Research in Gender and Ethics (RinGs): Building stronger health systems

Strengthening male involvement in the prevention of mother-to-child transmission of HIV in Enugu State, Nigeria

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This policy brief sets out the findings of an in-depth assessment of the extent of male involvement in prevention of mother-to-child transmission (PMTCT) in Enugu state, Nigeria and the effects on women's access to and use of PMTCT services. It also highlights strategies that could be used to strengthen male involvement in PMTCT.

Key messages

- **Male involvement in PMTCT is low in Enugu state, Nigeria.**
- **The level and extent of male participation in PMTCT are influenced by individual and relationship factors, gendered norms and expectations, and health system factors.**
- **Women do not discuss their visits with their male partners for fear of the repercussions of disclosure; non-disclosure of HIV status to male partners hinders male participation in PMTCT.**
- **Maternal and child health services, on the whole, are not designed with men in mind, and men often do not feel welcome or needed in PMTCT.**

Background

The prevalence of HIV among children in sub-Saharan Africa (SSA) is high and Nigeria has the second highest HIV prevalence in SSA. In Nigeria, the risk of mother-to-child transmission of HIV in children below the age of 15 is between 25-40% (Federal Ministry of Health Nigeria 2010). In 2010, the Nigerian government became committed to achieving 50% reduction in mother-to-child transmission of HIV and improving HIV counselling and testing. Factors contributing to a high mother-to-child transmission rate include: high prevalence of HIV among women of reproductive age, high fertility norms, prolonged breastfeeding, and sub-optimal implementation of measures to prevent vertical transmission of HIV during labour or delivery (National AIDS/STIs Control Programme 2014).

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PMTCT services offered to women in Nigeria include: ante-natal care, basic information about HIV transmission and prevention; HIV counselling and testing; prevention of unintended pregnancy; and antiretroviral treatment. Efforts to improve uptake of PMTCT in Nigeria and other SSA countries have been hindered by the lopsided focus on medical interventions while neglecting the social factors that contribute to mother-to-child transmission (Theuring et al. 2009). A lack of male involvement is considered a key challenge to the uptake of PMTCT (Morfaw et al. 2013). Male involvement entails male participation in PMTCT programmes. Potential benefits of male involvement in women's access to PMTCT include: better adherence of women to antiretroviral treatment and other practices to ensure delivery of a baby who is HIV negative, the empowerment of men to support their female partners financially and emotionally, and, the ability of women in discordant relationships to disclose their status without fear of stigma (Kalembo et al. 2013).

Methods

This research was conducted in Enugu state by researchers from the Health Policy Research Group (HPRG), University of Nigeria. Data were collected between September 2015 and February 2016 through review of published and grey literature, one-on-one in-depth interviews (IDIs) with key stakeholders in HIV control, women living with HIV and their male partners, and focus group discussions (FGDs) with male and female members of support groups. A total of 30 IDIs and 4 FGDs were conducted.

Key Findings

Male partners' participation in PMTCT

Only a few men accompanied their wives to antenatal care. Men's attendance with their partners to teachings on prevention of unintended pregnancies and HIV counselling and testing was also reported to be low. Women were said to come for their antiretroviral treatments alone and on some occasions would also collect medicine for their partners.

Factors affecting men's participation in PMTCT

Factors which contributed to the limited participation of men in PMTCT included individual and relationship factors, gendered community norms and expectations, and health system factors.

Individual and relationship factors

Individual and relationship factors, included: time constraint, poor spousal communication, and non-disclosure of status to one's partner.

"The reason why it is difficult for men to participate in PMTCT services is just because of time. Because the work men do, keeps them busy, like if a man is a driver, he will not be at home at the time his wife may want to go and access the PMTCT services. So, time is the main problem we have"
(P8 FGD Male support Group Nsukka).

"Most of them will confide in you, "my husband is negative, he doesn't know I'm going to this place; please, I don't want him to know". That is what they will tell you. And others will tell you, I am positive, I don't know about my husband"
(Health worker 2, at Facility A).

"...Because maybe, he has no clear knowledge of what the woman is going through, the issue of PMTCT, the need to assist her during that period. If he has clear knowledge of the situation, definitely he will make time to accompany her"
(P1 FGD Male support group Enugu).

Gendered community norms

Gendered community norms and expectations included: pregnancy being perceived as a woman's responsibility, male dominance in household decision making, and ridiculing of men who accompany women to ANC visits.

"...What happens to men all the time is that they feel that family planning is always for the women... that it is the women that need such services...that is why I don't follow my wife to go for it"
(P6, FGD male support group, Nsukka).

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"They see it as woman's work, to go for PMTCT services, especially this ANC"
(Health worker 3 at Facility B).

"For the man, it will look as if the woman now rules him"
(P3, FGD Female support group Nsukka).

Health system factors

Health system factors included: that antenatal care is woman focused, unwelcoming attitude of health workers to men who accompany their partners, and scheduling of different antiretroviral appointments for couples.

"...There are lots of things that cannot interest the male folk at the ante-natal... Yes, it is a woman's world; so you go there to discuss women and nothing for men"
(P3, FGD Male support group Enugu).

"We designed it (antenatal care, PMTCT, post-natal care) in such a way that men are excluded here."
(Health worker 4 at Facility A).

"The attitude of the nurses at times contributes a lot to why some don't like to follow their wives for antenatal"
(P2, FGD Male support group Enugu).

"The date of appointment differs. Because my wife will be coming next week and my own falls today. So, there is no way we can come together"
(P3, FGD, male support group, Nsukka).

Effects of male involvement (or lack of) on access and use of PMTCT by women

Perceived benefits of male partner participation in PMTCT included: male partners understanding and accepting the programme, women being more free to access the programme, reduction of the effects of male dominance on access to and uptake of PMTCT, male partners being better positioned to support their female partners emotionally and financially, couples being more able to work together towards preventing unintended pregnancies, and the promotion of adherence to treatment.

"So what I think that men do which is cultural for us is to ensure that the woman has the means of transportation to the clinic. And that is precisely the same thing that those whose wives are HIV infected do. The key male involvement in PMTCT is trying to understand that this woman needs to take her drugs everyday whether they are concordant positive, or discordant"
(Health worker 4 at facility A).

"... I receive my ART drugs in the same facility with my wife. And I normally make sure every morning, at 8 o'clock, I take the drug, my wife takes hers too, and in the night we take our drugs at the same time"
(P5 FGD Male support group Enugu).

Lack of men's involvement in PMTCT was found to contribute to: difficulty in breastfeeding properly or as recommended for a HIV positive woman, difficulty with keeping to scheduled ANC appointments, inability to discuss outcome of counselling visits, inability to discuss prevention of unwanted pregnancies, and poor adherence to antiretroviral treatment (drugs).

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Recommendations

Several strategies were identified that could be put in place to enhance male involvement in PMTCT:

- Public sensitization on the benefits of men accompanying their wives for PMTCT.
- Empowering male partners with adequate knowledge to allay their fears and eliminate misconceptions.
- Appreciation and recognition of male partners when they come to the clinic with their female partners.
- Making PMTCT services, and indeed all maternal and child health services, more male-friendly.
- Encouraging women to communicate to their partners their desire to be accompanied to the health facility for PMTCT.
- Health workers should be present when partners disclose their status. This will enable timely provision of counselling and reduce the likelihood of violence, stigmatization or extreme decisions against an infected partner.
- Government policy should be amended to ensure availability of adequate number of health workers in both public and private health facilities providing PMTCT services to reduce waiting times and enhance effective time management.
- As donor supply of ART drugs is dwindling and cost is a constraint for clients in accessing ART drugs in some private health facilities, government should embark on a policy of subsidizing ART drugs in private facilities as a strategy of sustaining their PMTCT programmes, and ensure free supply of ART drugs to public facilities.

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