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Participation of Male Partners inthe Prevention of Parent to Child Transmissionof HIV and AIDS and Ante Natal Care Programmes and Activities: A Case Study of Parirenyatwa Hospital in Harare, Zimbabwe

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ABSTRACT
The study sought to establish the main issues involved in the low involvement of male partners in matters to do with the prevention of parent to child transmission of HIV and AIDS and antenatal care education and information programmes and activities in Harare. The study was prompted by observations and attitudes noted at one of the major referral hospitals in Zimbabwe. The study used a qualitative paradigm guided by a qualitative design. The study found out that male partnersdid not freely take part in such programmes due to a number of reasons some of which were the lack of respect for confidentiality in the way they were handled at clinics as well as fear of knowing their HIV status. Other reasons included the poor quality of service that they received at clinics and the fact that traditionally antenatal care issues for example were generally regarded as an area of women. Male partners were also not comfortable with accompanying their female partners for fear of being identified by those who knew them since a good number of them indicated that they had families and they would not want to be seen accompanying their mistresses at theclinic. Other reasons had to do with cultural and religious restrictions and beliefs. The study recommended that user friendly and effective information and education strategies be put in place to accommodate the needs of male partners. Other recommendations included the need for policies and legislation to deal with religious groups and cultural beliefs that were working against man's active participation on health issues. Improved training of health personnel was also another recommendation.

Key words- transmission, HIV and AIDS, Ante natal care, programmes, male partners.

I. INTRODUCTION

The involvement of male partners in Ante natal care programmes and activities is an important aspect of the family institution. Regrettably men have been known to take a back seat when it comes to such issues. According to Clarke (2001) men could play a decisive role in determining the direction that Ante natal care programmes could take especially given the state of the family set up systems in the Zimbabwe set up. In Zimbabwe there appears to be an erroneous belief that Ante natal care issues were traditionally a women's preserve. However recent literature and developments in the family structure and dynamics appear to suggest that men do have a pivotal role to play in this area. This study therefore sought to interrogatethe challenges, opportunities and missed opportunities that go with the extent to which men can be involved in Ante natal care issues and prevention of parent to child transmission of HIV and AIDS

II. BACKGROUND TO THE STUDY

A visit to the MbuyaNehanda Maternity Section at Parirenyatwa Hospital in Zimbabwe demonstrates that very few males accompanied their partners to this critical section of family health issues.In this section of the hospital, healthcare staff assists with special lectures, information, as help on various issues such as on giving birth, sexually transmitted diseases,HIV and AIDS and other health related issues to pregnant women. One glaring concern noted was the limited presence and participation of male partners who had accompanied their spouses. A random check confirmed that a relatively lower number of men accompanied their spouses.

Coupleswho accompanied each other were treated with great respect and ushered to consulting rooms immediately.

On enquiring why these men were given such preferential treatment, it was found out that this was a strategytomotivate and encourage male partners to buy into the Ante natal programme so that they could also be a good example to other men.This was critical when considering thatthe welfare of the unborn child was the concern of both parents, and not just the mother alone. The death toll from HIV/AIDS has seen most men dying and leaving their families because of lack of knowledge on the part of men. Statistics from The Ministry of Health and Child Welfare confirm that the lack of knowledge or limited knowledge on the part of men has had a notable contribution to the high death rate due to HIV/AIDS.Interactions among women either at church, workshops, conferences or clubs appeared to point at a very important dimension which necessitated this study. Some women alluded to the fact that their spouses seemed not to be interested or bothered about their HIV status or how they gave birth. In one incident, a woman from a church in Harare, gave a touching testimony of how she felt when she gave birth to quadruplets and lost two of the babies in the process. The touching part was that the babies were born HIV positive. The husband was nowhere to be found for support. The woman indicated that she suffered emotional, physical and psychological distress. She narrated her story with so much agony. She indicated how she felt and wished her husband was thereby her side and to support her during this time of need. At another HIV workshop at a workplace, another woman gave a testimony on how many times she had pleaded with her boyfriend to accompany her for testing,but the boyfriend had refused several times. She was grateful to her husband's uncle, who came to her assistance and managed to convince him of the importance of doing so together. She convinced the gathering that it had not been easy. Armed with these real life experiences of different people, there was a strong case for interest in carrying out research on these issues in-order to establish the true state of things on the ground.

The benefits of involving male partners in women's reproductive health services and prevention of parent to child transmission in particular, are well documented and generally accepted and outweigh the disadvantages. Health authorities, Non-governmental organisations and other stakeholders have advocated for men to embrace this noble programme. Unfortunately, reports from various prevention of parent to child transmission sites still reveal agenerally low participation rate on the part of men. Achievements and inroads made in the area of drugs and treatment for the prevention and transmission of HIV/AIDS are to be acknowledged, and have been an important breakthrough in the prevention of parent to child transmission of HIV for infected parents. The rate of mother-to child transmission of HIV can hopefully be lowered if man also took an active role in this critical area. The involvement of man could contribute to a positive breakthrough in the prevention of HIV/AIDS, (World Health Organisation 2007). According to UNAIDS (2005), about 2,3 million children under 15 years were living with HIV/AIDS globally and at least ninety percent (90%) of these infections occur in developing countries. Sub-Saharan Africa has mainly been associated with parent to child transmission

HIV is considered to be a major threat to lives of women and children in Zimbabwe. (Parent to Child Transmission of HIV & AIDS inZimbabwe 2010).Research has established that the prevalence rate is higher in women than men (World Health Organisation 2007)ie one in every four females compared to one in every eight males and these rates are even higher in pregnant mothers Ministry of Health and Child Welfare, (MOHCW, 2007).

In 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) declaration set targets for prevention of mother to child transmission (PMTCT) to reduce the proportion of infants vertically infected with HIV by 20% by 2001 and by 50% by 2005. To achieve this, Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that the declaration aimed to ensure that 80% of all pregnant women attending Antenatal care should get information on PMTCT counseling and other HIV preventive services (UNAIDS, 2001). According to the Zimbabwe Demographic Health Survey (ZDHS) (2010), about 21.3% of people in Zimbabwe had been living with HIV/AIDS by 2012.

This prevalence rate has been gradually going down; by 2010 the prevalence rate was estimated to be 14.1%. It is also estimated that 39.5% of babies born to HIV positive mothers were HIV positive (ZDHS, 2005). In an effort to reduce increasing rates of HIV infection in children in the country, Zimbabwe introduced Prevention of Parent to Child Transmission (PPCT)programme in 2004 with a minimum package that included promotion of male involvement (Chandisarewa,2007). Traditionally, the involvement of women in matters relating to pregnancy, birth and infant care seemed to be higher as compared to boys or men. Monitoring data from MOHCW shows that in 2009/10, only 3,66% of male partners of women in Zimbabwe's Anti-natal (ANC) got tested for HIV versus 96% of women (MOHCWW, 2007).

Against this background, the researchers sought to establish the critical issues on limited or no male involvement at all of male partnersin reproductive health services in Harare.

Statement of the problem

To what extent has the low male involvement in the Antenatal care and prevention of parent to child transmission programs and activities negatively impacted on HIV/AIDS prevention and participation of male partners.

Research questions

- What are the socio-demographic factors that contribute to low male participation in the prevention of parent to child transmission programmes in Harare Province?
- How has the lack of knowledge and awareness on male participation in Ante natal care and prevention of parent to child transmission programmes impacted on family health issues in Harare Province
- How have socio cultural factors affected the prevention of HIV and AIDS parent to child transmission programmes in Harare

Significance of the study

Increased male involvement would contribute to the improvement of uptake of antenatal care education and information programmes as well as the prevention of parent to child transmissioninterventions by stakeholders. This will contribute to the reduction of parent to child transmission rates. Involving male partners in programmes to prevent mother-to-child transmission of HIV may improve programme coverage and other positive outcomes.It is believed that the uptake of prevention of parent to child transmission interventions by women would improve with the involvement of their male partners.Information provision will provide an entry point to early and comprehensive HIV/AIDS intervention strategies, including Antiretroviral therapy for the mother, the male partner and the child. The Health delivery system will benefit in that it will perform a variety of services and activities, including the delivery of basic health care, health education, and promoting uptake of facility-based health care from an informed position. The researchers will benefit in that the study will contribute to the growing body of knowledge on integration of HIV services into other primary health care services. Other researchers will find this study handy in that they can also use it as a stepping stone in highlighting the critical role of male involvement in antenatal and parent to child transmission of HIV and AIDS issues.

Delimitations

The study was confined to Parirenyatwa Hospital in Harare, Zimbabwe. Findings, conclusions and recommendations from the study apply primarily to Harare Province. Only women and men were part of the study. The study was limited to factors associated with low male involvement only in the prevention of parent to child transmission interventions for HIV infected pregnant mothers and antenatal care concerns.

Review of Related Literature.

Socio-demographic factors contributing to low male participation in ante natal care and prevention of parent to child transmissionprogrammes and activities.

There is some consensus that male involvement and support has positive effects onprevention of parent to child transmission in terms of willingness of women to test for HIV and increased commitment and adherence to prophylaxis (Dahl et al, 2008). A study carried out in Uganda demonstrated the positive impact of male involvement on the vertical transmission of HIV and the mortality risk of infected infants born to HIV positive mothers.

Interestingly, indications were that even though most women feared abandonment and violence, women who disclosed did not always actually experience either of their fears. In Zimbabwe, 92% of those who disclosed did not report either violence or separation and 82% indicated that they experienced supportive reactions (Chandisarewa, 2007). In Zambia, 28% of women experienced at least one social adverse event, 7.7% had to deal with their partner's violent or "quarrelsome" reaction upon disclosure (Sagay, 2006).

According to a study carried out in Mashonaland, in Zvimba district of Zimbabwe, supportive male involvement was found to boost women's willingness to be tested in the Ante-natal setting (Chandisarewa , 2007). On the other hand, women did not feel that they could take a decision to test without their partner's permission. In Botswana, they felt little need to consult their partners (Creek et al, 2007). Importantly, much of the research highlights issues of disclosure. It emerged in some studies that many women feared disclosing their status to their partners.

Common reasons for women not to disclose are those commonly cited by people living with HIV namely fear of stigma and discrimination; fear of abandonment/separation or social isolation as well as loss of confidentiality; and not wanting to worry others. (MinistryofHealthandChildWelfare,2007): In addition, many women were afraid of accusations of infidelity and physical violence at the hands of their partners. (Kasenga et al. 2007). However, apart from unprotected sex, these assumptions did not exclude other forms of HIV

transmission such as through blood transfusion with infected blood, exposure to contaminated body fluids, which may be a common form of HIV transmission in most women as they are vulnerable due to their gender role of taking care of the sick.

Factors influencing low male involvement of HIV testing in the Prevention of Parent to Child Transmission

A study by Kunene (2004), indicated that fathers were generally supportive of prevention of parent to child transmissionprogrammes, and interested to some extent in playing a greater role in pregnancy, birth and child care. According to the same source, Zimbabwean men mainly had reservations about attending the actual birth. Some studies report that men tend to see their main role mainly as a supportive one, that is providing financial and material support, including providing or paying for transport to the clinic (Theuring, 2009). Emotional support and actual participation in services featured much less prominently. Some key reasons that featured during the survey by Kunene (2004) were: work related excuses, being busy, poor prioritization, relationship dynamics, fragile marriages, stigma, fear or reluctance of HIV testing, structural and programme issues, lack of information on prevention of parent to child transmission,ante-natal care issues being regarded as women's affairs and men feeling marginalized to receive information through women.

Women's perspectives on male involvement in Prevention of Parent to Child Transmission

While many programmes rely on female clients to facilitate partner involvement, women are not always in a good position to fulfillthese roles. There are substantial fears around the implications of disclosure of positive results, which many women fear could result in a break-up, resulting in possible loss of financial and material support or even domestic violence. Some studies document that partner reactions are mainly supportive, whereas others show that significant minorities of women experience adverse reactions, including gender-based violence. In such instances, when women report their desire for men to play a greater part in pregnancy and infant care, indications are that they will carefully weigh the anticipated risks and benefits of male involvement.

Specific roles of men

In one study,several participants suggested making communication "male-led" such as through male support and peer groups and male Health Care Workers involving respected and influential male community members like elders and chiefs, especially in rural settings (Aarnio, 2009). Early research by Rutenberg (2003) indicated that speaking to men directly rather than through women as intermediaries' helps. Findings by Mlay(2008) also confirm that it does help.Rutenberg(2003) also reported that similarprogrammes in Zambia and Kenya which engaged male leaders and providing community education in places where men meet, saw higher levels of partner testing and partner communication. In Botswana, the Academy of Educational Development has implemented peer male prevention of parent to child transmission programmes to complement existing peer mothers'prevention of parent to child transmission programmes. Peer educators reached their audiences in male gathering places and community members' homes.

Community outreach targets locations where educators know, through female participants in the programme, where partners work or like to spend time so that partners to prevention of parent to child transmission clients can be reached in group settings without making it appear as if you were deliberately targeting males. The Botswana prevention of parent to child transmission programmes saw increased partner testing, disclosure and Ante-natal informationvisits.

User friendly service adjustments

Extended opening hours and appointments:

Addressing work-related challenges and extending opening hours to evenings and weekends were adjustments discussed by participants across studies(Theuring, 2009). Another suggestion was to give couples appointments to reduce waiting time. Weekend Voluntary Counselling and testing and fast tracking of couples in the queue have been services provided as part of the male participation strategy in Rwanda, which saw overall increased male involvement. However, Katz (2009) reported that in Namibia adding a Saturday clinic did not have a measureable impact on the proportion of men accompanying their partners. Katz (2009), concluded that it was possible that partners use work as an excuse not to attend the clinic Voluntary Counselling and Testing sessions because of their fear of being tested.

Separate waiting areas and services**:**

Separate waiting areas for men or couples provided more privacy and were also suggested by participants (Theuring, 2009) to address concerns of privacy and confidentiality. Again, appointments could be an alternative strategy as they would minimize waiting and thus public exposure time.

On the contrary, Tshibumbu (2006) found out that in Zambia the majority of respondents did not agree with the idea of gender separation in the provision of prevention of parent to child transmission services, such as male-only prevention of parent to child transmission clinics or attendance by male health workers only. In practice, a majority of men seemed to prefer to receive HIV test results alone over being couple counselled and tested when given the choice.

Contact letters:

Participants suggested and discussed invitation letters from the clinic to men.Some participants proposed official invitation letters that would help them to get leave from work. According to Nkuoh, (2010), in Cameroon the local prevention of parent to child transmission clinic had used such letters in conjunction with free testing and a men's involvement community programme, and still only attained an attendance of 18% of partners. Katz, (2009), argues that 16% of men invited via their partner reported to the clinic. Both the Rwandan and Zambian initiatives on prevention of parent to child transmission programmesused invitation letters in an integrated approach to foster male participation and found the response satisfactory (Brou, 2007).

Socio-cultural perceptions

In virtually all settings, men reported that traditionally, their role in pregnancy, birth and child care is limited.Kunene, (2004) reported that some of the people who subscribe to the Shona culture, believe that a father is not to attend the birth or even see the mother and child in the first three months after the birth as this would make him "weak". Tshibumbu, (2006) found negative community perceptions attached to men attending Ante-natalservices, they would be seen as "weak", "softies" or "not normal". However, indications are that in many settings, cultural and community perceptions of male involvement are mixed and may not always constitute the biggest obstacle to male involvement (Theuring, 2009).

The Zimbabwe scenario

There was not much research on male participation in prevention of parent to child transmission in Zimbabwe. There was however a study by Madzima (2009), which documents the evaluation of a pilot programme to facilitate male involvement in Mashonaland West Province. The programme was implemented atChinhoyi and Marondera hospitals, and reportedly achieved some success in changing cultural norms. Six focus group discussions were conducted with men of reproductive age.Women enrolled in the prevention of parent to child transmission programmes at Chinhoyi and Marondera hospitals.

With regard to perceptions of male involvement, Madzima (2009) found out that many participants equated support mainly with provision of financial and material support. Men at all sites were aware that support to their partners should go beyond financial and material support. Many felt that their potential for involvement was limited and not always desired by women and their female family members who often took charge during pregnancy. Some male participants felt that their duties began only after birth when it came to assisting with infant care. (NationalAIDSCouncil,2004). Actual reported male involvement in matters related to prevention of parent to child transmission and pregnancy was low, and many of the factors found to inhibit male involvement concurredwith international research findings that highlighted work, lack of knowledge, poor communication between partners, stigma and socio-cultural perceptions. As identified elsewhere in other African countries like Zambia, Uganda, Tanzania, basic awareness and understanding of prevention of parent to child transmission among male respondents were surprisingly good but did not appear to influence greater involvement.

Fear linked to stigma and discrimination was a dominant theme among many groups. On the other hand indicationswere that women were reluctant to speak to their partners about HIV-related issues, not to mention disclosing their positive status.

METHODOLOGY

Interpretive Research Design

Research design basically constitutes the blueprint for the gathering, measurement, and analysis of data. This research made use of the interpretive research design since it makes the research more vigorous and enables findings to be more effective.The design is a systematic subjective approach used to describe life experiences with the intention of giving them meaning. Best and Khan (1993). Research design made it possible to expose depth,gain insight, richness and complexity inherent in the specific issues being investigated. The interpretive design focused on the above by disclosing those "meaning making practices" while showing how those practices configured to generate observable outcomes. The interpretive research design does not start with concepts that

are preconceived or predetermined, but sought to allow these to emerge from encounters in the field. According to Flick, (2007) interpretive research is distinctive in its approach to research design, concept formation, data generation and standards of assessment.

Data Generation Instruments and Procedures

Interviews

One advantage of structured interviews was that all respondents were asked exactly the same set of questions in the same sequence and this increased the objectivity of the collected data even though different interviewers were used(Fisher and Foreit, 2002). Other advantages were that there was an increase in the response rate and a reduction of administrative costs. Difficulties of assembling all participantsat one place were also dealt with. Interviews also assisted in reducing difficulties related to low literacy levels of participants.(Borg and Gall 1996). which was a factor in this study.

Interviews were subjective, and because of this there can be an element of bias on the part of interviewees especially when they want to please the interviewer. Alternatively, interviewer bias can also have a bearing on the data generated if the interviewer seeks responses that suit his / her personal ego or preconceived ideas or position. Interviews are easily influenced by the personal attributes ofparticipants and informants.
To address the demands of interviewing and recording manually negatively affecting the flow of the interactions, the researchers complemented this process by recording the whole interview. This helped later in identifying specific areas or details that could have been missed during the interview process.

Trustworthiness and Authenticity

The researchers made use of some of the techniques of trustworthiness to ensure authenticity of the study. The techniques used were triangulation, member checking, thick description and prolonged engagement. The researchers attained triangulation through asking similar questions to participants during individual face to face interviews.

Target Population

The target population included all pregnant mothers who opted for HIV counseling and testing or jointly with their partners in Harare Province between April and May 2017.

Sampling

The actual sample used was that of 15 pregnant mothers and 15 male partners.Sampling describes the process of selecting a sample of elements from a target population in order to conduct the research.(Punch,1998).The Web Centre for Social Research Methods, (2000), defines sampling as the process of selecting units from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen. The principles alluded to above were utilized to gain insight into a true representation of the population as seen from the selected sample.

FINDINGS AND DISCUSSION

The following themes were identified as a result of this study: participation in antenatal care andprevention of parent to child transmission programmes,non- availability of information,lack of confidentiality at clinics,fear of knowing one's status,low male involvement in health issues, the general quality of service and religious and cultural beliefs.Other themes identified include the issue of hospital opening hours and customer consultation and satisfaction issues.

Participation in Prevention of Parent to Child Transmissionprogrammes and Activities.

The study found out that most of the participants had taken part in these antenatal and prevention of parent to child transmission of HIV&AIDS programmes and activities. One participant who was a teacher had this to say*"I took part in the programmes and I learnt a lot. I encourage all people to attend. I was alsotested when I was four months pregnant and my results were negative. The nursing sister was very friendly and I asked a lot of questions. My husband was also tested and on delivery day he was there supporting me. What I enjoyed most was to see him being the first to hold our baby*".

Thispositive response could have been due to the fact that HIV and AIDS issues have been talked about and shared by many people for some years now. People now found it quite easy to talk about various issues on this subject openly unlike some years back when it was seen more like a taboo to talk about it because of the

misconceptions, misunderstandings, stigma as well as half- truths and negative labels surrounding that topic. Another dimension could be that due to the availability and exposure to a lot of vital information through various media, people now find it quite useful to talk about issues to do with parent to child transmission of HIV&AIDS. Another critical reason could be that because of the important role that parent to child transmission of HIV & AIDS plays people find themselves faced with no other option but to talk about it openly with a view to getting assistance.

Fear of knowing HIV status

The study established that participantswere skeptical about finding out their HIV status. They were therefore afraid of participating in prevention of parent to child transmission programmesbecause they were afraid that there was a requirement for them to be tested. Fear of knowing one's HIV status could have been exacerbated by the beliefs and values that individuals and society subsribe to and therefore attach to HIV & aids issues. Firstly, society is awash with erroneous beliefs that HIV and AIDS are a problem of women alone. This probably explains why some married women have been sentaway from thehomes where they were married simply because they were HIV positive. A number of men do not want anything to do with their positive spouses as soon as they found out of the status, not knowing that they themselves could also be infected or that they could have infected their spouses. Because of the vulnerability of women, they end up being shortchanged. Another issue was that man were probably aware of what could happen in the event that the public came to know about their positive status. Society would definitelyostracise them. They would not getsupportfrom close relatives and other close associates who would then accuse them of not behaving in accordance with cultural noms and beliefs.The finding is similar to the findings byKunene,(2004),Haile &Brhan, (2014), Said, (2014),Morfaw, (2013) and Kangoma, (2011) which confirmed man's fears on knowing their HIV status in Zambia, Malawi,Uganda, Rwanda and Namibia. Fear of knowing one's HIV status has been known to present barriers to male involvement in the prevention of parent to child transmission.Those who did not take part in these programmes may have experienced time constraints due to work commitments or other reasons. The finding also differed with what Katz (2009) established which was the fact that males were merely using work as a scape goat for not taking an active role on antenatal and HIV and AIDS issues. One participant said that*"The nature of my job stops me from visiting the clinic more often. I start work at 6:30am every day and knock off at 5pm. The clinic will have closed. During the weekend I work half day. When I am on leave, I will visit my children who are staying with my mother in the rural areas. The nearest clinic is 15 kilometres away from home*". Another participant had this to say about the issue of flexibility in terms of time *"Women are the ones who are supposed to know about Antenatal care issues. If they want us to be tested together with our spouses, something should be done by the government. Do not forget men will be at work and clinics close early on Saturdays, Sundays they do not open. What am I supposed to do?"*

Non Availability of information and education

The study established that information on antenatal care issues and prevention of mother to child transmission was generally not available. The following excepts support this position very well.

One participant indicated that "*I feel health workers should visit different areas through the herdmen's permission then educate people. I discovered that in the area I am working from, men and women are unable to write or read. Health workers can come to people when they are in church. We will give them time to explain to parents so that knowledge is spread even to those who cannot write. We accept that kind of teaching*".

Another participant said*"My daughter, we have heard that there is HIV caused by having unprotected sex. Why don't our nurses do group discussions with us especially this time of the year when we are not going to the fields. It is not easy for me to tell my husband alone because I do not have enough information. If I get tested and discover that I am HIV positive, the moment I tell my husband, I will be divorced. We are facing a difficult time as women. The nurses and the government should assist us on these matters".*

Yet another participant had this to say *"If we are all human beings, we should be treated equally even if we are poor or not educated. If my partner was allowed to register, we could have known of our status much earlier. Look now, our baby is HIV positive and we only started on ARVs less than three months ago.What is going to become of my baby*?"

The lack of or limited information could have been due to poor planning on the part of Authorities. Health personnel may not have consulted adequately on the time that is most suitable for having such information and educational campaigns. They could have been more flexible by taking into account the dynamics of the communities so that at least more people were taken aboard. The otherchallenge could have been accounted for by limited literacy levels in given communities. While the country boasts of a very high literacy rate, it could have been possible that those who are illiterate also make up a sizeable part of members of

the community who really needed this education and information, but could not access it due to their literacy levels.

Another dimension could be that the participants expected too much from health personnel, not knowing that they also needed to take an active role themselves by looking for the information from different sources such as the media or even the internet. People of limited means felt shortchanged in this area. They probably lacked appropriate education about what they were supposed to do if their partners fell pregnant. The hospital workers and authorities appeared not to be doing enough to ensure that the less privileged in society were also catered for just like any other Zimbabwean.

This finding wasin agreement with studies conducted in Nairobi, Uganda, Tanzania, that found out there was an information deficit among men (Adera, Wudu, Yimam, Kidane, Woreta, Molla, 2015),(Amsalu, 2013), Kunene (2004). These findings were also contrary to what Amanuel&Abajobir (2013) who found out that in South Ethiopia a good understanding of the information on these issues helped to increase male participation in prevention of parent to child transmission programmes.

Confidentiality in HIV Testing

Another critical finding was that there was lack of privacy and confidentiality in the way issues to do with prevention of parent to child transmission, ante-natal care and HIV&AIDS were handled. The majority of participants had no confidence whatsoever about the way things were done. There was an indication that privacy and confidentiality were not guaranteed.

The need for confidentiality cannot be overemphasized, since it was discussed at length with different participants. A staff member could just open the door when counseling was in progress. Others were of the opinion that the staff were not educated on privacy and confidentiality. Only a few participants indicated that confidentially was guaranteed. Some said that there was only limited privacy and confidentiality while a few were not sure. One participant indicated that:

When we were given our results, the health workers took us to a certain room then she started counseling us. Afew minutes later I saw that my one of my colleague was also waiting for his turn to be counsselled. I was very embarrassed. At a certain clinic, those who are HIV positive have their special queue. Our cards are taken then we are called three at a time to be given our ARVs. Imagine the embarrassment. Why do they not call one person at a time then given them their medication? There is no privacy at all. At times you meet your neighbours, you may not be positive but because of the queue you will be in, they may get suspicious.

Another participant had this to say:

"Going for HIV testing is like you want people to laugh at you. During the counseling process other staff members can just open the door. There is no privacy, the staff do no put any signage indicating COUNSELLING IN PROGRESS*stickers on the door. The hospital staffhave a tendency of transferring you to your local clinic where you will meet friends and relatives. Clients should make a choice as to where they want to access their medication. The people in my community will stigmatise me if they see me in the queue waiting for ARVs".*

The view that there was lack of confidentiality in the whole process could have been necessitated by a number of factors. Firstly because of societal stereotypes, most people do not wish to be associated with HIV& AIDS issues in public or in the event that someone known to them sees or notices them at a health centre. There are stigmatization and labelling issues. This could probably stem from the fact that HIV & AIDS issues have erroneously been linked to promiscuous tendencies and multiple sexual partners, and yet there are people who have been infected with the disease but not necessarily due to promiscuous behaviour, but other reasons such as getting it from blood transfusion services, promiscuous partners and others. However, the challenge is that society does not generally take lightly to those of its members who are living with the disease. Another explanation could be that unlike other diseases like cancer, diabetes, elephantiasis and others, with HIV & AIDS the potential to have people with the disease being ostracized by their communities including even close relatives and associates is very high, and people do their best to avoid these unfortunate end results. Unless one is able to hide their positive status from the public domain there is a realization that the consequences can be dire for them. The worst part of the whole thing that could be complicating issues was the fact that there is no known treatment for the dreaded disease. The finding concurs with Theuring, (2009) who also found out that privacy and confidentiality issues were really a sticking issue.

Customer satisfaction and consultation

The study found out that the quality of service provided left a lot to be desired in terms of consultation of the clientand the form of assistance or servicesthat they wanted. Participants felt that besides the general assistance rendered to any other patient or someone who accompanies them, there was need to find out exactly

some of the underlying issues of what clients wanted, then help could be rendered in accordance with the client requirements.The following verbatim accounts of participants explain the issues involved. One participant indicated that *"The major challenge was that health authorities prefer to think and do things for us, without consulting or involving us."* He went on to justify his views with the famous quotation *"Nothing for us without us."*

Another participant who was a school teacher said:*"Healthcare workers thrive on taking those who visit Ante-natal clinics for granted. It will be best if men should be given special attention so that women will encourage their spouses to visit the clinic for help onprevention of parent to child transmission of HIV&AIDS and antenatal care issues*

Yet another participant said*"Sometimes you are assignedavery young staff member to take you through the counseling process and when you ask her/him questions they will not be able to answer the questions. One wonders if they were really trained for the job and whether we can trust them with our results and concerns. They shout at us as if we were ever taught about these issues."*

This finding can be accounted for by factors such as health personnel having an overinflated ego and probably feeling that they were on top of the situation and that they knew it all forgetting that they were dealing with adults who also had feelings and needs of their own that needed to be attended to. Health personnel needed to climb down from their ivory towers and be realistic with the clients they dealt with. Another explanation could be that people who require services from Health Personnel could be expecting or demanding too much from the Health Centres. Sometimes those who need help may also have inflated egos and tend to think that they can always have it their own way when the two sides were supposed to meet half way for things to work out. Another reason for the differences in approach could be that indeed Health personnel may need proper professional training in public relations and etiquette especially against a background where in Zimbabwe Health personnel have been generally known not to treat their patients unprofessionally.

Antenatal care seen as a preserve of women

The study revealed that antenatal care issues and prevention of parent to child transmission services were designed mainly for women. Males complained of a lack of space in the ante natal rooms, that the place is congested and full of women even if one decided to go there. A number of factors could have contributed to this view. One of these could have been the fact that traditionally women have taken a clearly leading role in issues to do with antenatal care. The involvement of man is a relatively new phenomenon that man and society generally need to embrace, accept and forge ahead with. Even most of the literature on this area is fairly recent. Another explanation for this position could be that traditionally males were known to be the only bread winners who would work and fend for their families. This belief kept males at their workplaces most of the time thus preventing them or isolating them from taking an active role on antenatal care concerns. Times have drastically changed now with women being bread winners as well. The need to share responsibilities has sharply risen hence calls for males to take an active role and partake in antenatal care programmes and activities. Another dimension could be that the strategies used to entice man to take an interest in antenatal care issues may not have been user friendly. Information on these issues may probably need to be properly packaged depending on whether it is being communicated through radio, television, public gathering, pamphlet, drama, social media or any other format. If information was not packaged and presented in the proper format men would most likely not take part or take it lightly. Most man will be at their work places most of the time and because of that have relatively limited time to forms of disseminating information such as Television or radio. All these are critical issues that need to be taken into account by stakeholders especially the custodians of the antenatal care and parent to child transmission programmes. The finding concurs with the Population Council (2005) which indicated that availing important information in the wrong format or through wrong means results in many people being left out. The same source also found out that in IndiaandSouthAfrica for example, whenmen were informedandinvolvedfromthebeginning, they providedinvaluablesupportfor their femalepartners.

Low Male involvement in Antenatal care and parent to child transmission programmes

The study revealed that there was generally a very low male involvement of males in ante natal care and parent to child transmission programmes. This could be accounted for by the fact that when this programme started it was actually referred to as the prevention of mother to child transmission of HIV &AIDS. On the other hand,the antenatal care programme was also generally known to be associated with women or mothers. Probably this historical background could have been responsible for the erroneous belief and understanding of these programmes to have an inclination towards women only. Males have also claimed that they were too busy to attend to what traditionally has been regarded and seen as a women‘s domain. The issue could also be perceived from a cultural point of view where traditionally matters to do with child care especially were considered to be women's turf while man concentrated on providing for the family needs as the breadwinner. Another view could have been the fact that there could have been misconceptions and misinformation on the proper role of antenatal

care education to males as well as their role on prevention of parent to child transmission issues. It should have been emphasized right from the beginning that children' s health concerns were every parent's concern. It also appeared that in the early days of these programmes there were probably no clear budgetary allocations for such programmes since the programmes in question seem to have started around the early nineteen eighties. The lack of clearly laid out budgetary allocations has been known to result in lack of accountability on those charged with carrying out certain functions or mandates. The finding has something in common with the findings by Kunene (2004) who established that males took refuge in being busy most of the time to the extent that they had no time to attend to antenatal care issues and parent to child prevention activities and programmes.

Religious Beliefs

The study revealed that while some males may have wanted to attend ante natal clinics with their spouses their hands were tied mainly due to religious beliefs and taboos. The reasons for this could be that some religious groups were very strict with their rules and regulations and the punishment for wrong doing by members was severe. Some man therefore probably found it difficult to leave those churches and religious groupings.Another explanation could be that some males were not flexible and therefore tended to sheepishly follow untenable rules and regulations some of which were not even in tandem with what was going on in the civilized world of the day. Man simply needed to be assertive and do away with counter- productive ways of doing things. Another issue could be that there was so much indoctrination and brainwashing at some so called churches that some male partners found it difficult to just leave the churches for fear of the unfounded reprisals that could befall them or their families.

Hospital Working Hours

This study also revealed that hospital opening and closing times were not user friendly to the daily routines of most man. One concern here could be the fact that some man may not necessarily operate from their homes where their wives and children ordinarily reside. Some man could be working in places that are far away from their homes or even their countries. When they visit their spouses maybe once in threeor , six months or a year the spouses may conceive during this time. Regrettably the wife will shoulder all the other responsibilities of child bearing including visits to ante natal clinics on their own while the spouse is away at work in some other remote district, provinceor country and it may be practically impossible to have the man at home. Even if they were working in the country, most man go to work during the day and may not get time to accompany their spouses to the antenatal clinic.This finding concurs with (Adeleke, 2013,Adelekan, Edoni, &Olayele, 2013).who found out in South Africa, Malawi, Uganda, Brazil, Bangladesh and Nigeria, men were too busy to wait at the clinic for the long procedures that women undergo. Contrary to this finding Katz (2009) indicated that male partners could just be using a busy work schedule as an excuse.

Cultural Beliefs

The study established that most males were not comfortable with being seen in the company of other pregnant women other than their official spouses. This position can probably be explained by the fact that culturally males were aware of how culture sees or views the idea of being seen in the company of another woman especially if they were married. Society generally considers this as a taboo although the same man continued to violate this understanding. Male participants confirmed the reality that as married men, with children at home they were not comfortable with being seen in the company of other women. They therefore knew that it was not acceptable to the society to accompany "mistresses" to theantenatal clinics. This was the reason why they could not openly accompany their partners. The other dimension that can be used as an excuse by man could be that since they were not legally married to these so called partners they found it uncomfortable to freely partake in visiting antenatal care clinics with their mistresses mainly because society would not approve of this since it would seem like indirectly encouraging and promoting promiscuity.This finding is similar to other findings by Kangoma, (2011),Ongweny-Kidero, (2014) .which also identified and confirmed culture as one of the factors associated with poor or low male involvement in antenatal care and prevention of parent to child transmission of HIV &aids programmes in communities

Recommendations

Based on the findings of this study the following recommendations were made;

- That there be more deliberate strategies to redouble efforts in providing more education and information on antenatal care and prevention of parent to child transmission of HIV&AIDSprogrammes to target males especially.
- Health care employees should be trained to respect ethical considerations of both man and women in the discharge of their duties.

- Male partners need to be more flexible in the way they respond to issues to do with ante natal care and prevention of parent to child transmission programmes
- Government needs to come up with stringent laws and policies to guide especially religious groupings that are bent on misinforming society thereby misleading communities into serious health challenges.
- All avenues of information disserminationshould be exploited in-order to facilitate informed attitudes on issues to do with ante natal care and prevention of parent to child transmission of HIV and AIDS concerns.

III. CONCLUSION

The study came up with a number of themes namely low male involvement in antenatal care and prevention of parent to child transmission programmes, the fear of knowing one's status, lack of information or limited information, the view that antenatal care and prevention of HIV and AIDS were meant for women only, lack of respect to confidentiality concerns at clinics, religious and cultural beliefs , clinic opening hours and the general quality of service as well as the need to consult clients on their needs. The study was able to expose some of the challenges that have bedeviled the participation of man in antenatal care and prevention of parent to child transmission of HIV and AIDS. These include lack of or limited information strategies, fear of knowing one's HIV status, the absence of confidentiality at the clinics, poor quality of service, erroneous cultural beliefs, religious beliefs that were not user friendly and hours of doing business used the clinics. Possible explanations for what could have been the source of the challenges were explored as well. Recommendations that could assist in addressing some of these challenges were also proffered.

REFERENCES

[1]. Aarnio,A.,Olsson,P,Chimbiri,A.andKulamala,T(2009):MaleInvolvementinAntenatalHIVCounselingandTesting:Exploringmen'sperceptionsinruralMalawi.In:AIDSCare,21(12)1546-1576.

[2]. Adera, A,Wudu,M., Yimam,Y. ,Kidane, M., Woreta, A., &Molla,T. (2015). Assessment of MalePartner's Involvement in Prevention of Mother-to-Child Transmission of HIV and Associated FactorsAmong Males in PMTCT Services. American Journal of Health Research, 3, (4), 221-231.

[3]. Best,J.W.& Khan, V. 1993 Research in Education.London.Allyn 7 Bacon PublishersBorg,W.R.&Gall, M.D. 1996Eduaction Research.An Introduction.New York

[4]. Burns,N.andGrove,S.K.(2005):The practice ofnursingresearch:conduct,critiqueand utilization. Missouri: Elsevier

[5]. Chandisarewa, W, Sranix-Chibanda, L, Chirapa, E, Miller, A, Simoyi,M,Mahomva, A(2007) Routine offer of antenatal HIVtesting: opt-outapproachtopreventmother-to-children'smission ofHIV in urbanZimbabwe.In: Bulletin of theWorld Health Organization, (85)843-850.

[6]. Clarke, S,(2001):Includingmen in reproductivehealth.AIDS Link (63):13

[7]. Haile, F., &Brhan, Y. (2014) Male partner involvements in PMTCT: a cross sectional study, Mekelle,

[8]. Kang'oma G. (2011). Exploring factors affecting men's involvement in Prevention of Mother to Child Transmission of HIV programme at Nkhoma Mission Hospital in Lilongwe. Open Journal of reventive Medicine, 1(2), 35-42. doi.org/10.4236/ojpm.2012.21006

[9]. Kasenga,F,Hurtig,A.KandEmmelin,M (2007):HIVpositivewomen'sexperiencesofa preventionofmother-to-childtransmissionprogrammeinruralMalawi.In: Midwifery,26(1)27-37.

[10]. Katz,A.D,Kiarie,J.N, John-Stewart,G.C,Richardson,B.A, John,F.NandFarquhar,C(2009): MalePerspectives on Incorporating Men into Antenatal HIV Counseling and Testing. In: Journal of Acquired ImmuneDeficiencySyndrome, 4 (11).

[11]. Kunene, B, Beksinska, M, Zondi, S, Mthembu, N, Mullick, S and Ottolenghi, E (2004): InvolvingMeninMaternity Care:A USAID study.Availableat: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/SA_mim.pdf(Accessed1304/2013:23:00).

[12]. Madzima,B,Nyamayaro,WandChadambuka,A(2009):Asurveyonlowmale involvement in ANC/PMTCTprogrammeinZvimbaDistrict:DepartmentofCommunityMedicine,University ofZimbabwe, Harare.

[13]. Mlay,R,Lugina,HandBecker,S(2008):CouplecounselingandtestingforHIVatantenatalclinic: Views from men,womenand counselors.In: AIDS Care, 20 (8)356-360.

[14]. Morfaw, F., Mbuagbaw, L., Thabane, L., Nana, P.& Rodrigues, C., (2013). Male participation inprevention programs of mother to child transmission of HIV: A systematic review to identify barriers.

[15]. BioMedicalCentral, 2 (5), 6. doi: 10.1186/2046-4053-2—5. Musheke,

[16]. MinistryofHealthandChildWelfare(2007)Preventionofmother-to-children'smissionofHIV,ZimbabweAnnualreport, 2006

[17]. NationalAIDSCouncil,Zimbabwe (2004):NationalHIV/AIDScommunicationstrategy2005. Harare:

NAC.

[18]. Nkuoh, G.N,Meyer,D.J,Tih,P.MandNkfusai,J(2010):BarrierstoMen'sParticipation in AntenatalandPreventionsofMother-to-Child HIVTransmissionCare in Cameroon.In:Journal of MidwiferyandWomen's Health, 55 (4)363-369.

[19]. PopulationCouncil(2005):Maternalandchildhealth:Mixedsuccessinvolving meninmaternalcareworldwide.PopulationBriefs11(1) Populationcouncilwebsite: www.popcouncil.org/publications/popbriefs/pb11(1)_1.html(Accessed on04/09/2017: 08:49).

[20]. Parent to ChildTransmissionof HIV & AIDS inZimbabwe (2010)Proceduresand LogisticsManual-PracticalPolicy Guidelineson implementingandmanagingPMTCTprogrammesforhealthserviceproviders:MOHCWTBand AIDS UNIT.

[21]. Rutenberg,N,Kabibala,S,Mwai,CandRosen, J(2003):IntegratingHIVpreventionandcare into maternalandchildhealthcaresettings:lessonslearnedfromHorizonsstudies,July23-27,2001.

[22]. Said, M. (2014). Factors influencing Prevention of Mother to Child Transmission (PMTCT)outcomes in the Rundu District of Namibia. (Unpublished master's thesis. University ofStellenbosch, South Africa.

[23]. Theuring,S,Mbezi,P,Luvanda,H,Jordan-Harder,B,Kunz,AandHarms,G(2009):MaleInvolvement inPMTCTServicesinMbeyaregion,Tanzania:In:AIDSandBehaviour,13(1)92-102.

[24]. Tshibumbu,D (2010):FactorsinfluencingMen'sInvolvementinPreventionofMother-to-Child TransmissionofHIV Programmes inMambweDistrict, Zambia.Master'sThesis. Pretoria: Universityof SouthAfrica.

[25]. United Nations(2001):Counselingandvoluntary HIV testingfor pregnantwomeninhigh HIV prevalence countries: elements and issues. In: UNAIDS library, 2003, version 2.0. Available: UNAIDS:Geneva

[26]. United Nations AIDS(2005): AIDS epidemicupdate. Geneva: UNAIDS

[27]. UNIGASS Declaration (2001): Resolution Adapted by the General Assembly: GenevaDeclaration ofCommitment on HIV/AIDS.

[28]. UnitedNationsInternationalChildren'sEmergency Fund(2001):Stigma,HIV/AIDSand prevention of mother-to-child transmission:apilot studyinZimbabwe, India, Ukraine and BurkinaFaso.Availableon:Panos website:http://www.panos.org.uk/aids/stigmacountriesstudy.htm(Accessed on08/06/2017: 10:46)

[29]. WorldHealthOrganization (2007): Antiretroviral drugsandPMTCTof HIV inresource limited settings: Recommendations for PublicHealth Approach, June2005, Geneva, Switzerland.

[30]. Zimbabwe Demographic Health Survey (2016): Prevention of mother-to-child transmission surveyof 2006/2007, Harare: MOHCW

[31]. Zimbabwe Demographic Health Survey (2010): Centre for disease control and prevention mother-to-child HIV transmission and prevention:CDC HIV/AIDS fact sheet, May2010