

UNIVERSITY OF NAIROBI

INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES

GENDER BARRIERS IN PMTCT SERVICES DELIVERY: A CASE STUDY OF
MISSION HOSPITALS IN THARAKA DISTRICT.

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PRESENTED BY: CATHERINE N. KARUGU

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A RESEARCH PROJECT PRESENTED TO THE INSTITUTE OF AFRICAN
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DECLARATION

I Catherine N. Karugu do declare that this project paper is my original work and has not been presented for examination in any other university.

C. Karugu

20/11/08

.....
CATHERINE N. KARUGU

.....
DATE

This Research Project has been submitted for examination with my approval as a University Supervisor

Isaac Were

25.11.2008

.....
MR. ISAAC WERE

.....
DATE

DEDICATION

To my sons

Alvin Karugu and Curtis Wanakasha,

the delight of my life

To my husband and friend,

Edwin Wanyonyi

To my parents

Mr. & Mrs. James Karugu

whose prayers, love, care, support and encouragement

made me what I am today

and

To the Lord God Almighty in whom I have my being.

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ABSTRACT

The HIV/AIDS epidemic has been increasing year by year throughout the world but more so in Kenya. The spread of the disease has caused a negative impact particularly among women and children. The study was designed to highlight gender barriers in the implementation of PMTCT programs within faith based setting. This study adopted both probability and non-probability sampling techniques.

The study scope was specifically on Northern part of the Eastern province which has 8 districts, each of which has about six to eight health clinics and centers. The population is quite heterogeneous and an attempt was made to capture the differences by using a method that ensured equal representation. With the help of the office of the District AIDS coordinator (DASCO) in- Meru the researcher obtained a list of all the mission health centers providing PMTCT services in the province. The findings of this study pointed out that most of the respondents, both couples and the pregnant women feared experiencing loss family support and the stigma associated with HIV/AIDS.

To make recommendations on gender related areas that are essential to PMTCT programming, a majority of the respondents indicated that they received PMCT services. Only a minority did not receive PMCT services.

From the findings the following conclusions were made. It is evident that the impact of HIV/Aids is mostly on women, this is especially so among those at their child bearing age. Lack of comprehensive interventions will further accelerate infection among infants and also HIV re-infection on both women and their partners. Programs must therefore target both men and women in provision PMTCT services.

Following the recommendations drawn from the study, there is need for community mobilization and awareness activities to ensure everyone has the right information. Involvement of both men and women in PMTCT activities are also imperative. These interventions will help save more infants from acquiring HIV and also ensure provision of comprehensive services to families.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
ART	:	Anti Retrovirals
CBO	:	Community Based Organizations
CVA	:	Capacities and Vulnerabilities Analysis
DASCO		District Aids and STI coordinator
FBO	:	Faith Based Organization
GAD		Gender and Development
GOK		Government of Kenya
HIV	:	Human Immuno Deficiency Virus
KAIS	:	Kenya Aids Indicator Survey
ICPD		International Conference on Population and Development
MCH	:	Mother Child Health
MTCT		Mother to child transmission
MOH		Ministry of Health
NACC		National AIDS Control Council
NGO		Non Governmental Organization
NASCOP		National Aids/STI Control Programme
NGO	:	Non-Governmental Organization
PLWHA		People living with HIV and Aids
PMTCT	:	Prevention of Mother to child transmission
PTB	:	Theory of planned behavior
STD	:	Sexually Transmitted Disease
UNAIDS		United Nations Programme on HIV / AIDs
UNICEF		United Nation Children Fund

UNDP	United Nations Development Program
UNFPA	United Nation Family Planning Association
U.S.A	United States of America
WID	Women in Development
WHO	World Health Organization .
VCT	Voluntary Counselling and Testing

CHAPTER ONE

INTRODUCTION

1.1. Background Information

The HIV/AIDS pandemic remains extremely dynamic with the virus exploiting new opportunities for transmission. The pandemic is a global issue. Virtually, no country remains unaffected; nevertheless the epidemic is not homogeneous within regions. Worldwide, in 2003, an estimated of 4.8 million people became newly infected with HIV. Today, 37.8 million people are living with HIV, which killed 2.9 million people in 2003, and over 20 million people since the first cases of AIDS were identified in 1981 (UNAIDS, 2004 PP6).

The Kenya Aids Indicator Survey, 2007 highlights that the prevalence of HIV in adults of 14- 64 years is 7.8% and 7.4% among adults in the reproductive age; 14- 49 years. There is however some differences in prevalence across the life span. Gender disparities are particularly of concern, this because HIV prevalence among the youth aged 15-24, women are 4 times more likely to be infected than men. A higher proportion of Kenyans aged between 30 to 34 years are currently infected with HIV than in any other age category. The decline in prevalence among women after age 34, and among men after age 44 could represent a decline in new infections in older age groups or an increase in HIV-related deaths in these age groups. The burden of infections is statistically higher among females than males until age 35 after which the ratio of male to female infections starts to approach 1 to 1 (KAIS, 2007 PP 13).

Though HIV/ AIDS is a health issue, the epidemic has gender concerns as well. Statistics show that both the spread and impact of HIV/ AIDS is not random. HIV/AIDS

disproportionably affect women and adolescent girls who are socially, culturally, biologically and economically vulnerable. Men too have their own vulnerabilities which at times they are unable to openly discuss. They however influence key decisions in the family and also in the society and this perhaps determines access to HIV services at the household level.

By the end of 2007, the estimated number of people living with HIV worldwide in 2007 was 33.2 Million (30.6–36.1 million), a reduction of 16% compared with the estimate published in 2006. Although prevalence has stabilized, continuing new infections (even at a reduced rate) contributed to the estimated number of people living with HIV; 33.2 million. HIV prevalence tends to reduce slowly over time as new infections decline and through the death of HIV-infected people. However this trend may decrease over time through reduced mortality of HIV-infected people on antiretroviral treatment and other interventions .UNAIDS pp 4, 5, 6

Currently an estimated 630,000 children world-wide became infected with HIV in 2003 most of them through MTCT (PATHFINDER 2005 PP 2). According to Pathfinder 2005, out of 100 infants born to women with HIV/AIDS and without intervention, 60-75 of them will not be infected. Of these, one-third who become infected, about 5-10 babies will be infected during pregnancy, 15 during labor and delivery, and 5-15 during breastfeeding, largely dependant on breastfeeding practices and duration. In 2003, nearly 500,000 children died of AIDS related causes. Most children born with HIV die before they reach their fifth birthday, with most not surviving even two years. WHO, CDC 2004 pp 4.

It is important to recognize that the use of the phrase MTCT is in no way intended to place blame on the mother, who may or may not know her HIV status and who transmits the virus to her child (W.H.O, 2002 PP 7). Often, pregnant women may have been infected by their male partners.

The need to uphold the reproductive rights of all women to choose when to have children, regardless of HIV-status is important. However in many situations, due to the limitation of women in negotiating for safe sex, vulnerability in decision making increases especially so during pregnancy and this has an effect when it comes to making a decision regarding to HIV services.

In poorer countries like Kenya, there is a 30-40% chance that an HIV-positive breastfeeding mother will pass HIV to her child in the absence of other interventions services, (Policy Project PP 3, 2004). It is critical that prevention procedures be integrated into maternal and child health (MCH) services reaching as many women as possible as well as involve the men in these procedures.

Specific steps must be taken to consider the non-medical barriers faced by those most vulnerable to HIV infection and to AIDS. For example, evidence shows that women are less likely than men to have access to or likely to be able to pay for primary, secondary, or tertiary care (Nanda 2002 PP 107). In some settings, women cannot seek care without the permission of their husbands. Moreover, in many developing counties 70% of the women deliver at home partly due to scarce resources. As a result, women have less access to diagnostic and testing services overall, and so the disease burden they carry may not be as readily apparent even when accepted criteria for determining priority access are applied across a community.

Despite the existing challenges, Kenya has marked an increase in the number of mothers accessing PMTCT services by end of December 2005, NACC 2005.

Other factors such as the rate of re-infection among the pregnant PLWHAs and new infections among children would be prevented if diagnosed in the prenatal period. However these are on rise, hence, the need to have comprehensive interventions.

The participation of both men and women in making decisions concerning their health is very important. Often, when implementing programs, the client is looked at as a patient and therefore they is very little involvement in decision making on matters concerning their own health. Instead, they are only supposed to follow instructions as prescribed by health care workers. To ensure adherence and efficacy of the PMTCT intervention, programs should be gender sensitive. Evidence shows that within the home and community, stigma, fear, and misinformation can affect adherence to PMTCT procedures. In a research carried out in Botswana, Kenya, and Zambia, 2003 for example, women report returning drugs provided to them for treatment because of opposition to their use from husbands. In other cases pregnant women, refused to take the ART prophylaxis due misconceptions that the drugs would harm the fetus (Attawall and Mundy 2003 pp 123). Furthermore, in PMTCT programming, the recognition that time constraints related to domestic and family responsibilities is a major limiting factor in women's ability to access and maintain treatment.

In other instances, studies indicate that women have been unable to make effective use of existing primary and secondary health care services because the services are provided within hours of operation and therefore the staffing patterns do no put into account

women's work and domestic schedules or responsibilities, or lack of access to reliable transportation (Kumar et al 2003 PP 305).

The study therefore focused on prevention of mother to child transmission where the focal point was on the various gender dimensions and how they relate to the enrolment and strategies used to effectively reach infected pregnant women and their families.

1.2. Problem Statement

The importance of involving both men and women in prevention of mother to child transmission is imperative in HIV/AIDS programming efforts. Many of the existing programs target women who are easier to access through the antenatal clinics. Thus, efforts to reduce HIV transmission of infected mothers to their children continuously fail to address the limited male participation in these programs.

According to KAIS, 2007 PP 18, preliminary reports indicated that over 90% of women who had a recent birth (within last 4 years) attended ANC and 57% among them were tested for HIV. In this same survey 47 % of HIV-infected women with recent births, received there tests in the ANC. It therefore is important to examine the participation of men and how their involvement influences uptake of these services. Additionally, it's important to note that PMTCT services are still not accessible to many women. Therefore, HIV interventions should seek to have comprehensive involvement of both men and women in their programming.

Overly, it is obviously critical, not to use what is commonly viewed as the norm or standard criteria. By not addressing gender barriers, HIV infected pregnant women may

be limited from accessing comprehensive services. These will therefore affect the prevention efforts of averting new infections and utilization of existing HIV services.

1.3. Objectives

1.3.1. Primary Objective The study will seek:

1. To understand the gender barriers in the implementation of PMTCT programs.
2. To identify the gender related factors that influence successful implementation of PMTCT programs.
3. To make recommendations on promising practices in gender-related areas which are key to PMTCT programming.

1.4. Research Questions

1. What are the gender barriers in the implementation of PMTCT programs?
2. What factors influence successful implementation of PMTCT program?
3. What are the recommendations on promising practices in gender-related areas that are key to PMTCT programming?

1.5. Hypothesis

1. Limited participation of men affects full implementation of PMTCT programs.
2. Majority of women accessing PMTCT services do not disclose their HIV status to their husbands or sex partners.
3. Pregnant women that are HIV infected get limited support from their husbands and families.
4. Gender related factors influence successful PMTCT Program.

1.6. Justification

Some past studies on gender barriers on PMTCT implementation indicate several underlying factors leading to women's failure to adhere to clinical recommendations, lack of disclosure of HIV status by mothers, low number of couples accessing counselling and testing services and male partner engagement (PMTCT Report card 2005 – UNICEF/Ngashi PP 2).

Further, there have been limited studies both within Kenya and else where in the world highlighting these factors. The PMTCT intervention is a recent phenomenon in sub-Saharan Africa, where traditional approaches are used to reach pregnant infected women. African women are considered to be at least 1.2 times more likely to be infected with the HIV virus than African men (UNAIDS and WHO, 2003). The impact of HIV/AIDS and access to treatment are markedly different for men and for women. Typically, women are more stigmatized and discriminated against. For instance, whereas the benefits of the reduction of infant infections are indisputable, the needs to further address the psychological and social effects of the mother's positive sero-status are often not recognized. In some settings, access to treatment for the mother herself is limited, and partners, who may be infected are often not being tested, which can cause a further threat to the HIV-positive women's maternal health due to exposure to re-infection.

Nevertheless, women are traditionally perceived as mothers, wives and caregivers. One might argue that gender is still thought of through these stereotyped concepts, which is essential when discussing HIV-positive women's rights and power to make reproductive health choices. In the context of empowerment, it is arguable whether women have a real

choice when it comes to their reproductive and sexual rights. The HIV testing among pregnant women is almost mandatory while the same does not apply to their partners.

Due to various factors such as women's economical , social dependency, fear of disclosing HIV-status due to apprehension of abandonment, discrimination and violence by their spouse or sex partners. Consequently, many women choose not disclose their status to their spouse or their relatives. Thereby, they miss out the possibility of receiving care and treatment for the infants and themselves.

We believe that addressing women's disposition to the pandemic of HIV/AIDS will not come about simply through preventive behavior change interventions, as it is mostly the case currently, but rather through changing unequal power relations. Challenging gender inequalities may be the solution to holistic programming.

Equally, men face their own vulnerabilities, social norms and expectations which shape their opportunities, attitudes and behavior, some of which heighten men's HIV/AIDS vulnerability and risk factors. Men are commonly socialized to exhibit masculinity, or manhood - expectations as to how men should act, such as being brave, not showing one's emotions and taking risks such as having unprotected sex and substance abuse The person reading your work should not have to fill in the dots for themselves..

Involvement of both men and women in the PMTCT will go along way in averting new infections among children and ensuring comprehensive service provision to those infected. Additionally, this approach will ensure effective ways of fighting stigma within the family and in the community. It is a reality that men are often reluctant to seek healthcare, more so accompanying their wives for the antenatal care since this is

considered to be a woman's thing. Men frequently feel pressured into hiding their lack of knowledge, stifling their ability to ask questions and get more information on HIV/AIDS (UNFPA 2005 pp 12). In addition men who are living with HIV/AIDS and facing stigma may be reluctant to seek help from and/or join support groups and networks.

This study took an inherent look at PMTCT implementation specifically the barriers that hinder meaningful engagement of men and women involvement in the implementation. I believe by doing so, more families will access HIV counselling and testing services and subsequently other care and treatment services. This therefore, makes gender a key component in the implementation and which if not address mothers will still be at higher risk for HIV transmission to infants. Hence, there is need for the proposed study to shed more light on the specific gender barriers to PMTCT implementation.

1.7. Scope and Limitations of the study

The study was carried out in Tharaka District in Nkubu and Materi MCH centres. Few challenges were experienced some of them being limitation of time and resources to carry out an in- depth research.

Data was collected within a span of two months, from mid May to mid July 2008. It took about four weeks to get the relevant authority from the administrators of the various hospitals and the DASCO in charge of the HIV program in the two districts. This delayed commencement of data collection by almost four weeks. On commencement of data collection, some nurses in charge of the surveyed health clinics were still sceptical and had to seek more clarification from the Hospital administrators, even after the researcher had presented the authorisation letter to carry out research. This delayed the exercise even

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Introduction

This chapter focuses on the global HIV prevalence rates, Sub-Sahara Africa and Kenya in particular, gender and HIV/AIDS, ART accessibility and adherence and lastly the theoretical framework.

2.2. Background on HIV/AIDS and MTCT

Infection rates indicate about 1.5 million people in Kenya have died from AIDS-related causes since 1984. Over recent years, the annual number of AIDS-related deaths has been steadily increasing. The death rate has actually doubled since 1999. Kenya's HIV/AIDS prevalence has fallen from 14% in 2000 to 7.9 % in 2007 and about 1.4 million Kenyans are HIV-positive NASCOP 2006 pp 2. According to UNAIDS 2005 pp 2), there is a dramatic increase in infection rates among young women and girls, which now accounts for up to 60% of those between the ages of 15-24 living with HIV and AIDS. At the end of 2004, almost half of the 37.2 million adults between the ages of 15 to 49 years living with HIV and AIDS worldwide were women. Estimates indicate that young women are 1.6 times more likely to be living with HIV than their male counterparts.

Over 40 million people are living with HIV/AIDS worldwide, and about two-thirds of PLWHA (25 million) live in sub-Saharan Africa. HIV/AIDS mainly affects people of reproductive age and increasingly affects women, who now account for 57% of new infections in sub-Saharan Africa. Here, women are 30% more likely to be living with HIV/AIDS than men, and young women aged 15-24 are nearly four times more likely to be infected than their male counterparts. Young, married women, who are often

monogamous, have become one of the most vulnerable groups to HIV in the region, (WHO 2003 pp 1). This requires new and rapid responses that broaden the focus beyond traditional “high risk” groups like commercial sex workers, truck drivers, and drug users. To reach young married women, who may not be aware of their vulnerability, HIV/AIDS prevention, care, and support activities must be integrated into already established health services that are used by the general population.

An estimated 630,000 children world-wide became infected with HIV in 2003-most through MTCT. In other words, out of 100 infants born to women with HIV/AIDS and without intervention, 60-75 of them will not be infected. Of the one-third who becomes infected, about 5-10 babies will be infected during pregnancy, 15 during labor and delivery, and 5-15 during breastfeeding largely dependant on breastfeeding practices and duration, UNAIDS 2004. In 2003, nearly 500,000 children died of AIDS related causes. Most children born with HIV die before they reach their fifth birthday, with most not surviving even two years (UNAIDS 2004 pp 10). The high rates of MTCT in developing countries, compared to much lower rates in richer countries, illustrate growing inequalities in global health. In most wealthy countries, the rate of MTCT is less than 2% because of widespread access to anti-retroviral therapy (ART), planned Cesarean sections, the means to safely formula feed, and access to quality medical services. In poorer countries like Kenya, there is a 30-40% chance that an HIV-positive breastfeeding mother will pass HIV to her child in the absence of these services WHO 2003 pp 4. In such settings, it is critical that prevention procedures be integrated into existing maternal and child health (MCH) services, reaching as many women as possible and lowering transmission rates. Although pharmaceutical company donations, donor support, and other government initiatives have helped expand access to HIV testing for pregnant

women and use of antiretroviral drugs, which reduces the chance of HIV transmission, still only 10% of pregnant women globally have access to these drugs (WHO 2003 PP 4).

A lot of efforts have been put in many countries towards ensuring HIV testing and counseling is a routine component of the package of care in all ANC, labour and delivery and postpartum care settings. WHO 2006 indicates that approximately 27% of health facilities providing ANC in sub-Saharan Africa also provide a minimum package of PMTCT services (12,805 out of 46,577); with significantly higher service coverage in East and Southern Africa (38%) compared to West and Central Africa (12%). In addition, forty-two per cent of health facilities in Central and Eastern Europe also provided PMTCT services in. 80% of health facilities in Central and South America and the Caribbean that provided ANC also provided HIV testing and counseling in 2006 but less than 10% provided the minimum package of PMTCT services. In countries with low and concentrated epidemics, the national strategy is often not to screen every pregnant woman but to target women who may be at particular risk for infections (Global Partners Forum, 2007 pp 3).

HIV/AIDS Transmission from Mother to Child in Kenya

HIV/AIDS is one of the biggest health and development challenges in Kenya. According to KAIS 2007 the prevalence rate of infection has gone up to 7.8 among adults aged 14 to 49 years. Although new infections appear to be declining in some districts, the virus continues to spread in most places. Young women are more vulnerable in Kenya than men, as evidenced by a nearly 9% prevalence rate among women and under 5% among men (KAIS 2007 pp 13). Kenya's National AIDS/STD Control Programme (NAS COP) estimates that there are 1.2 million babies born each year in Kenya and that as many as

10% of pregnant women in Kenya are living with HIV/AIDS. At least 50,000 to 60,000 infants in Kenya are thought to become infected with HIV as a result of MTCT each year. While knowledge that HIV can be passed from mother to child is high in Kenya, 72% of women and 68% of men reported that HIV can be transmitted through breast milk, only one-third of women and 38% of men know that the risk of MTCT can be reduced when the mother takes certain drugs during pregnancy (KDH 2003, PP 187).

2.3. Gender and HIV/AIDS.

2.3.1. Gender Inequality.

Gender inequality is very variable in the incidence of HIV/ AIDS. As gender disparities increase, the epidemic is affecting more women who bear the negative consequences of the gender imbalances.

The differential power and authority relations between men and women generally put women in a subordinate position in society. This position of women has led to negative effect on women and especially on HIV. Andersen, (1997 pp 24), sees institutions and social attitudes as the basis for women's position in society. In such sexist societies these institutions have created structured inequalities between men and women.

The social cultural importance attached to normative gender roles is such that women's ability to make decisions on access to treatment is sometimes pegged to male authority.

Women though educated about HIV/AIDS, their economic dependence on men leaves them feeling "helpless" to negotiate for safe sex. Men have always dominated women in economic, social and cultural spheres of their lives and are historically recognized as

authoritative decision makers in both public and private spheres. It is this social cultural and economic lack of autonomy of women, which places women at heart of HIV/AIDS pandemic (Boserup, 1970, PP 286). Women's oppression and subordination can be expressed in two ways. Firstly is through their sexual division of labour which allots women the bulk of domestic tasks, reproducing including maintaining current and future generations and yet they are excluded from enjoying social value and exercising social power. Secondly, the organization of sexuality and procreation permits individual appropriation of women's generative and sexual capacities and limits their autonomy and freedom of action (Catherine, pp 144 1985). This facilitates the negative impact on women.

From the colonial, era men migrated to towns to search jobs and left women behind to provide for their children. They went home after a certain period. The colonialists also discriminated women. Women were normally not invited to work only men to work in towns and still could they were the only ones trained in farming (Young, pp 125, 1998). Therefore the economic set up did not favour women at all and even when HIV/AIDS came up, it only worsened the situation. Men started long time ago to register land in their names even though they were not at home. The individual land registration provides men greater access to credit which they could use land as collateral. These set ups diminished or eliminated women and children access to resources. With HIV/AIDS pandemic, when women and children become sick, they are powerless and lack finances to seek not only medical treatment but also other forms of support (Clark, 1984 PP 102).

Women are also discriminated through land inheritance. Land is transmitted through men rather than women. Women are perceived as managers and in most cases men are

empowered to make useful land rights. They have the rights to make decisions on resource allocation and use. This becomes more serious when HIV/AIDS strikes the family because they are all under the mercy of the husband and if he dies they can even lose the land to in-laws (Boserup, 1970 pp 283)

2.4. Impact of HIV/Aids on Women

. Globally, the epidemic continues to exact devastating toll on individuals and families. In the hardest hit countries, it is erasing decades of economic and social progress, reducing life expectancy by decades, slowing economic growth, deepening poverty and contributing chronic food shortages.

The impact of HIV/AIDS on women is severe. They may hesitate to seek HIV testing or fail to return for their results because they are afraid that disclosing their HIV positive status may result in physical violence, expulsion from their home or social ostracism (UNAIDS 2004 PP 5).

In Tanzania, a study of voluntary counselling and testing services in the capital found after disclosure, only 57% of women who tested positive reported receiving support and understanding from partners (UNAIDS, 2004 pp 5).

Stigma has concrete repercussions for people living with HIV. A woman who discloses her HIV status may be stigmatized and rejected by her family. In most cases, women are the first to be diagnosed with HIV and maybe accused of being the source of it in the family (UNAIDS, 2004 pp 4 &5). AIDS related stigma and discrimination often lead to the social isolation of older women caring for orphans and ill children deny them psycho social and economic support.

After a spouse's death, a mother is more likely to continue caring for her children and women are more willing to take care of orphans (UNAIDS, 2004 pp 5). The burden on women also arises from looking after most of the huge number of orphans; about 1.5 million of them in the country. It is women who shoulder the bulk of the burden to care for and support HIV/AIDS orphans.

Roles are changing due to the impact of HIV/AIDS in that old women also shoulder the burden of their adult children when the latter fall ill. More families are also becoming female-headed where women play both productive and reproductive roles. The woman is overburdened by the two roles and situation worsens if she is infected with HIV virus.

Women are the care givers, producers and guardians of the family. When household head becomes sick or ill, women invariably take on the additional care duties. Providing care to an AIDS patient is tedious and time consuming, even more when it is done in addition to other household duties. It is even worse when water is scarce. It is indicated that with the increasingly inadequate state of provision of housing and basic services such as water and health, it is women who not only suffer most, but who are also forced to take responsibility for the allocation of limited resources to ensure survival of their households (Moser, 1989 pp 37).

Young women widowed by AIDS may lose properties and land after their husbands die, whether or not inheritance laws are designed to protect them. In Uganda a survey indicated that 1 in 4 widows reported their property was seized after their partner died (UNICEF, pp 2& 3 2003). A woman in Uganda also who refused to live with her husband

because he was demanding sexual rights even when sick lost all her possessions, business they had been running together and a house to in-laws when the husband died (Marge, 1993 pp 106).

Infected women die in their twenties and thirties. This reduces the life expectancy. Though men also die, women die at an earlier age than men with HIV (UNAIDS, 2004 PP.6). A study in USA and Brazil has found that women survive shorter time with AIDS than men. Lack of treatment could attribute to this difference. Women hardly live six months after diagnosed while men lived over a year. Some women live shorter period because they are exposed to more risks, for example, in Nairobi, 123 women sex workers with HIV all had signs of HIV disease, in less than 3 years they developed AIDS full blown. This is due to frequent exposure to HIV and other diseases, poor health and lower level of treatment (Marger, 1993 PP. 12).

Families may withdraw girls from school to take care of ill parents with HIV, look after households duties or take care of the young siblings (UNAIDS ,2004). A girl child from Naisula Orphaned Children Home said “My father died of AIDS and relatives deserted us. My mother was very sick and I skipped school many times to take care of her, I too wanted to die” (Daily Nation, pp 15 2004). In Zimbabwe a study showed that girls were withdrawn from school due to lack of school fees more than boys. Out of 46 children withdrawn from school, 70% were girls (UNAIDS, 2000 pp 2).

A woman may be prevented from using her property or inheritance for her family benefit, which in turn denies her the ability to qualify for loans or agricultural grants (UNAIDS 2004 pp 5). Women also find themselves discriminated when trying to access care and support when they are HIV positive. In many countries, men are more likely than women

to be admitted to health facilities. Family resources are more likely to be devoted to buying medicine and arranging care for ill males than females. Give the reason why to make your argument stronger.

2.5. HIV/AIDS and Women Vulnerability

Women and girls are more vulnerable to HIV/Aids due to their biological, sociological, economical and cultural set up. Medical evidence shows that transmission of HIV/AIDS and other STDS from men to women is two to six times greater, (KAIS 2007 pp 13). This is due to their physiological characteristic of the genitals. Young girl's reproductive system is not fully developed especially below 18 years and if they engage in sex the walls of the vagina are easily ruptured. The HIV virus is also found very concentrated in semen than in vaginal fluids thus increases the HIV infection chances in females.

Another factor that pushes women and girls to engage in commercial sex to put food on the table for the family is poverty. Most women and girls are discriminated against in education, employment and even in borrowing credits but the culture demands them to feed the families.

In low and middle income countries, having AIDS in the family poses strains on women in Agricultural communities. In addition to household work, many women play an important role in the economic activities that put food on their families table, as well as caring for the sick. In Tanzania, women with sick husbands spend up to 45 percent less time doing agricultural or income earning due to caring of their sick husbands. In Vietnam, recent household survey revealed that women are 75 percent of all caregivers for persons living with HIV. Mothers account for 51 percent of the total, while fathers make up 10 percent (UNDP, PP12 2003b).

Poverty and hardships drive girls and women into transactional sex with older and rich men. African women are infected more than men and at an early age than men and the gap of prevalence continuous to grow. Many girls and women look for older and rich men because they viewed them as good marriage partners or providers of better life to help them with better education, materials and work opportunities. Many girls and women in such relationships reported that gifts of clothes, jewellery and perfume enhanced their self-esteem and their status among their peers.

Most young girls also reported having had premarital sex more than men of their age. 22 percent of never married women of age 15-24 years indicated that they have had sex and only a quarter of this only used condom during sex (KDHS, 2003 PP 211). Women are also victims of sexual coercion by males either at work places , schools and in the community. This facilitates the spread of HIV virus to women. A recent study at Nairobi indicated that 4% of HIV infections in the adolescent 13-19 years group were as a consequence of rape, violence and abuse of women and girls in Kenya.

Women's low economic and social status limits their power to negotiate the use of condoms and discuss fidelity with their partners. Such disempowerment increases their vulnerability to HIV. This restricted ability to control ones own sexual safety comes not only from traditional societal values but also from physical technology and economic realities (UNAIDS, pp 14 2002).

Studies have shown that even if women are educated about HIV/AIDS and still economically dependent on men, they still feel "helpless" to negotiate safe sex (UNAIDS pp14 2002). Women are also powerless to deal with sexuality. They are not sexually

assertive and cannot suggest safer sex. Women reported in a workshop that they see their men moving with women whose husbands died of AIDS but they could not ask them because they will be told to pack and go yet they do not have anywhere else to go (UNAIDS, PP6 2000).

Men have always dominated women in all aspects; economic, social and cultural spheres of their lives and are historically recognized as authoritative decision makers in both private and public spheres. These socio-cultural, economic factors and lack of autonomy, places women at the very heart of the HIV/AIDS epidemic. The impact on women ranges from more women being infected due to their vulnerability, taking care of the sick, probably as well as losing their homes and other assets if they are widowed. Also, women tend to have more blood transfusions during childbirth and in case of abortions. This exposes them to higher risk of being infected. Poor women also use their sexuality to support their children and improve their social status by becoming concubines or lovers for wealthy men, either by working in bars or as prostitutes (Clark, pp137 1984).

2.6. Theoretical framework

2.6.1. Capacities and Vulnerabilities Analysis

The framework was designed specifically for use in humanitarian interventions and for disaster preparedness. It aims to assist outside agencies to plan interventions in a way that it meets the immediate needs of people, build on their strengths and support their efforts to achieve a long term development. The core concept of the CVA is that people's existing strengths (capacities) and existing weaknesses (vulnerabilities) determine the effect that a crisis has on them and their response to it. The theory relates well in addressing PMTCT interventions. The realization that, lack of comprehensive

involvement of all affected persons may impinge on the economy, social and political progress thus reducing the life expectancy by decades.

Women are more vulnerable not only because of the biological makeup but also due to social, economic and cultural factors hence make them to be at the centre of the epidemic. Therefore, this study focused to investigate how men's participation would improve implementation of PMTCT programs and turn around infants' HIV infection prevalence and encourage early diagnosis of HIV/AIDS.

Capacities relate to peoples resources, social organizational resources and their attitudes. Vulnerabilities are the long term factors that weaken people's ability to cope with unexpected disaster or prolonged emergencies. HIV/AIDS was declared a national disaster in 1993, NASCOP 2005 pp3. Women continue being affected more than men. Maternal and child health strategies and policies in Kenya seeks to address the needs of the children, the mothers and there is less involvement of male counterparts. Hence the reproductive health concerns affecting both men and women will not be comprehensively addressed. Identifying the various needs for both men and women on the PMTCT programming would go along way in providing comprehensive services. In this framework a distinction is made between vulnerabilities and needs. In the context of HIV/AIDS short term goals would be to ensure counselling and testing of a couples/ sex partners to determine the HIV status and provision of necessary interventions that ensures prevention of transmission from the child to the mother.

Capacities and vulnerabilities are divided into three levels.

Physical and material

These refer to land, environment, climate, housing, food, water supply, access to income and other assets. All these are different. Men and women possess resources including various skills and capacities which agencies can build on find long lasting solutions to problems. These are necessary for successful PMTCT implementation. There is need to identify who controls these resources in the family and in the community. The outcome of involvement of both men and women in decision making regarding utilisation of these resources is one step to address comprehensive PMTCT implementation not only in the affected family but also the community.

Social/organizational capacities and vulnerabilities

These include features of social structures and systems through which communities organize them. It refers to formal political structures and informal systems that people use to make decisions or organize economic and social activities. Mostly, women are excluded in decision making not only at the family level but also at the societal systems making it difficult for them to actively participate in solving problems that affect them. In PMTCT context, women are viewed as patients or clients and to which the real decision makers are their, Sex partners, health workers or the policy makers who decide on their behalf. This sometimes leads to their problems being addressed partially or they are may not be addressed at all.

Motivational/ Attitudinal capacities and vulnerabilities

These are related to how people react on a crisis. They can be influenced by psychological and cultural factors like religious believes. Appropriate intervention will

build on peoples own skills and increase their confidence. Inappropriate aid may result in people feeling dependent and despondent thereby reducing their capacity to cope and recover. The current implementation of PMTCT programming may make pregnant women vulnerable and helpless since all decisions are either made at the mercy of the clinician or by the sex partners/ husband at home. In this case the women's actions may be strictly to please the two sides and not what they may consider best choice for themselves.

2.6.2. Health care-seeking and PMTCT service utilization behaviour: Theory of Planned Behaviour

Seeking and utilizing health services is an area of great concern in the context of HIV/AIDS. Part of the challenge lies in identifying factors associated with seeking and utilizing HIV/AIDS-related health services. As such, the main barriers to seeking and utilizing health services are not only financial but also psychological, informational, cultural, social, and organizational factors play a substantial role (Donabedian, Axelrod, & Wyszewianski, 1980 PP26).

This framework has also guided research studies focusing on factors which inhibit or facilitate testing for HIV [see for example, (Holtzman, Rubinson, Bland, & Mcqueen, 1998)].The behavioral framework conceptualizes health care-seeking and health care-utilization behaviour as a consequence of the characteristics of the health system and characteristics of individuals who comprise the population at health risk.

On one hand, the characteristics of the health care system are related to the health technology (for example, HIV-antibody test, antiretroviral therapy), as well as health-

related beliefs (for example, believing that HIV infected people are likely to die faster if they are tested for HIV and informed of their positive results) as well as values (for example, confidentiality of HIV test results among service providers). Likewise, health service utilization may depend on the nature of the health services (for example, hospital-based services; ANC services meant for women and children); and policies related to health delivery (for example, visiting health services as a couple or single, going for a single visit or a series of visits).

On the other hand, the individuals in the population at risk are specifically characterized as having predisposed, enabling and need characteristics (Branch et al., 1981 pp 104). Predisposing variables normally exist prior to the onset of the illness and they consist of individual characteristics that can be altered (for example, perceived barriers to the use of PMTCT) or demographic characteristics (for example, level of formal education, age, gender, and marital status). The enabling component describes the means individuals have for using health care services including the resources available (for example, the extent to which the population at risk can afford the cost of the services) and some attributes of the community in which an individual lives (for example, attributes of the rural versus that of the urban).

The need component, which is the immediate cause of health care seeking and utilization, refers to the illness level. Need for health services can be based on individual's symptoms, evaluation of health status, and perceived susceptibility (chances of getting the disease) or severity (the extent to which the disease is perceived to be dangerous). The present study expected characteristics of the health care system and characteristics of individuals in the population at risk to be associated with an increased or decreased likelihood of having been tested for HIV among pregnant women in Kenya.

HIV/AIDS-related stigma as an anticipated discrediting phenomenon

The study on the prevalence and factors associated with anticipation of HIV/AIDS-related stigma (Paper II) employed Goffman's classic concept of stigma as "an attribute that is significantly discrediting" (Goffman, 1963; p.3). Stigma is usually discrediting mainly because it results from blemishes of personal character (having individual traits, actions and behaviours that are negatively marked), spoiled social identity (belonging to social group that has a tarnished image), and physical deformity (disfiguring conditions or physical defects) of an individual (Goffman, 1963).

Other researchers have also defined and explained stigma following Goffman's work. For example, Crandall & Coleman (1992: pp. 163), defines stigma as "a mark which legitimizes treating the bearer in some ways less humanly than those without the mark". This definition is based on the earlier notion that stigma is conceptualized by the community on the basis of what constitutes "difference" or "deviance" (Goffman, 1963).

In the era of HIV/AIDS, qualities which cause reactions directed toward individuals that are suspected or known to have HIV/AIDS may deserve the label "discrediting attributes" because they bring about sense of disgrace, indignity, shame, humiliation, or dishonor to an individual. Previous studies conducted in Tanzania (Biswalo & Lie, 1995; Kohi & Horrocks, 1994) for example, point out that people who are known or suspected to have HIV/AIDS are prone to reactions such as fear, anger, rejection, gossip, avoidance and blame from others. The survey on the general public's attitude toward people who are suspected or stigmatizing others or known to have HIV/AIDS in United States (Herek & Capitano, 1993) also identified that the public favoured coercive policies that would

control the spread of HIV/AIDS. The public was also found to exercise avoidant behaviours towards people living with AIDS.

Most of the previous research on HIV/AIDS-related stigma have been focused on 'self Stigma'. This is manifested in self-blame due to guilt feelings. For example, Duffy, 2005 (pp 4); defines it as 'enacted stigma'; that which is manifested in the actual reactions and behaviours. Lie & Biswalo, 1996), says it's 'perceived stigma', which refers to the attitude towards being stigmatized.

Unlike previous studies, the focus of the present study was on the social psychological consequences of HIV/AIDS-related stigma in form of anticipated stigma. This kind of stigma refers to the discrediting reactions that people may personally expect, foresee, look forward to, await, predict, or think likely to occur if they would be suspected or known to have HIV/AIDS. In practice, the experience of the stigmatizing reactions toward people who are suspected or known to have HIV/AIDS, is likely to evoke feelings of HIV/AIDS related stigma even before individuals are tested to know about their HIV status or even before they are actually stigmatized. As Kleinman (1988) noted, the stigmatization process usually begins with the society's actual responses, but eventually the person "comes to expect such reactions, to anticipate them before they occur and even when they don't occur" p. 160. The anticipation of the discrediting reactions was therefore taken as a point of departure in assessing HIV/AIDS-related stigma in this study.

PMTCT service uptake as a planned behaviour

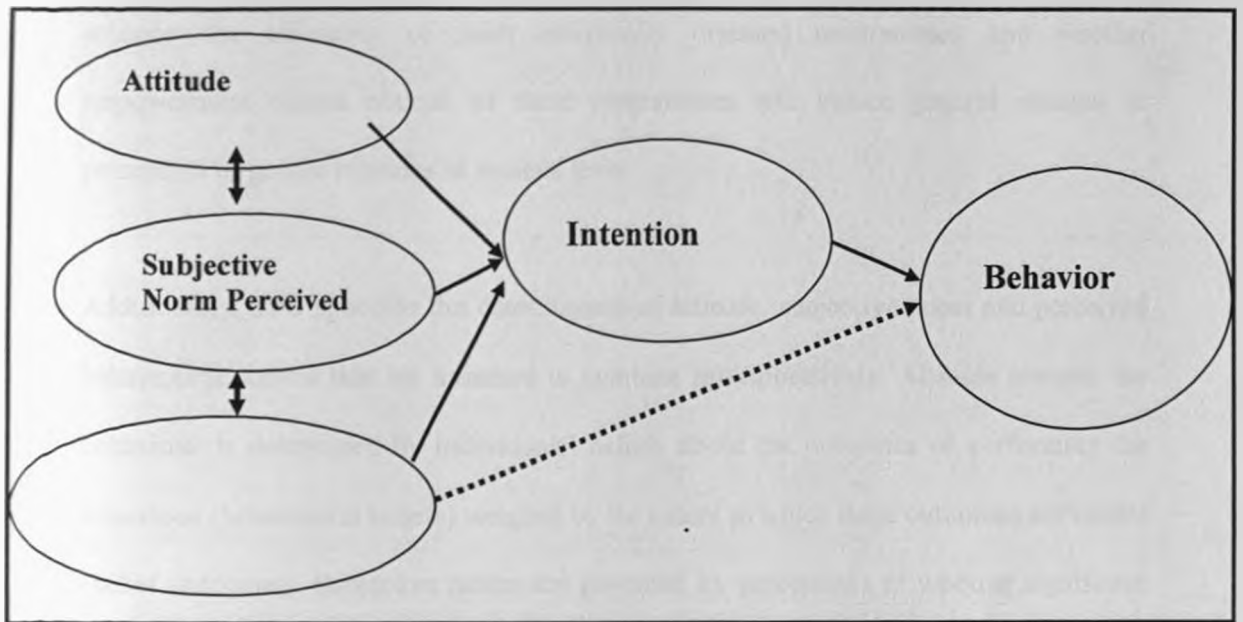
Theory of planned behaviour, TPB (Ajzen, pp 125 1991), is a social cognition model (SCM) that constitutes a promising framework for understanding and predicting

behaviours and behavioural intentions. The TPB is an extension of the earlier Theory of Reasoned Action (TRA) (Ajzen & Fishbein, pp 95 1980; Fishbein & Ajzen, PP140 1975) proposing that people are rational actors who voluntarily process and use available information before performing behaviour. According to the TRA, intention to perform the behaviour is a function of attitude and subjective norms and is the immediate determinant of behaviour performance (Ajzen,PP 11& 20 1985). Given that the TRA did not account for behaviours that were not under volitional control, Ajzen and Madden proposed the TPB that consisted of perceived behavioural control (Ajzen & Madden, PP 32 1986) which is similar to Bandura's concept of self-efficacy (Bandura,PP 57& 58 1982).

Perceived behavioural control was therefore added on a level with attitude and subjective norms as a predictor of intention so as to measure persons' perceived ability to perform a particular behaviour in different situations (Ajzen, 1991 pp 180. In the TPB, attitude towards performing behaviour reflects a favourable or unfavourable evaluation of the particular behavior. Subjective norm refers to the perceptions of specific significant others' preferences of whether one should or should not engage in behaviour and perceived behavioural control manifests the perceived ease or difficulty associated with behaviour performance.

The three predictors of the TPB influence subsequent behaviour indirectly through behavioural intention. However, perceived behavioural control may influence behaviour directly if it reflects actual control and whenever the behaviour in question is not under complete volitional control by the individual as shown in figure 1 below.

Figure 1: The Theory of Planned Behaviour (Ajzen, PP 179& 211 1991)



Using the illustration above, one can depict that empowerment is a key tool, that enables HIV-positive women deploy the opportunities that are provided and take informed decisions with a view to making free reproductive choices. Women who do get tested and receive an HIV-positive result are faced with a number of overwhelming consequences, ranging from fear for themselves and their infants to decision-making regarding their pregnancy, anxiety about whom to tell and how they will react, questions on how to get treatment, where to get support, how to take care of their children and how to relate to the community. Awareness of an HIV-positive status may have psychological, social, economical and practical consequences for women who consider becoming pregnant or are already expecting a baby.

In order to reduce psychological and social obstacles for women's participation in PMTCT programmes, initiatives such as the MTCT-Plus Initiative, attempt to overcome these obstacles through inclusion of partners and other members in the household.

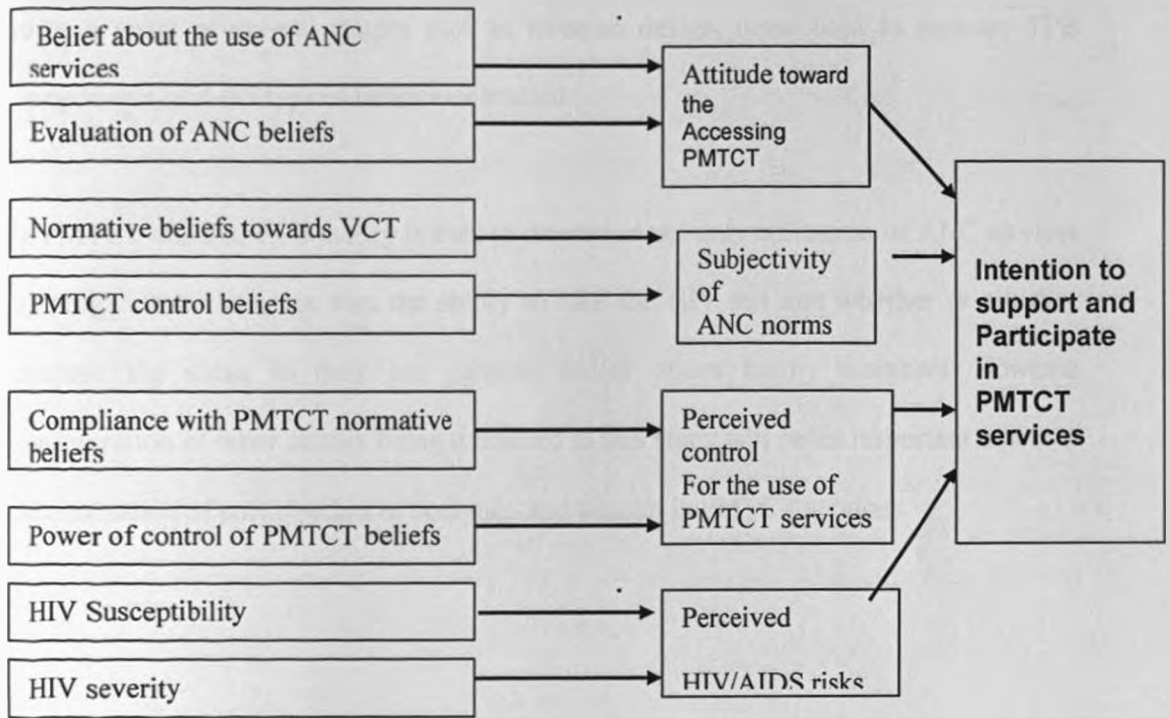
However, the question is whether there is sufficient political goodwill and resources to enhance the efficiency of such holistically oriented programmes and whether empowerment related notions of these programmes will induce general changes in perception of gender relations at societal level.

Additionally, TPB specifies the determinants of attitude, subjective norm and perceived behavioural control that are assumed to combine multiplicatively. Attitude towards the behaviour is determined by individuals' beliefs about the outcomes of performing the behaviour (behavioural beliefs) weighed by the extent to which these outcomes are valued (belief outcomes). Subjective norms are governed by perceptions of whether significant others think that one should or should not perform the behaviour (normative beliefs) and one's motivation to comply with the wishes of significant others (motivation to comply).

Similarly, beliefs about the presence of factors that might hinder the behavioural achievement (control beliefs) and perceived ability to control factors that might hinder the behavioural achievement (power of control) provide the basis for perceived behavioural control.

Despite the success of the core components of the TPB model in predicting behavioural intentions and subsequent behaviours, it has been recommended that the TPB is open to the inclusion of other variables if they increase the predictive utility of the model after the theory's core variables have been taken into account (Ajzen, 1991). Consistent with this reasoning about the sufficiency of this theory, the current study extended the TPB by adding a measure of perceived risk as indicated in figure 2.

Figure 2: The extended theory of planned behaviour as applied to the present study



This inclusion of perceived risk was deemed necessary because of the high prevalence of HIV in Kenya. In addition, perceived HIV risk has been reported to have a significant role in decisions related to HIV prevention in the previous studies that were not theory driven (Fylkesnes & Siziya, 2004; Gage & Ali, 2005; Holtzman et al., 1998 pp12).

The TPB is the most widely tested and validated model in the prediction of health behaviours in different social-cultural contexts (Godin and Kok, 1996 pp 136). Whereas most of studies have been conducted in western countries and cultures where the theory was developed, a few studies have been published in an African context. For instance, the TPB has been useful in predicting condom use behaviour in Kenya and other prevention programs. Similarly, the TPB was successful in predicting contraceptive use among

adolescent girls in Ethiopia (Fekadu, 2001). However, the differences in relation to the predictive validity of TPB components have also been noted. Such differences are likely to be a result of several factors such as research design, items used to measure TPB components, and the type of behaviour studied.

In PMTCT context, PTB theory is used to determine not only utilization of ANC services by pregnant mothers but also the ability to take the HIV test and whether or not they disclose the status to their sex partners and/or others family members. However consideration of other factors being examined in this study will be an important aspect in determination of participation of both men and women in PMTCT services.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

This chapter described the design and methodology used for the study. The research design, target population, sample size, techniques, research instrument, data collection procedures and data analysis is discussed.

3.2. Research Site

The study was carried out in Tharaka District Nkubu and Materi MCH centres. These are mission hospitals and PMTCT programs supported by Catholic Medical Mission board (CMMB).

3.3. Research design

This study adopted both probability and non-probability sampling techniques. The Northern part of the Eastern province has 8 districts, each of which has about six to eight health clinics and centres. The population is quite heterogeneous and an attempt was made to capture the differences by using a method that ensured equal representation of the districts. With the help of the office of the District AIDS coordinator (DASCO) at Meru central district offices, the researcher obtained a list of all the mission health centres providing PMTCT services in the province. To select the centers to be visited, multistage sampling method was used. At the first stage, a simple random sample of 2 districts was drawn using lottery method. At the second purposive random sampling was done to select 2 health centers which had the highest number of PMTCT clients from each district. Below are the 8 faith based health facilities from which the two facilities were selected from;

Name of Health facility	Number of ANC clients served between April – June
PCEA Chogoria mission Hospital	353
consolata Hospital Nkubu	545
St. John Hospital	36
Consolata cottage	62
St Orsola Consolata Hospital-Materi	603
Consolata hospital –Kyeni	85
St. Theresa consolata Kirwa	214
Maua Methodist	525

Source: ANC monthly summaries April – June 2008

To select the number of patients to be interviewed per health centre, the study considered the relative size of the catchments' population of each centre.

3.4. Target population

The target population comprised of HIV positive couples and women accessing MCH services from the above mentioned health facilities. The target population was drawn from persons' of reproductive age (15-49 years). The researcher interviewed 50 respondents selected from a group of HIV positive pregnant women and 20 HIV positive

pregnant couples. These helped the researcher make comparisons of various views and also identify the existing gaps.

3.5 Unit of analysis and observation

According to Singleton, in social research, the entities (objects/events) under study are referred to as units of analysis (Singleton, 1998: 69). Nachmias and Nachmias (1996: 53) define the unit of analysis as the most elementary part of the phenomenon to be studied. In this study, the unit of analysis was the health services point represented by MCH clinics / health centers. The units of observation were health service users at these clinics.

3.6. Sample size and sampling procedure

The study was carried out in Tharaka District in Nkubu and KYENI MCH clinics.

The process of selecting the sample size of the 50 women that were interviewed was done through purposeful selection of pregnant women whose HIV test results turned out positive. This was based on the number of women who turned out for MCH services on a weekly basis in the mentioned health centres. The process of selection of the 50 was based on two different criteria; the clients that were booked for their monthly appointment in the clinic's diary and the clients that underwent counselling and testing and were found to be HIV positive. Selection of the 20 couples was done through snowballing method. The respondents were requested by health workers to participate in the study. Some participants choose to bring their spouses to the clinic upon the request of the health workers. It is imperative to note that none of the participants were coerced to take part in the study. All details regarding the study were explained and participants were asked to consent to participate.

3.7. Data collection methods and instruments

3.7.1 Self administered Questionnaires

These questionnaires had both semi structured and structured questions. They were aimed at collecting both qualitative and quantitative data. They were administered to individual clients at the facility who were able to read and write.

3.7.2 Summary Tool

This tool was developed to obtain secondary data containing information of all clients who visited the facilities and the HIV services provided to them. These were useful in making comparison to the information obtained from the individuals interviewed. A data collection tool was developed to help in summarizing the information from the identified facilities.

3.7.3 Structured interviews

Structured interviews are interviews where the sequence in which the questions are asked is the same in every interview, and the number of questions and the wording of the questions are similar for all the respondents (Nachmias and Nachmias 1999:234). The research instrument used here was an interview schedule, which included both closed and open-ended questions. It was administered to the ANC and PMTC clients at the MCH clinics. The questions were developed based on the literature reviewed, problem statement and objectives of the study.

3.8. Data Analysis

After completion of data collection the information was coded. Both quantitative and qualitative data was used. The collected data was analyzed and interpreted. Closed-ended

questions were coded to enable all the responses to be keyed into the computer. The data was analyzed using the Statistical Package for Social Scientists (SPSS). Descriptive statistical procedures were used to describe the distribution and derive patterns from the data. These were percentages, frequency distribution tables, cross tables and pie charts. Part of the qualitative data was analyzed as it was being collected. Analysis involved reducing, selecting and transforming it into relevant themes.

3.9 Problems experienced in the field

The data was collected within a span of two months, from mid May to mid July 2008. It took about four weeks to get the relevant authority from the administrators of the various hospitals and the DASCO in charge of the HIV program in the two districts. This delayed commencement of data collection by almost four weeks. On commencement of data collection, some nurses in charge of the surveyed health clinics were still skeptical and had to seek more clarification from the Hospital administrators, even after the researcher had presented the letters of authority. This delayed the exercise even further.

The data collection exercise was tedious and took time. The researcher used an interview schedule to collect data. This took a lot of time as some concepts in the interview schedule needed detailed explanations. Was there need to translate the schedule to the local languages to facilitate easier understanding among respondent? If so did you do back translations? To complete this exercise on time, the researcher engaged the help of two research assistants.

Another problem was how to assure confidentiality among clients who had not disclosed their HIV status to their spouses/ sex partners. In some instances, it was impossible to

carry out in-depth interviews with the key- informants. So how did you deal with this problem? They insisted they had no time to sit and talk and opted to read and fill the interview schedule individually for me to collect later. This in a few cases left out important details that the researcher would have probed.

Majority of the respondents were not accompanied by their spouses to the health facility and this forced me to provide transport for them to bring their spouses to the health centre the following day. This however, only applied to clients who had disclosed their HIV status.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1. Introduction

This chapter presents and discusses the research findings. The data was collected through a questionnaires survey and interviews. The chapter is divided into three parts. The first part deals with gender barriers in the implementation, identifying the gender related factors that influence successful implementation and recommendations on gender-related areas which are key to PMCT programs. How about the second and third parts?

Descriptive techniques were used to organize, summarize and interpret quantitative information. Data was then presented in form of frequency table charts and cross tabulation tables where applicable. This presentation is based on the questionnaire that was administered.

4.2. Background characteristics of health users of the city council health clinics

This section presents the characteristics of personal attributes of individual respondents for both couples and pregnant women in the study. They include; gender, marital status, level of education and occupation for both couples and pregnant women in the study. The rationale behind inclusion of these attributes in the analysis is that they help to shed some light on respondents' characteristics as these may have some bearing on PMCT program. The study managed to capture all the respondents targeted in the sample size.

Couples

Table 1: Distribution of Respondents by their Sex

Sex	Frequency	Percentage
Male	20	50.0
Female	20	50.0
Total	40	100.0

Source: Field work 2008

In table 1 above there were 50% male and female respondents.

Table 2: Distribution of the Respondents by their Level of education

Education level	Frequency	Percentage
None	8	20.0
Std 1-5	6	15.0
Std6-8	6	15.0
Secondary	8	20.0
Diploma	12	30.0
Total	40	100.0

Source: Field work 2008

A significant number of the couples (30%) had achieved diploma level education, 20% of them had secondary and another 20% had no education. 15% of the couples had attained std.1-5 and stud.6-8 level of education.

Table 3: Distribution of Respondents by their Occupation

Occupation	Frequency	Percentage
Farmer	5	12.5
Housewife	5	12.5
Trader/ Market	11	27.5
Teacher	10	25.0
Artisan	4	10.0
Civil Servant	5	12.5
Total	40	100.0

Source: *Field work 2008*

About 27.5% of the couples were traders in the market, 25.0% of them were Teachers, while 12.5% of them were farmers, housewife, and civil servants respectively, only 10.0% of the couples who indicated that they were artisans.

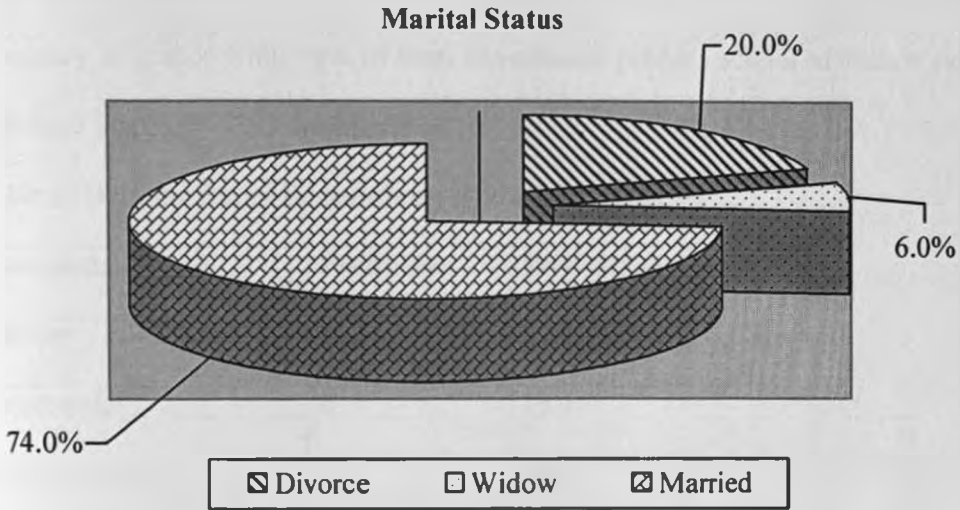
4.3. Demographic Data for the Pregnant Women It would be better if you followed the same order you used for couples the marital status comes thereafter.

Table 4: Marital status

Status	Frequency	Percentage
Divorced	10	20.0
Widowed	3	6.0
Married	37	74.0
Total	50	100.0

Source: *Field work 2008*

Fig I:



74.0% of the respondents indicated that they were married, while 10% of them indicated that they were divorced and only 6.0% of them were widowed.

It was important to know the respondents level of education the results are as indicated in the table below.

Table 5: Level of education

Education Level	Frequency	Percentage
None	11	22.0
Std 1-5	7	14.0
Std6-8	7	14.0
Secondary	8	16.0
Diploma	17	34.0
Total	50	100.0

Source: Field work 2008

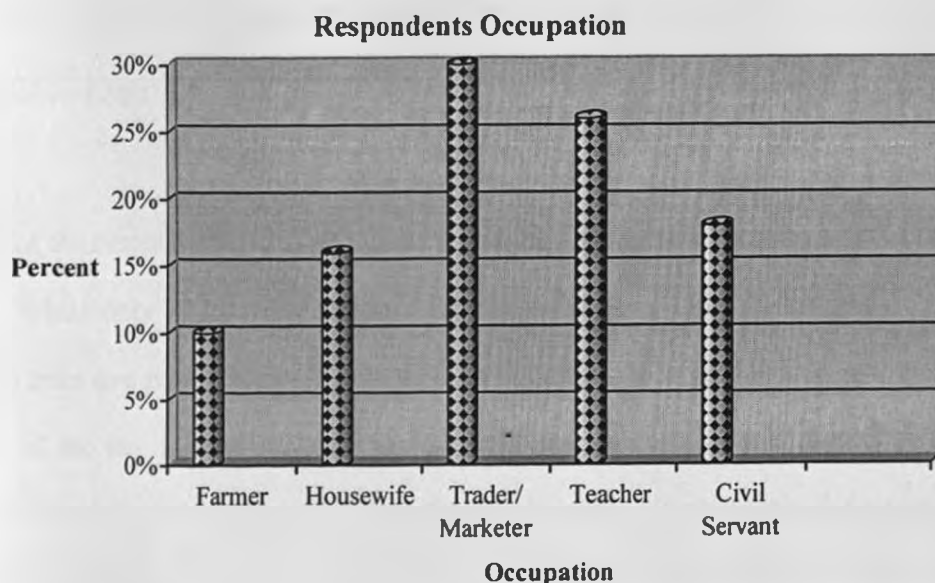
A sizable number of the respondents (34.0%) had attained diploma level of education, while 22.0% of them had no education. 16.0% of them indicated that they had attained secondary education while 14% of them had attained primary school education since they had either standard 1-5 or 6-8 education.

Table 6: Distribution of Respondents by their Occupation

Occupation	Frequency	Percentage
Farmer	5	10.0
Housewife	8	16.0
Trader/ Market	15	30.0
Teacher	13	26.0
Civil Servant	9	18.0
Total	50	100.0

Source: Field work 2008

Fig II



About (30%) of the pregnant women in the study were traders in the market, 26% of them were teachers , 18% of them were civil servants while 16% of them were housewives and only 10% of them were farmers.

4.4 Knowledge of HIV

The researcher wanted to establish whether the respondents had knowledge of HIV. The researcher hence enquired from the respondents whether they had been tested for HIV. All the couples and the pregnant women indicated that they had tested for HIV/ AIDS. The researcher then enquired to know whether they went together with their partners.

Table 7: Distribution of the Respondents by those who tested with their Spouses

	Frequency	Percentage
Yes	15	37.5
No	25	62.5
Total	40	100.0

Source: Field work 2008

Majority of the respondents (62.5%) indicated that they had gone for testing without their partners. While only 37.5% who indicated that they had gone with their partners. This may have been as a result of their health workers requesting their partners to come along. Majority of the key informants (82.0%) being the pregnant women too did not go for testing with their spouses and only 18.0% of them who went with their spouse for testing. This shows that many of the times spouse do not accompany their wife's to the clinic for testing.

Knowledge of HIV Status

The researcher also wanted to know whether the respondents were able to disclose to their partners about their HIV status. The table below indicates the results.

Table 8: Distribution of respondents by whether they had disclosed their HIV status to their spouses Status

	Frequency	Percentage
Yes	11	27.5
No	29	72.5
Total	40	100.0

Source: Field work 2008

Majority of the respondents (72.5%) indicated that they had known their HIV status but had not revealed to their spouse while 27.5% of them indicated that they had revealed to their partners. When the pregnant women were asked whether their spouse were aware of their HIV status, majority (82.0%) of them indicated that they did not reveal to their spouse their HIV status while only those who came with their spouse for testing were aware of their HIV Status.

4.5 Reasons for not disclosing HIV status

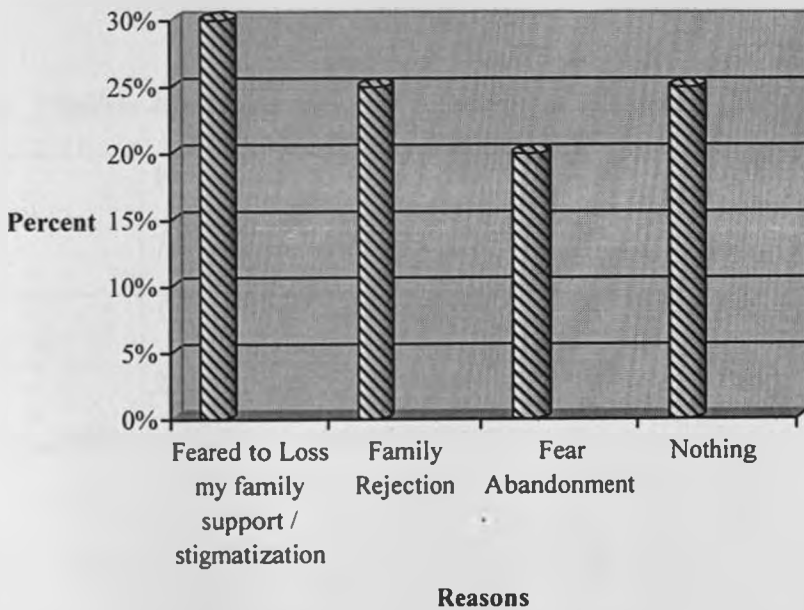
The researcher enquired from the respondents why they did not disclose their HIV status to their spouse. The results are as shown in the table below.

Table 9: Reasons for not disclosing HIV Status

Reason	Frequency	Percentage
Feared to loss family support / stigmatization	6	30.0
Family rejection	5	25.0
Fear of abandonment	4	20.0
Nothing	5	25.0

Source: Field work 2008

Fig. III: Reasons for not disclosing HIV Status



A good number of the respondents (30%) indicated that they feared the loss of family support and stigmatization while 25.0% indicated that they feared being rejected by their families and others never gave any reason. 20.0% of them feared abandonment. Though, it was difficult to disclose their status because of stigma associated with HIV, they had to gain courage to inform their spouses and families Most (48%) of the pregnant women indicated that they were not aware of their partners HIV status hence did not reveal their status. They feared family rejection. About 32.0% of them indicated that of feared

abandonment, loss of family and partners support, and stigmatization. 18% of them indicated that it was not necessary since their partners, already were aware of their status. Women may hesitate or fail to return and disclose their HIV status because they are afraid the results may be physical violence, expulsion from their home or social ostracism (UNAIDS, 2004pp 4).

4.6 Spouse Support during Pre and Post Natal Period

The researcher wanted to know whether there was any spouse support during pre and post natal period. The tables below indicated the results.

Table 10: Spouse Accompaniment for Antenatal or Post Natal Clinic

	Frequency	Percent
Yes	7	35.0
No	13	65.0
Total	20	100.0

Source: Field work 2008

Majority of the respondents (65.0%) indicate that their spouses do not accompany them for antenatal or post natal clinic, while 35.0% of the respondents indicated that they did accompany them.

Table 11: Spouse Accompaniment for Antenatal or Post Natal Clinic

	Frequency	Percent
Yes	2	10.0
No	18	90.0
Total	20	100.0

Source: Field work 2008

Majority (90%), of the respondents indicated that their partners did not accompany them for the antenatal or post natal clinic while only 10% indicated that sometimes they were accompanied to the antenatal or post natal clinic by their partners on the request of the health worker.

Reasons for not being accompanied by Spouse for the clinic

When asked the reasons why the men do not accompany them to the clinic, the following reasons were given as shown in the table below.

Table 11: Reasons that Limit Spouse from accompanying them to the Clinic

Reason	Frequency	Percent
Have never requested my spouse to accompany me	5	25.0
Men assume its women's role and duty	3	10.0
Busy	1	5.0
Culturally defined as woman's role	1	5.0
No explanation	4	20.0
N/A	6	30.0
Total	20	100.0

Source: Field work 2008

When the respondents were asked why their husbands do not accompany them to the clinic 25.0% of them indicated that they had never requested their spouse to accompany them to the clinic. 10.0% of them indicated that men assume it is women's role, while 5% of the respondents indicated that they were busy. A further 5% said that it was a culturally defined as a woman's role. About 20% of the respondents never gave any explanation. The question was not applicable to 30% of the respondents. . The reasons given by the key informants were that culturally, it was defined as a woman's role, they never requested their spouse to accompany them and that their spouses were busy working to earn a living and others were away from their homes. It is a reality that men are often reluctant to seek healthcare, more so accompanying their wives for the antenatal care since this is considered to be women's role. Men frequently feel pressured into hiding their lack of knowledge, stifling their ability to ask questions and get more information on HIV/AIDS (UNFPA2004). In addition, men living with HIV/AIDS and facing stigma may be reluctant to seek help from and/or join support groups and networks.

Support Received During Pregnancy and After Delivery

The researcher wanted to know the specific support women receive from their spouse during pregnancy and after delivery. The results are as shown in the table below.

Table 12: Support Received from you Spouses during Pregnancy Period and after Delivery

	Frequency	Percent
Moral support/ emotional Support	6	15.0
Do not even care only happy we got a baby	6	15.0
Financial support	4	10.0
Financial, moral support and emotional support	4	10.0
Total	20	100.0

Source: Field work 2008

Women were asked to indicate the specific support they had received from their spouses during the pregnancy period and after delivery. About 15.0% of them indicated that they did not care and were only happy they got a healthy baby. Others, 15% indicated they were offered moral and emotional support. Further, 10% of them indicated receiving financially, morally and emotionally from their spouses.

Men Section

The researcher also wanted to know from the men whether they accompanied their wives to the clinic during pregnancy. The results are as shown below.

Table 13: Ever accompanied wife to the clinic during pregnancy

	Frequency	Percentage
Yes	6	30.0
No	14	70
Total	20	100.0

Source: Field work 2008

When men were asked whether they had never accompanied their wives to the ANC clinic during pregnancy, a majority of them (70%) indicated that they had never accompanied their wife’s to the clinic while 30.0% of the indicated that they had ever accompanied their wives to the clinic during pregnancy.

The researcher inquired from the respondents why they did not accompany their wives for antenatal services. The results are as indicated in the table below.

Table 14: Reasons Hindering Men from accompanying their wives for Antenatal Services

	Frequency	Percentage
Engaged at work or elsewhere	5	25
It's not men's responsibility	5	25
It has always been women's role and therefore men find it difficult to do it	5	25

Source: Field work 2008

About 25% of the respondents indicated that they were engaged at work other engagements elsewhere, others felt that it is not men’s responsibility, while others felt it has always been women’s role and therefore men find it difficult to do it. Some indicated that they were not invited or asked by a health worker to accompany their wives to the clinic.

Specific Support offered by men to their wives

The researcher wanted to find out the specific support men provided to their wives during the pre and post pregnancy period. The results are as shown in the table below

Table 15: Specific Support provided to wife during the Pre and Post Pregnancy Period

	Frequency	Percentage
Financial support	6	30.0
Moral support	6	30.0
Sharing some family responsibility	5	25.0
All of the above	3	15.0
Total	20	100.0

Source: Field work 2008

Majority of the responses (30%) indicated that there was financial support. A similar percentage cited the availability of moral support. 25.0% of the respondents indicated that they shared some family responsibilities with the spouses.

Table 16: Whether Support Affected Receptiveness, Spouse Assistance and Reduced Stress caused by the Process

	Frequency	Percentage
Not affected	11	27.5
Reduced stress	20	50.0
Felt demotivated and less helpful	8	20
Total	40	100

Source: Field work 2008

Majority of the respondents (50%) indicated that the support they were given was reduced the level of stress and appreciated the process. Meanwhile 47.5 % of the respondents indicated that it they were either not affected or felt demotivated and less helpful.

Table 17: Received PMCT Services

	Frequency	Percentage
Yes	35	87.5
No	5	12.5
Total	40	100.0

Source: Field work 2008

Majority of the respondents (87.5%) indicated that they received PMCT services while 12.5% of them indicated that it did not receive PMCT services.

4.7 Informed Family of PMTCT Services

The researcher requested the respondents to indicate whether they informed their family when they were provided with the PMCT services.

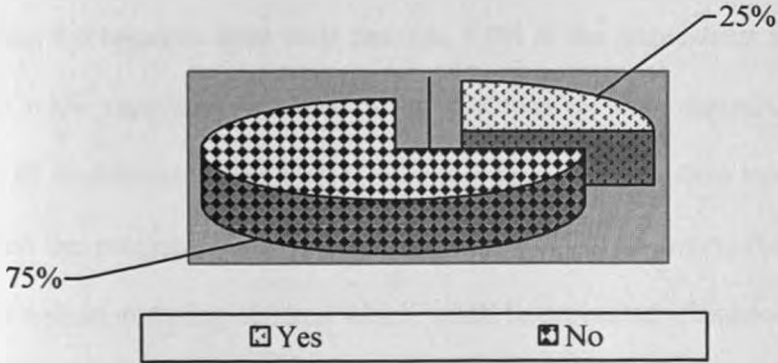
Table 17: Inform Family when Provided with the PMCT Services

	Frequency	Percentage
Yes	5	25.0
No	15	75.0
Total	20	100.0

Source: Field work 2008

Fig. IV

Informed Family when Provided with the PMCT Services



Majority of the respondents indicated that they did not inform their family when they were provided with the PMCT services. Only 10.0% of them indicated that they did inform their families.

Response from family on known of PMTCT services

The researcher wanted to know the reaction of the family when informed of the provision of the PMCT services. The results are as shown in the table below.

Table 18: Responses for Family when informed of Provision of PMCT Services

	Frequency	Percentage
Supportive	2	10.0
Mixed reactions	3	15.0
No Response	15	75.0
Total	20	100.0

Source: Field work 2008

About 15.0% of the respondents indicated that their families had mixed reaction. Only 10.0% of the respondents who indicated that their families were supportive when they were informed of provision of the PMCT services. When the key informants were asked to indicate the response from their families, 6.0% of the respondents indicated that their families were supportive but had mixed reactions on their status. An increase in the number of mothers accessing PMTCT services have risen but there have been challenges that faced the program, such factors as the rate re-infection among the pregnant women and new infection among children which would be prevented if diagnosed in the prenatal period is on rise hence all factors must be considered for effectiveness of the intervention.

Problems faced during the time they received PMTCT Services

The researcher also wanted to know the problems they WHO? faced during the time they were receiving PMTCT services. The results are as shown in the table below.

Table 19: Problems faced during the time you were receiving PMTCT services

	Frequency	Percentage
Fear associated with disclosure of HIV Status	6	15.0
Lack of financial support & social support from the spouse	4	10.0
Lack of following of clinician's advice	4	10.0
Domestic quarrel due to early stoppage of breastfeeding of infants	3	7.5
Fear Stigma and discrimination	3	7.5
Total	40	100.0

Source: Field work 2008

4.8. Summary of Findings

15.5% of the respondents both couples and the pregnant women indicated that they feared to lose family support and to be stigmatized or be rejected by their families and therefore they did not disclose HIV status. Meanwhile, 20.0% of them feared abandonment. Although this was difficult, they gained courage and informed their spouse of their HIV status. Majority of the pregnant women also indicated that they were not aware of their partners HIV status hence did not reveal their status since they feared family rejection, abandonment, loss of family support and stigmatization and partners support.

To identify the gender related factors that influence successful implementation of PMTCT program, the researcher asked the respondents how their families and spouses reacted to the use of medication during pregnancy. Majority of the respondents indicated that their families had mixed reaction and most of them indicated that their families were supportive when informed of provision of the PMTCT services. When the key informants were asked to indicate the response from their families most of them indicated that their families were supportive but had mixed reactions on their status. An increase in the number of mothers accessing PMTCT services has been noted but there have been challenges that face the program.

To make recommendations on gender related areas that are crucial to PMTCT programming, majority of the respondents indicated that they received PMCT services. Only a minority did not receive these services. This shows that if more male counterparts are involved in the PMCT program, more HIV infected pregnant women would be enlightened and also receive more support from their spouses. The community can also be involved in the program so as to support more mothers to prevent their unborn babies.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The chapter presents the summary, conclusions, and the recommendations of the study.

5.2. Summary

Most of the respondents both couples and the pregnant women indicated that they feared to lose of family support, due to stigma associated with HIV/ Aids. Hence it was difficult to disclose their status but had to gain courage to inform their spouse and other family members.

To identify the gender related factors that influence successful implementation of PMTCT programming the researcher asked the respondents how their families and spouses reacted to the use of ARV prophylaxis drugs in the course of their pregnancy. Majority of the respondents indicated that their families had mixed reaction. However most of them indicated that their families were supportive when well informed of the reason behind the ARV prophylaxis and other PMTCT services.

When the key informants were asked to indicate the response from their families, most of them indicated that their families were supportive but had mixed reactions on their HIV status. Although there has been an increase in the number of HIV infected mothers accessing PMTCT services, the various challenges facing these programs would be averted by targeting the pregnant mothers and their sex partners. These would ensure that rate of HIV re-infection among the pregnant women and new infection among children would be prevented if diagnosed in the prenatal period .

5.3 Conclusion

From the findings lack of comprehensive interventions will further accelerate infection among infants and re-infection on both women and their partners. Programs must target both men and women in provision of PMTCT services and encourage community support to reduce stigma on those who are HIV positive.

Further, the study has identified that women are socially, culturally and economically affected by HIV/AIDS. Most of the respondents reported that there is a lot of family disintegration and stigma especially when they practise the advice given by health providers to prevent infecting the newborns with HIV. This is not taken kindly by family members and spouses that are not well informed about the intervention strategies.

However, some interventions have been put in place to cope with the impact of HIV/AIDS on women especially with the provision of PMTCT services, trainings of health providers as well as mobilization activities geared to address both infected and affected persons on how to cope with the disease. Majority of the respondents however indicated that their families had mixed reaction because they did not have adequate information. Well informed families and spouses were supportive of the provision of PMTCT services.

5.4. Recommendations

It is clear from the study that there is a big impact of HIV/AIDS on women. There is need for community mobilization and awareness activities on the need for involvement of both infected and affected men and women in PMTCT activities. This will help save

more infants from acquiring HIV and provide comprehensive care services to families. There is need for more men to be involved in the program especially husbands or sex partners. Families should also be trained, made aware, supported and assisted to access PMTCT services.

Psychosocial activities should be introduced to counter stigma and discrimination affecting HIV pregnant women when they reveal their status. Men too are equally affected just as women are and therefore strategies that seek to address needs of both would be important. All should be supported by both the community and the extended family to cope and live positively with HIV.

A lot of women empowerment needs to be done. Community mobilization and awareness activities should be inclusive of the current interventions to ensure all are educated on PMTCT and to ensure full participation of both men and women in the intervention. .

The government and other nongovernmental organizations should promote accessibility and availability of PMTCT services in the health facilities. Further, they should change strategies in provision of care to equally target both men and women in the provision of PMTCT services to reduce the strain on women shouldering most if not all, the burden of prevention of HIV to unborn children.

The government could use the level community strategy commonly known as level 6 strategy to intensify awareness and information dissemination to the communities and households. The implementation of this strategy will help us address the issue of providing equitable access to PMTCT services and by so doing will help to “reverse the

trends” of new infections of HIV to unborn children and also re-infection among PLWHAs.

However, I am also aware that we will have to collectively, as stakeholders, face many technical, managerial and other challenges as we comprehensively address the problem. During the implementation process, we will learn many lessons from practice and these will enrich this strategy further. Further there is need to further educate everyone on PMCTC just as everyone knows they should be tested for HIV or use condoms.

5.5. Areas for further studies.

From the study further research needs to be done in some areas as follows.

- Establishing how stigma could be addressed since it was mentioned as an occurrence issue among all people despite a lot of awareness creation and trainings which have been done in the past .
- Investigating the impact of PMTCT programs would have if all fathers were to be are involved in the prevention of mother to child transmission of HIV.

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APPENDICES: QUESTIONNAIRE FOR PMTC CASES

001 QUESTIONNAIRE IDENTIFICATION NUMBER [] [] [] []

PMTCT CASE STUDY IN EMBU AND MERU Central DISTRICTs: GENDER BARRIERS IN PMTCT SERVICES

Please read out to the agent.

"My name is Catherine karugu. I am student in Nairobi University. I'm interviewing women and men accessing PMTCT services the gender gaps in service delivery and the responsiveness of the services to the needs of men and women. This is also part fulfilment of my course at the university and any information you provide will not be divulged to anyone else nor any penalty for refusing to respond to any question. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. Your honest answers to these questions will help identify crucial gender gaps that need to be prioritised for support and guidance. I 'm greatly appreciate your help in responding to this survey.

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

006 INTERVIEWEE: Code [] [] [] [] *(to be coded at a later date)*

007 DATE INTERVIEW: __ \ __ \ ____

Personal Details

1.1 Sex Female Male

2.0 Year of Birth 19 _____

3.0 Level of Education

Level	Tick✓
None	
Std I – Std 5	
Std6 – Std 8	
Secondary	
Diploma+	

Specify

4.0 Occupation

- Farmer
- Housewife
- Trader/Market
- Teacher
- Artisan
- Civil servant
- Other

Specify

4.0 State our average income.....

5.0 Marital status

- 1. single

- 2. divorced
- 3. Widow
- 4. widower
- 5. Married
- Others

Specify

KNOWLEDGE OF HIV

6.0 Have been tested for HIV?

- Yes
- NO

6.1 Were you tested together with your spouse?

- Yes
- No

6.1 If no, does your spouse know your HIV STATUS?

- Yes
- No

6.2 If no what some of the reasons why you have not disclosed? (List)

- 1
- 2
- 3
- 4

SPOUSE SUPPORT DURING PRE AND POST NATAL PERIOD

(Women's section)

7.0 Does you spouse accompany you for antenatal or post natal clinic

- Yes
- No

7.0.1 If no, list some of the factors that limit men from accompanying you to the clinic

- 1
- 2
- 3
- 4

Others

.....

7.1 List the specific support that you have received from the spouse during the pregnancy period and after Delivery

(Mem's Section)

7.3 Have you ever accompany your wife to the clinic during pregnancy?

- Yes
- No

7.3.1 If no, list some of the factors that hinder you from accompanying your wife for antenatal services

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

Others
.....

7.4 List the specific support you have provided to you wife during the pre and post pregnancy period

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

Others specify
.....

7.5 How did this support affect your receptiveness of your spouse assistance and reduction of stress caused by process?

- Not affected
- Reduced stress
- Felt demotivated and less helpful
- Felt supported
- Other (specify).....

8.0 PMTCT services provision

8.1 Do you know the PMTCT services provided to HIV pregnant mothers?

- Yes
- No
- Don't know

8.2 Have you received any of the services?

- Yes
- No
- Don't know

8.3 Did you inform you family when you were provided with the services

- Yes
- No

8.3.1 If yes what was their response?

- Supportive
- Not supportive
- Did not care
- Chased away from marital home

Others specify

.....
.....

8.4 List some of the problems you faced during the time you were receiving PMTCT services.

- 1.
- 2.
- 3.
- 4.
- 5.

Others specify

.....
.....

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