

**ASSESSING THE APPROACHES TO MALE  
PARTNER INVOLVEMENT IN PMTCT IN UGANDA**

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BY

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**Declaration**

I **Peter Mukobi** do hereby declare that this research report entitled ‘**assessing the approaches to male partner involvement in PMTCT in Uganda**’ has been prepared and submitted in fulfillment of the requirements of the MakSPH-CDC Fellowship Program and has not been submitted for any academic qualification.

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## **Abstract**

**Background:** Involving men in Prevention of Mother-to-Child Transmission (PMTCT) of HIV is now part of national and international policy guidelines. However, there is limited documentation of what constitutes ‘male involvement’ and approaches used to promote it. In order to inform future policy on male involvement, we describe the service providers and community perspectives of ‘male involvement’ and document the approaches used to during the involvement of men in PMTCT programs in Uganda.

**Methods:** This descriptive cross-sectional study was conducted in three districts (Kasese, Mayuge and Rakai) in Uganda in May – November 2012. Overall, a total of 89 out of 93 purposively selected service providers and community members participated. They included 42 male respondents. In total, 11 key informant interviews, six in-depth interviews and six focus group discussions were conducted. Data collected included understanding, approaches and obstacles to male involvement in PMTCT. Information obtained was analyzed thematically using Atlas Ti software.

**Results:** Male involvement in PMTCT was generally described as men: a) accompanying their spouses; b) providing social-economic support; and c) using family planning as well as HIV prevention measures. The commonly cited approaches at community and service provision levels were men escorting spouses and couple orientated services, respectively. While service providers promoted male involvement through incentives and education for men, community members (PLHIV inclusive) utilized HIV prevention measures and provided material and financial support to their spouses as ways to getting involved. Community members mostly appreciated that male involvement occurred within the fourth PMTCT prong. All participant categories cited lack of enforcement as a major obstacle to promoting male involvement. Other commonly mentioned challenges included stigma, fear of disclosure of HIV status and resistance to condom use.

**Conclusion:** The service providers’ and community approaches to male involvement in PMTCT in Uganda are influenced by variations in understanding of the concept. Existing variations need harmonization and enforcement for effective male involvement in PMTCT.

## **Acronyms and abbreviations**

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
CBO	Community Based Organizations
CSF	Civil Society Fund
DHO	District Health Officer
FGD	Focus Group Discussion
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IRB	Institutional Review Board
MCH	Maternal and Child Health
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
NCST	National Council of Science and Technology
NGO	Non-Governmental Organization
PMTCT	Prevention of Mother to Child Transmission of HIV
PLHIV	Persons Living with HIV
RH	Reproductive Health
STD	Sexually Transmitted Disease
UAC	Uganda AIDS Commission

## **Operational definitions**

<b>Community members:</b>	Refers to respondents that represented the study populations in focus group discussions
<b>Health facility:</b>	Refers to a designated service provision area like a hospital or a lower level health center
<b>Male Partner:</b>	A father to a pregnancy in which one or both parents are HIV positive
<b>Service providers:</b>	Refers to managers of NGOs, CBOs, government ministry officials and health workers
<b>Social support:</b>	Refers to the socio-economic and emotional assistance offered to vulnerable individuals or households to enable them cope with a problem. It includes provision of formal material goods, money, individual counselling, emotional encouragement etc.

## **CHAPTER ONE: INTRODUCTION AND BACKGROUND**

### **1.1 Introduction**

Efforts to involve men in reproductive health services began in the 1970s. They were later amplified by the emergence of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the 1980s. Men's advocates then argued that men had long been excluded from Prevention of Mother to Child Transmission (PMTCT) of HIV services yet they too deserved them, just like the women and children[1, 2]. This notion was also echoed at the International conference on population and development held in Cairo, Egypt in 1994 where it was reported that exclusion of men in programmes weakened the impact of health programmes[3].

Despite the importance accorded to inclusion of men in reproductive health programs, there is still no global agreement on what male partner involvement in PMTCT should constitute. It has however been described by some authors as the physical, moral or financial participation of both male and female partners as a couple in the prevention of vertical transmission of HIV to their baby[4].

### **1.2 Background**

HIV/AIDS is a major public health problem in Uganda. It is estimated that 15-20% of all new HIV infections occur from mothers to their babies. This translates into over 20,000 new infections annually. These figures make mother to child the second commonest mode of HIV transmission accounting for 95% of all childhood HIV infections in Uganda.

In order to address the HIV burden in children, a programme for PMTCT was started in Uganda in the year 2000[5, 6]. Progressively, PMTCT services were scaled up throughout the country. It was then ensured that services were integrated into mainstream Reproductive Health (RH) as well as Maternal and Child Health (MCH) services[7].

When integrated into RH and MCH, PMTCT is known to be an effective intervention for preventing transmission of HIV from mothers to their babies[8]. However, in the terms "Maternal and Child Health" and "Prevention of Mother to Child Transmission" the

primacy given to the mother and child is over emphasized. Prevention of Mother to child Transmission (PMTCT) may also be misunderstood as a woman's sole responsibility to prevent HIV transmission to the baby. This is ultimately reflected during service provision. This undermines male partner involvement in PMTCT despite its' known benefits to mothers and children. In order to address existing shortfalls, Global guidelines encourage male involvement through mutual HIV counseling, testing and disclosure among other approaches[6, 9, 10].

It is in line with global guidelines that countries like Botswana and Zambia promoted male partner HIV testing within Antenatal Care (ANC) Clinics. As a result, they were reported to have reduced the number of new HIV infections among children[8, 11].

In Uganda, varying approaches to male partner involvement in PMTCT exist from district to district and program to program. For example, while some implementers consider it as couple HIV Counseling and Testing (HCT) during ANC, others require male partner presence during delivery of babies or post natal attendance[12-15]. Due to variations and need to domesticate interventions, the national HIV/AIDS coordinating authority in Uganda i.e. Uganda AIDS Commission (UAC) decided to document existing perceptions and approaches to male partner involvement in PMTCT in the country[16].

## **CHAPTER TWO: LITERATURE REVIEW**

Global guidance on defining male partner involvement in PMTCT emphasizes the need to clarify the objective and motivations of involving men. Programs should recognize the risks women face and also anticipate the impact male involvement will have on gender relations. This should be done for a purpose of doing no harm at individual and society levels. The widespread reason for involving men seems to be the facilitation of women's use of reproductive health services. This was drawn from the conclusion of earlier studies that portrayed men as "obstacles" to women's use of services. The second commonly pursued goal is to provide reproductive health services for men, just as provided for women. Less acceptable though are the assumptions that there is complete symmetry between the sexes. Such assumptions lead to calls for services for men on the basis of "fairness"; and that clinical approaches to men's Sexually Transmitted Diseases (STDs) and other health needs will be enough[2, 17].

In addition to the above, male partner involvement in PMTCT is important because; as sole bearers of money in most communities, men influence their partners' decision-making including the use of services. Targeting men has also been documented to influence their sexual behaviors thus prevent STDs, HIV/AIDS inclusive[18]. It is also known to promote disclosure of HIV sero-status, prevent domestic violence, and the less often mentioned reason of promoting gender equity as well as social change[2, 19, 20].

Basing on known benefits, several approaches to male partner involvement in PMTCT exist globally. Those reported to have been successful include conducting Focus Group Discussions (FGDs) to promote male acceptance and support to their partners in Uganda[12], promoting men escorting women to antenatal clinics through written invitation letters in Uganda[13], masculinization of HIV home care by training male home care givers in Zimbabwe[4], and verbally inviting male partners to ANC clinics in Tanzania[21].

Despite existence of these approaches, male partner involvement in PMTCT is low in Uganda and other countries. There is lack of documentation of how existing approaches correlate with uptake of PMTCT services. Some of the factors that hinder women's use of

PMTCT services include lack of male partner support, fear of; disclosing HIV positive results, domestic violence, abandonment and stigmatization as well as health system factors such as poor access to health facilities. On the other hand, men are hindered to use services due to health system factors like unwelcoming health facilities as well as unclear roles for them. Socio-economic related barriers like lack of money and time as well as cultural and traditional hindrances have also been reported. However, higher education levels, knowing ones' HIV sero-status and having ever heard about PMTCT were reported to increase male involvement in PMTCT[14, 15, 22-24].

## **CHAPTER THREE: PROBLEM STATEMENT, JUSTIFICATION AND CONCEPTUAL FRAMEWORK**

### **3.1 Statement of the Problem**

There is no standard definition or approach to male partner involvement in PMTCT in Uganda. This lack of standardization may contribute to reports that male involvement in PMTCT is low and lacking in content within Uganda. It is estimated that only 5-25 percent of men are actively involved in PMTCT with variation existing in districts [25-27].

In order to ensure improvement of the indicators for male partner involvement in PMTCT, several actors in the country encourage men to accompany their spouses to health facilities to receive HCT or other services. Though not comprehensive enough, this is often used as a measure of support a woman receives from the partner as well as a measure of male involvement in PMTCT. Whichever approach or measurement is employed, male partner involvement is believed to enhance maternal and child health outcomes [28].

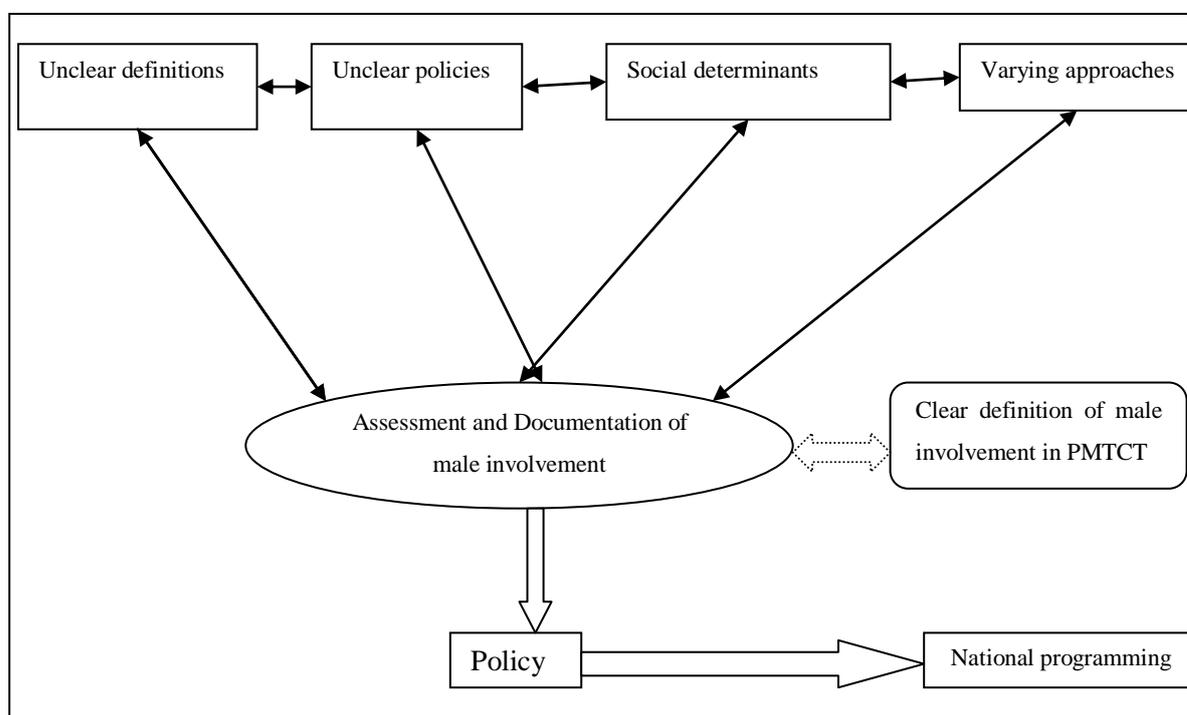
It stems from the perceived benefits of male partner involvement that the Uganda National HIV prevention strategy (NPS) 2011 – 2015 and the National HIV/AIDS Strategic Plan (NSP) 2011/12 – 2014/15 identify low male participation as a structural driver for the HIV epidemic [29-31]. In effort to implement these plans, actors do vary the scope of male involvement in PMTCT interventions to include several others beyond couple HCT services. The various approaches and perceptions need to be appreciated and documented. This will then enable development of a more encompassing definition of male involvement in PMTCT that will guide future policy and programming.

### **3.2 Justification of the study**

This study assessed and documents existing approaches and understanding of male involvement in PMTCT in Uganda. It is intended to inform the process of defining male involvement in PMTCT for Uganda.

The findings will inform policy makers to define approaches and measurement to male partner involvement in the country. They will contribute to forming a basis for developing a national evidence informed policy for male involvement in HIV prevention, PMTCT inclusive; in Uganda.

**Figure 1. Conceptual framework of assessing the implementation of male involvement in PMTCT**



Lack of a standard definition and guidelines for male involvement in PMTCT leads to disorganized program implementation. Such programs may be difficult to track especially at the national and operational levels. Once clear definitions and policies for male partner involvement are put in place, standardization of the interventions that promote male partner involvement in PMTCT will be achieved.

In the conceptual framework, there are unknown definitions, unclear policies and varying approach to male involvement in PMTCT within the country. These coupled with existing social determinants formed a basis for assessing and documenting existing understanding and approaches to male involvement in PMTCT in Uganda. In doing this, efforts were geared towards formulating a clearer and domesticated definition of male involvement in PMTCT for Uganda. This will inform policy formulation for male partner involvement in PMTCT that will ultimately guide future PMTCT programs.

## **CHAPTER FOUR: STUDY OBJECTIVES**

### **4.1 General Objective**

This study assessed the understanding and existing approaches to male partner involvement in respect to preventing HIV transmission from mothers to babies in Uganda. It was achieved through the following specific objectives:

### **4.2 Specific Objectives**

- 1). Documenting the existing understanding of male partner involvement in PMTCT in Uganda
- 2). Documenting existing approaches to male partner involvement in PMTCT in Uganda
- 3). Comparing the implementer's and consumer's (PLHIV) understanding of male partner involvement in PMTCT, to that of other women and men in the community
- 4). Establishing the PMTCT prong in which male partner involvement in PMTCT is most felt.

## **CHAPTER FIVE: STUDY METHODOLOGY**

### **5.1 Study site**

The study was conducted in Kasese, Mayuge and Rakai districts, which are found in the western, eastern and central regions of Uganda, respectively.

#### **5.2.1 Study population**

The study population included government ministries, Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs), District local governments and hospitals in the study districts. Community members' and PLHIV within the study districts were also included.

### **5.3 Study design**

The study was of a descriptive cross sectional design employing qualitative methods of data management. It took place from April 2012 to November 2012.

### **5.4 Sampling procedure**

Purposive sampling techniques were used to select respondents. A total of 15 Key Informants (KIs), six (6) In-Depth Interviews (IDI) respondents and six (6) Focus Group Discussions (FGDs) with 72 discussants were selected for the study.

#### Ministry interviewees:

One HIV Focal Person (FP) from each of the Ministry of Health (MoH) and Ministry of Gender, Labor and Social Development (MoGLSD) were selected for interviews. They were included because they are responsible for policy and supervision of interventions of male partner involvement in PMTCT within the country.

#### District local government interviewees:

The districts of Mayuge, Rakai and Kasese were selected from the eastern, central and western regions of the country, respectively. They were chosen out of six districts implementing the intensified combination HIV program in Uganda. Under this program, CBOs were supported by the Civil Society Fund (CSF) to implement structural HIV prevention interventions (promoting male partner involvement in PMTCT inclusive). The rationale for district selection was ease of access to the districts and coordinating the data collection process. The District Health Officer (DHO) identified an officer responsible for PMTCT for interviews from each district.

Non-Governmental Organization (NGO) interviewees:

Four national PMTCT implementing NGOs were identified for the study. They included Protecting Families against AIDS (PREFA), Baylor Uganda, Strengthening Tuberculosis (TB) and HIV/AIDS Responses in South-Western Uganda (STAR-SW) and Strengthening TB and HIV/AIDS Responses in East-Central Uganda (STAR-EC). One PMTCT program officer or manager was identified for interview from each of the NGOs.

Community Based Organization (CBO) interviewees:

One PMTCT implementing CBO was identified by the DHO in each of the study districts. Those selected were CBOs supported by CSF to implement structural HIV prevention interventions (promotion of male partner involvement in PMTCT inclusive). One PMTCT program officer was interviewed from each of the CBOs.

Hospital interviewees:

One PMTCT implementing hospital in each study district was selected. They were Bwera hospital in Kasese district, Buluba hospital in Mayuge district and Kalisizo hospital in Rakai district. The head of MCH department from each of the hospitals was interviewed.

Persons Living With HIV:

Persons Living with HIV (PLHIV) were subjected to In-Depth Interviews (IDIs). Those eligible were HIV positive people who had publicly declared their HIV sero-statuses and used PMTCT services over the last three years. Their identification was done by a PLHIV network coordinator within the study district. Two PLHIV (a female and a male) were interviewed in each study district.

Community members:

Community perceptions were sought through Focus Group Discussions (FGDs). For inclusion in the FGDs, the research assistants identified adult (18+ years old) women and men who had given birth to children in the last 3-5 years and thus hopefully used ANC services.

Records:

Reports and records of PMTCT were obtained from the study ministries, districts, organizations and hospitals. They included only those that covered activities within the last one year before the study. The review established those approaches to male partner involvement in PMTCT that were documented as well as any existing means of measurement.

## **5.5 Study variables**

The study variables included understanding of male involvement in PMTCT and approaches employed. Other variables were male partner involvement within PMTCT prongs i.e. prevention of: pregnancies, primary HIV transmission to the mothers, HIV transmission to the baby from the mother as well as male support to family care and treatment. The obstacles to existing approaches were also explored from all participants. The variables which were studied through each data collection method are further elaborated under each interview method.

## **5.6 Data Collection methods**

### ***5.6.1 Selection and training of research assistants***

All data were collected by two Research Assistants (RAs) who were conversant with the indigenous local languages i.e. Lusoga in Mayuge district, Luganda in Rakai district and Lukhonzu in Kasese district. They were recruited and trained by the Principle Investigator (PI) to collect and transcribe data. Under supervision of the PI, research assistants were paired during each interview or discussion. With exception of Rakai district where the research assistant's pair was made up of only men, the pairs in other districts were made up of a female and male. The pairing enabled one of them to write field notes while the other moderated the interviews. Engendering the pairs was intended to enable free information flow from both male and female respondents.

### ***5.6.2 Data collecting tools***

A KI guide, an IDI guide and FGD guide were used to collect information. With permission from participants, the RAs also recorded all interviews on a digital voice recorder.

### ***5.6.3 Pre-testing of tools***

The data collection tools were pre-tested as part of the research assistants' training. Improvements in content were thereafter made by the principal investigator before actual data collection.

#### **5.6.4 Interview methods**

##### **Key informant interviews**

Key Informant (KI) interviews were administered to 11 service providers that included managers from ministries, NGOs, CBOs, district health offices and district hospitals. Through these interviews, views of manager's in regards to promotion of male involvement in PMTCT were sought. The KI interviews also made it possible to clarify on processes at the service provision levels. Through this method, we explored the approaches, policies, programs and tracking (monitoring) methods of male involvement in PMTCT that existed at service provision level. Underlying obstacles as perceived by managers during promotion of male involvement were also sought. The manager's perceptions on involvement of men during: prevention of pregnancies, primary HIV transmission to the uninfected mothers, HIV transmission to the baby from the mother and support to family, were also explored.

##### **In-depth interviews**

In-depth Interviews (IDI) were conducted with the six PLHIV. The IDIs provided an opportunity for PLHIV to share their life stories and thoughts regarding male involvement. It also offered deeper insight into why and how persons that had used PMTCT services and were also infected with HIV, behaved in the ways they did. Each IDI was hosted at a venue selected by the respondent and lasted for about 1-2 hours. Through IDI, we explored the meaning of male involvement in PMTCT as perceived by PLHIV. We also sought enlightenment into the behaviours that PLHIV felt men were involved in PMTCT, their perceived benefits and obstacles as well as presence of socio-legal factors that influenced them in respect to male involvement.

##### **Focus group discussions**

A total of six Focus Group Discussions (FGDs) were conducted with 72 community members. They were held to examine what and why people thought the way they did without pressuring them into reaching a consensus on male involvement. Two FGDs (one composed of only female and other male discussants) were held in each of the study districts. Each discussion comprised of 11-13 adults and lasted for about 1-2 hours. The key variables studied during the FGDs included: community members' appreciation of the meaning of male involvement, how community members were involved in male involvement and community benefits and obstacles to male involvement in PMTCT.

Similarly, we investigated existence of socio-legal factors influencing male involvement, which were present in the communities.

#### ***5.6.4 Field editing of data***

During data collection, a daily debrief was held between the research assistants and the principle investigator. This enabled redress issues that required improvement within the data collection tools as well as the study themes and sub themes. Whenever required, the research assistants sought clarification from respondents by telephone.

### **5.7 Data Management and Analysis**

All collected data were edited, cleaned and transcribed from the local languages into English using Microsoft office word. Each English version of the transcripts was stored independently as a primary document and later assigned to Atlas Ti version 5.0 for analysis. A mix of hermeneutical[32] and content [33] analysis methods were used during data analysis. This enabled us understand what the participants made sense of the prescribed text while establishing what the recurring issues amongst them were.

Categorization of the ‘primary documents families’ was based on data collection methods i.e. KI, FGD and IDI primary document families. Intra-primary document family categorization was also further based on participants sex categories i.e. male/female FGDs family and male/female IDI family. While summarizing and coding the primary documents, continuous generation of new ideas and drawing of conclusions was done. The topics in the interview guides informed the predetermination of themes, which also served as structures for organizing, generating analytical outputs and reporting. Quotations in each primary document were coded in line with the predetermined themes, which were: a) understanding, b) approaches, c) obstacles, d) benefits, e) recommendations, and f) social-culture. Triangulation of KI, FGD and IDI data was done during analysis to acquire deeper insights into respondent perceptions and behaviors.

Quality assurance was done through cross-checking the data with the sources whenever need arose. While reporting, some typical quotes were included so that the original content of meaning was retained.

## **5.8 Ethical considerations**

The study was approved by Makerere university school of public health higher degrees, research and ethics committee (reference number: IRB00011353) and the Uganda national council of science and technology (reference number: SS2766). Permission to proceed with data collection was also obtained from Uganda AIDS Commission (UAC). After training of the RAs about ethical considerations during research, a letter (from UAC) introducing them to the study participants was issued. We assured the participants of confidentiality and obtained their verbal consent before each interview or discussion. The participant's confidentiality was later ensured by excluding their names and work based titles from the final report.

## CHAPTER SIX: FINDINGS

This section presents the key findings in respect to assessing the approaches to male partner involvement in PMTCT in Uganda. It details participant responsiveness, findings on existing understanding, approaches to male partner involvement and their obstacles as well as male involvement in respect to the PMTCT pillars.

### 6.1 Participant responsiveness

The total number of participants was 89 out of 93 that had been targeted. Forty two of the respondents were men while the rest were female. Three NGOs and one government ministry respondent were non-responsive. Details of the participant's responsiveness are shown in the Table 1:

**Table 1: Participant responsiveness disaggregated by data collection method**

Category	Data collection method			Total interviewed (targeted)
	KIs interviewed (targeted)	FGDs interviewed (targeted)	IDI interviewed (targeted)	
Ministry managers	1 (2)	0 (0)	0 (0)	1 (2)
NGO managers	1 (4)	0 (0)	0 (0)	1 (4)
DHO managers	3 (3)	0 (0)	0 (0)	3 (3)
CBO managers	3 (3)	0 (0)	0 (0)	3 (3)
MCH managers	3 (3)	0 (0)	0 (0)	3 (3)
PLHIV	0 (0)	0 (0)	6 (0)	6 (6)
Community members	0 (0)	72 (72)	0 (0)	72 (72)
<b>Total</b>	<b>11 (15)</b>	<b>72 (72)</b>	<b>6 (6)</b>	<b>89 (93)</b>

### 6.2 Existing understanding to male partner involvement

Varying perceptions of male partner involvement in PMTCT were found amongst the respondents. Broadly however, the concept was understood to mean:

- Men accompanying their spouses to health facilities to receive services like ANC, delivery of babies and post natal care
- Men providing social support to their spouses and family
- Men preventing HIV through measures like sexual abstinence, safe male circumcision and condom use
- Men using male controlled family planning measures such as vasectomy

#### *6.2.1 Service providers perceptions of male involvement in PMTCT*

Most KIs perceived male involvement in PMTCT as the resources that men gave to their spouses at home or health facilities; during antenatal, delivery or postnatal periods. They did

appreciate that such provisions were necessary irrespective of an HIV sero-status of a couple, which is illustrated in the following quote:

*‘...it is the social, moral, economic and physical support a man offers to the female partner during pregnancy, labour or after delivery, even if they are HIV positive or negative.’ (KI, DHO, Rakai)*

Some of the service providers felt that since it was intended to benefit the child, male involvement had to occur before, during and after the baby’s birth. To realize this, they suggested men’s involvement during the child’s growth, irrespective of their contributions during the antenatal and delivery periods. They advised men partaking of roles like feeding the baby after it was born.

*‘Male involvement is when a man prepares for a pregnancy, supports the wife financially and gives her company to the hospital for antenatal visits. Even during delivery, men should provide practical physical and social support to women.’ (KI, CBO manager, Mayuge)*

*‘...is when men take their female partners to hospital for safe delivery. It also includes men ensuring that children get good health as well as monitor their growth at home.’ (KI, CBO manager, Kasese)*

*‘...is where a couple shares responsibilities during pregnancy and feeding the infant. We need men not only to accompany wives but to have interest in what happens at ANC like having the HIV test together.’ (KI, Ministry HIV FP)*

In addition to other KIs who observed that male involvement in PMTCT was for the baby’s benefit. The interviewed managers from district health offices felt strongly that in addition to the targeted babies, it enhanced women’s decision making. They believed that presence of a man when a spouse was pregnant improved the decision making processes. A DHO in Mayuge said:

*‘Women are very poor thus have to depend on the men. Most women can’t take a decision thus rely on the man for decision taking.’*

Similarly, another DHO in Kasese said:

*‘...most African women do not have decisions hence it would be better when a man is around.’*

Contrary to the numerous responses from other categories of participants, few KIs considered male involvement to be the physical accompaniment that men gave to their spouses, when they sought PMTCT services at health facilities. Among the few KIs that suggested this, their perceptions were based on the way male involvement was measured at health facilities, as illustrated by a comment from service provider who said:

*'It means a man coming with a woman for HCT and supporting her through delivery though it is vague. The proxy of measurement is how many men come for HCT with their women...'* (KI, NGO manager, Mayuge)

However, there was a call for a general and more inclusive definition of 'male involvement' as observed from the service providers concern about lack of clarity on the scope of male involvement. An NGO manager said: *'I recommend that we clearly define what male involvement is. A man will tell you that he married the wife, made her pregnant, gave her money to the hospital and then you ask what male involvement is! That is rather unfair'*

### **6.2.2 Community member's perceptions of male involvement in PMTCT**

In contrast to KIs, all FGDs perceived men escorting their spouses to health facilities as male involvement in PMTCT. This was irrespective of whether the men were destined to receive or not to receive a service at the health facility. Both male and female FGDs also perceived male involvement as the engagement of men in HIV prevention behaviors like condom use and the provision of family needs like food. However, adult female FGDs suggested that HIV positive men deserved treatment for HIV/AIDS, as a way to involving them.

*'It is when both partners take an HIV test to know their status as a couple after which if your wife is positive then the husband protects himself, provides support in terms of escorting the wife to the hospital, providing for the needs of wife and child as well as any other necessary material support'. (FGD, adult male, Mayuge)*

*'....After the male partner gets to know that he is HIV positive he has to go at any treatment center for treatment and then after he should be using condom during sexual intercourse to prevent HIV transmission...'*

*'My opinion is that it is the provision of nutritional (food) and material support to the mother and child when found HIV positive.'* (FGD, adult female, Rakai)

While none of the men reported it, all female FGDs reported sexual abstinence as their perception of male involvement. They felt that an HIV positive man, who at least abstained from sex during the time of pregnancy, could remarkably reduce the chance of the baby being infected with HIV. A female discussant in Rakai district said:

*'It involves men being patient on the issues regarding sex until mother delivers in order to prevent the unborn child from acquiring HIV from the father if he is HIV positive. He should also support the wife and baby in all ways through pregnancy until birth and beyond...'* (FGD, adult female, Rakai)

Unlike their female counterparts who did not mention it, participants in all male FGDs revealed that coercive procedures existed at health facilities. Such procedures were reportedly intended to force men escort their spouses to health facilities. Among them, health workers were literally reported to chase away pregnant women whenever they were not accompanied by their spouses. Despite a possibility of women failing to receive a service in case the husband refused to be the coerced, forceful procedures had an advantage because they were cited to be informative for some men about male involvement in PMTCT. A male discussant in Mayuge said: *'For me I knew about our involvement when my wife was pregnant and chased away because I did not escort her. She only received care when I went back to hospital with her.'*

Even though not mentioned by the service providers, the reported coercion at health facilities implied that health workers understood male involvement in PMTCT as men's escorting of women.

### **6.2.3 Perceptions of PLHIV about male involvement in PMTCT**

While all other respondents did not comment about circumcision, female PLHIV cited it as a way of involving men in PMTCT. The HIV positive women reasoned that since male circumcision reduced the chances of their spouse's acquisition of HIV, the mother and child were also eventually protected. Other views presented by female PLHIV about the meaning of male involvement were that it included sexual abstinence during pregnancy for HIV positive men as well as the provision of food, material and other support during ANC, delivery and postnatal periods. Female PLHIV also correctly perceived the purpose of male involvement to be child protection against an HIV infection, as illustrated in the following quote from a female PLHIV Kasese: *'It means the delivery of children and helping the mother to deliver a safe child who is not infected'*.

On the side of male PLHIV, they only perceived male involvement as couple HCT and men escorting their spouses to health facilities. However, they believed that it was the women's role to influence the man's support. Similar to their female counterparts though, some of them appreciated that the desired outcome of male involvement was an HIV negative baby.

*'Male involvement refers to someone who is infected not to deliver a child who is infected and to make sure the woman encourages the man to take her for ANC'* said a male PLHIV in Kasese.

### **6.3 Existing approaches to male partner involvement**

#### **6.3.1 Approaches reported by service providers**

Eight out of 11 service providers reported that they promoted male involvement through couple HCT as well as encouraging disclosure of HIV status among couples. Other commonly cited ways of promoting male involvement were: a) engagement of community support groups; b) attraction of men to health facilities through an incentive including couples being served first, awarding certificates to couples and organizing sports events for men; c) conducting outreaches including home to home visits targeting men d) offering health education for men; e) promotion of male condoms and other male controlled family planning methods and f) positive living among HIV positive men. The following quotes illustrate some KI responses.

*'We organize and give certificates during the couple week to those men who test for HIV to encourage others to test. This week brings in more couples than all the other weeks hence we are now refocusing more funds to that week...'*

*'Inter-Religious Council of Uganda promotes male involvement through health education and facilitating outreaches on male involvement although the outcome is still very poor.'* (KI, service provider, Mayuge)

*'Baylor runs a family clinic where the family (mother, father and child) are catered for while the focus is on preventing mother to child transmission of HIV. We offer special services of measuring men's blood pressures'* (KI, service provider, Kasese)

*'We provide small incentives like packed milk to those mothers who breast feed and had managed to go together with their husbands to the hospital. Men who are involved are given pens, T-shirts, which help to influence others, to also to become involved.'* (KI, service provider, Rakai)

However, most service providers were wary of the low priority that implementing partners accorded to male involvement. Some of the KIs nevertheless cited that they occasionally integrated male involvement into general PMTCT services because they felt that involving men was an enabler of reaching women and children.

*'In the country, we have not been having partners spearheading male partner involvement in PMTCT until recently when World Health Organization (WHO) supported us to develop guidelines for health workers.'* (KI, policy maker, Ministry)

*'Most organizations here do not target or have a specific focus on male involvement. However those with general PMTCT services include PREFA, Rakai Health Sciences Program and others.'* (KI, service provider, Rakai)

*'We strongly recognize that without men, you cannot reach women. We have to reach men first with messages to be able to reach women as we have done in the HCT couple week.'*

### **6.3.2 Approaches used by community members**

Similar to service providers, some FGDs reported that incentive related services existed such as couples being attended to first. One adult female discussant in Kasese said that: *'...tokens of appreciation were given to women who went for ANC with their husbands like being attended to first.'*

However, all female FGDs cited men acting as treatment supporters and use of condoms as ways in which men were involved at individual level. Female discussants said that husbands acted as treatment supporters by escorting their spouses to health facilities and reminding them to take medications on time while providing counseling and love. A female discussant in Mayuge said: *'They escort their partners to health facilities for treatment and ensure that their medicine is taken as prescribed by the health workers'*. This was supported by male FGDs who also cited that they indeed provided support through reminders for medications and other ways.

In confirmation of the services available, several FGDs said that couple HCT was availed at health facilities. Both women and men discussants also reported use of condoms in addition to the material and financial support as other ways in which men were involved.

Male FGDs however reported sexual abstinence as one of their methods of involvement. This was said to be a known prevention strategy that they sometimes used. On the side of female FGDs, they too exclusively reported that male controlled family planning services were used as an approach to male involvement. This was seen as a way of avoiding future pregnancies that automatically led to zero possibility of exposure to HIV for a child.

*'STAR-EC works through existing village health teams that sensitize pregnant women and their spouses to go for HIV counseling and testing such that those found HIV positive are supported to give birth to health babies'* (FGD, adult female, Mayuge)

*'Men prevent unintended pregnancies among women living with HIV through use of family planning methods like condoms and vasectomy. There will of course be no children to infect with HIV if we do not get pregnant'* (FGD, adult female, Kasese)

### **6.3.3 Approaches reported by PLHIV**

All male PLHIV did not report to have ever benefited from an incentive related PMTCT service. This was in contrast to service providers reports indicating that such services existed. It was however not ascertained when the incentives were put in place at health facilities for comparison with the period that male PLHIV used PMTCT services.

The most common approach reported by PLHIV was the provision of material and financial support. One PLHIV in Mayuge said: *'My husband bought a cow that supplied milk for the baby. After weaning, when the baby cried a lot, he took turns in babysitting it at night.'*

Others reported other ways such as couple HCT, condom use and sexual abstinence as illustrated by a quote from another PLHIV in Kasese who said: *'When I explained to the man that I was infected and encouraged him to use the condom he understood.'*

All in all, the reported ways that male involvement in PMTCT was done included those that were initiated at health facility level and others at individual level.

### **6.3.4 Challenges to existing approaches**

Several obstacles to the existing approaches of male involvement in PMTCT were reported. They can broadly be categorised as follows:

- a) Absence of law to enforce male partner involvement in PMTCT.
- b) Stigma and fear of negative outcomes of disclosure such as violence and separation.

- c) Social, religious and economic barriers.
- d) Health system barriers.

Low male involvement in PMTCT was a commonly cited challenge amongst service providers. This can partly be attributed to lack of guidelines and policies for male involvement at national and community levels, which was reported by all service providers and community members, respectively. All participant categories advocated for more coercive methods like legislation to enforce male involvement. Similar to service provider's perceptions, some male FGDs attributed the low male involvement to the design of health facilities that was reportedly less-attractive to men. Male FGDs considered health facilities not accessible because men were never recognized. An NGO manager said:

*...health facilities are designed to accommodate women thus men lack what to do when they go there. As much as you tell them to come, men feel out of place because services do not attract them.'*

Service providers also cited obstacles including men's self-stigma associated with fear to disclose their HIV status as well as their impatience following long waiting times at health facilities. Though several participants believed that women liked men to escort them to health facilities, some service providers believed that some women disliked it in preference to be given money. This in itself may be an obstacle to male involvement since many of the men and women considered accompanying women as the meaning of male involvement, yet the women may dislike it. A CBO manager in Rakai said:

*'Women always want men to be involved, preferably, to be given money, which enables them to retain some balances(sic), for buying other necessities. They do not want men to go with them to the hospital but need practical financial support.'*

All female and male FGDs were wary of the men's dislike and fear of disclosure of their HIV sero-status. Another challenge among both female and male FGDs was the resistance of men towards condom use. Condoms were regarded as none traditional way of engaging in sex therefore participants could not use them willingly. This coupled with men's impatience while on waiting lines at health facilities as well as possibility of divorce were translated into men being difficult people.

*...Some men go for HIV testing and do not disclose yet they don't want to use condoms even when HIV positive, what should we do?'*(FGD, adult female, Rakai)

*'Most women after testing together with their husbands always emphasize using condoms while others prefer to separate whenever found positive'* (FGD, adult male, Rakai)

Though not reported by the male FGDs, another challenge observed by all female FGDs was women's rudeness to their spouses that reportedly led men to deny them support.

Unlike other respondents, female PLHIV were concerned about poor access to health services in event that men were not involved. They considered involvement of men as an avenue for receiving resources while it's' absence led to women's failure to access PMTCT services. A female PLHIV in Mayuge said: *'If they (men) are not involved it is difficult for us to convince them of the need to give birth in a health facility or even discuss issues of child spacing since its very risky for HIV positive women to give birth every year'* .

Other challenges cited by some female PLHIV were resistance to use of condoms, which men regarded unconventional while male PLHIV commonly cited stigma and discrimination as their challenges.

#### **6.4 Prevalence of male involvement in PMTCT prongs**

The global and national PMTCT guidelines recommend the four-pronged strategic approach that includes:

- Prong 1: Prevention of HIV among women of reproductive age and parents-to-be (primary prevention of HIV).
- Prong 2: Prevention of unintended pregnancies among women living with HIV.
- Prong 3: Prevention of HIV transmission from pregnant women living with HIV to their babies.
- Prong 4: Provision of care, treatment and support to women living with HIV and their families.

Within the arena of primary prevention of HIV, health education was reported as the way in which male involvement was promoted. Through health education, couple HCT was promoted as an entry point to knowing ones' HIV status, as well as demand for PMTCT services and safer sex was promoted. Men's involvement in this prong was also reported through use of condoms for HIV prevention, undertaking safe male circumcision as well as sexual abstinence, as quoted below:

*'As a hospital, male partner involvement is promoted through the ANC clinic where we educate mothers to come and open up. We encourage them to come along with their spouses to test for HIV as an entry point.'* (KI, MCH head, Mayuge)

*'Men are usually tricky; however we encourage couple HIV testing and disclosure. Out of 200 people we get about 4 couples. However the couples still report separately yet some may be discordant. We then try to link the couples through existing health facilities to facilitate disclosure.'* (KI, CBO manager, Rakai)

*'STRIDES organization is encouraging pregnant women's husbands to get circumcised for HIV prevention.'* (FGD, adult Male, Mayuge)

Under the 2<sup>nd</sup> PMTCT prong; use of male condoms was often reportedly used to prevent pregnancies. This was in addition to sexual abstinence, use of hormonal contraceptive methods and vasectomy.

*'I always plan for pregnancies because I know my safe days. I can tell my husband to use a condom, or if the husband is resistant, I use family planning pills.'* (IDI, female PLHIV, Rakai)

*'I was involved in preventing unwanted pregnancies through abstinence and use of condoms.'* (IDI, male PLHIV, Kasese)

Under the 3<sup>rd</sup> PMTCT prong, health facility interventions were used in preventing transmission of HIV to the baby. The existing interventions ranged from building capacity of health workers to offer services, conducting supervised deliveries of babies as well as offering Anti-Retroviral (ARV) treatment to mothers and babies. The involvement of men in this prong was minimal except where family centered clinics were promoted as an approach as illustrated in the quotes below:

*'Mothers that are HIV positive are counseled, investigated and given nevirapine or other ARVs for the mother and baby. The mothers are also encouraged to at least disclose to a trusted person about their status such that they are given support for treatment and care of the baby.'* (KI, MCH head, Mayuge)

*'In preventing transmission of HIV to the baby, we train health workers on safe delivery and avoid certain practices like episiotomy. We also sensitize health workers and mothers on dangers of prolonged labour. Baylor opened a family clinic at this hospital where the family (mother, father and child) are all catered for as a family while the focus is on preventing mother to child transmission of HIV.'* (KI, MCH head, Kasese)

*'In preventing HIV transmission to the baby, we always provide drugs, do safe delivery of babies as well as give mothers medicines to prevent transmission.'* (KI, MCH head, Rakai)

It was in the 4<sup>th</sup> PMTCT prong that community respondents (PLHIV inclusive) reported male involvement to occur frequently. This was mainly through provision of social support to foster care and treatment to their families. Unlike under other prongs, PMTCT service providers did not report much about this pillar.

*'My husband supported me to feed our baby. He bought a cow to supply milk to the baby. Sometimes the baby cried a lot after weaning, he then took turns in babysitting especially at night which enabled me to rest.'* (IDI, female PLHIV, Mayuge)

*'Men escort their partners to facilities for treatment and act as treatment supporters to ensure that women take their medicine. Men also endeavor to provide their wives with support in terms of food and other needs such that they have a balanced diet.'* (FGD, adult female, Mayuge)

*'In care and support, after discharge we tell mothers what to do or inform the caretaker. We do not go beyond that.'* (KI, MCH head, Rakai)

## **6.5 Review of records**

Amongst all reports and records studied, there was no qualitative information presented on male involvement in PMTCT. However, monthly Health management Information System (HMIS) reports captured quantitative data on male couples that attended ANC as well as couple HCT.

## **CHAPTER SEVEN: DISCUSSION**

In this study assessing the approaches to male involvement in PMTCT, it was established that the ways in which men are involved were coherent with the community, PLHIV and service providers understanding of the concept. Service providers mostly understood male involvement to mean the physical, social and financial assistance that men gave to their families, while community members understood it as men escorting their spouses to health facilities. At individual level, men were majorly involved through use of HIV prevention measures and providing material and financial assistance to their spouses. On the other hand, service providers mainly promoted innovations like couple HCT, family orientated clinics and gave incentives to attract men.

Much as male involvement is believed to be beneficial to mothers, and that its' lack hinders PMTCT service utilization[34, 35], some studies have refuted it. For instance, it was found that use of 'invitation letters' as an innovative approach to male involvement reduced mother's uptake of PMTCT services in Tanzania[36]. Some authors also concluded that male involvement could diminish the scarce resources available for women and children leading to a hindrance to the women[37]. Despite possibility of shortcomings to male involvement, the innovative approaches of family clinics and other incentives in PMTCT programs may be associated with positive outcomes in Uganda. If so, it would be in agreement with Reece et al and Katz et al who found men in Kenya responsive and motivated by tangible health related products and recommended couple HCT as a strategy for increasing male involvement in PMTCT [38, 39]. However, effects of use of incentives and other approaches to male involvement in Uganda have never been studied.

Though most respondents were in agreement with the need to involve men, some women were reported to dislike men's physical presence at PMTCT clinics. Similarly, men elsewhere were reported not to expect women to want more than payment for services during pregnancy [40]. However, some authors have reported that both men and women like men to get involved as a result of the extent to which they are culturally important or regarded in society[37]. This calls for future programs to build upon the traditional value of men's social and financial responsibility at the household.

The importance of condoms and vasectomy, which are known male controlled family planning methods, were cited as ways in which men were involved. However, condoms are usually promoted by service providers as a dual protection tool against pregnancies and sexually transmitted diseases but not as a PMTCT tool. Similarly, vasectomy is promoted as a male controlled contraceptive method [41]. In view of this study's findings and knowing that little emphasis exists on preventing unwanted pregnancies as a PMTCT strategy, there is need to further consider birth control methods that are controlled by men as areas for male involvement.

The reported approaches of couple HCT as well as offering material and financial support were in agreement with previous studies in Kayunga (Uganda) and elsewhere in Africa that reported the same as ways of promoting male involvement in PMTCT[4, 14]. The plausible reason for perception and promotion of male involvement as couple HCT may be the big emphasis that this approach receives from World Health Organization[6]. Although it is appreciated that men provide material and financial support to their spouses and families, studies have also reported that they often shift the burden of providing care and support disproportionately to women and girls[21]. This may be in support of the deep-seated ideas that exist about gender roles that are known to influence the response towards existing approaches to PMTCT[42, 43]. It may also explain the respondents' perception of PMTCT as a female domain and that men lacked clear roles while at health facilities.

The existing approaches to male involvement in PMTCT like family clinics and incentives such as attending to couples first are responsive to the national plan to eliminate Mother to child Transmission of HIV in Uganda, which calls for innovations to increase male involvement[31]. Other countries have also put in place innovations like legislative change, use of progressive male networks, training of service providers, and equipping young men and boys with sexual education, gender training and conflict-resolution skills; as a route to promoting male involvement in PMTCT[41]. Such programs provide an avenue to further understand the essential requirements for integration of men as partners in PMTCT programs. HIV counseling and testing is an entry point to all HIV prevention programs, PMTCT inclusive. However, research in Mbarara showed that women could undertake HIV testing only if their husbands approved of it[44]. These findings are supported by service providers in this study who believed that in order to reach women and children, it was important to reach the men first thus supporting the need for male involvement in PMTCT. This calls for special consideration of the 'men as gate keepers' notion while programming for interventions that

target women because they may or may not be obstacles to PMTCT service utilization. Early involvement of men as an entry point to reach their spouses also reduces likelihood of negative outcomes like domestic violence[45].

A major obstacle cited was fear to disclose due to likely negative outcomes like domestic violence and marital separation. Our findings were consistent with studies in Kenya and Tanzania whose participants had similar fear for disclosure of unfavourable results[45, 46]. Olga et al [47] however found that disclosure of HIV positive results could also lead to positive effects like spousal medical, social and physical support. Other perceived barriers to male involvement like PMTCT services being female orientated and lack of time as well as what to do at health facilities were also in agreement with findings of Stephanie et al [48] in Tanzania. However, in regards to female orientation of services, Katz et al [39] found men in Kenya with an opposing view to our findings. Men in Nairobi, Kenya preferred to use existing ANC services, which was a sign of conduciveness of the services to them. This necessitates us to examine such programs that are attractive to men for possible replication in Uganda's PMTCT program.

This study had some limitations including:

- The response rate amongst the national level implementers was low. This may limit generalization of the findings to the whole country.
- The retrospective design of the study may have led to a recall bias of the respondents. Similarly, CBOs that were expected to have programs on PMTCT had not yet received funding to start implementation. Due to this, CBO managers relied on past experience in previous programs thus could have suffered a recall bias. This was however minimized through triangulation of data collection by using similar tools on different categories of respondents.
- The analyzed information had been translated into English, which could have diluted the original richness of the data including possible loss of information. This was minimized by ensuring that translation was done by experienced data collectors as soon as each interview was accomplished.
- Lastly, the absence of qualitative reports on male involvement in PMTCT made it impossible to validate verbal reports thus limited the study.

## **CHAPTER EIGHT: CONCLUSIONS AND RECOMMENDATIONS**

### **8.1 Conclusions**

The existing variations in approaches to male involvement appeared to be influenced by ways in which organizations and individuals understood it. While service providers promoted male involvement through majorly creating demand for services, community members' were involved through socio-economic support and use of available HIV prevention measures. Despite existing challenges at individual, society and health system levels, the involvement of men in PMTCT was ultimately most appreciated by communities during the provision of care, treatment and support to families

### **8.2 Recommendations**

This study recommends that:

- In view of the varied perceptions and approaches to male involvement in PMTCT, UAC should develop a policy that harmonises communities and service provider's perceptions on the subject. The policy will further guide development of standard male involvement in PMTCT packages that may be replicated for other HIV/AIDS services.
- Researchers should study the effectiveness of existing approaches to male involvement in PMTCT to enable replication of those likely to succeed.

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## Appendices

### *Appendix 1: Consent form*

Hello Sir/ Madam,

My name is \_\_\_\_\_, working for the Uganda AIDS Commission (UAC). This study titled: **“Assessing the approaches to male partner involvement in PMTCT in Uganda”**, is funded by the MakSPH-CDC-fellowship program. The overall purpose of the study is to assess the existing understanding and approaches to male partner involvement in respect to preventing HIV transmission from mothers to babies in Uganda. This will enable UAC define and guide future processes of male partner involvement in preventing HIV transmission to babies.

You’ve been selected on purpose and we wish, with your permission, to interview/discuss with you. The interview/discussion will be recorded to ensure the information captured is accurate. Some of the questions asked, may be of a sensitive nature, but please note that your name will not be recorded in the questionnaire, and any details related to your privacy will be kept confidential. No personal information about you (such as your name) will be used or disclosed to anyone. Instead, you will be assigned a number and this will be used in place of your name. Your participation in this survey is very important and we rely on you to provide us with accurate information.

There are no risks 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. Be assured that we want to learn from your experience and all the information we collect will be used to help us control HIV/AIDS in your community and the country at large.

The interview/discussion will take approximately \_\_\_ minutes, but with your cooperation it can be done quickly. May I have your permission to include you in this interview/discussion?

Yes  No

If you do not want to participate, why.....

Names (Interviewer/respondent), signatures and date of the interview if verbal consent was obtained:

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## ***Appendix 2: Key Informant Interview guide***

### **A. The understanding**

1. What do you think the term “male partner involvement” in PMTCT means?
2. Are there any Ministries/Agencies/Working Groups that have been specifically supporting male partner involvement in PMTCT? If yes, what issues are they focused on?

### **B. Organizations’ Current Male Involvement approaches**

3. Please describe briefly your organization’s work in promoting male partner involvement in PMTCT.
4. Who are the beneficiaries of your organization’s interventions?
5. Please describe how your organization includes men in any of its male involvement in PMTCT activities? (e.g., as partners of women, as direct clients).
6. (*If men are not included in any of your activities*), Do you have any plans to work with men in your PMTCT programs?  
Yes\_\_\_\_\_ No\_\_\_\_\_ (How?)
7. (*If men are included in your activities*), what were the reasons your organization started to work with men?
8. Besides your beneficiaries, in what *other* ways does your organization have contact with men? (e.g., as service providers, policymakers, program managers, or community leaders). Please describe.
9. Do the women beneficiaries of your programs want men to be more involved? How?
10. Is your organization involved in any way in Primary prevention of HIV among women? If so describe approaches used
11. Is your organization involved in preventing unintended pregnancies among women living with HIV? If so, describe approaches used (probe for avenues involving male partners)
12. Is your organization involved in preventing HIV transmission from a woman living with HIV to her infant? If so, describe approaches used (probe for avenues involving male partners)
13. Is your organization involved in providing appropriate treatment, care and support to women living with HIV and their children and families? If so, describe approaches used (probe for avenues involving male partners)

### **C. Possible Areas in Which to Expand Work with promoting male involvement in PMTCT**

14. Would your organization like to work more extensively with promoting male partner involvement in PMTCT? If so, how?

15. What would make it easier to promote male partner involvement in PMTCT?

**D. Overall Benefits and Challenges**

16. In your view, what are the benefits of promoting male partner involvement in PMTCT?

17. What are the difficulties you undergo or foresee in promoting male partner involvement in PMTCT?

**E. Policies, Laws, and Regulations and Guidelines**

18. Would it help your organization if there were guidelines on promoting male involvement in PMTCT? How?

19. Are there any policies, laws, or regulations that you are aware of that are related to male partner involvement in PMTCT? If so, which ones?

20. Are there any policies, laws, or regulations that could make it more difficult to promote male partner involvement in PMTCT? If so, which ones and how would they make it difficult?

21. Is there anything in the local culture (s) that could be a barrier to male partner involvement in PMTCT? How do you think these barriers could be overcome?

22. To which sources do you look for guidance when working to promote male partner involvement in PMTCT? (*e.g., documents, websites, organizations*)

**THANK YOU VERY MUCH FOR YOUR PARTICIPATION.**

### *Appendix 3: Focus Group Discussion guide*

#### **Introduction**

Dear participants,

You have been selected to participate in this study “**Assessing the approaches to male partner involvement in PMTCT in Uganda**”. The overall purpose of the study is to document existing processes and understanding as well as define and guide future processes of male partner involvement in preventing HIV transmission to babies.. This will ultimately enable UAC to define male partner involvement in PMTCT for Uganda.

Having heard the information above, if you have any question about the study, raise it now. Feel free to ask further questions at any time. You are also free to withdraw from the discussion at any time. If you agree to provide information to the researcher under the conditions of confidentiality set out in the consent form, please register on the registration sheet.

*Thank you for agreeing to participate in this study.*

**General background (Note: This section is for building rapport and understanding context).**

**Researcher:** Peter Mukobi (*state your details including socio demographics*)

- a) Now that you know who I am, could you tell me about yourselves and your home life? (*age, education, tribe, marital status, number of children, type of work, Home life – follow-up at end of interview to complete socio demographic information on worksheet and make sure that all important characteristics have been covered*)
- b) Have you ever been involved in PMTCT services? If so, describe your involvement (*Target respondents who say yes*)

#### **Main Discussion section**

##### **A. The understanding**

1. What do you think the term “male involvement” in PMTCT means?
2. Are there any organizations that have been specifically supporting male partner involvement in PMTCT in your community? Please describe how they support.

##### **B. Communities knowledge of organizations’ Current Male Involvement approaches**

3. Who are the beneficiaries of the organization’s intervention in promoting male partner involvement in PMTCT?
4. Do existing organization (s) engage men in PMTCT activities? (*e.g., as partners of women, as direct clients*). Please describe.

5. Do the women beneficiaries want male partners to be more involved? How?

**C. Possible Areas in Which to Expand Working with communities to promote male involvement in PMTCT**

6. In which specific ways are male partners involved in preventing HIV transmission to their spouses
7. Are there any ways in which male partners are involved in preventing unintended pregnancies among women living with HIV? If so, describe existing actions by men
8. Are there any ways in which male partners are involved in preventing HIV transmission from a woman living with HIV to her infant? If so, describe.
9. Are there any ways in which male partners are involved in providing appropriate treatment, care and support to women living with HIV and their children and families? If so, describe existing ways.
10. In what additional ways would you like male partners to be involved in PMTCT programs?
11. What would make it easier to involve male partners in PMTCT?
12. Would it help you if there were guidelines on male partner involvement in PMTCT? How?

**D. Overall Benefits and Challenges**

13. What are the benefits of male partner involvement in PMTCT in your locality?
14. What are the challenges faced when male partners get involved in PMTCT?

**E. Policies, Laws, Regulations and Guidelines**

15. Are there any bye-laws that you are aware of that are related to male partner involvement in PMTCT? If so, which ones? Do they promote or inhibit male or their spouse's involvement?
16. Please describe anything in the local culture (s) that could be a promoter to male partner involvement in PMTCT?
17. Is there anything in the local culture (s) that could be a barrier to male partner involvement in PMTCT? How do you think these barriers could be overcome?
18. How do you think we should improve programs that promoting male partner involvement in PMTCT?

**THANK YOU FOR YOUR PARTICPATION**

## *Appendix 4: In-depth interview guide*

### **Introduction**

Dear sir/madam,

You have been selected to participate in this study “**Assessing the approaches to male partner involvement in PMTCT in Uganda**”. The purpose of the study is to assess the understanding and approaches to male involvement in respect to preventing HIV transmission from mothers to babies in Uganda. This will ultimately enable UAC develop guidelines for male partner involvement in PMTCT for Uganda.

Having heard the information above, if you have any question about the study, raise it now. Feel free to ask further questions at any time. You are also free to withdraw from the discussion at any time. If you agree to provide information to the researcher under the conditions of confidentiality set out in the consent form, please register on the registration sheet.

*Thank you for agreeing to participate in this study.*

**General background (Note: This section is for building rapport and understanding context).**

**Researcher:** Peter Mukobi (*state your details including socio demographics*)

- a) Before we get started, could you tell me about yourself and your home life? (*age, education, tribe, marital status, number of children, type of work, Home life – follow-up at end of interview to complete socio demographic information on worksheet and make sure that all important characteristics have been covered*)
- b) Who are all the people that you live with?
- c) If in relationship, how long have you been together with your partner?
- d) If in relationship, how would you describe your relationship with your partner?
- e) When did you know that you are HIV positive?
- f) Do you know the HIV status of your partner?
- g) You happened to have been selected because you used existing ANC services. During the last pregnancy of your partner, how did you generally find the reception at the hospital

### **Main Discussion section**

#### **A. The understanding**

1. Please describe what you think the term “male partner involvement” in PMTCT means?

#### **B. Interviewees’ knowledge of organizations’ Current Male Involvement approaches**

2. Are you aware of any organizations that are specifically supporting male partner involvement in PMTCT in your community? Please describe how they support.
3. Who are the beneficiaries of the organization's intervention in promoting male partner involvement in PMTCT?
4. Do the women beneficiaries want male partners to be more involved or not? How?

**C. Interviewees' experiences in male partner PMTCT**

5. Were you involved in preventing unintended pregnancies? If so, describe.
6. How was your partner involved in preventing pregnancy?
7. Can you describe how you were involved in preventing HIV transmission to the baby?
8. How did your partner get involved in preventing HIV transmission to the baby?
9. How did you participate in providing appropriate treatment, care or support to yourself and family?
10. How did your partner involve him/herself in providing appropriate treatment, care or support to you and your family?
11. In what additional ways would you like to be involved in PMTCT programs?
12. What would make it easier to involve you in PMTCT?

**D. Overall Benefits and Challenges**

13. What were the benefits you received following involvement in PMTCT?
14. What are the challenges you faced during your involvement?

**E. Policies, Laws, Regulations and Guidelines**

15. Are there any bye-laws that you are aware of that are related to male partner involvement in PMTCT? If so, which ones? Did they promote or inhibit your spouse's involvement in PMTCT?
16. Is there anything in the local culture (s) that could be a barrier to male partner involvement in PMTCT? How do you think these barriers could be overcome?
17. Is there anything in the local culture (s) that promotes male partner involvement in PMTCT? If so, describe how it promotes.
18. How do you think we should improve programs that promote male partner involvement in PMTCT?

**THANK YOU FOR YOUR PARTICPATION**