



PMTCT: ADDRESSING THE NEEDS OF WOMEN AND THEIR PARTNERS TO IMPROVE SERVICES

Background

Globally, HIV is the leading cause of death and disease among women of reproductive age, responsible for 42,000-62,000 maternal deaths in 2009 (WHO 2009). HIV-positive pregnancies cause the majority of the estimated 1,800 new HIV infections among children each day. WHO estimates that prevention of mother-to-child transmission (PMTCT) services can reduce the risk of transmission of HIV from a positive mother to her infant from 45-15% to just 5%. Integrating gender considerations into PMTCT services can help improve their quality, efficiency, and impact. This brief discusses gender issues to consider in efforts to improve PMTCT services and assure HIV-free survival of infants born to HIV-positive women.

The PMTCT cascade includes testing and counseling, clinic visits, and, depending on the HIV status of mother and child, antiretroviral therapy (ART) and feeding regimens that require strict adherence from early pregnancy through the child's infancy. Understanding gender roles in a community reveals issues and gaps affecting access and utilization of care by pregnant women and also how men can facilitate and support access and adherence to PMTCT programs. Conversely, men may also pose

Gender issues in PMTCT services:

- Negative social attitudes towards HIV-positive pregnant women
- Lack of male involvement
- Gender-based violence

significant barriers to the successful prevention HIV transmission to his child and to interventions that prevent maternal mortality. We cannot improve the quality and outcomes of PMTCT services without considering gender gaps and roles in the household and community and the roles of men as fathers, husbands and sexual partners.

Gender Issues to Consider in PMTCT Services

Social attitudes towards HIV-positive pregnant women

Providers and implementers must consider gender-based barriers pregnant women face in accessing and utilizing PMTCT services, including negative social attitudes toward women with HIV (see Box 1). In some communities women with HIV face significant stigma and isolation. At the household level, a woman's fear of divorce, abandonment or

abuse from her husband upon his knowledge of her HIV status may prevent her from seeking services.

For example, a clinical nurse in Kenya interviewed by the Integrated Regional Information Network (IRIN) news service of the UN Office for the Coordination of Humanitarian affairs reported that some women will stop returning to the clinic once providers mention inviting their partner and this even causes some with positive status to avoid birth at facilities for fear their status will be revealed in front of their partner.

Male involvement

WHO identifies the inclusion of men in PMTCT services as a key priority based on extensive evidence that male involvement improves access and retention in services and adherence to feeding regimens. For example, a sixteen-year prospective cohort study in Nairobi, Kenya found that male involvement reduced the combined risk of HIV infection and infant mortality by 44% compared to the birth outcomes of those born from mothers who received care alone (Alusio et al. 2011. JAIDS 56(1):76-82). In some societies and households, men make all decisions regarding health care, thus a women's access to and utilization of PMTCT services relies on her husband or partner's values and

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Couple receiving PMTCT services at Morogoro Clinic in Tanzania. Photo: Taroub Faramand, WI-HER, USAID Applying Sciences to Strengthen and Improve Systems Project

testing with their husbands had better retention in services throughout the PMTCT cascade (Theuring et al. 2009 AIDS Behav 13:S92-S102). A 2010 survey of over 10,000 women in rural Uganda found male decision-making was one of the most widely cited reasons for not attending PMTCT appointments (Alusio et al. 2011). In an antenatal clinic in Nairobi, among 2104 women testing for HIV, the women who came with partners were three times more likely to return for Nevirapine and to report receiving Nevirapine at delivery than women who attended alone. Furthermore, medication adherence was 88% among those who had couples testing, 67% among those where men were present but did not test, and only 45% among women who came alone (Farquhar et al. 2004 JAIDS 37(5):1620-1626).

perceptions of services. Men that are educated, empowered and involved in the process may be more likely to facilitate access and utilization of care by their wives or partners.

Involving men in PMTCT also capitalizes on an opportunity to test and counsel men for HIV. This addresses a gender gap in male access to HIV testing and services based on a common misperception in many African societies that HIV and reproductive health are “women’s issues.” The negative consequences of “feminizing” HIV have been shown to include fewer men tested and HIV-positive men beginning treatment at a later stage of infection, leading to higher morbidity and mortality. Not making HIV counseling and testing readily available to male partners of pregnant women is a missed opportunity to reach more men.

Men contribute half of the risk of HIV transmission to newborns and have the same natural responsibilities as women in protecting partners and children from transmission. Furthermore, couples counseling

has been shown to increase spousal communication on prevention and sexual negotiation. In some situations, joint testing and counseling may help overcome a woman’s fears of her partner learning her status. Studies found that women who underwent couple’s voluntary

Some of the most significant improvement outcomes from male involvement occur in infant feeding and infant health outcomes. A study in Tanzania found that among women prescribed exclusive breastfeeding regimens, adherence was 64% among those whose partners participated in PMTCT compared

Box 1. Examples of negative social attitudes faced by women with HIV regarding pregnancy

- Stigma of not having children:
 - Society does not see me as a woman
 - There is no one to look after me when I am ill or old
 - People say I am useless because I have not had children
 - If you have no children your partner leaves you
 - Pressure from relatives to have children
 - My name is not used to name a relative’s child for fear that my childlessness will be passed on
- Stigma of wanting to have or having children:
 - If a woman is HIV-positive she cannot bear children
 - She will miscarry or it will be stillborn
 - People with HIV who have children are selfish
 - Children will be orphans when the parents die

Source: WHO 2009 Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women’s needs. Accessed at: http://www.who.int/gender/documents/gender_hiv/en/index.html

to only 28% among those whose partners did not participate (WHO 2012). Along with facilitating access, including men has been seen to overcome stigma or discrimination against women from other members of the community when women are prescribed non-traditional feeding regimens. Similarly, a study in Kenya found significantly lower HIV acquisition and mortality among infants whose fathers participated in PMTCT services (WHO 2012).

First, do no harm

While many country teams are already aiming to increase male involvement in PMTCT, it is critical that these activities do not result in physical, sexual, emotional or economic abuse of women. Unfortunately, revealing a woman or man's positive HIV status to his or her partner can lead to violence in the relationship, most often perpetrated by the male on the female partner. Even when partners do not come to testing and counseling together, breaches in protecting patient testing results can lead to harmful consequences. One study conducted in Tanzania found that only 64% of women who tested positive for HIV chose to inform their husband; 52% of which attributed this to fear of abuse or abandonment (Maman et al. 2001 Population Council). If male attendance at clinical services is strongly enforced without regard for the possible negative consequences, women may be deterred from seeking PMTCT and antenatal care out of fear and avoidance of violence from their partners.

Considerations for Integrating Gender into PMTCT Services

If upon design and assessment of your program you find gender-related issues with stigma, lack of male involvement or gender-based violence, consider taking some of the steps suggested. A list of tools and manuals to address these issues is provided on page 4.



Father, mother and infant receiving PMTCT services at Morogoro Clinic in Tanzania. *Photo: Taroub Faramand, WI-HER, USAID Applying Sciences to Strengthen and Improve Systems Project*

1. Assess local and cultural practices related to men, women, violence, maternal health, and HIV

- Who makes decisions about women's and infant's care? (Also consider mothers-in-law or extended family members)
- Do women typically come to the clinic alone or with their husbands or partners?
- Is intimate partner violence common in the community? Is use of force seen as a justified way for a man to "correct" or "educate" a woman? Are there cases of abandonment of woman for positive HIV status?
- What is the community understanding of HIV in general? Is there stigma related to HIV in the community, including associated myths or discriminatory practices?
- What are health workers' attitudes towards pregnant women with HIV?

2. Create gender-sensitive and respectful clinical environments

- Train health care workers on respectful care
- Establish rules, monitoring systems, and patient-reporting mechanisms to ensure health worker accountability for respecting all patients

3. Cultivate an ethic of a shared male and female responsibility for the health and safety of mothers and children in the community

- Address negative social attitudes towards pregnant women with HIV through community sensitization
- Enlist male leaders of faith-based and community groups to serve as role models. For example, in Tanzania, health workers sent letters to church leadership with suggested text for church announcements encouraging men to promote family health

- Organize community events and develop publicity materials, like radio messaging, that promote a culture against gender-based-violence and encourage men to support women in taking care of their health
- Challenge the belief that antenatal care and reproductive health are “women’s issues” by educating men about transmission and prevention
- Consider alternative and expanded working clinic hours when and if feasible to make PMTCT services more accommodating for male involvement
- Consider (in the context of the local community preferences) whether female, male or both gender counselors can be available for couples testing
- Organize the space to allow appropriate privacy for women and men getting counseled
- Ensure privacy and confidentiality of anything discussed at clinic visits and of all test results
- Approach questions about violence in a non-isolating and open manner (“Some women experience...”) and do not push a woman to respond
- If you suspect a woman may be suffering from violence at home and is not ready to discuss it, provide a list of resources and always tell the client you are there if and when she decides she needs to talk about this issue

4. Ensure that on a case-by-case basis, women make the informed decision whether or not to include men in PMTCT. Take steps to prevent gender-based violence associated with HIV testing:

- Whenever it is possible, try to speak in private with the woman first, go over the counseling and testing process, and seek permission to send an invitation to her husband or partner to attend partner HIV testing. The 2009 WHO manual Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women’s needs provides tools for providers, including questions to ask to assess for potential violence and help women make the safest personal decision about partner involvement. Male involvement is only an option when it will improve outcomes safely.

Resources to learn more

Bott S, Guedes A, Claramunt MC, Guezmes A. 2010. Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries. New York: International Planned Parenthood Federation. Available at: http://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf. *This manual is based on experiences in the Caribbean and Latin America and provides tested strategies, policies, and evaluation plans for health care managers and organizations to integrate responses to gender-based violence into health care.*

Bowser D , Hill K. 2010. Exploring Evidence for Disrespect and Abuse in Facility-Based Child birth: Report of a Landscape Analysis. USAID-TRAction Project. Harvard School of Public Health, University Research Co., LLC. Available at: <http://www.tractionproject.org/sites/default/files/upload/RFA/Respectful%20Care%20at%20Birth%209-20-101%20Final.pdf>. *This report is a comprehensive overview of categories of disrespect and abuse in childbirth and contributors to disrespect and abuse including the stigma surrounding mothers with HIV. Some categories of abuse experienced by HIV- positive women are non-confidentiality and privacy of care, and discrimination by service providers including refusal of services. Pages 20-24 summarize issues in non-respectful maternal and child health care among providers and in service delivery and describe some drivers for these issues. Table 2 on page 28-35 provides a listing of tools and interventions for providers and program managers to consider and adopt according to program needs and local contexts.*

World Health Organization. 2012. Male involvement in the prevention of mother-to-child transmission of HIV. Available at: <http://www.who.int/reproductivehealth/publications/rtis/9789241503679/en/index.html>. *This report includes a review of the literature on the level and nature of and opportunities for male involvement in PMTCT with a focus on sub-Saharan Africa. The report documents barriers and facilitators for male involvement. It dissects the gap between men’s positive attitudes towards involvement and the low rates of engagement. The report provides promising strategies to encourage engagement and identifies areas for further research.*

World Health Organization. 2009. Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women’s needs. Available at: http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf. Available at: http://www.who.int/gender/documents/gender_hiv_guidelines_en.pdf. *This tool focuses on interventions to address gender inequalities and systemically mainstream gender into HIV care, including testing, counseling, PMTCT, treatment, and home-based care. It draws from tools and experiences of several organizations and governments and was field tested in Tanzania and Sudan. It maintains several job aids, checklists, and guiding documents.*