A study of the factors that limit the participation of couples in the PMTCT programme in the urban community of Mamou

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Summary

The Deutsche Gesellschaft für internationale Zusammenarbeit, in partnership with the Faculty of Medicine at Conakry, has carried out a research project in the urban community of Mamou, investigating factors that stop men from participating in the Prevention of Mother-To-Child Transmission (PMTCT) programme for HIV infections.

The data collection technique required 10 focus groups of 8 to 12 subjects each. Five of these groups consisted of pregnant women, while the other five consisted of men. Equally required for the data collection was an in-depth interview with health care staff and their superiors.

The information generated by the focus groups was accurately transcribed, while the core concepts – after first being identified and then re-assembled into homogenous groups - were subsequently evaluated on the basis of specific research questions. The next step was to achieve a triangulation of the data collected from the focus groups with those gained from the in-depth interview with medical staff members.

The results indicate that the factors limiting the participation of men in PMTCT are varied. Three categories of factors were identified as being responsible for the disappointing participation levels of men in PMTCT. The first group of factors relates to the fact that men are poorly informed, both about the disease itself and about PMTCT. It also relates to the fear of stigmatisation and rejection, fear of confidentiality breaches and being blamed, issues that HIV-positive individuals allegedly have to deal with frequently.

The second group of factors concerns issues attributable to the health care system. Two of these issues that stand out are poor treatment quality and the exclusionary manner in which partners are treated in the context of PMTCT interventions.

The third group of factors stopping men from participating in the PMTCT programme is gender-specific.

In order to deal with these manifold obstacles, the study participants propose to:

• inform and sensitize the community about the seriousness of the disease, about the relevance of PMTCT and about the need to encourage men to participate in the programme;
• encourage dialogue between medical staff and couples that are enrolled in the PMTCT programme;
• fight stigmatisation and actively support individuals living with HIV;
• protect the confidentiality of HIV test results;
• insist on a friendly reception and high-quality treatments;
• make the required input available so the PMTCT services run smoothly;
• train the staff responsible for the PMTCT programme, putting special emphasis on problems that concern both partners.
The participants in this study will jointly draw up an operational action plan focused on the implementation of these recommendations.

**Key words**: PMTCT, pregnant women, HIV, AIDS, diagnostic test, counselling, couple, stigmatisation, Health Centre

**Abbreviations and acronyms:**

1. AIDS: Acquired Immunodeficiency Syndrome
2. ARVs: Anti-retrovirals
3. COC: Couple orientated counselling
4. CVCT: Couples’ voluntary HIV counselling and testing centres
5. GIZ: Deutsche Gesellschaft für internationale Zusammenarbeit
6. HIV: Human Immunodeficiency Virus
7. HS: Health Centre
8. MCH: Mother and Child Health
9. MCT: Mother-Child Transmission
10. NACC: National AIDS Control Committee
11. NGO: Non-Governmental Organisation
12. PHD: Prefectural Health Division
13. PLWHIV: Person Living With the Human Immunodeficiency Virus
14. PMTCT: Prevention of Mother-to-Child Transmission
15. PNC: prenatal consultation
16. RHA: Regional Health Authority
17. UNAIDS: United Nations Programme on HIV/AIDS
19. VTC: Voluntary screening and testing centre
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I. Introduction:

Since the start of the HIV pandemic in the 1980s, a significant reduction in the number of new infections with the HI virus has remained the predominant objective of every policy in the fight against HIV. Although considerable progress has been made in recent years, the HIV epidemic remains a major public health issue. According to the global 2012 UNAIDS report on the HIV epidemic, 34 million [31.4 - 35.9 million at the end of 2011] people were living with HIV worldwide. Sub-Saharan Africa remains one of the worst affected regions with almost one in 20 adults (4.9%) living with HIV, which represents 69% of the total number of people living with HIV worldwide. (UNAIDS report, 2012).¹

In Guinea, the national HIV prevalence surveys of the past decade all show that the HIV prevalence level has generally remained stable, but it nevertheless exceeds 1% among the sexually active population aged between 15 and 49, placing Guinea on the list of countries where the epidemic has become generalized. The demographic and health surveys indicate that HIV prevalence in the sexually active population (15 to 49 years) in Guinea went up from 1.5% in 2005 to 1.7% in 2012 [2].²

The HIV prevalence surveys carried out among pregnant women give a better indication of the level of heterosexual HIV transmission. The most recent HIV control and prevention study, carried out among pregnant women in 2008, shows that HIV prevalence is 2.5% at national level versus 1.16% in the region around Mamou.³ Without intervention, the percentage of pregnant HIV-infected women forms the main source of pediatric HIV infections.

Clinical, epidemiological and operational research undertaken during the 1990s has made it possible to define «simple» public health strategies that can be applied during pregnancy and delivery, likely to reduce the mother-infant transmission risk to less than 2%⁴. These strategies involve: counselling and prenatal HIV testing, and for the women who are identified as being HIV positive, a preventive treatment course of antiretroviral medication (ARV), combined with the modification of maternal breastfeeding practices (breastfeeding for a shorter period during which the new-born receives no other liquids or solids). This intervention has been used for more than 5 years at the Health Centres in Guinea where women go for their prenatal check-ups.

¹ Global Report on the HIV Epidemic, UNAIDS, 2012, P1
³ DIALLO Adoulaye Mairie et all: Report on the National Inquiry about the sentinel survey on VIH and syphilis among pregnant women ; German Society for Cooperation, GTZ, 2008
⁴ European collaborative study, Institute for Public Health, Epidemiology and Development, Victor Segalen University, Bordeaux France, 2005, P4
Although it is widely acknowledged that the quality and effectiveness of the PMTCT programme, once it has been adopted by the health system, largely depends on human resources and available logistics, the social and cultural problems PMTCT creates, particularly regarding the role of the male partner in PMTCT, the relationship between the woman and her partner, and how they should deal with PMTCT as a couple, have not been investigated.

II. Explaining the research question:

The data relating to PMTCT uptake by pregnant women at the Health Centre in Sabou perfectly confirm the above statement. As a matter of fact, statistics collected at the Sabou Health Centre for 2013 indicate that of the 908 pregnant women who were invited, 680, i.e. 75%, attended an HIV counselling and screening session. Fourteen of them were found to be HIV positive (2%), while none of the men of the HIV positive women attended an HIV counselling and screening session.

One of the essential components of the PMTCT that is often forgotten, but which proves that the male partner is absolutely necessary, is the prevention of sexual transmission of the HIV between the partners. One of the tasks of the post-test counsellor is to encourage the HIV negative women to protect themselves against becoming infected, and to warn the HIV positive women against re-infection with a new type of virus and to be particularly vigilant throughout their pregnancy and breastfeeding period. This guideline, which sounds simple in theory, poses serious problems when applied in practice. At the Sabou Health Centre, the available data on PMTCT indicate that couples run a higher risk of HIV transmission when an infected woman has a partner whose HIV status is unknown.

For a closer examination of this problem, several factors need to be taken into account. These factors can be listed in two separate categories.

The first group concerns factors attributable to the woman and her family and friends. They include:

- The fear of the HIV positive woman of being stigmatised, discriminated against, and of being accused of infidelity if their HIV status is disclosed to her male partner or her family and friends;
- The community’s lack of comprehension of the fact that the partners need to share the information about their HIV status, particularly if the female partner is HIV positive;
- The community’s perception that the reproductive health services offered by the health system almost exclusively assist the women;
- The community’s perception that the use of condoms is not very important for a couple.

The second group concerns factors attributable to the medical staff and the specific services the Health Centre has to offer the community. These factors are:

- The small number of men involved in the PMTCT programme;
- The fact that during the counselling sessions, the medical staff don’t pay any attention to the role of the male partner in the PMTCT programme;
In order to increase the number of men participating in the PMTCT services in Sabou, the local authorities, in partnership with the GIZ and UNICEF, have implemented the following initiatives:

- Training laboratory technicians in HIV counselling, testing and communicating HIV positive test results;
- Training counsellors in HIV counselling;
- Regular deliveries of screening tests and lab equipment;
- Supervision of the activities;
- Starting an association for PLWHIV to assist with HIV prevention and to fight against stigmatisation and discrimination of patients;
- Opening a treatment facility for patients;
- Supplying the facility with ARVs;
- Training the staff to care for the patients;

One has to acknowledge that, despite the implementation of all the initiatives listed above, men are not making use of the PMTCT services. The principal reason is the fact that the solutions advocated in the past generally ignore the social and cultural issues which are raised by PMTCT.

If this phenomenon persists, the consequences could be that:

- the HIV infection is transmitted between partners and in the community;
- HIV-positive individuals who do not know their HIV status spread the virus;
- PMTCT services are rendered ineffective due to non-participation by the men. In that case, the HIV positive woman has to take her preventive medication in secret out of fear of being stigmatised or being accused of infidelity, without being able to ask her husband for support when she wants to adopt the appropriate nutritional practices for her child. This could further mean that the women neglect to take their ARV medication regularly, which in turn could lead to a higher infection rate among the children born of HIV-positive mothers;
- the increased number of AIDS cases among women and children will be an added burden on the Health System and a drain on its resources.

In order to resolve this complex problem, the GIZ, in partnership with the Faculty of Medicine, has carried out a study on the «factors limiting the participation of men in the PMTCT programme». For increased efficiency, a post-graduate student was asked to undertake this research project in the context of her thesis.
III. The practical aim and research questions:

The aim of the study is to collect the necessary information for a better understanding of the factors stopping men from participating in the PMTCT programme, so that the best strategies can be identified to achieve an effective involvement [of men] in the PMTCT programme.

In order to achieve this aim, this study has answered the following questions:

IV. General research question:

Why do men not participate in the prevention of mother-to-child transmission of the HIV infection?

V. Specific research questions:

1) What are the obstacles to the involvement of men in the PMTCT?
2) What is the perception of pregnant women, their men and health care staff members of the importance of the participation of men in the PMTCT programme?
3) What concrete recommendations should be made to bring about greater involvement of men in the PMTCT programme?
VI. Methodology:

6.1 Structure of the study:

The study was carried out in the urban community of Mamou, in the Health Centres of Sabou and Loppé. These two Health Centres are the only ones in the urban community of Mamou offering PMTCT services to the population.

The urban community of Mamou has 128,512 inhabitants, two voluntary HIV screening and testing centres, one screening and testing centre for combined TB/HIV infections, two PMTCT facilities, one patient care centre, one PLWHIV association and one youth counselling and orientation centre. Its main feature is the fact that it is a city at the crossroads with a great cultural and linguistic heterogenicity and a considerable migratory flux which explains the vulnerability of the population in this community to the spread of HIV.

6.2 Type of study:

The technique that was used in order to answer the research questions is known as a qualitative cross-sectional study in the form of a «research action» which entailed putting together focus groups chosen from among the pregnant women who use the Sabou and Loppé Health Centres on the one hand, and men whose wives live in the desert basin near the Sabou and Loppé Health Centres, on the other. This was complemented by a number of in-depth interviews with health care staff members of the one hand, and members of the management in charge of the medical facilities in the health district of Mamou (the regional health authority, the regional hospital and the national health authority).

6.3 The targeted population:

The target population of the study is made up as follows:

- Pregnant women who use the Sabou and Loppé Health Centres for their pregnancy check-ups;
- Married men living in the Sabou and Loppé districts whose wives, like they themselves, are potential users of the Sabou and Loppé Health Centres;
- The Sabou and Loppé health care staff and their superiors, both at the regional and national level.

6.4 Sampling:

The pregnant women were recruited at the Health Centres and their men at home, with the help of managers and directors of the Sabou and Loppé Health Centres.

Ten focus groups of 8 to 12 subjects each were recruited, of which five consisted of pregnant women and the other five of men. Two out of the ten focus groups had initially been intended for preliminary equipment testing, but due to the quality of the collected information, the

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6 Fascicule de monitorage, centre de sante de Sabou, 2013
research team decided to integrate them into the data analysis. It was decided to stick to five focus groups per target, since no new information was obtained after the fifth focus group of each respective target.

The in-depth interviews were conducted with the same health care staff members who are normally responsible for offering the PMTCT services. They include the director of the Health Centre, the midwife or midwives, the laboratory technicians, as well as the HIV counsellors and the other staff members in charge of the PMTCT programme. Health authority managers at regional and prefectural level (DRS, DPS and their technical staff) also took part in semi-formal in-depth interviews.

6.5 Data collection technique:

The data were collected from the focus groups with the help of an interview guide containing open-ended questions suitable for the exploration of the specific research questions. Two people with previous experience in holding group discussions acted as focus group facilitators.

The first of the two was expected to facilitate the group discussion by asking open-ended questions, without interfering in the answers. He was supposed to generate a group dynamic by encouraging each participant to express his personal opinion on every subject under discussion and, if necessary, to ask questions in return. The idea was that everything the participants had to say was valued, no matter whether it was marginal or had the approval of the group.

The second facilitator was tasked with recording the discussions by using a dictaphone and by writing down his most striking observations during the group discussion: facial expressions, and even gestures of approval or disapproval of the remarks that were made.

Each group encounter lasted a maximum of one hour. The focus group meetings were held after office hours in the waiting room of the Health Centre. Considering the fact that a Health Centre waiting room is normally used as a meeting place for Health Centre clients, it was the perfect venue for this kind of discussion.

The group discussions were conducted in the local language (Pulaar) with a facilitator, who was fluent in that language.

To ensure that order was maintained during the focus group discussions, the following rules had to be followed:  

- The data collection guide had to be translated from French into Pulaar;
- The objectives of the study had to be explained to the participants before the start of each session;
- An informal agreement on the topics;
- Protection of anonymity;
- If they wish, participants are allowed to leave the group before the group discussion ends;
- Each participant is encouraged by the facilitator to express his opinions;

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7 SUSAN Dawson, LENORE Manderson and VERONICA L. Tallo, : The Focus group manual: methods for social research in tropical diseases, no. 1 (TDR/SER/MSR/92.1)
• The facilitator will not interfere with the opinions expressed by the participants during group discussions.

The in-depth interviews with the health care staff and their superiors were carried out with the help of a semi-structured interview guide.

Before the actual data collection, all the tools used for the collection were subjected to a preliminary test. This preliminary test allowed the researcher to evaluate the feasibility of the study and to correct the collection tools if necessary.

In order to facilitate the collection, the participants of the focus groups were offered a light meal and a reimbursement for their transport costs.

6.6 Analysis of the data:

The content of each group discussion was accurately re-transcribed from Pulaar into French. After that, the re-transcribed information for each group, each taget and each topic of discussion was read out in order to:

• identify the core ideas for each topic;
• reorganize related core ideas into a homogenous group;
• draw up a table showing the frequency of the homogenous groups;
• interpret and discuss the ideas that were reorganized into homogenous groups by using data from from existing research.

The purpose of this analysis is to assess the value of the opinions depending on whether they were frequently expressed or only rarely.

The content of the in-depth discussions conducted with the health care staff and their superiors was analysed as follows:

• The encoding of the expressed ideas;
• The reorganization of the expressed ideas into homogenous groups;
• The interpretation of the content of the expressed ideas;

The results have been organized in relation to the specific research questions. Furthermore, a triangulation was worked out between the data collected from the focus groups and those collected from the in-depth interviews.

The purpose of the data analysis was to check whether the answers given to each one of the specific research questions make it easier to answer the general question, which is: why do men not participate in the PMTCT?
VII. Results

Table I: Opinions expressed by health care staff and health authority directors on the reasons that stop men from participating in the PMTCT programme, September 2014

<table>
<thead>
<tr>
<th>Expressed opinions</th>
<th>Number of ideas expressed by the health care staff</th>
<th>Number of ideas expressed by the health authority directors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of being stigmatized by society</td>
<td>30</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Fear of family break-up</td>
<td>45</td>
<td>17</td>
<td>62</td>
</tr>
<tr>
<td>The needs of the men not taken into account in offering MCP care</td>
<td>17</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Ignorance about the disease due to lack of information</td>
<td>17</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Fear of breach of confidentiality</td>
<td>8</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Fear of feelings of guilt/being blamed by loved-ones</td>
<td>22</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Men feeling invulnerable by AIDS and other false beliefs linked to AIDS</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Denial of test results and the perception that AIDS is a shameful disease</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Getting men to prioritize health over their normal occupations</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>PMTCT services are difficult to access</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Table II: Opinions expressed by health care staff and health authority directors on the need for men to be involved in the PMTCT programme, September 2014

<table>
<thead>
<tr>
<th>Opinions expressed</th>
<th>Number of ideas expressed by the health care staff</th>
<th>Number of ideas expressed by the health service directors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A couple’s health concerns both partners</td>
<td>19</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>The need to avoid HIV transmission</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>The need to provide medical, nutritional and psychosocial care</td>
<td>7</td>
<td>8</td>
<td>15</td>
</tr>
</tbody>
</table>
Table III: Opinions expressed by health care staff and health authority directors regarding the necessary recommendations to get men to participate in the PMTCT programme, September 2014

<table>
<thead>
<tr>
<th>Opinions expressed</th>
<th>Number of ideas expressed by the health care staff</th>
<th>Number of ideas expressed by the health service directors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including the needs of the couple in the PMTCT programme (group counselling, sensitization that targets men, counselling for couples with their families)</td>
<td>26</td>
<td>9</td>
<td>35</td>
</tr>
<tr>
<td>Making the necessary input for the implementation of the PMTCT programme available</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Welcoming the men in a friendly manner and not keeping them too long</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Keeping HIV test results confidential</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Getting men to join a PMTCT support group</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Integrating persons living with HIV into the job circuit</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Using education and information in the fight against HIV</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Making the intentional transmission of HIV a punishable offence</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Establishing a partnership between government structures and private clinics to deal with the needs of men in the context of PMTCT</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Training the staff in PMTCT for couples</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Table IV: Frequency of the Opinions expressed by the participants of the focus groups on the reasons that stop men from participating in the PMTCT programme, September 2014

<table>
<thead>
<tr>
<th>Expressed Opinions</th>
<th>Focus women f1</th>
<th>f2</th>
<th>f3</th>
<th>f4</th>
<th>f5</th>
<th>Focus men f1</th>
<th>f2</th>
<th>f3</th>
<th>f4</th>
<th>f5</th>
<th>Average Number of ideas expressed</th>
<th>Total of ideas expressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The fear of being stigmatized and rejected by society and loved-ones</td>
<td>1 5 3 5 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 0 5 14 6</td>
<td>8/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>The fear of family breakdown</td>
<td>27 12 14 9 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 19 7 26 12</td>
<td>10/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>146</td>
</tr>
<tr>
<td>Not taking the needs of men into account in the design of PMTCT programmes</td>
<td>1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 1 0 1 0</td>
<td>8/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Ignorance about the disease and the available services due to lack of information</td>
<td>0 9 8 1 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 11 17 4 14</td>
<td>9/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>The fear of confidentiality breaches</td>
<td>4 3 6 8 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14 4 13 21 6</td>
<td>10/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>88</td>
</tr>
<tr>
<td>The fear of feelings of guilt/blame by loved-ones</td>
<td>6 10 6 12 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 8 0 8 15</td>
<td>9/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>79</td>
</tr>
<tr>
<td>Denial of test results and perception of AIDS as an imaginary disease</td>
<td>2 0 1 7 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 3 4 2 1</td>
<td>8/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Men not prioritizing health over their habitual occupations</td>
<td>0 7 7 2 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 1 0 2 2</td>
<td>8/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>The obligation to pay consultation fees</td>
<td>2 0 6 0 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 1 2 0 13</td>
<td>7/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>The preception that there is no medication that can cure AIDS</td>
<td>1 0 0 2 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 7 6 4 3</td>
<td>8/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>Unwelcoming reception, very long waiting times at the HCs, lack of trust in the effectiveness of the medication and reliability of the diagnosis.</td>
<td>0 1 1 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 3 1 5 5</td>
<td>7/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>The perception that a couple can no longer have</td>
<td>0 1 0 0 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 2 0 1 1</td>
<td>5/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>
children or live together when one of the partners is HIV positive.

Table V: Opinions expressed by the members of the focus groups on whether men should get involved in the PMTCT programme, September 2014

<table>
<thead>
<tr>
<th>Most important opinions expressed</th>
<th>Focus women</th>
<th>Focus men</th>
<th>Average ideas expressed</th>
<th>Total ideas expressed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f1  f2  f3  f4  f5</td>
<td>f1  f2  f3  f4  f5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The health of a couple concerns both partners</td>
<td>8   2   0   2   1</td>
<td>2   5   1   1   0</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Avoiding transmission of the HIV infection</td>
<td>3   0   0   4   0</td>
<td>2   1   4   6   3</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Providing medical, nutritional and psychosocial care</td>
<td>6   0   5   6   0</td>
<td>1   3   3   10  3</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>Avoid family breakdown</td>
<td>5   0   0   1   0</td>
<td>0   1   1   0   0</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>
Table VI: Opinions expressed by the focus group members on the necessary practical recommendations to encourage the participation by men in PMTCT, September 2014

<table>
<thead>
<tr>
<th>Opinions expressed</th>
<th>Focus femmes f1 f2 f3 f4 f5</th>
<th>Focus hommes f1 f2 f3 f4 f5</th>
<th>Moyenne idées émises</th>
<th>Total idées émises</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/communication from the community on the seriousness of the disease</td>
<td>10 4 8 7 8</td>
<td>9 9 11 13 7</td>
<td>10/10</td>
<td>86</td>
</tr>
<tr>
<td>Make the necessary input for the functioning of the PMTCT programme available</td>
<td>1 0 0 1 0</td>
<td>1 0 2 2 1</td>
<td>6/10</td>
<td>8</td>
</tr>
<tr>
<td>Welcome clients with empathy and do not keep them at the HC too long</td>
<td>1 1 0 3 0</td>
<td>2 0 1 3 7</td>
<td>7/10</td>
<td>18</td>
</tr>
<tr>
<td>Keep HIV test results confidential</td>
<td>1 1 0 3 0</td>
<td>4 1 1 3 1</td>
<td>8/10</td>
<td>17</td>
</tr>
<tr>
<td>Encourage dialogue between staff and the couples involved in the PMTCT</td>
<td>13 7 9 9 11</td>
<td>8 8 8 7 11</td>
<td>10/10</td>
<td>91</td>
</tr>
<tr>
<td>Men must be examined by male health care staff members</td>
<td>1 0 0 0 0</td>
<td>1 0 0 0</td>
<td>2/10</td>
<td>2</td>
</tr>
<tr>
<td>Fight stigmatisation and support patients living with HIV/AIDS</td>
<td>5 2 3 9 5</td>
<td>4 0 1 5 1</td>
<td>9/10</td>
<td>35</td>
</tr>
<tr>
<td>Avoid criticising clients in public at the HCs or in front of their families</td>
<td>0 1 1 0 1</td>
<td>0 0 0 2 0</td>
<td>4/10</td>
<td>5</td>
</tr>
<tr>
<td>Sufficient high quality medication needs to be kept in stock at the HCs to treat men</td>
<td>0 0 2 0 0</td>
<td>0 0 0 5 0</td>
<td>2/10</td>
<td>7</td>
</tr>
<tr>
<td>Refer cases which are too complex for the health care staff to a specialist</td>
<td>0 0 0 1 0</td>
<td>0 0 0 0 0</td>
<td>1/10</td>
<td>1</td>
</tr>
</tbody>
</table>


VIII Discussion:

The aim of this study was to identify the main reasons stopping men from participating in the Prevention of Mother-To-Child Transmission of HIV programme (PMTCT). The approach that was used is the evaluation of the perception – by means of group discussions with pregnant women and their men, combined with in-depth interviews with members of the health care staff and their superiors – of the reasons why men do not participate in the PMTCT programme. These different target groups are the principal actors in the PMTCT programme. Although the methodology which was used quickly yielded many answers to the question why men do not participate in the PMTCT programme in the urban community of Mamou, a repeat-study in other parts of Guinea would be helpful in showing to what extent the results that were obtained were influenced by the local setting in which the study was carried out.

Despite the progress that has been made in antiretroviral treatments in recent years, the results indicate that AIDS is a disease which frightens the population. Members of the health care staff, a group of pregnant women and their men put forward a combination of factors in trying to explain the disappointing level of participation by the men in the PMTCT programme. (Tables I and IV). As the WHO document on «Involving the male partner in the Prevention of Mother-To-Child Transmission of HIV» shows, these factors can be divided into three categories:

The first one of these categories includes factors relating to the level of information about HIV, as well as to discrimination and stigmatisation. They are:

- the fear of being stigmatised and rejected by society, friends and family;
- the fear of family breakdown;
- ignorance about the disease and the available services due to lack of information;
- the fear of a breach of confidentiality;
- the fear of feelings of guilt or of being rebuked by friends and family;
- the fear of being tested because might implicate one’s sexual practices;
- the perception that AIDS is an illness without a cure;
- denial of the test results and the perception that AIDS is a shameful and imaginary disease;
- reluctance of the wives to inform their husbands about their HIV positive status;
- the perception that, when one of the partners is HIV positive, the couple can no longer have children or live together;
- the conviction that sexual fidelity is sufficient to prevent any potential contamination with the HI virus;
- the fact that the men believe AIDS is a punishment from God;
- the perception that as long as there are no signs of illness, there is no need to be tested;

The second category includes the factors relating to the health care service. They are:

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8 World Health Organisation : Male involvement in the prevention of mother-to-child transmission of HIV, 2012 p.11
• unwelcoming reception by unfriendly staff, long waiting periods at the Health Centres and lack of trust in the effectiveness of the medication and the reliability of the diagnosis;
• having to pay consultation fees;
• not taking into account the needs of men in the design of the PMTCT programme.

The third category includes factors related to gender-specific behaviours. They are:

• the fact that for men, health is secondary to their normal occupations;
• what interests men most is making their wives procreate;
• the reticence of men against attending joint consultations with their wives, against discussing their private life at the Health Centre and being examined by women or by very young members of staff.

An analysis of the first group of factors indicates that the majority of reasons responsible for the non-participation of men in the PMTCT programme are related either to a lack of information, the fear of being made to feel guilty or being blamed by friends and family or of a breach of confidentiality.

The fear of stigmatisation and the danger of being rejected by family and by society, which the studies of Le Cœur S et al. identified as the reason for the non-participation by men in the PMTCT, was expressed by the majority of participants of both sexes in the focus groups, and equally and emphatically by the health professionals (tables I and IV). There are other studies confirming the fact that the stigmatisation and discrimination to which persons living with HIV are exposed, are a major reason for the non-utilisation of the PMTCT.10,11,12,13

The outcome of the study shows unequivocally that the members of the focus groups singled out stigmatisation as one of the main reasons for non-participation in the PMTCT, by men in general and particularly by couples. Statements like «they don’t come because they

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9 Le Cœur S et al 2009, «Gender and access to HIV testing and anti retroviral treatment in Thailand : Why do Women have more and earlier access ?», Soc sci Med, vol 69, Num 6, p. 846-853

feel ashamed; being HIV positive means their families will reject them» were made frequently.
The study participants equally emphasized how important it is to them that positive HIV test results be kept confidential. They stated that the fear of a possible confidentiality breach might make them stay away from the PMTCT, or, in case they test HIV positive, hide the result from their partner. According to the participants, such a confidentiality breach might well be be committed by a member of the health care staff, and the way this is reported sounds like a call to order: «some of the doctors here need to guard their tongue; it’s the doctors who disclose to third parties that such-and-such is this or that». It was quite common to hear remarks like «if I come to the hospital for the test, the doctor will tell his next patient that the patient he’s just seen has tested positive. The doctors need to keep their mouths shut if they really want to help us». Other subjects said, when questioned, that such a breach of confidentiality can also come from the immediate family and friends of the HIV positive person: «the men don’t want their wives to know because some of them gossip too much. They will tell everybody». The fear of a breach of confidentiality is also highlighted by Sarah Castle et al\textsuperscript{14} in their study on «How to encourage men to participate in the HIV/AIDS prevention and screening services: evaluation of the approach Men as Partners in Ivory Coast in 2013».

The outcome of this study indicates that AIDS is very often associated with risky sexual practices which are incompatible with the socially acceptable sexuality of a couple. This state of affairs means that not only the men, but also the women, are often afraid of being blamed by their family and friends when they find out that they are HIV positive. The majority of the focus group members stated that «people are ashamed of getting tested for HIV because its by going to bars that one can get infected with AIDS». Several times, we have heard statements which prove that the men are afraid of getting tested for HIV because they might be blamed and victimized if they test HIV positive. «There are women who go outside – if they know their husband is infected – clapping their hands and telling everybody my husband has got AIDS. They will ask for a divorce on the grounds that the husband has AIDS, and they will claim their husband has been straying and now he has AIDS». Furthermore, being HIV positive is considered as a disgrace and a blemish on a person’s honour and prestige «and nobody will say he is such a great man who has practiced debauchery and has now got the disease».

One reason for the non-utilization of the PMTCT by men and even by couples which was observed again and again in the outcome of the study, no matter who was the respondent, is the fear of a family breakup when one of the partners is HIV positive. This phenomenon was

\textsuperscript{14} Sarah Castle et al.: «How to encourage men to participate in the HIV/AIDS prevention and screening
also observed in the study of Bor R\textsuperscript{15}, Gaillard P et al\textsuperscript{16}, de Paoli MM Manongi R et al\textsuperscript{17}, Kilewo C et al\textsuperscript{18}, Medley A et al.\textsuperscript{19}

According to the outcome of this study, being HIV positive is considered as incompatible with living as a couple «they are aware that AIDS is a serious illness, if people hear that a man is infected, he won’t be able to take a wife, he will be left without any woman at all. Certain men are afraid of that happening to them». Fear of divorce is also mentioned as a reason why HIV positive women try to hide their status from their men, even though they know that they run the risk of transmitting the HI virus to their husband. «They are afraid of losing their home because some of them have already had children, but they will still infect their husbands if they are not open with them».

Ignorance about the disease, as well as the available services to treat it, was equally mentioned as a crucial reason for the non-utilisation of PMTCT by the men, and this was also highlighted by Reece M, Hollub A et al.\textsuperscript{20} Ignorance about the disease can even include its denial «certain men are unsure whether AIDS actually exists. They think that it’s a lie, that it doesn’t exist». The denial of the disease is more pronounced in the case of a positive test result without clinical manifestations of the disease «They said I have it, but that’s not true. The person who said this to me only did so because I have a healthy appetite; I do my job to my satisfaction, so I cannot have that disease».

The outcome of the study indicates that the men would be much more inclined to make use of the PMTCT programme if they were better, or even sufficiently informed. «It must be the men’s ignorance that makes them neglect the PMTCT services, because if you are sufficiently informed, you’ve understood, you’ll keep that in mind and you’ll know if it’s true or not. If you are the head of a family, you have a wife, and if only the woman gets treated, you know that the disease will not leave the family».

\textsuperscript{15} Bor R. Disclosure. AIDS Care, 1997,9(1):49-53


\textsuperscript{17} De Paoli MM, Manongi R, Klepp KL. Factors influencing acceptability of voluntary counselling and HIV-testing among pregnant women in Northern Tanzania, AIDS Care, 2004a, 16 (4):


Sometimes a combination of factors is mentioned to explain the non-utilization of the PMTCT services by the men. «People are not informed, and in addition, the fact that you hear gossip the street about those who have taken the HIV test means the men stay away from the Health Centre».

Sexual fidelity between two partners is often seen as a very valuable social norm that will help protect couples against HIV. This opinion was stated especially emphatically by the women when trying to explain why a man will refuse to take the HIV test when he knows his wife is faithful to him. «Certain men don’t come because they trust their wives, but also because they feel healthy».

One possible reason for the reticence of couples against using PMTCT services is the fear that they won’t be able to have more children if one or both of the partners test HIV positive.

The majority of men and a smaller number of women are of the opinion that if one of the partners is HIV positive, they can no longer procreate «if the man is HIV negative and the woman is positive, the couple can go to the hospital and ask for condoms, if he loves his wife and does not want to leave her, they can use condoms during sexual intercourse whenever they want. But the trust between the partners and having children, that’s over».

The second group of factors that stop the couple from using PMTCT, we have listed the factors attributable to the health care facilities.

The results of this study are in agreement with what has been shown by other authors: BARRY I, BARRY I.S indicate that the unfriendly manner in which patients are received is a factor that stops men from making use of the health services in general and the PMTCT in particular. The majority of men confirm that the kind of reception they get at the Health Centre depends on the social status of the client. If the health care professionals think they are dealing with a wealthy individual, he is well received, and the rest receive no consideration whatsoever «when you arrive at the reception, they first check you out before they greet you. If you look like you have money, or if you have even come by car, they will look after you quickly and well by comparison with those who have arrived on foot. They will usually say hello Sir, come over here, please, and take a seat and the rest go over there and wait».

In our study, the men have talked about the negative attitude displayed by the health care staff in their area «I don’t feel that the staff at the Health Centre is very welcoming. When you are accompanying your wife, they tell you to leave. On the maternity ward, for example, men are not allowed in, one has to wait outside. And despite the fact that the delivery itself is free of charge, they give you a prescription and they insist that you buy the items right there. If you have no money, they just ignore you. This is really what’s wrong with our health service. If you have no money, they don’t even look at you, they have no idea how to welcome their

21 BARRY I, BARRY I.S: Perception des communautés sur la qualité des prestations offertes dans les structures de santé de la sous-préfecture de Maféryingah, Mémoire pour l’obtention du diplôme d’université en Santé publique et communautaire, Université de Nancy, France, 1999
clients. For example, if you come with your wife, they ask you to leave by saying that men are not allowed here». This hostile and exclusionary attitude that men are experiencing was also mentioned in the study by Theuring et al 2009.22

The fact that they are not allowed to be present during their wife’s consultation is even more difficult to tolerate for the men since at the end of the consultation, the health care staff are not prepared to give the husband any information about his wife’s test results. «The unwelcoming reception and the fact that the health care staff does not inform husbands about the outcome of their wives’ consultation - despite the fact that husbands are not allowed to attend – are all factors limiting the participation of men in the PMTCT programme».

The extreme youth of the health care staff members is sometimes also cited as a reason why men are so reticent about making use of the Health Centre, particularly for a health problem as sensitive as HIV. «When a man goes to the Health Centre, he is frequently seen by very young staff members; too young, in fact, to make a man want to confide in them about his health problem».

Lack of trust in the quality of the medication is also frequently given as a reason why men refrain from using the PMTCT services «I have health insurance, so when we go to the Health Centre and are given medication that doesn’t cure us, it is a concern for us». The clients at the Health Centres, particularly the men, tend to think that the prescriptions they are given at the Health Centres are always more or less the same, irrespective of the diagnosis. They say things like «whether you have typhoid or malaria, you get the same medicine, no wonder it doesn’t work».

The outcome of this study shows that the treatments offered by the PMTCT are not conducive to making men more willing to get involved in the PMTCT programme. According to the WHO, one of the reasons why the PMTCT treatments on offer do not adequately fulfill the needs of the men is the fact that they are mostly focused on the women, since only an HIV infected mother can be the causative factor in the vertical transmission of the HI virus to an infant. [7] (Involving men in infection prevention).

According to Betancourt et al. 2010 23-24 Njeru et al 2011, the focus of the PMTCT on the women is not taking into account the fact that they are partners in a relationship, a family and a community, while discouraging a more global view of family health, including that of the men.

The majority of women confirm that PMTCT is primarily their prerogative «it doesn’t concern the men since they don’t carry the baby in their belly». This way of looking at the PMTCT programme also means that screening tests are predominantly offered to the women and even in the case where men are offered HIV testing, such an offer take place in specific circumstances, without participation of the other partner. According to several authors, this neither helps communication on the topic of HIV nor on one’s personal HIV status, nor the adoption of preventive behaviours between the partners (Desgrées-du-Loû et Orne-Gliemann 2008). 25

A large number of men and women also mentioned the fear of having to pay fees at every consultation as a reason for the reticence of men against attending consultations at the Health Centre.

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23 Betancourt TS et al. Family-centered approaches to the prevention of mother to child transmission of HIV. Journal of the international AIDS Society,2010, 13(suppl.2):S2

24 Nejrou MK et al. Practicing provider initiated HIV testing in high prevalence settings: consent concerns and missed preventive opportunities. BMC Health Services research, 2011, 11:87


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«Most of the time, the men are afraid of coming for fear of being asked to pay a lot of money». Generally speaking, services relating to the treatment of HIV at Guinean health facilities are free of charge. In this particular case, one cannot be sure whether the participants of this study are referring to an illegitimate charge which the health care staff is asking them to pay, or whether, due to lack of information, they just believe the PMTCT services rendered by the health care staff have to be paid for, although they are normally free.

The third category contains the factors related to gender-specific norms responsible for the men’s non-participation in the PMTCT programme.

In the opinion of the majority of participants, the man as head of the family sees his primary occupation as having to provide food for his family. The fact that in terms of social conventions the man plays the role of head of the family means, that any health problems the family members might have are given secondary importance. Other authors are in agreement with this and have cited this as a reason for the disappointing level of participation in the PMTCT programmes by men [13] (Encouraging men to make use of HIV prevention and screening services «Men as Partners» in Ivory Coast).

It might be due to poverty that in our study we have observed several expressions relating to the low level of importance that men attach to health as opposed to the need to feed their families. «Men do not attend the Health Centre due to lack of means. They send their wives to the Health Centre so that they can get on with their daily tasks. If they don’t go out every day, they have nothing to live on the next day».

A minority of women think that men do not use the PMTCT services because they are convinced their main role in the relationship is to procreate «if they make you pregnant, their problem is solved». We have equally observed that a small number of women believe that men do not attend the PMTCT because they do not want to be examined by a woman. «In the Health Centres, most of the members of the health care staff are women. If Wahabi men come to the Health Centre, for example, they would rather discuss confidential issues of their private lives with a man than with a woman, and their wives dislike being examined by men».

In our study, despite the large number of factors that were brought up as reasons for the non-participation of the men in the PMTCT programme, the majority of both men and women in the focus groups and nearly all the health care staff members that were interviewed realized that regarding the PMTCT, the women only constitute one side of the equation, and that it is important for the men get involved in PMTCT because:

- a couple is jointly responsible for the health of both partners;
- it helps to prevent the transmission of HIV;
- it facilitates the administration of medical, nutritional and psychosocial interventions;
- it helps to prevent family breakdown (tables II and V)

The fact that both men and women are seeing PMTCT in such a positive light runs counter to the available statistics on the participation levels of men in the PMTCT programme in the urban community of Mamou. The statistics of the Sabou Health centre for 2013 show that of the 908 pregnant women who were expected, only 680, which means 75%, attended one of the HIV counselling and screening sessions. Out of that number, 14, which mean 2%, were
diagnosed as HIV positive, while not a single male partner of any of the HIV positive women made use of an HIV counselling and screening session.

The impact of the involvement of men on the different components of the PMTCT programmes has been studied very extensively (Falnes et al 2011). A woman’s risk of being infected with HIV depends just as much on the man (Msuya et al 2006b) as the prevention of the infection when the couple uses condoms (Farquhar et al 2004); (Desgrées-du-Loû et al 2009b).

The man equally plays a role when the woman makes use of the services, including the HIV screening test (Maman et al 2001); Baiden et al 2005; Banjunirwe et Muzoora 2005; Peltzer et al 2008) and when she receives the test results Peltzer et al 2008. [32]


Msuya SE et al. HIV among pregnant women in Moshi Tanzania: the role of sexual behavior, male partner characteristics and sexually transmitted infections. *AIDS Research and Therapy*, 2006b,3: 27


Peltzer K et al. Follow-up survey of women who have undergone a prevention of mother to child transmission program in a resource-poor setting in South Africa. *Journal of the Association*
The participants of this study, as is shown in tables III and VI, have made recommendations, suggesting what might be done in order to persuade the men to participate in the PMTCT programme. The bulk of the recommendations correspond to the reasons that were identified as being responsible for the disappointing participation levels of the men in the PMTCT programme. The most relevant recommendations that were made are the following:

- The need to inform and sensitize the community about the seriousness of the disease, the relevance of PMTCT and the active role of the man should play in it;
- The need to reinforce the dialogue between the health care staff and the couples involved in the PMTCT;
- The need to continue the battle against stigmatisation and the support for persons living with HIV;
- The need to keep HIV test results confidential;
- The need to improve the quality of the reception and care;
- The need to make the necessary input for the functioning of the PMTCT services available.

Regarding the need to inform and sensitize the community, most of the study participants feel that this should be fulfilled by all the main social actors taken together: religious leaders, elected local representatives and health care staff and that this should reach as many members of the public as possible. The participants have stressed the necessity to upgrade the content of educational messages concerning AIDS by highlighting the effectiveness of the treatments available today, the taboos and the myths about the disease and the overarching necessity to refrain from ostracizing and stigmatising those who are sick. «The health authorities need to work out practicable decentralised HIV sensitization programmes for the population and stress the fact that patients with HIV must not be stigmatized and ostracized. It’s because of this fear that many stay away from the counselling and screening centres».

In order to stress how serious they are about the fight against the stigmatisation of patients suffering from HIV/AIDS, a large number of participants feel that that sort of conduct should be made a punishable offence. «The health authority staff should fine people who gossip about someone else’s illness or makes fun of such a person, or the population should boycott ceremonies organised by people who have shown themselves culpable of stigmatisation or rejection of individuals living with HIV».

The majority of the participants of our study recognized that constructive dialogue between the partners is indispensable, since even if only one of them has tested HIV positive, prevention and treatment of the infection concerns them both. This dialogue has to include not only the couple but also the health care staff. «They need to talk to each other at home so they know what precautions to take in order to prevent the disease from being transmitted to others. They need to go to the hospital and get medication for their treatment. Equally, if they want to have a child that is free of HIV/AIDS they need to go to the hospital». The dialogue needs to take place in an environment conducive to the absolute protection of confidentiality «when you go to get tested and you find out you are HIV positive, the doctors need to keep their mouths shut». Certain participants proposed an extremely effective method to get the husbands to participate in PMTCT. «The men who do not come to the
Health Centre with their wives should be called in and their wives should be kept at the Health Centre until their husband responds».

One of the most significant recommendations made by the participants concerns the way people are received at the Health Centres «if you are well received in a place, you will find it easy to go back there another day». Some of the recommendations in this regard were specifically aimed at the men, like for example «the men must not be kept at the Health Centre for too long» or to «speed up the consultation for the women who have come to the Health Centre with their partners». Equally, some of the participants have recommended that the counselling for men should be done by men.

The health care staff stressed the need to change the institutional approach of the PMTCT which is currently mainly focused on the woman to the detriment of the man, despite the fact that his participation is crucial if the PMTCT is supposed to be effective. The health care staff made the recommendation that the needs of both partners must be integrated into the PMTCT activity packs. This means:

- Organising a PMTCT support group for the men;
- Making any intentional transmission of the HI virus a punishable offence;
VIII. Conclusion:

The goal of his study was to identify the reasons for the non-participation of men in the prevention of mother-to-child transmission of HIV (PMTCT). The results indicate that there are multiple factors limiting the participation of men in the PMTCT programme. Three categories of factors have been identified as being responsible for the disappointing level of participation of the men in the PMTCT programme. The first group of factors concerns issues such as the lack of information about the disease in general, and the PMTCT in particular, among the men, their fear of stigmatisation and rejection, combined with their fear of a breach of confidentiality and of being blamed, all of which are occurrences HIV positive individuals allegedly have to deal with. The second category comprises factors that can be attributed to the health care institutions, including such issues as poor treatment quality and more especially the unfriendly reception of the men and their institutional exclusion from the PMTCT programme. The third group of factors that stop from participating in the PMTCT programmes are gender-specific.

In order to encourage the men to get involved, the participants of the study propose:

- to inform and sensitise the community about the seriousness of the disease, the importance of PMTCT and the need for the man to take an active role in this programme;
- to promote the dialogue between the health care staff and the couples that are involved in the PMTCT;
- to fight stigmatisation and support persons living with HIV;
- to ensure HIV test results are kept confidential;
- to improve the reception at the Health Centre and the quality of the treatments;
- to provide the necessary input to ensure the PMTCT programme functions smoothly;
- to train professionals in the couple-centred PMTCT programme.

The details of these recommendations and how to implement them will form the subject of an operational action plan worked out by all parties that have been involved in this study.
IX. Practical recommendations:

Most of the recommendations that were made correspond directly to the reasons the participants identified for the non-participation of the men in the PMTCT programme. The most important of these are listed below:

9.1. Informing and sensitizing the community about the seriousness of the disease, the importance of the PMTCT programme and the need for the man to take an active role in it;

9.2. Promoting dialogue between health care staff and the couples involved in the PMTCT programme;

9.3. Fighting stigmatisation and supporting persons living with HIV;

9.4. Ensuring HIV test results are kept confidential;

9.5. Improving the reception and the quality of the treatments.
Bibliography:

1. Rapport mondial sur l’épidémie du VIH, ONUSIDA, 2012, P1

2. Prévalence du VIH et facteurs associés : Enquête Démographique et de Santé à Indicateurs Multiples (EDSMICS); Institut National de la Statistique, Ministère du Plan, Conakry, Guinée : MEASURE DHS, ICF International, calverton, Maryland USA, 2012

3. DIALLO Adoulaye Mairie et all: Rapport de l’enquête Nationale de surveillance sentinelle du VIH et de la syphilis chez les femmes enceintes ; Coopération allemande pour le développement, GTZ, 2008

4. European collaborative study, institut de santé Publique, d’épidémiologie et de développement, Université Victor Segalen-Bordeaux France, 2005, P4

5. Rapport d’activité de la PMTCT du centre de santé de Sabou, commune urbaine de Mamou, ANNE 2013

6. Fascicule de monitorage, centre de santé de Sabou, 2013

7. SUSAN Dawson, LENORE Manderson et VERONICA L. Tallo,: Le manuel des Groupes Focaux :Méthodes de Recherche en sciences sociales sur les maladies tropicales N°1 (TDR/SER/MSR/92.1)


15Bor R. Disclosure. AIDS Care, 199, 9(1):49-53


21BARRY I, BARRY I.S: Perception des communautés sur la qualité des prestations offertes dans les structures de santé de la sous-préfecture de Maférynjah, Mémoire pour l’obtention du diplôme d’université en Santé publique et communautaire, Université de Nancy, France, 1999


23Betancourt TS et al. Family-centered approaches to the prevention of mother to child transmission of HIV. Journal of the international AIDS Society, 2010, 13(suppl.2):S2

24Nejrou MK et al. Practicing provider initiated HIV testing in high prevalence settings: consent concerns and missed preventive opportunities. BMC Health Services research, 2011, 11: 87


27Msuya SE et al. HIV among pregnant women in Moshi Tanzania: the role of sexual behavior, male partner characteristics and sexually transmitted infections. AIDS Research and Therapy, 2006b, 3: 27

29 Desgrees-du-Lou A et al. From prenatal HIV testing of the mother to prevention of sexual HIV transmission within the couple. *Social Science and Medicine, 2009b, 69:892–899*

30 Maman S et al. Women’s barriers to HIV- testing and disclosure: challenges for HIV-1 voluntary counselling and testing. *AIDS Care, 2001, 12: 595-603*

31 Baiden F et al. Voluntary counseling and HIV testing for pregnant women in the Kassena-Nankana district of northern Ghana: is couple counseling the way forward? *AIDS Care, 2005, 17:648–657*

32 Bajunirwe F, Muzoora M. Barriers to the implementation of programs for the prevention of mother to child transmission of HIV: a cross sectional survey in rural and urban Uganda. *AIDS Research and Therapy, 2005, 2:10.*

33 Peltzer K et al. Follow-up survey of women who have undergone a prevention of mother to child transmission program in a resource-poor setting in South Africa. *Journal of the Association of Nurses in AIDS Care, 2008, 19:450–460*