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Midwives' perspectives on male participation in PMTCT of HIV and how they can support it in Lusaka, Zambia

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ABSTRACT

Objective: the purpose of this study is to describe midwives' perspectives on (1) male participation in Prevention of Mother-To-Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV) and (2) the methods that could be used to improve male participation in the Lusaka District, Zambia.
Design: a qualitative descriptive study. Data were collected using 10 open-ended questions.
Setting: 25 public antenatal clinics in the Lusaka District, Zambia.
Participants: midwives ($n=45$).
Findings: content analysis highlighted that a male partner can prevent his wife and his infant from being exposed to HIV by preventive behaviour in their intimate relationship and by utilising health-care services. Several barriers to male participation were identified. These were linked to the male partner himself, to health-care services and to society. Stigma as a multifaceted barrier was considered to permeate every level. The sources of the resources that a male partner needs to prevent Mother-To-Child Transmission (MTCT) were the male partner himself, health-care services and society. The methods that midwives can use to improve male participation were the following: first, influencing individuals, the community, employers and health personnel; second, intervening in risk behaviour; and third, providing disease intervention services.
Key conclusion: male participation in PMTCT of HIV is diverse, not only in HIV testing at the beginning of pregnancy, and it is influenced by various dimensions. Midwives' methods to improve male participation were broad, extending outside the antenatal clinic. A shortage of midwives and other typical issues of limited resources of developing countries pose challenges to male participation in PMTCT of HIV.
Implication for practice: the study showed that cultivating a male-friendly approach in antenatal care is urgent to protect infants.

Introduction

In many African countries the Human Immunodeficiency Virus (HIV) prevalence is high (WHO, 2010). This is also the case in Zambia, where in 2009 14.3% of the total population (12.9 million) had HIV, and in the Lusaka Province 20.8% had been diagnosed with HIV in 2007 (Zambia Country Report, 2010). HIV is a serious problem among families: in the Lusaka District, the HIV prevalence among pregnant women was about 21% (Stringer et al., 2008). The World Health Organization (WHO) has recognised this serious health concern and recommended the introduction of Voluntary Counselling and Testing (CVCT) for Couples in countries with a high HIV prevalence (WHO, 2002). In this task, midwives have an important role and midwives in Zambia are guided to encourage pregnant women to invite their partners to accompany them on visits to the clinic. The National Program of Prevention of Mother-To-Child Transmission (PMTCT) of HIV offers opportunities for HIV counselling and testing and involves male partners in the programme when necessary (National Protocol Guidelines of Zambia, 2008). The problem is, however, that the facilities offering antenatal services suffer from a shortage of midwives. The estimated number of working midwives was 2050 in 2008, when the minimum level required to meet the need is 4751 (Tjoa et al., 2010).

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Unfortunately, male partners have been reluctant to attend antenatal clinics for HIV testing (Msuya et al., 2008; Becker et al., 2010; Byamugisha et al., 2010a; Conkling et al., 2010; Larsson et al., 2010; Orne-Gliemann et al., 2010). On the other hand, in a recent Zambian study, it appeared that men had not been allowed to go inside the clinic. Men had also encountered unfriendly health workers (Auvinen et al., submitted for publication-b). Practices and attitudes that are not male friendly are not conducive to male participation in pregnancy monitoring at the clinics. Similarly, Theuring et al. (2010) found in Tanzania that health-care providers' attitudes towards male involvement were twofold. On one hand, the providers accepted male partners' overall involvement in the services. But on the other hand, the providers had restrictive attitudes towards male participation in the services. This was the case especially if the services were related to perinatal examinations or childbirth.

Midwives' attitudes and practices have been assessed in relation to male participation in PMTCT, which is not, actually, well defined. Male participation in PMTCT of HIV may refer only to males' HIV testing or to their involvement in the whole maternal or reproductive process. Midwives are aware of the opportunities and challenges in PMTCT in the families, and thus they are important informants to explore this relatively new aspect. The study provides an additional viewpoint on clinical practice in improving male participation. We therefore described midwives' perspectives on male participation in PMTCT of HIV and the methods that could be used to improve male participation.

Methods

Zambia is divided into nine provinces which are divided into 72 districts. The Lusaka Province is situated in south-east Zambia and borders on Mozambique and Zimbabwe to the east. The capital city Lusaka is situated in the Lusaka District, where all the 25 districts' antenatal clinics are located and where the data were collected. At the time of data collection, from April to June 2010, 11 of the 25 clinics had childbirth facilities. Midwives have two types of education: registered midwives have three years of nursing education and one year of midwifery and enrolled midwives have two plus one respectively.

The data were decided to be collected using forms with 10 open-ended questions on which the midwives were asked to write their views about male participation and how it might be improved in clinical practice. Due to practical obstacles, e.g. lack of proper venues and midwives' heavy burden of work, interviewing as a data collection method was not considerable. The open-ended questions were as follows:

1. How in your opinion can a male partner prevent his wife from being exposed to HIV during pregnancy?
2. How can you improve it in your practice?
3. How in your opinion can a male partner prevent his infant from being exposed to HIV during pregnancy, childbirth and feeding of the infant?
4. How can you improve it in your practice?
5. What in your opinion are the barriers that inhibit a male partner from preventing his infant from being exposed to HIV?
6. How can you eliminate these barriers in your practice?
7. What in your opinion are the resources that a male partner needs to prevent his infant from being exposed to HIV?
8. How can you increase these resources in your practice?
9. How in your opinion can HIV-related stigma inhibit male participation in preventing mother to child transmission of HIV?
10. How can you remove this negative effect in your practice?

Each form package had an informed consent sheet to indicate the participant's voluntariness and the background variable sheet. Institutional approval to conduct the study was obtained from the Biomedical Research Ethics Committee of the University of Zambia and from the Ministry of Health, Lusaka District Health Management Team.

Altogether fifty copies of open-ended question forms were given to the antenatal clinics in the Lusaka District, including both clinics that did not have childbirth facilities and clinics that had them (Table 1). The number of forms given to the clinics depended on whether the clinic had childbirth facilities and on the number of the midwives at each clinic. The 14 clinics that did not have childbirth facilities were given one from each because the number of midwives was less than eight. Clinics with childbirth facilities and where the number of midwives was 10–18 were given three forms, and if the number of midwives was 19 or more, the clinic was given four forms.

The forms with envelopes were given to the person in charge of each clinic and she/he was informed about how to proceed (sharing the form packages to the midwives, underlining the voluntary participation and the confidentiality of the study, and collecting the forms on time). The first author collected the returned form packages, which were in closed envelopes and paid 10,000 ZMK (approximately 1.9 USD) as a token of appreciation to the participants. In total, 45 of 50 forms were eligible for analysis. Two forms were returned empty and three were missing.

The qualitative data were analysed using inductive content analysis (Miles and Huberman, 1994). The forms were number coded to ensure confidentiality. The answers were read through several times and they were transcribed. Transcription was used as a data management strategy. A unit of analysis was any meaningful element or word of text and they were looked at depending on the purpose of the study. The transcribed data were reduced. In reduction (or coding) the original data were condensed aiming to capture all the important information. The codes, which were the outcomes of the data reduction process, were further coded into the lower categories and labelled. The lower categories were compared to each other and the analogous lower categories were grouped together, creating the upper categories. The main categories were created upon the analogous upper categories. The codes yielded from the data, have been understood as equal and their value is not in the high frequency but in diversity (Stern, 1991; Polit and Hungler, 1995). The findings were discussed in the research team.

Findings

All participants ($n=45$), were females, aged 45.7 years on average and most of them were married (Table 2). The participants were enrolled midwives and registered midwives (22 versus 21) and only one of them had a university level degree.

Table 1
Collecting the data.

Type of data	Sampling	Sample size	Eligible for analysis
Written answers to the open-ended questions	Purposive, 14 antenatal clinics without childbirth facilities	14, midwives	13
	Purposive, 11 antenatal clinics with childbirth facilities	36, midwives	32
	In all 25 antenatal clinics	Total 50	Total 45