles among the male partners of positive pregnant or lactating women, where male partners agreed and felt they had a greater responsibility to contribute and support their partners and were interested in developing avenues through which to do so by ignoring negative gender norms that impede their involvement. The approaches used in the study that facilitated positive experiences were implemented at both community and facility levels, tailored to the local context, taking into account cultural norms. The health facilities offered services that influenced male partners to participate as well as enhanced psychosocial interventions and community interventions that improved their experiences and increased their involvement. The interventions that involve men as agents of positive change serve the interests of men as well as women by increasing men's choices, their possibilities for learning and development, and the survival and well-being of

family members therefore male peers that have been involved should be used to improve male involvement through engaging these men as allies in the care of women and their infants..

5.3 RECOMMENDATIONS

5.2.1. Introduction

Men are a vital yet under-utilized human resource to promote male involvement in eMTCT/ANC. There is need for effective and sustainable male-friendly initiatives that ensure the existence of welcoming healthcare facilities that provide culturally appropriate and family-centric services for the prevention of the vertical transmission of HIV. The following recommendations are presented for consideration in the promotion of male involvement in eMTCT/ANC initiatives at all levels of the cascade and most of the recommendations were suggested by the men themselves.

5.2.2. Recommendations to policy makers

- Government can focus on creation and strengthening of male peer cadres that can move from village to village sensitizing men about male involvement. The peer educators can be trained on community sensitization including how to conduct large community dialogue meetings and on training on HIV. This will support programmes/ health facilities to move from seeing men solely as enablers of women's positive health seeking behaviors, to viewing them as integral partners in promoting gender equality and health.
- Government and implementers should adopt community based interventions into the PMTCT Cascade of care through engagement of influential community leaders and community-based health cadres like the VHT. Community and religious leaders and

influential figures can play an active role in community mobilizing for health because they command, respect, and influence, especially in rural communities. For example government through development partners can lobby community leaders, including religious leaders, strengthen their capacity through HIV training to help them understand what eMTCT is about and what is expected from them then constitute a committee that can be linked to the health facilities; meet each month and plan sensitization activities through the support of the health facilities. Also use local radio sessions to encourage men to come get tested and support their for example through skits/drama as well as getting men that have been supportive/involved to give their testimonies.

- Government should consider policies that provide for family centered approaches; a package on gender sensitive family centered comprehensive eMTCT service delivery approaches can be designed and incorporated in all communication, training and monitoring tools. National and district budgets can be put aside for the mainstreaming of gender, family centered care and for activities that specifically attract men as partners in an integrated health, HIV/AIDS and development programme i.e. recommended family support groups.
- Effectively packaged messages about eMTCT can be designed for different audiences to facilitate their awareness, understanding, and prioritisation of this issue. The IEC materials are then distributed and placed in public places like churches (places of worship), bars, local cinemas and betting places among others. The development of a coordinated national eMTCT communication strategy addressing behavioural influencers at the individual, service-delivery, community, and policy levels is recommended to support eMTCT expansion through a variety of channels that could be used to effectively

reach men and women including mass media, churches, schools, and door-to-door campaigns.

5.2.3. Recommendations to Health facility departments of ANC and ART clinics

- The health facilities should develop information/IEC directed to the men as partners; it is important that such materials are developed in a cultural sensitive manner which will allow the transfer of knowledge on the benefits of male involvement in antenatal care and eMTCT. Health facilities should also be accommodative not just to women but to men as well if they want to attract men into health services. In addition services should review staff numbers at the clinic as long waiting times is a deterrent and a huge barrier for both men and women. Comprehensive Behaviour Change Communication strategies and campaigns to change perceptions about men's involvement in ANC/eMTCT, address HIV-related stigma, and reduce GBV should be implemented in conjunction with campaigns to increase demand for eMTCT services.

- The government should consider deploying more trained personnel, and improving the supply chain to avoid stock-outs this can help to achieve male involvement. Systems level changes by advocating for increase in eMTCT funding, for better training of personnel, and for better integration of eMTCT within other health programs. Trained, competent and male-friendly staff is essential; offering refresher courses, including customer care can improve health workers knowledge on how to offer male friendly messages.

- Health facilities should strengthen interventions such as a men's psychosocial support group as an effort that is helpful in engaging and retaining men in HIV-related services.

Organise campaigns that highlight role models of responsible fatherhood in public information, education and communication efforts to increase partner involvement in antenatal care/eMTCT. It would also be it helpful to have organized discussions between health care workers and the community, to learn more about the services.

5.2.4 Recommendations to Implementing partners

- The partner organisations should conduct exchange visits among males involved in their lifelong ART from other districts to share their experiences and ensure continuous monitoring male involvement in programme implementation and quality i. e standards of performance for each of the programmatic areas.

- The organisations providing eMTCT should ensure health facility in-charges make timely and adequate requisitions for ARVs and septrine to prevent stock outs. Healthcare providers should ensure adequate and efficient management of ARVs and septrine tablets at the health facilities in order to facilitate adherence to treatment as well as positive involvement of males in their lifelong ART.

5.4 STRENGTHS AND LIMITATIONS

As limitations, this was a health facility based study, and participants were restricted to male partners who attended ANC/eMTCT, most of whom were from rural areas therefore limiting the application of results to the urban areas. However, the issues raised could be similar to other settings in the country.

This was a highly selected population whose views are not representative of all male partners or of male who accompany their wives to ANC/eMTCT programmes, views may differ from the men of urban areas.

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APPENDICES

APPENDIX 1: WORK PLAN

Activity	2017												2018									
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
Development of concept																						
Presentation of concept																						
Approval																						
Proposal development																						
Submission of draft 1																						
Updating draft 1																						
Submission of draft 2																						
Updating of draft 2																						
Submission of final copy																						
Approval																						
Recruitment of research assistants																						
Data collection																						
Data entry and analysis																						
Report writing																						
Submission of draft thesis 1																						
Updating thesis																						
Submission of draft 2																						
Submission of final copy																						
Defending Thesis																						
Updating thesis																						
Submission of approved final copy																						

APPENDIX II: STUDY BUDGET

Activity	Unit cost	Quantity	Amount (Ugx)
Research proposal writing (Data and Transport)	370,000	1	370,000
Printing and photocopying of tools (Proposal)	19,800	2	39,600
Printing report	28,000	3	84,000
Recruitment and training of research assistants	20,000	3	60,000
Data collection	15,000	12	180,000
Transport	20,000	5	100,000
Transcription	50,000	1	50,000
Data analysis	200,000	1	200,000
Report writing	150,000	1	150,000
TOTAL			**1,233,600**

APPENDIX III: LETTER TO CONDUCT RESEARCH

Uganda Martyrs University

Making a difference

Faculty of Health Sciences
Email: health@umu.ac.ug

12th January, 2018

TO WHOM IT MAY CONCERN

RE: INTRODUCING MS. EOJU WINNIE.

This is to introduce to you **Ms. Winnie Eoju** REG NO: 2015-M272-20017 as a bona fide student of Uganda Martyrs University. She is pursuing a programme leading to the award of Master of Public Health-Population and Reproductive Health. She will be collecting data to complete writing of her dissertation title '**Understanding Male Partners' experiences arising from supporting their spouses' lifelong ART at the Health Facilities in Soroti District.'**

The relevant university authorities have approved the topic and protocol.

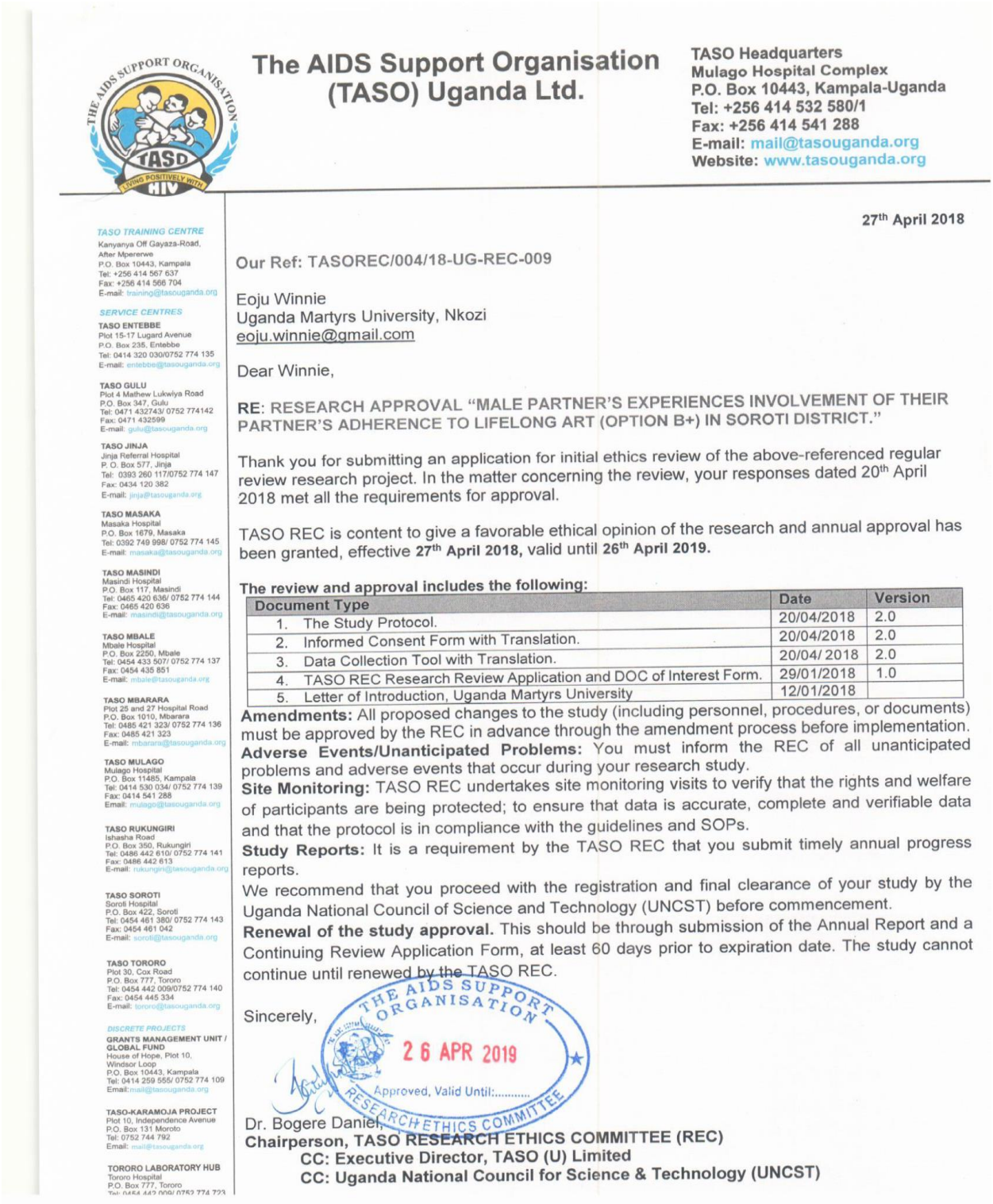
Any assistance rendered to her in this respect will be highly appreciated by the university

Yours sincerely,

DR. Miisa Nanyingi

Faculty of Health Sciences,
Uganda Martyrs University

APPENDIX IV: TASO RESEARCH ETHICAL COMMITTEE



The AIDS Support Organisation (TASO) Uganda Ltd.

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Fax: +256 414 541 288
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Website: www.tasouganda.org

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Fax: 0454 445 334
E-mail: tororo@tasouganda.org

DISCRETE PROJECTS

GRANTS MANAGEMENT UNIT / GLOBAL FUND
House of Hope, Plot 10,
Windsor Loop
P.O. Box 10443, Kampala
Tel: 0414 259 555/ 0752 774 109
Email: mail@tasouganda.org

TASO-KARAMOJA PROJECT
Plot 10, Independence Avenue
P.O. Box 131 Moroto
Tel: 0752 744 792
Email: mail@tasouganda.org

TORORO LABORATORY HUB
Tororo Hospital
P.O. Box 777, Tororo
Tel: 0454 442 009/ 0752 774 723

27th April 2018

Our Ref: TASOREC/004/18-UG-REC-009

Eoju Winnie
Uganda Martyrs University, Nkozi
eoju.winnie@gmail.com

Dear Winnie,

RE: RESEARCH APPROVAL "MALE PARTNER'S EXPERIENCES INVOLVEMENT OF THEIR PARTNER'S ADHERENCE TO LIFELONG ART (OPTION B+) IN SOROTI DISTRICT."

Thank you for submitting an application for initial ethics review of the above-referenced regular review research project. In the matter concerning the review, your responses dated 20th April 2018 met all the requirements for approval.

TASO REC is content to give a favorable ethical opinion of the research and annual approval has been granted, effective **27th April 2018,** valid until **26th April 2019.**

The review and approval includes the following:

Document Type	Date	Version
1. The Study Protocol.	20/04/2018	2.0
2. Informed Consent Form with Translation.	20/04/2018	2.0
3. Data Collection Tool with Translation.	20/04/ 2018	2.0
4. TASO REC Research Review Application and DOC of Interest Form.	29/01/2018	1.0
5. Letter of Introduction, Uganda Martyrs University	12/01/2018	

Amendments: All proposed changes to the study (including personnel, procedures, or documents) must be approved by the REC in advance through the amendment process before implementation.
Adverse Events/Unanticipated Problems: You must inform the REC of all unanticipated problems and adverse events that occur during your research study.
Site Monitoring: TASO REC undertakes site monitoring visits to verify that the rights and welfare of participants are being protected; to ensure that data is accurate, complete and verifiable data and that the protocol is in compliance with the guidelines and SOPs.
Study Reports: It is a requirement by the TASO REC that you submit timely annual progress reports.
We recommend that you proceed with the registration and final clearance of your study by the Uganda National Council of Science and Technology (UNCST) before commencement.
Renewal of the study approval. This should be through submission of the Annual Report and a Continuing Review Application Form, at least 60 days prior to expiration date. The study cannot continue until renewed by the TASO REC.

Sincerely,

THE AIDS SUPPORT ORGANISATION
26 APR 2019
Approved, Valid Until:.....
RESEARCH ETHICS COMMITTEE

Dr. Bogere Daniel,
Chairperson, TASO RESEARCH ETHICS COMMITTEE (REC)
CC: Executive Director, TASO (U) Limited
CC: Uganda National Council for Science & Technology (UNCST)

APPENDIX V: PERMISSION BY THE DISTRICT MEDICAL OFFICER, SOROTI LOCAL GOVERMENT

Uganda
Martyrs
University

Making a difference

Faculty of Health Science
Email: health@umu.ac.u

12th January, 201

Noted/Permission granted fo
health related research
Conducted in the district
Selected respondents are he
urged to co
with the rese

DISTRICT MEDICAL OFFIC
SOROTI DISTRICT LOCAL GOVT

TO WHOM IT MAY CONCERN

RE: INTRODUCING MS. EOJU WINNIE.

This is to introduce to you **Ms. Winnie Eoju** REG NO: 2015-M272-20017 as a bona fide student
Uganda Martyrs University. She is pursuing a programme leading to the award of Master of Publ
Health-Population and Reproductive Health. She will be collecting data to complete writing of h
dissertation title **'Understanding Male Partners' experiences arising from supporting the spouses' lifelong ART at the Health Facilities in Soroti District.'**

The relevant university authorities have approved the topic and protocol.

Any assistance rendered to her in this respect will be highly appreciated by the university

Yours sincerely,

DR. Miisa Nanyingi

Faculty of Health Sciences,
Uganda Martyrs University

Uganda Martyrs University P.O. Box 5498 – Kampala – Uganda
Tel: (+256)038-410611 Fax: (+256) 038-410100 E-mail; umu@umu.ac.ug

APPENDIX VI: INFORMED CONSENT FORM FOR MALE PARTNERS

Background

Thank you for taking the time to talk with me today! My name is **Winnie Eoju,** a student at Faculty of Health Sciences, Uganda Martyrs University. As part of my Masters in Public Health-Population and Reproductive Health, I am required to conduct a research. My research focuses on male involvement in eMTCT.

Purpose of the study

The title of this research is "male partners' experiences arising from supporting their spouses' lifelong ART at health facilities in Soroti district"

The purpose of this interview is to learn more about your experiences in eMTCT/ANC in order to provide insights into possible ways of increasing male partner participation in antenatal care and improve outcomes of pregnant women accessing eMTCT services (lifelong ART). We hope that the study will take us about 1:30- 2 hours.

Rights

Your participation in this research is voluntary and you are free to withdraw at any time from it and please feel free to decline to answer any of the questions asked any time to. The interview will be tape-recorded and will be used only for analysis. All the information you give will be kept confidential. Your name will not be linked with the research materials, and will not be identified in the report too.

Risks and benefits

There are no risks or direct benefits to you, associated with your participation in this study. However, we feel that your participation will contribute greatly in knowing how best to address

challenges related to improving program implementation in respect to preventing HIV transmission to babies; increase male involvement and improve outcomes of pregnant women accessing eMTCT services. This study is purely academic thus there is no financial compensation planned for it.

Please be assured that we want to learn from your experience and all the information we collect will be used to help us prevent the transmission of HIV/AIDS from mother to the baby in your community and the country at large. Your consent form will be stored for six to eight months until the final report is approved for its purpose.

Questions and Clarifications

In case you wish to ask or have clarification regarding this study, I can be contacted on **0783683575/0702139692** or by email eoju.winnie@gmail.com or chairperson Research Ethical Committee (REC) of TASO **Dr. Daniel Bogere on; +256 772 139126 and 705 812960** should you have any questions regarding your rights and welfare during participation in the study.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Participant

I, _____ have been adequately informed about the purpose, procedure, risks and benefits of this study. I was also given an opportunity to ask questions if any as well as need for clarification. Therefore, based on the information provided to me, I have agreed to participate in this study.

Signature: _____Date: _____ Mob. Contact:_____

Participant

Name: _____Signature: _____Date: _____

Interviewer

APPENDIX VII: SEMI-STRUCTURED, IN-DEPTH INTERVIEW GUIDE

Instructions to the interviewer:

Welcome the interviewee. Explain the purpose of the interview. Ask for the interviewee's consent to take notes and to record the interview. Go through informed consent paper and confidentiality. At the end of the interview, ask for the interviewee's consent for additional interviews in case of clarification needs. Thank the participant for deciding to take part in the study.

Date :_____

Starting time :_____

Ending time :_____

Name of Interviewer :_____

Background information of the Respondent:

ID	Variables	Responses
1	District	:_____
2	County	:_____
3	Sub County	:_____
4	Parish	:_____
5	Village	:_____
6	Date of Birth	:_____
7	Age	:_____
8	Marital Status	:_____
9	Level of Education	:_____
10	Occupation	:_____
11	Religion	:_____
12	Tribe	:_____

SEMI-STRUCTURED IN-DEPTH INTERVIEW GUIDE

Good morning/Good afternoon once again,
Let me kindly know if you are ready so that we begin; if so,

1. **Experiences do male partners have regarding their role and involvement in their spouses' lifelong ART at health facilities in Soroti district**

   A. **Tell me about your experience accompanying your partner to Antenatal Clinics.** *Ask the specific questions below too;*

      i. How did you feel the first time going with your partner to the antenatal clinics?
      ii. Thereafter, what motivated you to continue attending the clinics with her?
      iii. Kindly tell me how your involvement in spouse's lifelong ART has it interfered with your social life?
      iv. What role do you play during antenatal visits and in ensuring your partner continue to attend antenatal care/eMTCT? What experience can you say about it?

   B. **What experience have you had ever since your partner started taking lifelong ART?** *Ask the below questions too;*

      i. How have you been supporting your partners in taking her medication (ART)?
      ii. What home activities do you do to support your partner?
      iii. What good experiences do you have in supporting your partner take her medication (ART)? What challenges have you experienced in supporting your partner to attend and consistently take her medication (ART)?

2. **What experiences do male partners have on their spouses' lifelong ART arising from family and peer perceptions, roles and responsibilities?**

   A. **Kindly tell me about your experiences resulting from your family's perception towards your involvement in your spouse's lifelong ART?**

      i. What do your family members perceive of your supports to your partner including accompanying your partner to clinic as well as ensuring her take the medication?
      ii. How has your immediate family members contributed in supporting you towards accompanying your spouse to the antenatal/eMTCT clinic?

B. Please tell me about your experiences arising from your peers' perception, roles and responsibilities towards your involvement in supporting your spouse in lifelong ART

i. How did your peers contributed towards your involvement in your spouse's lifelong ART?
ii. What did they do specifically to you that contributed to your involvement?
iii. What experiences do you have in regards to their feedback? This can be positive or negative or both?

3. What experiences do male partners have on their spouses' lifelong ART resulting from community roles and responsibilities in Soroti district?

A. What does your community/culture perceive about men being involved in women's health issues? *Ask the below questions too;*

i. Cultural practices and beliefs and how they have been able to manoeuvre through such cultures and beliefs to support their partners.
ii. How do you think negative perceptions and gender norms can be addressed to have more men involved?

B. What experience do you have in regards to the roles and responsibilities of the community as you support your spouse in attending, continue and take her ARV/medications?

i. How has the community contributed in your life towards supporting your spouse in attending antenatal care/eMTCT and taking her medication (ART)? What exists at community level that support your involvement in your spouse's lifelong ART?
ii. What specific experiences do you have as a result of the community's contribution you mentioned?

What experiences do male partners have on their spouses' lifelong ART due to absence and presence of institutional approaches at health facilities in Soroti district?

i. What experience do you have due to the presence of eMTCT approach in the health facility/hospital you and your spouse visit? Have at one time wanted this service but it was not available? Yes/No if yes, what experience do you have during that time?
ii. What activities does this health facility/hospital do to enable you to become involved in your spouse's lifelong ART?
iii. Let me also know whether you receive support/counseling from the health workers on drug use, feeding for both mother and baby.
iv. What experiences do you have in relation to challenges towards your involvement?
v.

Concluding Questions

What messages do you think would be directed to your fellow men to have them involved their spouses' lifelong ART?

Probe in relation to;

1. Interventions that can be put in place to increase male involvement in eMTCT
2. Community support activities that can encourage male involvement
3. Health system related activities that can encourage male involvement

APPENDIX VIII: SEMI-STRUCTURED, IN-DEPTH INTERVIEW GUIDE

Instructions to the interviewer:

Aisukunyun ituan yen ingisio. Itetemik ngesi aipeleikinete naka aingito. Engit nges acamakini ijo aiwadik akiro nu oitabo kede aikam ekeporoto kosawa loka angiseta. Kirereo ebaluwa loka acamanara kede amunonut.

Aingeset naka aingito, ingit ituan yen ingisingisi ijo acamakin ijo abongun aingitingit ngesi aria ejaa akiro acie nu ikoto ijo acau komamke. Isialamik lo ingisingis ijo kanu acamakin ijo aitolot aingito kon kede ngesi kotoma aisisia kana.

Apaarasia :_____

Esawa lo egearor :_____

Esawa lo engetakinor :_____

Ekiror loka ekangitan :_____

Akiro nu okwap kanu lo ebongonokini:

ID	Akiro nu ijulanakinos	Abongonokineta
1	Edistrikta	:_____
2	Ebuku	:_____
3	Eitem	:_____
4	Eitela	:_____
5	Icaalo/Atutubet	:_____
6	Apaarasia nuka aurio	:_____
7	Ikaru	:_____
8	Edukone	:_____
9	Adoketait naka asioman	:_____
10	Aswam	:_____
11	Ediini	:_____
12	Ateker	:_____

SEMI-STRUCTURED IN-DEPTH INTERVIEW GUIDE

Yoga noi,
Elipit eong ajenun aria ikapakina ijo tape oni igeari aingito; arai ikapakina ijo,

4. **Aijen na ikiliok kanu ikamunitos eimorikikina kec kotoma aingaraikin angora kec aijar aojau kede ART kotoma adekesia kanu didika ko Sorori district**
5.

C. Kolimok eong amisikin kon arai bonat aijen kon kanu ikamunitos ijo ainymit akoni aberu adekis apaaran kana epotior nges. *Ingit aingiseta nu itebeikina kwape nat nu okwap nu da;*

v. Biai obu ijo opupio apaaran nasodit na inyamaara ijo nowaikon adekis kanu aroanaro naka apotu ke?
vi. Akaulo kangin, inyoni abu kisinyikoik ijo ainyamanar ngesi adekis?
vii. Kotoma apatan kolimokinai eong biai abu ainyamit aberu kon adekis kanu adumun eijanakine loka ART omunara aijar kon kocaalo?
viii. Aswam anyoin abu ijo kiswama apaaran na iupanarotor yes adekis kede naowaikon kanu awanyun ebe iducokini ngesi alosit adekis awanyanaar/eMTCT? Nu nyoeka epedori ijo alimun kanu ikamanara kede aupa kus?

D. Anu bo imisikit ijo egeun ne ageara no owaikon aitolot amukean naka ART? *AIngit aingiseta nu okwap nu da;*

iv. Biai ibu ijo ingarakina aberu kon kotoma ailik ikee luka ART?
v. Aswamisio anu iswamai ijo ore kanu aingarakin aberu kon?
vi. Aijen bo ani ijaatar ijo kanu awanyun ebe ingarakini ijo aberu kon ailik ikee luka ART? Doda ainingosia anu itereikinos ijo kede kanu awanyun ebe iducokinit na owaikon ailik ikee luka ART?

C. Aijen bo ani ejaatar ikiliok kane ejaasi angor kec nu ilikete ikee luka ART kolomunete kokalia kec kede da kane ejaasi itunga lu iteete kesi imorikikina, aswamisio kede da nu ibusakinit kes aswam?

D. Kapatan kolimokinai eong aijen kon na elomunit okale kus kanu ikamunitos ijo aingarakit aberu kon alosit adumun amukean naka aijar na aojau naka ART?

ii. Nu nyoeka eomitos itunga lu okale kon kane ewanyunatar kesi ijo inyamit akon aberu adekis kanu alosit adumun amukean?

iii. Biai ingarakitotor itunga luko okale kon ijo kanu awanyun ebe ingarakit ijo akoni aberu kede da ainyamit ngesi alosit adekis kanu adumun amukean ka awanyanario naka apotu ke/eMTCT?

E. Elipit kolimokinai eong aijen kon na elomunit kama ejaasi lu atur kon kanu ikamanara kede iaswamisio kon kowai kalo ijo aingarakit aberu kon adumun amukean naka aijar kana eoja naka ART.

iv. Biia apotu itunga luka atur kon ingarakinataar ijo kanu awanyun ebe adumuni aberu kon amukean naka aijar na aojan naka ART?

v. Kotoma aitebeikin, anu bo apotu kesi kiswamata kanu awanyun ebe ingarakinit ijo aberu kon?

vi. Ajen bo ani ijaatar ijo kanu ikamunitos nu apotu kesi kolimokisi ijo? Epedorete nu araunit nu ejokuka arai bo nu erooko kanenicie epedorete araunit nu aupanara?

6. **Aijen bo ani ejatar ikiliok kanu angora kec aijar aojau kede ART kolomunite kane ejaasi itunga lu atutubet kede aswam kec ko Sorori district**

C. Nu nyoeka eomitos itunga lu atutubet kon arai bon at einono loka ateker kon awanyun ikiliok ingarakitos angor kec alosit adumun amukean adekis kede akiro acie? *AIngit aingiseta nu da;*

iii. Inonosio kede da nu iyunitos itunga kede epone lo epedoritotor kesi awanyun ebe ingarakitos inonosio ngul kesi kowai kalo aingarakin angor kec.

iv. Biai iomitor ijo epedorere aitemokin akiro ngul nu iteete itunga bala mama ejokuka ikamanara kede angor ka ikiliok kanu awanyun ebe epote ikiliok lu ipu angarakin angor kec alosit adumun amukean adekis apak kana epotiotor kes

D. Aijen bo ani ijatar ijo ikamanara kede aswamisio nuka itunga kalu ocaalo apak kana ingarakina ijo aberu kon adumun amukean kede da aisinyikoikin ngesi ailik ikee luka ARV?

iii. Biai ingarakitotor itunga luko ocaalo kon ijo kanu awanyun eben ingarakit ijo aberu kon alosit adekis kanu airereonor kanuka apotu ke/eMTCT kede da ailik ikee (ART) ? Inyo ejai ocaalo kon yen ingarakit ijo kanu awanyun ebe ingarakit ijo aberu kon adumun amukean naka aijar aojau kowai kalo ailik ikee luka ART?

iv. Aijen ani ijaar ijo kodoco kanu ikamunitos epone lo ingarakitotor itunga luko ocaalo kon ijo kowai kalo ijo ainyamit aberu kon adekis?

Aijen ani ejatatar ikiliok kane ejaasi angor kec toma apak na edumuniatar kesi amukean naka aijar naka aojau naka ART arai emamete iponesio lu ingarakitotor adekesia kes ko Soroti distrkt?

vi. Aijen ani ijaar ijo erai ejaasi iponesio arai bon at ibore lu ijaikini adekis yes kwape nat luka eMTCT ne elosiotor ijo kede akoni aberu adekis? Biai ejai apaaran na adum ijo ikoto aijanakinio na konye komamei? Eebo/Mam. Arai kerai Eebo, aijen ani ijaar ijo kotoma apak osawa kangol?

vii. Aswamisio ani iswamai adekis kanu awanyun ebe ingarakit ijo aberu kon adumun amukean naka aojau naka ART?

viii. Apuda eong ajenun arai ijo idumuni agangat/aisisianakinio kane ejaasi eswamak lu angaleu kotoma oipone loka aitwasam ikee, einyame loka toto ka ikoku.

ix. Aijen bo ani ijaar ijo kowai kalo ikamanara kede ainingosia kotoma apak na ingarakinitor ijo aberu kon adumun amukean?

Aingiseta nuka awasia

Aisiraret bo ani iwomit ijo ibusakinit ikiliok kanu awanyun ebe ingarakinitos kes angor kec adumun amukean naka aojau naka ART?

Atiokusio nu itereikina kede;

1. Iponesio lu ebeit aitemokin kanu awanyun ebe iyatakin enaaba loka ikiliok lo ingarakinit angor kec adumun amukean naka eMTCT
2. Kanu awanyun ebe epote itunga luko ocaalo angarakit ikiliok ngul lu ingarakitos angor kec adumun amukean k'adeskis

Aswamisio nuka ejautene loka angaleu lo isinyikoikini ikiliok ajaut imorikikina kede angor kec kanu awanyun ebe edumunete angor amukean apak na epotiotor kes.