ACCEPTABILITY AND SATISFACTION OF MALE PARTNERS WITH ANTENATAL CLINIC-BASED HIV TESTING FOR PMTCT AT OLD-MULAGO HOSPITAL, UGANDA

BY

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A dissertation submitted to Graduate School in partial fulfillment of the requirements for the award of Master of Health Services Research of Makerere University

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Declaration

I**, Amos Drasiku** do hereby declare that the work submitted in this thesis is original and a result of my own study except where otherwise stated and acknowledged. This dissertation has not been submitted for any other degree award in this or any other university or institution in Uganda or elsewhere.

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Signature **Date**

My supervisors do hereby certify that they have read and recommend to the school of Graduate Studies and Research for acceptance, this thesis titled "Acceptability and Satisfaction of Male Partners with Antenatal Clinic-based HIV testing for PMTCT at Old-Mulago Hospital, Uganda" by Amos Drasiku in partial fulfillment of the requirements for the award of a degree of Master of Health Services Research.

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DEDICATION

"To Joint Clinical Research Centre for her commitment in health research especially HIV/AIDS and TB, from where I gained some experience that inspired me to take a research career and made me qualify for this course"

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Lastly for those whose names or positions I have not mentioned here, please your contribution is recognized. Thank you very much.

Operational Definitions

Acceptability of ANC-based HIV counseling and testing

This refers to undergoing HCT in the antenatal clinic and receiving the results. This includes men who tested for HIV in the antenatal clinic on the interview day together with their wives or alone irrespective of any prior HIV tests.

Antenatal HIV counseling and testing for PMTCT

Is the process where antenatal mothers and/or their spouses undergo counseling to enable them make informed choices about being tested for HIV and subsequent preventive and/or care choices.

Antenatal mother: This is a pregnant woman seeking antenatal services in preparation for safe delivery.

Counseling: This refers to a confidential dialogue between a client and a care provider to enable the client make an informed decision on HIV testing and subsequent preventive and/or care choices.

Discordant couples: These are couples where one sexual partner is HIV infected and the other is not.

Male partners' Satisfaction: Male partners' perception of whether or not antenatal HIV testing meets their expectations.

PMTCT: PMTCT is a package of interventions to reduce chances of a HIV infected mother transmitting the virus to her baby during pregnancy, birth and after birth.

Service duration: This is the time taken by male partners from arrival through receipt of HCT to departure from the clinic.

Staff composition by gender: This refers male to female ratio of the service providers.

List of acronyms and abbreviations

AHCT	-	Antenatal HIV Counseling and Testing
AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	Antenatal Clinic
AOR	-	Adjusted Odds Ratio
COR	-	Crude/unadjusted Odds Ratio
AHCT	-	Antenatal HIV counseling and testing
FGD	-	Focus Group Discussion
HCT	-	HIV counseling and testing
HIV	-	Human Immunodeficiency Virus
MCH	-	Maternal and Child Health
MOH	-	Ministry of Health
MUSPH	-	Makerere University School of Public Health
MTCT	-	Mother to Child Transmission
NCST	-	National Council of Science and Technology
PMTCT	-	Prevention of Mother to Child Transmission
PLWHA	-	People Living with HIV/AIDS
SSA	-	Sub-Saharan Africa
TBA	-	Traditional Birth Attendants
UAC	-	Uganda AIDS Commission
UNAIDS	-	Joint United Nations Program on HIV/AIDS
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization

Abstract

Introduction: Despite benefits of and strategies to increase male partner participation in AHCT at Old-Mulago ANC, their attendance has remained very low (15.8% tested). It is not clear whether they accept AHCT and how satisfied those who have undergone it are.

Methodology: A cross-sectional study of 214 male partners of antenatal mothers at Old-Mulago ANC selected by simple random sampling was done. Quantitative data was collected using semi-structured interviewer administered questionnaires. Multivariable logistic regression analysis were performed in Stata 10SE to obtain Odds ratios of satisfaction and their 95% CI so as to identify factors which influence satisfaction with AHCT services. Qualitative data was obtained through four FGDs and analyzed by thematic content analysis method.

Results: AHCT acceptance was 99.8%, most respondents (81%) were satisfied with their overall AHCT experience and 71% were satisfied with service setting. FGD participants reported that AHCT for male partners is good but some men do not want to be tested together with their wives. The FGD participants too reported satisfaction with AHCT services. Factors with statistically significant association towards overall satisfaction were cleanliness/hygiene (AOR 2.53, 95% CI 1.12-5.70) and service duration (AOR 13.05, 95% CI 2.97-57.44).

Conclusion/Recommendation: Men who escort their wives to the antenatal clinic tend to accept AHCT and tend to be satisfied with the testing experience. However, service duration should be reduced by minimizing delays and commencing work early. More staffs should be allocated to the antenatal clinic especially for antenatal examinations and laboratory.

CHAPTER ONE

1.0 INTRODUCTION AND BACKGROUND

1.1 Introduction

Despite decades of prevention efforts, millions of persons worldwide continue to get infected by the Human Immunodeficiency Virus (HIV) annually. By the end of the year 2008, about 33.4 million people including 15.7 million women and 2.1 million children less than 15 years were living with HIV/Acquired Immuno-deficiency Syndrome (AIDS) globally. In 2008 alone, 2.7 million people got infected with HIV globally, of whom 430,000 were children under 15 years. The greatest burden of HIV/AIDS worldwide continues to be carried by Sub-Saharan Africa (SSA) with 22.4 million people living with the disease by the end of the year 2008. About 1.9 million people including 390,000 children below 15years acquired HIV infection in 2008 (1). In Uganda, 135,300 people got infected with HIV in 2007, of whom 19,500 were children below 15 years (2). Globally, most of the HIV infections in the children occur through mother to child transmission (MTCT), a mode of infection that is preventable through Prevention of Mother-to-Child Transmission (PMTCT) interventions.

Prevention of mother-to-child transmission (PMTCT) is a four pronged strategy to prevent pediatric HIV infections. The four prongs include primary prevention, prevention of unintended pregnancies among HIV infected women, prevention of HIV transmission from HIV infected pregnant women to their babies (core PMTCT intervention) and provision of treatment, care and support for HIV infected women, their children and their families. The core PMTCT interventions include HIV counseling and testing (HCT), Antiretroviral therapy (ART) and or

Antiretroviral Drugs (ARVs) prophylaxis for the HIV infected mother and her baby, and counseling on infant feeding.

1.2 Background

Prevention of Mother-to-Child Transmission (PMTCT) of HIV is one of the many strategies used to curb the HIV/AIDS epidemic in Uganda. The PMTCT services were piloted in Uganda in 2000 and by mid 2008, 57% of all health facilities up to health centre III were implementing core PMTCT interventions (the third prong of the comprehensive PMTCT package) (3).
The core PMTCT services have been integrated into routine maternal and child health (MCH) programs including antenatal care which traditionally are attended by women. During antenatal care, mothers and their husbands are tested for HIV thus offering the opportunity to identify and serve couples who need to receive PMTCT interventions. Currently, the PMTCT policy in Uganda requires all antenatal mothers and their male partners to undergo HCT in the antenatal clinics but very few male partners are reached. The PMTCT program also aims to increase the proportion of male partners of pregnant women who are offered HCT services from 3% to 25% by 2010 (4). The program hopes to achieve this target through appropriate linkage with the general HCT services but the progress is slow with only 5% of male partners tested between mid 2007 and mid 2008.

The antenatal clinic at Assessment centre, Mulago National Referral (NRH) is one of the sites offering PMTC services including HCT for the mothers and their husbands. On average, 1833 new antenatal mothers and 290 male partners are tested for HIV in the clinic monthly. All the antenatal mothers and their partners who escort them are registered. They then receive health education and group counseling about syphilis, HIV infection, PMTCT and the occurrence of

HIV discordance within couples. They are offered individual or couple counseling before blood samples are drawn for testing at an on-site laboratory providing same-day results. Couples are served quickly so as to minimize time men spend in the clinic. New antenatal mothers who have not come with their partners are given invitation letters to invite them. The antenatal clinic is manned by midwives, counselors, laboratory personnel and nursing assistants.

On week days, the clinic offers free antenatal services including HIV counseling and testing for antenatal mothers and their male partners from 8.00am-5.00pm. Registration of new clients and retrieving files for mothers who had visited the clinic before for the current pregnancy starts before 9am and continues as more clients come. Health education starts at around 9am and lasts 30-45 minutes. Clients for HCT are sent to the counseling department when health education is over. Group, couple and individual HIV counseling is done. On average, the first groups of couples or mothers finish pretest counseling at around 10.30am and then go for bleeding. On average giving out HIV test results begins from noon and most people receive their results by 3pm. While waiting for results, history taking, antenatal examinations, and drug supply are done. During the male access clinic (Thursday 5:00pm) registration and pretest counseling start at around 6pm followed by HIV testing. As they wait for results after bleeding, health education is given. On average, giving out their HIV test results begins at around 8.30pm and ends by 9.30pm depending on the numbers of clients present.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Mother to Child transmission of HIV

Perinatal transmission of HIV from an infected mother to a child is the most common mode of infection among new born infants. Without any prevention intervention, the risk of MTCT ranges from 15-45% (5). The transmission risk being higher among mothers with advanced disease, low CD4 counts, high viral load and maternal infections such as herpes simplex (6). A study in Uganda showed that without any prevention intervention the transmission risk is 27.5% (4).

Transmission risk with prevention interventions varies from site to site. This depends on a number of factors such as obstetric care, ARVs use and mode of infant feeding. Recent data from early diagnosis of HIV among exposed infants in the era of PMTCT shows that 18.2% acquire the infection. Whether or not all received PMTCT intervention is not known (7). Among those exposed to single dose Nevirapine, 15.7% had acquired the infection (8). However, result of PMTCT interventions at Nsambya hospital indicates transmission risk of 7.6% (9).

2.2 The PMTCT Interventions

PMTCT is one of the main strategies to combat HIV globally. Four elements constitute a comprehensive approach to preventing HIV in infants and young children. These include primary prevention of HIV transmission, prevention of unintended pregnancies among women living with HIV, prevention of HIV transmission from pregnant women living with HIV to their

babies and Provision of treatment, care and support for women living with HIV, their children and families (6).

The package of interventions to reduce transmission by HIV infected mothers include antenatal HIV counseling and testing for the mother and her male partner, Antiretroviral treatment or prophylaxis for the mother and baby, modification of obstetric care and infant feeding (4). HIV counseling and testing for PMTCT mainly takes place in the ANC. It increases knowledge of HIV status, identifies HIV infected pregnant mothers to receive HIV treatment or prophylaxis for mothers and their babies. It also prepares the mothers or couples for appropriate infant feeding, promotes safer sex especially among discordant couples thus reducing transmission.

PMTCT services have been scaled up in many countries with varying successes. In developed countries, where comprehensive interventions are used with good adherence, transmission risk has been reduced from 13–43% to less than 2% (10). In resource-poor settings where elective caesarean section and formula-feeding are less feasible options, the MTCT rate can be reduced to less than 10% through the use of antiretroviral drugs (10). Such a result has been achieved at Nsambya hospital where transmission risk has reduced to 7.6% (9).

The PMTCT program in developing countries including Uganda has been confronted with several challenges. These include low enrolment for PMTCT by women, failure to adhere to the interventions, home deliveries and loss to follow-up. These result from social cultural factors which include lack of or limited male involvement in PMTCT programs, stigma and community attachment and trust towards the traditional birth attendants (TBAs) (11).

Despite routine opt-out HCT in ANCs using rapid tests with same-day results, 2.8% of counseled women opted not to get tested (12). If such a mother is HIV infected then she will not access the available interventions to avert HIV infections in their infants. The main reason given for not accepting HCT was the need for a partner's consent or presence before testing followed by fear of knowing one's status or disclosure of the test result to one's partner. Perceptions about the husband's approval have been shown in a rural Ugandan context to be a strong predictor of willingness of antenatal mothers to be tested (13-14). Low levels of community awareness and mobilization also negatively affects PMTCT program (11).

2.3 Acceptance of AHCT by men

Attendance of antenatal clinics by couples and male partners of pregnant women has remained low in many parts of Africa despite efforts to attract the men. Acceptance of AHCT can be measured at three levels such as proportion of male partners who escort their wives to the ANC, proportion of those tested and proportion of those who received results. However, only those who receive their HIV test results can access PMTCT interventions. Studies have reported men's willingness to accompany their wives to ANC and labor wards especially the qualitative study in Tanzania which showed that men aged 20 to 34 years desire to escort their wives to ANC and labor wards. However, when they go with their wives, the nurse-midwives tell them to remain outside the examination or labor-rooms, making them bored and discouraged (15).

Another study in Moshi to describe the prevalence, predictors and effects of male partner participation in HIV voluntary counseling and testing (VCT) on uptake of HIV perinatal interventions found 13% (332/2654) attendance by men. All of them were counseled and tested (16).

Studies in Uganda have also reported low attendance of antenatal clinics by male partners. A cross-sectional study between December 2004 and September 2005 to compare acceptability, feasibility and uptake of maternity and ANC PMTCT services found only 107 out of expected 3696 men accompanied their wives to ANC. Ninety seven percent (97%) of the male partners who escorted their wives to the ANC accepted HCT (12). Similar findings were reported in a study to examine uptake of HCT by pregnant women and their male partners at ANC in Entebbe and compared with uptake of syphilis testing. Only 236 male partners underwent HIV and syphilis counseling, of whom 191 (80.9%) requested syphilis and HIV tests, 41 (17.4%) requested HIV testing only and 4 (1.7%) requested syphilis testing only. This shows only 1.8% of women tested had partners who accepted an HIV test (17). Apart from the woman's HIV status, this study did not assess factors associated with AHCT acceptance as well as their satisfaction with the services. In these studies, pregnant women were told to inform their partners and encourage them to come to the antenatal clinics for HCT.

2.4 Role of men in PMTCT

Men are the sexual partners of the pregnant women. They can infect their wives with HIV or be infected especially in discordant relationships where they are unaware of their status hence unlikely to practice safer sex (18). Although 93.5% of all pregnant women in Uganda are HIV negative, some of them are at high risk of infection due to serodiscordance of their male partners. Five percent of married or cohabiting couples, 9.5% of couples in antenatal clinics are discordant and sero positivity is equal in males and females (12, 17, 19). Unfortunately, most of these discordant cohabiting couples are not aware of their HIV status and therefore not motivated to take action towards prevention such as using condoms consistently. This can be seen in a case

where a mother tested HIV negative during ANC, her husband not tested and few months after delivery the baby diagnosed with HIV/AIDS. The mother tested HIV positive with high CD4 count and her husband too tested positive but with low CD4 count (20). This implies recent infection in the mother possibly from her husband. This is possible because of increased risk of HIV infection during pregnancy due to physiological changes (21).

As husbands and fathers of the children, they make decisions for their wives on whether, where and when to seek antenatal, intra and postpartum care (18). PMTCT is a multi-step intervention requiring serial decisions and actions on the part of women. Unfortunately most women in Uganda like majority of Sub-Saharan African cultures are not empowered to make decisions especially concerning family resource allocation and reproductive choices or get involved in activities without the consent of their male partners. This too affects acceptance and adherence to PMTCT services. The influence of partner in decision making regarding HIV testing has been demonstrated in a study conducted in Mbarara district. Women attending PMTCT programs who thought their husbands would approve of their HIV testing were almost six times more likely to report willingness to take an HIV test (22). The study did not assess whether the male partners would also be willing to take up HIV test in the ANC.

For men with HIV positive partners, they allow their wives to access ARV for themselves and their babies. They also permit and support modification of infant feeding. They make informed choice on future child bearing as a couple (18). A cohort study in Nairobi ANC in 2004 showed increased uptake of interventions to prevent vertical and sexual HIV-1 transmission by HIV infected mothers whose spouses participated in VCT. Women whose partners came to the

antenatal clinic for counseling were more likely to receive Nevirapine during follow-up, avoid breastfeeding their infants and report condom use. The association between partner participation and uptake of these interventions was strongest when partners who came to the clinic agreed to be counseled as a couple (23). Similar findings were reported in Uganda (17). When male partner is involved, they are likely to support their wives at critical decision making points such as whether to take HIV test, ARV, practice safer sex and family planning and support safer/appropriate infant feeding methods. As family heads, they provide financial, psychosocial and other logistical support for their wives to access MCH services thus improving maternal child health and survival (18).

2.5 Barriers to male involvement in Antenatal HCT

Offering HCT at antenatal clinics has been the main entry point into PMTCT programs, but few male partners are reached by this approach. This is partly due to the belief by men that antenatal care is solely for women, inconvenient ANC hours since most men work outside their homes, poor reception at the clinic and lack of awareness that they can make important contribution towards decreasing the spread of HIV/AIDS (15). In addition to the above barriers, male partners are also hindered from attending ANC/PMTCT by lack of time, neglected importance and fear of HIV-test results (24). Similar barriers to male partner participation in antenatal HCT were found by studies in Uganda (25-26)

2.6 Satisfaction with HCT Services and associated factors

Satisfaction with health services is very important determinant of clients' decisions regarding choice of subsequent health care plans, compliance with regimens and outcome of the management. Before service utilization, clients have expectations of service quality and after service utilization; they have perceptions of the quality of services they receive. If their

perceptions exceed their expectations, then the clients are satisfied. However, several factors influence satisfaction with health services. These include demographic factors, social economic status and general health status, characteristics of the health provider such as experience, age and gender. Other determinants include the reliability of services, responsiveness of services, courtesy of providers and security of services, including the security of records and the physical facilities and equipment available, the appearance of the staff, how easy it is to understand communication materials. Physical comfort, emotional support and respect for patient preferences have been identified as the most important determinants (27).

Antenatal HCT is a component of MCH services offered in ANC for antenatal mothers and their male partners. The context and processes are unique from HCT in other settings especially for the men. A cross sectional study conducted in Dodoma Tanzania to assess clients' satisfaction with PMTCT services found that 28.2 % of clients who accessed PMTCT services were not satisfied with the waiting time spent at the facilities, 24.8% were dissatisfied with the counseling they received on PMTCT of HIV, 76% of clients were satisfied with privacy when accessing services (27). However this study did not include male partners who escort their wives for ANC plus AHCT.

CHAPTER THREE

3.0 STATEMENT OF THE PROBLEM, JUSTIFICATION, CONCEPTUAL FRAME WORK

3.1 Statement of the Problem

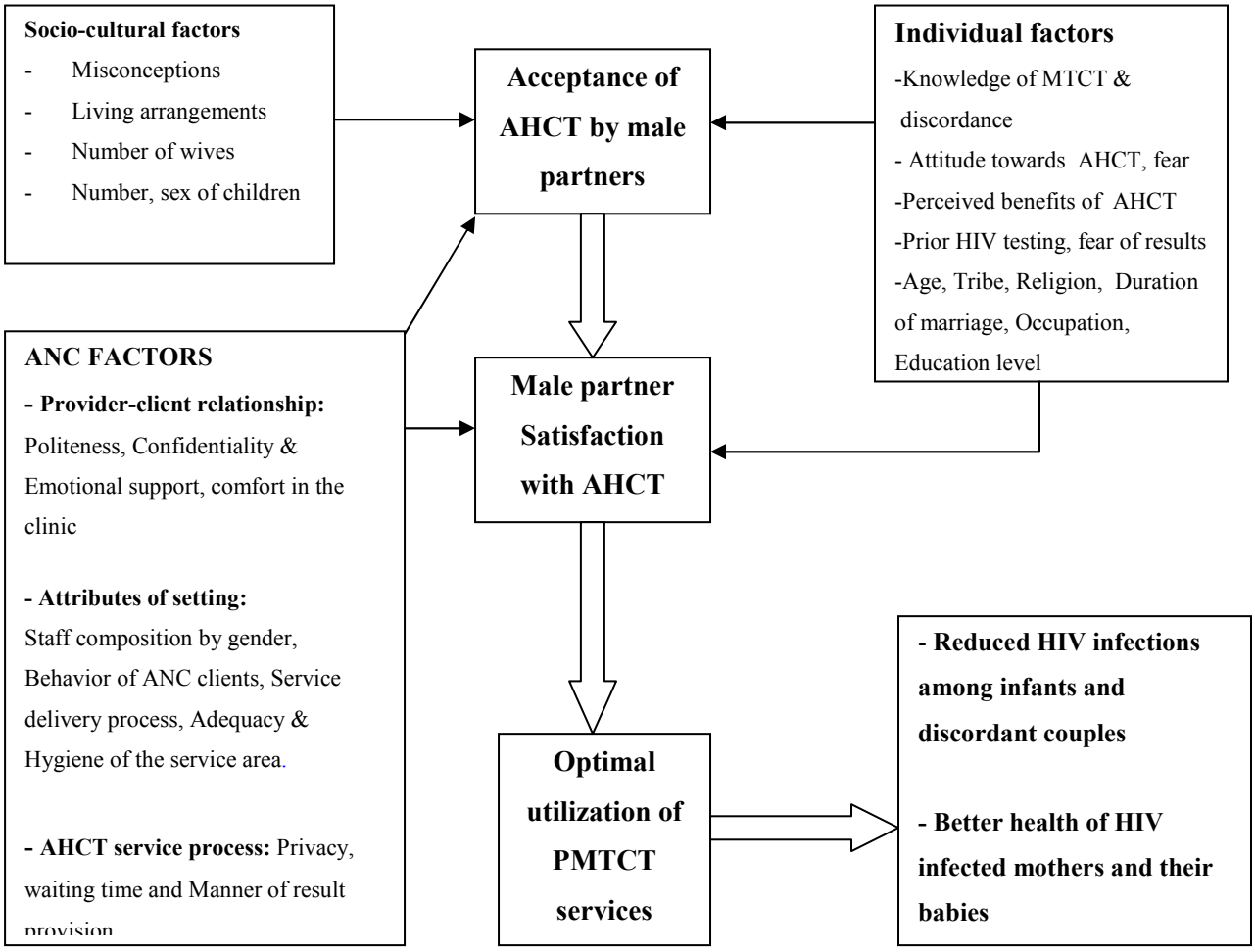
Despite benefits of and strategies to promote couple antenatal HIV testing in SSA, very few husbands do accompany their pregnant wives to the clinic and get tested together. In Uganda, only 5% and about 15.8% of the husbands of antenatal mothers attending ANC at Assessment centre, Mulago NRH are tested for HIV in the clinic together with their pregnant wives (ANC records 2008). Having few male partners tested for HIV in the antenatal clinic could impair uptake of and adherence to preventive interventions by their wives thus increasing the risk HIV infections.

To increase access to AHCT at Old Mulago ANC by male partners, mail invitations are sent through the ANC mothers to their husbands, couples are served as soon as possible and clinic time has been extended (Thursday 5:00pm-9:30pm). However, the response of male partners is still poor. Studies elsewhere reported associations of time constraints, societal stigma, and perceiving ANCs as women's spaces with low male partners AHCT uptake but non assessed men's satisfaction with their AHCT experience. Clients' satisfaction with services they receive is very important as it determines decisions regarding subsequent service usage, compliance with regimens/interventions and attracts more clients. Secondly, acceptance AHCT by the accompanying male partners at ANC in assessment centre, Mulago NRH is not well known. This study therefore assessed acceptance of AHCT by male partners and their satisfaction with the services.

3.2 Justification

There was insufficient information on AHCT acceptance by male partners of antenatal mothers at Assessment centre, Mulago NRH. In addition, whether men who undergo AHCT are satisfied with their HIV testing experience was not known yet their satisfaction can determine uptake of and compliance with a service or attract more users. This study generated an understanding of AHCT acceptance and satisfaction with the services by male partners. It helped to identify practices related to HIV testing in the antenatal clinic that meet the expectations of the male partners. It also helped to identify AHCT service delivery aspects that need to be improved to suit the needs of the men. The information generated could be of help to PMTCT program managers and service providers to improve services so that they are focused to the expectations of male partners or couples. This eventually would increase uptake of AHCT by male partners and identify couples that should receive PMTCT and other HIV preventive interventions. The study will inform policy makers on practices desired by male partners. The study also helped in making recommendations on the male focused interventions for other ANCs.

3.3 Conceptual Frame Work



The above framework shows that individual characteristics such as demographic factors, knowledge of MTCT and sero-discordance and attitudes towards AHCT influence acceptance of AHCT by male partners. Male partners' satisfactions with AHCT services may be affected by demographic factors. Dimensions of AHCT services such as interpersonal relationship, service setting including adequacy of clinic space and service characteristics like privacy could also

influence acceptance of AHCT services. For those who accept AHCT and undergo it, how satisfied they are with the three service dimensions determines how PMTCT services are utilized. This eventually determines the success of the PMTCT program evidenced by reduction in HIV infections among infants and discordant couples and better health of HIV infected mothers and their babies.

3.4 Research Questions

i. How acceptable is AHCT to male partners who escort their pregnant wives for antenatal care at Old-Mulago NRH?

ii. Are the male partners who escort their pregnant wives for antenatal care at Old-Mulago NRH satisfied with AHCT services they receive?

iii. What are the ANC factors associated with male partners' satisfaction with AHCT services at the ANC, Old-Mulago NRH?

CHAPTER FOUR

4.0 STUDY OBJECTIVES

4.1 General Objective

To determine AHCT acceptance level and satisfaction of accompanying male partners with the antenatal HIV testing services so as to identify best practices and areas for improvement.

4.2 Specific Objectives

i. To determine the level of AHCT acceptance by male partners who escort their pregnant wives for antenatal care at Old-Mulago NRH.

ii. To assess male partner's satisfaction with AHCT services at Old-Mulago NRH.

iii. To identify ANC service delivery factors associated with AHCT acceptance by male partners.

iv. To identify AHCT service delivery factors associated with male partners' satisfaction.

CHAPTER FIVE

5.0 METHODOLOGY

5.1 Study Area

This study was conducted at the ANC, Assessment centre, Mulago Hospital Complex. Mulago Hospital is the National referral hospital in Uganda located 2km north of the Kampala city centre. The clinic has two waiting areas; one for triage and the other for mothers awaiting clinical examination, vaccination and bleeding. It also has an onsite laboratory, separate counseling station, and consultation rooms where midwives and doctors examine the mothers. The majority of the service providers at all points including reception, laboratory, counseling and antenatal examinations are females.

5.2 Study participants

-**Study population**- All male partners of pregnant women who attend antenatal care at Assessment centre, Mulago NRH.

- **Target Population**- All male partners of pregnant women attending antenatal care at Assessment centre, Mulago NRH that visit the ANC for HCT for PMTCT.

- **Accessible Population**- All male partners aged 18 and above who escort their pregnant wives to or come after their wives' ANC visits for HCT for PMTCT and have undergone HCT at Assessment centre, Mulago NRH.

5.3 Study Design

This was a cross sectional study combining both quantitative and qualitative methods of data collection. The qualitative method was used to establish views of antenatal mothers and male

partners about AHCT for men. Quantitative method on the other hand, was used to establish acceptability and satisfaction of male partners with AHCT.

5.4 Sample Size

Sample size was determined using Kish Leslie formula (1965) for random sampling using single proportions.

$$n = Z^2_{\alpha/2}pq / d^2$$

Where;
n = Sample Size

z = Standard normal value corresponding to 95% confidence interval = 1.96

d = Margin of error ±5% = 0.05

p = Expected proportion of male partners tested at ANC Assessment centre Mulago hospital which is 15.8% (289/1833). That is the average number of male partners tested per month divided by average number of new antenatal mothers per month.

q = 1-p = 1-0.16 = 0.84

$$n = \frac{1.96^{2*}0.16*0.84}{0.05^2}$$

n=3.84*0.16*0.84/0.0025
n=0.52/0.0025=206
n=210

To cater for non response, 10% of the estimated sample was added to get the final sample size. Therefore the sample size for this study was to be 230 participants. A total of 214 male partners were interviewed thus giving a response rate of 93%.

5.5 Sampling Procedure

The study units were male partners who accompanied their wives to the ANC during the study period. They were approached at the point of clinic exit, randomly using ballot with replacement

and screened according to the study's inclusion criteria. Those who met the inclusion criteria were informed about the study objectives, procedures, benefits and risks. Written informed consent was obtained from male partners at point of clinic exit prior to interview.

5.6.0 Inclusion and Exclusion criteria

5.6.1 Inclusion criteria

Male partners aged 18 or older, who accompanied their pregnant wives to the ANC at Assessment Centre, Mulago NRH.

5.6.2 Exclusion Criteria

- Male partners with sick wives since they were referred.
- Male partners who accompanied mothers that were not their own wives.
- Male partners who were not tested for HIV on the day of interview.

5.7.0 Study Variables

5.7.1 Independent Variables

The independent variables assessed included respondents' age, privacy, service duration, adequacy of space, staff composition by gender, cleanliness/hygiene of the clinic, politeness of the staff, comfort of the clinic and convenience of clinic time.

5.7.2 Dependent variables

i. Acceptance of AHCT by accompanying male partners. Acceptance of AHCT here means undergoing HCT and receiving the results. This was measured as proportion of accompanying male partners who underwent HCT and received their results out of all male partners who accompanied their wives to the ANC. Men who had tested for HIV in

the clinic before the interview day or escorted mothers who were not their wives were excluded. These men were not counseled and did not take HIV test.

ii. Male partners' satisfaction with the AHCT services here refers to male partners' perception of whether or not antenatal HIV testing met their expectations. Male partners satisfaction with AHCT services was measured on a five point Likert scale (score 5 "very satisfied" and score 1 "very unsatisfied") through self reports. Satisfaction scores were grouped into two categories 'Satisfied if individual score was 4 or 5 and unsatisfied when less than 4' as was in a study conducted by a study in Tanzania (27). Service dimensions with which satisfaction was assessed included overall AHCT experience, service setting, interpersonal relationship with providers and actual services focusing on counseling and health education.

5.8.0 Quality control

5.8.1 Training Research Assistants

Two interviewers with research experience were selected and trained on the study procedures before the study began. They were trained for four hours per day for two days.

5.8.2 Pre-testing

The questionnaires were pre-tested among male partners in the ANC at Kiswa Health centre IV. Amendments were made accordingly and a final version of the questionnaires was made as agreed upon.

5.8.3 Translation of data collection tools

The consent forms, questionnaires and FGD guide were translated into Luganda and back translated to make sure that meaning of the contents of the tools were not altered.

5.9.0 Data Collection

5.9.1 Data collection Methods and Tools

Client exit interviews were conducted by the trained research assistants under the supervision of the Principal Investigator (PI). Quantitative data on acceptability and satisfaction were collected using semi-structured questionnaires administered by the research assistants in a private area. Visual aid (diagrammatic illustration of levels of satisfaction) was also used to enable respondents to rate their satisfaction (see appendix 10). In addition to the questionnaires, data on AHCT acceptance was collected using observation checklist to extract from clinic records the number of male partners registered, counseled, from whom blood samples were collected and received results.

Two focus group discussions (FGD) were conducted with male partners and two with antenatal mothers. Antenatal mothers who participated in FGDs were selected irrespective of whether they had ever undergone AHCT with their husbands or not. Each Focus Group comprised 6-7 informants aged 18 years or older. All the FGDs were facilitated by the moderator and tape recorded by the note taker. Each FGD lasted 40-45 minutes and the same FGD guide was used for each discussion. The interviews were conducted in English if all the selected members spoke it or in Luganda (most common local language spoken) for groups with participants who could not speak English.

5.9.2 Field editing of data

The research assistants were supervised during data collection. The filled questionnaires were cross-checked for completeness and accuracy or errors made during recording when the client

was still around. Discussions were held with research assistants regarding mistakes made, challenges faced and how to deal with them.

5.10.0 Data Management and Analysis

5.10.1 Data Management

Quantitative data was coded using predetermined codes and entered in Epi Info version 2002 with checks to avoid wrong or multiple entries. Data was entered daily by the researcher after every data collection exercise. Data was then cleaned and exported to Stata version SE 10 for analysis. Qualitative data was transcribed prior to analysis.

5.10.2 Data Analysis

i. Qualitative data: Contents of FGDs were grouped according to the emerging themes and analyzed manually through thematic approach.

ii. Quantitative data:

a. **Objectives one and two.** Univariate analysis was performed where descriptive statistics (percentages and frequencies) were used to summarize level of AHCT acceptance, satisfaction towards services and the independent variables.

b. **Objective three.** No further analysis was performed for objective three because of unidirectional outcome variable.

c. **Objective four.** Bivariate analysis was performed and associations between independent (service delivery factors) and outcome variable (satisfaction with overall AHCT experience) were assessed using cross tabulation. Strength of association was measured using Odds ratios and statistical significance assessed using P-values and

95% confidence intervals for the odds ratios. Fisher's exact test was done for variables with low cell values or observations (≤5). All independent variables with significant (P-Value <0.05) or border line significance (P-Value 0.15) of association with the dependent variables, biologically plausible variables such as age and variables known to be associated with the outcome variables in previous studies were considered for multivariate analysis. At multivariable analysis, logistic regression was performed to identify factors associated with satisfaction towards overall AHCT experience, control for confounders such as age and effect modifiers. All the variables entered in the logistic regression model were categorical with two levels except for age that had three levels. Strength of association was measured using Odds ratio at 95% confidence interval. Forward elimination method and log likelihood were used to identify variables associated with satisfaction towards AHCT services in the final models. The final models were checked for goodness-of-fit using estat gof command in Stata and model sensitivity tested by lstat command. The results are presented in tables and charts in the next chapter.

5.11 Dissemination of findings

The findings will be submitted as a dissertation in partial fulfillment of the requirements for the award of a degree of Master of Health Services Research of Makerere University. A copy will be submitted to Mulago Hospital and power point presentation to the staff of ANC assessment centre Old-Mulago hospital. For the general public, results will be published.

5.12 Ethical considerations

Ethical approval was obtained from Makerere University School of Public Health (MUSPH) Higher degrees research and Ethics Committee, Mulago Hospital Institutional Review Board and

National Council of Science and Technology (NCST) through MUSPH. Written informed consents were obtained from interviewed male spouses and FGD participants. Confidentiality was ensured by use of anonymous identifiers or codes. Interviews were carried out in side rooms or screened area for privacy and confidentiality.

CHAPTER SIX

6.0 RESULTS

6.1.0 Quantitative data

6.1.1 Socio-demographic characteristics of the respondents

Table 1 Socio-demographic characteristics of the respondents

Socio-demographic characteristics	Frequency	Percentage (%)
Age groups (N=214)		
<25	51	23.83
25-30	101	47.20
>30	62	28.97
Education level (N=214)		
No education	7	3.27
Primary	59	27.57
Secondary	107	50.00
Tertiary institution	19	8.88
University	22	10.28
Religion (N=214)		
Catholic	60	28.04
Protestant	49	22.90
Muslim	59	27.57
Pentecostal	33	15.42
SDA	13	6.07
Occupation (N=214)		
Unemployed	6	2.80
Peasant	2	0.93
Business	76	35.51
Civil servant	20	9.35
Private organization	59	27.57
Others	51	23.83
Living patterns (N=214)		
Lives with wife	207	96.73
Live separately	7	3.27
Duration of marriage (years) (N=211)		
< 1	54	25.59
1-5	122	57.82
>5	35	16.59
Marital status (N=214)		
Not married	5	2.34
Monogamous	187	87.38
Polygamous	22	10.28
Number of children (N=214)		
No child	145	67.76
One child	42	19.63
Two-three children	21	9.81
>three children	6	2.80

In table 1, 47% of the respondents were 25-30 years of age and a half had attained secondary education (50%). Most respondents were monogamous (87%), living with their pregnant wives (97%) and expecting their first child from the escorted wife (68%).

6.1.2 Prior HIV testing by the male partners

Table 2 Previous HIV testing by male partners

Past HIV testing	Frequency (N=213)	Percentage (%)
Ever tested for HIV together with the pregnant wife		
No	115	53.99
Yes	98	46.01
Place of HIV test for those who had ever tested		
Antenatal Clinic	13	13.40
Family planning clinic	3	3.09
Stand alone HCT clinic	30	30.93
Others	51	52.58
Tested before marriage		
No	42	44.21
Yes	53	55.79

As shown in table 2, over half of the respondents have never taken HIV test together with their wives that they accompanied. Of all the men who had ever tested together, 56% did so after marriage.

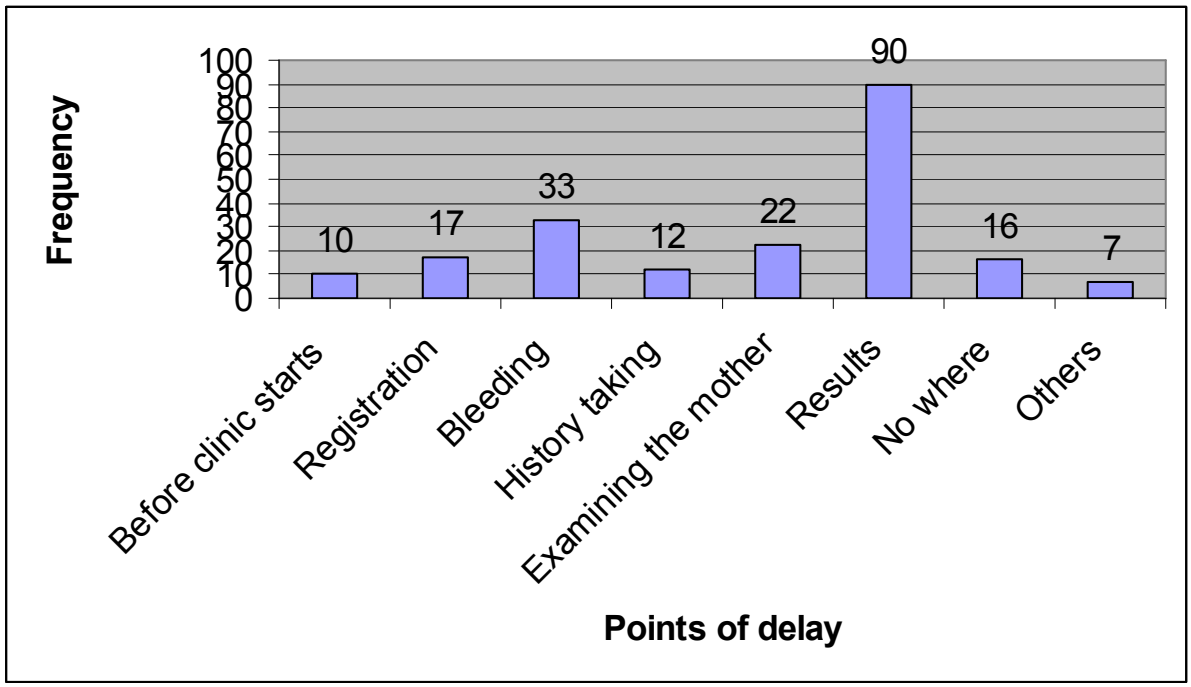
6.1.3 Antenatal HIV counseling and testing service factors

Table 3 Service delivery factors that could influence satisfaction

Dimension assessed	Frequency (N=214)	Percentage (%)
Size of space in waiting areas		
Inadequate	163	76.17
Adequate	51	23.83
Privacy		
Inadequate	34	16.75
Adequate	169	83.25
Cleanliness/Hygiene		
Poor	50	23.58
Good	162	76.42
Felt comfortable in the clinic		
No	24	11.27
Yes	189	88.73
Acceptance of staff composition by gender		
No	53	24.88
Yes	160	75.12
Convenience of clinic time		
Not convenient	116	55.24
Convenient	94	44.76
Politeness of the staff		
Not polite	25	11.74
Polite	188	88.26
Time spent with counselor		
Not enough	16	7.66
Enough	193	92.34
Service duration		
Too long	142	67.30
Adequate	69	32.70

Seventy six percent (76%) of respondents said the clinic space was inadequate while 17% said privacy in the clinic was inadequate. Three quarters (76%) of the respondents thought that the cleanliness/hygiene in the clinic was good and 75% liked the staff mix by gender. Sixty seven percent (67%) of the respondents felt the time they spent in the clinic was too long implying that they delayed at some points. On inquiring where they delayed several responses were given as shown below.

Figure 1 Bar chart showing points at which men reported to have waited too long (N= 207).



Waiting for results (90), bleeding (33) and examining the mother (22) were the most common service points at which respondents waited for long. Only 16 respondents never waited for long at any point.

6.1.4 Acceptance of AHCT by male partners who escort their pregnant wives for antenatal care at Assessment centre, Mulago NRH

The first objective of the study was to determine the level of AHCT acceptance by male partners who escort their pregnant wives for antenatal care at assessment centre, Mulago NRH. Data was obtained by reviewing HCT attendance records of Male Access and routine clinics from 09th December 2009 to 08th February 2010 and respondents' self reports of service activities they had undergone. Table 2 shows the results.

Table 4 Antenatal HIV Counseling and Testing acceptance by Male Partners

Service stages	Frequency (415)	Percentage (%)
Male partners registered	415	100
Male partners who got pretest counseling	415	100
Male partners bled	415	100
Male partners who received results	415	100
Male partners who received posttest counseling	414	99.8

A total of 415 male partners attended AHCT of whom 298 (72%) attended during the routine clinic. Out the 415 male partners that attended, only one person did not receive his HIV test results and he was not a study participant.

6.1.5 Service delivery factors associated with AHCT acceptance by male partners.

The third objective of this study was to identify ANC service delivery factors associated with AHCT acceptance by male partners. Acceptance of AHCT was measured by receipt of HIV test results. In the study all the respondents received their results and review of records also showed similar findings. Therefore association between service delivery factors and AHCT acceptance was not assessed.

Table 5 Reasons for low Antenatal HIV Counseling and Testing attendance by male partners (N=211).

Reasons given	Frequency	Percentage (%)
Fear to know or doesn't want	77	21.15
Don't want wife to know his HIV status	15	4.12
Lack of time	140	38.46
Believe status same as that of wife	5	1.37
Carelessness	32	8.79
Not living together or misunderstanding	21	5.77
Negative attitude about ANC and HIV testing	15	4.12
Others	59	16.21
Total	**364**	**100%**

Some respondents gave more than one response. Frequencies and percentages are of responses not respondents

On inquiring from the respondents why few men escort their wives to ANC for AHCT 38% reported lack of time (men are busy or committed at work) and 21% mentioned fear of knowing one's status. Other reasons included fear of taking long in the clinic, feeling ashamed to be seen in the ANC, ignorance regarding need and importance of knowing your status.

Table 6 showing sources of information about need for men to accompany their wives for antenatal care (N=214).

Source	Frequency (226)	Percentage (%)
Given a letter	18	7.96
Told by wife	63	27.88
From radio	33	14.60
From TV	8	3.54
From news paper	5	2.21
Own decision or responsibility	47	20.80
She didn't know the place	06	2.65
Told by relative/friends	34	15.04
Other sources	12	5.31
Total	**226**	**100**

Some respondents gave more than one response. Frequencies and percentages are of responses not respondents

Most men (28%) knew that they had to escort their wives to ANC because they were told by the partners, 21% considered escorting wife to ANC as their responsibility and decided on their own and 15% were told by relatives or friends. Only 8% got invitation letters.

Table 7 showing importance of testing male partners for HIV together with their pregnant wives in ANC (N=211).

Importance	Frequency	Percentage (%)
Know each other's serostatus together	163	53.80
Plan for the family	17	5.61
Protect baby from HIV	51	16.83
Prevent infecting the HIV negative partner or self	19	6.27
Behavior change	28	9.24
Others	25	8.25
Total	**303**	**100**

Some respondents gave more than one response. Frequencies and percentages are of responses not respondents

Fifty four (54%) of the respondents said testing male partners for HIV together with their pregnant wives is important because you get to know each other's HIV status together at once and it helps to protect baby from acquiring HIV (17%).

6.1.6 Male partner's satisfaction with AHCT services at Assessment centre, Mulago NRH.

The second objective of the study was to assess male partner's satisfaction with AHCT services at Old-Mulago NRH. Data was obtained by asking respondents to rate on Liker scale their satisfaction with service dimensions, while FGD participants narrated their feelings. Table 5 shows the results.

Table 8 Satisfaction levels of Male Partners with Antenatal HIV Counseling and Testing Services at Assessment Centre, Mulago Hospital

Response	Frequency(N=213)	Percentage (%)
Male Partners' satisfaction with AHCT setting		
Very unsatisfied	1	0.47
Unsatisfied	9	4.23
Fairly Satisfied	52	24.41
Satisfied	130	61.03
Very satisfied	21	9.86
Male Partners' satisfaction with Interpersonal Relationship with health workers		
Unsatisfied	2	0.94
Fairly Satisfied	15	7.08
Satisfied	151	71.23
Very satisfied	44	20.75
Male Partners' Satisfaction with Pretest Counseling		
No	1	0.47
Yes, somehow	12	5.63
Yes, completely	200	93.90
Male Partners' Satisfaction with Posttest Counseling		
No	4	1.94
Yes, somehow	7	3.40
Yes, completely	195	94.66
Male Partners' overall satisfaction with AHCT services		
Unsatisfied	7	3.32
Fairly satisfied	34	16.11
Satisfied	132	62.56
Very satisfied	38	18.01

In table 8, most respondents (63%) were satisfied and 18% very satisfied with their overall experience of AHCT, 61% were satisfied while 24% fairly satisfied with AHCT service setting. Satisfaction scores were categorized as ‘satisfied or unsatisfied’; results are shown in table 9.

Table 9: Male Partners' Satisfaction with Antenatal HIV Counseling and Testing Services

Satisfaction	Frequency (213)	Percentage (%)
Overall satisfaction		
Unsatisfied	41	19.25
Satisfied	172	80.75
Satisfaction with service setting		
Unsatisfied	61	28.64
Satisfied	152	71.36
Satisfaction with interpersonal relationship of providers		
Unsatisfied	16	7.51
Satisfied	197	92.49
Satisfaction with actual services		
Unsatisfied	4	1.88
Satisfied	209	98.12

As shown in table 9, 172(81%) male partners were satisfied with their overall AHCT experience, 152 (71%) satisfied with AHCT service setting.

6.1.7 Factors that influence male partners' satisfaction with AHCT services

Table 10 Service delivery factors associated with Male Partners overall satisfaction towards their AHCT experience

Variable	Dissatisfied 41 (19.25%)	Satisfied 173 (80.84%)	Unadjusted/crude Odds ratio (COR) 95% CI, P	Adjusted Odds ratio (AOR) 95% CI, P
Age				
<25	10 (24.4)	41 (23.7)	1.00 (ref)	1.00 (ref)
25-30	22 (53.7)	79 (45.7)	0.88 (0.78-2.03) 0.76	0.71 (0.29-1.77) 0.47
>30	09 (22.0)	53 (30.6)	1.44 (0.53-3.89) 0.47	0.98 (0.34-2.85) 0.98
Clinic hygiene/cleanliness				
Poor	16 (39.0)	34 (19.9)	1.00 (ref)	1.00 (ref)
Good	25 (61.0)	137 (80.1)	**2.6 (1.22-1.43) 0.00***	**2.53 (1.12- 5.70) 0.03***
Acceptance of staff composition				
No	11 (26.8)	42 (24.4)	1.00 (ref)	1.00 (ref)
Yes	30 (73.2)	130 (75.6)	1.13 (0.52-2.46) 0.75	0.56 (0.24-1.33) 0.19
Privacy in the clinic				
Inadequate	09 (25.7)α	25 (14.9)	1.00 (ref)	-
Adequate	26 (74.3) α	143 (85.1)	1.98 (0.82-4.76) 0.12	
Adequacy of clinic space				
Inadequate	36 (87.8)	127 (73.4)	1.00 (ref)	-
Adequate	05 (12.2)	46 (26.6)	3.78 (-)0.05**	
Politeness				
Not polite	09 (22.0)	16 (09.3)	1.00 (ref)	1.00 (ref)
Polite	19 (78.1)	156 (90.7)	**2.74 (1.10-6.84) 0.02***	2.37 (0.87-6.44) 0.09*
Service Duration				
Too long	39 (95.1)	103 (60.6)	1.00 (ref)	1.00 (ref)
Adequate	02 (04.9)	67 (39.4)	**17.90 (-) 0.00****	**13.05 (2.97-57.44) 0.00***

*** p<0.05 indicates a significant result, *odds ratio significantly different from 1 *95% CI does not include 1**
**** Fisher's exact test**
*****Log likelihood = -87.37, Pearson chi2 (26) = 34.96, Probe > chi2 =0.11 and correctly classified= 80.86%**
α N=35

As shown in table 10, 80% of the men who were satisfied with their overall AHCT experience felt the clinic was clean, 73.4% said the space was inadequate and 60.6% felt service duration was too long. With or without controlling for other factors, respondents who felt the hygiene in the clinic was good were thrice more likely to be satisfied compared to those who said it was

poor. The associations were statistically significant (**COR** 2.6 (1.22-1.43) and **AOR** 2.53 (1.12-5.70)). Adjusting for other factors, respondents who felt the time they spent in the clinic was adequate were thirteen times more likely to be satisfied compared to those who said it was too long. The association was statistically significant (**AOR** 13.05 (2.97-57.44). The Pearson/Hosmer-Lemeshow goodness-of-fit-test for the model showed chi-square value 26 degrees of freedom = 34.96, P-value > 0.11 and correctly predicted 80.86% of the observations.

6.1.8 Description of the model for male partners' satisfaction with overall AHCT experience.

Male partners' satisfaction with overall AHCT experience increased if they considered time spent in the clinic to be adequate, felt hygiene was good, and the staffs were polite. Male partners' satisfaction was lower for men above 25years of age and for those who liked staff composition by gender.

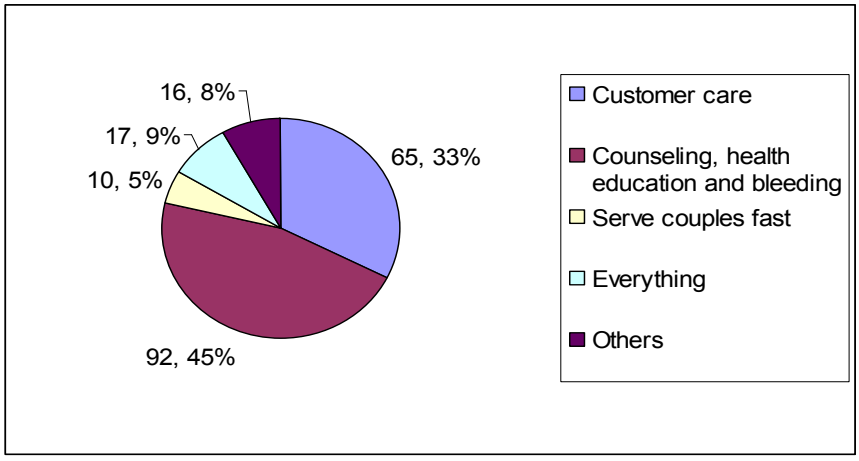
Table 11 showing Most liked aspects of AHCT (N=191).

Most liked aspects	Frequency	Percentage (%)
Good customer care by the HWs	30	14.85
Services free of charge	14	6.93
Serving couples fast	12	5.94
Knowing HIV status of self and partner's	93	46.04
Good services	31	15.35
Clean and organized clinic	6	2.97
Others	16	7.92
Total	**202**	**100**

Some respondents gave more than one response. Frequencies and percentages are of responses not respondents

Knowing one's HIV status and that of the partner (46%), the services especially counseling and health education (15%) and good customer care (15%) were the most liked aspects of AHCT. Others (7.9%) included services being free of charge, attending to couples first and clean place.

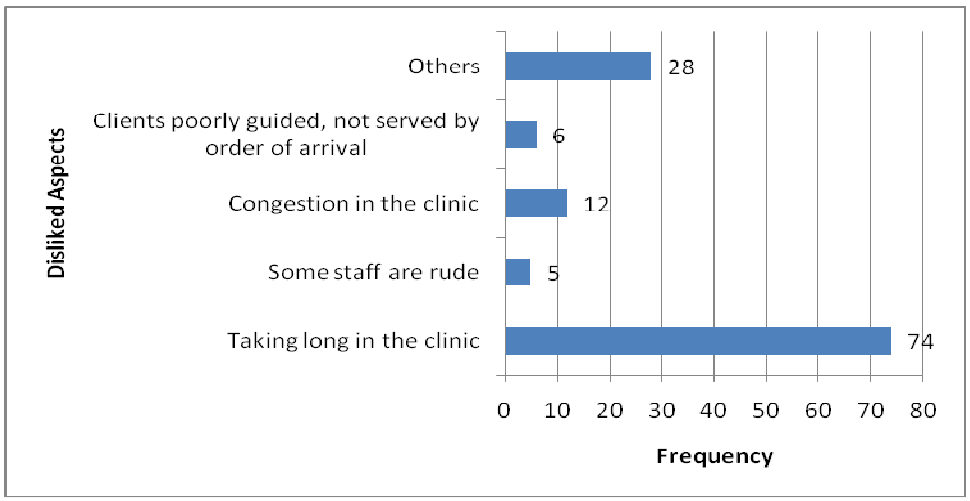
Figure 2 Pie chart showing what the staff do well (N=187).



Some respondents gave more than one response. Frequencies and percentages are of responses not respondents

The participants identified counseling, health education and bleeding (45%) and customer care (33%) as things that the health workers do well.

Figure 3 Bar chart showing AHCT service delivery aspects most disliked by men (N=109).



Some respondents gave more than one response. Frequencies are of responses not respondents.

Taking long in the clinic (74) was the predominant aspects of AHCT disliked by the respondents. Other disliked aspects included failure to serve people according to order of arrival, overcrowding, being bled in an open room and confusion by non clinic staff around the clinic entrance who ask mothers to be taken for scan.

Table 12 Reasons for escorting the partner again in case of subsequent pregnancy (N=198).

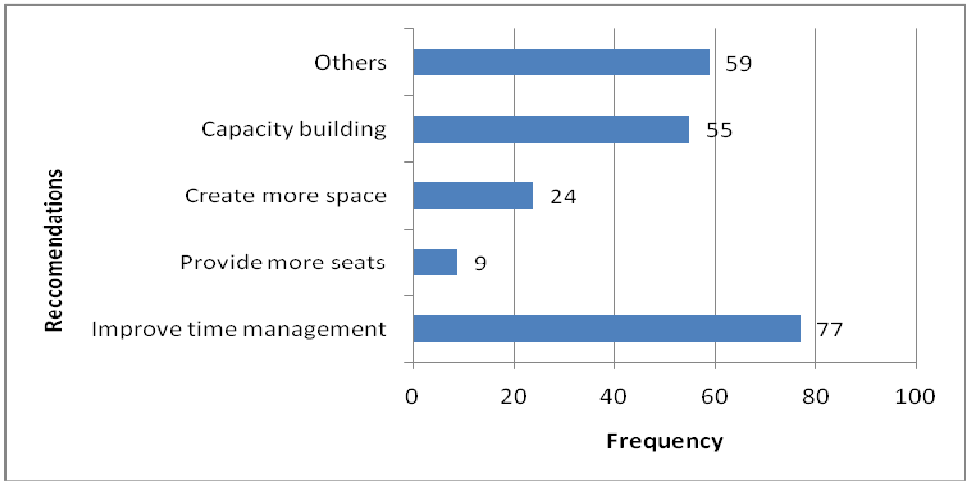
Reasons given	Frequency	Percentage (%)
Repeat HIV test	57	27.67
Own responsibility	58	28.16
Because I love her	9	4.37
Good services	19	9.22
Couples are given priority	20	9.71
Services are free	5	2.43
having time or being around or lack of money	9	4.37
Others	29	14.08
Total	**206**	**100**

Some respondents gave more than one response. Frequencies and percentages are of responses not respondents.

Ninety five percent (95%) of respondents expressed willingness to escort their wives again for AHCT at Mulago hospital in case of subsequent pregnancy. The most common reasons for coming again were to fulfill obligation as a husband (own responsibility) (28%), repeat HIV test (28%) and couples are attended to fast (10%). Others reasons included love for wife, it is now a requirement, good services especially counseling as well as the personnel.

6.1.9 Respondents' recommendations for improvement

Figure 4 Bar chart showing recommendations by respondents for improvement (N=182).



Some respondents gave more than one response. Frequencies are of responses not respondents.

Recommendations respondents gave for improvement included improving time management by starting work early or quickening service delivery (77) and Capacity building particularly increasing man power in examination and bleeding points as well as in-service training (55).

6.2.0 Qualitative Data

Concerning AHCT acceptance, all the FGDs reported that testing male partners of pregnant women for HIV during ANC is good. On inquiring why AHCT for men is good, various reasons were given. Most participants mentioned knowing one's HIV status and that of partner together as a benefit of AHCT for men. This was expressed in all FGDs.

> *"Some men are not trust worthy. If positive, they will not disclose to the women. So couples should test together" (FGD, female).*

> *"I support it very much. If a woman is tested alone and happens to be positive, she may not tell her husband the truth that she is HIV positive. So both should be tested together and protect the baby" (FGD, male).*

Despite support for AHCT for couples, female FGD participants however, expressed reservations towards it as shown by the quotes below.

> *"If you both come and found discordant, it causes divorce, conflicts, misunderstanding, the man refuses to care for you. So if you are not sure of yourself you come alone" (FGD, female).*

On inquiring whether men accept being tested for HIV together with their pregnant wives in the antenatal clinic, some FGDs reported that they do not like it.

> *"The majority do not like it. They are ever asking their wives 'Am I also pregnant?' Why go there for checkup? They answer their wives rudely when told to come to ANC implying they do not want it" (FGD, male).*

> *"It is good but men do not want" (FGD, female).*

Regarding reasons as to why few male partners attend AHCT, most FGDs reported fear of being found HIV positive, lack of time, lack of awareness about need to test, being irresponsible and delay in the clinic.

> *"Others fear knowing that they are HIV positive since they might have been having risky life styles" (FGD, male).*
>
> *"Other men are irresponsible; they do not care about their wives" (FGD, male).*
>
> *"Some women conceive by accident, so do not know the potential fathers" (FGD, male).*
>
> *"There are many mothers in the clinic. Others fear the line at Mulago which causes delay in the clinic, yet some work for others hence fear being chased by their bosses" (FGD, female).*

Regarding satisfaction with overall AHCT experience, FGDs reported that they were satisfied with the experience of seeking care, as exemplified by the two responses:

> *"They give good care, talk well to people (clients), handle people well and the place is clean" (FGD, male).*
>
> *"I have been satisfied. We were handled well" (FGD, male).*

Considering satisfaction with service setting, FGDs reported mixed views with some reporting that they were satisfied with the ambience of the setting, while others were not satisfied, as exemplified by two respondents:

> *"The infrastructure is not okay- seats are not modern, it is hot no fan or Air Conditioner" (FGD, male).*
>
> *"The place looks good and clean but its size is small, there is no fresh air" (FGD, male).*
>
> *"The setting is not satisfactory or not up to date. Where testing is done is convenient but the toilets are not in good condition" (FGD, male).*

Regarding satisfaction with interpersonal relationship of the providers, FGDs said the staff were doing well, but needed improvement in time keeping, as suggested by the following respondents:

"The way staff treat us is good but they come late (9-10am)" (FGD, male)

"I'm very happy because the staff handled us well" (FGD, male).

"The experience was good because the staff were caring, there was no problem, he was not on hurry" (FGD, female).

The FGDs also reported that the clients were happy with the services they received as suggested by the following respondents.

"The staffs are doing good job, they are organized, direct people where to go, the place is clean except people are many" (FGD, male).

"They are doing well. We appreciate their services" (FGD, female).

On inquiring about escorting partner again for AHCT in case of subsequent pregnancy, the FGDs reported that they may do so, but would decline if circumstances had not improved, as suggested by the following respondents:

"We shall still bring them so as to know if things have changed." (FGD, male)

"No. if the time taken is still long, I will bring her, leave her behind and come to pick her later." (FGD, male)

The FGDs with male partners had mixed feeling regarding bringing their wives again for AHCT at Mulago hospital in case of a subsequent pregnancy. Some FGD participants expressed willingness to return if their wives conceive again while others were not willing.

"We shall still bring them so as to know if things have changed" (FGD, male).

"No. if the time taken is still long, I will bring her, leave her behind and come to pick her later" (FGD, male).

"Some of us work for people up country, travel a lot so you cannot be sure" (FGD, male).

CHAPTER SEVEN

7.0 DISCUSSION

7.1 Acceptance of AHCT by male partners

This study showed a very high (99.8%) acceptance level of HIV test offered routinely to men who escorted their wives for antenatal care at Assessment centre, Mulago NRH. The FGD participants also reported that AHCT for men is good. This shows that if all the husbands of antenatal mothers at assessment attended ANC, the majority would take up HIV test. However, it is possible that the acceptance level would reduce because the men who never came to the clinic might be more likely to refuse to be tested. The men who escorted their wives could have been those who wanted to take HIV test or had special interest in the expected child. The high AHCT acceptance level by interviewed respondents could have been as a result of good quality counseling since most of them (98%) were satisfied with counseling and health education they got. According to Karin 2009, quality of counseling influences HIV test acceptance (28). Other men could have accepted HIV test just because the services were free of charge. The study finding is in agreement with previous studies in Uganda which found 98.3% testing acceptance by male partners who accompanied their wives to ANC (17).

7.2 Male Partners' Satisfaction with AHCT Services

The study found a fairly high level of satisfaction among male partners with regard to their overall AHCT experience (81%) and FGD participants too reported satisfaction. The high level of satisfaction towards overall AHCT experience could be because couples were given priority and the staff talked well to the couples. This finding is consistent with that of a study at San Francisco General Hospital which found 89% of women satisfied with their experience of HIV

testing (29). However, this study did not assess satisfaction of men and was conducted in the labor suit.

This study found relatively low level of satisfaction with service setting (71%) compared to the other dimensions. This could be due to congestion in the clinic, lack of enough space for men while waiting for results or antenatal examination of their wives, poorly ventilated counseling room and occasional flooding in the toilets. This finding is in agreement with that of Hasan 2007 who found that patients were satisfied with service facilities (30).

Most respondents (92%) and FGDs responses expressed satisfaction towards interpersonal relationship with the providers. This could be because the staffs tried to direct the clients including the male partners to their subsequent service stages, talked well to clients and were organized. This finding is consistent with that of client satisfaction and quality of health care in rural Bangladesh which found provider behavior towards the patient especially politeness and respect as the most significant predictor of satisfaction with government health services (31). Similar finding was reported by Karunamoorthi 2009 who found staffs impoliteness as a cause of dissatisfaction with pharmacy services at an Ante-retroviral therapy unit (32).

Nearly all respondents (98%) were satisfied with the actual service (counseling and health education) they received. This finding is similar to that of a study conducted in South Africa, which showed client satisfaction with counseling of 100% for those seen by nurses and satisfaction been at 80% for those seen by community volunteers (33). The study finding also agrees with that of clients' satisfaction with services for prevention of mother-to-child

transmission of HIV in Dodoma, Tanzania which showed that 76% of respondents being satisfied with the counseling they received (27).

7.3 AHCT Service Delivery factors associated with Male Partners' Satisfaction

Overall satisfaction with AHCT experience was low if the male partner felt the time he spent in the clinic was too long and considered hygiene in the clinic to be poor. Overall satisfaction was not significantly associated with privacy. The finding that long service duration is associated with clients' dissatisfaction is consistent with that of Elshabrawy et al (34) who found an association between long waiting time and dissatisfaction. Similarly Tweheyo reported that men are inpatient and inconvenienced by the long durations spent at the health facility (35) thus justifying the association between long service duration and dissatisfaction. This study found some association between politeness of the service providers and satisfaction but the relationship was not statistically significant. According to Aldana, impoliteness of the providers is related to clients' dissatisfaction (31).

7.4 Study Limitations

i. The study did not document HIV status of the male partners therefore; the data was not stratified by HIV status during analysis. The HIV status of the male partners could have influenced satisfaction levels.

ii. The study did not evaluate the effectiveness of interventions used at the clinic to encourage more men to accompany their wives to the antenatal clinics.

iii. The study population did not consist of the entire spectrum of men whose wives are pregnant. The men who escorted their wives to the antenatal clinic could have had levels of AHCT acceptance different from those who did not accompany their spouses.

CHAPTER EIGHT

8.0 CONCLUSION

The study found a very high level of AHCT acceptance among men who accompanied their wives for antenatal care at Assessment centre, Mulago hospital. It was also found in this study that male partners who underwent HIV testing in the ANC at Assessment centre, Mulago NRH tended to be satisfied with the AHCT services. The major gap in accessing HIV testing at antenatal clinics by male partners is to get the male partners come to the clinic.

CHAPTER NINE

9.0 RECOMMENDATIONS

This study found high levels of acceptance and satisfaction with AHCT services among men who accompany their wives for antenatal care at Assessment centre, Mulago NRH. However, certain service areas need further improvement. These include reducing waiting time by starting work early and minimizing delays at areas where it is possible. Where service duration at a point cannot be shortened, the clients could be explained on arrival the process or minimum expected time required to perform a service.

Staffing levels especially at the reported points of delay such as the laboratory, antenatal examinations and registration be increased. The number of male staff especially counselors and laboratory personnel allocated to work in the antenatal clinic be increased too.

Effectiveness of the current strategies to promote attendance of male partners should be evaluated. Other interventions to encourage more male partners to accompany their wives to the antenatal clinic could be explored.

To improve on cleanliness or hygiene in the clinic, more dust bins be provided and the leakages in the toilets be repaired.

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Appendix 1

Informed consent

Introduction

Good morning/afternoon sir. My name is _____ from Makerere University School of Public Health. Together with Mulago Hospital, we are conducting a study to establish the level at which HIV testing in the antenatal clinic is accepted by male partners and extend to which their expectations are met. As a husband you have been selected to give your views about it by answering questions on aspects of antenatal HIV testing for men.

Procedure

A questionnaire will be administered to you by the research assistant who will read to you the questions. A question can be read again if it is not clear to you. You will tell the researcher your answer to the questions. The interview will take not more than 20 minutes. We shall be very grateful for your participation.

Benefits and risks

The information you provide will help Mulago hospital to improve services to suit needs of men and couples. This will therefore increase uptake of HIV testing by male partners and reduce further infections among babies and partners. Apart from the extra time you will spend in the clinic for the interview, there are no risks expected.

Confidentiality

The information you provide will be treated with high level of confidentiality and only used for the purpose of this study. Your name will not be recorded any where during the study or reporting findings. So feel free to answer the questions.

Voluntary consent

You are free to choose to participate in the study or not, withdraw from the study without any conditions at any stage. You can ask questions before, during and after the interview.

Questions and/or Problems

For any questions about this study or your rights as a participant, please contact:

i. **The Principal Investigator, Amos Drasiku on 0712-417580 or**

ii. **The Chairperson of the Ethics committee Makerere University School of Public Health, Dr David Guwatudde, P.O.BOX 7062, tel. 0414,543872.**

The above information has been explained to me and I fully understand the contents. I hereby agree to take part in the study.

Respondent's signature: _____Date:___/____/_____

Interviewer's Signature: _____Date:___/___/_____

Appendix 2

Exit interview questionnaire for male partners of antenatal mothers.

Identification	Code
Name of Interviewer: _____	{_____}
Date of interview: _____	{_____}
Questionnaire Number: _____	{_____}
Type of Clinic visit: 1. Routine 2. Male Access	{_____}

A. Characteristics of male partners

NO	Questions	Responses	Code (√)	Com-ment
101	How old were you at your last birthday?	……..years		
102	What is the highest level of education you attained?	No education Primary Secondary Tertiary institution University	1 2 3 4 5	
103	What is your religion?	Catholic Protestant Muslim Pentecostal SDA Others…… (specify)	1 2 3 4 5 6	
104	What is your tribe?	……		
105	What is your occupation (kind of work you mainly do to earn your living)?	Unemployed Peasant Business Civil servant Private organization Others…… (Specify)	1 2 3 4 5 6	
106	Do you live together with your wife who is pregnant?	Yes No	1 2	
107	For how long have you been in marriage with your wife who is pregnant?	……..years		
108	All together, how many wives or partners do you live with?	…….....		
109	How many children do you have with your wife who is pregnant now?	_____ …….Boys ……Girls		

B. Knowledge, Attitudes and behavior related to MTCT

NO	Questions	Responses	Code (√)	Com-ment
201	How did you know that men should accompany their pregnant wives to the ANC?	Given a letter Told by wife From radio From TV From newspaper Other……	1 2 3 4 5 6	Specify
202	Among married people can one partner be HIV positive and the other negative?	Yes No	1 2	
203	Can the virus that causes AIDS be transmitted from a mother to her baby?	Yes No Do not know	1 2 3	
204	If yes can transmission of the virus from the mother to the baby be prevented?	Yes No Do not know	1 2 3	
205	How can it be prevented? ……			
206	Is it shameful to see a man amongst pregnant women in the antenatal clinic?	Yes No	1 2	
207	Do you fear being identified as a client undergoing HCT in the antenatal clinic?	Yes No	1 2	
208	Is it important to test male partners of pregnant women for HIV?	Yes No	1 2	
209	Explain your answer……			
210	Apart from today, have you ever tested for HIV together with your wife who is pregnant now?	Yes No	1 2	
211	If yes, from where?	Antenatal clinic Family planning Clinic Stand alone HCT clinic Other …… (specify)	1 2 3 4	
212	By then were you already married?	Yes No	1 2	

C. Acceptability of AHCT by male partners

NO	Questions	Responses	Code (√)	Com-ment
301	Have you ever undergone counseling for HIV test?	Yes No	1 2	
302	If yes, when were you last counseled for HIV test?	Today Before today	1 2	
303	If yes, were you counseled together with your pregnant wife	Yes No	2 1	

304	Was your blood taken off for HIV testing today?	Yes No	2 1	
305	At any of the service stages, do you think you were served before other mothers ahead of you in the queue who did not come with their?	Yes No	2 1	
306	Are you happy about the way you went through the queue?	Yes No	2 1	
307	Why do you think few men accompany their wives to the ANC for HIV counseling and testing? ……			

D. Male partners' satisfaction with AHCT Service Setting

NO	Questions	Responses	Code (√)	Com-ment
401	Comment on the size of the space in the waiting areas	Adequate Inadequate	2 1	
402	Explain your answer ……..			
403	Comment on the privacy in the antenatal clinic area	Adequate Inadequate	2 1	
404	Explain your answer ……..			
405	Comment on the hygiene in the clinic	Good Poor Fair	3 2 1	
406	Why do you think so? ……..			
407	Did you feel comfortable in the antenatal clinic?	Yes No	2 1	
408	Explain your answer …….....			
409	Comment on the process/steps of HCT in the antenatal clinic.	Organized Unorganized	2 1	
410	Explain your answer …….....			
411	Do you like the composition of the health workers by gender?	Yes No	2 1	
412	Explain your answer ……..……			
413	How convenient do you think ANC hours are for men?	Convenient Not convenient	2 1	
414	If not convenient, why? ...……			
415	If not convenient, suggest how this can be solved ……..……			
416	Please rate your satisfaction with the setting in which HIV counseling and testing for PMTCT is done	Very satisfied Satisfied Fairly satisfied Unsatisfied Very unsatisfied	5 4 3 2 1	

E. Male partners' satisfaction with Provider-client relationship

NO	Questions	Responses	Code (√)	Com-ment

501	Overall, how would you rate the politeness of the health workers?	Excellent Very Good Good Fair Poor	5 4 3 2 1	
502	The health workers are supportive. Do you agree?	Yes No	2 1	
503	Do you believe that the information you shared with the health worker about yourself is kept confidential?	Yes No I don't know	3 2 1	
504	Comment on the time you spent for health education	Too long Adequate Too short Did not attend	1 2 3 4	
505	Is the health education necessary?	Yes No	2 1	
506	Did you spend as much time with your counselor as you wanted?	Yes Somehow No	3 2 1	
507	If no, why? ……..			
508	Did you ask any questions at any services stage?	Yes No	1 2	
509	If yes, were you satisfied with the answers given?	Yes Somehow No	3 2 1	
510	Explain your answer……			
511	How would you rate the competence of the health workers?	Very competent Competent Somewhat competent Incompetent Very incompetent	5 4 3 2 1	
512	Are you happy about the behavior of antenatal mothers?	Yes Somehow No	3 2 1	
513	Explain your answer ……..…….			
514	Please rate your satisfaction with the way the health workers interacted with you.	Very satisfied Satisfied Somewhat satisfied Unsatisfied Very unsatisfied	5 4 3 2 1	

F. Male partners' satisfaction with AHCT Service Attributes

NO	Questions	Responses	Code (√)	Com-ment
601	What is the last service activity that you received today?	……..…… ……		
602	Are you satisfied with the pretest information you received?	Yes, completely Yes, somewhat No	3 2 1	
603	Explain your answer ……...			

604	At what stage do you think you waited for long?	……		
605	**I do not want to know your results,** If you were bled today, have you received your HIV test results today?	Yes No	2 1	
606	If yes, did you receive your results together with your wife?	Yes No	2 1	
607	If no to question 605, explain why you did not receive your HIV test results? …….			
608	Did you have to wait too long to receive your test results?	Yes, definitely Yes, some what No	1 2 3	
609	Did you receive posttest counseling after getting your results?	Yes No	2 1	
610	If yes, are you happy about the medical advice you received?	Yes, completely Yes, somewhat No	3 2 1	
611	Explain your answer ……...			
612	Please rate your satisfaction with the way your HIV test results were given.	Very satisfied Satisfied Fairly satisfied Unsatisfied Very unsatisfied	5 4 3 2 1	
613	Have you found HIV testing in the ANC together with pregnant women helpful?	Yes No	2 1	
614	Explain your answer……			
615	If your wife got pregnant again after her current pregnancy, would accompany her to this ANC for the same services you received today?	Yes No	2 1	
617	May you explain your answer……			
618	What do you like most about testing male partners for HIV in the antenatal clinic? …….			
619	What do you dislike most about testing male partners for HIV in the antenatal clinic? ……			
620	According to you what are the health workers doing well?.....			
621	What can the health workers do to improve?			
622	Comment on the time you have spent in the clinic from your arrival to the end of the last service you received?	Too long Adequate Too short	1 2 3	
623	All things considered, how satisfied are you with your experience of HCT in the antenatal clinic?	Very satisfied Satisfied Fairly satisfied Unsatisfied Very unsatisfied	5 4 3 2 1	

Thank you for your co-operation

Appendix 3

Consent form for Focus Group Discussion (FGD) with antenatal mothers and their male partners to understand acceptability and satisfaction of men with Antenatal HIV Counseling and Testing (AHCT)

Introduction

Good morning/afternoon. We are from Makerere University School of Public Health. We are conducting a study to establish whether men whose wives are pregnant accept HIV testing in the antenatal clinic and how satisfied they are with it. This will help us make recommendations to improve AHCT services to suit the needs of men. As a father/mother, we request you to give your views about this issue. The discussion will last 30-45 minutes only.

Confidentiality

The information you provide will be treated with high confidentiality. It will only be used for the purpose of the study.

Voluntary consent

Your participation is voluntary and you can withdraw at any time if you so wish without any untoward consequences. We request that a tape recorder be used so as to avoid missing of important information you provide.

Questions and/or Problems

For any questions about this study or your rights as a participant, please contact:

i. **The Principal Investigator, Amos Drasiku on 0712-417580 or**

ii. **The Chairperson of the Ethics committee Makerere University School of Public Health, Dr David Guwatudde, P.O.BOX 7062, tel. 0414,543872.**

The above information has been explained to me and I fully understood the content. I hereby agree to take part in the study.

Thank you for your participation.

Participants signature: _____Date: ___/___/___

Moderator's signature _____ Date___/___/____

Note taker's signature _____ Date___/___/____

Starting time _____ End time _____

Appendix 4

Focus Group Discussion guide

Opening questions

1. The government is encouraging HIV counseling and testing for male partners of pregnant mothers in the antenatal clinic. **What is your opinion about this service? Is it important? Why? Do men like being tested for HIV in the ANC together with their pregnant wives?**

2. Why do you think few men accompany their wives to the ANC for HIV counseling and testing?

3. Are men happy about the antenatal setting where men and their pregnant wives are tested together for HIV? – **Infrastructure, space and behavior of antenatal mothers.**

4. Are men who have tested for HIV in the ANC together with their pregnant wives happy about the HCT services they received? **Time spent in the clinic, interpersonal relationship with the staff and organization of the services.**

5. What do you suggest should be improved upon?

6. What do you think should be done to increase the number of husbands of pregnant mothers tested for HIV in the antenatal clinic?

Thank you for your co-operation.

Appendix 5

Informed consent form translated into Luganda

Ebikkiriziddwaako

Ennyanjula

Wasuze otyanno/Osiibye otyanno sssebo. Erinnya elyange nze _____ okuvamu yunivasite ye Makerere mu ssomero ly'eby'obulamu. Nga tukolaganira wamu ne edwaliro ly'e Mulago tulina kye tunoonyerezako nga kyetugenderera kwe kumanyakiseera ki ekituufu omuntu ali olubuto ng'ajja mu kilinika y'ab'embuto weyandye keberezza okumanya oba alina akawuka ka mukenenya era nga ekiseera kino kiba omwami we akikkiriza era tunakomawa okutukiriza ebyo by'aba atusuubiramu. Ggwe ng'omwami w'omukyala olondeddwa okutwa birowoozo byo ng'oddamu ebibuuzo ebikwata ku kwekebeza akawuka ka mukenenya mu abaami b'abakyala abaliembuto.

Enkola enegobererwa

Olupapula okuli ebibuuzo lujja kukuweebwa oyo ayamba kw'a nonyereza, era ajja kukusomera ebibuuzo ebiriko ekibuuzo kiyinza okuddibwaamu okukusomerwa bw'oba ng'olina ky'oba totegedde bulungi. Ebiddibwaamu mu bibuuzo bino ojja kubitegeeza anonyeraza okwogereganyamu nawe kijja kutwaala ekiseera ekitajja kusukka dakiika 20. Tujjakusiima nnyo okwetaba kwo mu kintu kino.

Okuganyulwa era N'ebizibu ebikirimu

By'onotutegeeza bijja kuyamba eddwaliro ly'mulago okulongoosa mu mpereza zalyo eri abaami era n'abafumbo. Kino kijja kuviira ko ba bba ba bakyala bano okujjumbira okwekebeza aka

wuka ka mukenenya kini kiviiremu. Okukendeeza kw'okusaasaana kw'oblwadde mu baana abazalibwa ere ne mu bafumbo. Okugyako akaseera k'oneefiriza ng'oli naffe mu kilinika tewali kilala kijja kusumbuwa.

Kukuuma Ebyama

Byonnaby'ontutegeeza bijja kukuumibwa nga bya kyama nnyo, era nga bijja kweyambisibwa mu kunnonyereza mwokka. Erinnya lyo telijja kuwandiikibwa wantu wonna bwe tunaaba nga tukola okunonyeza oba nga tuangirira ebinaana bivudde mu kunonyereza; nolwekyo ddamu ebibuuzo byonna muddembe nga tewali kyewekengera.

Okukkirizza okwa kyeyagalire

Oliwa ddembe okusalawo okwetaba oba obutetaba mu kunonyereza kuno oba okusalawo oku ku vaamu ekiseera kyonna awatali kwennyonnyo lako kwonna. Oyinza okubuuza ebibuuzo nga tetunnatandika oba nga tutandise oba nga tumaze okwogeraganyamu naawe. Ebintu ebyo waggulu binyonnyoddwa bulungi ere ne mbiteera bulungi era wano ngikirizza okwetaba mu kunonyereza kuno.

Ebibuuzo ne/oba Ebizibu

Bw'oba olina ekibuuzo byonna ebikwaata ku kunonyereza kuno oba ebikwata ku ddembe lyo ng'ayetabyeemu mwattu tuukirira bano wa mmanga:

i. **Akulira okunonyereza nga ye Amos Drasiku ku ssimu namba 0712-417580 oba**
ii. **Ssentebe wa kakiiko akakwasira amateeka g'okunonyereza mu Yunivasite y'e Makerere mussomero ly'ebyobulamu nga ye Dokita David Guwatudde ku ndagiriro eno P.O.Box 7062, essimu 0414,543872.**

Omukono gw'akkirizza mukwetaba mu kunonyereza ----------Olunaku---------- Omukono lw'omwezigw'amubuuzizza ---------- Olunaku---------- Omukono

Appendix 6

Questionnaire translated into Luganda

Olupapula okuli ebibuuzo ebiddibwamu abaami ba bakyala obomu kilinika ya b'embuto bwebaba nga bagala okwanduka mu kunonyereza

Ayidentite	ennamba
Erinnya ly'abuuza: _____	{_____}
Olunaku olwokubuuzibwa: _____	{_____}
Kiwandikiiko namba: _____	{_____}
Ekika kya kilinika: 1. Eyabulijjo 2. Eya basajja	{_____}

A. Ebikwata ku Basajja (abaami ba bakyala bano abembuto)

Namba	Ekibuuzo	Ekiddibwamu	ennamba (√)	Biki by'okyogerako
101	Walina emyaka emeka ku lunaku lw'ewazaali lwaako olwasebayo?	_____ Emyaka		
102	Buyigirie ki obusemberayo ddala waggulu bwe wakomako?	Ssa somako Pulayimale Sekenduli Amatendekero aga waggulu Univasite	1 2 3 4 5	
103	Enzikiriza yo ?	Mukatuliki Mupolotestante Musilamu Eza balokole SDA Endala yonna _____	1 2 3 4 5 6	
104	Oli wa ggwanga ki?	……..		
105	Okola mulimu ki?	Sirina mulimu Mulimi Bizinesi Mukozi wa gavumenti Ekitongole ekyo bwannannyini Ebilala_____	1 2 3 4 5 6	

		(Binnyonnyole)		
106	Osula ne mukyala wo ono ali olubuto?	Yee Nedda	1 2	
107	Obufumbo bwamwe ne mukyala wo ono ali olubuto mubu mazeemu bbanga ki?	_____ Emyaka		
108	Bonna awamu bakazi bo balibameka b'osula nabo?	…….....		
109	Abaana bameka be mulina ne mukazi woo no kati ali olubuto?	_____Abalenzi _____Abawala		

B. Ebikwataku Byenneyisa

Namba	Ekibuuzo	Ekiddibwamu	Ennamba (√)	Biki by'okyogerako
201	Wakitegeera otya nti abaami bandiwerekedde ku bakyala baabwe nga bagenda mu kilinika y'abembuto?	Nawandii kiwa bbaluwa Omukyala ye ya ngamba Nawulira ku radio Nategereera ku televizoni Nategeerera mu mpapula za mawulire Emikutu emilala (gyogere)_____	1 2 3 4 5 6	
202	Mu mufumbo omuntu omu ayinza okuba ng'alina akawuka ka mukenenya ng'ate omulala takalina?	Yee Nedda	1 2	
203	Akawuka ka mukenenya kayi nza okusasaana nga kava ku maama w'omuwana nekakwata omwana?	Yee Nedda Ssimanyi	1 2 3	
204	Bwe kiba nga kituufu akawuka kano kayinza okuziyizibwa okuva ku maama okukwata omwana?	Yee Nedda Ssimanyi	1 2 3	
205	Kaziyizibwa katya? ……..			
206	Kiswaaza omusajja okulabika ng'ali n'abakyala abali embuto mu kilinika yaabwe.	Nkikkiriza Ssikikkiriza	1 2	
207	Ofaayo singa abantu bakulaba ng'oze okwe kebeza akawuka ka mukenenya mu kilinika y'ab'embuto?	Yee Nedda	1 2	
208	Kyamugaso/kikulu okukebera abaami ba bakyala abali embuto akawuka ka mukenenya?	Yee Nedda	1 2	
209	Nnyonnyola okuddamu kwo …….…….			
210	Ng'ojeko olwaleero, wali wekebeezako wamu nemukyala no ono ali olubuto?	Yee Nedda	1 2	

211	Bwekiba bwe kityo mwekebeza wa?	Mu kilinika yabembuto Mu kilinika ya famule pulaningi Mu kilinika webekebereza kinoomu clinic Awalala_____ (yogera yo)	1 2 3 4	
212	Mukiseera ekyo mwali mwafumbiriganwa dda?	Yee Nedda	1 2	

C. Okukkiriza kwa Baami Okwetaba mu Kubuulirirwa N'okwekebeza akawuka ka Mukenenya nga kino bakikolela mu kilinika y'abembuto bakyala baabwe gye bajjanjabirwa

Namba	Ekibuuzo	Ekiddibwamu	Ennamba (√)	Biki by'okyogerako
301	Wali obuulilidwa ng'ogeenda okwekebeza akawuka ka mukenenya?	Yee Nedda	1 2	
302	Bwe kiba bwe kityo, ddi lwe wasembayo okubuulirirwa?	Leero Ng'olwa leero telu nna tuuka	1 2	
303	Bwe kiba bwe kityo, mwabulilirwa wamu ne omukazi woo no ali olubuto?	Yee Nedda	2 1	
304	Wagyiddwaako omusayi ogw'oku kebera akawuka ka mukenenya leero?	Yee Nedda	2 1	
305	Mu mitendera gyonna gy'oyiseemu nga bakukolako, olowooza wakoledwaako ng'obuuse abakuli mu maaso mulunyiriri?	Yee Nedda	2 1	
306	Olimusanyufu ku ngeri gyo yisiddwamu mu mitendera egyenjawulo munyiriri nga eyasuse ya suuka okukolebwako?	Yee Nedda	2 1	
307	Olowooza lwaki abaami abawerekera bakyala babwe mu kilinika y'abembuto okwekebeeza omusaayi gwa mukenyenya batono? …..……			

D. Abaami obumativu bwe balina mu ngeri okwekebeza akawuka ka mukenenya mu baliembuto gye kwa tegekebwamu

Namba	Ekibuuzo	Ekiddibwamu	Ennamba (√)	Biki by'okyogerako
401	Yogera ku bugazi bw'ekifo awalindirwa oba bulala	Bumala Tebumala	2 1	
402	Ky'ozzeemu kinnyonnyoleko ….……			
403	Yogera ku bwekufisu bw'ekifo okubuulirirwa we kukolerwa	Bumatiza Tebumatiza	2 1	
404	Ky'ozzeemu kinnyonnyoleko …….……			

405	Yogera ku buyonjo bwekifo	Bulungi Bubi Bwetyo	3 2 1	
406	Ky'ozzeemu kinnyonnyoleko ……..			
407	Wawulira emirembe ng'oli mu kilinika y'abembuto?	Yee Nedda	2 1	
408	Ky'ozzeemu kinnyonnyoleko …….....			
409	Yogera ku mitendera egyanjawulo omwami nomukyala gyebayitamu mu kilinika y'abembuto.	Mitegeke bulungi Simitegeke bulungi	2 1	
410	Ky'ozzeemu kinnyonnyoleko …….....			
411	Entabikatabika yabasawo abakazi n'abasajja gye yakolebwamu ogyagala ?	Yee Nedda	2 1	
412	Ky'ozzeemu kinnyonnyoleko ……..…….			
413	Olowooza obudde abasajja bwe bamala mu kilinika y'abembuto bu basuumbuwa kye nkana wa?	Tekibasumbuwa Kibasumbuwa	2 1	
414	Bwe kiba nga kibasumbuwa, olwaki? ……			
415	Bwe kiba nga kibasumbuwa wa amagezi ekintu kino bwe kiyinza okuvvuunukibwa ……			
416	Okugerageranya ku kipimo 1-5 laga obumativu bwo bw'olina mu kifo awabuulilirwa n'okukebeza akawuka ka mukenenya okuziyiza maama obutasiiga omwana we.	Ssiri mumativu n'akamu Ssiri mumativu Mmatira kitono tono Ndi mumativu Ndi mumativu nnyo	1 2 3 4 5	

E. Emmatira y'abaami ku ngeri omujjanjabi n'ajjanjabibwa gye bakwataganamu

Namba	**Ekibuuzo**	**Ekiddibwamu**	**Ennamba (√)**	**Biki by' okyo gerako**
501	Nga ogasse byona, abasawo abenjawulo abakukolako enkola yabwe enjogera nekwata yabalwadde yabwe eryetya?	Nnungi nnyo ddala Nnungi nnyo Nnungi Bwetyo	5 4 3 2	

		Mbi	1	
502	Abasawo bazzaamu amaanyi	Yee Nedda	2 1	
503	Okkikiriza nti ebintu bye muba mwogeddeko gwe n'omusawo bikuumibwa nga bya kyaama ?	Yee Nedda simani	3 2 1	
504	Yogera ku budde bwe mwamaze nga mwogera ku bikwaata ku bulamu	Buwaanvu nnyo Bubadde bumala Bubadde bumpi nnyo Si somye	1 2 3 4	
505	Okusomesa kubyo bulamu mukilinika kyetagisa?	Yee Nedda	2 1	
506	Bwe wabuuzizza ebibuuzo wafunye okudibwaamu kw'obadde otegeera?	Yee Somehow Nedda	3 2 1	
507	Bwoba ozzeemu nti nedda, kyonyonyoleko? …**……**			
508	Olina ekibuuzo kyonna kyobuziza ngoyita mu mitendera gyenjawulo?	Yee Nedda	1 2	
509	Obadde olina ekikuluma nga wandibadde oyagala kyogerweeko naye nemutakikola?	Yee Bwetyo Nedda	3 2 1	
510	Ky'ozzeemu kinnyonnyoleko **……**			
511	Obukugu bw'abasawo obugerageranya otya?	Bakugu nnyo Bakugu Bakugu bwebatyo bwebatyo Ssi bakugu Ssi bakugu n'akamu	1 2 3 4 5	
512	Olimusanyufu ku ngeri abakyala bembuto abanjanjabirwa wano gyebeyisaamu?	Yee Sirimusanyufu nnyo Nedda	3 2 1	
513	Ky'ozzeemu kinnyonnyoleko **……**			
514	Okugerageranya ku kipimo 1-5 laga obumativu bw'olina ku ngeri abasawo gye bakolaganyee mu naawe	Ssiri mumativu n'akamu Ssiri mumativu Ndi mumativu mu Ndi mumativu Ndi mumativu nnyo	 1 2 3 4 5	

F. Okumatira abaami kwebafunye nga betabye mu ku buuliririrwa n'okwekebeza akawuka ka mukenenya nga kino bakikoledde mu kilinika y'ab'embuto bakyala baabwe gye bajjanjabirwa

Namb	**Ekibuuzo**	**Ekiddibwamu**	**Code (√)**	**Com-ment**

a				
601	Kiki ekisembyeeyo okukukolako leero?	**…….……**		
602	Olimumattivu ku kubuulirirwa kwofunye nga tonaba kujjibwako musayi gwo kwekebeza akawuka ka mukenyenya?	Yee, ndi mumattive ddala Yee, ndi mumattive ko Nedda	3 2 1	
603	Ky'ozzeemu kinnyonnyoleko **……**			
604	Olowooza ku mitendera ki wosinze okulinda ekiseera ekiwanvu era nolwaawo?	**……..**		
605	**Sagala kumanya bivudde mu musaayi gwo,** bwoba ogiddwako omusaayi gw'okwekebeza akawuka kamukenenya olwaleero musaayi obifunye leero?	Yee Nedda	2 1	
606	Bwoba obifunye ebivudde mu musaayi obifunye oli wamu ne mukyala wo?	Yee Nedda	2 1	
607	Bwoba wazzemu nti nedda ku kibuuzo 605, nnyonyolako lwaki tofunye bivudde mu kwekebeza kawuka kamukenenya **……**			
608	Walinze ekiseera kiwanvu nnyo nga tonna manya bivudde mu kukebereza?	Yee, mazima ddala Yee kibadde kiwanvu ko Nedda	1 2 3	
609	Wafunye okubulirirwa okwekuteekateka ku funa ebivudde mu musaayi gwokebeza kawuka ka mukenenya?	Yee Nedda	2 1	
610	Bwoba wafunye okubulirirwa olimusanyufu olwamagezi abasawo gyebakwadde?	Yee, ndi musanyufu ddala Yee, ndi musanyufu ko Nedda	3 2 1	
611	Ky'ozzeemu kinnyonnyoleko **……**			
612	Gerageranya okumatira kwo mu ngeri ebivude mu kukeberebwa omusaayi gwo gye by aku weereddwamu.	Ssimatidde nakamu kokka Matidde mu Ssimatidde Matidde Matiridde ddala nyo	1 2 3 4 5	
613	Okwekebeza akawuka ka mukenenya mu kilinika y'ab'embuto ng'oli wamu n'abakyala abali embuto okisange nga kyamugaso?	Yee Nedda	2 1	
614	Ky'ozzeemu kinnyonnyoleko **……**			
615	Singa mukyala wo bwaliddamu okufuna olubuto olulala nga ojeko luno, oli muwerekerako mukilinika eno eyabakyala bembuto mwebajanjabirwa okufuna okubulirirwa	Yee Nedda	2 1	

	nokwekebeza byofunye?			
617	Osabibwa onnyonyoleko kyozeemu……..			
618	Kiki ky'osinga okwagala mu kyabaami okwekebereza akawuka ka mukenenya mu kilinika ya bakyala abali embuto ? ……			
619	Kiki ky'osinga okukyaawa mu ky'abaami okwekebereza akawuka ka mukenenya mu kilinika ya bakyala abali embuto? ……			
620	Okusinziira kuggwe abasawo kiki kye bakola obulungi? ….……			
621	Abasawo kiki kye bayinza okukola okutumbula enkola yaabwe? ……			
622	Yogera kubudde bw'omaze mu kilinika okuva lwe watuuse okutuka ku kukolebwaako okusembieyo?	Bubadde budde buwanvu nnyo Bubadde bumala Bubadde bumpi nnyo	1 2 3	
623	Okutwalira awamu oli omumativu kyenkanawa mu by'oyiseemu ng'obuulirirwa ku bifa ku kawuka ka mukenenya ne mu kwekebeza mu kilinika y'abembuto?	Ssimatidde nakamu kokka Matidde mu Ssimatidde Matidde Matiridde ddala nyo	1 2 3 4 5	

Webale enkolagana ennungi gyo tuwadde

Appendix 7

Informed consent form for FGD translated into Luganda

Olupapula okuli ebyakkiriziddwaako abantu abalondeddwa okuva kunjuyi zombi ol'wabaami n'olwabakyala ku kikwaata ku ky'abaami okwekebereza akawuka ka mukenenya mu kilinika y'ab'embuto bakyala baabwe gye bajjanjabirwa.

Ennyanjula

Wasuze Otyanno/Osiibye Otyanno. Tuvudde mu yunivasite ye Makerere mussomero ly'eby'obulamu. Tulina okunoonyereza kwe tukola nga twagala okumanya oba abaami abalina abakyala baabwe nnga bali mbuto bakkiriza okwkebeza akawuka ka mukenenya mu kilinika y'ab'embuto era n'okumanya engeri kino gye bakimatira mu. Kino kijja kutuyamba okusalawo biki bye tunakola okulongoosa mu ngeri okwekebeza akawuka ka mukenenya mu b'embunto okutuukagana n'obwetaavu bwa abaami. Gwe nga taata/maama tukusaba otuwe ebirowoozo byo ku nsonga eno. Okukyogerako kujja kututwalira eddakika 30 okutuuka ku 45 zokka.

Okukuuma ebyaama

By'onotubulira bijja kukuumibwa nga bya kyamaa nnyo. Bijja kweyambisibwa mu kunonyereza kwokka.

Okukkiriza okwa kyeyagalire

Okwetaba mu kunonyereza kuno kwa kyeyagalire era oyinza okukuvaamu ekiseera kyonna awatali buzibu bwonaTusaba ebintu bino bikwaatibwe ku lutambi okwewala okulekeyo ekintu kyonna eky'omugaso ky'onooba otubuulidde.

Ebibuuzo ne/oba Ebizibu

Bw'oba olina ekibuuzo byonna ebikwaata ku kunonyereza kuno oba ebikwata ku ddembe lyo ng'ayetabyeemu mwattu tuukirira bano wa mmanga:

iii. **Akulira okunonyereza nga ye Amos Drasiku ku ssimu namba 0712-417580 oba**

iv. **Ssentebe wa kakiiko akakwasira amateeka g'okunonyereza mu Yunivasite y'e Makerere mussomero ly'ebyobulamu nga ye Dokita David Guwatudde ku ndagiriro eno P.O.Box 7062, essimu 0414,543872.**

Webale nnyo okwetaba mu kunonyereza kuno.

Omukono gw'akkirizza mukwetaba mu kunonyereza ----------Olunaku---------- Omukono

Mukono gw'akubirizza olukiiko_____ olunaku lw'omwezi_____

Omukono gwomuwandiisi_____olunaku w'omwezi_____

Essawa olukiiko we lwatandikidde_____essawa olukiko we lwaggweeredde_____

Appendix 8

Focus Group Discussion Guide translated into Luganda

Ebyagobereddwa mu lukiiko

Ebibuuzo ebyabuziddwa

1. Gavumenti ekubiriza abaami babakyala abali embuto okwekebeza akawuka aka mukenenya mu kilinika ya b'embuto. Endwooza yo ku ndabirirwa eno eri ki? Kyetagisa? Lwaki? Abaami bagala okwekebeeza akawuka ka mukenenya mu kilinika ya b'embuto nga bali wamu ne bakyala babwe abali embuto?
2. Olowooza lwaki abaami batono abawerekera bakyala babwe mu kilinika ya b'embuto okwekebeza akawuka ka mukenenya nga bali wamu nebakyala babwe abali embuto?
3. Mwe abaami muli basanyufu ku mbeera yekijo kilika ya b'embuto abaami nebakyala baabwe abaliembuto mwe babakeberera akawuka kamukenenya gyerimu ebyokozesa, ekijo, eneyiisay'abakyala bembuto?
4. Abaami abakebereza akawuka ka mukenenya mu kilika ya b'embuto wamu nebakyala babwe basanyufu ku labirirwa kwokebeza akawuka okubaweebwa? Obudde bwe bamala mu kilika, enkolagana nabasawo wamu ne mitendera kyo bujjanjabi.
5. Kiki ekyetaaga okulongoosa mu?
6. Olowooza kiki ekyetaaga okukula okwongera ku mwendo g'wabaami babbakyala b'embuto abekebereza akawuka ka mukenenya mu kilika ya b'embuto?

Webale nnyo olw'enkolaganayo naffe.

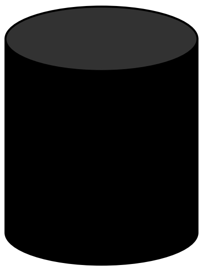
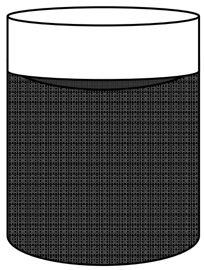
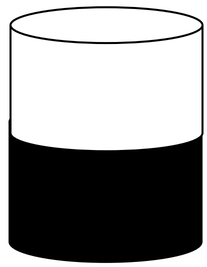
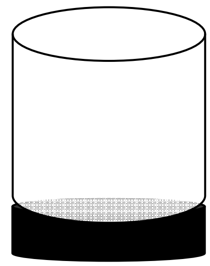
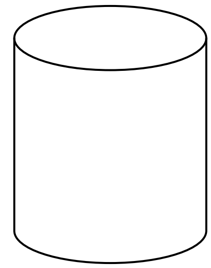
Appendix 9

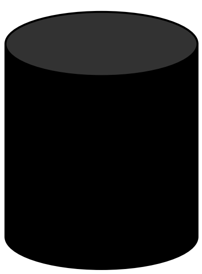
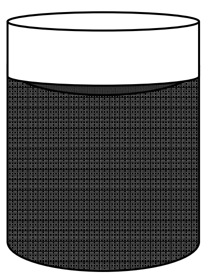
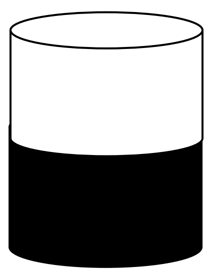
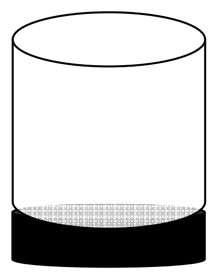
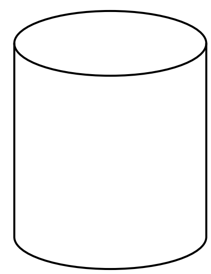
Observation checklist for uptake of AHCT by male partners

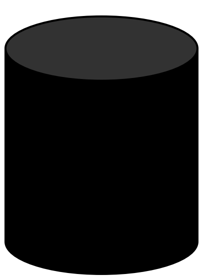
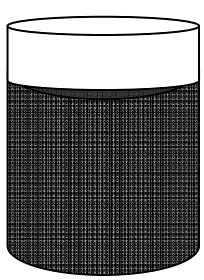
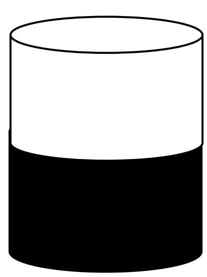
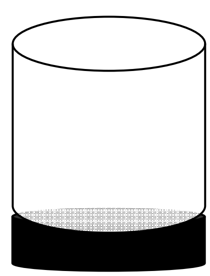
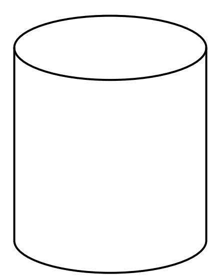
Identification	**Code**
Name of Interviewer: _____	**{_____}**
Date of interview: _____	**{_____}**
Observation checklist number: _____	**{_____}**
Type of clinic visit: 1. Routine 2. Male Access	**{_____}**
Number of male partners registered _____	
Number of male partners Counseled _____	
Number of male partners bled _____	
Number of male partners who received HIV test results _____	

Appendix 10

Visual aid to rate satisfaction

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
				

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
				

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
				

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SCHOOL OF PUBLIC HEALTH
HIGHER DEGREES, RESEACRH AND ETHICS COMMITTEE

Ref:

23 November 2009

To Whom It May Concern

Dear Sir/Madam,

RE: PERMISSION TO CONDUCT RESEARCH

I here by introduce to you Mr. Amos Drasiku a year III Master of Health Services Research student at Makerere University School of Public Health.

he is required to conduct a research study as a requirement for the award of the Masters of Health Services Research degree. The title of his study is: "**Acceptability and satisfaction of male partners with Antenatal Clinic-Based HIV Testing for PMTCT at Old Mulago Hospital, Uganda**". This proposal was reviewed and approved by Makerere University School of Public Health Higher Degrees, Research and Ethics Committee meeting. "

Your support in this regard will be highly appreciated.

Thank you.

Assoc. Prof. Fred Wabwire-Mangen
Chairman Higher Degrees, Research and Ethics Committee

TELEPHONE : Direct 256-41-554008
Fax No 256-41-5
E-mail: d.mh@uga.healthnet.org

MULAGO HOSPITAL
P. O. BOX 7051
KAMPALA, UGANDA.

THE REPUBLIC OF UGANDA

IN ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE.....

1st December 2009.

Mr. Amos Drasiku

Dear Mr. Drasiku,

RE: **YOUR RESEARCH PROPOSAL ENTITLED: "Acceptability And Satisfaction Of Male Partners With Antenatal Clinic-Based HIV Testing For PMTCT At Old Mulago Hospital, Uganda.**

This is to certify that your Research Proposal by the above title was received, reviewed and passed by the Mulago Hospital Research and Ethics Committee.

You may now go ahead and conduct your research as outlined in your proposal and under the guidance of your stipulated supervisors. At completion of your study, you are required to provide us with a copy of your research report.

Sincerely,

Prof. Seggane Musisi
Chairman
Mulago Research and Ethics Committee.

c.c. Assoc. Prof. Fred Wabwire-Mangen
Chairman Higher Degrees, Research and Ethics Committee

c.c. Dr. Bosco M. Ddamulira and
Dr. Elizabent Nabiwemba
Supervisors.

c.c. The In Charge
Old Mulago Hospital.