Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Knowledge, Attitude and Practices of Male Partners Involvement in Reducing Antenatal HIV Infection and PMTCT

By Tsehay Birhanu

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ACRONYMS

AIDS = Acquired Immunodeficiency Syndrome

ANC = Antenatal Clinic

ART = Antiretroviral Therapy

CDC= Centre for Disease Control

FHAPCO= Federal HIV AIDS Prevention and Control Office

HTC= HIV Testing and Counseling

HIV= Human Immune Virus

MTCT= Mother-to-Child Transmission

PMTCT = Prevention of Mother-to-Child Transmission

UNAIDS= Joint United Nations Program on HIV

WHO = World Health Organization

SRH= Sexual Reproductive Health

Abstract

Ethiopia is one of sub Saharan African counties has been facing highest number of mother to child transmissions of HIV. Prevention of mother to child transmission (PMTCT) program plays a big role in reducing the MTCT. Nevertheless its effectiveness depends on involvement of male partners considering the fact that men are decision makers in Ethiopia families. They make important decisions that have major impact on women's health. Male partner involvement has been seen to increase uptake of PMTCT services and their involvement underscores their importance in reducing HIV infection in children. But the program strategy is facing challenge of low male partner involvement. The purpose of this study was to examine the knowledge, attitude and practice of male partner in ANC and PMTCT services. The mixed methods design was employed in this study. A cross-sectional study was conducted using both quantitative and qualitative methods on a systematically selected 126 male partners of pregnant mothers attending in ANC clinic in Addis Ketema sub city and in-depth interviews on 6 health workers working in ANC/PMTCT service providing health institutions of the Addis ketema sub city. Data was collected in the study using questionnaire and structured interview. Methods of data analysis included descriptive statistics, correlation matrix and logistic regression analysis. The result revealed that majority of the respondents (76.2%) good knowledge about HIV, MTCT and PMTCT and majority of them (60.3%) score above the mean which shows high male involvement. Male involvement was found to have a statistically significant association with good knowledge about PMTCT (AOR= 3.0, 95%CI: 1.30-7.1), attitude (AOR=2.6, 95%CI: 1.09-6.13) and low socio-cultural factors (AOR= 5.8, 95%CI: 2.0-17.1). The level of male partner involvement was 69(60.3%). Information socio-cultural belief and male –friendly PMTCT service should be provided to the Public.

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CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

HIV pandemic created a huge challenge to the survival of humankind worldwide. At the end of 2012, an estimated 35.3 million people were living with HIV globally, including 3.3 million children less than 15 years. There were 2.3million new HIV infections, including 260, 000 among children less than 15 years (UNAIDS, 2013). More than 90% of the children who acquired HIV infection live in sub- Saharan Africa. In the same year, in African countries about 25.0 million people were estimated living with HIV including 2.9 million children. There were 1.6 million new infections and 230,000 million among children less than 15 year and 1.2 million AIDS related death (UNAIDS, 2013).

Ethiopia is one of sub Saharan African counties facing high AIDS burden, at the end of 2012; approximately 760,000 people were estimated living with HIV, with 20, 000 new HIV infections and estimated AIDs related death were 47,000. There were 9,500 new infection among children (UNAIDS, 2013). Besides the dominant heterosexual transmission, vertical HIV transmission from mother to child accounts for more than 90% of paediatric AIDS and without any intervention about half of them will die before their second year birth day. The prevention of mother to child transmission (MTCT) plays a major role in limiting the number of children being infected by HIV. Without any intervention, 20-50% of infant would be infected but by implementing effective PMTCT program the overall risk can be reduced to less than 5% with breast feeding population (WHO, 2011).

As a result, Ethiopia adopted the World Health Organization (WHO) four pronged prevention of mother to child transmission (PMTCT) strategy as a key entry point to reduce risk of HIV transmission from mother to child and care for women, men and families. These include primary prevention of HIV infection,

prevention of unintended pregnancies among HIV-infected women, prevention of HIV transmission from HIV-infected women to their child, provision of care and support to women infected with HIV, their infants and families (WHO, 2011).

Prevention of Mother to Child Transmission of HIV (PMTCT), provided integrally with MNCH services by the Government of Ethiopia to mitigate the impacts of the HIV epidemic in general population and particular in children. The achievement of the National PMTCT program to date is not in parallel to other Maternal and Child Health Programs. Very serious gaps remain in terms of utilization of available service by the pregnant mother. The federal Ministry of Health identified some of the challenges; one of the challenges is low male partner involvement. Traditional reproductive health program including PMTCT focus mostly on women and ignore the important role of men (Betancour andAbrams, 2010). Hence, the moderate levels of PMTCT success can be partially explained by this narrow focus on women alone. The uptake of PMTCT interventions relies on complex decision-making dynamics in some cases (Theuring, 2010). This is most relevant in sub-Saharan Africa where reproductive health decisions are significantly influenced by male partners and where male partners tend to have an upper hand in sexual and reproductive health decision-making (Mlay; Lugina and Becker, (2008) and Peltzer,(2011)).

Thus, adequate uptake and adherence to these PMTCT interventions have been challenging for some women in Ethiopia. A study conducted to assesses male partners influence on pregnant women towards voluntary HIV testing and support on PMTC revealed that only 10.4% of male partners presented to PMTCT centres along with pregnant mother and 47.3% of the pregnant women were reported to be influenced by their male partners on decision of HIV testing. Those women who were not influenced by their male partners on HIV testing are 2.56 times more likely to accept HIV testing than those who had been influenced. But pregnant women need their male partner psychological, social and financial support as well as active involvement in PMTCT services in order to utilize the service properly.

Similarly, different studies from Eastern and Southern Africa have found testing rates ranging from 8% to 15% of male partner's at antenatal clinic (Farquhar et al. (2004), Msuya et al. (2008) and Katz et al. (2009)). Also, the study done in Tanzania found a lower male testing rate at the antenatal clinic, at 3% (Falnes et al., 2011).

Likewise, global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive by Ethiopia government in June 2011, the overall aim of this plan is to ensure that all pregnant women living with HIV have access to HIV prevention and treatment services from 34% to 90%, and that new HIV infections among children are eliminated by 2015 (UNAIDS, 2012). The plan further identified the crucial role of male partners in scaling up programmes to stop new HIV infections among children.

In this regard, the knowledge and awareness of male partner on the PMTCT matters for the active participation play crucial role for the effective implementation of the program because sexual and reproductive health (SRH) programmes and services have been focused primarily on women. Men have often lacked information to make informed decisions about healthy behaviours and the roles they might play in promoting overall family health, including accessing HIV prevention, care and treatment services. Much is not known about the extent to which male partners having adequate information about sexual reproductive health in general and PMTCT program in particular. However, knowledge, attitude and practice of PMTCT and identifying factors that influence male partner involvement needs to be addressed for effective intervention and to improve their involvement in prevention of mother to child transmission of HIV. Hence, this study attempts to asses knowledge, attitude and identifying factors influencing male partner involvement in PMTCT program.

1.2. Statement of the Problem

The Government of Ethiopia undertaking different efforts to mitigate the impacts of HIV epidemic among the whole population in general and among children in particular. One of the strategies being Prevention of Mother to child Transmission of HIV (PMTCT) services provided integrated with maternal, neonatal child health (MNCH) services as one strategy.

Thus, the government is working towards accelerated plan for scaling up PMTCT service as of 2012. According to this accelerated plan, for all women who attended ANC clinics at health facilities that are providing PMTCT services in 2011, more than 300,000 of them (25%) were not tested and ARV prophylaxis was provided for 8365(40%) of women identified as HIV+ at the health facilities and 4945(24%) of their newborns. The service report reveals that there is a 23% drop out from counselling to testing and 60% from identification to provision of ARV prophylaxis to HIV positive pregnant women. One of the challenges identified for this is low male partner involvement.

Male involvement has been recognized as a priority for PMTCT programmes (WHO, 2007). Different scholars documented the impact of men's involvement on the various components of PMTCT programmes men play an important role in terms of women risk of acquiring HIV, prevention in terms of condom use in the couple's relationship and male partners also influence women's utilization of service including testing for HIV and on decisions of infant feeding options (de Paoli et al. 2004, Brou et al. 2007, Farquhar et al. 2004, Peltzer et.al.2008, Msuya et al., 2008 and Tijou Traore et al., 2009)

Inadequate knowledge and awareness of prevention of mother-to-child transmission has an impact on the practice of HIV testing among male partners and also it plays a key role in prevention of mother-to-child transmission of HIV infection and improve both maternal and child health. In this regard the knowledge, awareness and attitude of male partner toward PMTC very crucial for their involvement.

However, little research is done to assess knowledge, awareness and attitude toward MTCT/PMTCT program where these studies are limited in their scope, which focus only on pregnant mothers and there is a gap in examining knowledge and attitude of male partners. Assessing the knowledge, attitudes and practice of male partner in ANC and PMTCT service and identifying the factors that influence their involvement on PMTCT program are vital for interventions on men. To this end, this study addresses the following research questions:

- What is the level of knowledge and attitudes toward PMTCT service among male partners?
- What is the level of male partner's involvement in PMTCT?
- Is there a statistically significant relationship between level of knowledge, attitude toward PMTCT among male partner and their level of involvement?
- What are the factors that influence male partner involvement in PMTCT program?
- What can be done to improve male participation in PMTCT program?

1.3. Objectives of the Study

The general objective of this study is to assess the knowledge, attitude and practices of male partner on PMTCT and identify factors that influence male partners' involvement in PMTCT program.

1.4. Significance of the Study

Mother-to-child transmission is the single most important source of HIV infection among children. Reducing transmission requires an increase in access to integrated and comprehensive prevention mother to child transmission program. But there is a gap in understanding the program in general population. Currently due this reasons most of the PMTCT program in Ethiopia facing challenge of low male involvement on the program. Similarly, Addis ketema sub city health office PMTCT program facing the problem of low male partner involvement in the ANC and PMTCT services. Thus; this study asses the knowledge, attitude and level of male partners involvement in PMTCT. What makes this study unique is that it examines the significance of the variables under study, identifying factors that influence male partner

involvement in the program and find ways to improve. Therefore; study is significant to Addis ketema sub city health office as baseline information to improve male partner involvement on the services. The finding may help health workers to understand how it influences male partner participation in the service as well as on the program and ways to improve it. Finally, the results of this study may show future directions of research in the area.

1.5. Delimitation of the Study

There are many issues to be studied regarding the male partner involvement on PMTCT program, such as accessibility, availability and quality of the service. However, this study is delimited to the examination of the knowledge, attitude of male partner toward the ANC and PMTCT. To make it manageable the study is delimited to two health centres those currently providing the PMTCT services in Addis Ketema sub city.

1.6. Operational Definition

In this study the following terms are defined as follows:

- Male partner refer to husband or a father at a pregnancy.
- Knowledge refers to respondent's knowledge about HIV transmission, risk reduction on MTCT and PMTCT.
- Attitude refers male partners belief and perception about the services like fear of HIV testing counseling and receiving test result, confidentiality issues and concern about MTCT and PMTCT.
- Male involvement refer to male partner participation in dialogue on decision of couple counseling and testing, condom use, child feeding, place of birth and taking medication during pregnancy and after delivery child medical treatment follow up.

Measurement of knowledge; attitude and level of male partner's involvements in PMTCT service:

- **Knowledge**

  Basic knowledge questions were assessed using participant's correct responses. The four questions had a total of 22 points. Each correct response was given a score of 1 and a wrong response a score of 0. The points assessed basic knowledge on HIV transmission, risk factors, mother to child transmission during pregnancy, labour delivery and preventive measure

  On assessment of knowledge, Modified Bloom's (Blooms BS, 1956) cut off points was adopted and used during analysis. A score of 75% – 100%, 50% – 74% and less than 50% placed the respondent in good, moderate and poor basic HIV/AIDS knowledge

  Knowledge

- Good = 17-22 correct out of 22 items
- Moderate = 11-16 correct out of 22 items
- Poor = 0-10 correct out of 22 items.

- Attitude refers to respondent's belief, opinion toward the mother to child transmission of HIV, prevention of mother to child HIV transmission services.

Attitude

Attitude was assessed by 10 questions. These were put on a likert's scale and respondents were provided with statements asked to indicate the extent to which they agree with those statements on whether they strongly agree, agree, undetermined, disagree or strongly disagree with what they were asked. The scoring system used with respects to respondents' responses was as follows: strongly agree scored 1, agree 2, undetermined 3, disagree 4, strongly Disagree 5.

Attitude of the respondent measured by summed up the participants total score on the 10 items then mean score used to categories the respondent.

Attitude

- Positive = if score $\leq$ mean score
- Negative = if score > mean score

Male involvement

Level of male involvement in PMTCT assessed using 14 questions (Getu , 2011). Respondents were asked a total of 14 questions to assess their level of male participation in PMTCT and graded as low if they responded got correct response below the mean score and high if more than the mean score correct answers.

Chapter Two

Literature Review

2.1. Introduction

In scaling up prevention of mother to child HIV transmission program male partner's involvement is very crucial to eliminate new HIV infection among children by 2015 and keeping their mothers alive. Porgrammes have largely focused on ecouraging women to come for PMTCT services with their male partners but the program faceing low male particpation (FHAPCO, 2012). Acquiring knowledge about mother to child HIV transmission is an important step towards participation of male partner's in PMTCT. If men are not informed of the benefits of PMTCT and clearly understand the risks to their childern, they will not become a supportive force for PMTCT uptake and compliance.

This chapter reviews, the Mother to child HIV transmission (MTCT) and Prevention of mother to child transmission (PMTCT) program overview globally and national including previous studies on male's awareness, attitude toward the service and their trend of participation in the PMTCT service. It also includes conceptual framework of this study.

2.2 Mother-to-Child HIV transmission (MTCT)

Mother-to-child HIV transmission was first recognized to be the major source of HIV infection among children under the age of 15 years in the mid-1980s (WHO, 2001). In 2012, about 260,000 new HIV infections had occurred among children globally; of which 230,000 are from sub-Saharan Africa (UNAIDS, 2013). There is a declining trend in the occurrence of new infection and AIDS related mortality among children in the region. Although the mortality rate in 2009 was said to be 20% less compared to 2010, 330,000 children died of AIDS related causes. By 2012, over 9,500 Ethiopian children were estimated to acquire new HIV infections from their mothers. According to the UNAIDS progress report of 2013,

Ethiopia is among the ten countries in the world with the highest burden of HIV infection and new HIV infection among children. Also about 700 children died of AIDS related causes (UNAIDS, 2013).

Besides the dominant heterosexual transmission, vertical HIV transmission from mother to child accounts for more than 90% of pediatric AIDS. Transmission of HIV from mother to child can take place during pregnancy, labour and delivery as well as after birth via breastfeeding especially mixed feeding. The risk of transmission varies at different stages ranging from 5% -10% during pregnancy, 10% - 20% during labour and delivery, and 10% - 20% through mixed infant feeding. It is estimated that in the absence of any intervention to prevent mother to child transmission the risk ranges from 15% - 45%. This rate can be reduced to levels below 5% with effective interventions (WHO, 2011). PMTCT was introduced as a comprehensive package of interventions known as Prevention of Mother to Child Transmission (PMTCT) programme with an aim of reducing MTCT.

2.3. Prevention of Mother-to-Child HIV Transmission Programmes (PMTCT)

A four pronged comprehensive strategies encompassing primary, secondary and tertiary preventions where mother's and infants' survival are at the core have been proposed for PMTCT. To facilitate implementation of these strategies, guidelines have been developed internationally by the Joint United Nations programme on AIDS (UNAIDS) and the World Health Organization (WHO), and at national levels governments adapt the international guidelines taking into consideration the local contexts (WHO, 2010).

These prevention strategies are integrated in existing maternal and child health programmes and are implemented mainly under the help of the health system. These include (1) prevention of HIV among women of reproductive age, (2) prevention of unintended pregnancies among HIV-positive mothers, (3) the prevention of vertical transmission, and (4) provision of treatment, care and support to HIV-positive mothers, their children and family. The effectiveness of the PMTCT programmes is largely dependent on proper implementation and utilization of the recommended services. In developed countries, where the

recommended services are properly implemented, MTCT is on the verge of elimination, whereas it still represents a threat to child survival in many developing countries like Ethiopia (UNAIDS, 2013).

However, the recent UNAIDS report has created optimism about the success of the PMTCT programmes all over the world (UNAIDS, 2013). The report highlights 43% reduction in global incidence of MTCT and 38% reduction in the sub-Saharan African region in the past three years which is largely due to proper implementation of the third and the fourth prongs. But still the burden of HIV remains constant which is also the main focus of this study. The third prong addressing the prevention of vertical HIV transmission has four major components. These are HIV counseling and testing; provision of prophylactic/therapeutic ARV drugs for mothers and their infants; safe obstetric practices for HIV-positive mothers and infant feeding counseling and support. Moreover, male partner involvement in PMTCT and exposed infant follow up are important aspects of the prevention of vertical HIV transmission programmes.

2.4 Knowledge and Attitude of Male Partners towards MTCT and PMTCT services.

Awareness and knowledge about PMTCT programmes is important for men's involvement; men need information about reproductive health issues and their possible role in these services and how they can access them (Kumah, 1999). It is obvious that males at least need to be aware of ANC/PMTCT programmes and their existence if they are expected to participate in these programmes. Studies conducted in Rwanda, revealed that, low male particpaticpation has been found to be attributed to inadequate information for male on PMTCT as they depend on second handed information from their wives which tends to be inadequate most of the time.

Similarly, Wynter and Hamilton's (2002:108) survey findings among males in Jamaica indicated that males are interested in fertility issues and would like to know more about and participate in reproductive health (RH). This suggests that awareness may matter the way for better male participation in RH and PMTCT. Studies have also suggested that poor male participation in RH can be linked with lack of information on

reproductive health. A study conducted in Gujarat state of India concluded that a perceived "neglect" of RH by males may be linked to a serious lack of information regarding reproductive health matters (Action Research in Community Health and Development 2000:15).

In a qualitative study conducted in Tanzania, lack of knowledge was the most frequently mentioned reason for male's failure to attend ANC/PMTCT services in both recent and non-recent fathers who participated in the study (Theuring et al, 2009). Similarly, another study also found out that a low level of knowledge was one of the prominent barriers to male participation in maternal health (Mullany, 2006). Women and thier partners have limited informatin on PMTCT and PMTCT is still a relatively new concept for many. while some information campaigns have been underway, there are still many people that lack the basic information (Zambia national PMTCT, 2004).

There is a gap in knowledge related to discordance. Some men questioned the need for testing if their partners had already been tested, believing that they would have the same test results as their partners (Falnes et al. 2011). Men also feared discordance because of the anger and bitterness it would cause in the relationship, further challenging men's desire to support their wives and even to participate in services (Reece et al. 2010).

Another study done by Mbezi(2010), revealed that those with high knowledge score were almost 4times likely to practice optimal involvement in PMTCT (OR=3.86; P<0.001) compared to respondents with low knowledge score. Other study similar found, Tshibumbu (2006:59) also found a statistically significant (p=0.00) positive correlation (r=0.483) between the composite scores of knowledge and male participation in PMTCT.

Aonther study conducted in Eastern Uganda, showed that men were well aware of media efforts to promote their involvement in testing, but they said that these media campaigns did a less effective job of explaining why men should be tested and what benefits they would derive from testing (Larsson et al. 2010). This

shows that men lack comprehensive knowledge about couple testing and counseling as well as on MTCT and PMTCT service.

A study conducted in Debremarkos town, northwest of Ethiopia, showed that male with moderate knowledge about PMTCT services were more likely to participate in PMTCT service than those with poor knowledge (Endawoke, 2013). Other studies in three public hospitals in Addis Ababa and in Mambwe district of Zambia revealed a significant association between knowledge of male partner and their involvement in PMTCT service (Katz, Kiarie, John-Stewart et al., 2009; Getu, 2011). Lack of information on PMTCT and HIV testing in Tanzania has contributed to low male partner involvement in PMTCT service (Family Health International, 2011).

In general, a study in sub-Saharan African counties shows reason for low male involvement is that knowledge and attitudes of male partner's on VCT/PMTCT is still a problem and the role of male is a key contributor to community acceptance and support of PMTCT programme. A Study conducted in Tanzania on Willingness and participation toward PMTCT among male of reproductive age pointed out that, most males do not participate in PMTCT programs because most of them don't realise their importance due to inadequate knowledge about the programs, while others are hindered by cultural settings in the community which pose negative perceptions toward the programs (Boniphace, 2009).

2.5 Factors that Influence Male Involvement in ANC /PMTCT

This sub-section discus the potential factors that associated with male involvement in ANC/PMTCT.

2.5.1. Socio-Cultural Factors:

Socio-cultural factors relate to male opinion on and perceptions of their role in PMTCT, on women's right to access PMTCT services, on couple communication, counseling and testing, and their potential reactions to a positive HIV test in their female partners. Socio-cultural and gender norms negatively influence the involvement of male in PMTCT programmes. The gender and cultural norms define the role of male in

women‘s reproductive health life as perceived by males themselves in the community in which they live (Lee, 1999 and Rutenberg et al, 2002).

Traditionally, in sub-Saharan Africa, support and care are seen as women’s work (Peacock, 2003). In Tanzania, social and religious norms that prohibits males from attending female health services and the wide spread attitude that female reproductive health is not male responsibility was found to inhibit male involvement in PMTCT (FHI, 2010). Similar, studies conducted in different sub-Saharan African countries identified, antenatal care as a woman’s activity and it was thus shameful for man to be found in ANC clinic(Aarnia et.al, Theuring et.al, Tonwe-Gold et.al (2009), Becker et.al, Nkuoh et.al, (2010) and Falnes et.al,(2011)). This cultural perception demotivaites man from attending antenatal care and involved in PMTCT.

In Eastern Uganda, the power structure of marriages in which men are decision makers and have power over wives’ action results men resisting women’s effort to influence them to have HIV testing (Larsso, 2010). A study conducted in four countries; (Cameroon, Dominican Republic, Georgia and India) indicated that male partners rarely participated in antenatal care services, mainly because these are traditionally a woman’s domain (Pulerwitz, 2010). Cultural setting in the community and men’s perception hinder their involvement in the PMTCT programme.

2.5.2 Health System Related Factors:

The PMTCT programmes themeselves are not friendly and accessible to males. In Uganda, men reported having been forced to wait an entire day for care at antenatal clinics, a heavy sacrifice for someone who needs to work to support his family. They were also excluded from the session where their wives were examined and had to wait outside without any information about what was happening to their pregnant wives. Furthermore, health workers mistreatment of the spouses made them feel uncomfortable and embarrassed (Theuring et al., (2009) and Larsson et al., (2010)).

Stigma and lack of confidentiality on the service provision hinder men’s from seeking services. A study conducted in rural western Uganda, AIDS related stigma and lack of confidentiality created barriers to

seeking VCT among men. More than half of the men feared to test for HIV because of stigma. Men were worried of being labelled HIV-infected because they would lose their social privileges. They expressed fear of meeting familiar people in HIV testing clinics, and preferred to test in distant clinics where they were not known by the staff (Bwambale, Ssali, Byaruhanga, Kalyango, and Karamagi, (2008).

Lack of adequate space in the antenatal clinics coupled with shortage of health workers and an increase in women attending antenatal care discourage men from attending ANC with their spouses since they have to wait for a long time before they are attended to (Byamugisha, 2010). Additionally, HIV testing usually proposes to men and women separately and on very different occasions which hinder communication between the couple regarding HIV, their status or the adoption of prevention behaviour (Desgrees du-Lou and Orine-Gliemann, (2008)).

Similarly, a study conducted in Ethiopia revealed that, the PMTCT service is not truly addressing the women and men equally since maternal child health (MCH) clinic typically do not reach men. Maternal and child health linkage, PMTCT services at the health institutions are highly female – centred. As a result male participation on the program is very low and the male involvement as the key component for achievement of the programme is minimal. The more HIV testing & counselling involvement of male, the more supportive he is in his partner dilemmas and choices of HIV matters (Anteneh, 2007).

2.6The Level of Male Partner Involvement in PMTCT

AIDs epidemic have reinforced the urgency of encouraging men to take responsibility for their own sexual and reproductive health and that of their partners (Salem, 2004). Despite global recognition at the level of international agreements, many countries have not developed large scale programs that reach out to men. As a result, many men are not aware of why they need to be involved in sexual and reproductive health how they can be involved and what services are available for them and their partners (Walston,2005).

Some studies show that there is low male partner involvement in PMTCT services in many sub-Saharan African countries (Larsson et al, 2010). In sub-Saharan Africa, male participation rate levels in hospital settings vary between 12.5% and 18.7% (Ditekemena, 2011). In Malawi, male partners do not often come forward to test for HIV with their wives. This has contributed to drop outs and non-compliance at many levels of PMTCT services (Malawi MoH, 2008). In Tanzania, male involvement in reproductive and child health services is low, which is estimated at 5% and lower in urban areas (FHI, 2011).

Participation by men in antenatal HIV testing and counselling is very low. Despite the many benefits of male involvement, studies from eastern and southern Africa have found testing rates ranging from 8% to 15% (Chandisarewa et al. 2007, Farquhar et al. 2004, Msuya et al. 2008 and Katz et al.2009, Falnes et al. (2011) found a lower male testing rate at the antenatal clinic, at 3%, in the United Republic of Tanzania (Kilimanjaro Region). Similarly, anecdotal observation in Ethiopia indicates that a larger number of males do accompany their female partner in labour to labour wards than they do in ANC clinics (Wondale et al 2009). Additional other study in Ethiopia revealed that only 10.4% of male partners had presented to PMTCT centres along with their pregnant and 47.3% of the pregnant women were reported that they will be influenced by male partners on decision of HIV testing (Abenet .T, 2007).

Other researchers found low couple discussion about HIV, as reported by most women interviewed in India and Cameroon (Orne-Gliemann, Tchendjou, Miric, Gadgil, Butsashvili, Eboko, Perez-Then, Darak, Kulkarni, Kamkamidze, Balestre, Desgrées du Loû and Dabis (2010)). Similarly, Byamugisha, Tumwine, Semiyaga and Tylleskar (2010), in eastern Uganda, found that only three in ten males interviewed discussed intervention at ANC clinics.

In the Ethiopian context, the country progress report of 2012 identified low male partner involvement in the PMTCT and it also identified as one of the challenges in the scaling up the programme (FHAPCO, 2012).

2.7 The Reasons /Rationale for Male Involvement in PMTCT

As studies show, in Africa men tend to have an upper hand in sexual and reproductive health decision-making and the uptake this reproductive health (RH) services including PMTCT by their partners is significantly influenced by males (Theuring(2010), Mlay, Lugina and Becker (2008) and Peltzer and Akarro, (2011)). Without working with men change would be very difficult or impossible (Sternberg, 2004). Similar studies explained that risk behaviours change dramatically among couples where partners are aware of their HIV sero-status (Medley, 2004). One major factor that prevents some women from accepting HIV testing is the need to seek their partner consent or assent (Omatayo, 2007). Cross sectional study in Uganda found that the strongest predictor of willingness to accept an HIV test was the woman's perception that her husband would approve of her testing for HIV. Women who thought their Husbands would approve were almost six times more likely to report a willingness to be tested compared to those who thought their husbands would not approve (Bajunirwe, 2005).

Studies in Uganda, Malawi and Nigeria have shown that the utilization of PMTCT services by pregnant women is influenced by individual factors such as fear of disclosure of HIV results, lack of male partner support, fear of violence, abandonment and stigmatization (Byamugisha, 2010). In Coted'Ivoire, 3.5% to 14.6% of pregnant women reported negative consequences of HIV status disclosure to their spouses (Brou, 2005).

In sub-Saharan Africa women's economic vulnerability and dependence on men coupled with traditional male superiority over women increase their vulnerability to HIV by constraining their ability to negotiate the use of a condom, discuss fidelity with partners, or leave risky relationships (Peacock, 2009). This means that if men are involved in PMTCT their understanding in HIV prevention will be higher and they would cooperate with their spouses in using condoms and other HIV preventive measures. The rate of violence, stigmatization and abandonment can also be reduced. Men always play a leading role in terms of initiating sex. In Malawi, men initiate sex in 92% of relationships and women feel powerless to refuse sex

or negotiate safe sex (Malawi MoH, 2007). Traditionally, it is common for men to have extra marital relationships thereby putting their spouses at risk of contracting HIV. A study in Tanzania found that the risk for HIV was greater among women whose male partner had other sexual partners (Orne-gliemann, 2010). Another study in Tanzania found that male partner played a role in terms of woman's risk of acquiring HIV (Pignatelli, 2006). With male partner involvement in PMTCT, a couple has a chance to make informed decisions together on living positively with HIV, share responsibility for preventing HIV in the unborn child and they can discuss safer sex practices and make informed decisions to access care and treatment (Ethiopia MoH, 2008). Men can play an important role of supporting HIV positive pregnant women to get to clinics or hospitals where chances of safe delivery are higher, they can assist HIV positive pregnant women to choose safe infant feeding method (Medley.2004).

Men as supportive partners can influence the family's social environment, especially with extended family, to create an environment that is more conducive to seeking treatment, being adherent to medications and clinical appointments and remaining in care both during the pregnancy and after delivery. Thus, involving men as supportive partners can help ensure the ongoing health of both parents as well as the prevention of prenatal transmission (Greene et al, 2013). In general, Partner testing and involvement in PMTCT programme can create an opportunity for identifying at risk partners for early initiation of ART or pre-exposure ARV prophylaxis which could ultimately contribute to the success of the HIV prevention efforts.

Lack or low male involvement in PMTCT program and in health system is a challenge for many sub-Saharan countries (Larsson et al, 2010). This is also the case in Ethiopia, where the estimated prevalence of HIV in pregnant women attending antenatal care during 2011 was 3%. There are very few numbers of male participants in Antenatal clinic for testing and counselling of HIV to reduce risk of MTCT (FHAPCO report, 2012).

2.8 Theoretical Framework of the Study

AIDS Risk reduction model (ARRM) and Health Belief Model (HBM) are used as theoretical models of male involvement in the reproductive health particularly in PMTCT. The AIDS risk reduction model developed in 1990, specifically for AIDS prevention, uses constructs from health belief model to describe the processes individuals go through while changing behaviour regarding HIV risk. The model identified three stages; 1) problem perception; 2) Commitment to change, and 3) taking action. For each stage the model hypothesized factors that influence individual efforts for successful completion. The first stage of the problem perception is recognizing the problem, using three factors: these are knowledge of HIV transmission and mother to child HIV transmission method, the belief that one is susceptible, and the belief that AIDS is undesirable. Social norms also influence the individual by disapproving high risk behaviour and approving safe alternative (Catania, Kegele and Coates, 1999).

In the second stage individuals make commitment to change. The hypothesized factors that influence an individual's commitment include perceived psychological and social cost as well as benefits to make a decision about commitment.

These cost and benefits reflect three areas; knowledge of the health utility (response efficacy), and actual success in reducing their risk of HIV, and the ability to perform the action (self–efficacy). Social factors (group norms and social support) are also believed to influence an individual's cost and benefit to make a decision about commitment as well as self–efficacy beliefs. In the final stage, individuals will take action to make the behavioural change. There are three phases in this stage; looking for information, finding solutions (obtaining remedies) and carrying out the solutions.

Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. It was developed in 1950 and holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model a person must hold certain beliefs in order to be able to change behaviour. This means that promoting action to change a particular behaviour

includes changing individual's personal beliefs. The model is also based on the premise that the likelihood of engaging in preventive health behavior is influenced by certain beliefs about a given condition (Eisen, 1992).

2.9. Summary /Synthesis

Different studies emphasize the importance of male partner's involvement in a wide range of RH services including PMTCT. The studies also show that it is not easy to convince male to be involved in the program that are designed for women. The men's uptake of the services is considerably affected by his knowledge, attitude toward the services and different other factors like socio-cultural and health system related factors.

Most studies focused on assessing the barriers and opportunities of male involvement in reproductive health issues and some assessed the level of male involvement in reproductive health services and others on factors related to male involvement in PMTCT service which are mostly in other developing counties. However, studies conducted on male involvement in PMTCT and male acceptance of Couple HIV counselling and testing are scarce in Ethiopia. Very few studies were conducted on the male perception about PMTCT, even most of these studies mentioned women as source of information about attitude, knowledge and practice of male instead of male themselves and they are qualitative in nature. There has also been a knowledge gap in these subjects, specifically in the Ethiopian context. Therefore, there is a need to conduct a study that assess the knowledge, attitude and practices of male partners from the view of male themselves as well as identify the factors associated with their involvement in PMTCT in the Ethiopian context.

In general, the literature reviewed in the preceding sections laid a ground to a better understanding of concepts such as MTCT, PMTCT of HIV, level and benefit of male involvement and factors that affect male involvement in PMTCT.

The following conceptual model is developed to guide the study based on the review of the literature. The conceptual model included variables such as socio-demographic factors this includes age, educational status, martial relationship and occupational status, and other factors that hindering male involvement in PMTCT like socio-cultural which includes beliefs, norm, taboos and community perception on male partner involvement in PMTCT and health system related factors this includes how the service is friendly for male partner, setting of clinics, location confidentiality and time of service provide associated with male involvement in ANC/PMTCT.

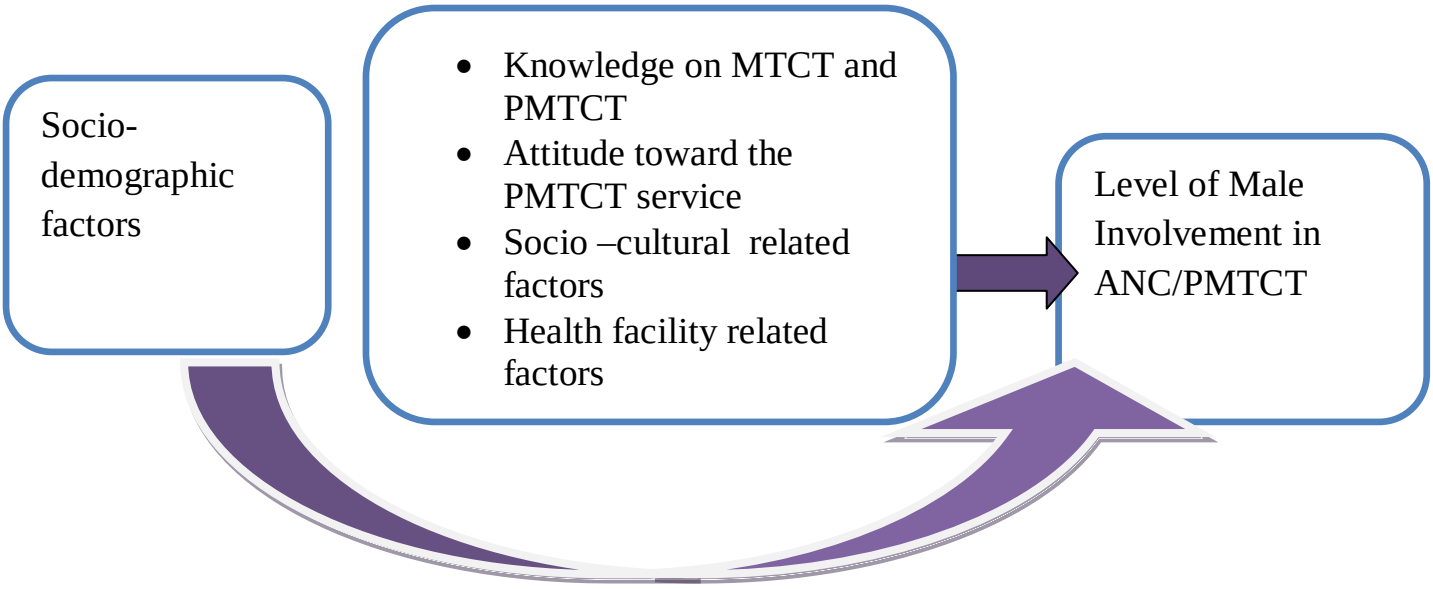

Figure 2.1: The Conceptual Model for the Study.

(Adapted from Rosenstock (1990). In Glanz, Lewis, & Rimer, *Health Behavior and Health Education).*

In the diagram, the arrows show the relationship between the independent variables (socio-demography, knowledge & attitude, and other related factors (socio-cultural, health facility) with the dependent variable level of male involvement in ANC/PMTCT.

Chapter Three

Research Design and Method

This chapter describes the research design and methodology adopted for the study. It discusses the design, the study population, the sampling methods and sample size, the research instrument, data collection process, data analysis process, pilot testing and ethical and legal considerations.

3.1 Research Design

An institutional based cross-sectional study was conducted in two health centres in Addis ketema sub city to assess knowledge, attitude and practices of male partner in PMTCT and the factors associated with their involvement in PMTCT service.

3.2 Methods

Mixed method (both quantitative and qualitative method) was employed to get in-depth and rich information on the topic of the study. Thus, the qualitative data were used to complement the quantitative information.

3.2.1. Participants

The study populations were all male partners who were either sexual partners or husbands of pregnant women attending antenatal clinic and health workers who were directly involved in the provision of ANC/ PMTCT service in the two health centres of Addis ketema sub city. During the study period there were 400 pregnant women attending antenatal clinic in the two health centers. Number of study participants for each health centers was allocated proportionally and samples were selected by systematic sampling techniques using the list of pregnant women for registration book as a sample frame.

3.2.2. Sampling

For the quantitative method the sample size was calculated using single population proportion formula with estimated proportion of 10% (0.1) male partner's participation in ANC/PMTCT (Abenent, 2007) assuming that 0.05 marginal error and 10% non-respondent rate respectively;

$$n = \frac{(1.96)^2 X 0.1 X 0.9}{0.05 X 0.05} = 138$$

Accordingly, it was 138. Systematic sampling method was used to select study sample of all male partners with pregnant women attending at antenatal clinics and every third persons were approached and asked to participate in the study.

For qualitative study participants were selected using purposive (judgmental) sampling technique by the researcher because they were purposefully informed about the research and the central phenomena of the study. This helped the researcher to get in-depth and rich information on the topic of the study.

3.2.3. Data Collection

A structured questionnaire was prepared in English language based on review of previous studies on the study area and translated in to Amharic language. The questionnaire consists of five sections:

1. Section 1: Socio-demographic characteristics
2. Section 2: knowledge, awareness of male partners on HIV transmission, risk acquire issues, mother to child HIV transmission (MTCT) and Prevention of mother to child HIV virus transmission (PMTCT).
3. Section 3: question on attitude of male partners toward MTCT and PMTCT.
4. Section 4: level of male partner's involvement in PMTCT services.
5. Section 5: factors associated to male partner's involvement in PMTCT services.

Measurement of knowledge; attitude and level of male partner's involvements in PMTCT service:

Knowledge

Basic knowledge questions were assessed using participant's correct responses. The four questions had a total of 22 points. Each correct response was given a score of 1 and a wrong response a score of 0. The points assessed basic knowledge on transmission (5 points – knowledge on how HIV is transmitted, unsafe blood transfusion, sharing sharps with an infected person, mother to child transmission, unprotected sexual intercourse), risk factors (3 points – knowledge on the risks of HIV transmission, unprotected sexual intercourse with an infected person, multiple sexual partners, having sexually transmitted infections, mother to child transmission(MTCT)(3points –mother to child transmission during pregnancy, labour ,delivery and after delivery through breast feeding and preventive measures (10 points).

On assessment of knowledge, Modified Bloom's (Blooms BS, 1956) cut off points was adopted and used during analysis. A score of 75% – 100%, 50% – 74% and less than 50% placed the respondent in good, moderate and poor basic HIV/AIDS knowledge, respectively. Eight questions assess participant's knowledge on HIV transmission, four question on mother to child transmission and 10 questions on prevention measures of mother to child transmission and had a total of 22points. A score of 1 was assigned for a correct response and 0 for a wrong response. Therefore the scores were as follows:

i) 17 – 22 points = good knowledge

ii) 11 - 16 points = moderate knowledge

iii) 0 – 10 points = poor knowledge

Attitude

Attitude was assessed by 10 questions. These were put on a likert's scale and respondents were provided with statements asked to indicate the extent to which they agree with those statements on whether they strongly agree, agree, undetermined, disagree or strongly disagree with what they were asked. The scoring system used with respects to respondents' responses was as follows: strongly agree scored 1, agree 2, undetermined 3, disagree 4, strongly Disagree 5. The responses were summed up and a total score was

obtained for each respondent. The mean score was calculated and those scored above the mean and the mean score had positive attitude and scores below the mean meant negative attitude towards prevention of mother to child transmission strategies. The highest score was expected to be 50 and the lowest score was 10.

Level of male partner's participation in PMTCT services:

Level of male involvement in PMTCT assessed using 14 questions (Getu , 2011). Respondents were asked a total of 14 questions to assess their level of male participation in PMTCT and graded as low if they responded got correct response below the mean score and high if more than the mean score correct answers.

The variable "socio-cultural factors"

A 10-item Likert scale was used to measure the variable socio-cultural factors. The scale included statements on various socio-cultural issues in PMTCT with a 5-response option from "strongly agree" to "strongly disagree". The scoring of responses ranged from 1 to 5, taking into account the agreement with positively worded statements and disagreement with negatively worded statements (Getu K, 2011). The statements included in the scale covered the following issues: gender responsibilities of men and women in PMTCT; couple visits, couple counselling and testing in an antenatal/PMTCT setting; men's possible reactions to positive HIV results in their female partners.

Four categories were established for the composite measure of socio-cultural factors:

• Low socio-cultural influence: 0 to 19 total score

• Moderate socio-cultural influence: 20 to 29 total score

• High socio-cultural influence: A total score of 30 to 39

• Very high socio-cultural influence: A total score of 40 to 50

The variable "health facility related factors"

Health facility related factors were measured also using a 8-item Likert scale. This scale includes statements about the following issues: the friendliness of PMTCT clinics to men, the biased gender representation amongst clinic workers; the compatibility of PMTCT clinic times with other men's activities; the level of confidentiality at PMTCT clinics; the attitude of staff towards men; the level of efforts made by PMTCT services to involve men.

Four categories were established for the composite measure of the influence of health facility related factors on men's involvement. These categories are based on the total marks obtained from the Likert scale, following the same principles as in the previous section:

• Low health facility influence: a total score of 0 to 9

• Moderate health facility influence: a total score of 10 to 19

• High health facility influence: A total score of 20 to 29

• Very high p health facility influence: A total score of 30 to 40

The questionnaire was administrated by four research assistants who had experience to conduct an interview. The research assistants was trained for one day (including half day of pre-test) on the objective, relevance of the study, confidentiality of information, respondent's right, informed consent and techniques of interview.

A semi-structured interview guide questions to examine level of male partners' involvement in PMTCT service provision were designed in English and translated into Amharic was used for qualitative data collection. The researcher carried out the key informants (in-depth) interviews with key informants PMTCT services provider nurses in health centres.

3.2.4. Data Collection Procedure

The researcher and researcher assistants approached individually male partners' who came with pregnant women to attend ANC clinic to explain the purpose of the study and asked for consent for them to participate. Only those who consented were enrolled in the study. A place was prepared for the researchers

for interview and both the researcher assistants had their working rooms that they used. Before the interviews male partners were requested to sign a written consent. The data were collected using structured face-to-face interviewer administered questionnaire prepared to address male partners' knowledge, attitude, level of their involvement in PMTCT service and factors associated with their involvement in PMTCT services. The interviews took a maximum of 30min and male partners were interviewed after consultation with the service providers.

In-depth interviews were conducted. A total of 6 participants were selected using purposive sampling technique till reached to a point of redundancy of information. The selection was done by consulting administrators of the health centres, in order to identify health workers (the key informants) who were directly involved to the PMTCT/ANC service provision. They were purposefully informed about the research, the fact of the study and their consent were asked only the volunteers were interviewed by the researcher using a semi-structured interview guide questions to examine level of male partners' involvement in PMTCT service. Note were taken in the field by the researcher and also voice were recorded using tape recorder.

3.3 Data quality control

The structured interview schedules were administrated by four research assistants who had experience to conduct an interview. They were trained for one day (including half day of pre-test) on the objective, relevance of the study, confidentiality of information, respondent's right, informed consent and techniques of interview. The researcher has supervised the data collection process.

3.4 Data analysis

The quantitative data were checked, cleared and entered into SPSS data sheet software and analysis was done by using SPSS (version 20.0). Initially, bivaratie analysis was performed between socio-demographic factors, knowledge; attitude of male partners and each of the potential factors associated to male partner's involvement in ANC/PMTCT services (independent variable) with level of male partner involvement in

PMTCT services (dependent variables), one at a time. The association between variables was measured and tested using correlation and logistic regression analysis. A P-value < 0.05 was considered to be statistically significant in all cases.

Pilot testing

The questionnaires were pre- tested in Addis ketema sub city health centres which are not included in this study. The pre-test done on 15% of the total sample size reliability and the questionnaire was assessed for its clarity, length and completeness. Finally, the responses of the participants were entered to SPSS version 20 to compute the reliability of the 68 items in Cronbach-Alpha in order to evaluate the scales and their reliability. The measure was found to be reliable with Alpha 0.637 (68 items).

3.5 Ethical and Legal Considerations

Permission to conduct the research was obtained from the Review committee of Addis Ababa University of behavioural studies, Psychology department. Permission was obtained from respective health institutions, and informed consent was obtained from individual respondent. All the interviews with subjects were made with strict privacy after getting informed consent from the respondents and assuring the confidential nature of the responses. The right of the respondents to refuse to answer few or all of the questions was respected.

CHAPTER FOUR

Results, Analysis and Interpretation of Data

This chapter presents results of the data analysis. The results are organized in to four sections. Section one presents descriptive statistical results for the variable in the study, level of knowledge, attitude toward the service and level of male partner involvement. Section two presents findings of association of the independent variables (socio-demographic, level of knowledge, Attitude, socio-cultural factors and health facility related factors) and dependent variable (male involvement). Findings of correlation and logistic regression analysis are presented in section three.

4.1 Results of Simple Descriptive Statistical analysis

Descriptive statistics were calculated for each variable in the study. A frequency distribution (both in absolute and relative term) was calculated for categorical data. In this study primary source of data was presented using frequency distribution. The mean and standard deviations were used to descriptive the data.

4.1.1 General Characteristic of the Study Population

A total of 126 male partners of pregnant mothers attending ANC from Addis ketema health centres and woreda seven health centres were selected systematically. Face to face interview was conducted to assess their knowledge, attitude and their involvement on PMTCT service.

Table 1 shows that majority of the respondents (63.5%) were in the age range of 25-35 and the mean of their age was 24 (SD ±0.718). More than half of the interviewed respondents had completed secondary school. Majority of them were married 113(89.7%). Among the study population, 67(53.2%) of the respondents had own their businesses, 30(23.8%) were employed and 8(6.3%) were unemployed.

Table .1 Socio-demographic characteristics of the study population (N=126)

Variables	Frequency	Percent (%)
Sex		
Male	126	100%
Age		
15-24	4	3.2%
25-34	80	63.5%
35-44	29	23%
45-49	13	10.3%
Mean 24 SD ±0.718		
Marital status		
Married	113	89.7%
Cohabitating	12	0.8%
Divorce	1	9.5%
Educational status		
Can't not read and write	8	6.3%
Read and write	8	6.3%
Completed primary school	39	31%
Completed secondary school	58	46%
Diploma	13	10.3
Occupation status		
Daily labour	21	16.7%
Employed	30	23.8%
Own businesses	67	53.2%
Unemployed	8	6.3%

Table 2. Mean and Standard deviation of the Respondents on the scales

Scale	N	Mean	SD
Knowledge	126	18.01	±2.76
Attitude	126	33.92	±3.12
Involvement	126	11.69	±1.66

4.1.2 Knowledge of the Respondent about HIV Transmission mode, way of reducing of risk, MTCT and PMTCT.

Table 3. The respondent's knowledge about HIV transmission mode, risk acquiring factors and MTCT

Knowledge indictors (N=126)	**Response in number (%)**					
	Yes		**No**		**Don't know**	
	N	%	N	%	N	%
Knowledge HIV transmission and risk of acquiring						
Unprotected Sexual intercourse	121	96	5	4		
Unsafe blood transfusion	120	95.2	6	4.8		
Sharing of Contaminated sharps/needles	125	99.2	1	.8		
Mother to child transmission	112	88.9	3	10.3	1	0.8
Do you know the risks of acquiring HIV?	116	92	10	7.9		
Unprotected sexual intercourse with an infected person	115	91.3	11	8.7		
Having multiple sexual partners.	122	96.8	4	3.2		
Having sexually transmitted infections	118	93.7	8	6.3		
Sub total	119	94.4	6	4.76	1	0.8
Knowledge about MTCT						
HIV can be transmitted from infected mother to child during pregnancy	97	77	28	22.2	1	0.8
HIV can be transmitted from infected mother to child during labor and delivery	93	73.8	32	25.4	1	0.8
HIV can be transmitted from infected mother to child while sleeping with baby on same bed			126	100		
HIV can be transmitted from infected mother to child during breast feeding after birth	74	58.7	52	41.3		
Sub Total	66	52.38	59	46.82	1	0.8

As shown in table 2 above, majority of the respondents have general knowledge about HIV transmission, risk of acquiring and mode of HIV transmission.

Table 3. The respondent's knowledge about prevention mother to child transmission (PMTCT)

Knowledge indictors (N=126	**Response in number (%)**					
	Yes		**NO**		**Don't know**	
	N	%	N	%	N	%
Knowledge about PMTCT						
HIV counselling and testing for pregnant mothers	122	96.8	4	3.2		
HIV counselling and testing for male partners	108	85	85		18	14.3
Antiretroviral drugs to infected mother and new baby born form her	80	63.5	46	36.5		
Delivery by caesarean section	86	68.3	40	31.7		
Complete avoidance of breast feeding is one option	69	54.3	57	45.2		
Exclusive breast feeding for first 6 months is one option	67	53.2	55	46.8		
Using contraception by HIV positive couple	56	44.4	70	55.6		
Have you ever heard about a program called Prevention of Mother-To-Child Transmission (PMTCT) of HIV?	114	90.5	12	9.5		
Do you know that PMTCT services are offered in all government health facilities?	113	89.7	12	9.5	1	0.8
Do you know that pregnant women are counseled and tested at antenatal care clinic?	116	92.2	10	7.9		
Sub Total	93	73.81	32	25.39	1	0.8

Concerning the knowledge on the ways of reducing MTCT, majority (96.8%) of the respondents knew that HIV counseling and testing for pregnant mothers and their male partners 108(85%) could reduce MTCT of HIV except 44.4 % of the respondents don't know that using contraception by HIV positive couples reduce the risk of HIV transmission from mother to child.

As shown in Table 4, Most of the respondents (92%) are aware of that pregnant women counseled and tested at antenatal care clinic and 114(90.5%) were heard about a program of Prevention of Mother-To-Child Transmission (PMTCT). 113(89.7%) of the respondents knew that PMTCT services are offered in all government health facilities.

The level of knowledge of mode of HIV transmission, risk of acquiring, mother to child transmission and ways of reducing the MTCT range from 10-22 on the 22 scale measurement. The mean of the respondents score was 18.01 and standard deviation (SD) ± 2.76.

Table 4. Summary table for the respondent's level of knowledge on MTCT and PMTCT

Correct response score	Level of knowledge	N o of respondents	%
17-22	Good	96	76.2%
11-16	Moderate	26	20.6%
0-10	poor	4	3.2%

As shown in Table 4 above 96(76.2%) of the respondents have a good knowledge about HIV, MTCT and PMTCT.

4.1.2 Attitude of respondents toward MTCT and PMTCT service

As indicated in Table 5, ten statements used to measure the opinion of the male partners were constructed using a likert scale of five categories.

The five categories are regrouped to three categories to make the analysis easy. Accordingly, 125(99.2%) of the respondents agreed that it is important that every pregnant woman gets tested for HIV with her partner. And majority 120(95%) of the respondents disagree that it is better to live with unknown HIV status than live depressed with positive HIV status known. 102(81%) of the respondents disagreed with the idea that any HIV test result of a pregnant woman indirectly confirms HIV status of her partner. Also 117(92.9%) of the respondents disagree with idea of that if couples are infected with HIV then they shouldn't think of having child.

Table 5. Attitude of Male Partners toward ANC and PMTCT N (126)

Questions	**Responses in Number (%)**					
	Agree		**Undetermined**		**Disagree**	
	N	%	**N**	%	**N**	%
It is important that every pregnant woman gets tested for HIV with her partner	125	99.2			1	0.8
If couples are infected with HIV then they shouldn't think of having child.	8	6.3	3	2.4	117	92.9
Using condom during pregnancy and breastfeeding reduce MTCT?	63	50	30	23.8	33	26.2
Some male don't accompany their wife at ANC clinic despite their HIV status due to stigma.	23	18.3			103	81.7
Some male partners don't undergo for HCT to know their HIV status due to fear of disclosure.	29	23			97	77
Male should support his wife choice of feeding the baby	119	94.4	2	1.5	5	3.9
An HIV test result of a pregnant woman indirectly confirms HIV status of her partner	22	17.5	2	1.5	102	81
Couples should use condoms at least until they know their HIV status is negative	78	61.7	17	13.4	31	24.6
It is better to live with unknown HIV status than live depressed with positive HIV status known	6	4.8			120	95
Even If couples believe they are faithful to each other, they should be tested for HIV together during ANC follow up for the sake of PMTCT	110	87.3	2	1.5	14	11.1
Sub Total	58	46.03	6	4.76	62	49.20

To measure the attitude of respondents the responses were summed up and total score obtained for each respondent and the mean score was used to create categories. Accordingly, 63(50%) of the respondent have positive attitude and 63(50%) negative attitude toward PMTCT service.

4.1.3 Level of Male Partner Involvement in ANC and PMTCT

As indicated in Table 6, the respondents' total score on male involvement was calculated by summing up the scores of 14 items designed to assess male involvement. All items had an equal weight of score 1. For all items except item 13, a score of 1 was given for "Yes" responses for positive connotation and 0 (zero) for "No" responses for negative connation while for Item 13 a score of 1 was assigned for "No" response because of its negative connation and 0 (zero) for "Yes" response.

Table 6**.** Level of Male Partner Involvement in ANC and PMTCT (N=126)

Statements	**Responses N (%)**			
	Yes		**No**	
	N	**%**	**N**	**%**
Have you ever self initiated the discussion on importance of PMTCT service with your partner during her pregnancy?	84	66.7	42	33.3
Have you ever requested your wife to be tested for HIV during her pregnancy?	101	80.2	25	19.8
If your partner had ANC follow up, have you ever asked her what information/service she got at ANC clinic?	107	84.9	19	15.1
Have you ever reminded your partner of her ANC follow up (schedule)?	111	88.1	15	11.9
Did you cover medical expenses of your partner in the ANC follow up during her pregnancy?	126	100		
Did you accompany her to ANC clinic at least once during her pregnancy?	120	95.2	6	4.8
If yes to q.6 did you enter in to ANC room together with your partner?	102	81	24	19
Were you counselled and tested for HIV during your spouse's/partner's pregnancy?	119	94.4	7	5.6
If yes to Q 8, were you counselled and tested together with your partner?	117	92.9	9	7.1
Assuming you are willing for HIV test now, will you confide in your female partner if you test positive for HIV?	124	98.4	2	1.6
Assuming your female partner gives consent for HIV test and tests positive, will you accept that she and the newborn take ARVs for PMTCT?	118	93.7	8	6.3
Assuming your female partner tests HIV positive, would you be confident to help in the newborn's medical follow up until the HIV status is known?	116	92	10	7.9
Assuming your female partner and you both give consent for HIV test and your female partner tests positive while your test negative, would you decide to discontinue you conjugal or love relationship?	43	34	83	65.9
Assuming you and your partner are HIV tested, If you are positive while she is negative, would you be confident to use condom consistently to prevent transmission to her and thus to the child?	86	68.3	40	31.7
Sub Total	105	83.33	21	16.66

In general, as shown in Table 6 majority of the participants reported their involvement in PMTCT expect 34.1% of the respondents who mentioned that they would discontinue conjugal or love relationship if their female partners tests result were positive while their test results were negative.

For the simplicity of analysis, the composite scores on level of male involvement were grouped into two categories. The composite score of level of involvement in PMTCT ranged from 0 to 14 with a mean of 11.7(±1.6 SD). The score of respondents more than the mean score were categories into higher level of male involvement and the scores of respondents less than the mean score were categorized into low level of involvements.

Table 7 Categories of Composite score of Male Involvement (n=126)

Category	Score range	Number	Percent
Low level of involvement	0-11	50	39.7%
High level of involvement	12-14	79	60.3%
Total		126	100

As shown in Table 7 Majority of the respondents (60.3%) were highly involved in PMTCT.

4.1.5 Factors that influence the level of male involvement in ANC/PMTC service.

4.1.5.1 Socio-Cultural related factors

To know the opinion of male partner's on socio-cultural related factors that influence the level of male involvement in ANC/PMTCT service. Ten statements to measure the opinion of respondents were constructed using a likert scale of five categories. For the sake of analysis, "Strongly agree" and "Agree" were grouped together as "Agree", while "Strongly disagree" and "Disagree" were grouped together as "Disagree". Respondents' opinions for each statement are shown in table 8 below.

Table 8 Summary of respondent responses on socio-cultural related factors (N=126)

Statements	Responses in number (%)					
	Agree		Undetermined		Disagree	
	N	%	N	%	N	%
A pregnant woman can be tested for HIV without the permission of her husband/partner	120	95.2			6	4.8
Men should accompany their pregnant wives/partners to ANC/PMTCT clinics	116	92.0	1	0.8	9	7.1
Men who accompany their female partners to ANC /PMTCT clinics are weak or bewitched	28	22.2	1	0.8	97	76.9
It is a shame for men to discuss with women about HIV testing during pregnancy	18	14.3	1	0.8	107	84.9
Men and women should undergo HIV testing at the same time at PMTCT clinics	116	92.1			10	7.9
Couples can use condoms to reduce chances of mother to child transmission of HIV	76	60.3	13	10.3	37	29
ANC/PMTCT clinics are for women and children only.	10	7.9	1	.8	115	91.2
A positive HIV test in a pregnant woman shows that she has been unfaithful to her husband	13	10.3			113	89.6
If a pregnant woman is found to be HIV positive, she should be divorced	18	14.2			108	85.7
PMTCT Information should first be given first to men then to women	42	33.3			84	66.6
Sub Total	55	43.65	3	2.38	68	53.97

As indicated in Table 8, majority of the respondents (95.2%) agreed that a pregnant woman could be tested for HIV without the permission of her husband/partner. Moreover, 107(84.9%) disagreed with the statement which says it was a shame for men to discuss with women about HIV testing during pregnancy. The majority (89.6%) of males believed that a positive HIV test result of the female partner implied her unfaithfulness. Almost all of the respondents, (91.2%) disagreed that PMTCT clinics were only for women and children.

The composite measure of the level of influence of socio-cultural factors for each respondent was measured by the total score on the Likert sale with a possible maximum score of 50. Respondents' scores were categorized into four groups using cut-off values used in other study (Getu , 2011).

Table 9. Categories of Composite score socio-cultural influence (n=126)

Category	Score	N	%
Low level of socio-cultural influence	0 to 19	49	38.9%
Moderate level of socio-cultural influence	20 t0 29	77	61.1%
High level of socio-cultural influence	30 to 39	0	0
Very high level of socio-cultural influence	40 to 50	0	0

As shows above in table 9, majority of respondents, (61.1 %) were in the category of moderate socio-cultural influence and 49(38.9%) of the respondents were in the category of low level of socio-cultural influence.

4.1.5.2 Health Facility Related Factors

The level of influence by health facility related factors on each respondent was measured by an 8-item Likert Scale. The respondents' opinions on each statement are presented in the table below Table 10. For the purpose of analysis, "Strongly agree" and "Agree" were grouped together as "Agree", and "Strongly Disagree" and "Disagree" were grouped as "Disagree.

Table 10. Summary of respondent responses on Health Facility related Factors (N=126)

Questions	**Responses in Number (%)**					
	Agree		**Undermined**		**Disagree**	
	N	%	N	%	N	%
Men should have "male only PMTCT clinics	13	10.3			113	89.6
At the MCH/PMTCT clinics Men should be attended to by Male health workers only	25	19.8			101	80.1
Health workers do not like to see men at MCH and PMTCT clinics	21	16.6			105	80.1
MCH/PMTCT clinics are made for women and children only	37	29.3			89	70.6
PMTCT /MCH clinics should be opened during weekends and evening so that men can access	118	93.6			8	6.3
Men should be invited by health workers to come and attend PMTCT clinic	23	18.2	7	5.5	96	76.1
Distance from health facility was major obstacle for you to attend ANC/PMTCT clinic with your partner	88	69.8	16	12.6	22	17.4
You can do HIV test with your wife, only if you are promised to be given ARVs afterwards	14	11.1	15	11.9	97	76.9
Sub Total	42	33.33	13	10.31	70	56.36

The results show that majority of the respondents did not agree with idea of female and male separation in the provision of PMTCT services. 113(89.6%) they did not think of men should have "male only PMTCT clinics and 108(80.1%) did not think that at the PMTCT clinics men should be attended by male health worker. Almost all 118(93.6%) of the respondents agreed with idea of PMTCT/MCH clinics should be opened during weekends and evening so that men can access. 88(69.8%) of the respondents agreed that distance from health facility was major obstacle for men to attend ANC/PMTCT clinic with their partner.

Composite measure of the level of influence of health facility factors .The composite measure of the level of influence of health facility factors for each respondent was measured by the total score on the Likert

scale with a possible maximum of 40. In general, the higher the score, the higher the level of health facility influence on the respondent. Respondents' scores were categorized into four groups using cut-off values used in other study (Getu K, 2011).

Table 11 Categories of Composite health facility influence (n=126)

level	Score	N	%
Low level of health facility influence	0 to 8	0	0
Moderate level of health facility influence	9 t0 19	79	62.7%
High level of health facility influence	20 to 29	46	36.5%
Very high level of health facility influence	30 to 40	1	0.8%

As shown in table 11 (above), the total health facility related factors score for the majority of respondents (62.7%) lies in the category of moderate level.

Results of in-depth interview question with health workers in ANC/PMTCT service provider

The data obtained using interview with the health workers were analyzed qualitatively. The interview was conducted with 6 health workers in ANC/PMTCT service providers in the health institutions and their responses of health workers were analyzed in the following ways:

Among the participants 1 of the woreda seven health centre and 1 Addis ketema health centre were not trained on PMTCT; however, all of the participants in one or another way encountered of couple counselling and they were responsible in providing PMTCT services in the specified department of the health centres.

Regarding the effort of health workers on conducive male partners to decided taking couple counselling, most of health workers mentioned that they provide health education on the importance of couple counselling and PMTCT then inform all pregnant women to come with their male partners for counselling

and testing and sending invitation card for their male partners but still the male partner's involvement is low.

Concerning the time took in average for each couple counseling session, almost all agreed that the time that took for one couple counseling were in average 45mintes. However, there is point should be taken in account during post counseling the time taken depended on the couples results if it different it took more time to convince both of them.

Regarding the conducive of the room for couples counseling, almost all the participants stated that the room is not conducive e for the couple counseling because there is shortage of space in the health centers. The ANC service like abdominal examination of the pregnant women done also in the same room for the issues of confidently we will make other mother to wait by giving health education outside and do couple counseling.

Concerning the common barriers or obstacle for male partner who deter their involvement in PMTCT service, lack of knowledge and awareness about Couple counseling, time of the service provision one of the obstacle and fear of test result are the barriers that mentioned by all of the respondents.

Concerning the strategies to improve the male partners' involvement in PMTCT services the following points are explained. Using Mass media, health education, and providing the invitation card as well as leaflet on the service is important to increase the awareness of the male partners on ANC and PMTCT. Also conducting male partners dialog session at the health centers which gives chance for other male to participate and a good opportunity for services providers to share information.

4.1.2 The Relationship between Independent and Dependent Variables

This section presents results of inferential statistics (correlation, regression analysis and analysis of variance).

4.1.2.1 Results of Correlation Analysis

Correlation coefficients were computed to see the degree of association among the independent variables and dependent variable.

Table12 Correlation matrix of Socio-demographic and Male involvement (N=126)

Variables	Involvement	Age	Marital status	Educational status	occupation status
Involvement	1.000				
Age	.065	1.000			
Marital status	-.101	.130	1.000		
Educational status	.015	.069	-.111	1.000	
occupation status	-.023	-.057	-.106	.305**	1.000

** Correlation is Significant at level 0.01 level (2 tailed)

* Correlation is Significant at level 0.05 level (2 tailed)

As shown in table 12. birvairate analysis result shows that level of male partner involvement and age has non-significant (p=0.472) and very weak positive correlation with a Spearman correlation coefficient (r_s) of 0.065.

Marital status and level of the male involvement has non-significant (p=0.260) and very weak negative correlation with a (r_s= -0.101). This negative relationship might tell us a longer of relationship between a man and a woman may have negative influence on the men's involvement in PMTCT. Also male's

occupation and level of involvement had insignificant and negative correlation with (rs=-0.023 and P=0.800).

This study finds that male involvement in PMTCT and educational status had insignificant association with an r_s=0.015 and P=0.869 at 0.01 level which was very weak positive relationship. This positive correlation might suggest that as the level of education increased there is as positive influence on male partner involvement in PMTCT services.

Relationship between other independent variables and dependent variables

Table 13. Correlation matrix of independent and dependent variables (N=126)

Variables	Involvement	knowledge	Attitude	socio-cultural influence	Health facility influence
Involvement	1.000				
knowledge	.319**	1.000			
Attitude	.162	.126	1.000		
socio-cultural influence	-.381**	-.223*	.081	1.000	
health facility influence	-.154	-.044	-.115	.299**	1.000

** Correlation is Significant at level 0.01 level (2 tailed)

* Correlation is Significant at level 0.05 level (2 tailed)

As shown in Table 13, bivairate analysis result shows knowledge of respondents and degree of socio-cultural influence has statistically significant relationship with level of male involvement in PMTCT services. The results indicate that knowledge of respondents and male involvement have statistically significant relationship (r_s=0.319, $p<0.05$). They were positively correlated and this might tell us that

respondents with high level of knowledge have also high level of involvement and vice-versa. Whereas socio cultural influence and level of male involvement in PMTCT service have statistical significant relationship (r_s=-0.381, p<0.01). They were negatively correlated and this might tell us that low socio cultural influence highly involved in the PMTCT services and vice-versa.

But the level of male involvement and attitude were not statistically significantly correlated (rs=0.162; p> 0.05). The results of this study show that health facility related factors has a weak negative and insignificant correlation (rs=-.154: p >0.05).

Results of Logistic Regression Analysis

Logistic regression analysis is an extension of multiple regressions. The goal of logistic regression analysis is to enable the researcher to examine the influence of various factors on a dichotomous outcome of dependent variable by examining the relationship between several independent and dependent variables. The logistic regression analysis was employed to address the question of how much does each independent (predictor) variable uniquely contributed to that relationship. In standard logistic regression all predictor variables were entered into the regression equation at once.

Table 14. Logistic Regression Model Variables in the Equation

Involvement		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
								Lower	Upper
Step 1[a]	Knowledge	1.111	.432	6.601	1	.010	3.036	1.301	7.085
	Attitude	.951	.440	4.679	1	.031	2.589	1.093	6.130
	Socio-cultural factors (1)	1.766	.548	10.403	1	.001	5.849	2.000	17.111
	Health facility related factors			.459	3	.928			
	Health facility related factors(1)	-21.176	40193.098	.000	1	1.000	.000	.000	.
	Health facility related factors (2)	-21.530	40193.098	.000	1	1.000	.000	.000	.
	Health facility related factors (3)	-21.844	40193.098	.000	1	1.000	.000	.000	.
	Constant	17.871	40193.098	.000	1	1.000	57710811.270		

a. Variable(s) entered on step 1: knowledge, Attitude, So factor, Health facility related factors.

As Table 14 shows, results on binary logistic regression model knowledge, attitude and socio- cultural related factors were statistically significant predictors of male involvement in the PMTCT services. And health facility related factors is not statistically significant predictors of male involvement.

CHAPTER FIVE

Discussion

This chapter discusses the study findings in line with the basic research question and the review of the literature.

5.1 The level of Knowledge and attitude of male partner toward PMTCT service

This study found that majority of respondents 96(76.2%) have adequate knowledge about MTCT and PMTCT. This finding is in line with the findings of study conducted in Tanzania by Mbezi (2010). However; the present findings contrary with findings in a study conducted in Debermarkos town and in three public hospitals in Addis Ababa, Ethiopia where majority of males had moderate level of knowledge. This difference can be explained by the fact that study time and setting of the study for the Debermarkos town. This study revealed that almost equal proportion of respondents has positive (50%) and negative (50%) attitude toward PMTCT services. There are other factors that affect the attitude of the respondent's stigma and discrimination.

5.2 The Current level of Male partner's Involvement in PMTCT service

The study revealed that as shown on the table 7 for the total score 79(60.3%) of the respondents were scored highly involved and 50(39.7%) were scored less than the mean of the score and scored low level of involvement. The study result shows that 79(60.3%) male partners were highly involved in PMTCT service.

This finding was lower than the result reported from Debermarkos ,Ethiopia is 198 (72.26%), (Amsalu et.al, 2013) and the result reported from three public hospitals in Addis Ababa, Ethiopia, which revealed that male participation in the PMTCT services is 190 (88%), (Getu K, 2011). However, a higher than result reported in eastern Uganda that is only 99 (26%) of the respondents had high level of participation (Byamugisha R, James KT, Nulu S et al., 2010). This difference attributed to the method used and the

setting of the study, being busy on own businesses, individual difference in health seeking behaviour and belief toward the service.

The result from the in-depth interview with health workers shows consistent with this finding that male partners have better knowledge and awareness on MTCT and PMTCT compared to the pregnant mothers but number of the male partner's participation is still low. Due to barriers individual related factors, lack of time for ANC/PMTCT service and being busy.

5.3 The association between independent variables and dependent variables.

Correlations and logistic regression analysis were conducted to answer this research question. This study found none of the socio-demographic variables were statistically significant association with male involvement in the PMTCT services. However, there is relationship between the socio-demographic variables and male involvement in PMTCT services. This study revealed that Age and education level has weak positive association with male involvement. This positive association might suggest that age and level of education have positive influences on male involvement.

However, the results in table 12 showed that there is a low negative relationship between the marital status and occupation of respondents with the criterion variable male involvement, which is not statistically significant. The negative relationship might tell us a longer of relationship between a man and a woman may have negative influence on the men's involvement in PMTCT. This is consistent with previous findings obtained by Tshibumbu (2006), which showed that non-significant ($p=0.989$) and very weak negative correlation ($r=-0.01$) between male participation and duration of male's conjugal relationship with the female partner. other, Kasaye et al .(2005:129) in Metu and Gore towns of Ethiopia also found a non-significant association that women who had a longer relationship with male partner or boyfriend were more likely to disclose their HIV status to and receive support from the male partner.

Level of knowledge of the respondents and level of male involvement in PMTCT results were statistically significant relationship ($r_s=0.319$, $p<0.01$). This positive correlation might tell us that respondents with

good knowledge have also high level of involvement and vice-versa. Consistent with the finding of this study, Getu k (2011) also found a statistically significant (p=0.011) positive correlation (r=0.172) between the composite scores of knowledge and male participation in PMTCT. Other study done in Debermarkos in Ethiopia found that males with moderate knowledge about PMTCT services were more likely involved in PMTCT than those with poor knowledge. Also other study in Mambwe district of Zambia revealed a significant association between knowledge of male partner with their involvement in PMTCT services (Katz DA, Kiarie JN, John-Stewart GC et al., 2009). Lack of information on PMTCT and HIV testing in Tanzania has contributed to low male partner involvement in PMTCT services (Family Health International, 2011)

Other study similar found, Tshibumbu (2006:59) also found a statistically significant (p=0.00) positive correlation (r=0.483) between the composite scores of knowledge and male participation in PMTCT. Similarly, Byamugisha et al (2010), in the Mbale district of eastern Uganda found that males who had heard about the PMTCT programmer were twice more likely to participate in PMTCT activities than those who had not.

The findings of this study revealed that socio-cultural factors and the level of male involvement in PMTCT services results were statistical significant relationship (r_s=-0.381, p<0.01). They were negatively correlated and this might tell us that low socio cultural influence highly involved in the PMTCT services and vice-versa. In agreement with this study Getu k (2011), found a statistically significant (p=0.01) weak negative correlation between composite score of socio-cultural belief of males and their participation in PMTCT. Other study done by Tshibumbu (2006:60), found a negative association between socio-cultural factors and the level of men's involvement in PMTCT: an r= -0.154 and p of 0.084. These findings may suggest that strong socio-cultural beliefs and opinions may have a negative influence on men's involvement in PMTCT programmes. Similarly, Theuring et al (2009:95) also found that males expressed "general cultural or traditional habits" [37(30%)] and thought of ANC/PMTCT service as a female domain

[36 (29%)] and “fear of results of HIV test” [25(20%)] to be a potential barrier to male attendance of ANC/PMTCT services.

The results of this study show that health facility related factors has a weak negative correlation (rs=-.154: p >0.05) which was not significant. Similarly, Tshibumbu (2006:61) found a very weak negative correlation (r=-0.014) between programmatic and PMTCT participation scores which was not significant (p=0.881). Other study done in three public hospitals in Addis Ababa, Ethiopia found a weak positive correlation (r= 0.092) but not significant (p=0.176) correlation is found between programmatic score and level of male participation.

The logistic regression analysis result found that male involvement was found to have a statistically significant association with good knowledge of respondents (AOR=3.04, 95%CI: 1.30-7.09), attitude (AOR=2.59, 95%CI: 1.09-6.13), socio-cultural factors (AOR=5.85, 95%CI 2.0-17.11)

This finding consistent with Amsalu et.al, (2013) found that male involvement was found to have a statistically significant association with moderate knowledge about PMTCT (AOR= 4.4, 95%CI: 1.9-10.0), good knowledge about PMTCT (AOR= 3.2, 95%CI: 1.29-7.9) and moderate programmatic factors (AOR= 10, 95%CI: 2.0-56.0).

5.4. The factors that influencing male partner involvement in PMTCT program.

The results summarized in table 13 and table 14 have showed majority of respondents, 77 (61.1 %), were in the category of moderate socio-cultural influence. And 49(38.9%) of the respondents were in the category of low level of socio-cultural influence.

As shown in table 8.1 (above), the total health facility related factors score of respondents largely 79(62.7%) lies in the category of moderate level and 46(36.5%) were in highly level and 1(0.8%) very high level of health facility influence.

Consistent with study funding previously, by Amsalu et al. (2013:19) found Majority of the participants, 208 (79.7%), scored 'moderate' on programmatic influence where as 45 (17.2%) and 7 (2.7%) scored for high and low programmatic influence respectively.

Consistent with study funding previously, by Amsalu et al. (2013:19) found Majority of the participants, 208 (79.7%), scored 'moderate' on programmatic influence where as 45 (17.2%) and 7 (2.7%) scored for high and low programmatic influence respectively.

As the result show on the logistic regression analysis male partner involvement in PMTCT program influenced by knowledge of participants who had moderate and good knowledge about PMTCT services were 3.04 times more likely involved in PMTCT services. Moreover, male partners who were highly influenced by the socio-cultural were 5.8 times more likely involved in PMTCT service than with low socio-cultural influence.

Another factors mentioned was distance from health facility was major obstacle for men to attend ANC/PMTCT clinic with their partner. 88 (69.8%) respondent mentioned that distance from health facility affect the involvement of male partner in PMTCT. Similarly study done by Larsson (2010), found distance, the cost of transport and clinic operation hours was also mentioned with some frequency.

Other factors that influence the male partner involvement in PMTCT was time of the service provided. 118(93.6%) of the respondents agreed on that PMTCT /MCH clinics should be opened during weekends and evening so that men can access. They verified that time of service provision has a great contribution to low male partners involvement in the PMTCT. Literature review stated that men consistently cited a series of challenges of daily life that prevented them from participating in PMTCT programmes. Men talked about their perceived principal responsibilities as providers. Thus, time spent at clinics and away from work or other income-generating activities was clearly perceived as a barrier to their participation in PMTCT programmes (Byamugisha et al. 2010, Larsson et al. 2010, Reece et al. 2010 and Falnes et al. 2011).

Others such as shortage of space in the MCH clinic, lack of special support from the management of the health facilities and to improve male partner's involvement in PMTCT services and lack of community support were the factors that contributed to the low involvement in the PMTCT service.

Moreover, the interview with health professional showed that to address overall challenges related to low male involvement in PMTCT service there should be weekend time service provision and problem with inadequate space in the MNCH should be improved and other IEC /BCC materials should have to promote male partner involvement in PMTCT program.

CHAPTER SIX

Conclusions and Recommendations

6.1 Conclusions

On the basis of the findings of this study the following conclusions have been reached.

The results of this study showed that 96(76.2%) of male partners have a good general knowledge on HIV and MTCT/PMTCT and equal proportion of male have positive and negative attitude toward PMTCT services. And higher proportion of male partners participated in PMTCT services and which is reasonably good but not to the expected level.

Male involvement was also found to have a statistically significant weak correlation with Knowledge, attitude and socio-cultural belief. Socio cultural factors, knowledge and attitude accounted for 5.9%, 3.0% and 2.6% of the variation in male participation in PMTCT service respectively. The proportion of variance in male involvement that is accounted for by the three predictor variables was 11.5%, which is low. This shows that the great amount of variance in the criterion variable is unexplained by the predictor variables in this study.

In general, this found that a higher proportion of respondents have a good knowledge about HIV transmission, mother to child HIV transmission and ways of reducing the risks. Also higher proportions of male partners participate in ANC /PMTCT. Therefore, as it also revealed from the in depth interview there are other factors which influence level of male involvement in the PMTCT such as fear of test results, time of the services provision, inconvenient of the ANC room and socio cultural related factors. On the other hand, the findings of this study reflect the situation in health centre in urban setting and may not be generalize able to different setting.

6.2 Recommendations

The following recommendations are made based on the findings of the study.

- Interventions aimed at improving male participation in PMTCT should consider the factors related to it. Priority should be given to addressing socio-cultural belief and fear of participation because of perceived risk. Dissemination of cultural sensitive messages that acceptable socio-cultural issue through PMTCT health promotion.

- Arrangements should also be made to allow males access ANC consultation rooms with their partners and time of services provision. This promotes interaction with the males, partners and the provider and provides an opportunity to engage males in MCH in general and PMTCT in particular.

- Comprehensive and comparative research should be done on male involvement in PMTCT services in different setting like urban-rural, public- private and hospital and health centre.

- Further research should be done to identify socio- cultural related factors that affect male partner's involvement to address the issues.

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ADDIS ABABA UNIVERSITY

SCHOOL OF PSYCHOLOGY

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If yes, proceed

If no, thank and stop here._____

(Signature of interviewer certifying that respondent has given informed consent verbally)

Thank you

Questionnaire

I. Socio- demographic questions

Instruction: - please provide short answer to the socio-demographic questions.

S/N	Question	Coding categories	Skip
1.1	Age	1. 15-24	
		2. 25-35	
		3. 36-40	
		4. 41-49	
1.2	Marital status	1. Married	
		2. Divorces	
		3. Cohabitating	
		4. Other _____	
1.3	Education status	1. Cannot read and writ	
		2. Read and write	
		3. Completed Primary school	
		4. Complete secondary school	
		5. Diploma and Higher	
1.4	Occupation	1. Daily labour	
		2. Employed	
		3. Own Businesses	

II. Knowledge and awareness on HIV/MTCT/PMTCT

Instruction: for the statements assessing knowledge and awareness on HIV/MTCT, please answer "yes" if you agree , "No" if you disagree or "don't know" if uncertain.

S/N	**Question**	**Coding categories**	**Skip**
1	***HIV is transmitted through?***		
1.1	Unprotected Sexual intercourse	1. Yes 2. No. 3. Don't know	
1.2	Unsafe blood transfusion	1. Yes 2. No. 3. Don't know	
1.3	Sharing of Contaminated sharps/needles	1. Yes 2. No. 3. Don't know	
1.4	Mother to child transmission	1. Yes 2. No.	

		3. Don't know	
1.5	Do you know the risks of acquiring HIV?	1. Yes 2. No. 3. Don't know	If no skip question 2.
1.6	**Risks of acquiring HIV infection**		
1.6.1	Unprotected sexual intercourse with an infected person	1. Yes 2. No. 3. Don't know	
1.6.2	Multiple sexual partners.	1. Yes 2. No. 3. Don't know.	
1.6.3	Having sexually transmitted infections	1. Yes 2. No. 3. Don't know	
2	***Mother- to-child transmission of HIV***		
2.1	HIV can be transmitted from mother to child	1. Yes 2. No. 3. Don't know	
2.2	HIV can be transmitted from infected mother to child during pregnancy	1. Yes 2. No. 3. Don't know	
2.3	HIV can be transmitted from infected mother to child during labor and delivery	1. Yes 2. No. 3. Don't know	
2.4	HIV can be transmitted from infected mother to child while sleeping with baby on same bed	1. Yes 2. No. 3. Don't know	
2.5	HIV can be transmitted from infected mother to child during breast feeding after birth	1. Yes 2. No. 3. Don't know	
3	**What helps reduce mother to child transmission of HIV**		
3.1	HIV counselling and testing for pregnant mothers	1. Yes 2. No. 3. Don't know	
3.2	HIV counselling and testing for male partners	1. Yes 2. No. 3. Don't know	
3.3	Antiretroviral drugs to infected mother and new baby born form her	1. Yes 2. No. 3. Don't know	
3.4	Delivery by caesarean section	1. Yes 2. No. 3. Don't know	
3.5	Complete avoidance of breast feeding is one option	1. Yes 2. No.	

		3. Don't know	
3.6	Exclusive breast feeding for first 6 months is one option	1. Yes 2. No. 3. Don't know	
3.7	Using contraception by HIV positive couple	1. Yes 2. No. 3. Don't know	
4	Have you ever heard about a program called Prevention of Mother-To-Child Transmission (PMTCT) of HIV?	1. Yes 2. No. 3. Don't know	
5	Do you know that PMTCT services are offered in all government health facilities?	1. Yes 2. No. 3. Don't know	
6	Do you know that pregnant women are counselled and tested at antenatal care clinic?	1. Yes 2. No. 3. Don't know	

III. QUESTIONS ON ATTITUDE TOWARDS PMTCT

<u>Instruction:</u> for the following statements related to socio-cultural belief about PMTCT, please express your opinion by stating "strongly agree", "agree", "undetermined", "disagree" or "strongly disagree"

SA: Strongly agree; A-Agree ; U-undetermined ; D: Disagree; SD: Strongly disagree

S/N	Question	SA	A	U	D	SD
		1	2	3	4	5
1	It is important that every pregnant woman gets tested for HIV with her partner					
2	If couples are infected with HIV then they shouldn't think of having child.					
3	Do you think using condom during pregnancy and breastfeeding reduce MTCT					
4	Some male don't accompany their wife at ANC clinic since it women issues					
5	Male should support his wife choice of feeding the baby					
6	Some male partners don't undergo for HCT to know their HIV status due to fear of disclosure.					
7	An HIV test result of a pregnant woman indirectly confirms HIV status of her partner					
8	Couples should use condoms at least until they know their HIV status is negative					
9	It is better to live with unknown HIV status					

	than live depressed with positive HIV status known					
10	Even if couple belive they are faithful to each other they should be tested for HV together during ANC follow up for the sake of PMTCT					

IV. LEVEL OF MALE INVOLVEMENT IN PMTCT

Instruction: for the questions assessing level of male participation in PMTCT, please answer "yes" if you agree , "No" if you disagree or "don't know" if uncertain

S/N	Question	Coding categorise	Skip
4.1	Have you ever self initiated the discussion on importance of PMTCT service with your partner during this pregnancy?	1. Yes 2. No. 3. Don't know	
4.2	Have you ever requested your wife to be tested for HIV during her pregnancy?	1. Yes 2. No. 3. Don't know	
4.3	If your partner had ANC follow up, have you ever asked her what information/service she got at ANC clinic	1. Yes 2. No. 3. Don't know	
4.4	Have you ever reminded your partner of her ANC follow up (schedule	1. Yes 2. No. 3. Don't know	
4.5	Did you cover medical expenses of your partner in the ANC follow up during her pregnancy?	1. Yes 2. No. 3. Don't know	
4.6	Did you accompany her to ANC clinic at least once during her pregnancy?	1. Yes 2. No. 3. Don't know	
4.7	If yes to q.6 did you enter in to ANC room together with your partner?	1. Yes 2. No. 3. Don't know	
4.8	Were you counselled and tested for HIV during your spouse's/partner's pregnancy?	1. Yes 2. No. 3. Don't know	
4.9	If yes to Q 8, were you counselled and tested together with your partner?	1. Yes 2. No.	

		3. Don't know	
4.10	Assuming you are willing for HIV test now, will you confide in your female partner if you test positive for HIV?	1. Yes 2. No. 3. Don't know	
4.11	Assuming your female partner gives consent for HIV test and tests positive, will you accept that she and the newborn take ARVs for PMTCT	1. Yes 2. No. 3. Don't know	
4.12	Assuming your female partner tests HIV positive, **would you be confident** to help in the newborn's medical follow up until the HIV status is known?	1. Yes 2. No. 3. Don't know	
4.13	Assuming your female partner and you both gives consent for HIV test and your female partner tests positive while your test negative, would you decide to discontinue your conjugal or love relationship	1. Yes 2. No. 3. Don't know	
4.14	Assuming you and your partner are HIV tested, If you are positive while she is negative, would you be confident to use condom consistently to prevent transmission to her and thus to the child?	1. Yes 2. No. 3. Don't know	

V. Factors Affect Male Involvement in PMTCT program

Instruction: if the following statements affect male partner involvement in PMTCT, please express your opinion by stating "strongly agree", "agree", "undetermined", "disagree" or "strongly disagree"

S/N	**Question**	**1**	**2**	**3**	**4**	**5**
		SA	A	U	D	SD
5.1	**SOCIAL-CULTURAL FACTORS :**					
5.2.1	A pregnant woman can be tested for HIV without the permission of her husband/partner					
5.2.2	Men should accompany their pregnant wives/partners to ANC/PMTCT clinics					
5.2.3	Men who accompany their female partners to ANC /PMTCT clinics are weak or bewitched					
5.2.4	It is a shame for men to discuss with women about HIV testing during pregnancy					

5.2.5	Men and women should undergo HIV testing at the same time at PMTCT clinics					
5.2.6	Couples can use condoms to reduce chances of mother to child transmission of HIV					
5.2.7	ANC/PMTCT clinics are for women and children only.					
5.2.8	A positive HIV test in a pregnant woman shows that she has been unfaithful to her husband					
5.2.9	If a pregnant woman is found to be HIV positive, she should be divorced					
5.2.10	PMTCT Information should first be given first to men then to women					
5.3	**HEALTH SYSTEM FACTORS:**					
5.3.1	Men should have "male only PMTCT clinics					
5.3.2	At the MCH/PMTCT clinics Men should be attended to by Male health workers only					
5.3.3	Health workers do not like to see men at MCH and PMTCT clinics					
5.3.4	MCH/PMTCT clinics are made for women and children only					
5.3.5	PMTCT /MCH clinics should also be opened during weekends and evening so that men can access also					
5.3.6	You can attend PMTCT clinic if invited by health worker to come					
5.3.7	PMTCT programmes have done very little to involve men					
5.3.8	PMTCT clinics are conducted very far from your home and transport is expensive					
5.3.9	You can do HIV test with your wife, only if your are promised to be given ARVs thereafter					

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If yes, proceed

If no, thank and stop here.

_____

(Signature of interviewer certifying that respondent has given informed consent verbally)

In- depth interview Question for the health personnel

1. What was your effort to convince male partners deciding to take couple counselling?
2. How long are you taking in average for each counselling session?
3. Is your room convenient for couple counselling?
4. Do you have an appropriate document system to provide the necessary data to concerned body?
5. What do you think that the common barriers or obstacles for male partners which deter them for PMTCT service?
6. What do you think the most common reason for the male partner to seek for couple counselling? probe
7. Is your room convenient for confidential counselling?
8. What do you observe about the trend of male partners participation on PMTCT service compared with past years?
9. What are the challenges you encounter in providing couple counselling for couples?
10. What do you think about the challenges that must be done to improve the services?
11. What is your education qualification?
12. Have you had training on PMTCT?

መግቢያ

ስሜ.....ይባላል፡፡ እኔ በአዲስ አበባ ዩኒቨርሲቲ የሳይኮሎጅ ፋካሊት የእየተካሄደ ላለዉ ጥናትዊ ደስሳ ሚጃ በማብሰቢ ነኝ፡፡ ኤች አይ ቪ ቫይረስ ከእናት ወደ ልጅ የሚላለፍበትን መንገዱ እንዲሁም እንዳይተላለፍ ለማከላከልና ተዛማጅ በሆኑ የዕወቀት የአስተሳሰብና የልምድ ተሞክሮዎች ለወንዶች ማስይቅ እያደረግን ሲሆን፡፡ ከላይ በተጠቀሱት እንቅስቃሴዎች ዙርያ ወንዶች ተሳትፎ እንዳያደርጉ ጎጂ ተጽኖዎችን ለይቶ ማመጣት ያስፈልጋል ምክንያቱም ጠቃሚ የሆኑ ሚጃዎችን ለማመጣትና ተስማሚ የሆኑ ስልቶችን ለማዳድ ስለሚስቅም በክፍለ ከተማ በአገር አቀፍ ደረጃ የወንዶችን ተሳትፎ በአግባቡ ከፍ ለማድረግ ሚጃ በማብሰብ ላይ ነኝ፡፡ ይህንኑ ዓላማ ከግብ ለማድረስ የእናንተ ታማኝነትና እዉነተኛ ተሳትፎ በጣም ጠቃሜ ከፍተኛ አደናቆት የሞቸረው መሆኑን ለመግለጽ እንወዳለን፡፡

ሚስጥርን የማበቅና የፈቃደኝነት መግለጫ

በቅድሚያ አንዳንድ ሰዎች ለመሞላስ ሊያሰቸግራቸዉ የሞቹሉ በጣም ግላዊ የሆኑ ጥያቄዎች ላይ ሞልስ እንዲሰጡ ትብብርዎን ስንጠይቅ ሞልሶቹ ሞሉ በሞሉ አስተምኝኝ ቢሆኑ ይሚጣል በማረቱ በዚህ ቅጽ ላይ የእናንተ ስም አይጻፍም፡ ከስማቸሁ ጋር በተያያዘም ለነርሶች ለዶክተሮችና ለሌሎች ሰዎች ምንም ነገር አይነገርም ሚለት በሚስጥር ይያዛል፡፡ ነገር ግን ያለፍላጎታቸሁ ወይም ካልማለላችሁ ሞልስ አለማስጠት ትችላላችሁ ቃለማስይቁንም ቢሆን በማናኛዉም ጊዜ ማስቆም ትችላላችሁ:: ይሁንና ከእናንተ ታማኝነት ያለው ሞልስ ማግኘት ወንዶች ኤች አይ ቪ ከእናት ወደ ልጅ የሚላለፍበትንና በማከላከያው ዙርያ በተመለከተ ያላቸው ልምድ በምን ደረጃ ላይ እንዳለ በበለጠ ለሚዳት ያስችላል፡፡

ቃለ ማስይቁ የሜጅዉ ከ20-30 ደቂቃዎች ብቻ ስለሆን ለጥናቱ ምላሽ በማጠት እንድትተባበሩን ከምስጋና ጋር በአክብሮት እንጠይቃለን፡፡

ፈቃደኛ ነዎት

አዎ/ፈቃደኛ ነኝ/ ----------

አይደለሁም---------- በፊርማ አረጋግጫለሁ፡፡

እናማስግናለን !

ማጠይቅ

1. ግለስቧ እና ሚህበሪዊ ሁኔዎች ላይ የቀረቡ ጥያቄዎች

ሚሊያ ቁጥር	ጥያቄ	ግለስቧ እና ሚህበሪዊ ሁኔዎች	ይዘላል
1	እድሜ	1.15-24	
		2.25-35	
		3.36-40	
		4.41-49	
2	የጋብቻ ሁኔታ	1. ያገባ 2. ፊች ያደረገ (የፈታ) 3. ሳይጋቡ አብረው የሜሩ 4. ሌላ ይጠቃል----------	
3	የትምህርት ደረጃ	1. ማንበብና መጻፍ የሚቹሉ 2. ማንበብና መጻፍ የሚቹሉ 3. አንደኛ ደረጃ ትምህርት አጠቀዋል 4. የሁለተኛ ደረጃ ትምህርት አጠናቀዋል 5. ዲፕሎማ 6. ድግሪ	
4	ሥራ ሁኔታ	1. የቀን ሰራተኛ 2. ቅጥር ሰራተኛ 3. በግል ስራ ላይ 4. ስራ የሌለው	

II ኤች.አይ.ቪ ከእናት ወደ ልጅ ስለሚተላለፍበትና ስለመከላከያው ያላቸው እውቀትና ግንዛቤ በተመለከተ ማጠይቅ

መመርያ፡- ኤች.አይ.ቪ ከእናት ወደ ልጅ ስለሚተላለፍበት ሁኔታ ያሉትን እውቀትና ግንዛቤ በተጠቀሰው መለጫ መሰረት ለመመለስ እንዲቻል፡፡እባክዎን የሚመሙ ከሆነ ‹‹**አዎ**›› የሚስማሙ ከሆነ ‹‹**አይደለም**›› ፣ ወይም እርግጠኛ ካሆኑ ‹‹ **አላወቅም** በሚለት ይገለጽ፡፡

ቁጥር	ጥያቄ	መልስና ኮድ			ይዘላል
		አዎ 1	አይደለም 2	አላወቅም3	
	ኤች.አይ.ቪ ቫይረስ የሚተላለፍባቸው መንገዶች ?				
1	ልቅ የሆነ የግብረ ሥጋ ግንኙነት ማድረግ				
2	ለአደጋ የሚገልጥ የደም ልገስ				
3	የተበከሉ ስልቶች /መርፌዎችን መጋራት				
4	ከእናት ወደ ልጅ ማስተላፍ				
5	ኤች.አይ.ቪ ቫይረስ በደም ወስጥ ከተገኘ የሚያስከትለውን አደጋ ያውቃሉ				
	ኤች.አይ.ቪቫይረስ የሚጋልጡ አደጋዎች				
7	ኤች.አይ.ቪ ቫይረስ ካለበት ሰው ጋር ያለኮንዶም (ያለመከላከያ) ግብረ ስጋ ግንኙነት ማድረግ				
8	ከተለያዩ ሰዎች ጋር ግብረ ስጋ ግንኙነት ማድረግ				
9	በግብረ ስጋ ግንኙነት ለመተላላፊ በሽታ መያዝ				
	ኤች.አይ.ቪ ከናት ወደ ልጅ መተላለፊያ መንገዶች				
1	በእርግዝና ወቅት ኤች.አይ.ቪ ቫይረስ በደምዋ ወስጥ ያለ እናት ወደ ልጅዋ ይተላለፋል				
2	ኤች.አይ.ቪበደምዋ ወስጥ ያለ እናት በምጥና በወሊድ ወቅት ወደ ልጅዋ ይተላለፋል				
3	ኤች.አይ.ቪበደምዋ ወስጥ የተገኛባት እናት ከህጻን ጋር በአንድ አልጋ ላይ በመኛት ሊተላላፍ ይችላል				
4	ኤች.አይ.ቪ በደምዋ ወስጥ ያለ እናት ከወሊድ በኋላ ጡት በማጥባትዋ ይተላለፋል				
	ከእናት ወደ ልጅ እንዳይተላለፍ መከላከል መንገዶች				
1	የኤች አይ ቪ የምርናምርመራ ልግሎት ለእርጉዝ እናቶች				
2	የኤች.አይ.ቪ የምርናምርመራ ልግሎት ትዳር ለያዙ ወንዶች				
3	ኤች.አይ.ቪ በደምዋ ወስጥ ላለ እናትና ከእስዋ ለሚወለደው ህጻን ጸረ ኤች.አይ.ቪ መድህኒት እንዲጠቀሙ ማድረግ				
4	በቀዶ ጥገና መወለድ				
5	ጡት በማጥባት ማቆም				
6	ለሚጀመርያዎቹ ስድስት ወራት የእናት ጡት ብቻ ማጥባት እንደአንዱ አማራጭ መወሰድ ነው፡፡				
7	ኤች.አይ.ቪ በደማቸው ወስጥ ለተገኘባቸው ጥንዶች የወሊድ መከላከያ በማጠቀም ነዉ				
8	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላፍ ለመከላከል ሚሀ ግብር እንዳለ ያውቃሉ?				
9	የመንግስት ጠፍ ተቋማት ከእናት ወደ ልጅ እንዳይተላለፍ የመከላከል አገልግሎት እንደሚሰጡ ያውቃሉ?				
10	ለእርጉዝ ሴቶች በእርግዝና ከትትል ጊዜ የምርናምርመራ አገልግት እንደሚሰጥዉ ያውቃሉ?				

III.ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ያለዎት አቋም ላይ ጥያቄዎች

መመርያ :- በሚቀጥሉት መግለጫዎች ላይ ከሚሀበራዊና እምነት ጋር በተዛመደ ከእናት ወደ ልጅ ኤች አይ ቪ እንዳይተላለፍ ስለመከላከል፡፡ እባክዎን ‹‹1 **አጥብቄ እስማማለሁ**›› ፣ ‹‹2-**እስማማለሁ**›› ፣3 ‹‹**አልወሰንኩም**››፣ 4‹‹**አልስማማም**››፣ 5‹‹**አጥብቄ አልስማማም**›› በሚለት ሀሳዎን ይግለጹ፡፡

መለያ ቁጥር	ጥያቄ	SA	A	U	D	SD
		1	2	3	4	5
1	ለማንኛውም እርጉዝ ሴት ከነደኛዋ (ባለቤትዋ) የ ኤች.አይ.ቪ ምርመራ ማድረግ ይጠቅማል					
2	ጥንዶች በደማቸው ወስጥ ኤች.አይ.ቪ ከተገኘ ልጅ ስለማግኘት ስለመለዳድ ሚነብ የለባቸውም					
3	ከእናት ወደ ልጅ ኤች.አይ.ቪ እንዳይተላለፍ ለመቀነስ በኮንደም ማጠቀም በእርግዝና ወቅትና ጡት አለማጥባት ነዉ					
4	ጥቂት ወንዶች በኤች.አይ.ቪ ምክንያት አድልዎና መገለልን በመፍራት ከሚስቶቻቸው ጋር ለእርግዝና ክትትል ክሊኒክ አብሮ መሄድ አይፈልጉም					
5	ጥቂት ያገቡ ወንዶች የኤች አይቪ ምርመራ አያደርጉም ይህ ሚስጥር እንዳይወጣ በመፍራት ወይም በመስጋት ነዉ					
6	ወንድ የባለቤቱን የልጅ አመጋገብ ምርጫዉን መደገፍ አለበት					
7	የአንድ እርጉዝ ሴት የኤች.አይ.ቪ የምርመራ ዉጤት በተዘዋዋሪ ባለቤቷም ኤች.አይ.ቪ ቫይረስ በደሙ ወስጥ እንደሌለ ያረጋግጣል፡፡					
8	ጥንዶች ኤች.አይ.ቪ ቫይረስ በደማቸው አለመኖሩ እስከሚታወቅ ቢያንስ በኮንዶም መጠቀም አለባቸው፡፡					
9	ኤች.አይ.ቪ ቫይረስ በደሙ ወስጥ እነዳለበት አወቆ አዝኖ ከሜር ሰው የኤች.አይ.ቪ ምርመራ ሳያደርግ መኖር ይሻላል፡፡					
10	ምንም እንኳን ጥንዶች እርስ በርሳቸው ታማኝ ቢሆኑም፡ በጋራ ሆነው የHIV ምርመራ ማድረግ የ HIV ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ይከላከለል፡፡					

IV. ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላፍ ለመከላከል የወንዶች ተሳትፎ መጠን ደረጃ

መመርያ፡ – ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላፍ በመከላከል ረገድ የወንዶችን የተሳትፎ ደረጃ (ድርሻ) ለማወቅ እባክዎን ለቀረቡት ጥያቄዎች የሚመልሱ ከሆነ ‹‹አዎ›› የሚለውን ከሆነ ‹‹ ‹‹አላወቅም›› በሚለት መልስ ይስጡ፡

መለያ ቁጥር	ጥያቄ	ኮድ		
		አዎ 1	አላወቅም 2	ይዘለል
1	በራሱ ተነሳሽነት ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ ስለሚጠው አገልግሎት ከባለቤትዎ ጋር በእርግዝና ወቅት ወይይት አድርገው ያወቃሉ?			
2	ባለቤትዎን በእርግዝና ወቅት ኤች.አይ.ቪ ምርመራ እንዲያደር ጠይቀው ያወቃሉ?			
3	ባለቤትዎ ከቅድመ ወሊድ ክትትል ሲኖራቸው ከክሊኒኩ ስላገኙት ሚጃ አገልግሎት ጠይቀው ያወቃሉ?			
4	በባለቤትዎ የቅድመ ወሊድ ክትትል/ ህክምና እንክብካ ቀጠሮ አስታወሰው ያወቃሉ?			
5	ባለቤትዎ በእርግዝና ወቅት ተከታታይ ህክምና ሲያደር የህክምና ወጪዎችን ሸፍነው ያወቃሉ?			
6	ባለቤትዎ በእርግዝና ወቅት ለህክምና እንክብካ ክሊኒክ ሲሄዱ ቢያንስ ለአንድ ጊዜ አብረዋቸው ሄደው ያወቃሉ?			
7	ለ6ተኛ ጥያቄ መልስዎ አዎን ከሆነ ከባለቤትዎ ጋር ህክምና እንክብካቤ ወደ ሚሰጠው ክፍል ገብተው ያወቃሉ?			
8	ባለቤትዎ በእርግዝና ወቅት ሳሉ እርስዎ የ ኤች.አይ.ቪ የምክር አገልግት ምርመራ አድርገዋል?			
9	የ8ተኛው ጥያቄ መልስዎ አዎን ከሆነ በጋራ ሆነችሁ የምክር አገልግሎት ምርመራ አድርጋችኋል?			
10	ኤች.አይ.ቪ ምርመራ አሁኑ ለማድረግ ፈቃደኛ መሆንዎን እንገምትና ተመርምረው ኤች.አይ.ቪ እንዳቦዎት ቢያወቁ ለባለቤትዎ ይህን ሚስጥር ያካፍላሉ?			
11	የትዳር ጓደኛዋ በፍቃደኝነት የ ኤች.አይ.ቪ ምርመራ አድርገው ቫይረሱ ቢገኝባቸው ባለቤትዎና የሚወለደው ህጻን ጸረ ኤች አይ ቪ መድህኒት ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል እንዲወስድ ይፈቅዳሉ?			
12	የትዳር ጓደኛዎ ኤች.አይ.ቪ በደማቸው ወስጥ እንደለ እንገምትና			

	የሚወለደው ህጻን የምርሙ ጨቅላ እስከሚዝመቅ ድረስ የህክምና ክትትል እንዲያደርግ ይድገፉ፡፡			
13	እርስዎና ባለቤትዎ ፈቃደኛ ሆናችሁ ኤች.አይ.ቪ ምርመራ ካደረጋችሁ በኋላ ኤች.አይ.ቪ ቫይረስ እንዳለባቸው ብንገምት እርስዎ ከ ኤች.አይ.ቪ ነጻ ቢሆኑ ትዳርዎን ለማቋረጥ ይወስናሉ?			
14	እርስዎና ጓደኛዎ የኤች.አይ.ቪ ምርመራ አድርጋችኋል ብለን ብንገምት እርስዎ ኤች.አይ.ቪ ቫይረስ ቢኖርበዎት ባቤትዎ ነጻ ቢሆኑ ኤች.አይ.ቪ ወደ እናቱና ህጻኑ እንዳይተላለፍ ኮንደም በዘላቂነት ለማቅም ቁርጠኛ ነዎት?			

V. ከእናት ወደ ልጅ ኤች.አይ.ቪ ቫይረስ እንዳይተላለፍ ለማላከል በሜረገው ጥረት የወንዶችን ተሳትፎ የሚቱ ተጽኖዎች መጠየ

ከዚህ በታች የተገለጹ መግለጫዎች የወንዶችን ተሳትፎ የሚወክ ከሆኑ ‹‹ 1,አጥብቅ እስማማለሁ››፣ ‹‹2 እስማማለሁ›› ‹‹3 አልወሰንኩም››፣ ‹‹4 አልስማማም››፣ ፣ ‹‹5 አጥብቅ አልስማማም›› በማለት ሀሳዎን ይግለጹ፡፡

መለያ ቁጥር	ጥያቄ	1 SA	2 A	3 U	4 D	5 SD
	ማህበራዊና ባህላዊ ተጽኖዎች					
1	እርጉዝ ሴት ያለባለቤትዎ ፈቃደኝነት የኤች.አይ.ቪ ምርመራ ልታደርግ ትችላለች					
2	ወንዶች ከእርጉዝ ባለቤቶቻቸው ጋር ወደ ቅድመ ወሊድ የህክምና እንክብካቤና ኤች.አይ.ቪ እንዳይተላለፍ መከላከያ ወደ ሜረግለት ክሊኒክ አብረው መሄድ አለባቸው፡፡					
3	ከሚቶቻቸው ጋር ወደ ቅድመ ወሊድ ጠፃነት ክትትል ክሊኒክ አብረው የሚዳበት ወንዶች ደካች ናቸው፡፡					
4	ሴቶች በእርግዝና ውቅት ስለ ኤች.አይ.ቪ ምርመራ ወይይት ሜድረግ ለወንዶች አሳፋሪ ነው፡፡					
5	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላፍ የሚላለፍበትን የመከላከያ አገልግሎት ወደሚጥበት ክሊኒክ ወንዶችም ሴቶችም በጋራ ሆነው በተመሳሳይ ጊዜ ምርመራ ሜድረግ አለባቸው					
6	ኤች.አይ.ቪ ከእናት ወደ ል የሚላፍበት አጋጣሚ ለመቅነስ ጥዶች ኮንዶም መጠቀም አለባቸው					
7	በእርግዝና ውቅት የቅድመ ወሊድ ጠፃነት ክትትል ክሊኒኮች ለሴቶችና ለህጻናት ብቻ የታቀዱ ናቸው					
8	እርጉዝ ሴት ኤች.አይ.ቪ ቫይረስ በደሚ መስጥ ከተገኘ ለባለቤትዋ ታማኝ አለመሆንዋን ያሳያል					
9	እርጉዝ ሴቶች ኤች.አይ.ቪ ቫይረስ በደምዋ መስጥ ከተገኙ መፈታት አለባት					
10	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላፍ የመከላከያ መጀ በቅድሚ መጠጡ ያለበት ከሴቶች በፊት ለወንዶች ነው					
	የጠፍ ተቋማት ተጽኖዎች					
1	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የመከላከያ እንክብካቤ ክሊኒክ ለወንዶች ለብቻ ሊኖራቸው ይገባል					
2	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የመከላከያ እንክብካቤ አገልግሎት የሚጥባቸው የእናቶችና የህጻናት ክሊኒኮች መስጥ ወንዶች እንክብካቤ ሊያገኙ የሚገባቸው በወንድ ጠፍ ባለሙያ መሆን አለበት፡፡					
3	ለእናቶች ለህጻናት እንዲሁም ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የመከላከያ እንክብካቤ የሚጥባቸው ክኒኮች መስጥ የጠፍ ባለሙያ ወንዶችን ማት አይፈልጉም፡፡					

4	የእናትና የህጻናት/ ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የማከላከያ እንክብካቤ አገልግሎት ማጫ ክሊኒኮች የምሞጭ ለሴቶችና ለህጻናት ብቻ ነው ።					
5	ወንዶችም ቅዳሜ እሁድ እንዲሁም በምሽት አገልግሎት እንዲገኙ የእናቶች የህጻናት ጠፍ እንክብካቤ ክሊኒኮች ክፍት መሆን አለባቸው ። ።					
6	ወንዶችኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የማከላከያ እንብካቤ የሚጥበት ክሊኒኮች ሜዴድ የሜለወት የጠፍ ባለሞያ ጥሪ ሲያደርግላቸዉ ብቻ ነው ።					
7	ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ ማከላከያ ክብካቤ አገልግሎት የሚጠቀቸው ክኒኮች ከመኖርያ ቤት ስለሚቁ የትራንስፖርት አገልግሎት ወጪ ብዙ (ወድ) ነው ።					
8	ከባለቤትዎ ጋር የኤች.አይ.ቪምጮሙ የምያደርጉት የፀረ ኤች. አይ.ቪመድህኒት እንደሚጥ ቃል ከተገቦለዎትበኋላ ብቻ ነው ።					
9	ስለ ቅድመ ወሊድ ክብካቤ ክሊኒክ ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ ለማከላከል ባሉት ስልቶች ላይ ወንዶች ለሚቶቻቸው ድጋፍ እንደሜደርጉትና በጠፍ ተቁማት የራሳቸዉን ሜ አላቸዉ ።					
10	በጠፍ ተቁማት የሚጥዉ ኤች.አይ.ቪ ከእናት ወደ ልጅ እንዳይተላለፍ የማከላከል፣ ድጋፍ እንክብካቤ አገልግሎት ወንዶችን የሜበረታታ መሆን አለበት ። ።					

መግቢያ

ሰም--------ይባላል፡፡ የመኪኦት ከአዲስ አበባ ዩንቨርሲቲ ነዉ፡፡ እዚህ የተገኝህብትም የኤችኤች አይ ቪ ቫይረስ ከእናት ወደ ልጅ መተላለፍበትን ለመከላከልና የምጥዉ አግልግለኦት ላይ የወንዶች ተሳትፉ በተመለከተ አዲስ ከተማ ክ/ከተማ በሚኙ ጠፍ ድርጅቶች ዉስጥ በመጠጡ ላይ ያሉ ጠፍ መያተኖችን ቃል መጠይቅ ለሜድረግ ነዉ፡፡ የጥናቱም አላማ ከላይ የተገለጡት አገልግሎቶች በአገረቲ ዉስጥ ለሜከፍከር የሜያስችሉ አሰራሮችን /ሰልቶችን/ ለመቀየስ የሚጠቅሙ ሚጃዋችን ለማገኘት ነዉ፡፡ ስለዚህ የሚሠጡን ማንኛዉ አይነት መልሶች እንቀበላለን፡፡ ከእርስዋ የምገኙችዉ መልሶች ለ ጥናቱ አላማ በጣም ሰለሚጠቅማን በትክክል መልሰዋን መቀበለችንን ለሚጋገጥ እንዲረዳን ቴፕሬከርደር እንጠቅማለሁ፡፡ ሆኖም የሚሠጡ መልሶች በሚጥር የሜዝና ለጥናቱ አላማ ብቻ የምንጠቀምበት እንደሆነና የተቀረፀዉ ንግግር ለማንም እንደሜይሰጥና ስምዋም በማጠይቁ ስዓት ፍዴሞ እንደሜይጠቀሰ ልገልድልዋ እወዳለሁ፡፡ በቃል መጠይቁ ለመጠፍ ፋቃደኛነዋትን?

ስለፈቃደኛነትዋ አመሰግናለሁ፡፡

የጠፍ ድርጃቱ ስም----------

መጠይቁ የተካኄደነት ቀን----------

የተጠየቂዉ የሥረ ደረጃ----------

ክፍል 1 የቃል መጠይቁ ሚ ጥየቄዋች

ኤች አይቪ ከእናት ወደ ልጅ እንዳይተላለፈ የማከላከል አገልግሎት በሚሰጥበት ክፍሎች ዉስጥ ለሚሥሩ ጠፍ ባለሙያዎች የተዘጋጀ ቃለ ማጠይቅ፡

የ ቃለ ማጠይቁ ሙሉ ጥየቄዎች

1. በጥንድ በጋራ ሆነ ው የ ምክር አገልግሎት እንዲያገኙ ወንዶችን ለማሳማ የእርስዎ ጥረት ምንድን ነ ው ?
2. ለእያንዳንዱ የ ምክር አገልግሎት ለማጠሠት በአማካይ ምን ያህል ጊዜ ይወስድብዎታል?

3. ጥንድ ለሆኑ የ ምክር አገልግሎት የ ሚሰበት ክፍል አመቺ ነ ወን? በራስ መተማመን እንዴት ያዩታል?

4. አስፈላጊወን መረጃ ለሚሟላከተው አካል ለማጠሠት ተስማሚ የሆነ የ ሰነ ድ አያያዝ ሥርዓት አለዎት?

5. ከእናት ወደ ልጅ ቫይረሱ እንዳይተላለፍ የ ማከላከል አገልግሎት ወንዶች እንዲርቁ የ ሚያደርጋቸወን ማነ ከሎችና እንቅፋቶችን ምንድን ናቸው?

6. ጥንድ ሆነ ው የ ምክር አገልግሎት ለሚዙ ወንዶች በተለምዶ የ ሚታይ ምክንያት ምንድን ነ ው?
7. ካለፉት ዓመታት ጋር ሲወዳደር የ ወንዶች ተሳትፎ ከእናት ወደ ልጅ ቫይረሱ እንዳይተላለፍ ተሞክሮ ምን ያስተዋሉት ነ ገር አለ ?

8. ለጥንዶች የ ምክር አገልግሎት በምክጠበት ጊዜ እርስዎን ያጋጠሙ ችግሮች ምንድን ናቸው?

9. ችግሮችን ለመፍታትና የ አገልግሎት አሰጣጡ ለማሻሻል ምን መደረግ አለበት ብለው ያስባሉ?
10. የ ትምህርት ብቃትዎ እስከምንድረስ ነ ው? ከእናት ወደ ልጅ እንዳይተላለፍ የ ማከላከያ እንክብካቤ አገልግሎት አሰጣጥ ላይ ስልጠና ወስደዋል?

11. ከእናት ወደ ልጅ እንዳይተላለፍ የ ማከላከያ እንክብካቤ አገልግት አሰጣጥ ላይ የ ወንዶች ተሳትፎ እንዲሻሻል የ ሚጠሠ አስተያየት ምንድን ነ ው?

እናመሰግናለን ! !

Letter of Declaration

I undersign graduate student, declare that this thesis is my original work and has never been defend in any undergraduate or graduate program any university I have also credited accordingly the reference I have used in the work.

Name Tsehay Birahnu Signature _____Date _____

I confirm that this thesis has been submitted of examination with my approval as a University advisor.

Name : Mulu Nega (PH.D)

Signature _____

Date _____