

**MEN'S INVOLVEMENT IN PREVENTION OF MOTHER-
TO-CHILD TRANSMISSION IN HIV PROGRAMMES IN
FEDERAL TEACHING HOSPITAL IDO-EKITI, EKITI
STATE, NIGERIA**

BY

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DSS/12/0911

**A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF
SCIENCE DEGREE (HONOURS) IN DEMOGRAPHY AND SOCIAL
STATISTICS**

**DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS
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SEPTEMBER, 2016

CERTIFICATION

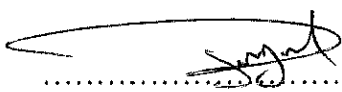
I certify that Ojo Racheal Abosedo of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a research on the topic men's involvement in prevention of mother-to-child transmission of HIV programmes in Federal Teaching Hospital Ido-Ekiti, Nigeria in partial fulfilment of the requirement for the award of Bachelor of Science (B.Sc) in Federal University, Oye-Ekiti, Nigeria under my supervision.

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DEDICATION

This research work is dedicated to Almighty God, the Alpha and Omega, the source of all wisdom and understanding to whom I give all glory to, for the success and completion of a first degree in my academic journey pursuit.

ACKNOWLEDGEMENT

It is a great pleasure to express my sincere gratitude to the Almighty God, for His protection provision and guidance since my first year till now. Thousands of words cannot express the much you have done for me, I am so grateful.

I express my gratitude to my able supervisor, Dr E.K Odusina of the Department of Demography and Social Statistics, Faculty of Social Science, Federal University, Oye Ekiti, Ekiti State for his mentorship throughout the period of this study. He has painstakingly gone through this research project and made necessary corrections. His guidance and advice contributed to the success of this project.

I use this opportunity to express my profound gratitude to my late father Mr E.A OJO who started this race with me but wasn't able to finish the race. Daddy continue to rest to rest in the Lord till we meet to part no more, I miss you Daddy. To his lovely wife, my precious mother i say a big thank you.

My parents Mr and Mrs E.A OJO, who had laboured through thick and thin and are still struggling for my wellbeing in life. Your contributions are much appreciated.

I also thank my partner, Mr Iyiola Olayioye for his support both financially and morally during the period of my studentship. God will preserve us for many more years in Jesus Name.

To my wonderful son, Emmanuel EriOluwa Olashubomi. I thank you so graciously for your cooperation and understanding throughout the period of my academics and particularly on this project. I love you so much.

To my loving siblings, Mrs Esther Adebanye, Mrs Adefunke Adeyemi, Mrs Taiwo Owoeye, Mrs Kehinde Adeyanju and my new Daddy Mr Adeyinka Ojo, I say thank you all for your support financially and morally. To my friends Prof A.A Atere and Mr Abiodun Adeniji I express my gratitude for your love and contributions.

Finally, i remain grateful to all the lecturers in the Department of Demography and Social Statistics Federal University, Oye Ekiti, also to all the authors whose work I consulted and my amiable course mates, God bless you all.

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ABSTRACT

The study examined men's involvement in prevention of mother-to-child transmission (PMTCT) of HIV programmes in the Federal Teaching Hospital Ido-Ekiti, Ekiti State, Nigeria. The study aimed at identifying correlates of PMTCT in the hospital. Questionnaires was used to elicit information from eligible respondents in the study area. Response were analysed at univariate by using simple frequency distribution and percentage. Cross- tabulation was done to examine the relationship between men's involvement in PMTCT and other selected variables. Multivariate analysis was done with the aid of logistic model.

Knowledge of PMTCT was the strongest factor which was positively associated with the level of men's involvement in PMTCT. Socio-cultural and programmatic factors were found to be negatively influencing men's involvement in PMTCT while demographic characteristics, which were age and level of education were positively associated with an increase in the level of involvement in PMTCT. The duration of the relationship with the female partner was also found to be positively associated with the level of men involvement in PMTCT. The study concluded that factors that were positively associated with men's involvement in PMTCT may help in choosing relevant intervention programmes to increase men's involvement in PMTCT programmes.

CHAPTER ONE

1.1 INTRODUCTION

Should men be involved in women's reproductive health services like prevention of mother-to-child transmission (PMTCT) of HIV? This issue of involving men in women's reproductive health services has been attracting a lot of interest especially after the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Women's Conference in Beijing (Drennan 1998; Lee 1999; Ntabona 2002). This increased interest resulted from the realisation by all stakeholders of the many roles men can play in the success of these services (Clark 2001; Ekouevi, Leroy, Viho, Bequet and Horo 2004; Greene 2002).

PMTCT programmes form an important component of the overall HIV prevention strategy. Even though the involvement of men in these programmes has been associated with an increased uptake of PMTCT interventions by women, it remains one of the major challenges faced by programme implementers (Rutenberg, Kalibala, Back and Rosen 2003). This study tries to understand the reasons behind this low involvement among men, in the specific context of Ido Ekiti, Ekiti State, Nigeria.

1.2 BACKGROUND INFORMATION OF THE STUDY

Mother-to-child transmission (MTCT) of HIV, also called vertical transmission of HIV, is a very important mode of HIV transmission for children. The majority of children who die of HIV/AIDS acquire the infection through MTCT, and most of these children live in the developing world. According to UNAIDS (2005), By 2009, during the year 2005 there were about 2.3 million children under 15 years living with HIV/AIDS in the world, and the vast majority of these were in sub-Saharan Africa. According to Rutenberg et al (2003), MTCT is associated with up to 90% of all HIV infection in children up to six years. It is estimated that without any intervention about 35% of children born to HIV-infected mothers will be infected with the virus (UNAIDS 2005). This percentage has reportedly been reduced to levels as low

as 2% in developed countries with the advent of antiretroviral drugs and the implementation of core PMTCT interventions (Newell 2001; Phoolcharoen and Detels 2002). The benefits of involving men in women's reproductive health services and PMTCT in particular are well recognised and have been advocated by many (Ekouevi et al 2004; Clark 2001; Greene 2000). However, reports from various PMTCT sites still show generally low involvement by men, with its negative impact on the level of uptake of interventions in these programmes by women (Rutenberg, Kabibala, Mwai and Rosen 2002). This lack of involvement by men deprives women of their partners' care and support in coping with the HIV infection, in taking antiretroviral therapy and in making appropriate infant feeding choices (UNICEF 2001).

According to the 2001/2002 Zambian Demographic and Health survey, about 16% of the adult population in Zambia is HIV positive (Central Statistical Office, Central Board of Health, Zambia & ORC Macro 2003). The Central Statistical Office, Zambia (2005) estimated this rate to be 14.4% in 2004 and anticipated a decline to 12% by 2010. HIV/AIDS is considered to be a major threat to the lives of women and their children in Zambia. The prevalence is higher in females than males: approximately one in every six females, compared with almost one in every eight males, and these ratios are even higher in pregnant women (Ministry of Health, Zambia 2004; Central Statistical Office, Central Board of Health, Zambia & ORC Macro 2003). It is also estimated that approximately 39.5% of babies born to HIV positive mothers are infected with the virus in Zambia (Central Statistical Office, Zambia 2005).

In the effort to reduce the increasing rates of HIV infection among infants and young children in the country, the Ministry of Health established the PMTCT programme in January 2005, with a minimum package which also includes the promotion of male involvement (Kankasa, Mshanga, Baek, Kalibala & Rutenberg 2002). However, men's involvement has continued to be one of the major challenges for the programme. The 2007 report by the

National AIDS Council, Nigeria (2004) showed that many women in Nigeria avoided PMTCT because they feared the reaction of their spouses.

The PMTCT programme was also scaled up to Ekiti State in March 2005, a total of 801 women were counselled and tested at Federal Teaching Hospital Ido Ekiti for PMTCT and 9.9% proved to be HIV infected. Male involvement is also one of the major challenges for the PMTCT programme. All counselled and tested women (both positive and negative) were advised to come with their male partners at subsequent visits so that they could also be counselled and tested. Only 0,6% (5 out of 801) managed to do so, and the rest were afraid of their partners reactions.

1.3 PROBLEM STATEMENT

Men's involvement in PMTCT interventions has been associated with an increase in uptake of interventions by women. However, various PMTCT sites continue to experience low levels on involvement by men. Why, this low involvement, and what are the factors influencing it? Exploring these factors is important if appropriate recommendations are to be made.

1.3.1 RESEARCH QUESTIONS

The following are the study questions:

- What is the level of men's knowledge and awareness on their involvement in PMTCT programmes?
- What is the influence of socio-cultural factors on men's involvement in PMTCT programmes?
- How do programmatic factors influence men's involvement in PMTCT programmes?
- How do demographic factors affect men's involvement in PMTCT programmes?

1.4 GENERAL OBJECTIVES

The study aimed at assessing factors that influence men's involvement in PMTCT services in Ido Ekiti in particular. Based on the findings, recommendations will be made on how to improve the level of men's involvement in PMTCT.

1.5 SPECIFIC OBJECTIVES

- To ascertain the level of knowledge and awareness,
- To assess the influence of demographic characteristics,
- To examine the socio-cultural factors, and
- To determine the programmatic factors on men's involvement in PMTCT programmes.

1.6 SIGNIFICANCE OF THE STUDY

- The HIV infection rate among infants and children in Nigeria is increasing.
- It is believed that the uptake of PMTCT interventions by women would improve with the involvement of male partners.
- Until now very little success has been reported with regard to men's involvement.
- The reasons for men's low involvement need to be explored.
- The study findings will be used as a base for recommendations on how to improve the level of men's involvement in PMTCT programmes. This increase would contribute to the improvement of uptake of PMTCT interventions by women and this in turn would contribute to the reduction of MTCT rates.
- The study will also make a contribution to the already existing body of knowledge on the involvement of men in women's reproductive health services.

1.7 CONCEPTUAL AND OPERATIONAL DEFINITIONS OF TERMS USED IN HIS RESEARCH REPORT

The definitions of key concepts used in this research are given below:

1.7.1 HIV

Human Immunodeficiency Virus. The virus that causes HIV infection and AIDS (Chin 2000).

1.7.2 AIDS

Acquired Immune Deficiency Syndrome. This describes the end of the clinical spectrum of HIV infection. It occurs when the immune system of a person who is infected with HIV becomes so weak that they are vulnerable to a variety of illnesses (Chin 2000; Ministry of Health, Zambia 2004).

1.7.3 MEN

In this study, men are individuals of male gender who are either married to or sexual partners of women who have at least been counselled and tested for HIV in PMTCT settings, in Federal Teaching Hospital Ido Ekiti, Ekiti State.

1.7.4 MENS INVOLVEMENT

The understanding of the concept *men's involvement* varies with the context in which it is used and its definition differs from source to source in the literature. According to Ntabona (2002), men's involvement is dependent on the socio-cultural context and there are as yet no clear-cut guidelines on how far the partner/husband's participation can go. It includes the following as part of men's participation: attending women's health education sessions; attending counselling sessions; using condoms; acting as community-based volunteer. For Rutenberg et al(2002), men's involvement may mean that men choose to come to the clinic with their

partners, be counselled and get tested for HIV, support their partners in coping with HIV infection and support them financially or with transport to the clinic.

1.7.5 FACTORS INFLUENCING MEN'S INVOLVEMENT

Many factors which may possibly influence men's involvement in women's reproductive health are found to be numerous. For the sake of this study, these factors have been grouped into knowledge and awareness; socio-cultural factors; and programmatic factors. Demographic characteristics of respondents have been included because of their potentially confounding role.

- ***Knowledge and awareness:*** These relate to the level of awareness and misconceptions amongst men about PMTCT services (Kamal 2002). In this study, knowledge and awareness relate to the general knowledge on MTCT and ways to prevent it, and also awareness of the existence of the PMTCT programme in the hospital.
- ***Socio-cultural factors:*** These factors relate to the gender and cultural norms which define the role of men in women's reproductive health life as perceived by men themselves in the community in which they live (Rutenberg et al 2002). In this study, socio-cultural factors relate to men's opinion on and perceptions of their roles in PMTCT, on women's right to access PMTCT services, on couple communication, counselling and testing, and their potential reactions to a positive HIV test in their female partners.
- ***Programmatic factors:*** These are factors that are related to the PMTCT programmes themselves and how friendly and accessible they are to men (Clark 2001; Greene 2000;Rutenberg et al 2002). In this study, programmatic factors relate to men's opinion on gender-specific

PMTCT clinics, on the compatibility of PMTCT clinic times with men's other daily activities, and on staff attitudes and other barriers encountered by men at PMTCT sites.

- **Demographic characteristics:** include age, level of education, tribe, and duration of relationship with female partner.

1.7.6 PREVENTION OF MTCT OF HIV

PMTCT refers to preventive interventions aimed at reducing the chances of transmission of HIV from an infected mother to her baby. In this study, PMTCT includes the following core interventions: Voluntary counseling and testing of pregnant women in an antenatal setting; the use of prophylactic antiretroviral drugs during pregnancy or in the immediate postnatal period; and counselling and adoption of appropriate infant feeding options (CHGA 2004; De Cock et al 2000).

1.8 SCOPE AND LIMITATIONS OF THE STUDY

The study is limited to men's involvement in the core PMTCT interventions included in the third prong of PMTCT or MTCT preventive interventions for HIV-infected pregnant women (Rutenberg et al 2003). This is because the involvement of men in the other PMTCT prongs, such as primary prevention of HIV and family planning, has been extensively covered in the literature and belongs to the field of general reproductive health (Baggaley, Sigxashe, Gaillard & Osborne 2000).

The second study limitation is that it may be too context-specific to the culture and environment of Ido-Ekiti, which may limit the generalisability of findings.

The third limitation may emanate from possible unnoticed biases which might arise from the use of a data collection tool developed by an inexperienced researcher; the use of many different interviewers who, although trained, might influence the data collected through their own understanding and might influence responses through their physical presence, or interviewer bias (Polit & Beck 2004); and information bias from incorrect information provided by respondents.

1.9 SUMMARY

This chapter introduces the entire study. The chapter highlights the importance of men's involvement in the uptake of PMTCT interventions by women. The background information to the research problem, which is the low incidence of men's involvement in the PMTCT programme, is covered at international, national and local level. The study's aim and objectives are also covered. The study aims to examine the factors which influence men's involvement in PMTCT services and to make recommendations for improvement. These factors were grouped as knowledge and awareness, socio-cultural and programmatic factors and demographic characteristics.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This literature review highlights the types, quantities and content of consulted sources and also the way in which they were acquired. The review covers theoretical or empirical sources related to the main concepts found in this study. They were reviewed with the aim of gathering enough insight into the topic to refine the problem being studied; to become acquainted with the existing body of knowledge on the topic; and to choose and define the methodology used for this study. For this study, the literature review was conducted before data collection and documents were consulted after being acquired from various sources like the Internet, UNISA library and many others.

2.2 PURPOSE OF THE LITERATURE REVIEW

Every research report should be placed in the context of the general body of scientific knowledge. The general purpose of a literature review is to gain an understanding of the current state of knowledge about the research topic (Johnson and Christensen 2004). For this study, the literature was reviewed to gain more understanding on men's involvement in PMTCT and reproductive health programmes and also place this study against the general picture of men and PMTCT. The review also helped the researcher specifically to:

- Refine the research problem and problem background information
- Acquaint herself with current knowledge of men's involvement in PMTCT and identify literature gaps supporting the choice of this topic
- Identify the relevant concepts to be included in this research
- Identify and refine the study methodology and process
- Develop the data collection instrument (Johnson and Christensen 2004; Katzenellenbogen, Joubert & Abdool Karim; Polit and Beck 2004).

2.3 SCOPE OF THE LITERATURE REVIEW

The literature review included both theoretical and empirical sources. The most consulted were primary sources, although secondary sources were also used. An internet search was conducted and a considerable amount of information was found on PMTCT and men's involvement in reproductive health programmes. Some of the journal articles were requested from the UNISA library, and research methodology and theoretical textbooks were also used in the review.

2.3.1 THEORETICAL RESOURCES

These can generally be grouped into research methodology sources and conceptual theoretical sources. Sources on research theory reviewed for this study mostly included textbooks on research methodology. However, some journal articles and other academic methodology guidelines were also used in refining the research design and process. Theoretical conceptual resources reviewed for this study included textbooks on health education and health promotion theories, and sociology. These sources were important for identifying and refining concepts relevant to men's involvement in PMTCT.

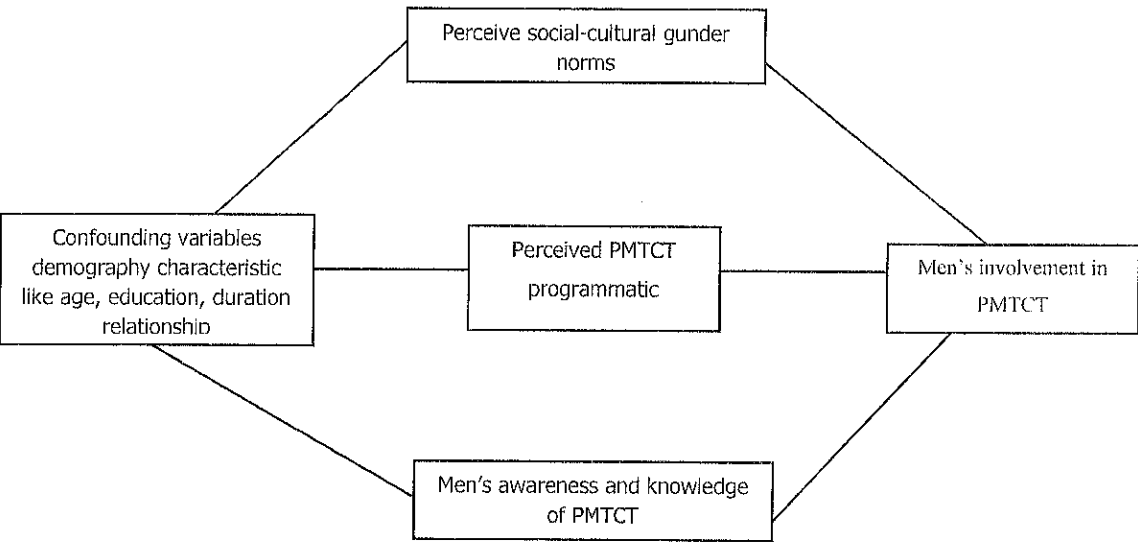
2.3.1.1 CONCEPTUAL FRAMEWORK

The main concepts used in this study did not originate in a single theory. Instead, many different theories and models were used in the selection and definition of relevant concepts forming the conceptual framework of this research. White, Greene and Murphy (2003) found out that the theory of diffusion of innovations (DOI) is the most used in programmes trying to involve men in reproductive health projects. The main theories used to construct the conceptual framework for this study are the DOI theory and the social cognitive theory, as elaborated below:

From the theory of DOI, the concept of adoption was adopted and adapted (Glanz, Rimer and Lewis 2005). This concept in theory refers to the uptake of the programme (PMTCT) by the target audience (men). According to the DOI, the decision to adopt a

programme is influenced by three types of knowledge: awareness knowledge that the innovation exists; procedural knowledge about how to use the innovation; and principles knowledge, or understanding how the innovation works (Glanz et al 2002). In this study, knowledge and awareness were used as potential factors influencing men's adoption of PMTCT. Men need to know that the PMTCT programme exists, they need to know what roles they can play in the programme and they need to know how PMTCT programmes work.

From the social cognitive theory, the concepts of environment and situation were adopted and adapted (Glanz et al 2002). The concepts of environment and situation in theory refer to the objective factors that can affect a person's behaviour but are physically external to that person and are external to the cognitive representation of the environment by that person (Glanz et al 2002). In this study, these concepts were used in the conceptualisation of socio-cultural factors like gender norms which may influence men in their own community or environment.



2.3.2 EMPIRICAL LITERATURE SOURCES

2.3.2.1 PRIMARY SOURCES

The literature review was based mainly on primary empirical sources contained in scientific journals and textbooks. During the review, it was found that most of the previous studies had been conducted on the involvement of men in other reproductive health programmes like family planning, and very few on PMTCT. Furthermore, the majority of the studies on men and PMTCT were of a qualitative nature, such as the study by Burke, Rajabu, Ramadhani and Burke (2004).

2.3.2.2 SECONDARY SOURCES

Secondary sources were also consulted, not only to support primary sources but also to help in the identification of additional primary studies from systematic reviews on men's involvement in reproductive health and PMTCT. These sources include publications from UNAIDS, the Population Council, the Horizon Programme, UNFPA and many others.

2.4 LITERATURE REVIEWED ON MEN'S INVOLVEMENT IN PMTCT

2.4.1 PREVENTION OF MTCT OF HIV

2.4.1.1 VERTICAL TRANSMISSION OF HIV

HIV may be transmitted to the infant during pregnancy, at the time of delivery, and through breastfeeding (Family Health International 2006). For a known HIV-infected mother who becomes infected in the antenatal period, the additional risk of transmission of HIV to her infant through breastfeeding has been estimated at 14%; it may reach 29% for mothers who acquire HIV in the postnatal period.

The factors that may increase the risk of perinatal transmission include: high maternal viral load; recurrent sexual transmitted diseases (STDs); malaria; Vitamin A deficiency; preterm delivery; vaginal delivery; duration of rupture of membranes longer than four hours; placental disruption; invasive procedures during delivery (like vacuum extraction, episiotomy, use of forceps); breastfeeding and mixed feeding (Family Health International 2003:1800

Phoolcharoen and Detels 2002).

The majority of children who are infected with HIV were infected through MTCT or vertical transmission (CHGA 2004; Rutenberg et al 2003). Without any appropriate interventions, about a third of children born to HIV-infected women are likely to be infected (Phoolcharoen and Detels 2002). These children who acquire HIV through this mode of transmission face severe morbidity and mortality, especially in settings where specialized care is not available.

2.4.1.2 STRATEGY TO REDUCE MTCT OF HIV

United Nations agencies recommend a four-pronged strategy to prevent MTCT of HIV, which includes (McIntyre and Gray 2002; Rutenberg et al 2003):

1. The primary prevention of HIV infection among parents-to-be.
2. The prevention of unwanted pregnancies in HIV-infected women.
3. The prevention of HIV transmission from infected women to their infants.
4. Treatment, care and support of infected and affected women, their children, partners and families.

The third prong is based on what are considered as key PMTCT interventions (Family Health International 2006). During pregnancy: the provision of voluntary counselling and testing (VCT) and psychosocial the diagnosis and treatment of malaria, STDs and other infections as early as possible; the provision of basic antenatal care which includes iron supplementation, education about MTCT and infant feeding options; starting antiretroviral therapy (ART) for MTCT; and provision of information on risk reduction and practice of safer sex. During labour and delivery: delay in artificial rupture of membranes; reducing the number of vaginal examinations to a minimum, vaginal cleansing; reducing the use of assisted delivery with forceps; reducing the use of episiotomy; elective Caesarean section; and the use of antiretroviral drugs.

Of these interventions, three are considered to be core PMTCT interventions; these are

VCT, ART and counselling for infant feeding options. VCT is considered by some as the most important intervention for PMTCT (Chopra, Doherty, Jackson & Asworth 2005). According to Rutenberg et al (2002), the importance of VCT in PMTCT

lies in the fact that it has the potential to reach large numbers of women who may already be infected with HIV or at high risk of becoming infected. According to the Horizon Programme (2002), experiences from a number of PMTCT sites have shown that VCT in PMTCT is a key to successful men's involvement, especially when it takes the form of couple counseling. This view is also supported by Clark (2001), who considers VCT programmes which work with couples to be more successful than those working with women alone.

Another core intervention considered important is the use of ARVs in PMTCT. Giving ARVs to pregnant, HIV-infected women is associated with a significant decrease in the rate of MTCT by reducing transmission during pregnancy and childbirth (CHGA 2004; McIntyre and Gray 2002). Various ARV drug regimens have been tried in PMTCT programmes. These regimens are either single drug-based regimens or combination drug-regimens based on drugs like Zidovudine (AZT) and Nevirapine (NVP). According to Msellati, Hingst, Kaba, Viho, Welfens-Ekra and Dabis (2001), clinical trials have demonstrated that a reduction of 37-50% in mother-to-child transmission of HIV can be achieved through a short course of Zidovudine or Nevirapine. Nevirapine short courses have been widely used in poor-setting PMTCT programmes because of low cost and ease of administration (Newell 2001; Rutenberg et al 2002).

A third core intervention considered to be important is counselling and support for appropriate choice of infant feeding option. Although important, this intervention is also considered as one of the most demanding and challenging components of PMTCT

programmes (Rutenberg et al 2003). Persuading HIV-infected mothers to accept replacement feeding can be difficult because of affordability, lack of clean water, and lack of sources of energy for sterilisation; or because of fear of stigmatisation (Newell 2001).

2.4.2 MEN'S INVOLVEMENT

The treatment of men's involvement in the literature is examined in terms of its meaning and its importance, as elaborated below.

2.4.2.1 WHAT IS MEN'S INVOLVEMENT?

Men's involvement or participation in women's health programmes has been a source of much interest in the recent years, even though its meaning continues to vary from source to source. According to Lee, men's involvement can be viewed from programme perspectives and may mean men supporting choices and rights of their female partners, or men doing something about their own reproductive and sexual behaviour as a way of protecting their partners. For Rutenberg et al (2002), men's involvement may mean many things, depending on the couple and community; some men may choose to go to the clinic with their female partners, get involved in counselling and be tested for HIV, while many choose not to visit the clinic, but instead support their partners in coping with HIV in other ways, pay for their partner's health care and/or provide transport for their partner to reach the clinic. The topic of men's involvement is also complicated by the wide range of terms used in the literature to qualify it. This terminology includes: men's participation, men's responsibility, male motivation, male involvement, men as partners, and finally men and reproductive health. The terminology used does not matter as long as the purpose is to describe the process of social and behavioural change that is needed for men to play more responsible roles in reproductive health services.

A further challenge is posed by the difficulty of measuring men's involvement. According to the Horizon Programme (2003), measuring the ideal degree of involvement is very difficult because male involvement is so couple-specific.

2.4.2.2 WHY INVOLVE MEN?

Despite the above challenges, the importance of involving men in the prevention and treatment of HIV/AIDS programmes for women has gained increased recognition in the literature, especially after the 1994 Cairo and 1995 Beijing consensus documents, which agree that men are crucial to bringing about changes in women's health status. The call for involving men in reproductive health issues has emphasised the role of men in improving the health of their families and themselves (White et al 2003). Involving men is important because men do influence women's access to health services through their control of finances, women's mobility, means of transportation, and health care decisions (Greene 2002). Lee calls this role the "gate keeping" authority of men. The need to involve men, as defined by the ICPD and the Beijing Conferences, is even more crucial in the African context, because of the rapid spread of the HIV/AIDS pandemic and because of cultural norms and taboos which reinforce negative stereotypes about male involvement in reproductive life issues. These factors call for responsible sexual and reproductive behaviour by both men and women if HIV/AIDS is to be controlled. Rutenberg et al (2003) also recognise the importance of men's roles in PMTCT. According to these authors, it is difficult to consider optimal uptake of PMTCT interventions without the partner's understanding and consent. In the case of breastfeeding, for example, lack of partner support has been identified as a barrier to replacement feeding for HIV-infected women. Even women who choose to exclusively breastfeed need partner support (Baggaley et al 2000).

While the benefits of men involvement seem to be indisputable, Kumah mentions opposing views in some circles that consider men's involvement as a way of increasing men's control over women's reproductive life. Their argument is that as men are already involved in all major human activities, why should they acquire more control over women's reproductive life as well?

Finally, Clark (2001) warns against some of the pitfalls to be considered in the

process of involving men: firstly, the fact that involving men should be constructive, in the sense that it should always protect women's interest without being paternalistic. Secondly, involving men should not result in subtraction of resources from women's programmes for the sake of men's programmes.

2.5 CURRENT UNDERSTANDING OF THE QUESTIONS IN THE STUDY

The following lines present the current understanding of the questions which this study aims to answer.

2.5.1 WHAT IS THE LEVEL OF MEN'S KNOWLEDGE AND AWARENESS ON THEIR INVOLVEMENT IN PMTCM PROGRAMMES?

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). As stated above, according to the theory of DOI, adoption of programmes by recipients is influenced by knowledge and awareness (Glanz et al 2002). Lack of knowledge by men may be due to inadequate access to information about PMTCT. In a qualitative study on factors influencing men's involvement in Tanzania, Burke, Rajabu and Burke (2004) found that men felt marginalised by the inadequacy of access to information as they received second-hand information through their wives. In Pakistan, Kamal (2002) found that even women identified lack of information among men as a serious issue and wished that dissemination programmes could also be held for their male partners. In a study in India and South Africa, the Population Council (2005) found that when men are informed and involved from the beginning through couple counselling, they provide a better support for their female partners. For Baggaley et al (2000), the level of ignorance amongst men in most PMTCT settings is so significant that very

few are even aware that their female partners have been tested during their antenatal care and are enrolled in PMTCT programmes. It is clear that providing reproductive health information to men has many benefits, as it is associated with an increase in the uptake of interventions by women (PATH 1997).

2.5.2 WHAT ARE INFLUENCE OF SOCIO-CULTURAL FACTORS ON MEN'S INVOLVEMENT IN PMTCT PROGRAMMES?

According to the sociologist Giddens (2001), all cultures have values that give meaning and provide guidance to humans as they interact with their social world. These values and beliefs influence men and women living in the same society about what are considered appropriate roles and responsibilities for each gender (Ntabona 2002).

According to Kumah (1999), these values and perceptions are sometimes reinforced by social institutions like traditional and religious groups in the community. A number of cultural factors which limit men's ability to take an active role in reproductive health have been reported in the literature.

PATH (1997) reports on the unfavourable social and religious climate in some societies where sexual matters are not discussed openly and men may feel uncomfortable talking about reproductive health needs with their partners and health workers. Kumah (1999) and Drennan (1998) mention that some cultural norms and taboos in Africa reinforce negative stereotypes about male involvement in reproduction matters, and some even condone abuses of women's reproductive rights by men. According to Gupta (2002), although gender is considered culture-specific, there is consistency across cultures in the difference between women's and men's roles, access to resources, and decision-making authority. In Zimbabwe, Rutenberg et al

(2002), report on male involvement projects which revealed cultural beliefs reinforcing the community perception of men who publicly supported their wives by accompanying them to the clinic as “weak” or “bewitched”. In Tanzania, Burke et al (2004) found that because of cultural norms, men preferred to receive information about PMTCT from fellow men who were their peers or older, and in gender-specific groups.

According to White et al (2003), social, gender-related issues also affect men as they may engage in high-risk behaviours more frequently than women in order to meet the perceived expectations of social norms.

2.5.3 HOW DO PROGRAMMATIC FACTORS INFLUENCE MEN'S INVOLVEMENT IN PMTCT PROGRAMMES?

Programmatic factors can also be a barrier to men's involvement in reproductive health services. According to PATH (1997), reproductive health services are designed to meet women's and children's needs and these results in men not considering these programmes as a source of information and help for them. Furthermore, because service providers are mostly females, they may be biased towards female related services (PATH 1997). According to Rutenberg et al (2002; 2003), PMTCT programmes have done very little to involve men, this despite acknowledging their key roles and positive experiences in other reproductive health programmes like family planning services. According to these authors, antenatal and mother and child health clinics are women's spaces that cannot be easily adapted to accommodate men. Kamal (2002) is of the opinion that men want to make use of the existing public health care facilities, but the way these facilities function is not very conducive to their utilization because of constraints related to the time

schedule, the attitude of the health care providers, and the expenses involved. In Tanzania, Burke et al (2004) found that men considered themselves marginalised by PMTCT programmes.

Another issue to be considered is the lack of privacy in many antenatal settings which makes it difficult to maintain confidentiality and so discourages both women and men from taking the test, for fear of stigmatisation (Berer 1999). The manner in which PMTCT services are provided and organised can therefore be a limiting factor to men's involvement.

2.6 RESEARCH FINDINGS ALREADY IN USE

The following sections present some of the research findings already in use on the important concepts and questions studied in this research.

2.6.1 FINDINGS ON THE IMPORTANCE OF MEN'S INVOLVEMENT IN PMTCT

Bajunirwe and Muzoora (2005), in their study on barriers to the implementation of PMTCT programmes in Rwanda, found that 72% of rural women were of the opinion that husbands should be consulted before testing for HIV in PMTCT. They also found that among the women living with their husbands, the majority (89%) informed their partners about their going to the antenatal clinic on that day. Also, the majority of these women (71%) thought that their husbands would accept being tested for HIV. Women who thought they should consult their husbands before being tested were less likely to accept the test compared with those who thought they did not need to consult their husbands. Women who thought their husbands would allow them to test were more likely to accept the test than those who thought their husbands would not approve. Burke et al (2004) also found that there was similar thinking among men themselves, who believed that women should be expected to seek permission from men before VCT, otherwise there would be conflict. Ekouevi et al (2004) found similar

opinions in the Ivory Coast, where the fear of male partners had a negative effect on the uptake of PMTCT interventions among HIV infected women, to the point that women who were single accepted the PMTCT package more frequently than those who had a male partner. However, in Ethiopia, Kassaye, Lingerh and Dejene (2005) found that a good percentage of women were able to share their HIV test results with their male partners (69%). But among those who did not share, fear of partner reactions was the concern most raised.

In terms of feeding options in PMTCT, Kiarie, Richardson, Mbori-Ngacha, Nduati and John-Stewart (2004), in their study on infant feeding practices of HIV infected women in Kenya, found that male partners had a considerable influence on the feeding options chosen by women. The low use of replacement feeding in HIV-infected women (30%) was also explained by reasons which included fear of loss of confidentiality and the negative attitudes of partners and the family. It was also found in the same study that although partner knowledge of the HIV status of the woman was a factor influencing feeding decisions, a supportive partner attitude was very important for women.

2.6.2 FINDINGS ON MEN'S WILLINGNESS TO BE INVOLVED

Perez, Mukotekwa, Miller, Orne- Gliemann, Glenshaw, Chitsike and Dabis (2004), while reviewing the first 18 months of the implementation of a rural PMTCT programme in Zimbabwe, found that although the majority of women interviewed suggested that partners should be tested, only 2,3% of partners accepted the test and very few returned for their results. Similar findings are reported by Semrau, Kuhn, Vwalika, Kasonde, Sinkala, Kankasa, Shutes, Aldrovandi and Thea (2005) in Zambia, where only 10% of women were able to encourage their husbands' participation in PMTCT. Burke et al (2004) found that men were willing to participate in PMTCT programmes when there were incentives like ARVs and when sources of information flow respected gender and cultural norms.

2.6.3 FINDINGS ON FACTORS INFLUENCING MEN

In a qualitative study on factors influencing men's involvement in PMTCT in Tanzania, Burke et al (2004) found that the source and the order of information flow on new programmes like PMTCT were important for the involvement of men. Men consider themselves traditionally as bringers of health information to the family. If information on PMTCT interventions is first given to women, this information is less trusted by men. Men prefer to receive the information directly from health workers and in gender-specific groups, because cultural norms do not encourage mixing of men and women when discussing reproductive health issues. Similar findings are reported by Horizon Programme (2003) in a study conducted in Zambia and Kenya on feasibility and acceptability of PMTCT. The study found that attempts to involve male partners are most successful when information about PMTCT is provided directly to men and preferably outside the antenatal clinic setting, which is perceived by men as exclusive to women. This lack of friendliness of PMTCT clinics to men was again identified as a barrier by Horizon Programme (2002) in another multi-sites study in which it was found that in Zimbabwe, female clients at the ANC clinic considered men as intruders, and that clinics were usually closed at the times when working men could most easily access them. The findings also report the perceptions among many men that male involvement is for the benefit of women and not men.

The study by Burke et al (2004) also revealed that men did not like to attend the local PMTCT clinic and would prefer to be tested at a distance from home for fear of lack of confidentiality at their local clinic, and of stigma and discrimination. Nyblade and Field-Nguer (2001), in a qualitative study in Zambia and Botswana on women, communities and PMTCT, reported that community members (including men) had opinions, beliefs, and values that directly affected their decisions about participating in programmes such as PMTCT. They also reported that men were less informed than women about MTCT and this disparity in knowledge could be

attributed to the place and manner in which information is usually shared, mostly by female health workers at antenatal clinics, where men are unlikely to be found.

2.7 CONCLUSIONS FROM THE LITERATURE REVIEW

The studies referred to in the previous sections confirm the importance of involving men in PMTCT services. Women's uptake of these services is considerably influenced by the attitudes of their male partners. These studies also show that it is not very easy to convince men to be involved in programmes which are designed for and provided by women. Some of the factors influencing the attitudes which are found in these studies are related to gender norms and roles, to the flow of information about the programmes, and programmatic factors related to the unfriendliness of PMTCT clinics towards men.

2.8 STRENGTHS AND WEAKNESSES OF OTHER STUDIES

Most of the abovementioned studies used women as respondents instead of men themselves, and a good number of them are qualitative in nature, using a small sample. They focused mostly on the impact of men's attitude on the uptake of PMTCT services by women, and very little is said about the actual reasons behind the men's attitude. However, one of the strengths of some of these studies is the fact that they are multi-sited, and the data collected from different countries illustrate the variations of norms across cultures.

2.9 FURTHER RESEARCH NEEDED

Following the above, there is a need to conduct more quantitative research with men themselves as respondents to understand their attitude better.

Exploring the factors which influence men's adoption of programmes like PMTCT from men's own perspective is important, hence the choice of this study's topic.

2.10 SUMMARY

The literature was reviewed to gain more understanding on men's involvement in PMTCT and reproductive health programmes, to place this study against the general picture of men and PMTCT and to identify literature gaps which might support the choice of this topic. Various sources were accessed to find the literature and these included the Internet and library and many others. The sources on men's involvement in PMTCT which were reviewed assisted in the conceptualisation and understanding of concepts like PMTCT of HIV, men's involvement, and the factors influencing it. Current understanding of these concepts was highlighted in this chapter and findings from other studies were evaluated to reveal strengths and weaknesses, with a view to justifying the choice of this research topic.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The methodology used to conduct the research on men's involvement in PMTCT is discussed in this chapter. The chapter covers the study design, the study population, sample, data collection method and instrument, ethical considerations, validity and reliability, and data analysis plans.

3.2 DELIMITATION OF THE STUDY

The study was limited to the involvement of men in PMTCT programmes in the Federal Teaching Hospital Ido Ekiti, Ekiti State, Nigeria.

3.3 STUDY AREA

Ido Ekiti is located in Ido-Osi Local Government Area of Ekiti State, Nigeria. It is situated in the northern part of the state where the routes from Oyo, Osun and Kwara states respectively converge. Ido-Ekiti is the headquarters of Ido-Osi local council. Ido Ekiti was populated with 186,830 persons in 2011. There are primary and secondary schools as well as school of nursing and federal teaching hospital which has an annex of AFE BABALOLA University, also a school of mentally retarded in Ido-Ekiti.

3.4 RESEARCH APPROACH

A quantitative approach was used to study the factors influencing men's involvement in PMTCT. According to Burns and Grove (2005), quantitative methodology involves reductionism, logical deductive reasoning, a certain degree of control by the researcher, the use of a structured data collection instrument, statistical analysis and generalization. In this study, reductionism involved breaking the PMTCT programme down into components which were then studied. Logical, deductive reasoning involved generating conclusions from a sample of men and generalizing them to a larger population of men. There was researcher control over the choice of the research problem, research

methodology, variables to be studied and control on the effect of extraneous factors. Data collection and analysis involved the use of a structured data collection instrument and statistical analysis.

3.5 STUDY DESIGN

A descriptive, cross-sectional, correlation design was used to examine the relationship between the level of men's involvement in PMTCT and the various factors which may influence it. This study has a descriptive aspect to every studied variable; it is cross-sectional because it is conducted in the present and all the data were collected at the same time. On the correlation aspect, the suspicion of a relationship between men's involvement and the different potential factors influencing it emanated from the review of the literature (refer to chapter 2); the literature search did not yield any documented covariance between these variables; and no single theory predicting the possible relationship between them was identified. The factors were studied as they exist in the population without any manipulation. The method used for selecting and estimating the sample made it representative.

3.6 RESEARCH POPULATION

3.6.1 SELECTION OF RESEARCH POPULATION

This study's population included all men who were either husbands or sexual partners of women who had been at least counselled and tested for HIV for PMTCT, in Ido Ekiti without any consideration of the HIV sero-status of the women.

3.6.2 TYPE OF SAMPLE AND SAMPLING TECHNIQUE

A random sample was selected to represent the above defined study population. A systematic random sampling technique was used to select the sample units. According to Polit and Beck (2004), systematic sampling technique involves the selection of every k th case from a list or group (sampling frame) and, this k (the sampling interval), is established by dividing the total study population by the desired sample size. The following steps were taken to select units to be included in the sample:

The sampling frame was established from federal teaching hospital's PMTCT registers to identify a total of 721 women who had been counselled and tested during the stated period. Personal records of these women were used to identify addresses of their male partners. The study population of 721 men was then divided by 120 (sample size) to establish a sampling interval of about 6. Every sixth person on the list was selected, as sample selected randomly by dropping a pencil on the register. The advantage of the systematic random sampling technique is that it can yield essentially the same results as simple random sampling, but with less work involved (Polit and Beck 2004). The technique was also found appropriate for this study because the units in the sampling frame were not numbered at intervals coinciding with the sampling interval (Fisher and Foreit 2002).

3.6.3 SAMPLE SIZE

The sample size of 120 was calculated with the help of the computer software SPSS. The confidence level was fixed at 95%.

3.7 METHOD OF DATA COLLECTION

3.7.1 DATA COLLECTION APPROACH

The data collection method for this study was a face-to-face interview using a structured questionnaire.

3.8 RESEARCH INSTRUMENT

The instrument used to collect and measure data on men's involvement in PMTCT was a structured interview protocol/questionnaire.

3.9 RELIABILITY AND VALIDITY

3.9.1 VALIDITY

Validity refers to the question whether there is evidence to support the assertion that the methods are really measuring the abstract concepts that they purport to measure. Another aspect of validity concerns the quality of the researcher's evidence regarding the effect of the independent variable on the dependent variable (Polit and Bec2004).

3.9.1.1 INTERNAL VALIDITY

Internal validity refers to the extent to which the findings of a study are a true reflection of reality, rather than the result of extraneous variables (Burns and Grove 2005). The following efforts were made to reduce the impact of possible extraneous variables in the study and by so doing increase internal validity: The use of random sampling techniques; the homogeneity of the selected group of men making up the sample; and blocking of some of the possible extraneous variables by including and measuring them (such as demographic characteristics of respondents).

3.9.2 RELIABILITY

Reliability refers to the accuracy and consistency of Information obtained in a study and the term is most associated with the methods used to measure research variables (Polit and Beck 2004). In surveys, reliability problems commonly result when the respondents do not understand the question, are asked about something they do not clearly recall, or asked about something of little relevance to them (Fisher and Foreit 2002). The use of face-to-face interview and the use of a structured questionnaire are some of the methods used to improve reliability in this study.

3.10 ETHICAL CONSIDERATIONS

The main ethical issues most considered when conducting research include the voluntary nature of participant, reduction of risk for participants, obtaining if informed consent, ensuring confidentiality and privacy of participants, and institutional ethical issues, which include obtaining authority to conduct research and scientific honesty (Babbie and Mouton 2001; Katzenellebogen et al 1997; Plit and Beck 2004).

3.11 DATA ANALYSIS

The collected data were cleaned and coded and entered in the computer for analysis with the computer using SPSS computer software .

Frequency distribution tables and descriptive statistics were used to present the analysis Of each variable. Correlation analysis was also conducted to assess the relationship between men's involvement and the different factors, to measure the level of influence of each.

3.12 SUMMARY

This chapter discussed the methodology used to conduct this study on men's involvement in PMTCT. A quantitative approach was used and a descriptive, cross- sectional correlational research design was adopted. A systematic random sampling technique was used to select 142 sample units from a population of 801 male partners of women involved in PMTCT. The chapter also discussed the data collection method and instrument; face-to-face interview by trained interviewers using a structured protocol was the method used to collect information from respondents in the community. This instrument measured the variables 'men's involvement' and 'factors influencing men'. Validity and reliability of measurement and findings and ethical considerations were also discussed in the chapter, followed a presentation of plans for analysis of data.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF DATA

4.1 INTRODUCTION

This chapter discusses the analysis and interpretation of data. The data were collected with the aim of answering the research questions, which were:

- What is the level of men's knowledge and awareness on their involvement in PMTCT?
- What are the influence of socio-cultural factors on men's involvement in PMTCT?
- How do programmatic factors influence men's involvement in PMTCT?

How do demographic factors affect men's involvement in PMTCT?

Data collection took place from 5th to 12th July 2016. The returned questionnaires were numbered, and the data cleaned and then transferred to an electronic SPSS spreadsheet for analysis with the same computer software.

4.2 SAMPLE SIZE

Data were collected from 120 respondents in the community through face-to-face interviews using structures questionnaires.

4.3 ANALYSIS AND INTERPRETATION OF THE DATA

The results of the analysis of data are presented below, according to each questionnaire section and item, using tables and summary statistics.

4.3.1 DEMOGRAPHIC AND OTHER SELECTED CHARACTERISTICS OF RESPONDENTS.

This section examines the Demographic attributes of respondents such as their age, level of education, duration of spouse, religion, ethnicity, etc. Table 4.1 reveals the percentage distributions of men according to their age group. The respondents are categorized

into six age groups. Age group <20years constitute 5.0% of respondents, 20-29years constitute 34.2% of respondents, 30-39years constitute 49.2% of respondents which constitute the highest respondents, 40-49years constitute 9.2% of respondents, 50-59 years constitute 1.7% of respondents, while 60+ years constitute 0.8% of respondents.

Men with primary education constituted 39.2% with 47 respondents, followed by those with higher education with 27.5% with 33 respondents, no formal education constituted 18.3% while 15.0% was constituted by secondary education. As for ethnicity, Yorubas have the highest proportion of men with 53.3%, followed by the Igbos with 37.5%, while the Hausa/Fulanis with 4.2%, and others constituted 5.0%. Christian with 47.5%, followed by Muslim with 27.5%. 18.3% of the respondents were others and 6.7% is Traditionalist .About 38.3% had been with their spouse for 5-10 years, followed by <5 years with 33.3% and 10+ years with 28.3% of respondents.

TABLE 4.3.1 DEMOGRAPHIC AND OTHER SELECTED CHARACTERISTICS OF RESPONDENTS.

Age

	Frequency	Valid Percent
<20	6	5.0
20-29	41	34.2
30-39	59	49.2
40-49	11	9.2
50-59	2	1.7
60+	1	.8
Total	120	100.0

The majority of respondents, namely 83.4% (n=100), were between 20 and 39 years (combination of 20 to 29 and 30 to 39 years' categories).

Level of Education

	Frequency	Valid Percent
No formal education	22	18.3
Primary	47	39.2
Secondary	18	15.0
Higher	33	27.5
Total	120	100.0

The level of education of respondents varied from "no formal education" to "higher education". As shown in the table above, 18.3% (n=22) of the respondents never

attended school, while 15% had at least a secondary school qualification.

Duration with spouse

	Frequency	Valid Percent
<5	40	33.3
5-10	46	38.3
10+	34	28.3
Total	120	100.0

As shown in the table above, 33.3% (n=40) of respondents have been in a relationship with their female partners for less than 5 years, 38.2% (n=46) for 5 to 10 years and 28.3% (n=34) for more than 10 years.

Religion

	Frequency	Valid Percent
Christian	57	47.5
Muslim	33	27.5
Traditionalist	8	6.7
Others	22	18.3
Total	120	100.0

Almost all respondents belonged to the Christian religion with 47.5%, as shown in table. The Muslim with 27.5 % (n=33), followed by other religion with 18.3% (n=22) and 6.7% (n=8).

Ethnicity

	Frequency	Valid Percent
Yoruba	64	53.3
Hausa/Fulani	5	4.2
Igbo	45	37.5
Others	6	5.0
Total	120	100.0

The table presents the percentages of respondents per tribe. Yoruba were in the majority with 53.3% (n=64), followed by Igbo with 37.5% (n=45) and Hausa/Fulani and others had 4.2% (n=5) and 5.0% (n=6) respectively.

Knowledge1

	Frequency	Valid Percent
Yes	78	65.0
No	36	30.0
don't know	6	5.0
Total	120	100.0

Of the respondents, 65% (n=78) were aware that MTCT can occur during pregnancy, 30% (n=36) did not know and 5% (n=6) were not sure.

Knowledge2

	Frequency	Valid Percent
Yes	102	85.0
No	11	9.2
don't know	7	5.8
Total	120	100.0

The majority of the respondents, namely 85% (n=102) knew that an HIV-positive mother could transmit the virus to her baby through breastfeeding; only 9.2% (n=11) did not know and 5.8% (n=7) were not sure.

Knowledge3

	Frequency	Valid Percent
Yes	96	80.0
No	15	12.5
don't know	9	7.5
Total	120	100.0

Of the respondents, 80% (n=96) knew that a HIV positive woman could transmit the virus to her baby during delivery, 12.5% (n=15) did not know, and 7.5% (n=9) were not sure.

Knowledge4

	Frequency	Valid Percent
Yes	69	57.5
No	37	30.8
don't know	14	11.7
Total	120	100.0

Of the respondents, 57.5% (n=69) knew that ARVs can reduce the chances of MTCT, 30.8% (n=37) did not know and 11.7% (n=14) were not sure.

Factor1

	Frequency	Valid Percent
Yes	33	27.5
No	84	70.0
don't know	3	2.5
Total	120	100.0

These results show that 70% (n=84) thought that women should get permission from their male partners before undergoing HIV test for PMTCT, 27.5% (n=33) do not think so while 2.5% (n=3) are not sure.

Factor2

	Frequency	Valid Percent
Yes	76	63.3
No	43	35.8
don't know	1	.8
Total	120	100.0

The results also show that the majority of the respondents (63.3%; n=76) think that men should accompanied their female partner to PMTCT, 35.8% do not agreed that men should accompanied their female partner while 0.8% are not sure.

Factor3

	Frequency	Valid Percent
Yes	20	16.7
No	88	73.3
don't know	12	10.0
Total	120	100.0

In this study, 16.7% of the respondents found it a taboo for men to discuss HIV testing in pregnancy with women, while 73.3% do not find it a taboo for men to discuss HIV testing in pregnancy with women and 10% were not sure.

Factor4

	Frequency	Valid Percent
Yes	51	42.5
No	61	50.8
don't know	8	6.7
Total	120	100.0

The results also show that 42.5% (n=51) of respondents agreed to couples using condoms to reduce MTCT, 50.8% do not agree and 6.7% are not sure.

Programme1

	Frequency	Valid Percent
Yes	31	25.8
No	83	69.2
don't know	6	5.0
Total	120	100.0

Of the respondents 69.2% (n=83) did not think men should have “male only PMTCT clinics”, while 25.8% (n=31) think men should have male only PMTCT clinic, 5% (n=6) were not sure.

Programme2

	Frequency	Valid Percent
Yes	13	10.8
No	93	77.5
don't know	14	11.7
Total	120	100.0

77.5% (n=93) did not think that at the PMTCT clinics men should be attended to by male health workers only, while 10.8% (n=13) think men should be attended to by male health workers and 11.7% (n=14) were not sure.

Programme3

	Frequency	Valid Percent
Yes	18	15.0
No	93	77.5
don't know	9	7.5
Total	120	100.0

The results also show that the majority of the respondents, 77.5% (n=93) did not think the clinic are made for women and children only, while 15.0% (n=18) thinks it is and 7.5% (n=9) were not sure.

Programme4

	Frequency	Valid Percent
Yes	8	6.7
No	104	86.7
don't know	8	6.7
Total	120	100.0

The majority of the respondents 86.7% (n=104) also did not think clinics should also be opened during weekends and evening while 6.7% (n=8)thinks it should be and 6.7% (n=8) were not sure.

Programme5

	Frequency	Valid Percent
Yes	38	31.7
No	64	53.3
don't know	18	15.0
Total	120	100.0

About 53.3% (n=64) do not think the programmes have done very little to involve men while 31.7% (n=38) thinks the programmes have done very little to involve me and 15.0% (n=18) were not sure.

Programme6

	Frequency	Valid Percent
Yes	38	31.7
No	76	63.3
don't know	6	5.0
Total	120	100.0

63.3% (n=76) do not think the clinic are conducted very far from their home and transport is not expensive while 31.7% (n=38) thinks the clinic is conducted very far and 5.0% (n=6) were not sure.

Involvement1

	Frequency	Valid Percent
Yes	70	58.3
No	31	25.8
don't know	19	15.8
Total	120	100.0

Of the respondents, 58.3% (n=70) knew their partners had been counselled and tested for HIV during the last pregnancy; 25.8% (n=31) indicated that their partners were not tested; and 15.8% (n=19) were not sure.

Involvement2

	Frequency	Valid Percent
Yes	91	75.8
No	22	18.3
don't know	7	5.8
Total	120	100.0

Of the respondents, 75.8% (n=91) said they were ready to discuss HIV counselling and testing at the next pregnancy with their partners, 18.3% (n=22) said they were not ready and 5.8% (n=7) were not sure.

Involvement3

	Frequency	Valid Percent
Yes	17	14.2
No	97	80.8
don't know	6	5.0
Total	120	100.0

Of the respondents, 14.2% (n=17) said they had previously gone to a PMTCT clinic with their partners, 80.8% (n=97) said they had never done that and, 5% (n=6) said they were not sure.

Involvement4

	Frequency	Valid Percent
Yes	108	90.0
No	11	9.2
don't know	1	.8
Total	120	100.0

Of the respondents, 90% (n=108) were prepared to accept that their partners took ARVs for PMTCT when found HIV positive during pregnancy, 9.2% (n=11) were not ready to accept this, and 8% (n=1) were not sure.

Involvement5

	Frequency	Valid Percent
Yes	23	19.2
No	94	78.3
don't know	3	2.5
Total	120	100.0

Of the respondents 19.2% (n=23) agreed to be counselled and tested for HIV together with partners, 78.3% (n=94) said they had not, and 2.5% (n=3) said they were not sure.

4.3.2 DISTRIBUTION OF RESPONDENTS BETWEEN LEVEL OF MEN'S INVOLVEMENT AND OTHER SELECTED CHARACTERISTICS OF RESPONDENTS.

The result revealed that there was a weak positive association between age and the level of involvement, with a Pearson $\chi^2(5) = 15.8658$ Pr = 0.007 (statistically significant at 0.05 level). The table also revealed a weak positive association between level of education and level of involvement, with a Pearson $\chi^2(3) = 6.8020$ Pr = 0.078 (not statistically significant at 0.05 level). An association was found between the duration of the relationship with female partner and the level of involvement. However, this association was found to be not statistically significant at 0.05 level with a Pearson $\chi^2(2) = 3.5781$ Pr = 0.167. The table revealed an association between the socio-cultural factors and the level of involvement, with a Pearson $\chi^2(2) = 33.1198$ Pr = 0.000 (statistically significant at 0.05 level). The result also shows that the association between programmatic factors and the level of involvement, with a Pearson $\chi^2(2) = 35.7256$ Pr = 0.000 (statistically significant at 0.05 level).

TABLE 4.3.2 DISTRIBUTION OF RESPONDENTS BETWEEN LEVEL OF MEN'S INVOLVEMENT AND OTHER SELECTED CHARACTERISTICS OF RESPONDENTS.

CHARACTERISTICS	YES	NO	TOTAL
AGE			
<20	11.8	3.9	5.0
20-29	70.6	28.2	34.2
30-39	11.8	55.3	49.2
40-49	5.8	9.7	9.2
50-59	0.0	1.9	1.7

60+	0.0	1.0	0.8
Pearson chi2(5) = 15.8658 Pr = 0.007			
LEVEL OF EDUCATION			
No formal education	0.0	21.4	18.3
Primary	47.1	37.9	39.2
Secondary	29.4	12.6	15.0
Higher	23.5	28.2	27.5
Pearson chi2(3) = 6.8020 Pr = 0.078			
DURATION WITH SPOUSE			
<5	52.9	30.1	33.3
5-10	23.5	40.8	38.3
10+	23.5	29.1	28.3
Pearson chi2(2) = 3.5781 Pr = 0.167			
RELIGION			
Christian	35.3	49.5	47.5
Muslim	35.3	26.2	27.5
Traditional	0.0	7.8	6.7
Others	29.4	16.5	18.3
Pearson chi2(3) = 3.7050 Pr = 0.295			
ETHNICITY			

Yoruba	64.7	51.5	53.3
Hausa/Fulani	0.0	4.9	4.2
Igbo	35.3	37.9	37.5
Others	0.0	5.8	5.0
Pearson chi2(3) = 2.3215 Pr = 0.508			
IT IS A TABOO FOR MEN TO DISCUSS WITH WOMEN ABOUT HIV TESTING DURING PREGNANCY			
Yes	58.8	9.7	16.7
No	17.7	82.5	73.3
Don't know	23.5	7.8	10.0
Pearson chi2(2) = 33.1198 Pr = 0.000			
MEN SHOULD HAVE MALE ONLY PMTCT CLINIC			
Yes	94.1	14.6	25.8
No	5.9	79.6	69.2
Don't know	0.0	5.8	5.0
Pearson chi2(2) = 48.2065 Pr = 0.000			
AT THE MCH/PMTCT CLINIS MEN SHOULD BE ATTENDED TO BY MALE HEALTH WORKERS ONLY			
Yes	58.8	2.9	10.8
No	5.8	89.3	77.5

Don't know	35.3	7.8	11.7
Pearson chi2(2) = 64.6903 Pr = 0.000			
MCH/PMTCT CLINICS ARE MADE FOR WOMEN AND CHILDREN ONLY			
Yes	70.6	5.8	15.0
No	5.9	89.3	77.5
Don't know	23.5	4.9	7.5
Pearson chi2(2) = 60.6938 Pr = 0.000			
CLINICS SHOULD BE OPENED DURING WEEKENDS AND EVENING			
Yes	35.3	1.9	6.7
No	41.2	94.2	86.7
Don't know	23.5	3.9	6.7
Pearson chi2(2) = 37.5241 Pr = 0.000			
PMTCT PROGRAMMES HAVE DONE VERY LITTLE TO INVOLVE MEN			
Yes	94.1	21.4	31.7
No	5.9	61.2	53.3
Don't know	0.0	17.5	15.0
Pearson chi2(2) = 35.7256 Pr = 0.000			
CLINICS ARE CONDUCTED VERY FAR FROM THEIR HOMES			
Yes	94.1	21.4	31.7
No	5.9	72.8	63.3

Don't know	0.0	5.8	5.0
	Pearson chi2(2) = 35.7053 Pr = 0.000		

4.3.3 BINARY LOGISTIC REGRESSION OF LEVEL OF MEN'S INVOLVEMENT AND OTHER SELECTED CHARACTERISTICS.

The results shows the association between age(30-49), programmes and level of involvement with a p= 0.035 and p= 0.043 respectively (statistically significant at 0.05 level).

TABLE 4.3.3 Binary Logistics regression showing the relationship between level of men's involvement and selected characteristics of men in Nigeria.

	Odds Ratio	P>z	[95% Conf.	Interval]
AGE				
<20	1.0(RC)			
20-29	.3758718	0.584	.0113426	12.45564
30-39	.0060967	0.043	.0000438	.8486566
40-49	.0016406	0.035	4.26e-06	.6313532
50-59	1	-	-	-
60+	1			
LEVEL OF EDUCATION				
No Formal				
Education	1.0(RC)			
Primary	1.43e+07	0.995		

Secondary	9.62e+07	0.995		
Higher	1.13e+08	0.995		
DURATION WITH SPOUSE				
<5	1.0(RC)			
5-10	1.440478	0.786	.1031184	20.12227
10+	.9200461	0.969	.0129844	65.19245
RELIGION				
Christianity				
Islam	4.694147	0.333	.2047507	107.6187
Traditionalist	1			
Others	7.416857	0.342	.1185309	464.0964
ETHNICITY				
Yoruba	1.00(RC)			
Hausa/Fulani	1			
Igbo	4.008422	0.338	.2336793	68.75855
Others	1			
KNOWLEDGE OF PMTCT				
no	1.00(RC)			
yes	.2153202	0.627	.0004413	105.0548
FACTORS INFLUENCING PMTCT				

no	1.00(RC)			
yes	.0615705	0.158	.0012811	2.959075
PROGRAMMES OF PMTCT				
no	1.00(RC)			
yes	.0243102	0.043	.0006647	.889096

4.4 SUMMARY

This chapter discussed the analysis and interpretation of data. The analysis was based on 120 respondents. The analysis was conducted with the help of a computer and results of the analysis were presented according to the questionnaire items.

Results from the analysis of data on respondents' demographic characteristics, on knowledge and awareness, on the influence of socio cultural factors, on the influence of programmatic factors and on the level of respondents' involvement in PMTCT are all discussed in this chapter with illustrative tables and figures.

CHAPTER FIVE

5.0 FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter discusses the study findings in line with the study objectives, the recommendations drawn from these findings, and the study limitations.

5.2 FINDINGS

In this section, the research findings are discussed according to the three research objectives.

These objectives were to

- To assess the influence of demographic characteristics,
- To ascertain the level of knowledge and awareness,
- To examine the socio-cultural factors, and
- To determine the programmatic factors on men's involvement in PMTCT

5.2.1 ASSEESSING THE FACTORS INFLUENCING MENS'S INVOLVEMENT IN PMTCT

5.2.1.1 INFLUENCE OF DEMOGRAPHIC CHARACTERISTICS

INFLUENCE OF AGE

The findings revealed that there was a weak positive association between age and the level of involvement, with a Pearson $\chi^2(5) = 15.8658$ Pr = 0.007, (statistically significant at 0.05 level).

INFLUENCE OF LEVEL OF EDUCATION

Findings also revealed a weak positive association between level of education and level of involvement, with a Pearson $\chi^2(3) = 6.8020$ Pr = 0.078 (not statistically significant at 0.05 level).

INFLUENCE OF THE DURATION OF THE RELATIONSHIP WITH FEMALE PARTNER

An association was found between the duration of the relationship with female partner and the level of involvement. However, this association was found to be not statistically significant at 0.05 level with a Pearson $\chi^2(2) = 3.5781$ Pr = 0.167.

5.2.1.2 INFLUENCE OF KNOWLEDGE AND AWARENESS

The findings revealed that the level of knowledge amongst respondents about PMTCT interventions was above average.

A positive association was also found between knowledge and the total score on level of involvement with a Pr=0.00 (statistically significant at 0.05 level).

This positive association was the strongest compared to all other associations between involvement and other factors.

5.2.1.3 INFLUENCE OF SOCIO-CULTURAL FACTORS

The findings also revealed a negative association between socio-cultural factors and the level of men's involvement in PMTCT: a pearson $\chi^2(2) = 33.1198$ Pr = 0.000 (not statistically significant). These findings may suggest that strong socio-cultural beliefs and opinions may have a negative influence on men's involvement in PMTCT programmes.

5.2.1.4 INFLUENCE OF PROGRAMMATIC FACTORS

The findings also revealed a very weak negative association between programmatic factors and the level of involvement with a pearson $\chi^2(2) = 35.7256$ Pr = 0.000 (not statistically significant).

These findings may suggest that programmatic factors have a very weak negative influence on men's involvement in PMTCT programmes.

5.3 RECOMMENDATIONS TO IMPROVE THE LEVEL OF MEN'S INVOLVEMENT IN PMTCT PROGRAMMES

Based on the above findings, the following recommendations can be made for improving men's involvement in PMTCT.

- To increase their knowledge and awareness about PMTCT, information about the programme should be given to all men and in particular to those in a relationship with women in reproductive age. This information could be provided through couple counselling or campaigns to sensitise men to the issue.
- To reduce the negative influence of socio-cultural beliefs and opinions among men, context-specific and cultural sensitive messages should be formulated and disseminated through health education on reproductive health and PMTCT.
- PMTCT clinics should be made friendlier to men and service providers should ensure that all efforts are made to involve men from the beginning in every PMTCT intervention.

5.4 LIMITATIONS OF THE STUDY

The study was conducted in the community (Federal Teaching Hospital) of Ido Ekiti in Nigeria and may be too context specific. This may affect the generalisability of the findings to other sites.

The other limitations may emanate from possible unnoticed biases arising from the use of an instrument developed by an inexperienced researcher and from possible incorrect information given by respondents.

5.5 SUMMARY

Chapter 5 discussed the research findings based on results of data analysis and interpretation presented in chapter four. These findings were presented and discussed under the headings of the research objectives.

In general the findings showed the level of men's involvement amongst respondents was moderate and that knowledge had a positive influence on involvement, while socio-cultural factors had a negative influence, Limitations of this study were mentioned. On the basis of these findings, recommendations were also put forward on how men's involvement could be promoted.

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QUESTIONNAIRE

My name is and I am a fourth year student in the Department of Demography and Social Statistics, Faculty of Social Science, Federal University, Oye-Ekiti. I am conducting a survey on men's involvement in prevention of mother-to-child transmission of HIV programmes in Federal Teaching Hospital Ido-Ekiti, Ekiti State, Nigeria. The overall aim of this study is to equip men with sound knowledge about mother-to-child transmission of HIV programmes. The questionnaire usually takes between 20 and 60 minutes to complete. Whatever information you give will be strictly confidential and will not be shown to other persons. The study is solely for the purpose of improving men's involvement in PMTCT programmes.

SECTION 1: DEMOGRAPHIC CHARACTERISTICS

- 1 What is your age as at last birthday? ____
- 2 What is your highest level of school education? ____primary education
____secondary education ____university education
- 3 How long have you been living with your wife/partner? ____ Less than 5 years ____ 5 to
10 years ____ More than 10 Years
- 4 What religion do you belong to? ____Christian ____Muslim ____Traditional ____Other
religion specify
- 5 What tribe are you _____

SECTION 2: KNOWLEDGE AND AWARENESS OF PMTCT.

- 1 Can a mother who is HIV positive transmit the AIDS virus to her child during Pregnancy and breastfeeding? Yes No Don't know

- 2 In your own opinion, can giving Anti Retro Viral drugs to the mother and the Child and avoiding breastfeeding reduce the chance of transmission of HIV from a mother to her child? Yes No Don't know.

- 3 Have you ever heard about a programme called Prevention of Mother to Child Transmission (PMTCT) Yes No Don't know

- 4 Are PMTCT services offered at Federal Teaching Hospital Ido Ekiti? Yes No Don't know.

SECTION 3: SOCIO CULTURAL FACTORS:

1. A pregnant woman can be tested for HIV without the permission of her husband/partner. Yes No Don't know

2. Men should accompany their pregnant wives/partners to ANC/PMTCT clinics. Yes No Don't know

3. It is a taboo for men to discuss with women about HIV testing during pregnancy. Yes No Don't know

4. Couples can use condoms to reduce chances of mother to child transmission of HIV. Yes No Don't know